Marketing Health Services

FOURTH EDITION

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PREFACE TO THE FOURTH EDITION

Since the publication of the third edition of *Marketing Health Services* five years ago, the world of healthcare has changed significantly—and with it, the practice of healthcare marketing. At that time, healthcare had just entered the era of the Affordable Care Act (ACA), the most significant healthcare reform in decades. Since then, the healthcare arena has seen the emergence of value-based reimbursement, with all that implies. Simultaneously, population health management has come to the fore, with its emphasis on community health rather than individual patient care. All of these developments have served to turn the healthcare system on its head.

At the same time, the role of marketing has changed in response, demonstrating once again its indispensability during the uncertain times between the implementation of new rules and processes and the rush to adopt compliant strategies and adjust existing practices. In each case, the paradigm shifts in healthcare marketing have offered an opportunity to adapt to a changing environment.

This book, like the first three editions, enumerates the forces that are changing the healthcare environment and challenging the healthcare establishment. It chronicles the evolution of healthcare marketing—from a field purely associated with advertising and promotion to one that counts research, education, and strategy formulation as major responsibilities.

Since the 1970s when marketing was first introduced into healthcare, the field has gone through a series of highs and lows. The acceptance of marketing as a legitimate activity by healthcare organizations in the 1980s represented a milestone. At that time, healthcare organizations began to establish marketing departments, set marketing budgets, create new positions dedicated to marketing functions, and adopt marketing concepts and methods from other industries while realizing that the marketing of healthcare was much different from the marketing of other goods and services.

Through the 1990s and 2000s, healthcare marketing continued to prove itself a legitimate organizational function. More full-service marketing departments were being established in-house, and a cadre of professional marketers was elevated to the board room as partners in administration.

Sophisticated and healthcare-specific marketing techniques were developed and implemented. This proliferation of marketers dedicated to the business of healthcare imparted several lessons that still resonate today. First, marketing is so much broader than mass media advertising. Second, understanding the market in which the business operates, the customers who live in that market area, and those customers' needs, wants, behaviors, and motivations is critical. Third, marketing should drive the strategic direction of the organization and not vice versa, as was historically the case.

Although healthcare marketing has adopted concepts and methods from other industries, it continues to be distinguished from the marketing that takes place in other sectors. Its methods must be unique and appropriate for healthcare products and their consumers—not a copy of the prevailing techniques used in other industries. This book walks readers through the traditional and contemporary approaches that healthcare marketers rely on and that enable healthcare organizations to rise above current trends and turmoil to position themselves for the future healthcare environment.

Instructor Resources

This book's instructor resources include an instructor's manual, updated and enhanced PowerPoint slides, answers to selected case study questions, and a test bank.

For the most up-to-date information about this book and its instructor resources, go to ache.org/HAP and search for the book's order code (2404I).

This book's instructor resources are available to instructors who adopt this book for use in their course. For access information, please email hapbooks@ache.org.

INTRODUCTION

T his book explores the history, perspectives, concepts, processes, and role of marketing in the healthcare industry—particularly the health services delivery setting. This fourth edition retains the features that readers found useful in previous editions, such as the examples, case studies, discussion questions, key points, and additional resources. In this edition, new examples, exhibits, recommendations, and statistics have been added; some case studies have been revised; and updated resources have been included. Definitions of important terms and concepts appear in the margins, supplementing the full-length discussions.

The content—although it remains true to its original intent of being a comprehensive guide—has been updated at every possible turn to reflect the changes that have taken place in the healthcare environment. The Affordable Care Act (ACA) has been the law of the land for a decade, and that initiative continues to have implications for healthcare marketing. The use of social media, described in the previous edition, has exploded, with an ever-increasing number of social media channels.

Of particular importance has been the emergence of a new paradigm that is upending the healthcare system. The population health model is gaining momentum, and it will have significant implications for healthcare marketing. This model promises to transform healthcare marketing as it shifts the emphasis among healthcare providers from quantity to quality, from sick people to well people, from individual patients to groups of consumers, and from treatment to prevention.

The Target Audience

Students in healthcare administration and healthcare marketing programs as well as students in business administration programs with a healthcare marketing component make up the primary audience for this book. It can also serve as a reference text for professors or instructors of healthcare administration

or marketing courses and for academicians who conduct research on these topics but are not marketing practitioners themselves.

Health professionals (including physicians, nurses, and other clinicians) represent the secondary audience for this book, as well as healthcare executives and administrators, health planners, and other facility staff involved in marketing activities. In today's ultracompetitive environment, most health professionals—regardless of official title or span of responsibilities—are expected to be at least familiar with marketing concepts.

The third category of audience is composed of marketing professionals—whether they work for a marketing agency or related consulting firm or as independent agents—who intend to do business in the healthcare arena. Whether they are new to the marketing field or are seasoned marketing veterans, they will find something in the book that will prove useful for their healthcare clients.

The Content

At times, the topics covered in the chapters overlap or appear in more than one chapter. That is intentional—to emphasize and review the basic points or to put them in context. The following sections summarize the content of each chapter.

Part I: History and Concepts

- Chapter 1 presents an overview of the history of marketing—from its introduction to healthcare to its contemporary incarnation. The ways in which healthcare differs from other industries and the ways in which healthcare marketing is different from other types of marketing are examined. In addition, the chapter sheds light on the factors that have helped marketing become accepted in healthcare and the contribution that marketing can make to the industry. Finally, it reviews current developments in healthcare and their implications for marketing.
- Chapter 2 defines the key terms and concepts that form the foundation of marketing and reviews their application to healthcare. The "four Ps" of marketing and their expansion to the seven Ps (for the healthcare industry) are discussed. Marketing functions, techniques, and approaches are enumerated, and the challenge of adapting marketing processes from other industries to healthcare is addressed.
- Chapter 3 focuses on marketing as a function in healthcare organizations. It identifies the types of marketing techniques typically used by different types of organizations. The factors that influenced

healthcare's adoption of marketing are reviewed, along with the factors that are affecting the contemporary nature of healthcare marketing.

Part II: Healthcare Markets and Products

- Chapter 4 discusses how a healthcare market is described and delineated. Among the concepts addressed are geographic and nongeographic boundaries, consumer demand, market profiling, mass marketing and micromarketing, and effective markets.
- Chapter 5 answers the questions "Who are healthcare customers?" and "How are they similar and dissimilar from other customers?" It explains consumer behavior and attitudes, the different types of market segmentation (e.g., geographic, demographic, psychographic), and the consumer decision-making process.
- Chapter 6 is all about the healthcare product—the goods sold and services provided by healthcare organizations. The product mix is explained, as well as the different types of goods and services available in the market. The common classifications and coding systems used in healthcare are highlighted.
- Chapter 7 addresses the factors that contribute to the demand for health services. It touches on healthcare wants and needs, recommended standards for healthcare, and utilization patterns. It also proposes methods marketers can use to measure demand and introduces various indicators of health services utilization. The numerous factors that determine the demand for and ultimate consumption of health services are identified.

Part III: Healthcare Marketing Techniques

- Chapter 8, new in this edition, sets the stage for subsequent chapters dealing with strategy development, health communications, traditional and contemporary marketing techniques, and the use of social media in marketing. This chapter reviews the changes taking place in the healthcare environment and outlines the implications of those changes for healthcare marketing.
- Chapter 9 focuses on marketing strategies. The need to align marketing strategies with the organization's overall strategic plan is emphasized. It summarizes the steps in strategic planning, the processes for developing and selecting a strategy, and the strategic approaches that may be taken. Branding as a strategy is discussed as well. The possible implications for healthcare marketing of the ACA and the emerging population health model are highlighted.

- Chapter 10—new to this edition—addresses the topic of health communication and its crucial role in healthcare marketing. This chapter reviews the nature of communication, its function, and the process of developing a communication plan. The attributes of effective communication initiatives are described, along with the variety of ways in which communication may be employed within the healthcare setting.
- Chapter 11 details the traditional marketing techniques commonly used by healthcare marketers, such as public relations, advertising, personal sales, sales promotion, and direct marketing. It provides an overview of media options, social marketing, and integrated marketing. It also explains the modifications marketers must make to adapt traditional promotional approaches to the healthcare arena.
- Chapter 12 presents contemporary marketing techniques. One set of techniques is based on traditional marketing programs and includes direct-to-consumer marketing, business-to-business marketing, internal marketing, and affinity marketing. The other set of techniques is based on technology and includes database marketing, customer relationship management, and internet marketing. Consumer engagement as an emerging theme in marketing is addressed.
- Chapter 13 focuses on social media and their application to healthcare marketing. It identifies the common types of social media, their value to consumers and marketers, and their healthcare-specific uses.

Part IV: The Marketing Endeavor
- Chapter 14 explores the ins and outs of managing a marketing campaign. It breaks down the steps involved—from concept to plan to implementation to evaluation. It pinpoints the players (including both internal and external marketing agents, suppliers, and consultants) and departments (including creative, production, and media planning and buying departments) of the marketing function. The financial aspects—the marketing budget and return on investment—are also described.
- Chapter 15 presents an overview of the healthcare marketing research process. It describes the types, steps, and methods researchers undertake to collect data and information on markets, products, prices, promotions, and distributions. Geographic information systems, quantitative and qualitative research, and surveys and interviews are among the tools discussed.
- Chapter 16 offers a comprehensive look at marketing planning. It presents the common steps in the planning process and examples of how the steps are applied in real-world marketing scenarios.

- Chapter 17 examines the various types of marketing data and the sources of such data. It discusses the complications of mining and using patient and customer information under Health Insurance Portability and Accountability Act rules as well as the dimensions and traits that make data useful to healthcare marketers. Methods for generating population data and estimating demand in the absence of actual data are included, along with data compendia collected and released by the federal government.

Part V: The Future of Healthcare Marketing

- Chapter 18 summarizes where healthcare marketing is at present and where it is headed in the near future. The discussion revolves around the current trends and factors that are likely to influence the future characteristics of both healthcare and marketing.

HISTORY AND CONCEPTS

Part I places the field of marketing and its applications to healthcare in a historical context and introduces basic marketing concepts. Chapter 1 presents the history of healthcare marketing, chapter 2 introduces the terms and concepts used throughout the book, and chapter 3 describes the role of marketing in healthcare organizations.

THE ORIGIN AND EVOLUTION OF MARKETING IN HEALTHCARE

Since the notion of marketing was introduced to healthcare providers during the 1970s, the field has experienced periods of growth, decline, retrenchment, and renewed growth. This chapter reviews the history of marketing in the US economy and traces its evolution in healthcare over the second half of the twentieth century and the first two decades of the twenty-first century. The chapter then turns to the challenges marketers have faced in their efforts to gain a foothold in healthcare.

The History of Marketing

Marketing, as the term is used today, is a modern concept. The term was first used around 1910 to refer to what is now called *sales*. Marketing is also a uniquely American concept; the word has been adopted into the vocabularies of other languages that lack a word for this activity. Although the 1950s mark the beginning of the marketing era in the United States, the marketing function took several decades (in stages) to become established in the US economy, and marketers had to overcome a number of factors that slowed the field's development.

Many of these factors reflected economic characteristics carried over from the World War II period. In the 1950s, America was still in the Industrial Age, and the economy was production oriented until well after the war. Because all aspects of the economy were geared to **production**, the prevailing mind-set emphasized the producer's interests over the consumer's. This production orientation assumed that producers already knew what consumers needed. Products were made to the manufacturer's specifications, and then customers were sought. A "here is our product—take it or leave it" approach characterized most industries during this period.

The evolution of marketing took place in four stages.

Stage 1: The Rise of Product Differentiation and Consumerism
A wide variety of new products and services emerged during the postwar period, particularly in consumer goods industries. Newly empowered consumers demanded a growing array of goods and services. This development

production
A focus on generating (rather than distributing) goods that deemphasizes the role of marketing.

contributed to the emergence of marketing, for three main reasons. First, consumers had to be introduced to and educated about these new goods and services. Second, the entry of new producers into the market gave rise to a level of competition that was unknown before World War II. Mechanisms had to be developed to make the public aware of new products and to distinguish those products (in the eyes of potential customers) from those offered by competitors. Consumers had to be made aware of opportunities to purchase goods and then persuaded to buy a certain brand. Third, the standardization of existing products during this period contributed to the need to convince consumers to choose one good or service over another. When few differences existed between the products in a market, marketing became crucial. Marketers were enlisted to highlight and, if necessary, create differences between similar products.

As a result of these developments, the seller's market was transformed into a buyer's market. Once companies began to tap the consumer market, a highly elastic demand for many types of goods became evident. The prewar mentality had emphasized meeting consumer needs and assumed that a population could purchase a finite amount of goods and services. As discretionary income increased and consumer credit was introduced after World War II, consumers began to satisfy their wants. Fledgling marketers discovered that they could influence consumers' decision-making processes and create demand for certain goods and services.

culture
A society's tangible and intangible aspects reflecting its beliefs, values, and norms.

The acceptance of marketing was aided by changes in American **culture**. The postwar period was marked by an emphasis on consumption and acquisition. The frugality of the Great Depression gave way to a degree of materialism that shocked older generations. The availability of consumer credit and a mind-set that emphasized "keeping up with the Joneses" generated demand for a growing range of goods and services. This period witnessed the birth of the first generation of Americans with a consumer mentality.

By the 1970s, there was a growing emphasis on self-actualization in American culture. This development called for additional goods and services and even created a market for consumer health services (e.g., psychotherapy, cosmetic surgery). A consumer market with expanding needs, coupled with a proliferation of products, created fertile ground for marketing.

As American society underwent major transformations, change not only became accepted as inevitable but took on a positive connotation. An emerging future orientation underscored the importance of change in forging a path toward a better future. People began changing jobs, residences, and even spouses at faster rates. The social and economic advancement of each generation over the previous one became an expectation—a part of the American dream.

Stage 2: The Shifting Role of Sales

The second stage in the evolution of marketing focused on **sales**. Many US producers had enjoyed regional **monopolies** (or at least **oligopolies**) since the dawn of the Industrial Age. Under these conditions, sales representatives took orders from what were essentially captive **audiences**. Marketing would have been considered an unnecessary expense.

As competition increased in most industries after World War II, these regional monopolies began to weaken. Companies with new products took advantage of the growing economy and newly empowered consumers to compete with well-established companies. The notion of *marketing* as distinguished from *sales* emerged, and the "Mad Men" phenomenon was born.

The emphasis on sales persisted through the last third of the twentieth century, reflecting the residual production orientation of society. Sales representatives served as a bridge between the production economy and the service economy as they developed and maintained relationships with customers. Their role progressed from being "order takers" to serving as "consultants" to their clients, sending information from customers back to producers and facilitating the emergence of a market orientation in American business. Despite seismic shifts in the American economy, the emphasis on product sales overshadowed the nascent emphasis on marketing of services until at least the 1990s.

Stage 3: The Emergence of the Consumer's Point of View and the Service Economy

By the last quarter of the twentieth century, the industrial economy had given way to a service economy, and the production industries that remained became increasingly standardized. The shift from a product orientation to a service orientation represented a sea change for marketing. Service industries tend to be market driven, and American corporations began abandoning their outdated mind-set in favor of a market orientation. For the first time, progressive managers in a wide range of industries sought to determine what consumers wanted and then strived to fulfill those needs. This shift opened the door to marketing research and the exploitation of consumer desires by professional marketers. The new market-driven firms adopted an outside-in way of thinking that viewed service delivery from the customer's point of view.

The emergence of the service economy had important implications for both marketing and healthcare. Services are distinguished from goods in that they are generally consumed as they are produced and cannot be stored or taken away. The marketing of services is different from the marketing of goods, presenting a different set of challenges for marketers in any field, including healthcare. A different mind-set accompanied by new promotional approaches to the marketing of services had to be developed as the United States became a service-oriented economy.

sales
An approach to business that emphasizes transactions rather than promotions.

monopoly
Control of the total market for a good or service by one organization.

oligopoly
Domination of a market or an industry by a few organizations.

audience
People or organizations that read, view, hear, or are otherwise exposed to a promotional message.

Stage 4: The Rise of the Electronic Age

At the turn of the twenty-first century, healthcare marketing—like marketing in other sectors of the economy—experienced an electronic revolution. Electronically empowered consumers could now research, compare, and buy health-related products on the internet and, with the advent of social media, instantaneously share their healthcare experiences and opinions. In addition, consumers could consult websites for information on medical conditions, healthcare providers, and healthcare facilities. Healthcare organizations, too, increasingly began to incorporate electronic health records and other secure data systems into their operations. Healthcare organizations also started interacting with their patients online—for example, through websites, blogs, and social media.

    Social media platforms such as Facebook—through profiles "owned" by an organization, a provider, or an individual consumer—have become forums for consumers to discuss the quality of care at a facility, a doctor's characteristics or expertise, general information about a provider or a group, disease symptoms and diagnoses, treatment options, pricing or cost of services, and healthcare industry news. For example, when the **Patient Protection and Affordable Care Act (ACA)** was enacted in 2010, social networks were abuzz with information (and misinformation) on the healthcare reform's provisions and implementation. (Chapter 13 is devoted to social media, reflecting its ascendancy in American society.)

Patient Protection and Affordable Care Act (ACA) Legislation enacted in 2010 that aimed to expand health insurance coverage and improve healthcare delivery and quality.

The Introduction of Marketing in Healthcare

Healthcare did not adopt marketing approaches to any significant extent until the 1980s, although some healthcare organizations in the retail and supplier sectors had long employed marketing techniques to promote their products. Long after other industries had adopted marketing, these activities were still uncommon among organizations involved in patient care.

    Nevertheless, some precursors to marketing were well established in the industry. Every hospital and many other healthcare organizations had long-standing public relations functions that disseminated information about the organization and announced new developments (e.g., new staff, equipment purchases). Public relations staff worked mainly with the media—issuing press releases, responding to requests for information, and dealing with reporters when a negative event occurred.

    Most large provider organizations also had communications functions, often under the auspices of the public relations department. Communications staff developed materials to disseminate to the public and to the employees

of the organization, such as internal newsletters and, later, patient-oriented educational materials.

Some of the larger healthcare organizations also established government relations offices. Government relations staff were responsible for tracking regulatory and legislative activities that might affect the organization, interfaced with government officials, and acted as lobbyists when necessary. Government relations offices frequently became involved in addressing the requirements of regulatory agencies.

Healthcare organizations of all types undertook informal promotional activities to an extent. Hospitals sponsored health education seminars, held open houses at new facilities, and supported community events. Hospitals marketed themselves by making their facilities available to the community for public meetings and otherwise attempting to be good corporate citizens. Physicians marketed themselves through such activities as networking with colleagues in social and professional settings, sending letters of appreciation to referring physicians, and providing services to high school athletic teams.

The Evolution of Healthcare Marketing

The periods through which marketing has evolved in the healthcare setting are outlined in this section. Exhibit 1.1 summarizes the implications of this evolution for the hospital industry.

The 1950s

Although the 1950s are often viewed as the "age of marketing," marketing did not appear on healthcare's radar until several decades later. The emerging pharmaceutical industry, however, was beginning to market to physicians, and the fledgling insurance industry had begun to market **health plans** to consumers. Hospitals and physicians, for the most part, still considered marketing to be inappropriate and even unethical. This stance, however, did not preclude hospitals from offering free educational programs or implementing

health plan
Public or private medical insurance.

Business orientation	Organizational goal	Desired outcome
Production	Produce quality product	Deliver quality care
Sales	Generate volume	Fill hospital beds
Marketing	Satisfy consumer needs and wants	Satisfy consumer needs and wants

EXHIBIT 1.1
The Evolution of Marketing in Healthcare

public relations campaigns, nor did it prevent physicians from cozying up to potential referring physicians and networking with colleagues.

Since the demand for physician and hospital services was considered inelastic, little attention was paid to the characteristics of current patients or prospective customers. The emphasis was on providing quality care, and most providers held monopolies or oligopolies that shielded them from competition within their markets.

The 1960s

As the health services sector expanded during the 1960s, the role of public relations also grew. Although the developments that would force hospitals and other healthcare organizations to embrace marketing were at least a decade away, the public relations field was flourishing as the healthcare organization's primary means of maintaining contact with its constituents.

The stakeholders of this period were primarily the physicians who admitted or referred patients to healthcare facilities and, in the case of **not-for-profit** organizations, the donors who made charitable contributions. Consumers were not considered an important constituency because they did not directly choose hospitals but were referred by their physicians.

Print was the medium of choice for communications throughout the 1960s, despite the increasingly influential role of **electronic media** (e.g., television and radio) for marketing in other industries. This era was marked by polished annual reports, informational brochures, and publications targeted to the community. Healthcare communications became a well-developed function, and hospitals continued to expand the role of public relations.

Some segments of the healthcare industry that were not involved in patient care entered the sales stage (stage 2 in the evolution of the marketing function) during this decade. For example, pharmaceutical companies and insurance plans established sales forces to promote their drugs to physicians and market insurance plans to employers and individuals, respectively.

Significantly, the 1960s witnessed the introduction of the **Medicare** and **Medicaid** programs during the administration of President Lyndon B. Johnson. The operation of these two programs had a major impact on medical practice patterns and, ultimately, the nature of the healthcare system. The Medicare program was designed to provide coverage for senior citizens, with all Americans automatically enrolled in this federally administered program at age 65. The Medicaid program is a joint federal–state program designed to cover low-income patients who would not otherwise have access to health services. Between the two programs, the federal government accounts for about one-third of the expenditures for medical care, while the states provide matching funds for (and administer) the Medicaid program. It has been suggested that the introduction of Medicare had a

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not-for-profit
An organization granted tax-exempt status by the Internal Revenue Service.

electronic media
Media that transmit content electronically, such as radio, television, and the internet.

Medicare
The federal health insurance program for Americans aged 65 or older.

Medicaid
The joint federal–state health insurance program for low-income individuals.

greater influence on practice patterns in the US healthcare system than any other single development.

The 1970s

By the 1970s, competition for patients among hospitals was heating up. The desire for greater market presence was reinforced by the growing conviction that, in the future, healthcare organizations would need to be able to attract customers. The for-profit hospital sector grew in importance during the 1970s. With few limits on reimbursement, both not-for-profit and for-profit hospitals expanded their services. Continued high demand for health services and the stable payment system created by Medicare made the industry attractive to investor-owned companies. Numerous national for-profit hospital and nursing home chains emerged during this period.

Some early attempts at **advertising** health services were made, and interest in marketing research began to emerge. The marketing movement in healthcare was given further impetus by rulings that relaxed restrictions on advertising for healthcare providers, which previously had been imposed by regulatory agencies.

advertising
Any paid form of presentation or promotion of ideas, goods, or services.

For hospitals, the marketing era began in the mid-1970s, spurred by changes in reimbursement practices. Under the system of cost-based reimbursement (e.g., Medicare), competition with other hospitals had not been a major concern. However, once hospitals recognized that patients might play a role in the hospital selection decision, their appreciation for marketing increased. By the mid-1970s, some hospitals adopted mass advertising strategies to promote their programs.

The marketer's goal was to convince prospective patients to use a particular hospital when presented with a choice between competing providers (Berkowitz 2016). Communications began to target patients, and patient satisfaction research grew in importance. Even so, marketing in the sense of managing the flow of services between an organization and its customers was still not a recognized function of most healthcare organizations.

The 1980s

If healthcare marketing was born in the 1970s, it came of age in the 1980s. The healthcare industry had evolved from a seller's market to a buyer's market, a change that would have a profound effect on the marketing of health services. Employers and consumers had become purchasers of healthcare, and the physician's role in referring patients for hospital services was beginning to diminish. The hospital industry continued to grow during the 1980s, as centrally managed health systems (both for-profit and not-for-profit) expanded and national chains of hospitals, nursing homes, and home health agencies were established.

Marketers had to begin looking at target audiences in an entirely different way. The importance of consumers was heightened by changes in insurance reimbursement patterns. Hospitals began to think of medical care in terms of product and service lines, a development that had major consequences for the marketing of health services. Hospitals realized that marketing directly to consumers for such services as obstetrics, cosmetic surgery, and outpatient care could generate revenue and enhance **market share**.

market share
The percentage of the total market captured by a company.

Although marketing was beginning to be accepted in healthcare, the industry suffered from a lack of professional marketing personnel. Few marketers had experience with healthcare, and attempts to import marketing techniques from other industries were generally unsuccessful. Many healthcare administrators still saw marketing as an expensive gimmick and considered marketers to be outsiders with no place in healthcare.

The rise of service-line marketing launched the great hospital advertising wars of the 1980s. Barely a blip on the healthcare marketing radar a decade earlier, advertising grew dramatically during this decade. In 1983, hospitals spent $50 million on advertising; by 1986, that figure had risen to $500 million, a tenfold increase in three years (Berkowitz 2016). Once an enterprise of dubious respectability, advertising was now hailed as a marketing panacea for hospitals.

Advertising epitomized marketing for many in healthcare during this period. Marketers themselves perpetuated this notion, and even today, many healthcare executives equate marketing with advertising. Ultimately, the surge in advertising was both a blessing and a curse. On the one hand, advertising campaigns were relatively concrete: An organization could invest in them and reasonably expect to receive some benefit as a result. On the other hand, the ineffectiveness of much of this advertising and the negative fallout it often generated were setbacks for proponents of healthcare marketing. After experiencing the initial rush of seeing their billboard advertisements and television commercials, hospital administrators began to question the expense and, more important, the effectiveness of the marketing initiatives they were funding.

During the 1980s, healthcare organizations faced serious financial retrenchment. Hospitals were looking to cut costs wherever possible, and marketing expenditures were easy targets. Budgets were cut and marketing staff were laid off. Although the marketing function was not entirely eliminated, it was often carried out under the umbrella of business development or strategic planning. In some healthcare organizations, marketing disappeared as a corporate function and was never reinstated. On the positive side, this retrenchment allowed healthcare marketers to reassess the field and concentrate on developing baseline data that could be used if a marketing revival occurred.

The 1990s

Healthcare became more market driven in the 1990s, and as a result, the marketing function grew in importance in the industry. The institutional perspective that had long driven decision-making gave way to market-driven decision-making. Every hospital was trying to win the hearts and minds of healthcare consumers.

Advertising by healthcare organizations resurged during the mid-1990s, spurred by a wave of hospital mergers. The consolidation of healthcare organizations into ever-larger **healthcare systems** resulted in the creation of larger organizations that had more resources and more sophisticated management. Many executives entered the field from outside healthcare, bringing a more businesslike mind-set with them.

The consumer was rediscovered during this process, initiating a shift to **direct-to-consumer marketing**. The popularity of guest relations programs during the 1990s solidified the transformation of patients into customers. As consumers gained influence, marketing became increasingly integrated into the operations of healthcare organizations. The consumers of the 1990s were better educated and more assertive about their healthcare needs than consumers of the previous generation had been. The emergence of the internet as a source of health information contributed to the rise of **consumerism**. Consumers began to take on an increasingly influential (if informal) role in reshaping the US healthcare system.

During the 1990s, health professionals developed a new perspective on the role of marketing, driven by a new generation of healthcare administrators who were more business oriented. A more qualified corps of marketing professionals brought ambitious but realistic expectations to the healthcare industry. Pharmaceutical companies began advertising directly to consumers, making everyone in the industry more aware of marketing's potential.

Marketing research grew in importance during this decade. The need for information on consumers, customers, competitors, and the market demanded an expanded research function. Patient and consumer research was augmented, and newly developed technologies brought the research capabilities of other industries to healthcare. For example, patient satisfaction and consumer surveys were introduced, and database marketing techniques developed in other industries were adopted.

Business practices in general came to be more accepted in healthcare during this period, and marketing was an inevitable beneficiary. Marketing was repackaged in a more professional guise, and the shift away from advertising was noticeable. By the end of the decade, marketing was a more mature discipline, emphasizing marketing research and sensitivity to the needs of consumers. Healthcare had finally reached stage 3 in the evolution of the marketing function.

healthcare system
A multifacility healthcare organization; also may refer to the overall healthcare delivery system in the United States.

direct-to-consumer marketing
A marketing approach that targets the end user rather than referral agents or intermediaries.

consumerism
A movement in which consumers participate in defining their healthcare needs and how those needs are met.

With the repackaging and maturation of healthcare marketing in the 1990s, the field became more sophisticated. The market was more competitive in many ways, and even the managed care environment held opportunities for promotional activities. In addition, mergers not only created more potential marketing clout but also often involved for-profit healthcare organizations, which were inherently more marketing oriented.

The 2000s

By the end of the 1990s, a new cohort of healthcare administrators was more accepting of business practices, including marketing. The industry had witnessed massive turnover in hospital administrators as a result of retirements, mergers, and downsizing. Many among this new wave of administrators came from other, more profit-oriented industries, where marketing was considered a normal corporate function. These administrators instilled a marketing mind-set in healthcare, in keeping with the strategic orientation they brought to the industry.

By the first decade of the twenty-first century, the marketing activities of hospitals were beginning to look more like those of their counterparts in the for-profit sector (e.g., pharmaceutical and medical device companies). The typical hospital marketing department included a staff of five or more and a budget in the millions of dollars. Marketing executives were increasingly promoted to the vice president level, earning salaries comparable to those of other healthcare executives.

Although some marketers still focused on advertising and sales, twenty-first-century marketing executives added to their toolboxes to encompass the full range of activities to support the marketing function. Market segmentation and target marketing techniques were adapted from other industries. Reliable and effective public, media, and community relations; customer service; and reputation and relationship management made a comeback, demonstrating the effectiveness of carefully designed, low-cost methods of reaching audiences and swaying public opinion.

The consumer was increasingly considered the key to success, and data management and customer relations techniques were put into place. *Consumer engagement* became a buzzword in healthcare, and efforts to secure the buy-in of healthcare consumers grew. This new healthcare environment

population health
An approach to community health improvement that focuses on the health status and health behavior of groups rather than individuals.

demanded a different approach to marketing health services, including a **population health** component that focused on the health of the community rather than on that of individual patients. As healthcare providers were increasingly paid for performance rather than volume, a more thoughtful approach to marketing health services was required.

The emergence of social media during this decade played an important role in the marketing of health services. By the end of the twentieth century,

nearly all healthcare providers had established an internet presence; for many, the internet was not only a core component of their marketing initiatives but also a means of interacting with customers and prospective customers. Providers' electronic communication capacity expanded with the explosion of social media. Patients could now instantaneously communicate with each other and, increasingly, with health professionals. Prospective customers could interact with existing customers before using health services. The flooding of cyberspace with healthcare "chatter" required close monitoring by marketers.

The 2010s

The second decade of the twenty-first century witnessed continued realignment and restructuring of the US healthcare system. Trends that had begun in previous decades, such as the merger of healthcare organizations, increased vertical integration, and the acquisition of medical practices by hospitals and health systems, continued. From a marketing perspective, the emphasis on consumer engagement continued to grow, and the use of social media as a force for healthcare marketing gathered steam as healthcare consumers became increasingly internet savvy.

The most significant development in healthcare since 2010 has been the introduction of the ACA. The ACA made quality health insurance more accessible and affordable to tens of millions of Americans and put significant restrictions on the practices of health insurance companies. The establishment of a national health insurance exchange and the creation of levels of insurance coverage led to a surge in marketing activities. Traditional insurers now had access to millions of consumers who had once been beyond their reach. As a result, insurers needed to better understand the characteristics of a larger number of consumers, many of whom had not been previously insured, to price coverage appropriately and to determine the needs of new populations.

The ACA mandated that not-for-profit hospitals conduct community health needs assessments at least every three years. As part of this mandate, hospitals were required to assess the needs of the broader community (i.e., beyond their patient pool), identify community health needs, and develop ameliorative approaches to addressing health needs identified in the community. These functions were often relegated to the marketing department. An important related issue was the political and ideological controversy surrounding the introduction of the ACA—a fight that continues today.

Another development during this decade was the emergence of the *pay-for-performance* model of healthcare—a reimbursement arrangement with the potential to turn the healthcare system on its head. Providers historically were reimbursed on a fee-for-service basis for the treatment of individual

patients. The emerging pay-for-performance model, however, emphasized quality over quantity, outcomes over processes, and group health improvement over clinical care for individual patients. This emphasis often involved a shift to some form of *capitated* payment, whereby providers are paid a specified amount "per head" for the management of a defined group of patients, and their rewards are based on their ability to improve the overall health status of that group rather than their success with any individual patient. As with the ACA, the pay-for-performance movement has meant that providers need to know much more about their patients and prospective patients to effectively manage their care.

One approach developed to address the pay-for-performance environment was the establishment of *accountable care organizations* (ACOs). ACOs typically involve the joint efforts of providers and insurers, which together take responsibility for the management of a defined group of patients to more effectively control their health status and ensure the appropriate use of health services. The Centers for Medicare & Medicaid Services has sponsored a number of initiatives to encourage the establishment of ACOs. Under an ACO system, providers share any cost savings that are identified, but they also face the threat of financial penalties if there is no demonstrated improvement in group health. The ACO model is still in the early stages of development, and only time will tell whether ACOs will become a mainstay of the healthcare system. The movement toward ACOs will require both providers and insurers to develop a better understanding of the needs of patients and other healthcare consumers.

Another major development of the decade—and one that promises to overshadow the rest—is the growing influence of the population health model. This model represents the culmination of several decades of efforts to address dysfunction in the US healthcare system and reflects changes in the makeup of the patient population, the nature and causes of disease, and, most important, the failure of the healthcare system to effectively address twenty-first-century health problems. *Population health* refers to an approach to determining health status that focuses on a defined population as a whole rather than on individual patients or consumers, and it involves using innovative means to measure health status beyond traditional epidemiological metrics. Population health also refers to a method of advancing community health improvement that emphasizes upstream rather than downstream approaches—focusing on the **social determinants of health** status and deemphasizing the importance of clinical care for the improvement of health.

social determinants of health
Characteristics of society that contribute to conditions of health or illness in a population, thereby mitigating the effects of disease pathology and genetics.

These developments have implications for healthcare marketing and reinforce the importance of marketing in the contemporary healthcare environment. There is a growing need to understand the characteristics of

patients and consumers (primarily nonclinical), the attributes of groups of patients (including their lifestyles and motivations), and the social determinants of health status and to use that information to predict future health problems and health services demand. Among health professionals, marketers are in the best position to perform these functions, and marketers may conceivably become as influential as clinicians in determining the future health status of target populations.

Exhibit 1.2 summarizes the development of healthcare marketing from the 1950s to the 2010s.

Why Healthcare Is Different from Other Industries

The healthcare industry is distinct from other sectors of the economy because of its specific characteristics. In particular, healthcare providers behave in a manner that is often inconsistent with that of organizations in other industries. Health professionals, especially clinicians, fall into a special category, and the fact that clinicians—not administrators or businesspeople—make most of the decisions regarding patient care creates a dynamic that is unique to healthcare. The nature of healthcare goods and services sets them apart from the goods and services offered in other industries. Further, significant differences exist between healthcare consumers and the consumers of every other good or service. These differences are particularly apparent with regard to consumer decision-making (see chapter 5 for a discussion of the consumer decision-making process).

Characteristics of the Healthcare Industry

The development of a marketing culture in any industry is predicated on assumptions about that industry and the marketing enterprise, including the existence of a rational market for the goods and services proffered by the organizations in that industry. The market is presumed to involve organized groups of sellers and informed buyers, an orderly mechanism for carrying out transactions between sellers and buyers, and a straightforward process for transferring payments for products between buyers and sellers. The existence of a market is also predicated on the assumption that buyers are driven by economic motives and seek to maximize their benefits from the exchange.

In healthcare, however, a number of factors prevent the buyers and sellers of health services from interacting in the same way as buyers and sellers in other industries. Oligopolies of healthcare organizations commonly dominate particular markets, and providers often maintain monopolies over particular services. Thus, buyers of health services are often limited in their options. In view of the prerequisites for the existence of a market, one

EXHIBIT 1.2
Healthcare Marketing Timeline

	1950	1960	1970	1980	1990	2000	2010
Stage	Premarketing →			Introduction →	Growth →	Maturity →	
Primary techniques	Public relations Communication	Government relations		Advertising Marketing research Direct marketing Personal sales	Direct-to-consumer marketing Relationship marketing Social marketing Internet marketing	Social media	
Main theme	Publicity Information management	Regulatory influence Consumer research		Sales Technology applications	Relationship management	Consumer engagement	
Marketing target	General public	Government agencies Health plans		Physicians Employers	Referral agents Businesses	Consumers Market segments	

could argue that, to the extent that any type of market for health services exists, it is not "rational" in the way that the markets for other goods and services are.

Healthcare also differs from other sectors of the economy in that its key organizations have diverse goals. In other industries, the intent is to sell as many units as possible while extracting the maximum profit from the transactions. Anything other than making a profit is secondary to the single-minded goal of selling consumer products. Most healthcare organizations, on the other hand, are obligated to accept clients whether or not they can pay for the services they receive. Emergency departments cannot turn away patients needing care until they have at least been stabilized. Physician offices may require some payment up front from those who do not have insurance, but ethical considerations prohibit turning away a clearly symptomatic individual. Thus, the economic considerations that apply to other industries may be compromised by factors that are unique to healthcare.

Unlike other industries, healthcare lacks a straightforward means of financing the purchase of goods and services, particularly patient care services. Customers in other industries typically pay directly—either out of pocket or through some form of credit—for the goods and services they consume. While healthcare consumers may pay some portion of the cost out of pocket, most fees are paid by a third party, whether a private insurance plan or a government-sponsored plan such as Medicare or Medicaid. The seller may have to deal with thousands of different insurance plans, and the cost of health services is reimbursed using a combination of different payment mechanisms. Thus, it is not unusual for an elderly patient to have the costs of one hospital visit paid for by Medicare reimbursement, supplementary private insurance reimbursement, and out-of-pocket payments. This arrangement is not found in any other industry and creates a much more complicated financial picture for healthcare.

Finally, healthcare is different from other industries in that the normal rules of supply and demand seldom apply. An increase in the supply of health services, for example, does not necessarily result in a decrease in price, nor does increased demand invariably drive up prices. For one thing, the availability (supply) of services dictates, to a certain extent, the demand for those services. Pent-up demand for health services often surfaces when more facilities become available. As a result, neither the increased supply of beds nor the increase in demand has a significant impact on prices.

The factors that govern supply, demand, and price in healthcare are complex and unique to the industry. The supply of health services is affected by the vagaries of training programs for health professionals, restrictions enforced by regulatory agencies, and even health fads. The level of demand—arguably, the most problematic of these three factors—is typically not

controlled by the end user. Except for elective procedures for which the consumer pays out of pocket, most decisions that affect the demand for health services are made by **gatekeepers**, such as physicians and health plans. Thus, the level of demand is more often a function of such factors as insurance plan provisions, the availability of resources, and physician practice patterns than of the level of sickness in the population. Exhibit 1.3 describes the emergence of healthcare as a major institution in US society.

EXHIBIT 1.3

The Emergence of Healthcare as an Institution in the United States

A healthcare system can be understood only within the context of the society and culture in which it exists, and no two healthcare delivery systems are exactly alike. Differences among healthcare systems around the world are primarily a function of differences in context. The structure of a society, along with its cultural values, establishes the parameters for the healthcare system. In this sense, the form and function of the healthcare system reflect the form and function of the society in which it resides. Ultimately, the development of marketing in healthcare (or any industry) reflects the characteristics of both that industry and that society.

The ascendancy of the healthcare institution in the twentieth century was given impetus by the growing dependence on formal organizations of all types. Industrialization and urbanization in the United States reflected a transformation from a traditional, agrarian society to a complex, modern society in which change, not tradition, was the central theme. In such a society, formal solutions to societal needs take precedence over informal responses.

Healthcare provides possibly the best example of this dependence on formal solutions because it is an institution whose very development was a result of this transformation. Our great-grandparents would have considered formal healthcare to be the last resort when faced with sickness and disability. Few of them ever entered a hospital or regularly saw a physician. Today, in contrast, the healthcare system is often seen as the first resort when health problems arise. Traditional, informal responses to health problems have given way to complex, institutionalized responses. Healthcare has become entrenched in the fabric of American life to the point that Americans turn to it not only for clear-cut health problems but also for a broad range of psychological, social, interpersonal, and spiritual concerns.

The restructuring of institutions during the twentieth century was accompanied by a cultural revolution that resulted in an extensive **value** reorientation in American society. The values associated with traditional societies (e.g., kinship, community, authority, primary relationships) were overshadowed by the values of modern industrialized societies (e.g., secularism, urbanism, self-actualization). Ultimately, the restructuring of American values was instrumental in the emergence of healthcare as an important institution.

(continued)

The modern values that emerged after World War II supported the emergence of an institutional structure that would spawn the development of modern Western medicine. These values shifted the emphasis in American society to economic success, educational achievement, and scientific and technological advancement and supported the ascendancy of healthcare as a dominant institution. The conceptualization of health as a distinct value in society represented a major development in the emergence of the healthcare institution. Before World War II, health was generally not recognized as a value by Americans, though it was vaguely tied to other notions of well-being.

Public opinion polls before the war did not identify personal health as an issue for Americans, nor was healthcare delivery considered a societal concern. By the 1960s, however, public opinion polls showed that personal health had become a top concern, and the adequate provision of health services was an important issue in the minds of Americans (Thomas 2003b). By the last quarter of the twentieth century, Americans had become obsessed with health as a value and with the importance of institutional solutions to health problems.

By any measure, healthcare could be considered a dominant institution in contemporary American society. Other institutions—such as politics, the military, and the arts—receive comparatively fewer resources. In public opinion polls, Americans frequently cite health as one of their most pressing personal concerns and healthcare as a leading national concern. The accompanying graph displays trends in healthcare costs as a proportion of gross domestic product (GDP).

US Healthcare Spending as a Percentage of GDP, 1960–2017
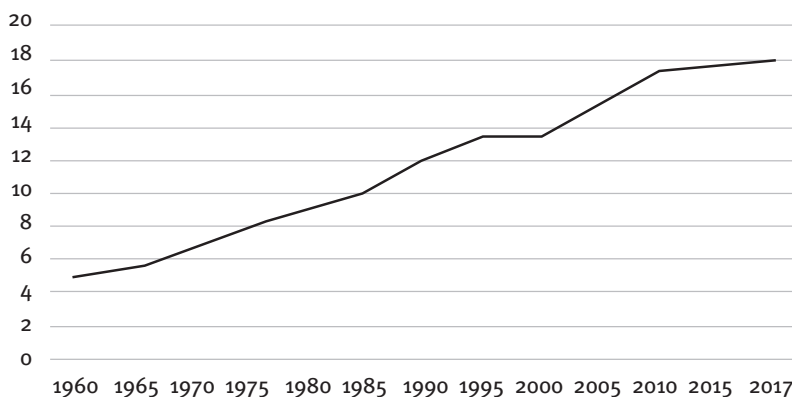
Source: Centers for Medicare & Medicaid Services (2019c).

Characteristics of Healthcare Organizations

Healthcare organizations tend to be multipurpose organizations. Although some purveyors of healthcare goods or services are single-minded in their intent, large healthcare organizations such as hospitals are likely to pursue a number of goals simultaneously. Indeed, the main goal of an academic medical center may not be to provide patient care at all. It may be education, research, or community service, with direct patient care as a secondary concern. Even large specialty practices are likely to be involved in teaching and research, and although they are not likely to neglect their core activity, they often have a more diffuse orientation than organizations in other industries.

Further, a large proportion of healthcare organizations—most notably, hospitals—are chartered as not-for-profit organizations. Although physician groups are usually incorporated as for-profit professional corporations, many community-based clinics, faith-based clinics, and government-supported programs operate on a not-for-profit basis. This "charitable" orientation creates an environment that is much different from that of other industries. The governmental financial support provided to some health facilities and programs also creates a different dynamic. For some organizations, the unpredictability of government subsidy is an unsettling factor. For others, the assurance of government support means they may not be as vulnerable to the vagaries of the market.

Characteristics of Healthcare Products

The goods and services that constitute healthcare products are also unique. Although many health-related goods (e.g., adhesive bandages, fitness equipment, over-the-counter drugs) may be marketed like any other products, most **consumer health products** do not fall into this category. Even the most common consumer health product—pharmaceuticals—must often be prescribed by an intermediary before it can be acquired and consumed.

consumer health products
Healthcare goods distributed through retail outlets and purchased directly by the customer.

Healthcare providers generally seek to promote the services they offer, yet the nature of their services is difficult to describe. A physician might break down services by procedure code (e.g., Current Procedural Terminology codes), but few services stand alone. Services are often delivered in "bundles," such as the group of services that make up a surgical procedure. Although clinicians (and their billing clerks) may see these services as discrete, the patient perceives them as a complex bundle of services related to a heart attack, diabetes management, or cancer treatment.

As discussed in chapter 6, the products generated by a healthcare organization are difficult to conceptualize. The things that healthcare organizations and health professionals think they provide (e.g., quality care, prolonged life, elimination of pathology) are hard to define and measure. The difficulty

of specifying the services provided becomes obvious when a marketer asks a hospital department head what services that department provides.

Healthcare services are also characterized by their inability to be substituted or replaced by other goods or services. For example, although one form of transportation can be substituted for another, a surgical procedure can seldom be substituted for another. Unlike other industries, healthcare often provides only one solution to a particular challenge.

Characteristics of Health Professionals

Historically, the healthcare industry has been dominated by professionals rather than by administrators. Clinical personnel (usually physicians but other clinicians as well) define much of the demand for health services and are directly or indirectly responsible for most healthcare expenditures. The situation in healthcare is complicated by the fact that clinicians and administrators may not share the same goals.

The medical **ethics** that drive the behavior of health professionals exist independently of system operations. Clinicians are bound by oath to do what is medically appropriate, whether or not it is cost-effective or contributes to the organization's efficiency. Decisions made in the best interests of the patient may not reflect the best interests of the organization. Although health professionals have had to become more realistic regarding the use of resources, clinical interests continue to outweigh financial considerations in most cases. Conflict between the goals of clinicians and administrators is inherent in healthcare organizations, and no comparable situation can be found in any other industry.

ethics
A code of behavior that specifies a moral stance, particularly in professional dealings.

The conflict between the clinical and business sides of the healthcare operation is exacerbated by the antibusiness orientation of many health professionals. Most healthcare workers enter the field because they want to be in a profession, not a business, and physicians and other clinicians often have distorted perceptions of the business world. If health professionals cannot appreciate the business side of the operation, they are not likely to appreciate the importance of marketing. Even among nonclinicians, many common business practices may be considered inappropriate for the not-for-profit healthcare world.

Characteristics of Healthcare Consumers

What probably sets the healthcare field apart from other industries most is the nature of its consumers. In healthcare, the term *consumer* refers to any person with the potential to consume a good or service. Everyone is likely to use healthcare goods or services and thus to be involved in the healthcare system at some time or another. Despite this unique attribute, healthcare organizations historically failed to perceive their consumers in

this manner. Until recently, the assumption was that a person was not a prospect for health services until he or she became sick. Thus, healthcare providers made no attempt to develop relationships with nonpatients. Today, however, numerous parties cater to nonpatients. Major industries have developed around disease prevention, fitness, and lifestyle management. Much of the social marketing that takes place in US society is geared to nonpatients.

Healthcare consumers are perhaps most distinguished from the consumers of other goods and services by their insulation from the price of the products they buy. Because of healthcare's unusual financing arrangements and lack of access to pricing information, healthcare consumers seldom know the price of services until after they have received those services. In typical cases, the physician or clinician providing the service is also not likely to know the price of those services. Because **third-party payers**—and not necessarily the end users—usually pay for the services performed, healthcare consumers may not even notice how much their care costs. As a result, clinicians are likely to provide or recommend the services they believe are medically necessary, regardless of price. However, this situation creates at least two problematic consequences.

First, consumers are not likely to willingly limit their resource utilization. If they do not know the amount of the fees being charged—and, further, do not have to pay them—they have no incentive to consider the cost. Similarly, physicians and clinicians have no incentive to provide services efficiently if cost is not a consideration. In fact, under traditional fee-for-service arrangements, the incentives available to physicians encourage greater use of resources because physicians receive an additional fee for each additional service they perform.

Second, few healthcare providers are able to use price as a means of competition or a basis for marketing. With the exception of organizations that provide elective services or that serve a retail market, providers cannot compete on the basis of price. Few healthcare organizations make their fee schedules public, and even when they do, they are likely to employ different mechanisms for determining the price of a service. For example, the per diem rates for a hospital room may be determined on the basis of different factors by two competing hospitals, making comparisons meaningless.

Another factor setting healthcare consumers apart from other consumers is the personal nature of the services involved. Most healthcare encounters involve an emotional component that is absent in other consumer transactions. Every diagnostic test is fraught with the possibility of a positive finding, and every surgery—no matter how minor—carries the risk of complications. Today's well-informed consumers are aware of not only the severity of

third-party payer
An entity—other than the provider and the patient—that pays the cost of goods or services.

medical errors that can occur during a hospital stay or procedure but also the rate of system-induced morbidity. Even if consumers remain stoic about their own care, they are likely to become emotional when the care concerns a parent, a child, or some other loved one.

Initial Barriers to Healthcare Marketing

Given the pervasiveness of marketing in the United States, how can the relative lack of marketing be explained in an industry that accounts for as much as 18 percent of GDP? This section discusses some of the barriers that have slowed the acceptance of marketing in the healthcare arena.

No Real or Perceived Need

Until the 1980s, most healthcare organizations thought they had no competitors. They had plenty of patients, and revenues were essentially guaranteed by third-party payers. Competition was often minimized through unwritten agreements among healthcare providers. If providers did not overtly collude to carve up the patient market, they respected informal boundaries that were set to reduce competition. They often maintained monopolies or oligopolies in their market areas.

These factors contributed to the perception (and, in many cases, the reality) that marketing was an unnecessary activity for healthcare organizations. From the perspective of mainstream providers, physicians referred their patients to the hospital, and insurance plans steered their enrollees to the facility. Why market to end users who were not going to make the decision anyway? This mind-set perpetuated the belief that marketing was not needed and overlooked such important marketing tasks as physician relationship development and health plan contract negotiation.

Resistance to Business Orientation

Much of health professionals' resistance to marketing reflected their misconceptions about the nature of business and marketing. For health professionals, business practices carried an unfavorable connotation—that clinical concerns were subjugated to business priorities. A similar misperception existed regarding the nature of marketing. "Marketing equals advertising" was the dominant perception early in the history of healthcare marketing, and even today, many health professionals retain that narrow (and negative) perception of marketing. The concern over contaminating a helping profession with business principles led healthcare organizations to enact provisions against advertising.

Perceived Marketing Costs

Concerns related to the cost of marketing also played a role in healthcare organizations' slow acceptance of marketing practices. Marketing (again, primarily advertising) was seen as an expensive undertaking. While more commercial operations, such as pharmaceutical companies, saw marketing expenses as a normal cost of doing business, hospitals and physicians with no experience in this regard suffered sticker shock at the marketing price tag. This lack of experience with marketing also caused them to overlook many aspects of marketing that involved little or no expense.

Even today, healthcare organizations are seldom able to measure the cost of providing a service, making **cost–benefit analyses** difficult to perform. Further, so many factors come into play in determining the use of services (e.g., referral patterns, consumer attitudes) that isolating the impact of marketing activities (or doing an **impact evaluation**) is hard. Even if marketing is cautiously accepted, there is widespread concern that marketing can do little to alter practice patterns, market shares, or other indicators of importance to the provider. Thus, given a chronic shortage of resources, many health professionals question the appropriateness of expending scarce resources on an activity perceived to have limited benefit. These concerns have been reinforced by disgruntled patients who have linked their high hospital bills to spending on expensive advertising. Even if the spending does not affect the patient's bill, highly visible marketing efforts could have a negative impact on the public image of many healthcare organizations.

Ethical and Legal Constraints

Ethical and legal constraints have also posed a major barrier to the incorporation of marketing into healthcare. The nature of health-related goods and services has made them the target of restrictions not found in other industries. As stated earlier, until recently it was considered unethical for physicians and many other clinicians to advertise. Although other types of marketing were generally accepted, overt advertising initiatives were discouraged, if not prohibited. Physicians were restrained by professional considerations, and hospitals often imposed internal constraints on their marketing activities.

In some cases, legal restraints have been put in place to prohibit advertising and other overt forms of marketing. The Federal Trade Commission, for example, limits the types of advertising and the advertising content that pharmaceutical companies and companies that make other healthcare consumer products can provide. Legislation also has been enacted to limit the marketing activities of providers reimbursed under the Medicare and Medicaid programs. Exhibit 1.4 presents additional ethical issues in healthcare marketing.

cost–benefit analysis
An evaluation technique that compares the cost of a project with its anticipated benefits.

impact evaluation
An assessment of the changes brought about by a marketing effort.

EXHIBIT 1.4
Ethical Issues
in Healthcare
Marketing

Concerns over the marketing of medical remedies can be traced back 200 years—to the days when patent medicines were sold on street corners, at carnivals, and by traveling salesmen. The claims made for such potions were often exaggerated or clearly false. Eventually, government regulations were put in place to control the claims of purveyors of such products; with the support of the American Medical Association (AMA), the first medicine labeling laws were passed in 1938. Today, in the United States, the federal Food and Drug Administration and the Federal Trade Commission serve as watchdogs over health-related products and medical devices.

Since the advent of the marketing era in the United States after World War II, ethical issues have nagged the healthcare industry. During the 1950s and 1960s, physicians commonly endorsed products in exchange for payment from the manufacturer. Physicians were paid to endorse pharmaceutical products, for example, by indicating that one drug was superior to its competitors. During this period, physicians sometimes strayed from their areas of expertise and endorsed other products as well. The most controversial of these actions involved physicians who endorsed cigarette brands. Doctors were paid to attest that brand X was healthier for consumers to smoke than brand Y.

These experiences led the AMA to enforce a virtual prohibition on marketing by physicians. As early as 1947, the AMA forbade physicians to advertise for self-promotion. This prohibition continued through 1957, when it was modified to only restrict physicians from soliciting patients. These restrictions did not affect such traditional marketing activities as networking and entertaining would-be referrers, and it was even customary at that time for doctors to provide kickbacks (called "fee splitting") to referring physicians.

By the 1960s, the strict injunction against advertising had been eased somewhat, and physicians were allowed to cite their name, address, and specialty in telephone directories and similar publications as a means of demonstrating their professionalism and distinguishing themselves from other health professionals. The AMA eventually stepped back from its strong stance against physician advertising, and in the 1990s, many physicians initiated aggressive marketing campaigns. Even so, such physicians are often perceived negatively by their colleagues.

Although hospitals were not constrained to the same extent, many hospital administrators also had ethical qualms concerning marketing (or

(continued)

EXHIBIT 1.4
Ethical Issues
in Healthcare
Marketing
(continued)

at least advertising). These qualms did not restrict marketing activities such as public relations, educational activities, and communication strategies, but they did discourage many hospitals from overt media advertising. Ultimately, the combined effect of increasing competition, reduced revenues, and more demanding consumers overcame any lingering reluctance of hospitals and health systems to engage in marketing.

Much of the controversy surrounding marketing in healthcare has involved the pharmaceutical industry. The marketing of over-the-counter drugs, of course, is covered by federal regulations that control the claims that can be made regarding a drug's efficacy. The marketing of prescription drugs directly to consumers is also tightly controlled by federal regulation, and until the end of the twentieth century, pharmaceutical companies were prohibited from marketing directly to consumers. Even with relaxed rules on pharmaceutical marketing, there are still strict limits on the claims that can be made in drug advertisements.

Drug manufacturers have stirred up the most controversy by focusing their marketing activities almost exclusively on the physicians who prescribe drugs to their patients. Pharmaceutical companies spend up to 25 percent of their budgets on marketing and sales activities, and the bulk of this sum has historically been allocated to advertising in medical journals, supporting continuing education programs for physicians, and making sales calls to physician practices.

Pharmaceutical companies' long-standing practice of providing free samples of drugs to physicians eventually came under fire and is now facing restrictions. More controversial, however, have been the blatant attempts to "buy" physician support by providing gifts, free trips, and other incentives designed to encourage physicians to endorse a particular drug through their prescribing practices. The US Congress eventually reacted to the perceived excesses of pharmaceutical companies attempting to influence the decision-making of physicians, and legislation was enacted that severely limited the ability of drug companies to provide incentives to physicians.

Although the marketing activities of health professionals will continue to be guided by self-imposed ethical standards, regulations governing the marketing of health-related products are not likely to disappear. Because of the nature of healthcare products and services, continued oversight by regulatory agencies can be expected. As marketing activities expand in healthcare, they will continue to be affected by a combination of ethical restraints and legal regulations.

Why Healthcare Marketing Requires a Unique Approach

Because marketing philosophies and techniques cannot be readily transferred from other industries to healthcare, healthcare marketing requires its own approach. The following summarizes the main ways in which healthcare marketing differs from marketing in other industries:

- **Health services are more of a challenge to market than goods.** Most of the products marketed in healthcare are services rather than goods. Health services are extremely difficult to segregate, and most episodes of care involve the consumption of both goods and services.
- **The demand for many health services is relatively rare and highly unpredictable.** Except for patients who suffer from chronic conditions and require ongoing care, significant health episodes are infrequent occurrences. Current hospital admission rates suggest that only 10 percent of the US population is hospitalized each year, and even that number overstates hospital use because some patients may be admitted more than once during a year. Further, the onset of significant health episodes is hard to predict, and the conditions that require the most intensive resources typically arise unexpectedly.
- **The healthcare end user may not be the target for the marketing campaign.** Healthcare is unique in that the end user may not be the decision maker regarding the consumption of services and goods. Further, the consumer may not be the party responsible for paying for the services and goods consumed. For these reasons, healthcare marketing is more difficult than marketing for typical consumer products, and price—a critical differentiating factor for most products—may not be relevant.
- **The healthcare product being marketed may be highly complex and may not lend itself to easy categorization.** With a few exceptions, healthcare products cannot easily be separated from other goods and services involved in an episode of care. For reimbursement purposes, costs are divided between professional fees and facilities fees, and a medical procedure (e.g., a hip replacement) can be complex, involving many parties and cost centers. Pricing is particularly a challenge when so many overlapping aspects of care exist.
- **Not all prospective customers for a health service are considered desirable.** While most healthcare providers have a moral, if not a legal, responsibility to care for all patients, the fact is that not all patients are considered desirable from a business perspective. Given the complexity of reimbursement for services, the availability of insurance coverage and the type of coverage may determine the desirability of a patient from

a financial perspective. The marketer's challenge is made even greater in that the organization cannot appear to be "skimming" the most profitable patients and neglecting the less profitable ones.

- **The outcome of health services is difficult to measure.** Promoting a service on the basis of superior outcomes represents a challenge for healthcare marketers. Although there is a growing movement toward "standardizing" medical protocols, a number of factors can lead to a favorable or unfavorable **outcome** in a clinical episode. Although a provider may be perceived as providing high-quality care, one or two adverse outcomes can distort this perception and increase the challenge for the marketer.

- **The impact or outcome of healthcare marketing efforts is difficult to measure.** Perhaps the greatest difference in healthcare marketing is its inability to definitively demonstrate that it is responsible for any observed change in organizational outcome (e.g., increased patient volume, higher revenues). Many different factors contribute to the flow of new patients to health services providers, so it is difficult to parse out the effect of marketing. Referral patterns of clinicians and steering by insurance plans are just two examples of factors that can mitigate the perceived benefit of marketing.

- **The differences between healthcare organizations and their services are difficult to quantify.** Over time, providers have become increasingly similar in the services they offer and the resources they bring to bear. Even differences in pricing may not be distinguishing factors because cost data are hard to acquire and may be calculated in a variety of ways, making comparison impossible. When all hospitals offer the same services, use the same equipment, and possibly even have overlapping medical staffs, it is challenging for the marketer to make the case for a superior (or even a different) organization.

outcome
In healthcare, the consequences of a clinical episode; in marketing, the results of a promotional campaign.

Developments That Encouraged Healthcare Marketing

Despite the barriers to incorporating marketing into healthcare, significant progress was made toward establishing marketing as an integral function of healthcare organizations during the 1980s and 1990s. Marketing was finally accepted by many healthcare organizations as a legitimate corporate function as a result of a number of developments that reflected shifts in society, trends in the healthcare industry, and changes in the nature of consumers. These key developments, many of which are discussed in later chapters, included the following:

- Introduction of competition
- Overcapacity in the hospital industry
- Rise of the consumer

- Introduction of new services
- Growth of elective procedures
- Introduction of a retail component
- Entry of entrepreneurs
- Mergers and acquisitions
- Need for social marketing
- Consumer engagement movement
- Enactment of the ACA

All of these developments occurred within the framework of a changing healthcare paradigm. Exhibit 1.5 traces the ongoing evolution from medical care to healthcare.

Since the 1970s, there has been a movement away from medical care toward healthcare. The growing awareness of the connection between lifestyle and health status and the realization that medical care is limited in its ability to control the disorders of modern society have prompted a move away from a strictly **medical model** of health and illness toward one that incorporates more of a social and psychological perspective. Originally noted by Engel (1977), this paradigm shift, in which medical care was redefined as healthcare, gained momentum during the 1980s and 1990s.

Medical care is narrowly defined as the formal services provided by the healthcare system that are under the control of a physician. This concept focuses on the clinical or treatment aspects of care and excludes the nonmedical dimension. **Healthcare**, on the other hand, consists of any function that might be directly or indirectly related to restoring, maintaining, or enhancing **health**. This concept includes not only formal activities (e.g., visiting a health professional) but also informal activities such as preventive care (e.g., brushing teeth), exercise, proper diet, and other health maintenance activities.

Since the beginning of the twentieth century, the dominant paradigm in Western medical science has been the medical model. Built on the germ theory, which was formulated in the late nineteenth century, the medical model provided an appropriate framework within which to address and respond to the acute health conditions that were prevalent well into the twentieth century. By the 1970s, however, enough anomalies had been identified to call this paradigm into question. Despite the ever-increasing sophistication of medical technology, the importance of the nonmedical aspects of care was increasingly recognized.

(continued)

EXHIBIT 1.5
From Medical Care to Healthcare

medical model
The traditional paradigm of Western medicine, which is based on germ theory and emphasizes a biomedical approach.

healthcare
Any formal or informal activity intended to restore, maintain, or enhance the health status of individuals or populations.

health
Traditionally, a state reflecting the absence of biological pathology; today, a state of overall physical, social, and psychological well-being.

EXHIBIT 1.5
From Medical
Care to
Healthcare
(continued)

epidemiologic transition
A change in a population's epidemiologic profile—from acute to chronic health problems—as a result of aging and changing demographic characteristics.

healthcare model
A holistic view of health and illness that includes biological, social, and psychological dimensions.

health status
The degree to which an individual or a population is characterized by health problems; the level of ill health in a population.

Clearly, the **epidemiologic transition**—by which acute conditions were displaced by chronic disorders—has played a major role. As acute conditions waned in importance and chronic and degenerative conditions came to the forefront, the medical model began to lose salience. Once the cause of most health conditions ceased to be environmental microorganisms and became aspects of lifestyle, a new model of health and illness was required. The chronic conditions that had come to account for most health problems did not respond well to the treatment and cure approach of the medical model. Chronic conditions could not be cured but had to be managed over a lifetime, and this called for a different approach.

Independent of this trend, patients had been expressing growing dissatisfaction with the operation of the healthcare system. The traditional approach to care was not a comfortable fit with the attitudes that baby boomers were bringing to the doctor's office. This population—more than any other group in US society—has been instrumental in placing the emphasis on healthcare. This cohort emphasizes convenience, value, responsiveness, patient participation, and other attributes not traditionally incorporated into the medical model. Further, the runaway costs of the healthcare system have led observers to question the wisdom of pursuing the one-size-fits-all approach to solving health problems that is traditional in medical care.

The transition from the medical care model to the **healthcare model** has affected every aspect of care, from the standard definitions of health and illness to the manner in which healthcare is delivered. **Health status** is now defined as a continuous process rather than a static condition. Causes of ill health are now sought in the environment, and the patient's social context is now often under the microscope. The importance of the nonmedical component of therapy has come to be recognized to the point that fathers are now allowed to participate in childbirth and family members are encouraged to participate in the treatment of cancer patients. Ultimately, this paradigm shift called for a significant change in the way healthcare organizations structure their marketing activities.

Why Healthcare Should Be Marketed

With marketing firmly established as a legitimate function in healthcare today, it may seem unnecessary to justify healthcare marketing efforts. However, some healthcare administrators and financial managers still question the need for and importance of marketing. The following arguments have been offered in defense of marketing throughout the years:

- **Building awareness.** With the introduction of new products and the emergence of informed consumers, healthcare organizations needed to build an awareness of their services and expose target audiences to their capabilities.
- **Enhancing visibility or image.** With the increasing standardization of healthcare services and a growing appreciation of reputation, healthcare organizations needed to improve top-of-mind awareness among consumers and distinguish themselves from their competitors.
- **Improving market penetration.** In the face of growing competition, healthcare organizations needed to increase patient volumes, grow revenues, and gain market share. With few new patients in many markets, marketing was critical for retaining existing customers and attracting new ones away from competitors.
- **Increasing prestige.** Many healthcare organizations, especially hospitals, believed success hinged on being able to surpass competitors' prestige. If prestige could be gained through having the best doctors, the latest equipment, and the nicest facilities, these factors needed to be conveyed to the general public.
- **Attracting medical staff and employees.** As the healthcare industry expanded, competition for skilled workers increased. Hospitals and other healthcare providers needed to promote themselves to potential employees by marketing the superior benefits they had to offer.
- **Serving as an information resource.** As healthcare became more complex and the array of available services grew, healthcare organizations needed to constantly inform the general public and the medical community about the products they offered. Whether through press releases or recorded telephone announcements, the pressure to get the word out was growing.
- **Influencing consumer decision-making.** Once healthcare organizations realized that consumers had a say in healthcare decision-making, the role of marketing in influencing this process was recognized. Whether it involved convincing consumers to select a particular organization's services or to speed up the decision-making process, marketing was becoming increasingly important.
- **Offsetting competitive marketing.** Once healthcare organizations realized their competitors were adopting aggressive marketing approaches, they began to adopt a stance of defensive marketing. They felt compelled to respond to the gambits of competitors by out-marketing them.
- **Demonstrating community involvement.** Not-for-profit healthcare organizations needed to demonstrate their contribution to improving the health of their communities, especially in light of the ACA's

focus on population health management. Increasing scrutiny of tax-exempt institutions encourages them to use marketing techniques that showcase how they address unmet health needs in their service areas.

Summary

Since the concept of marketing was introduced to healthcare providers in the 1970s, the field has undergone periods of growth, decline, retrenchment, and renewed growth. Initial resistance to healthcare marketing had to be overcome by an industry that was primarily not-for-profit and averse to self-promotion. The healthcare industry is unique in a number of ways, and numerous barriers prevented the immediate acceptance of marketing as an essential function.

Healthcare organizations slowly adopted marketing concepts and techniques from other industries and eventually developed approaches better suited to the unique nature of healthcare. Early on, marketing was often equated with advertising, so many healthcare organizations mounted major advertising campaigns during the 1980s. Realizing the limitations of advertising in a service industry, healthcare organizations added direct sales capabilities and technology-based marketing approaches to supplement their more traditional public relations and communication marketing techniques.

Today, a new generation of health professionals more oriented to business principles is in place, positions for directors and vice presidents of marketing are well established, and marketing is an accepted part of healthcare administration. Marketers are increasingly part of the corporate inner circle, reflecting the conversion of marketing from an external activity to a core function of progressive healthcare organizations.

Healthcare, like any other infrastructure for meeting US society's needs, has evolved to address the needs and wants of a population that is increasingly seeking solutions for a wide range of problems. The fact that healthcare now accounts for as much as 18 percent of the GDP reflects, among other trends, the population's growing concern for their health.

Key Points

- Although US industry adopted marketing in the 1950s, a number of factors initially prevented the healthcare industry from accepting marketing.
- The pioneers in healthcare marketing can be traced to the 1970s, but marketing was not widely accepted as a legitimate function for healthcare organizations until later.

- Early on, healthcare lacked experienced marketers, and marketing experts had to be imported from other industries.
- Changes in healthcare over time (particularly increasing competition) resulted in a surge of interest in marketing—interest that has been fostered with each new development in the field.
- Once health professionals accepted marketing, the field underwent periods of growth and contraction in response to market developments.
- Initially, healthcare marketing was often equated with advertising, and healthcare organizations underwent considerable trial and error before accepting other promotional techniques.
- By the 1990s, healthcare marketing was maturing as a field, and a new generation of healthcare administrators and healthcare marketers was on board.
- By the turn of the twenty-first century, healthcare organizations considered marketing an essential function, and marketing resources were increasingly tied to strategic planning and development efforts.
- Since 2000, social media have heavily affected marketing in healthcare, as in other industries.
- By the second decade of the twenty-first century, healthcare increasingly emphasized a population health model that focused on the health of groups of consumers rather than that of individual patients, significantly affecting the orientation of marketers.

Discussion Questions

1. Why didn't healthcare professionals consider marketing to be important until the 1980s?
2. What factors slowed the acceptance of marketing in healthcare?
3. Why do health professionals view marketing in a different way than their counterparts in other industries?
4. How do ethical and legal constraints affect marketing in healthcare more than in other industries?
5. What factors ultimately forced the incorporation of marketing into healthcare?
6. Why is today's healthcare environment more hospitable to marketing and marketers than past environments were?
7. What indicators attest that marketing has matured as a legitimate function in the healthcare field?

Additional Resources

American Marketing Association: www.ama.org.

Health Marketing Quarterly: www.tandfonline.com/toc/whmq20/current#.

Marketing Health Services: www.ama.org/publications/MarketingHealthServices.

Omran, A. R. 1971. "The Epidemiologic Transition: A Theory of the Epidemiology of Population Change." *Milbank Memorial Fund Quarterly* 49 (4): 509–38.

Society for Healthcare Strategy & Market Development: www.shsmd.org.

Thomas, R. K. 2003. *Society and Health: Sociology for Health Professionals*. New York: Springer.

BASIC MARKETING CONCEPTS

This chapter introduces the basic marketing concepts used in healthcare and other industries. Standard marketing terminology is presented, and relationships between the concepts are outlined. Many of these concepts are foreign to healthcare, and some are problematic in the healthcare setting. However, these definitions lay the groundwork for an understanding of the marketing endeavor and help health professionals understand the language that marketers use. Most of the concepts considered in this chapter are addressed in more detail in later chapters.

Defining Fundamental Concepts and Terms

Authors of textbooks often dive straight into the intricacies of their subject matter without clearly defining the concepts with which they are working. They assume the reader already has an appreciation of the basics. This assumption is often not valid, and it is certainly not likely to be the case for those approaching healthcare marketing for the first time. For this reason, the fundamental concepts of marketing are presented here, along with a discussion of their applications in the healthcare arena.

Marketing

Marketing can be defined in a variety of ways. According to the **American Marketing Association**, marketing is "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" (Bennett 1995). Another definition depicts marketing as a management process that identifies, anticipates, and supplies customer requirements efficiently and profitably. Philip Kotler (1999), an early proponent of marketing in healthcare, defines marketing as a social and managerial process by which individuals and groups obtain what they need and want by creating and exchanging products and value with others.

The first definition provides some important information about marketing. First, marketing is a process, which implies that the marketing operation involves several systematic steps. The definition specifies planning as part of the process. In other words, marketing should not be done impulsively;

marketing
A multifaceted process that involves research, planning, strategy formulation, promotion, and other activities in support of an organization, product, or idea.

American Marketing Association
The primary professional organization devoted to the marketing field.

marketing campaign
A formal, organized effort to promote a product to a target audience.

products
Ideas, goods, and services.

goods
Tangible products typically purchased in an impersonal setting on a one-at-a-time basis.

services
Activities or processes (or sets thereof) that meet the needs of a consumer.

the execution of a **marketing campaign** should be well thought out. This definition notes four components of the marketing process (elsewhere referred to as the "four Ps"): product, price, place, and promotion.

Products include the ideas, goods, or services an organization is promoting. Ideas may involve such concepts as a hospital's image or the notion that pregnant women should receive prenatal care. **Goods** and **services** together are thought of as products. In healthcare, products include tangible goods (e.g., crutches, hospital beds, adhesive bandages) and intangible services (e.g., physical examinations, immunizations, cardiac catheterizations).

The economic aspect of the marketing transaction is demonstrated by the fact that an exchange is regarded as the end result of the marketing process. Thus, a physician offers medical services in exchange for money (directly from the patient or from a third party), a hospital offers physicians staff privileges in exchange for their admissions, and an insurance plan offers healthcare coverage in exchange for the insured's premiums. All of these exchanges are facilitated through marketing at some level. Ultimately, the intent of marketing is to meet the goals of the organization (the seller) while, at the same time, meeting the needs of the customer (the buyer). Unless the goals of both parties are met, the marketing process is considered unsuccessful.

Healthcare Marketing

When marketing is extended to the healthcare field, not all components of the original definition fit comfortably, and the process must often be modified for application to the healthcare environment. While healthcare marketing is presumably meant to educate consumers about health issues and the resources that are available to them, it often has a self-serving dimension, in that it seeks to improve the market position of the organization doing the marketing. Healthcare marketers, however, may face restrictions that are not found in other industries. For example, healthcare providers may have limited ability to use price as a marketing tool because third-party payers are willing to pay only a specified amount, regardless of the provider's fee. Or hospitals may be limited in their ability to change their location in response to consumer demand. Thus, one challenge for healthcare marketers is to adapt marketing principles to the unique characteristics of the healthcare industry. Exhibit 2.1 moves beyond the standard definitions and discusses what marketing really *is*.

market
A setting in which buyers and sellers (actual and potential) come together to exchange goods and services.

Market

The concept of marketing implies the existence of a market. Initially, a **market** referred to a real or virtual setting in which potential buyers and potential sellers of goods or services came together for the purpose of exchange. In this sense, it refers to both function (a system for exchange) and form (a

Most health professionals think of marketing in terms of advertising, public relations, direct mail, or any number of other promotional techniques. All too often in healthcare, the term *marketing* is used in reference to one of these specific functions, masking the range of activities carried out under the banner of marketing and the extent to which marketing should pervade an organization.

Marketing has been defined as any activity related to the development, packaging, price, and distribution of healthcare products, along with any mechanisms used for promoting these products. This definition, however, does not capture the essence of marketing. Marketing is a multifaceted process that involves a wide range of activities, of which the promotional piece (e.g., advertising) is a small—albeit highly visible—part. Marketing involves research, planning, strategy formulation, and a number of activities that have little to do with promotion. (Indeed, promotion is only one of the four Ps that constitute the marketing mix.)

Considered in a less pecuniary light, marketing serves the healthcare consumer as a force for health education, an information resource, a guide to decision-making, and an opportunity to make the customer's perspective known. From the organization's perspective, the marketing program can provide input into strategic direction, coordinate a wide range of corporate activities, and support the development of a customer service organization. Marketing can make or break the organization's reputation and can serve as the driving force in relationship development efforts.

Marketing—and marketers—are often viewed in a less than favorable light, not only in healthcare but in other industries as well. However, if one understands the true functions of marketing, it is clear that marketing can make a more significant contribution to the success of the organization than is generally acknowledged.

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marketplace). The notion of a marketplace has been modified to refer to the individuals or organizations in a market that are potential customers. Thus, to marketers, a market is a set of people (or organizations) who have an actual or a potential interest in a good or service or, according to Kotler (1999), a set of actual and potential buyers of a product. Alternatively, a market is defined as a group of consumers who share some characteristic that affects their needs or wants and makes them potential customers for a good or service.

Markets are often thought of in terms of a **market area**—that is, a geographic area containing the potential customers for a particular organization's goods or services. Markets may also be defined in nongeographic terms and refer to segments of the population independent of geography. The

market area
The actual or desired area from which organizations draw or intend to draw customers; also known as *service area*.

market, however defined, is thought to generate a measurable level of *market demand*, which represents the total volume of a product or service likely to be consumed by specific groups of customers in a specified market area during a specified period. (Demand is a problematic concept in healthcare; chapter 7 is devoted to this topic.)

Marketing Functions

Now that the basic definitions are out of the way, it may be worthwhile to consider the actual functions of marketing in healthcare (or any other industry). The functions of marketing form a hierarchy, with the broad, big-picture functions at the top and the narrow-focused functions at the bottom. This section describes the types of marketing functions at the different levels of the hierarchy.

Enterprisewide Functions

The most expansive marketing operations carried out by a healthcare organization affect the entire enterprise (i.e., hospital, health system, health plan). At this level, marketers perform the following functions:

- **Conceptualizing the market.** From the organization's perspective, a marketer's primary function is to conceptualize the market in which the organization operates. Conceptualization involves profiling the organization in terms of its attributes, determining the market it serves (and the characteristics of the market area population), assessing the environment in which healthcare functions, and determining how the organization relates to the market.
- **Determining strategic direction.** The marketer's functions include identifying the organization's strategic vision (if one has been stated), examining the organization's position in the market, and identifying opportunities in the marketplace. The marketer considers strategic options and chooses the approach that best fits the organization and the market it seeks to cultivate.
- **Supporting business goals.** The marketer supports the organization's business development by identifying segments of the market on which to focus, clarifying opportunities in the marketplace, determining the organization's position in relation to its competitors, and assessing the nature of the services the market desires. A range of promotional techniques can be used to support this function.
- **Establishing a reputation.** Some marketers would argue that the essence of marketing is building and enhancing an organization's

reputation. All organizations are assigned a reputation by the consuming public, whether they want one or not. Marketers are responsible for proactively creating a positive reputation, enhancing it through an integrated marketing approach, and protecting it against the efforts of competitors.

Operational Functions

Enterprisewide marketing addresses the needs of the organization through strategy development and reputation management. Marketing also supports narrower concerns related to the operations of the organization, as indicated by the following functions:

- **Performing marketing research.** Marketing research provides the foundation for all other marketing functions. On an ongoing basis, the marketer should delineate the service area for the organization, specify the service area's characteristics and population, and analyze the competition. Marketing research should identify opportunities in the market in terms of growing demand, underserved populations, and new product potential.
- **Developing a marketing plan.** Health professionals often neglect to develop systematic plans for accomplishing their goals, and marketers sometimes have a tendency to rush into a marketing campaign without an overarching plan. The marketing plan should reflect the goals and objectives established by the organization, not just for marketing but also for overall organizational advancement. The marketer's primary responsibility is to ensure that a well-conceived marketing plan is in place before any promotional activities are implemented.
- **Coordinating enterprisewide promotional efforts.** One of the first things any marketer should do is identify all existing promotional efforts that are underway on the part of the organization. Existing marketing efforts should be evaluated and standards should be developed to ensure a consistent message across all promotional activities. The marketer should coordinate the marketing efforts of the entities in the organization and serve as a liaison between internal marketing efforts and external marketing resources.
- **Developing relationships.** Many would argue that the primary goal of marketing is to develop relationships, which is also an area of emphasis in contemporary healthcare. Relationships may involve patients and other customers, referring physicians, health plans, business partners, government representatives, and a host of other entities with whom the healthcare organization needs to maintain

relationships. The marketer has a key role in most aspects of developing and maintaining relationships.

- **Creating a marketing organization.** Organizations' marketing efforts often overlook their own employees. Healthcare organizations can establish a marketing mind-set among their employees through internal marketing, thereby turning every associate into a salesperson and creating a marketing organization. Ideally, every employee should have some marketing skills, and every decision should be made with marketing implications in mind. The marketer is responsible for ensuring that marketing is incorporated into the organization's DNA.

Educational Functions

An important but sometimes overlooked function of marketing is educating the public. As indicated by the following list, providing information to existing and prospective customers, referring physicians, potential donors, and other constituent groups is a major responsibility of marketing professionals.

- **Educating patients and the general public.** With the introduction of new products and the emergence of informed consumers, healthcare organizations must build awareness of their services and educate target audiences about their capabilities. Healthcare consumers have short attention spans, and the public must be continually reminded of the organization's availability. For some, the educational function of marketing takes precedence over all other functions.
- **Providing information and referral resources.** Healthcare organizations are considered an important resource for the community. Not only does marketing make consumers aware of the organization's services, but also it fulfills the organization's responsibility to educate the community regarding positive health behavior. In community after community, the most trusted healthcare organizations are those that are perceived as reliable sources of health information.
- **Enhancing visibility and corporate image.** With the increasing standardization of healthcare services and a growing appreciation of reputation, healthcare organizations find it necessary to initiate marketing campaigns that improve top-of-mind awareness and distinguish them from their competitors. Consumers are bombarded by ever-increasing message "clutter," and marketers must be able to communicate the organization's message effectively to maintain a high level of visibility and promote a positive corporate image.
- **Differentiating the organization and its services.** At a time when it is increasingly difficult for healthcare consumers to distinguish one healthcare organization from another, the marketer needs to impress

upon the target audience how the organization is different from its competitors and why consumers should care about the difference. In the unlikely case that little or no differences exist, the marketer must make a creative case that establishes a competitive advantage.

Promotional Functions

Promotional activities are generally the first things that come to mind when the topic of marketing comes up. The following functions relate to the day-to-day activities of marketers in a healthcare setting:

- **Influencing consumer decision-making.** With consumers now taking a more active role in healthcare decision-making, marketers have an unprecedented opportunity to make a case for their organization. After building awareness among consumers, the marketer's next responsibility is to influence consumer behavior. Marketers should be sensitive to the stage of readiness of customer groups and implement marketing techniques accordingly.

- **Improving market penetration.** Healthcare organizations faced with growing competition can use marketing as a means of increasing patient volumes and growing market share. With few new patients in many markets, marketing becomes critical for retaining existing customers and attracting competitors' customers. Marketers are well positioned to identify opportunities in the marketplace and implement programs that will attract customers and increase market penetration. If the organization cannot establish a favorable position in the market, its competitors will dictate its position.

- **Increasing profit.** On the surface, we might assume that the raison d'être for healthcare marketing should be to increase profits, and hence it should be first among marketing functions. However, the obvious conclusion may not be the most appropriate conclusion in healthcare, given the high proportion of not-for-profit organizations in the industry and the need to satisfy other goals in addition to bottom-line profits. More important is the need to perform a wide range of other functions before the profit motive can even be considered.

- **Winning awards versus being effective.** Note that the previous statements say nothing about winning awards for marketing campaigns. For many marketing professionals who entered healthcare from other industries, the goal was to sponsor award-winning media campaigns that involved flashy promotional materials or television spots. Unfortunately, there appears to be little correlation between receiving accolades for marketing campaigns and the success of the organization being promoted. Decision makers and those paying for services in

healthcare are less influenced by slick advertising campaigns than they are by the actual substance offered by the healthcare organization.

Marketing Techniques

The action dimension of marketing is embodied in the techniques marketers use to support the marketing functions. On a day-to-day basis, marketers are likely to pay less attention to the lofty goals of the marketing endeavor and more attention to concrete marketing activities. The techniques marketers use to achieve their objectives are summarized in this section and described in detail in chapters 11 and 12.

Public Relations

public relations (PR)
The management of communication that uses publicity and other persuasive techniques to influence feelings, opinions, or beliefs.

Public relations (PR) is a form of communication management that uses publicity and other forms of promotion and information to influence feelings, opinions, or beliefs about an organization and its products. The PR function is carried out through press releases, press conferences, distribution of feature stories to the media, public service announcements, and other publicity-oriented activities. In the past, healthcare organizations have used PR to manage crises and control damage, justify questionable actions, and explain negative events. Over time, however, PR has been cast in a more proactive light as healthcare organizations have come to appreciate the benefits of a strong PR program.

Communication

communication
The process of conveying information to internal and external audiences.

Large healthcare organizations typically establish mechanisms for communicating with their stakeholders (internal and external). Communications staff develops materials to disseminate to the public and to the employees of the organization, generates internal newsletters and publications geared to relevant customer groups (e.g., patients, enrollees), and develops patient education materials. Separate communications departments may be established, or this function may overlap with the public relations or community outreach functions. Marketers expend a great deal of effort in determining the best approaches to communication. Exhibit 2.2 discusses **communication** concepts applied to healthcare marketing.

Community Outreach

community outreach
A presentation of an organization's programs and services to the community to establish a relationship.

Community outreach is a form of marketing that seeks to present the organization's programs to the community and establish relationships with community organizations. Community outreach may involve episodic activities, such as health fairs or educational programs for community residents, or

Communication refers to the transmission or exchange of information and implies the sharing of meaning among those who are communicating. Students of marketing have expended considerable effort on specifying models of communication that relate to the marketing process. Communication in marketing may be directed at (1) initiating actions; (2) making needs and requirements known; (3) exchanging information, ideas, attitudes, and beliefs; (4) advancing understanding; or (5) establishing and maintaining relations.

Communication in marketing can occur in a variety of ways:

- **Face-to-face communication** includes formal meetings, interviews, and informal contact.
- **Oral communication** includes telephone contact, public address systems, and video conferencing systems.
- **Written communication** includes letters (external), memoranda (internal), e-mails, reports, forms, notice boards, journals, bulletins, newsletters, and manuals.
- **Visual communication** includes charts, films, slides, videos, and video conferencing.
- **Electronic communication** includes internet chat, voice mail, and electronic data interchange.

A number of communication models have been developed for application to marketing, and Berkowitz (2016) has adapted one of these models for healthcare. According to Berkowitz, this marketing communication model has nine components in healthcare. An understanding of each of these components is important for effective marketing communication.

1. **Sender.** The sender is the party sending the message to the other party. Also referred to as the communicator or the source, the sender is the "who" of the process and takes the form of a person, company, or spokesperson for someone else.
2. **Message.** The message is the combination of symbols and words the sender wishes to transmit to the receiver. The message is the "what" of the process and indicates the content the sender wants to convey.
3. **Encoding.** Encoding is the process of translating the meaning of the message into symbolic form (e.g., words, signs, sounds). At this point, a concept is converted into something transmittable.

(continued)

EXHIBIT 2.2
Communication
Theories in
Marketing
(continued)

4. **Channel.** The channel is the means used to deliver a marketing message from sender to receiver. The channel is the "how" of the process and connects the sender to the receiver.

5. **Receiver.** The receiver is the party receiving the message, also known as the audience or the destination. Marketing efforts are directed toward a receiver.

6. **Decoding.** Decoding refers to the process carried out when the receiver converts the "symbols" transmitted by the sender into a form that makes sense to him or her. This process assumes that the receiver is using the same basis for decoding that the sender used for encoding.

7. **Response.** Response refers to the receiver's reaction to the message. At this point, the effect of the message is gauged in terms of the meaning the receiver attaches to it.

8. **Feedback.** Feedback refers to the aspect of the receiver's response that the receiver communicates back to the sender. The type of feedback depends on the channel, and the effectiveness of the effort is gauged in terms of the feedback.

9. **Noise.** Noise refers to any factor that prevents the receiver from decoding a message in the way the sender intended. Noise can be generated by the sender, the receiver, the message, the channel, the environment, and so forth.

The marketing communication process could be unsuccessful for any number of reasons. Factors that might influence this process include selective attention of the receiver, selective distortion by the receiver (i.e., changing the message to fit preconceptions), selective recall (i.e., the receiver absorbs only part of the message), and message rehearsal (i.e., the message reminds the receiver of related issues that tend to distract from the point of the message).

Communication experts indicate that effective communication requires certain attributes: It must contain value for the receiver; be meaningful, relevant, and understandable; and be transmittable in a few seconds. Further, the communication must lend itself to visual presentation, if possible; be relevant to the lives of everyday people; and stimulate the receiver emotionally. Marketing communication must also be interesting, entertaining, and stimulating.

Source: Adapted from Berkowitz (2016).

it may involve ongoing initiatives carried out by outreach workers who are visible in the community. This aspect of marketing emphasizes the organization's commitment to the community and its support of local organizations. Community outreach initiatives seek to generate word-of-mouth publicity for the organization or its services.

Government Relations

Long before most healthcare organizations considered incorporating a formal marketing function, they were involved in **government relations** activities. Healthcare organizations are typically regulated by state and federal government agencies. Decisions related to adding, eliminating, or changing a service may be constrained by government regulations, and the reimbursement available to healthcare providers may be controlled by government agencies. Not-for-profit organizations must continually demonstrate that they deserve their tax-exempt status. For these reasons, healthcare organizations must maintain discourse with a variety of government agencies, cultivate relationships with politicians and other policymakers, and often initiate lobbying activities directed toward different levels of government.

government relations
Organizational liaisons with government agencies that enact regulations, determine reimbursement levels, provide funding, and monitor activities.

Networking

Networking involves developing and nurturing relationships with individuals and organizations with which mutually beneficial transactions can be carried out. Physicians and other clinicians—who, until recently, would never deign to advertise—actively network with their colleagues. Networking may take the form of a specialist casually running into potential referring physicians in social situations or a hospital administrator attending meetings that involve potential clients, partners, or referral agents. Networking is particularly effective when dealing with parties who are reluctant to provide "face time" or when one prefers an informal setting involving personal interaction for getting to know prospective business associates.

networking
The process of establishing and nurturing relationships that may result in a mutual benefit.

Sales Promotion

Sales promotion involves any activities or materials that act as a direct inducement to customers by offering added value to a product. Sales promotions are more likely to be associated with the sale of consumer health products (e.g., rebates) or business-to-business healthcare sales (e.g., low-interest financing) than with the provision of health services. The sales promotion mix might involve health fairs and trade shows, exhibits, demonstrations, contests and games, premiums and gifts, rebates, low-interest financing, and trade-in allowances. Sales promotion is separate from, but often an adjunct to, personal sales.

sales promotion
The process of highlighting the value of a product to induce a purchase.

Advertising

Advertising refers to any paid form of nonpersonal presentation or promotion of ideas, goods, or services by an identifiable sponsor transmitted through mass media for the purpose of achieving marketing objectives. The advertising mix might include print advertisements, electronic advertisements, mailings, catalogs, brochures, posters, directories, outdoor advertisements, and displays. These activities are organized in the form of an advertising campaign that involves designing a series of advertisements and placing them in advertising media to reach a target market.

Personal Sales

personal sales
An oral or conversational presentation of promotional material to a prospective purchaser for the purpose of sales.

Personal sales involve the presentation of promotional material in a conversation with one or more prospective purchasers for the purpose of making sales. The salesperson attempts to foster a mutually profitable economic exchange between buyer and seller through interpersonal contact. The success of personal sales depends on the seller's ability to communicate the product's qualities and its benefits for the buyer. Personal sales might encompass sales presentations, sales meetings, incentive programs, distribution of samples, and participation in health fairs and trade shows.

Database Marketing

database marketing
The use of a data set of past, current, and prospective customers to promote an organization's products.

Database marketing involves establishing and exploiting data on past and current customers and future prospects in a way that allows effective marketing strategies to be implemented. Database marketing can be used for any purpose that can benefit from access to customer information. These functions may include evaluating new prospects, cross-selling related products, launching new products to potential prospects, identifying new distribution channels, building customer loyalty, converting occasional users to regular users, generating inquiries and follow-up sales, and establishing niche marketing initiatives. The database established for this purpose often provides the basis for customer relationship management and may be an integral part of an organization's call center.

Direct Marketing

direct marketing
The process of targeting groups or individuals with specific characteristics and transmitting promotions directly to them.

Direct marketing targets groups or individuals with specific characteristics and transmits promotional messages straight to them. These promotional activities may take the form of direct mail or telemarketing as well as other approaches aimed at specific individuals. Increasingly, the internet is being used for direct marketing. An advantage of direct marketing is that the message can be customized to meet the needs of target populations.

Customer Relationship Management

Customer relationship management (CRM) is a business strategy designed to optimize profitability, revenue, and **customer satisfaction** by focusing on relationships rather than transactions. Although long used in other industries, CRM is relatively new to healthcare. The industry's lack of focus on customer characteristics and its limited data management capabilities have slowed the acceptance of CRM in healthcare. However, the new market-driven environment is encouraging healthcare organizations to develop and use customer databases.

Social Marketing

In healthcare, **social marketing** involves applying commercial marketing techniques to influence the attitudes, knowledge, and behavior of target audiences related to the improvement of individual and community health status. Social marketing differs from other types of marketing only with respect to the objectives of marketers and their organizations. Social marketers seek to influence social behaviors for the benefit of their target audience and general society, not for the benefit of the marketing organization. In contrast to the top-down approach of traditional marketing, social marketers listen to the needs and desires of the target audience and build the marketing campaign from the bottom up.

Case study 2.1 describes a marketing campaign that used a variety of marketing techniques.

customer relationship management (CRM)
A business strategy designed to optimize profitability, revenue, and customer satisfaction by focusing on customer relationships rather than transactions.

customer satisfaction
The degree to which customers' wants and needs are fulfilled.

social marketing
An approach to effecting behavior change in the general population through public relations, advertising, and other techniques.

Case Study 2.1
Capturing the "Older Adult" Market

Many healthcare organizations came to see the aging of the baby boom generation as an opportunity to expand their services. Regional Medical Center (RMC, a fictional organization on which this case study is based) responded to this opportunity by establishing a service line devoted to older adults. The intent was to capture the business—and the loyalty—of this large, relatively affluent, and increasingly needy segment of the population. The service line was designed to meet the emerging needs of this population for specialty services such as cardiology, orthopedics, ophthalmology, and urology in a way that would be appealing to this relatively demanding consumer segment.

Because this service was considered innovative in the community served by RMC, an aggressive promotional campaign was undertaken. RMC's

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marketing department considered a wide range of marketing options and decided on a multipronged campaign to approach the target population from a variety of directions. The first phase of the promotional campaign focused on internal marketing. It was important that RMC's employees be familiar with this new program and be able to articulate its merits to potential customers. Many of the customers for the new program were likely to be existing patients of RMC.

Well before the new program was scheduled to open for enrollment, an aggressive PR campaign was initiated. Press releases were distributed, articles were prepared for local publications and professional journals, and celebrity spokespeople were lined up. Simple yet attractive **collateral materials** (e.g., business cards, letterhead, envelopes, brochures) were developed for distribution to prospective customers and to referral agents who might channel customers to RMC. Information was distributed to providers and organizations that might serve other needs of the target population, and the community's major insurance plans were made aware of the new program and its benefits. Tours of the facility housing the new program were provided to key constituents (e.g., referring physicians and health plan representatives), and open houses were scheduled for both medical professionals and the general public.

The marketing initiative also involved direct solicitation of members of the target population. RMC extracted data from its internal database on existing customers and purchased mailing lists of households that included members aged 50 to 65. Using the findings from previous research on the "buttons to push" in this age cohort, marketing staff prepared materials that would appeal to the particular needs of older adults. The address lists were then used to mail materials directly to targeted individuals.

While RMC did not want to rely on expensive media advertising for attracting customers, its marketers felt that some media presence was necessary—not only to attract customers who might be missed through the direct mail campaign but also to make the general public aware of this new program. In some cases, other family members might be making decisions for the older adult population, and awareness of this program on the part of the general public was considered important. After careful research on the communication attributes of family caregivers, a series of newspaper, radio, and television advertisements were produced. These advertisements were placed in the sections of the local newspaper that members of this age group read, aired on the radio stations they preferred, and presented on the television channels they viewed most often. For the electronic media, particular

collateral material
Material in any form used to reinforce an organization's image or support a media advertising campaign.

attention was paid to the time of day and day of the week members of the target population were expected to be engaged.

The success of RMC's new older adult service line during the first year exceeded the expectations of the organization's administrators. While it was difficult to determine which of the promotional techniques used had the most impact on the program's early success, the marketing staff concluded, on the basis of its evaluation of the campaign, that it was the integrated approach—a variety of coordinated activities—that led to the successful program launch.

Case Study Discussion Questions

1. Why did RMC think that older adults presented enough of a market opportunity to establish an entirely new program?
2. What information did RMC need to gather about this target population before the program could be established?
3. What information did RMC need to gather about this target population before the marketing campaign could be planned?
4. What were the different paths through which RMC attempted to reach the target audience?
5. Which marketing techniques did RMC use to reach the target population?
6. Why was internal marketing an important first step in marketing this new program?

Marketing Approaches

Marketers employ marketing strategies that reflect the audience they are soliciting. A campaign aimed at the general population will involve a different approach from one targeting a population subgroup. Depending on the circumstances, the approach may include mass marketing, target marketing, or micromarketing.

Mass Marketing

Mass marketing involves the development of generic messages that are widely broadcast to the entire service area. No attempt is made to target specific audiences, identify likely best customers, or tailor the message to a particular subgroup. This approach involves the use of mass media (e.g., newspaper, radio, television) to blanket the market area. The message has to

mass marketing
An approach that targets the total population—typically through network television or newspapers—as if it were one undifferentiated conglomeration of consumers.

be general and typically touts the merits of the organization rather than any specific services.

Hospitals' use of mass marketing in the past reflected their desire to promote the organization overall (rather than specific services) and their belief that they could be all things to all people. No attempt was made to distinguish between different segments of the population, and only the crudest distinction based on geography was made between markets. This type of approach is effective at disseminating a small amount of information to a large number of people, and it can be useful when marketing a basic product that appeals to a homogenous audience.

Target Marketing

target marketing
An approach that focuses on a market segment to which an organization desires to offer goods or services.

Target marketing refers to marketing initiatives that focus on a market segment to which an organization desires to offer goods or services. Target marketing stands in contrast to mass marketing, which aims promotional efforts at the total market. Target markets in healthcare may be defined on the basis of geography, demographics, lifestyle, insurance coverage, usage rate, and other customer attributes. Thus, target marketing is likely to involve the use of customer segmentation systems.

As healthcare marketing has matured as a routine function of healthcare organizations, the emphasis has shifted from mass marketing to target marketing. Target marketing, it could be argued, represents a more advanced approach to customer engagement since it identifies segments of the population, profiles these segments, and implements marketing initiatives geared to the attributes of the specific segments.

Micromarketing

micromarketing
An approach that breaks the market down to the household or even the individual level to target those most likely to consume a product.

Micromarketing is a form of target marketing. Companies that use micromarketing tailor their marketing programs to the needs and wants of consumers narrowly defined in terms of geography, demographics, psychographics, or the benefits they desire. Customers and potential customers are identified at the household or individual level and directly marketed to using customized communication techniques. Micromarketing is most effective when marketers want to reach consumers with a narrow range of attributes.

Healthcare Products and Audiences

The definition of marketing offered at the beginning of this chapter refers to the promotion of ideas, goods, or services. (The term *product*, used throughout this text, is sometimes used interchangeably with *service*.) The product to be marketed in healthcare is often difficult to specify, unlike the products of

other industries. Most of what healthcare organizations offer takes the form of services, and unlike goods, they tend to be harder to precisely describe.

In addition, the nature of the product in healthcare has changed dramatically over the past couple of decades. Twenty years ago, one could define the product simply as a medical procedure, an orthotic device to correct a physical disability, or a consumer health product. In today's climate, healthcare products include not only these traditional products but also prepaid health insurance plans offered by health maintenance organizations or a group purchasing contract offered by a provider network. (The nature of healthcare products is discussed further in chapter 6.)

Many healthcare organizations offer a variety of products to their customers. Certainly, the hospital is an example of an organization that offers a wide range of services and goods. A major hospital offers hundreds, if not thousands, of different procedures. In addition, hospitals offer a variety of goods (in the form of drugs, supplies, and equipment) that are charged to the customer. An organization's product mix can be described in terms of the combination of ideas, goods, and services it offers.

Healthcare Products

Ideas

Much of what healthcare organizations promote takes the form of *ideas*—intangible concepts that are intended to convey a perception to the consumer. The organization's image is an idea that is likely to be conveyed through marketing activities. The organization may want to promote the perception of quality care, professionalism, value, or some other subjective attribute. The development of a brand, for example, involves the marketing of an idea. The intent is to establish a mind-set that places the organization at the top of the consumer's mind on the assumption that familiarity will encourage consumer action.

When healthcare organizations first incorporated advertising, most of the attention was focused on promoting ideas. In particular, early marketers attempted to promote the organization's image and establish it as the preferred provider in its market. Although the trend has shifted away from image advertising and toward service advertising, many healthcare organizations continue to market ideas to their target audiences.

Goods

For the purposes of this text, products can refer to goods or services. *Goods* are tangible products typically purchased in an impersonal setting on a one-at-a-time basis. The purchase of goods tends to be a one-time transaction, while the purchase of services may be fulfilled in an ongoing process. Although healthcare is generally perceived in terms of a service, the sale of

goods is ubiquitous in the industry. Consumer health products (e.g., soap, condoms, toothpaste) are household products. Pharmaceuticals—whether prescription or over the counter—are purchased by nearly everyone at some point. Consumers are even gaining access to home-testing kits (e.g., pregnancy and ovulation tests) and therapeutic equipment (e.g., hearing aids), and the sale or rental of durable medical equipment (e.g., wheelchairs) is a major industry. Even in a hospital setting, the bill for care is likely to include a number of goods among the itemized charges.

Services

Relative to goods, *services* are difficult to conceptualize. Services (e.g., physical examinations) are intangible in that they do not take the concrete form of goods (e.g., drugs). Services are more difficult to quantify, and consumers evaluate them differently than tangible products. Because services are often more personal (especially in the case of healthcare), they are likely to be assessed in subjective rather than objective terms. They are variable in that they cannot be subjected to the quality controls placed on goods but reflect the variations that characterize the human beings who provide the services. They are inseparable from the producer in that they are dispensed on the spot without separation from the provider. They are perishable in that they cannot be stored and, once provided, have no residual value. Finally, they defy ownership rules in that, unlike goods, they do not involve transfer of tangible property from the seller to the buyer.

Healthcare Audiences

Consumers

Consumer, as the term is usually used in healthcare, refers to any individual or organization that is a potential purchaser of a healthcare product. (This definition differs from the more economics-based notion of a consumer as the entity who actually uses the product.) Theoretically, everyone is a potential consumer of health services; consumer research, for example, is generally aimed at the public at large. The consumer is often the end user of a good or service but may not necessarily be the purchaser. The term **consumer behavior** refers to the utilization patterns and purchasing practices of the population of a market area.

Customers

In healthcare, the **customer** is typically thought of as the actual purchaser of goods or services. Although a patient may be a customer for certain goods and services, the **end user** (e.g., the patient) is often not the customer. Someone else may make the purchase on behalf of the patient. Further, treatment decisions may be made by someone other than the patient. For this reason,

consumer
In healthcare, any individual or organization that is a potential purchaser of goods and services.

consumer behavior
The consumer's pattern of consumption of goods and services.

customer
In healthcare, the actual purchaser (but not necessarily the end user) of goods or services.

end user
The person or organization that ultimately consumes a good or service, regardless of who makes the purchase decision or pays for the product.

hospitals and other complex healthcare organizations are likely to serve a range of customers, including patients, referral agents, admitting physicians, employers, and a variety of other parties who may purchase goods or services from the organization. For this reason, the customer identification process in healthcare is more complicated than it is in other industries.

Clients

A **client** is a type of customer that consumes services rather than goods. A client relationship implies personal (rather than impersonal) interaction and an ongoing relationship (rather than a single encounter). Professionals typically have clients, whereas retailers have customers or purchasers. The relationships between service providers and clients are likely to be more symmetrical than the relationships between service providers and patients, who are typically dependent on and powerless relative to the service provider. Many also believe the term *client* implies more respect than the term *patient*.

client
In healthcare, a customer that consumes services rather than goods; in advertising, the entity being served by the advertising agency.

Patients

Although the word **patient** is used loosely in informal discussion, a patient is someone who has been defined as sick by a physician. This definition almost always implies formal contact with a clinical facility (e.g., physician's office, hospital). Technically, a symptomatic individual does not become a patient until a physician officially designates the individual as such, even if the prospective patient has consumed over-the-counter drugs and taken other measures for self-care. Under this scenario, an individual remains a "patient" until discharged from medical care.

patient
An individual who has been officially diagnosed with a health condition and is receiving formal medical care.

Nonphysician clinicians may treat patients, but because they do not provide medical services, they are discouraged from using the term. For example, behavioral health counselors are likely to refer to their patients as *clients*. Dependent practitioners, who work under the supervision of physicians (e.g., physical therapists), however, are likely to define their charges as patients.

Enrollees

Although health insurance plans have historically called their customers **enrollees**, use of this term has only recently become common among healthcare providers. However, with the ascendancy of managed care as a major force in healthcare, other healthcare organizations began to adopt this term. Thus, providers who contracted to provide services for members of a health plan began to think in terms of enrollees. This shift in nomenclature is significant because enrollees and patients have different attributes. Enrollees may also be referred to as *members*, *insureds*, or *covered lives*.

enrollee
An individual who is enrolled in a health plan; also known as a *member, insured*, or *covered life*.

Exhibit 2.3 discusses how different definitions of healthcare customers have implications for the operation of the system.

EXHIBIT 2.3

What's in
a Name:
Implications of
Redefining the
Patient

A development in healthcare that has had significant implications for marketing is the redefinition of health services users. The historical term *patient* is being replaced by the terms *client*, *consumer*, and *customer*. Although the nomenclature has changed to reflect the different parties that deal with the patient, this redefinition represents a paradigm shift in the health system's orientation toward the health services user.

Patient refers to a person who is formally under the care of a physician. Although other clinicians may also refer to their charges as patients, the term implies that a symptomatic person has been formally diagnosed as sick and now takes on a new set of attributes. Conceptually, a patient is more clearly differentiated from a nonpatient than, for example, a customer is from a noncustomer.

The patient role (also referred to as the "sick role"), like any social role, involves certain characteristics. Someone in this role is considered to be "abnormal" and thus different in important ways from other people. The patient role implies a degree of helplessness and a state of dependence on clinicians and health facilities. It also implies a condition of relative powerlessness and an inability to take an active part in the therapeutic process. A patient is also typically characterized by a relative lack of knowledge concerning the situation in question. The patient remains in this role until officially discharged by a physician.

A client is similar to a patient in many ways. In the healthcare context, a client is a patient of a nonphysician. Outside of healthcare, a client is someone who uses the services of a professional, and certain health professionals—such as mental health professionals, social workers, and other nonmedical personnel—may refer to their customers as clients.

The difference between patients and clients extends well beyond the professionals involved. Clients have a more symmetrical power relationship with their service providers than patients do with their doctors. Clients are not typically thought of as being dependent to the extent that patients are, and clients can fire their providers much more readily than patients can fire their doctors. Thus, clients are theoretically less dependent, more involved in the decision-making process, and more knowledgeable about the issue at hand than patients are. Ultimately, clients have more control over their situation than patients do.

As healthcare became more marketing oriented, terms such as *consumer* and *customer* were introduced. Although purists may consider the use of these terms a sacrilege, the fact is that—like it or not—patients are steadily taking on the characteristics of consumers and customers, not because of redefinition by marketers but because of the dramatic changes that have occurred in healthcare.

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EXHIBIT 2.3
What's in
a Name:
Implications
of Redefining
the Patient
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For the purposes of this text, a consumer is anyone who has the potential to purchase a healthcare good or service. In other industries, a consumer is often thought of as the end user of the product, but this is not necessarily a comfortable concept in healthcare. From a marketing perspective, anyone could be considered a consumer because nearly everyone is a potential user of health services. Whereas patients or clients are effectively under the direction, if not control, of health professionals, consumers are thought to independently determine the choices they make regarding health services. Thus, the consumer decision-making process is referred to more often than the patient decision-making process, which implies that the consumer is objectively evaluating health services options and making choices based on a variety of factors.

A customer, on the other hand, is a consumer who is currently using a good or service. For whatever reason, the customer has chosen to purchase a healthcare product. In many cases, this definition may be synonymous with the concept of patient, but from a marketing perspective, customers are thought of in different terms.

Unlike a patient (even if it is the same person), a customer is someone who is knowledgeable about the available options and has made a rational choice to consume particular goods or services. A customer is considered to be more independent and assertive than a patient and is likely to have expectations that differ from those of a patient. A patient might be concerned about humane treatment and effective outcomes, whereas a customer is also likely to expect fast and efficient service, convenient location, respectful treatment by practitioners, value for the money, and a meaningful role in the process.

This new *patient-customer* is having a major impact on the healthcare system, and the baby boom generation now coming to dominate the patient pool epitomizes the patient-customer. This person wants the outcomes of the healthcare system (as a patient does) as well as the benefits of being a customer. This development not only has implications for the delivery of care but also is important from a marketing perspective. Marketers solicit customers and patients in different ways. Customers and patients bring different traits to the examination room and use different criteria for measuring their satisfaction with services.

Healthcare marketers must be able to recognize the differences among the users of health services and adapt marketing approaches accordingly. Clearly, the marketing approach, the message, the medium, and the means of evaluation will differ depending on whether the marketer is addressing patients, clients, consumers, or customers.

The Four Ps of Marketing

The **marketing mix** is the set of controllable variables that an organization involved in marketing uses to influence the target market. The mix includes product, price, place, and promotion. These four Ps have long been the basis for marketing strategy in other industries and are increasingly being considered by healthcare organizations. However, these aspects of the marketing mix do not necessarily have the same meaning for health professionals as they do for marketers in other industries.

Product

As discussed earlier, the product of healthcare represents what healthcare providers are marketing. Because it takes the form of ideas, goods, or services, the product is difficult to precisely define in healthcare, which creates a challenge for healthcare marketers. For example, if a psychiatric problem is being treated with drugs (a good), the product is easy to specify (e.g., how many pills of how much dosage per day). If the same condition is being treated through counseling (a service), the description of the product is not as precise or standardized (e.g., an unpredictable number of counseling sessions).

In the past, healthcare providers seldom gave much thought to the product concept. A surgical procedure was considered just that and not something that had to be packaged. Today, however, the design of the product, its perceived attributes, and its packaging are all becoming more important concerns for healthcare providers and healthcare marketers.

Price

price
The amount of money charged for a product.

Price refers to the amount charged for a product, including the fees, charges, premium contributions, deductibles, copayments, and other out-of-pocket costs to consumers of health services. In economic terms, price is thought of in terms of an exchange. In other words, a healthcare provider offers a service in exchange for its customers' dollars. An employee paying an annual premium to a health plan, an insurance company reimbursing a physician's fee, or a consumer purchasing over-the-counter drugs are all exchanges involving a price. The price to the customer could also include the pain, discomfort, embarrassment, anxiety, frustration, and other emotional costs of dealing with providers, plans, and the disease or injury that prompted the experience. An obvious objective of marketing is to convince consumers that they will receive benefits for the price they pay.

Given the financing structure in healthcare, price has not historically been a basis for competition. The issue of pricing for health services is a growing concern for marketers as the healthcare environment changes, and a number of factors are increasing the role of the pricing variable in developing a marketing strategy. For marketers, the challenge is understanding what a

customer is willing to exchange for some want-satisfying good or service and developing a pricing approach compatible with the organization's goals and cost constraints.

Place

Place represents the way goods or services are distributed for consumer use. Place relates to all factors of the transaction or relationship experience that make it easy, rather than difficult, for consumers to obtain an organization's products. The obvious factors of location and layout are included, and so are hours, access, obstacles, waits for appointments, claims payment, and so on. In most cases, negative place aspects of an encounter impose such costs as lost time, frustration in finding the service site, a parking fee, boredom, or other emotional burden. Positive place aspects usually nullify such costs. For example, when a physician offers early morning or evening hours, patients can obtain care on their way to or from work and thus avoid having to take time off from their jobs.

In some cases, place factors may enhance perceptions of the product's quality, as when the physician's office or hospital is in a trendy location or on a campus that facilitates efficient treatment. Systems or health plans may speed up scheduling by allowing patients to make appointments online. The electronic storage of and online accessibility to medical records have added a different dimension to the concept of place. Allowing patients to sign up for health plans, check their status, and make benefit changes online at a workplace kiosk or at a home computer adds value to place.

place
The point of distribution for a healthcare product.

Promotion

For many people, **promotion** has historically meant advertising, and advertising has meant marketing. Promotion includes any means of informing the marketplace that the organization has developed a response to meet its needs. Promotion involves a range of tactics involving publicity, advertising, and personal selling.

Promotion covers all forms of marketing communication and includes materials that deliver content in addition to those that foster transactions. For example, health plans can devise communications that help new members better understand their coverage, thereby enabling them to use their health plan more effectively. Providers can advise new patients on how to avoid place frustrations and costs, and address symptoms and concerns online before appointments to improve quality and patient satisfaction. The **promotional mix** describes the combination of techniques used by the marketer to achieve promotional goals.

promotion
Any means of informing the marketplace that the organization has developed a response to meet its needs.

promotional mix
The combination of marketing techniques used to execute a marketing campaign.

Applying the Four Ps

Many observers find applying the traditional four Ps of the marketing mix to healthcare problematic. Some believe these dimensions of marketing are

inappropriate for a service-oriented industry such as healthcare. The uncomfortable fit between the four Ps of marketing and healthcare has even led some to pronounce the death of the four Ps and suggest their replacement with some other, more appropriate model for healthcare. Indeed, in today's competitive environment, some contend that additional Ps should be added to the list. Exhibit 2.4—written by Brian Tracy (2008)—presents the seven Ps, an update of the four Ps. These seven Ps may be more applicable or comprehensive for healthcare marketing purposes.

EXHIBIT 2.4
The 7 Ps of
Marketing

Once you've developed your marketing strategy, there is a "Seven P Formula" you should use to continually evaluate and reevaluate your business activities. These seven are: product, price, promotion, place, packaging, positioning and people. As products, markets, customers and needs change rapidly, you must continually revisit these seven Ps to make sure you're on track and achieving the maximum results possible for you in today's marketplace.

PRODUCT

To begin with, develop the habit of looking at your product as though you were an outside marketing consultant brought in to help your company decide whether or not it's in the right business at this time. Ask critical questions such as, "Is your current product or service, or mix of products and services, appropriate and suitable for the market and the customers of today?"

Whenever you're having difficulty selling as much of your products or services as you'd like, you need to develop the habit of assessing your business honestly and asking, "Are these the right products or services for our customers today?"

Is there any product or service you're offering today that, knowing what you now know, you would not bring out again today? Compared to your competitors, is your product or service superior in some significant way to anything else available? If so, what is it? If not, could you develop an area of superiority? Should you be offering this product or service at all in the current marketplace?

PRICE

The second P in the formula is price. Develop the habit of continually examining and reexamining the prices of the products and services you sell to make sure they're still appropriate to the realities of the current market. Sometimes you need to lower your prices. At other times, it may be

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appropriate to raise your prices. Many companies have found that the profitability of certain products or services doesn't justify the amount of effort and resources that go into producing them. By raising their prices, they may lose a percentage of their customers, but the remaining percentage generates a profit on every sale. Could this be appropriate for you?

Sometimes you need to change your terms and conditions of sale. Sometimes, by spreading your price over a series of months or years, you can sell far more than you are today, and the interest you can charge will more than make up for the delay in cash receipts. Sometimes you can combine products and services together with special offers and special promotions. Sometimes you can include free additional items that cost you very little to produce but make your prices appear far more attractive to your customers.

In business, as in nature, whenever you experience resistance or frustration in any part of your sales or marketing activities, be open to revisiting that area. Be open to the possibility that your current pricing structure is not ideal for the current market. Be open to the need to revise your prices, if necessary, to remain competitive, to survive and thrive in a fast-changing marketplace.

PROMOTION

The third habit in marketing and sales is to think in terms of promotion all the time. Promotion includes all the ways you tell your customers about your products or services and how you then market and sell to them. Small changes in the way you promote and sell your products can lead to dramatic changes in your results. Even small changes in your advertising can lead immediately to higher sales. Experienced copywriters can often increase the response rate from advertising by 500 percent by simply changing the headline on an advertisement.

Large and small companies in every industry continually experiment with different ways of advertising, promoting, and selling their products and services. And here is the rule: Whatever method of marketing and sales you're using today will, sooner or later, stop working. Sometimes it will stop working for reasons you know, and sometimes it will be for reasons you don't know. In either case, your methods of marketing and sales will eventually stop working, and you'll have to develop new sales, marketing and advertising approaches, offerings, and strategies.

PLACE

The fourth P in the marketing mix is the place where your product or service is actually sold. Develop the habit of reviewing and reflecting upon the exact

location where the customer meets the salesperson. Sometimes a change in place can lead to a rapid increase in sales.

You can sell your product in many different places. Some companies use direct selling, sending their salespeople out to personally meet and talk with the prospect. Some sell by telemarketing. Some sell through catalogs or mail order. Some sell at trade shows or in retail establishments. Some sell in joint ventures with other similar products or services. Some companies use manufacturers' representatives or distributors. Many companies use a combination of two or more of these methods.

In each case, the entrepreneur must make the right choice about the very best location or place for the customer to receive essential buying information on the product or service needed to make a buying decision. What is yours? In what way should you change it? Where else could you offer your products or services?

Packaging

The fifth element in the marketing mix is the packaging. Develop the habit of standing back and looking at every visual element in the packaging of your product or service through the eyes of a critical prospect. Remember, people form their first impression about you within the first 30 seconds of seeing you or some element of your company. Small improvements in the packaging or external appearance of your product or service can often lead to completely different reactions from your customers.

Packaging refers to the way your product or service appears from the outside. Packaging also refers to your people and how they dress and groom. It refers to your offices, your waiting rooms, your brochures, your correspondence and every single visual element about your company. Everything counts. Everything helps or hurts. Everything affects your customer's confidence about dealing with you.

Positioning

The next P is positioning. You should develop the habit of thinking continually about how you are positioned in the hearts and minds of your customers. How do people think and talk about you when you're not present? How do people think and talk about your company? What positioning do you have in your market, in terms of the specific words people use when they describe you and your offerings to others?

In the famous book by Al Reis and Jack Trout, *Positioning*, the authors point out that how you are seen and thought about by your customers is the

EXHIBIT 2.4
The 7 Ps of
Marketing
(continued)

critical determinant of your success in a competitive marketplace. Attribution theory says that most customers think of you in terms of a single attribute, either positive or negative. Sometimes it's "service." Sometimes it's "excellence." Sometimes it's "quality engineering," as with Mercedes Benz. Sometimes it's "the ultimate driving machine," as with BMW. In every case, how deeply entrenched that attribute is in the minds of your customers and prospective customers determines how readily they'll buy your product or service and how much they'll pay.

Develop the habit of thinking about how you could improve your positioning. Begin by determining the position you'd like to have. If you could create the ideal impression in the hearts and minds of your customers, what would it be? What would you have to do in every customer interaction to get your customers to think and talk about you in that specific way? What changes do you need to make in the way you interact with customers today to be seen as the very best choice for your customers of tomorrow?

PEOPLE

The final P of the marketing mix is people. Develop the habit of thinking in terms of the people inside and outside of your business who are responsible for every element of your sales and marketing strategy and activities.

It's amazing how many entrepreneurs and businesspeople will work extremely hard to think through every element of the marketing strategy and the marketing mix, and then pay little attention to the fact that every single decision and policy has to be carried out by a specific person in a specific way. Your ability to select, recruit, hire and retain the proper people, with the skills and abilities to do the job you need to have done, is more important than everything else put together.

In his best-selling book, *Good to Great*, Jim Collins discovered the most important factor applied by the best companies was that they first of all "got the right people on the bus, and the wrong people off the bus." Once these companies had hired the right people, the second step was to "get the right people in the right seats on the bus."

To be successful in business, you must develop the habit of thinking in terms of exactly who is going to carry out each task and responsibility. In many cases, it's not possible to move forward until you can attract and put the right person into the right position. Many of the best business plans ever developed sit on shelves today because the people who created them could not find the key people who could execute those plans.

Source: Tracy (2008). Used with permission from Brian Tracy International:
www.briantracy.com.

Other Marketing Processes

This section explains additional marketing concepts that are useful for readers to understand. Each of these concepts is addressed in greater detail later in the book.

Marketing Planning

marketing planning
The development of a systematic process for promoting an organization, a good, or a service.

Marketing planning may be defined as a systematic process for developing a plan for promoting an organization, service, or product. This straightforward definition masks the wide variety of activities and potential complexity that characterize marketing planning. Marketing planning may be limited to a short-term promotional project, or it may be a component of a long-term strategic plan. It can focus on a product, a service, a program, or an organization. The marketing plan should summarize a company's marketing strategy and serve as a guide for all those involved in the company's marketing activities.

Of the types of planning that could be carried out by a healthcare organization, marketing planning is most directly related to the customer. Marketing plans are, by definition, market driven, and they are single-minded in their focus on the customer. Whether the targeted customer is the patient, the referring physician, the employer, the health plan, or any number of other possibilities, the marketing plan is built around someone's needs. Although a consideration of internal factors is often pertinent (and **internal marketing** may be a component of many marketing plans), the marketing plan focuses on the characteristics of the external market with the objective of affecting one or more of these characteristics.

internal marketing
The process of training and motivating customer service employees and support personnel to work as a team to generate customer satisfaction.

marketing management
The analysis, planning, implementation, and control of marketing programs.

Marketing Management

Marketing management refers to the analysis, planning, implementation, and control of programs designed to build and maintain beneficial exchanges with targeted buyers for the purpose of achieving organizational objectives. The steps involved in the marketing management process include (1) analyzing marketing opportunities, (2) selecting target markets, (3) developing the marketing mix, and (4) managing the marketing effort.

Although marketing management is a well-defined function in most industries, it is still in its infancy in healthcare. The fragmented approach to much of the marketing that has taken place and the immature status of marketing in healthcare are reflected in the slow development of marketing management skills.

Marketing Research

Marketing research is the function that links the consumer, customer, and public to the marketer through information. It is used to identify and define marketing opportunities and problems; to generate, refine, and evaluate marketing actions; to monitor marketing performance; and to improve understanding of the marketing process. Often used interchangeably with the term *market research*, it also encompasses product research, pricing research, promotional research, and distribution research. The marketing research process serves to identify the nature of the product or service, the characteristics of consumers, the size of the potential market, the nature of competitors, and any number of pieces essential to the marketing puzzle.

marketing research
The collection of information for myriad marketing purposes, such as identifying opportunities and problems, evaluating actions, monitoring performance, and clarifying the process.

Summary

As the healthcare industry has come to accept marketing as a legitimate function, health professionals have been exposed to a new vocabulary—the language of the marketer. Because health professionals hold misconceptions about marketing, it is important to be on the same page when it comes to marketing terminology. Many marketing terms could be adopted by healthcare organizations unchanged, whereas others require modification based on the unique characteristics of healthcare.

Health professionals have many misperceptions about what marketing is and what its functions are. Marketing cannot be pigeonholed as advertising, direct mail, or any specific activity; it involves a whole range of activities—from conducting marketing research to evaluating a completed promotional campaign. Further, the functions of marketing are numerous and range from big-picture functions (e.g., determining the strategic direction of the health system) to highly focused functions (e.g., increasing participation in a patient education class).

The healthcare industry presents a challenge in the application of marketing techniques. The concept of market does not exist in healthcare as it does it other industries, health professionals do not think in terms of products, and the nature of the customer is highly complex. A change of health professionals' mind-set is required for marketing to be effectively used in healthcare.

The traditional four Ps of marketing—product, price, place, and promotion—have been adapted to healthcare, although not without some limitations. All four are somewhat problematic when applied to healthcare because of the peculiar characteristics of the industry. As a result, attempts

have been made to modify these components of the marketing mix or replace them with concepts that are more suitable to the healthcare environment.

Key Points

- The field of marketing has its own vocabulary with which health professionals must become familiar.
- The healthcare field can adopt many marketing concepts directly from other industries, but others must be modified to address the uniqueness of healthcare.
- Marketing should be viewed in the broadest possible light—not simply as a set of marketing tools but as a contributor to organizational development.
- Marketing serves a number of functions in healthcare, and healthcare administrators should be sensitive to the implications marketing has for different levels of the organization.
- A wide range of marketing techniques are available to marketers, and their choice of technique depends on the circumstances.
- The traditional four Ps of the marketing mix—product, price, place, and promotion—can be applied to healthcare with modifications.
- Marketing involves so much more than promotions and must consider such processes as marketing research, marketing planning, and marketing management.

Discussion Questions

1. Why is it difficult to directly apply the marketing approaches used in other industries to healthcare?
2. Why do many health professionals have misconceptions concerning the nature of marketing, and what are those misconceptions?
3. What is the distinction between goods and services, and what are the implications of this distinction for healthcare?
4. What is the role of marketing as it relates to the levels of the healthcare organization (e.g., senior managers versus product line managers)?
5. Which components of healthcare marketing have health professionals been comfortable with historically, and which techniques are gaining more acceptance today?

6. What factors have contributed to the conversion of the patient into a consumer, customer, or client, and what are the implications of this conversion for marketing?
7. What characteristics of healthcare make the four Ps of marketing difficult to apply directly to the healthcare organization?

Additional Resources

American Marketing Association: www.ama.org.

Berkowitz, E. N. 2016. *Essentials of Healthcare Marketing*, 4th ed. Sudbury, MA: Jones & Bartlett.

MarketingProfs: www.marketingprofs.com.

3

MARKETING AND THE HEALTHCARE ORGANIZATION

T he notion of marketing as a corporate function was accepted by different healthcare organizations at different times. This chapter discusses the unique attributes of healthcare that require healthcare organizations to tailor their marketing approaches and the factors that influenced the acceptance of marketing in healthcare (continuing the historical discussion in chapter 1). The range of marketing experiences and activities of healthcare organizations are explored in this chapter as well.

Unique Attributes of Healthcare

By the mid-1980s, the scope and nature of healthcare marketing had broadened considerably. Like other industries, healthcare modified its marketing approach to fit its particular needs. Some marketing techniques from other industries could be adopted without change, but many techniques were adapted specifically for healthcare. At the same time, novel marketing approaches were required to address the unique attributes of the healthcare industry.

Several attributes of the healthcare industry complicate marketing. First, healthcare organizations serve multiple markets and consumer groups. A traditional business focuses its marketing on prospective customers in the general population, but healthcare marketers have to consider physicians, nurses, patients, employee assistance personnel, managed care plans, and regulators as well. For example, the marketing staff for a mental health or substance abuse program for adolescents might also have to accommodate the needs of judges, probation officers, and social workers. Likewise, a marketer for a sports medicine program might have to consider employers, schools, and health plans among the potential customers, in addition to individuals.

Second, healthcare organizations have to compete for employers' business and must market to them accordingly. In the past, major employers were not considered an important market for healthcare organizations, even though companies typically bore their employees' healthcare costs. Today, however, major employers often attempt to control rising healthcare costs by dealing directly with providers to meet their employees' healthcare needs.

Third, health insurance plans are likely to influence members' or enrollees' choice of medical facilities. Although health plans may make allowances for using out-of-network practitioners (or provide the option of paying higher out-of-pocket costs for that privilege), most health plans specify which facilities and practitioners their insured population can use. Healthcare organizations of all sizes spend a great deal of time and effort negotiating contracts with health plans; more aggressive organizations see this situation as a marketing opportunity.

Factors Affecting the Acceptance of Healthcare Marketing

For-profit commercial businesses have led the way in carrying out formal marketing activities. From the start of the marketing era, these businesses employed the full range of marketing techniques, including advertising. The same was true of traditional businesses in healthcare, such as consumer products companies and retail-oriented organizations. As early as the 1950s, many healthcare brands had become household names as a result of marketing efforts.

Marketers of consumer health products typically used the same techniques as marketers of other types of products. However, some approaches that were unique to healthcare emerged. For example, insurance companies pioneered the concept of group sales, and pharmaceutical companies developed physician-oriented sales approaches. In general, however, the primarily not-for-profit nature of the healthcare industry stifled the growing acceptance of marketing. Healthcare purists often equated marketing with advertising and considered it incompatible with the principles of a charitable organization. Charitable organizations were typically conservative and thought that allocating resources for marketing purposes was in bad taste at best and unethical at worst.

Beginning in the 1970s, academic marketing experts asserted that marketing activities were common and acceptable among not-for-profit organizations (see, e.g., Kotler 1975). Nevertheless, health professionals continued to resist the use of formal marketing techniques. Further, as a practical matter, marketing was not a reimbursable expense for hospitals under the Medicare program. By the end of the 1970s, however, the mind-set of not-for-profit healthcare organizations had begun to change, giving rise to a new attitude toward business practices such as marketing. This section covers this evolution. Exhibit 3.1 reviews some of the changes that occurred in not-for-profit healthcare organizations.

By the 1980s, conditions in healthcare had changed significantly, creating an environment that not only encouraged marketing on the part of all

> **EXHIBIT 3.1**
> Putting the Profit in the Not-for-Profit Organization
>
> Many healthcare entities are chartered as not-for-profit organizations (NFPs). NFPs are typically conservative with regard to the expenditure of funds, restricting their spending to activities that are directly related to their mission. Historically, NFPs did not consider marketing to be a worthy use of scarce organizational resources. Further, NFPs tended to view their goals as altruistic, setting them apart from their for-profit kin. This stance fostered the perception that NFPs have nobler intentions than for-profit healthcare organizations.
>
> During the 1980s, however, many NFPs in healthcare—particularly provider organizations—found that they needed to rethink their stance on profit. The adage "no margin, no mission" was increasingly expressed during this period as NFPs began to realize the importance of profit for organizational survival. Although healthcare professionals are still loath to use the "p word," the pursuit of profit or net revenue under some other moniker came to be accepted. As a result of this new attitude, NFPs began to adopt many of the business practices of other industries and of the for-profit organizations that had become prominent in healthcare.
>
> Marketing was one of the business practices that healthcare organizations came to accept. The margin necessary to support ongoing operations and continued development of the organization had to be nurtured, and the role of marketing in this process came to be recognized. If revenue was to flow to the bottom line, the organization had to increase customer traffic, sales volumes, market share, and all of the other indicators normally used in industry. Marketing was recognized as critical to the processes that would contribute to the bottom line. NFPs came to recognize the need to turn a profit and the importance of profitability to their continued viability and, ultimately, came to appreciate the contribution that marketing made in this regard.

healthcare entities but demanded it. Developments related to the increasing "corporatization" of the healthcare industry, the standardization of existing products and introduction of new goods and services, and, in particular, changing reimbursement arrangements made the emergence of marketing as an organizational function inevitable.

From Monopoly to Competition

During the 1980s, healthcare providers faced unprecedented competition on a number of fronts. Hospitals, healthcare systems, and even specialty practices that had once operated as monopolies or oligopolies in their market areas now had to compete—often in a cutthroat environment—for customers they

had historically taken for granted. For the first time, healthcare organizations were forced to profile their customers to determine their needs. They also had to develop a greater level of market intelligence to better understand their competitors.

From Inpatient Care to Outpatient Care

At one time, medical care was synonymous with inpatient care, and hospitalization was often a prerequisite before insurance coverage kicked in. By the 1980s, however, numerous factors discouraged the use of inpatient care. The outpatient market was growing, physician referrals to inpatient care were being deemphasized, and consumerism was emerging as a force. Hospitals had to rapidly adjust to these market conditions and change their approach to marketing.

From Specialty Care to Primary Care

In the past, hospitals relied on the specialists on their medical staffs to admit patients and generate revenue. By the late 1980s, the use of specialists gave way to the use of primary care physicians. Hospitals and health systems had to examine their referral patterns and began to actively court family practitioners, internists, and pediatricians. Marketers had to develop ways to showcase the primary care capabilities of their healthcare organizations to customers, consumers, and health plans. Today, although reimbursement practices still favor specialists, primary care physicians are seen as significant players in healthcare's future.

Employers as Major Customers

After World War II, employers began offering health insurance to their employees, passively footing the bill for their medical expenses. By the mid-1980s, employers were taking a more active role in managing their employees' health benefits. Suddenly, healthcare providers found they had a new set of customers—employers—with needs that were different from those of other customers. Business coalitions formed to negotiate with healthcare providers from a position of strength, and the health benefit costs borne by employers became a major driver of healthcare reform.

The Increased Consumer Focus

report card
A mechanism for comparing the performance and outcomes of providers and health plans.

Until the healthcare industry became market driven in the 1980s, patients' opinions were seldom considered important. A greater focus on consumers, however, necessitates that healthcare providers understand patients' opinions about the services they were provided. Patient satisfaction surveys became commonplace, and **report cards** became a tool by which patients rated the

performance of providers and health plans. Marketers had to not only identify the **needs** and **wants** of consumers but also recommend ways to improve customer satisfaction.

The Dominance of Managed Care

The emergence of managed care as a major force changed the ground rules for healthcare providers. The patient was transformed into an enrollee or plan member. Instead of searching for sick patients who required health services, marketers were encouraged to identify healthy people who would not run up costs by using a lot of services. Healthcare providers participating in managed care plans had to shift their focus from treatment and cure to health maintenance. Managed care plans developed marketing expertise to capture the employer market, and healthcare organizations began to consider managed care negotiations a marketing function.

The Changing Decision Maker

Before marketing took hold in healthcare, physicians made most clinical decisions, and patients had limited control over their medical care. Later, health plans began exercising more influence over the use of health services, directing their enrollees to specific provider networks. Consumerism, however, surged in the 1970s, 1980s, and 1990s and continues today. This shift has ushered in a new set of decision makers, forcing healthcare organizations to research the characteristics of existing and potential customers and determine their needs and wants.

The Range of Marketing Experiences

Healthcare organizations are highly diverse, a fact that limits the ability to make marketing generalizations that apply to all types of service providers. Therefore, this section addresses the marketing experiences and activities of a broad range of healthcare organizations, including providers, suppliers, consumer health product companies, pharmaceutical companies, insurance companies, and support services vendors.

Providers

Most people think about healthcare marketing campaigns as initiated by providers. The term **provider**, originally defined by health insurance companies, refers both to health professionals (e.g., medical doctors, nurses, behavioral and mental health practitioners) and to organizations that provide healthcare and related services to patients. The categories of providers are described here.

need
A condition objectively determined as requiring a health service.

want
A consumer's desire (rather than a need) for a health service.

provider
A health professional or an organization that provides direct patient care or related support services.

Hospitals

Hospitals are the most visible provider organizations. Marketing by general hospitals can be traced to the late 1970s, when a few hospitals hired marketers or established basic marketing departments. Marketing activities picked up in the early to mid-1980s, when many hospitals became enamored with advertising. Ads for hospitals and their services flooded print, radio, television, and outdoor media. Although the ultimate benefit of these marketing expenditures was hard to determine, increased competition among providers during this period fueled a surge in media advertising. Exhibit 3.2 presents an example of a hospital advertisement.

EXHIBIT 3.2
Sample Print
Advertisement

Source: Edward Hospital, Naperville, IL. Used with permission.

By the 1990s, a balanced approach to marketing replaced strategies that relied primarily on media advertising. This new approach integrated advertising with public relations and communications activities and added direct sales capabilities. Hospitals adopted more contemporary forms of marketing by establishing marketing databases and call centers. Customer relationship marketing, direct-to-consumer marketing, and internet marketing (then new to the scene) were also adopted. These trends evidenced a shift from a sales approach to a relationship management approach to marketing.

Media advertising (print, television, radio) was the approach of choice for cultivating the interest of the general public; specialty hospitals in particular attempted to maintain high visibility in their communities. National hospitals and health system chains often conducted nationwide marketing campaigns supplemented by customized advertising in the local communities they served. Many of these chains employed sales forces that called on potential referrers of consumers requiring specialized or elective services (e.g., psychiatric or substance abuse treatment). Public relations approaches, including holding open houses and disseminating feature stories, also were commonly used.

A compelling website became customary for specialty hospitals, as for other healthcare facilities, as most hospitals took advantage of the electronic revolution. Driven by a variety of forces—including the implementation of the Affordable Care Act (ACA)—marketers recognized the need to better understand consumers and to have more direct interaction with their existing and potential customers. Healthcare consumers quickly adopted social media, and cyberspace was flooded with information on health and healthcare. Healthcare organizations took advantage of social media to help with communications, marketing, and customer relations.

Nursing Homes and Assisted Living Facilities

The target market for nursing home care is much smaller than that for general hospital services, so marketing for these organizations is typically less visible and more subtle. Because their clientele need **long-term care**, nursing homes require fewer patients than acute care and other facilities. Since someone other than the resident (the end user of the service) may be involved in the admission decision, any marketing activity must consider not only the prospective client but also his or her healthcare decision maker.

Advertising tends to be the means used to remain top of mind and, where appropriate, to solidify relationships with referral agencies. **Word of mouth** is another important means of promoting nursing homes. Exhibit 3.3 describes research on the factors that contribute to positive nursing home recommendations; although the study was released in 2000, its findings are still relevant today. Additionally, websites such as A Place for Mom

long-term care
Nonacute care provided for an extended period or, sometimes, until death.

word of mouth
Positive or negative communication among consumers about an organization, a good, or a service.

(www.aplaceformom.com) use social media to connect those seeking nursing care with appropriate providers.

Assisted living facilities are more like nursing homes than hospitals in their approach to marketing. They do not require a large volume of patients but rather a small number of qualified **prospects**. Typically, residents of assisted living facilities do not make the decision to enter the facility, so administrators gear the marketing efforts toward their caregivers or decision makers. Although fewer nursing homes are being built, assisted living facilities continue to spring up around the country. Print and electronic media advertising, along with word-of-mouth endorsements, are important ways in which these facilities create and maintain positive publicity.

prospect
A consumer who might be swayed to buy or use a good or service.

EXHIBIT 3.3
Nursing Home Marketing: What Are Customers Looking For?

As the US population ages, the demand for nursing services is expected to increase. In preparation, healthcare marketers must develop a better understanding of the factors that influence the choice of nursing home. Customers for nursing home services include not only residents but also third-party payers, employees, doctors, hospitals, and caregivers. As the market for senior services of all sorts grows, keeping current customers satisfied is vital for generating positive word of mouth. Nursing homes must also recognize residents' family, friends, and guardians (referred to as proxies) as customers who may generate positive word-of-mouth publicity. Both residents and their proxies may be considered customers for nursing home services, so it is important to understand the needs of these two distinct groups. Meeting the needs of residents is the organization's mission, but meeting the needs of proxies can help generate referrals to the business.

Data obtained from a survey of 2,709 residents living in 26 nursing homes across the United States provide some insight into the marketing of nursing homes. Of the residents surveyed, 71 percent were women. The average age of residents was 75 for men and 80 for women. Many residents were relatively new to their facility: 43 percent of the men had lived in the facility for less than one month, compared to 30 percent of the women. In addition, 21 percent of the female residents had been in the facility for more than three years, whereas only 12 percent of the male residents had been there that long. The reported health status of the residents (as measured on a 5-point scale, where 1 indicated "very poor" and 5 indicated "very good") did not vary by gender. Fifty-six percent of the residents were identified as having less than good health (fair, poor, very poor ratings).

Survey administrators found that only 31 percent of the questionnaires were completed by residents. The others were completed by a family

(continued)

member other than a spouse (40 percent), a spouse (12 percent), some other person (10 percent), a legal guardian (4 percent), or a friend (3 percent). Completion of the questionnaire by a proxy was strongly associated with poorer resident health.

The questions covered 39 service issues related to the nursing home experience. The questionnaire also asked respondents to assess the facility's "positive word of mouth," which was defined as the "likelihood you would recommend the (facility) to others." Respondents reported that the nursing homes did well in the areas of courtesy and friendliness but not as well with noise, food, and responsiveness. The service variables with the lowest scores were noise level in and around the room, followed by the variety of food selections and the quality of the food. The highest marks were given to courtesy of the admitting staff, friendliness of nurses, and courtesy of the housekeeping staff. Services provided by the aides (e.g., information from aides, assistance with meals, response to the call button) required the greatest attention.

Interestingly, the satisfaction ratings differed depending on who was doing the rating. Residents tended to give higher ratings than their family and friends. For example, residents were more positive about the aides and the facility than their family and friends. Proxies gave lower scores than residents, although the difference between the scores given by the residents and by other respondents was significant only when the other respondents were friends. The likelihood of recommending a nursing home was significantly higher among family members than among residents.

This differences in ratings may indicate that residents are reluctant to criticize staff or service delivery processes on which they depend. In contrast, family members' responses were particularly critical of the aides and of housekeeping. On the other hand, some of the differences may stem from anxiety or guilt associated with placing a loved one in a nursing home. Family members want to be certain that the quality of care meets an appropriate standard. Quality of care encompasses many components, and patient and family assessments are just one element. Nevertheless, these ratings can help organizations identify perceived strengths and weaknesses in service delivery and take corrective action to meet customer needs and manage word of mouth in the community.

Fortunately for the facilities, the items with the lowest scores were not among those with the highest correlation with likelihood to recommend. Items that had the highest correlation with likelihood to recommend included respectful, dignified treatment and nurses' technical skill, ability to explain care, and friendliness—domains in which nursing facilities tend

EXHIBIT 3.3
Nursing Home Marketing: What Are Customers Looking For? *(continued)*

EXHIBIT 3.3
Nursing Home
Marketing:
What Are
Customers
Looking For?
(continued)

to score relatively well. Among the eight service domains, nursing was most strongly related to likelihood to recommend the facility. Experiences with dining and aides were also important predictors of likelihood to recommend. Admission issues, not surprisingly, influenced the families' and residents' likelihood to recommend, but not the other respondents' likelihood to recommend. Similarly, finance issues were strongly related to likelihood to recommend only for the residents and their legal guardians. When taken together, the service domains explained about 60 percent of the variation in likelihood to recommend.

The difficulty in identifying the customers for nursing home services creates special challenges: Should the facility operate with an eye toward resident ratings or family ratings? Or should it attempt to meet the expectations of the respondents who gave the lowest scores, assuming that meeting the requirements of that group will exceed the requirements of the other groups? Nursing homes would be wise to collect data from all identified customers—patients and proxies—and make efforts to satisfy both. The net result is not only more data from "other" consumers but potentially more data from the healthy residents whose voices previously have been lost to proxies.

Irrespective of customer segment, the data suggest that nursing homes can maintain positive word of mouth by ensuring that residents' nursing, aide services, and dining needs are met. Because the scores for nursing are already relatively high, the greatest opportunity appears to be in improving scores for aides and food quality.

Source: Adapted from Becker and Kaldenberg (2000).

Other Residential and Inpatient Facilities

The marketing activities of residential and inpatient treatment centers are similar to those of specialty hospitals. They tend to focus on ads for the general public and building relationships with potential referral agents. They often employ sales forces and may aggressively seek prospective customers.

Residential and inpatient facilities use public relations, advertising, and community outreach as their primary marketing techniques. Many use direct sales as well. Contemporary approaches—such as customer relationship management, database marketing, and internet marketing—have become common. These providers often focus on relationship development and harness sophisticated information technology–oriented tools. Case study 3.1 discusses some low-intensity marketing approaches.

Ethical and regulatory considerations constrain the marketing activities of many provider organizations. For the most part, it is inappropriate for healthcare providers to offer **incentives** to potential sources of business (a typical practice in other industries). For example, it is unethical and even illegal for hospitals to give physicians bonuses for admitting patients.

incentive
An enticement offered by a healthcare organization to current or potential customers to achieve a desired result.

CASE STUDY 3.1
Low-Intensity Marketing

Like many healthcare organizations, Yale New Haven Hospital (YNHH) was being asked to do more with less when it came to marketing. Given its modest advertising budget and the area's high media costs, YNHH had focused its advertising on billboards, newspapers, and the Yellow Pages. Advertising via radio, television, and magazines was considered too expensive. From 1995 to 1999, most of its advertising dollars went into three-quarter-page display ads in daily newspapers across Connecticut. These ads, developed through a lengthy review process with a traditional advertising agency, were ineffective at increasing consumer awareness because the limited budget prevented consistent exposure to the public.

To find a more effective yet inexpensive means of advertising, YNHH considered banner ads in newspapers. These ads are small strips that are 2 to 3 inches tall and 5 to 12 inches wide. Usually one topic is covered per ad, and the ads may or may not include artwork. Banner ads are designed to stand out by using color and regular placement in the newspaper. They generally run on a daily basis at the top or bottom of the front page. The cost of the banner ad depends on size and location. Most banner ads include a "call to action," giving the reader an opportunity to respond to the sales pitch.

To test the effectiveness of banner ads, YNHH placed a 0.5-inch by 12-inch strip ad at the bottom of the front page of the local newspaper twice a week. After a few months, however, the hospital found no noticeable increase in calls to YNHH for information or physician referrals. A meeting was held with the local paper's sales executives to share the unfavorable results. The hospital informed the newspaper that it would stop running the banner ads if the newspaper did not develop a better approach. The paper proposed a new format that would involve a major redesign of the front page to allow space for a bigger ad, at no additional cost to the hospital.

YNHH expanded its banner ad initiative in the fall of 2000, eventually developing more than 350 newspaper ads. Most of the ads promoted clinical programs such as cardiac, cancer, and diabetes treatment; maternity care; and ongoing clinical trials. Other ads directed consumers to YNHH's call

(continued)

center, promoting its physician referral program, health information library, nurse advice line, and women's heart line. Another group of ads promoted consumer-oriented services, such as internet-based services, press conferences to announce newborn babies, and support groups. A final category of ads promoted general awareness of YNHH's programs and announced special events, such as National Nurses Day.

Follow-up research found that the banner ad campaign was highly successful. Over a two-year period, consumer awareness of YNHH in the southern Connecticut market increased from 29 percent to 49 percent. The proportion of consumers associating YNHH with state-of-the-art care increased from 22 percent to 40 percent. Because the hospital's marketing budget had declined 30 percent between 2000 and 2002, and there had been no increases in other marketing activity, the bulk of the change in consumers' attitudes and behaviors was attributed to the banner ads. In addition, 49 percent of the calls routed to the call center were generated by the banner ads during this period, and a large portion of follow-up calls for other services was stimulated by the banner ads. Evidence also suggested that callers who had found YNHH through the Yellow Pages often had been encouraged to seek it out after seeing the banner ads.

Although banner ads are not a panacea for marketing challenges, they were generally beneficial to YNHH. They generated considerable inquiries and allowed the organization to spread its marketing budget much further than traditional advertising would have allowed. The volume of consumer interaction with the hospital grew dramatically, and most of the increase in admissions during this period was attributed to the campaign. Furthermore, the banner ad campaign contributed substantially to the development of YNHH's customer database.

As a result of the ads, 40,000 names were added to the hospital's consumer database within two years. These positive results were obtained at a time of declining newspaper readership. YNHH marketers found that their best customers were among the most loyal newspaper subscribers; because they experience more health problems, older people were the last loyal customer group for this medium. (Note: With the continued decline of newspaper publishing and newspaper readership, many providers have shifted to online banner advertising, discussed in chapter 12.)

Using banner ads as the focal point of a marketing campaign has few downsides. Organizations must ensure, however, that they have the capability to respond to demand and must maintain a wide range of publications and other resource materials as references when responding to inquiries.

Source: Adapted from Gombeski et al. (2003).

(continued)

Case Study Discussion Questions

1. What prompted YNHH to rethink its use of banner ads in newspapers?
2. What changes were implemented to make the banner ads more effective?
3. What types of services seem to be best suited to this type of advertising?
4. What was the impact of the new banner ads in terms of traffic generated for YNHH?
5. How could the declining importance of newspapers affect YNHH's reliance on this marketing technique?
6. What are the implications of the demographics of loyal newspaper subscribers for the use of this medium to reach healthcare consumers?
7. Are there more contemporary forms of media in which banner ads might be more effective?

Physicians and Other Clinicians

The marketing efforts of clinicians have, for the most part, lagged behind those of hospitals and other provider organizations. Many physicians did not face the same competition that hospitals began facing in the 1980s. In addition, ethical constraints limited the amount of advertising considered acceptable by the medical profession. Individual physicians and professional medical associations were long hostile to the notion of formal marketing, although most doctors engaged in low-intensity forms of marketing to promote their practices.

Today, increasing numbers of physicians and physician practices are using advertising to gain visibility and increase volume. These practices are often specialty groups that want to distinguish themselves from other specialists in their field. Physicians who offer elective procedures engage even more heavily in advertising than traditional practitioners. Thus, ophthalmic surgeons who perform laser eye surgery and cosmetic surgeons, for example, are more likely to advertise directly to consumers than specialists who provide traditional services. Because insurance usually does not cover such services, these practitioners depend less on referrals from colleagues and more on direct solicitation of potential customers.

In the past, physicians emphasized networking and relationship development for marketing purposes. More recently, some have ventured into advertising, although much of the hard-sell advertising has been initiated by physicians involved in retail or elective aspects of healthcare. Physicians may

send direct mail to reach selected audiences or to announce changes related to their respective practices, and they are increasingly taking advantage of the internet as a means of promoting their services and maintaining contact with patients. In some markets, large physician groups are using managed care and health plan contracting as a means of market development.

The amount of marketing and the approach that clinicians use vary by profession and market. Among independent practitioners, such as dentists, podiatrists, and chiropractors, low-key advertising is a common technique to attract patients and maintain visibility. Some practitioners may rely on referral relationships, while others may use direct mail to contact prospects directly. Some of these practitioners have also embraced internet marketing.

Alternative therapists (e.g., chiropractors, acupuncturists, herbal healers) employ a wide range of marketing techniques. Many advertise their services, often targeting select populations that are thought to be receptive. An outreach approach is often important for alternative therapists who may have to educate the public about the forms of therapy or procedures they offer. Some providers of alternative or complementary services may exclusively use the internet for marketing purposes.

Behavioral Health Providers

Behavioral health providers (e.g., psychiatrists, psychologists, licensed counselors and therapists) and their agencies take particular care when formulating and conveying their marketing messages. For example, advertising for behavioral health programs (designed for patients with psychiatric or substance abuse issues) tends to be more sensitive to the audience and more subtle than ads for other programs. Much of the marketing efforts for such programs center on behind-the-scenes relationship building, especially with private-pay patients.

Providers of Specialized Services

Some services require a circumscribed approach to marketing. Marketers for HIV/AIDS programs, for example, face a number of challenges. First, individuals with HIV/AIDS may be difficult to identify and contact because they are not likely to want their condition broadcast. Second, they may be resistant to receiving unsolicited information from unknown parties. Third, they may have concerns about the confidentiality with which their condition and personal information are handled by providers or marketers. Thus, marketers need to reach out to those in need of services without inviting undue attention to the providers. Some organizations, for example, adopt generic names (e.g., Adult Special Services) or put up minimal signage to limit the potential for the stigmatization of current and prospective clients. Public service announcements and other forms of impersonal social marketing are often

used to divert attention from individual sufferers and to minimize stigma. Brochures and other materials are often given to physicians to encourage referrals of such patients.

Public Health Agencies

Most public health activities—such as those monitoring air and water quality or inspecting sites where food is prepared—do not directly involve healthcare customers. But some activities—such as child immunization and nutritional counseling—necessitate interacting with the public. Noncontroversial initiatives are typically promoted through word of mouth as well as traditional information and referral channels. More controversial programs—such as family planning, teen pregnancy prevention, and treatment of sexually transmitted infections—require aggressive but sensitive marketing approaches. In addition to health education, many public health agencies provide medical treatment and psychological counseling, services that also need to be promoted.

Public health agencies rely on information and referrals as well as public relations to publicize their services, often deploying community outreach programs to promote their work in local areas. In recent years, public health agencies have begun to address health concerns that are now regarded as public health issues, such as breastfeeding, obesity, and domestic violence. Public health agencies have become much more aggressive marketers and have integrated health communication into their marketing techniques. Social media initiatives have been launched, many of which are coordinated by the Centers for Disease Control and Prevention or other federal agencies. These initiatives are aimed at reducing the rates of sexually transmitted infections and tuberculosis, for example, as well as nonclinical programs, such as nutritional counseling and family planning.

Suppliers

In healthcare, suppliers include a wide range of organizations that provide goods and equipment to support the clinical, business, and other operations of a hospital, health system, physician practice, or other facility. Healthcare organizations use an extensive range of supplies, including office supplies (e.g., paper, pens, clipboards), cloth products (e.g., linens, gowns), medical disposables (e.g., gloves, syringes, gauze), and machinery (e.g., MRI, X-ray). In addition, facilities use patient care equipment (e.g., sterilizers, blood pressure machines, scales, stethoscopes, lab microscopes) and durable medical equipment (e.g., hospital beds, examination tables, wheelchairs). A large physician practice's vendor list may include several dozen suppliers, and a hospital's list may number in the hundreds.

Supplies and equipment may be obtained directly from their manufacturers, but often they are obtained from distributors or vendors that

handle a range of products. In either case, vendors are likely to advertise to their customers in trade publications read by hospital administrators, physicians and nurses, practice managers, and other personnel. Suppliers typically rely on sales representatives, who use a direct sales approach. They attend professional or association meetings that healthcare leaders, managers, and other facility decision makers, as well as clinicians, are likely to attend. They display and promote their products and talk to potential customers at healthcare exhibits.

Vendors that market medical supplies, biomedical equipment, and durable medical equipment operate in much the same manner as vendors in other industries. The primary difference is the logistics involved in connecting with a busy physician or the right administrator at a hospital or clinic to whom the vendor can make a presentation. The decision makers in other industries are often much more available and easier to identify. The types of marketing techniques that healthcare suppliers generally use include direct sales, business-to-business marketing, advertising, and sales promotion. Suppliers also use the internet for marketing and promotion.

Consumer Health Product Companies

Although marketing by healthcare providers is still evolving, marketing by consumer health goods companies is well established. Consumer health products have long been marketed to the American public; arguably, some of the best-known early consumer brands are associated with health-related products. Bayer, Johnson & Johnson, and Ex-Lax were household brand names before the modern healthcare system emerged in the United States.

Today, pharmacy shelves are filled with consumer health products such as headache remedies, cold and cough medicines, adhesive bandages, heating pads, feminine hygiene products, and baby teething gels, among many other household and personal items. Household inventories may also include foot care, dental care, and eye care goods. Advances in home diagnosis, monitoring, and treatment have added kits and equipment to the consumer health options available. (Over-the-counter drugs are discussed later in this chapter.) Over-the-counter medicines and personal healthcare products are supplemented by a plethora of nutritional products, **cosmeceuticals** (e.g., anti-aging creams), and **nutraceuticals** (e.g., fish oil). These products bridge the gap between cosmetics and drugs and promise such results as younger skin, hair regrowth, or enhanced energy or immunity.

Complementary and alternative (or integrative) medicine and therapies (e.g., acupuncture, biofeedback, meditation, yoga, massage)—now widely accepted by American consumers—have also contributed to the rapid growth of consumer health products. A variety of natural products have

cosmeceuticals
Health or beauty products that combine the attributes of a cosmetic and a drug.

nutraceuticals
Food or dietary supplements that contain nutritional value and provide health benefits.

entered the market, serving as alternatives or supplements to more conventional health goods and services.

The market for consumer health products in the United States is large and continues to expand, keeping pace with the population's more health-conscious and do-it-yourself attitudes. The level of competition in this sector is high and thus makes the use of aggressive marketing techniques essential to a consumer health product company's business strategy. In general, these products are marketed like other non-healthcare goods. Marketers rely heavily on media advertising along with advertising inserts in popular publications. They also use sales promotion techniques such as discount coupons, rebates, and contests. They secure highly visible shelf space for in-store advertising.

One of the most important developments in the marketing of consumer health products has been the use of the internet as a marketplace for a wide range of products. For many unconventional new products, the internet has become the primary promotional channel. These products are often shut out of mainstream marketplaces, for example, because of their lack of access to retail shelf space. Online, they can cater to a wider market that is receptive to innovation and to consumers who prefer to find and buy goods and services electronically.

Pharmaceutical Companies

Pharmaceutical manufacturing is an enormous and highly profitable industry in the United States. Sales of prescription drugs in 2016 totaled approximately $329 billion, accounting for more than 10 percent of annual healthcare expenditures in the United States (Foley 2019). Profits on pharmaceutical sales average nearly 20 percent—more than three times the average for all industries (US Government Accountability Office 2017). Despite its huge profit potential, the drug industry is highly risky and competitive. After receiving approval from the US Food and Drug Administration, a new drug often faces stiff competition from other drugs already on the market and is granted patent protection for a limited time.

Prescription drug use has grown dramatically since the research breakthroughs of the post–World War II period. The increased availability of effective pharmaceuticals has shifted the therapeutic emphasis from invasive procedures to drug therapy. Patients today spend less time in the hospital and more time at the prescription counter. As a result, US healthcare expenditures, including expenditures on prescription drugs, are rising faster than expenditures on other healthcare products and services. After a brief slowdown, the growth rate for drug expenditures has picked back up, with an estimated 30 percent increase between 2012 and 2018 (Pew Charitable Trusts 2018).

Pharmaceutical Marketing Techniques

Pharmaceutical companies historically used traditional marketing techniques within the limits required by ethical and regulatory considerations. With the pharmaceutical industry spending as much as 30 percent of revenue on marketing, many of these techniques are still used today, with heavy investments in conventional marketing techniques. In 2016, for example, approximately $30 billion was spent in the United States on pharmaceutical marketing (Bulik 2019b), of which $3.73 billion was spent on national television advertising. Magazine advertising remains strong, based on the assumption that popular magazines reach a fertile audience. In 2015, the pharmaceutical industry spent $1.53 billion on magazine ads, more than any other industry (Bulik 2016). A total of $9.6 billion was spent on advertising to consumers through television, radio, magazines, newspapers, and outdoor billboards in 2016. Pharmaceutical companies spent more than half of their marketing dollars trying to reach physicians.

Because of industry competition and pressure to recoup investments in research and development, the drug industry has developed sophisticated, aggressive, and expensive marketing strategies. In an attempt to take advantage of social media, pharmaceutical companies spent almost $20 billion on digital advertising in 2018 (Bulik 2019a). The interest in digital advertising reflects the intensive use of the internet by healthcare consumers, who spend more time viewing healthcare content than any other type of information. Social media allow marketers to engage consumers along a variety of interfaces. At the same time, pharmaceutical marketers are able to obtain real-time data on drug use, consumer preferences, and market trends that can inform subsequent marketing initiatives.

Medical publications. One of the ways pharmaceutical companies promote themselves is by disseminating medical information in medical journals, industry-oriented newsletters and newspapers, research compendia, and other publications. They are heavy advertisers in medical journals (although many journals do not accept advertising). They sponsor research that generates articles submitted to—and, they hope, published in (if the findings are favorable)—medical journals. (Unfortunately, some drug manufacturers have been found guilty of paying medical scientists to write favorable reports on their drugs even when the research did not support positive outcomes.)

Drug companies send doctors unsolicited "throwaway journals," which are typically newsletters or mini-newspapers containing summaries of research published in academic journals (which doctors may not have time to review). These throwaways may also take the form of trade journals in which the companies advertise or to which the medical professionals or researchers in their employ submit articles that promote their brand and products. Often,

a company produces its own publication to offer a "journalistic" format for its marketing efforts.

The volume of published medical information from pharmaceutical companies has expanded, giving doctors an alternative to the tedious process of sifting through the vast medical literature. By acting as information intermediaries, these companies help doctors save time and expense while maintaining some control over what doctors see and hear. This tactic used to be exclusively in print format but has now spread to the internet.

Continuing medical education. Continuing medical education (CME) is one area of medical communication that is massively subsidized by the drug industry. Since the 1970s, physicians and other clinicians have been required to complete a minimum amount of accredited training each year to maintain their hospital privileges and professional certifications. As a result, thousands of CME conferences are held each year. Drug companies participate as passive financial sponsors of CME conferences or as active partners in planning and staging these meetings. Most CME conferences now have pharmaceutical industry support; although some limitations have been placed on drug companies' influence, the conferences are still largely sponsored by these manufacturers.

Detailers and physician gifts. Field representatives (known as "detailers") are a crucial link in the information chain between drug companies and clinicians. More than 30,000 detailers—one for every 20 American doctors—make tens of millions of office visits to doctors annually. They dispense promotional brochures and medical literature, speak with physicians and other staff about their products, and give out free samples. Physicians obtain much of their information about proprietary drugs in this way, making this activity—at least from the drug company's perspective—a successful marketing technique.

Gifts to physicians were a cornerstone of pharmaceutical marketing for many years. The most abundant category of gifts includes reminder items such as pens and notepads, which prominently display the name of a drug. Gifts are often offered to physicians in exchange for their attention to promotional material or presentations. "Drug lunches" in large hospitals and clinics are one such example, whereby the detailer buys lunch for an audience—usually medical students and junior physicians—and gives a presentation while they eat. Similarly, pharmaceutical companies sponsor dinner meetings during which representatives or other speakers tout the traits and benefits of their products. Physicians may offer testimonials regarding the merits of a drug, and they are often compensated for their time. Exorbitant gifts and cash payments of any amount were banned by the American Medical Association in

1990 and have been replaced with other gifts, such as medical textbooks and medical instruments. The lengths to which drug companies are allowed to go in marketing to doctors continues to be a source of controversy.

Pharmaceutical Industry Adaptation to Market Trends

Over the years, consumer, insurance, technology, medical innovation, and other trends in the US healthcare industry have changed the way prescription drugs are promoted, chosen, sold, and bought. Marketing techniques have rapidly adapted to each of these developments. The growth of managed care, for example, has had a profound effect on drug selection, as managers of private and public health plans are in a position to control billions of dollars of drug purchases each year. As a result, pharmaceutical marketers have increased their attention to wholesale purchasers while physicians and consumers have become secondary targets.

During the late 1970s and the 1980s, the mail-order pharmacy industry grew dramatically, fueled by the greater pharmaceutical needs of an aging population and the cost advantages of this sales model. Because mail-order businesses sell drugs at lower costs than many retail pharmacies, they obtain exclusive contracts to supply prescriptions to members of many managed care organizations. They also influence which drugs millions of people have access to. Thus, they have become targets for acquisition by pharmaceutical companies. By controlling mail-order businesses, drug manufacturers can influence these pharmacies' recommendations.

In the 1990s, the pharmaceutical industry introduced direct-to-consumer marketing. While pharmaceutical companies once marketed almost exclusively to physicians, they now market directly to consumers. Direct-to-consumer advertising often prompts patients to seek treatment for previously untreated or undiagnosed conditions (e.g., low testosterone, dry eyes, shift work disorder); patients, in turn, ask their physicians to prescribe drugs they have seen in print ads or on television commercials. A significant portion of the nearly $4 billion that the pharmaceutical industry spends on consumer marketing consists of direct-to-consumer advertising. Surveys have found that these ads encourage patients to ask their doctors about a condition and its drug therapy and, to a lesser extent, about a specific drug (e.g., ads for Viagra, Chantix, NuvaRing, Abilify, among other drugs).

The development of generic drugs has also affected pharmaceutical marketing. These unbranded drugs are comparable (although not identical) in effectiveness to their brand-name, highly advertised counterparts but sell for a much lower price. Consumers can reduce prescription drug costs substantially by substituting generics for brand-name drugs. Not surprisingly, pharmaceutical companies have sought to limit the availability of generic drugs that could be substituted for their name-brand prescriptions. Because

of the lack of access to some medications and the generally high cost of prescribed drugs in the United States, many patients in the United States cross the border to Canada or Mexico to obtain the drugs they need. In fact, drug manufacturers in those and other countries market both their brand-name and generic drugs to US consumers.

Many pharmaceuticals that do not require a prescription are sold over the counter. These drugs are promoted like consumer health products, but over-the-counter medicines often have the power of pharmaceutical marketing behind them. Growth in sales of over-the-counter drugs has been boosted by the introduction of complementary and alternative therapies and natural products, which may not face the same advertising restrictions governing pharmaceutical marketers.

The second decade of the twenty-first century has seen the development and growth of prescription drug sales on the internet. This commerce is carried out by mainstream pharmaceutical companies, mail-order pharmacies, and other entrepreneurs hoping to capture this lucrative market. Most online drug sellers are legitimate and adhere to ethical and professional guidelines, but some online drug distributors are less than wholesome: They sell prescription drugs without requiring a doctor's order from the buyers, and many (mostly based overseas) retailers are outright scammers. Online sales have significant implications for marketing. Because customers can easily access drug and related information on the internet, the importance of and need for traditional marketing techniques are diminished.

Insurance Companies

Health insurance companies were among the earliest healthcare organizations to develop marketing strategies after World War II. In the early days of health insurance, policies were generally sold to individuals or families, and health insurance plans were marketed in the same manner as other types of insurance. Health plans advertised their programs using a variety of techniques and marketed them through a network of agents. Because health insurance was relatively novel until the 1960s, the marketing approach often involved educating prospective customers.

By the 1960s, health insurance was predominantly sold wholesale through employers that purchased group plans on behalf of their employees. Group plans came to be the norm, and individual policies became increasingly uncommon. The spread and entrenchment of employer-based insurance was facilitated by a substantially unionized workforce for whom health benefits became an almost inalienable right. Although group plans were advertised by insurance companies (e.g., through print, radio, television, billboards), they were primarily sold to large employers by sales forces representing a particular insurance company or brokers representing several health plans.

Managed Care and Defined Contribution Plans

During the last quarter of the twentieth century, alternative forms of financing for healthcare coverage were created for the purpose of competing with traditional indemnity insurance. In the 1970s, health maintenance organizations (HMOs) emerged as a form of prepaid insurance that minimized the fee-for-service aspect of reimbursement. HMOs and other alternatives to indemnity insurance came to be generically referred to as *managed care*.

Although a certain level of competition had always existed among health plans, the competition for enrollees was typically low key. The emergence of managed care incited much more intense competition with existing indemnity plans (and with each other). The marketing of managed care plans involved the same approaches used for group plans and individual plans. Legislation was passed that required employers to offer their employees a managed care plan, which meant that employees were likely to have a choice between two or more plans. Thus, the first task for managed care marketers was to convince employers to offer their organization's plan to employees. Subsequently, marketers had to encourage employees to choose their organization's plan over the others offered. Managed care plans began to offer special benefits to encourage enrollment and to retain employees once they were enrolled.

In the late 1990s, managed care enrollment leveled off, with at least half of all insured enrolled in some type of managed care plan. The defined contribution approach to health insurance benefits also emerged during this decade. Both traditional insurance and managed care plans offered *defined benefits*, which meant the provisions of the plan were established up front and all enrollees received the same benefits regardless of their circumstances or preferences, with defined contributions. Employees were given credit for a certain amount of insurance resources and could disburse these funds in the manner they saw fit by choosing options from a menu of benefits. The introduction of defined contribution plans made modifications of existing marketing approaches necessary, as plans could now be customized for individual enrollees. The standardized approach to benefits that had become common gave way to a tailored approach. This development was propelled by health plans' use of the internet to offer enrollees access to information on their benefits.

Self-Insurance, No Insurance, and Government-Sponsored Insurance

By the end of the 1990s, the conventional approach to group insurance had lost ground, for a number of reasons. A growing number of employers were no longer offering insurance as a benefit, cutting back their coverage, or becoming "self-insured." In addition, a growing number of Americans were going without health insurance. This population included not only marginal participants in the economy but an increasing number of working-class and

middle-class individuals who lacked access to group insurance. This state of affairs led to a revival of the individual insurance policy, a development driven by internet marketing and distribution. Insurers began to offer health plans online, and they advertised this option through print and electronic media. Because they are national plans, they can enroll millions of individuals and thereby create a large enough pool of plan members to spread the risk. In 2010, the number of uninsured individuals and families in the United States totaled 47 million, by some estimates. Since the passage of the ACA, this number has been reduced.

Another important aspect of health insurance involves government-sponsored insurance programs—namely, Medicare and Medicaid. There has been no competition among insurance plans for Medicare enrollees because US citizens and legal immigrants are automatically enrolled in the program when they reach age 65. Although alternatives to simple Medicare enrollment have been around since the 1970s, the federally approved (and subsidized) Medicare Advantage program was reorganized in 2003. Medicare Advantage plans are offered by private insurers to Medicare enrollees who seek additional coverage on top of Medicare benefits. Again, the federal government does not have to market Medicare because those eligible are automatically enrolled, but Medicare Advantage plans employ a variety of marketing techniques to convince seniors that they are a more favorable option than traditional Medicare or competing Medicare Advantage plans. The introduction of the Medicare drug benefits program (Part D) required a social marketing effort to encourage Medicare beneficiaries to participate.

Medicaid enrollees sign up through the state in which they reside on the basis of federally approved eligibility criteria. However, states have increasingly contracted out management of their Medicaid programs to private healthcare networks. Government agencies responsible for Medicaid programs have historically employed social marketing techniques to ensure that eligible individuals knew about these programs and the services they offer. In particular, new supplemental insurance programs, such as those for children, need to be promoted to those who could benefit from them.

Affordable Care Act

A major healthcare marketing effort in 2013 involved the national implementation of a key provision of the ACA: enrollment in a health insurance plan to avoid a tax penalty. To facilitate this enrollment drive, the US Department of Health & Human Services (HHS) encouraged each state to set up its own health insurance exchange. Residents of states that did not set up an exchange could enroll through the federal exchange. States were offered incentives to expand their Medicaid coverage to low-income residents, although only half of the states took advantage of this offer.

Given the politically driven controversy surrounding the ACA and its insurance coverage mandate, HHS embarked on a multipronged promotional effort. The effort included airing public service announcements on television and radio, posting advertisements on popular websites, and engaging celebrity **campaign spokespeople**. Furthermore, HHS funded states to advertise their exchanges and contracted with organizations to train and deploy "navigators" to assist people in the enrollment process.

Although the insurance coverage mandate met with immediate negative publicity upon its launch (because of persistent glitches in the federal exchange system that initially prevented people from completing their enrollment), it more than met its goal with 7.1 million signups by March 31, 2014. Whether the marketing efforts of HHS and its partner organizations contributed to the ACA's enrollment success may be hard to determine, but it is safe to say that an overwhelming number of Americans saw, heard, or read the myriad announcements, reminders, and coverage related to this national campaign.

campaign spokesperson
An individual—typically well known—who represents the organization's marketing campaign.

Support Services Vendors

Although hospitals and other facilities may provide many types of support services in-house, there have always been services that internal resources could not easily provide. Since the 1980s, healthcare organizations have been outsourcing an increasing number of services to specialized service providers.

Among the support services that hospitals require are transcription services, billing and collections services, utilization review, recruitment and staffing services, hazardous waste disposal, laboratory services, and information technology. Information technology services have become particularly important as healthcare's dependence on technology has increased. In many cases, hospitals and other healthcare organizations have benefited from outsourcing these services.

Vendors that provide these services typically market via direct sales and often sponsor community events. They may also advertise in print or electronic media or use direct mail to maintain visibility. The internet, too, has increasingly gained popularity as a vehicle for marketing a wide range of support services.

Summary

Healthcare's acceptance of marketing as a corporate function occurred at different times for different organizations. Even today, different healthcare organizations are at different stages of marketing maturity. For-profit healthcare businesses led the way in adopting formal marketing activities, while not-for-profit organizations were slow to do so. Although the scope

of healthcare marketing had broadened considerably by the mid-1980s, few marketing techniques could be applied from other industries unchanged. Marketers had to develop novel approaches that took into consideration the unique attributes of the healthcare industry.

Hospitals' marketing activities are usually significant in scope, and other provider organizations (nursing homes, assisted living facilities, other residential facilities) face their own marketing challenges. Most physicians have long engaged in informal types of marketing, although most were loath to advertise. Today, however, more physician practices are using advertising as a means of gaining visibility and attracting patients. Public health agencies promote activities—such as child immunizations and nutritional counseling—through traditional information and referral channels and through word of mouth and social marketing. Controversial programs—such as those dealing with family planning, teen pregnancy, and sexually transmitted infections—require aggressive yet sensitive approaches.

Supplier organizations typically engage marketing techniques in much the same manner as suppliers in other industries, and consumer health products are marketed aggressively. Pharmaceutical companies allocate more of their budgets to marketing than any other type of healthcare organization. Health insurance companies were among the earliest healthcare organizations to employ marketing techniques. In the early days of health insurance, policies were generally sold to individuals or families, and health insurance plans were marketed in the same manner as other types of insurance. By the 1960s, health insurance was predominantly sold in wholesale fashion to employers on behalf of their employees. By the end of the 1990s, individual policies experienced a resurgence prompted in part by the ability to purchase insurance via the internet. The 2010 passage and ongoing implementation of the ACA created new opportunities and challenges for insurance companies.

Key Points

- Healthcare organizations adopted marketing practices at different rates, and the type of marketing technique chosen varies with the type of organization and its marketing maturity.
- For-profit entities such as pharmaceutical, supplier, and insurance companies adopted marketing practices much faster than organizations providing patient care.
- The nature of healthcare—and particularly the dominance of not-for-profit organizations—contributed to the slow adoption of marketing practices.

- Although organizations in other industries typically have one target audience, the constituents for healthcare services are multiple and varied.
- Historically, pharmaceutical companies' approach to marketing was unique in that they did not market directly to end users but to intermediaries—physicians—who then prescribed the products to patients.
- Every type of healthcare organization has unique marketing challenges and applies the techniques that are appropriate for its circumstances.

Discussion Questions

1. What factors account for the different rates at which healthcare organizations have adopted marketing techniques?
2. How does the marketing of cardiology services by a hospital differ from the marketing of cosmetic surgery by a plastic surgeon?
3. In what ways are the approaches used by pharmaceutical companies to market prescription drugs unique to the healthcare industry?
4. In what ways does the marketing of individual health plans by insurance companies differ from the marketing of group insurance plans?
5. What marketing techniques were so routinely used by healthcare organizations that they were not recognized as marketing?
6. What role has technology played in the evolution of marketing in healthcare?
7. How has the healthcare industry progressed from an emphasis on sales to an emphasis on developing long-term customer relationships?

Additional Resources

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II

HEALTHCARE MARKETS AND PRODUCTS

All marketing efforts begin with an assessment of the market to be served. This assessment typically involves identifying potential customers and determining their characteristics. In healthcare, this task is a challenge because the markets for health services are different from other markets. Marketers must define their customers, products, and marketing targets; understand customer decision-making; and be knowledgeable about the sources of information that consumers use. Healthcare encompasses a diverse set of customers, providers, and payers that marketers must consider. These and other issues are discussed in these chapters.

4

THE NATURE OF HEALTHCARE MARKETS

Marketing professionals in any industry must demonstrate an understanding of the market in which they operate. This understanding is particularly important in healthcare because of the unique nature and variety of markets for health services. This chapter reviews the methods of defining markets, delineating market areas, and profiling markets; discusses how to determine the effective market for a product or service; and addresses the changing nature of healthcare markets.

Marketing activities do not take place in a vacuum but are products of their sociocultural environment. Understanding the intersection of healthcare and marketing requires understanding the societal framework in which both enterprises exist. For healthcare organizations to succeed in today's environment, they must develop an in-depth knowledge of their target population's social, political, and economic characteristics, along with its lifestyles, attitudes, and other prominent traits. (These factors are discussed in more detail in chapter 5.)

Although it is not possible to describe all the social and health systems dimensions that are important in developing marketing initiatives, the key market dimensions are addressed in this chapter.

Defining Markets

The establishment of a marketing function implies the existence of a *market*, which refers to both a marketplace and the potential customers—both individuals and organizations—for a good or service. In healthcare, this notion of the market is expansive, reflecting the fact that every person is a potential consumer of health services. For healthcare marketers, a market is defined as a group of consumers who share some characteristics that influence their needs or wants and make them potential buyers of a healthcare product.

A market for healthcare goods or services can be delineated in a number of ways. The definition that is used depends on the purpose of the analysis, the product that is being marketed, the competitive environment,

and the type of healthcare organization cultivating the market. Further, the nature of the market depends on the orientation of the organization involved in marketing. For example, the market for cardiac care may be identified as a five-county referral area, regardless of which providers offer cardiac care. In other words, everyone in that geographic area who may need cardiac care constitutes the market. However, the market can also be defined as the geographic area served by a particular healthcare organization—that is, hospital X controls a five-county market area (regardless of the services it offers).

     The term *market area* as it is used here is comparable to the term *service area*. A service area identifies the geographic area served by a not-for-profit organization or the areas officially designated as the territory of a particular organization. For example, a service area assigned to a health clinic by a regulatory authority or a territory delimited on the basis of a health plan contract can constitute a service area. For-profit healthcare organizations, pharmaceutical companies, and distributors of consumer health products are more likely to think in terms of market areas. As the healthcare industry has become more competitive and accepted marketing as a healthcare function, healthcare organizations are increasingly framing their activities in terms of market areas.

Geography

The most common method of defining a market is by geography. A *geographic-based market* is delineated in terms of specified **geographic units**. Most marketing research focuses on a census tract, zip code, or county (or a group of any of these units) as the basis for analysis. This type of market area is typically delineated in terms of the "official" boundaries of the geographic unit chosen for analysis. Geographic-based markets are commonly used because analysts and decision makers are familiar with established geographic boundaries, the operating spheres of many organizations often correspond with specified geographic boundaries, and market data are typically collected and reported for established geographic units. Exhibit 4.1 describes the most common geographic units used by marketers: **political or administrative units**, **statistical units**, and **functional units**.

     In actuality, few markets (for healthcare or anything else) neatly follow political or administrative, statistical, or functional boundaries. In fact, markets nearly always change faster than their formal boundaries do, and inevitably a mismatch occurs between a geographic-defined market area and the actual market area. Furthermore, market areas are often constructed to conform to geographic boundaries that approximate the service area under study, primarily because the available data are usually organized on the basis of these geographic units. In addition, a market is difficult to visualize unless it is considered in terms of concrete, recognized boundaries.

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geographic unit
A physical area that is demarcated by defined boundaries and used as a basis for market analysis.

political or administrative unit
A bounded geographic area that is formally defined for administrative purposes, such as a state, county, municipality, or school district.

statistical unit
A bounded geographic area that is formally defined for data collection purposes, such as the geographic units developed by the US Census Bureau.

functional unit
A bounded geographic area that is formally defined for the execution of some practical function, such as mail delivery.

EXHIBIT 4.1
Units of
Geography
in Healthcare
Marketing

Nearly all healthcare marketing activities are linked to some geographic area. Public health agencies and community-based organizations typically serve specific geographic areas. Private sector healthcare organizations typically plan for markets that are delineated on the basis of geography. For the purposes of this discussion, the geographic units that healthcare marketers use are divided into three categories: political or administrative units, statistical units, and functional units.

POLITICAL OR ADMINISTRATIVE UNITS

Political or administrative divisions are the most commonly used geographic units in marketing. Many healthcare organizations have market areas that coincide with the political boundaries of cities, counties, or states. Standard political or administrative units are not only convenient for private-sector organizations to use in establishing their boundaries but also facilitate data collection because most statistics are compiled using these boundaries. The following political and administrative units are frequently used in marketing.

Nation

A nation (in this case, the United States) is defined by national boundaries. Although some national chains or consumer health product companies may be interested in national-level data, few healthcare organizations operate in a national market. Nevertheless, statistics for the nation (e.g., mortality rates) are often used as a basis of comparison with other geographic levels.

States

States are major subnational political units. Data are typically available for the 50 states, the District of Columbia, and several US territories. Because individual states are responsible for a broad range of administrative functions, states tend to be useful sources of social, demographic, economic, and environmental data. State agencies also are an important source of health-related data.

Counties

Counties (or, in some states, boroughs, townships, or parishes) are the primary units of local government. The United States is divided into more than 3,100 county units (including some cities that are politically designated as

(continued)

US Census Bureau
The federal agency
responsible for
the decennial
census and other
data collection
activities.

counties). The county is a critical unit for marketing, as many healthcare organizations view their home county as their primary service area. States typically report most of their statistics at the county level, and the county health department is likely to be a major source of health data.

Cities

Cities are officially incorporated urban areas delineated by boundaries that may or may not coincide with other political boundaries. Although cities are typically contained within a particular county, many city boundaries extend across county lines. Because cities are incorporated according to the laws of the state in which they are located, there is little standardization with regard to boundary delineation. For this reason, cities are not useful units for market analysis. In many cases, however, certain city government agencies are involved in data collection activities that may be useful to marketers.

Congressional Districts

Congressional districts are established by the states and approved by the federal government. They are typically delineated by means of political compromise and do not correspond well with any other geographic unit. Although the **US Census Bureau** reports data for congressional districts, limited data are collected at the congressional district level. In addition, because district boundaries can change over time, these units are not particularly suitable for marketing purposes.

State Legislative Districts

State legislative districts have characteristics similar to those of congressional districts. They are drawn up by states primarily on the basis of political compromise. Although the Census Bureau reports data for state legislative districts, few data are collected specifically for these units. Further, their boundaries are subject to change. For these reasons, they are not useful as units of analysis for the purposes of healthcare marketing.

School Districts

School districts are established for the administration of local educational systems. Such districts theoretically reflect the distribution of school-aged children in the population, but factors such as the migration of students into and out of a district may play a role in determining the configuration of school districts in a community. Although school districts may be useful

sources of data in developing population projections, few statistics are generated for this unit of geography, limiting the usefulness of this source for marketing.

STATISTICAL UNITS

Statistical areas are established to allow government agencies to collect and report data in an efficient and consistent manner. The guidelines for establishing most statistical units are promulgated by the federal government. The following are the most important statistical units in marketing.

Regions

The federal government establishes regions for statistical purposes by combining states into logical groupings. The Census Bureau groups the 50 states into four regions—Northeast, Midwest, South, and West—on the basis of geographic proximity and economic and social homogeneity. Although this unit is seldom used for marketing purposes, some federal health agencies report statistics at the regional level. (The term *regional* is also used to refer to a group of counties or states delineated for some other purpose than data compilation, e.g., the Delta Regional Authority.)

Divisions

For statistical purposes, the federal government divides the nation's four regions into nine divisions. Each division includes several states, providing a finer breakdown of the nation's geography. Divisions are seldom used as a basis for health services marketing. The following list breaks down the nine census divisions by region:

Northeast Region
1. New England Division: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
2. Middle Atlantic Division: New Jersey, New York, Pennsylvania

Midwest Region
3. East North Central Division: Illinois, Indiana, Michigan, Ohio, Wisconsin
4. West North Central Division: Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, South Dakota

(continued)

South Region

5. South Atlantic Division: Delaware, District of Columbia, Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia

6. East South Central Division: Alabama, Kentucky, Mississippi, Tennessee

7. West South Central Division: Arkansas, Louisiana, Oklahoma, Texas

West Region

8. Mountain Division: Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Utah, Wyoming

9. Pacific Division: Alaska, California, Hawaii, Oregon, Washington

Metropolitan Statistical Areas

The federal government delineates metropolitan statistical areas (MSAs) as a means of standardizing the boundaries of cities and urbanized areas. Because states have different criteria for incorporating cities, the MSA provides a mechanism for creating comparable statistical areas. An MSA includes a central city, a central county, and any contiguous counties that are logically included in the urbanized area. Data available on MSAs are increasing, and this unit is often used to define market areas.

Census Tracts

Census tracts are small statistical subdivisions of a county established by the Census Bureau for data collection purposes. In theory, census tracts contain relatively homogeneous populations ranging in size from 1,500 to 8,000. For many purposes, the census tract is the ideal unit for compiling market data. It is large enough to be a meaningful geographic unit and small enough to contribute to a fine-grained view of larger areas. The Census Bureau collects extensive data at the census-tract level, and relatively current data are available through the American Community Survey. Limited health data are available at the census-tract level, although some government agencies do collect and report data for this unit of geography.

Census Block Groups

Census tracts are subdivided into census block groups that include approximately 1,000 residents. A tract is composed of a number of block groups, each containing several blocks. The block group provides an even finer picture of a community than does the tract level, although fewer data elements

are likely to be compiled at the block-group level. Few health data are available at the level of the census block group. This is the smallest unit of census geography for which the American Community Survey reports data.

Census Blocks
Census block groups are subdivided into census blocks, the smallest unit of census geography. The term *block* comes from the four-sided shape formed from the perpendicular intersection of four streets, although some other visible feature (e.g., railroad track, stream) or invisible feature (e.g., city limits) sometimes serves as a boundary. Census blocks tend to be the most homogeneous of any unit of census geography, and the average block houses approximately 30 people. Virtually no health data and only limited demographic data are available for census blocks.

Zip Code Tabulation Areas
Zip code tabulation areas (ZCTAs) were developed by the Census Bureau for tabulating summary statistics from the 2000 census. ZCTAs are generalized representations of US Postal Service zip code service areas. They are created by aggregating the blocks used for the 2000 census (whose addresses use a given zip code) into a ZCTA, and then that zip code is assigned a ZCTA code. These units approximate Postal Service five-digit zip codes found in a given area. The Census Bureau's intent was to create zip code–like areas that would remain stable from **census** to census. Today, most population and housing data collected by the Census Bureau are available at the ZCTA level.

census
A complete count of the people residing in a specific place at a specific time.

FUNCTIONAL UNITS
Healthcare marketers use other geographic units that are better suited to business development activities than are political or statistical units.

Zip Codes
Unlike the geographic units previously discussed, zip codes are not formal government entities. Their boundaries are set by the US Postal Service and can change in response to population shifts or the needs of the Postal Service. Therefore, zip codes have limited value for historical analyses or for tracking phenomena over a long period. Further, zip codes seldom coincide with census tracts or other political or statistical boundaries, making the synthesis of data for multiple geographies extremely difficult. Zip codes tend to be much larger than census tracts, sometimes including tens of thousands of residents.

(continued)

**commercial data
vendor**
A private
organization that
collects, compiles,
analyzes, and/or
disseminates data.

**area of dominant
influence (ADI)**
The geographic
territory covered
by a particular
form of media.

Nevertheless, zip codes are useful for defining the market areas of smaller physician practices, smaller hospitals, and even specialty niches for larger health systems. **Commercial data vendors** compile a great deal of information at the zip code level. More important, healthcare organizations typically acquire a zip code for virtually every consumer they come in contact with, making this unit an accessible geographic identifier linked to every customer record.

Areas of Dominant influence

Taken from media advertising, an **area of dominant influence** (ADI) refers to a geographic territory (typically a group of counties) over which a form of media (e.g., television, newspaper) maintains predominance. ADI is useful for healthcare marketers who are interested in media promotions and want to determine the reach of a particular marketing campaign.

Natural Regions

Some areas are considered "natural" regions, as opposed to the official regions established by the Census Bureau. Natural regions are geographic-based areas that are defined in terms of some unifying characteristic or characteristics. Two examples are Appalachia (which includes parts of 13 states that share the Appalachian Mountains and associated terrain) and the Mississippi River delta (which includes parts of several states that are in or adjacent to the floodplain of the Mississippi River). Both regions exhibit distinct physical features and cultures that set them apart from surrounding areas. Appalachian culture is built around coal mining and farming, while Mississippi delta culture is built around agriculture. The conditions of existence in both natural regions create a lifestyle with distinct characteristics. These two regions have been singled out by the federal government because of their high levels of poverty and lack of resources. Other less expansive natural regions can be identified in the United States.

Population Segment

A second way of defining a market is in terms of a segment of the population. When marketers report that the "market for product X" is this or that market segment, they typically are not referring to a geographic-based market area but to a market defined in terms of demographics, **psychographics**, or some other population characteristic. Examples of markets defined in this way are active seniors, young families, and psychographically defined segments such as "soccer moms."

psychographics
The lifestyle
characteristics of a
population.

Markets conceptualized in terms of population segments can be broad or narrow. For example, a market defined as "seniors" cuts a broad swath through the US population. On the other hand, a market defined as "seniors who require nursing home care" is a much narrower segment of the population. Similarly, the nature of the market could depend on whether one is speaking of a broad range of services (e.g., comprehensive inpatient services) or a narrowly defined individual service (e.g., outpatient eating disorder treatment). Even when a population segment is the target audience, it may be further delineated by geography. For example, the focus of a marketing initiative may not be *all* seniors everywhere but rather seniors residing within a specific geographic boundary—a much different representation of the market.

Consumer Demand

A third way of delineating a market is to define it in terms of consumer **demand**. For example, healthcare organizations may seek to identify geographic areas that have large concentrations of potential patients for a particular service. Markets defined by geography or demographics start with the general characteristics of the population and drill down to the population's specific healthcare needs, whereas markets defined by consumer demand start with a particular need or service and work backward to identify the relevant population of consumers.

demand
The extent to which a target population needs or wants a product or service.

Examples of markets defined by consumer demand are populations in need of geriatric services or behavioral health services. A hospital may consider nearly the entire population in its service area as part of the market for hospital services, whereas a home health agency may target a narrowly defined segment of the population as its potential market. Although markets defined by consumer demand may coincide with established boundaries, they are just as likely to cut across geographic units.

Opportunities

A fourth way of looking at markets is to consider the healthcare opportunities in a given area. A geographic area might be viewed with interest if there is a shortage of providers or a lack of facilities in that area. An area characterized by a lack of competition is obviously attractive to an opportunistic organization. In other cases, the number of providers may be adequate, but their fragmentation may offer an opportunity for an organization that can appropriately package its services.

Areas (or populations) characterized by a high level of unmet healthcare needs may present additional opportunities. An area (or a population) may appear to need a certain level or type of service, but for whatever reason, that service is not available. For example, according to a demand

model, a specified population should record a certain number of mammograms per year based on its size and composition. If the number of mammograms performed annually is significantly lower, this population may have an unmet need.

Many unmet needs exist among populations with limited ability to pay for services. Depending on the type of organization performing the marketing research, these populations may or may not be appropriate target markets. Similarly, opportunities may exist in areas where a gap analysis indicates a service shortfall or a mismatch between needs and services. The number of physicians or hospital beds that a given population can support can be determined using computer models. If the number of physicians or hospital beds located in the area falls below the expected number, there may be opportunities in that market (see exhibit 4.2).

Markets Without Walls

Certain markets are not defined by geographic units or population segments but can be described as "markets without walls." For example, the markets for contact lenses, health food supplements, and certain home-testing products have become less dependent on location. These products may be purchased by mail order, through television shopping services, or via the internet. In addition, the advent of telemedicine allows a specialist in one location to receive electronically transmitted test results for a patient in a different location. Patients and their doctors can interact via the internet, diminishing the importance of geographically defined markets. The trend toward purchasing prescription drugs from abroad or crossing national boundaries to obtain medical care reflects this approach.

EXHIBIT 4.2
Geography as
Destiny: The
Link Between
Zip Code and
Health Status

A growing body of evidence identifies geographic location, particularly an individual's zip code of residence, as an important predictor of health status (Roeder 2014). Indeed, the conditions that characterize the community in which an individual lives, works, and plays have a powerful impact on health and well-being. The environment has both an immediate effect on the health status of residents and an impact that can last for years and even generations (Chetty et al. 2014).

The physical features, social relationships, services, and opportunities available in a neighborhood can enhance or constrain an individual's choices. Although the links between neighborhoods and health are not simple, overwhelming evidence indicates that both the features of

(continued)

neighborhoods and the characteristics of individual residents influence health. One study that compared heart disease among people living in different neighborhoods found that individuals who lived in the most socio-economically disadvantaged neighborhoods were more likely to develop heart disease than socioeconomically similar individuals who lived in the most advantaged neighborhoods (Diez Roux et al. 2001).

The "built environment" influences the healthiness of the circumstances in which individuals find themselves and creates constraints on health-producing resources. For example, proximity to supermarkets (which typically sell fresh produce) has been linked to lower obesity rates, whereas proximity to small convenience stores (which generally do not sell fresh produce) has been linked to higher rates of obesity (Pereira et al. 2005).

Aspects of the physical environment that can adversely affect health include poor air and water quality and proximity to concentrations of toxic or hazardous substances; substandard housing conditions that expose residents to lead paint, mold, dust, or pest infestation; lack of access to nutritious foods and safe places to exercise, combined with concentrated exposure and ready access to fast-food outlets and liquor stores; and adverse traffic conditions (Cubbin et al. 2008).

Disadvantaged groups are not only exposed to more pollution and toxic substances but also to environments in which it is harder to engage in health-promoting behaviors (Taylor et al. 2007). For example, if the environment is dominated by energy-dense, low-cost food outlets, a lack of supermarkets, a scarcity of affordable and appealing fresh fruits and vegetables, and unsafe and uninviting community conditions that restrict activity, the odds will be stacked against the inhabitants of those communities.

Many studies have found a relationship between disadvantaged neighborhoods and health status even after controlling for individual characteristics, reinforcing the contention that health status is at least partly determined by community characteristics (Cubbin et al. 2008). Children may be particularly vulnerable to unhealthy conditions in neighborhoods, with consequences for their health during childhood and later in life. Members of minority racial or ethnic groups also are more likely to live in poor neighborhoods; nearly half of all blacks live in poor neighborhoods, compared with one in ten whites. The uneven pattern of neighborhood disadvantage across racial or ethnic groups is not fully explained by differences in family income. Among families with similar incomes, blacks and Latinos live in neighborhoods with higher concentrations of poverty than whites.

EXHIBIT 4.2
Geography as Destiny: The Link Between Zip Code and Health Status *(continued)*

Delineating Market Areas

Geographic Boundaries

If a market area is defined geographically, the first step in understanding that market is delineating its boundaries. This defined geography then serves as the basis for profiling the market area population. (Not-for-profit healthcare organizations may refer to a service area rather than a market area, although the terms denote the same geography.) A number of methods can be used to specify a market area; the method chosen depends on the type of organization and the service involved.

Current Customer Distribution and Point of Origin

For a healthcare organization, the most direct means of delineating the market area is to determine the point of origin of current customers (e.g., by county, zip code, address). This information can be easily extracted from internal records and summarized at the appropriate geographic level; customer residences can be plotted on a map to illustrate their spatial distribution. This exercise often allows the organization to infer additional information about their customers. It is not unusual, in fact, for an organization to be surprised by where its customers originate.

A growing number of healthcare providers are automating this process, either by purchasing mapping software or by accessing online marketing systems that facilitate strategic marketing activities. The geographic area (e.g., zip code, county) from which a specified percentage of customers are drawn may be designated as the provider's market area. As a rule of thumb, the area from which 75 percent to 80 percent of customers are drawn represents the core market area. (Although it may be worthwhile, in some cases, to target the area covered by 100 percent of the organization's customers, this is usually not practical.)

A healthcare organization may identify primary, secondary, and even tertiary market areas. For example, the area that accounts for 60 percent of patients could be considered the primary market area, and the area that accounts for the next 25 percent of patients might be considered the secondary market area. The area accounting for the remaining 15 percent of patients would be considered the tertiary market area. By taking this approach, healthcare organizations can develop a more refined view of the distribution of their customers. This information helps marketers craft campaigns that address the respective needs of those in the organization's primary, secondary, and tertiary markets.

Analyzing a market in terms of the location of existing patients can generate valuable insights. Almost no phenomenon is randomly distributed, and patient origin is no exception. An analysis of patient origins is likely to

show that the distribution of patients follows clear-cut patterns. For example, analysis may reveal that patients are clustered in certain parts of the market area or that the distribution of patients is associated with one or more other variables (e.g., deteriorating housing, environmentally compromised areas).

Multiple market areas may exist for organizations that provide multiple services. Typically, the market area for general hospital services will be different from that for facilities with more specialized offerings. Similarly, the market area for a hospital's obstetrics services may differ significantly in size and configuration from the market area for trauma care or orthopedic surgery. A specialized or unique service may be characterized by a distinct distribution of patients.

Delineating the market area in this way assumes that customers are coming from their residences when they seek care. Although this assumption is usually correct, the location analysis should also account for customers who do not come from their residences but from other facilities (e.g., nursing homes) or from industrial or commercial sites (Pol and Thomas 2013). It is also important to consider the role of health insurance plans in steering customers to a facility. Plan provisions may require the use of in-network providers, making customers' geographic origin less relevant for delineating the market area.

Ideal Markets

In some situations, the existing market area may not match the organization's objectives. It could be that the characteristics of the residents in the existing market area have changed, or the organization's clientele may have moved away from the facility. The mobility of many US residents may mean that longtime customers have moved out of the service area and new potential customers have moved into it. For example, a physician practice providing chronic care to the elderly may find that, over the years, the senior residents in the community have been replaced with young families who have limited or no need for the practice's services. In the case of an inner-city hospital whose clientele has moved to the suburbs but continues to patronize the facility, the provider must determine whether the existing market area is appropriate for delineating the "ideal" service area.

Prospective Markets

There may be times when it is necessary to delineate a market area for a service that is not yet offered. For a new service or a new location, data on customers' points of origin are, obviously, not yet available. An alternative approach to market area delineation is to determine the maximum distance or driving time consumers would be willing to travel for a particular health service. Research is likely to yield information on the distance or travel time

that consumers are willing to accept for certain services. Computer software is available to perform this task, although in rapidly shifting areas, driving times can change significantly over a relatively short time.

Delineating prospective boundaries is more difficult and usually requires multiple analytical techniques. One approach is to determine the residential distribution of customers who use similar services. If another organization is offering the same or similar services, its market area boundaries might be used as a guide. Distance or driving-time data may be considered as well.

A more indirect approach may be required when the service in question is new to the area. Data on the same service in a different market area may be available through professional networks. These data could help establish time and distance parameters. Surveys of potential consumers of these services (e.g., physicians, patients) may also provide valuable time and distance information. Case study 4.1 describes an effort to capture an emerging market.

Once delineated, market area boundaries must be continually monitored. Traffic patterns and driving times change, and the entrance or exit of a competitor may significantly alter market area boundaries over a short time. Changes in preferences for physician services (e.g., increased interest in alternative therapies) or changes in patient type (e.g., increased proportion of uninsured patients) must also be monitored to determine their effect on market area boundaries. Exhibit 4.3 presents evidence of geographic-based disparities in the use of health services.

CASE STUDY 4.1
Capturing an Emerging Market

The growing racial and ethnic diversity of the US population presents a challenge for healthcare providers. Health systems that once provided one-size-fits-all care are now faced with patient populations that are increasingly heterogeneous and whose members often have different perspectives on healthcare than providers. Providers that can adapt to the needs of this changing market will find many opportunities.

Promoting the opening of a birthing center to a community is challenging enough, but it becomes even more complicated when local residents speak many different languages and have different customs and practices surrounding childbirth. One hospital in an urban midwestern community

took on this challenge and turned it into one of the organization's greatest marketing successes.

Thirteen hospitals within a ten-mile radius of the primary service area provided obstetrics services to the community. An estimated 24,274 women of childbearing age lived in the primary service area. Another 134,055 women of childbearing age lived in the secondary service area. A service area analysis identified the ethnic breakdown of the population: 53.3 percent white, including 18.9 percent Hispanic; 11.2 percent Asian or Pacific Islander; 9.1 percent other; 7.0 percent African American; and 0.5 percent American Indian. The percentage of Asians in the service area was quadruple the state and national averages, and the percentage of Hispanics was double the state and national figures. The racial and ethnic breakdown, however, failed to convey several unique features of the service area. The white population included many recent immigrants from the Middle East and Eastern Europe. Asian immigrants in the area came predominantly from Korea, Pakistan, India, and the Philippines.

To more narrowly define the composition of the childbearing market, obstetrics discharge data by physician were reviewed. Physicians were asked to identify the major ethnic or cultural groups of their patients. The following major groups using obstetrics services were identified: Indian, Pakistani, and Middle Eastern (29 percent); Korean (23 percent); Hispanic (13 percent); and Assyrian (6 percent). Research into cultural considerations for these groups identified a significant subgroup of Indian, Pakistani, and Middle Eastern patients who were Muslim. On the basis of this information, four target markets were defined: Korean, Middle Eastern, Muslim (Indian, Pakistani, and Middle Eastern), and Hispanic (Mexican, Puerto Rican, and Cuban) customers.

To increase the market share for obstetrics services at the hospital, marketing strategies were developed to raise awareness of the new family birthing center within these ethnic communities. To achieve this goal in a highly competitive market, the following objectives were adopted:

1. Differentiate the hospital's services from those of competitors by means of the following:
   - Graphic images and color coding of directional signage in the facility
   - Multilingual and multicultural physicians (men and women), nursing staff, cultural liaisons, and interpreters
   - Culturally diverse artwork throughout the facility

(continued)

- Large state-of-the-art labor, delivery, recovery, and postpartum rooms with hot tubs and space for family members
- Ethnic menus, along with microwaves and refrigerators for patient use
- Childbirth preparation classes taught in Korean, Arabic, Hindi, and Spanish by native speakers
- Family-centered program of care
- Superior quality measures

2. Enhance the hospital's marketing presence through these initiatives:
   - Creating a new maternity services brand for the hospital, featuring the image of infant footprints
   - Aggressively marketing and promoting the new features and benefits of the hospital's maternity services
   - Reinforcing the hospital's unique position as a provider of culturally sensitive, family-centered maternity care

3. On the basis of these objectives, the following marketing initiatives were identified for the hospital:
   - Tailor marketing research to build knowledge and understanding of each ethnic group
   - Implement culturally appropriate advertising campaigns for each targeted group, including native-language posters and fliers, newspaper ads, billboards, and radio ads
   - Develop a comprehensive guide to hospital services in Korean, Arabic, Hindi, and Spanish
   - Launch aggressive media relations efforts to promote the hospital's unique commitment to meeting the needs of its "neighborhood of nations"
   - Implement a comprehensive community-relations program
   - Tailor a series of grand-opening events to each ethnic market, with ethnic menus, appropriate dignitaries, and entertainment
   - Develop a strong community presence for customized ethnic maternity services, with photos of the physical space and amenities in the hospital newsletter distributed to 125,000 households in the primary and secondary service areas
   - Distribute fliers to the religious institutions in the target market

Source: Adapted from Noonan and Savolaine (2001).

(continued)

CASE STUDY DISCUSSION QUESTIONS

1. What changes taking place in American society make a one-size-fits-all healthcare system obsolete?

2. What particular challenge did this community hospital face?

3. What marketing techniques were used to address the needs of a diverse population?

4. In what ways did the hospital disseminate its message to the community (rather than relying on impersonal advertising)?

5. What indicators could the hospital have used to evaluate the impact of these marketing efforts?

Healthcare analysts and policymakers realized long ago that the **utilization** of health services varies significantly from community to community in the United States. As early as the 1970s, research revealed that variations in the rate of procedures performed in different communities—even in adjacent states—could not be explained simply by population differences. The procedure rate could range from 10 percent of the patient population in some markets to 50 percent in others. These studies suggested that the volume of health services delivered was less a function of disease prevalence and more a reflection of the characteristics of the medical community and the practice patterns of local physicians.

One of the first studies to compare health services utilization was conducted by Wennberg, Freeman, and Culp (1987). This seminal study examined patterns of care in Boston, Massachusetts, and New Haven, Connecticut. Although the two cities were similar in terms of the factors that *should* determine the use of health services, they differed dramatically on almost every indicator of utilization. For example, the hospital admission rate in Boston was nearly twice that in New Haven. Further, residents of Boston were much more likely to be hospitalized for both acute and chronic conditions than residents of New Haven. The average annual per capita expenditure on healthcare in Boston was twice that of New Haven. However, the comparative utilization patterns were not consistent. The rates of performance for certain procedures were much higher in Boston, but for others, they were much higher in New Haven. These findings have subsequently been reinforced by numerous additional studies.

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EXHIBIT 4.3
Geographic Variations in Health Services Utilization

utilization
A measure of the extent or level of health services use.

EXHIBIT 4.3
Geographic
Variations in
Health Services
Utilization
(continued)

A number of factors account for these seemingly inexplicable differences. A major factor is variation in physician practice patterns from community to community. In some communities, treating a problem with surgery is standard practice; in other communities, the standard calls for less invasive treatment. In some communities, conventional medical wisdom calls for hospitalization for certain diagnostic tests and procedures, whereas in others, handling such cases on an outpatient basis is customary.

Other factors contributing to differences in utilization rates include the relative supply of facilities and services. For example, a hospital may feel pressure to fill beds if they are available or to use medical technology in which it has invested. In contrast to other industries, competition in healthcare often drives up both utilization levels and costs, accounting for greater variation. Even the presence of a medical school may influence the level of utilization and the types of procedures performed. Increasingly, the level of managed care penetration is a significant factor influencing utilization rates.

Given these variations, how does an analyst determine the appropriate level of utilization? Is the reported level of utilization high or low? What should be realistically expected? Of course, one way to address these questions is to use a standard rate of utilization, such as the rates developed by the National Center for Health Statistics. These rates provide useful benchmarks, but because most analyses focus on local markets, how appropriate are they for the market in question? There is no easy answer to this dilemma. The analyst must be able to gain enough knowledge about the local healthcare environment to make reasonable assessments about the appropriate level of utilization.

Nongeographic Boundaries

Identifying market area boundaries on the basis of factors other than geography is more complicated. In an ideal world, the mere presence or absence of a target population (e.g., active seniors, women of childbearing age, Latinos, baby boomers) would be adequate to define the market. However, situations are seldom this clear-cut, and a nongeographic-defined market is likely to be interspersed with populations that have other characteristics. In other words, marketers seldom find an either/or situation; market concentrations are more a matter of degree. Thus, measures of the concentration of the target population in a geographic area need to be developed.

Data analysis may focus on identifying areas with high or low concentrations of people susceptible to certain illnesses or areas with shortages or surpluses of healthcare providers. For example, if a healthcare provider is interested in identifying geographic areas with high concentrations of older people, several procedures can be used. Suppose the larger market is a particular state, and the substate markets of interest are counties in that state. The goal is to identify the counties with the highest concentrations of people aged 65 or older. The percentages of the population aged 65 to 74 and 75 or older are used as the basis for constructing the index. The indicator chosen depends on a number of factors, including the nature of the population, the type of service, and the marketing methodology being used. A methodology that combines both the number and the percentage of seniors may be appropriate.

When viewing markets from a nongeographic perspective, a different identification strategy is required. The point of reference is a larger population, such as that of the United States or a region in the United States. This strategy seeks to identify concentrations of people with certain characteristics in subgroups of the population. For example, if a health insurance plan wants to identify the segments of the population with the highest rates of uninsured residents, it might examine the composition of the nation's uninsured population.

Nongeographic-based markets can also be defined in terms of consumer propensity to obtain a particular good or service. Market analysts in other industries have long identified population segments on the basis of their willingness, ability, or interest in a particular product. Although healthcare services cannot be viewed in exactly the same way as other products, there is increasing interest in identifying potential markets in terms of their propensity to be affected by a particular condition or to use or need a particular service. This approach is often based on demographic or psychographic profiling. If, for example, a propensity score of 100 indicates average use of a particular service, a score of 200 for a particular population segment suggests a propensity to use this service that is twice the average for the total population. On the other hand, a propensity score of 50 indicates a use rate that is half the average.

Profiling Markets

Once geographic boundaries for a market area or the parameters for a nongeographic-defined market have been established, key attributes of the population within those boundaries should be specified. Developing a market profile involves collecting and analyzing detailed information about the

primary data
Data generated
directly through
surveys,
focus groups,
observational
methods, and
other techniques.

secondary data
Data gathered
through primary
data collection
and used for some
other purpose,
such as marketing
research.

market area(s) in question. All characteristics relevant to service provision must be catalogued on the basis of the **primary data** and **secondary data** sources that are available.

Market Size

Markets can be distinguished along several dimensions. The first dimension is market size, which refers to the absolute number of potential consumers in a specific market area. The marketer typically begins by determining the total population of the market area. This figure indicates the universe of potential customers and must be refined to reflect the portion of the population relevant to the analysis. Thus, the total population is only a starting point—the size of the *effective* population must be determined. A refined assessment of market size would include only those segments that represent prospective customers for the organization or its services.

Market Composition

composition
Characteristics
exhibited by a
population, such
as demographics,
lifestyle patterns,
or payer
categories.

The second dimension addressed in the market profile is market **composition** or the makeup of the defined population. Composition is usually framed in terms of the number of people in a particular area who have certain characteristics (e.g., demographic traits, socioeconomic attributes, psychographic profile). These characteristics might include marital status, household structure, educational level, and income. More detailed data on economic characteristics (e.g., labor force characteristics, housing values) may also be considered.

Demographic analysis is often accompanied by an assessment of the psychographic characteristics of the market area population. Information on the lifestyle of the target audience can be used to determine the likely health priorities and behavior of a population subgroup. Consumer attitudes are also considered as a component of **psychographic (or lifestyle) segmentation**. The attitudes of consumers in a market area have considerable influence on the demand for almost all types of health services.

**psychographic
(or lifestyle)
segmentation**
The process of
subdividing a
population into
groups of like
individuals on
the basis of their
psychographic
designation.

During the profiling process, insurance coverage is typically assessed. The emphasis on insurance coverage varies depending on the nature of the healthcare organization. The payer mix of a market area and of an organization is a main consideration in the financial viability of the organization. Implementation of the Affordable Care Act (ACA) has had a major effect on patterns of health insurance coverage, and understanding the implications of this act for a defined market is essential.

vanity services
Health services,
usually elective,
intended to
improve physical
appearance or
functioning.

Although many providers attempt to limit the number of self-pay patients they serve, there is a multibillion-dollar market for elective services that are not typically covered by insurance plans. The market for **vanity services**—

such as facelifts, tummy tucks, and other cosmetic procedures—is driven by patients who do not have insurance that covers these procedures. Another example is the **alternative therapy** industry, which emerged to challenge mainstream medicine and depends almost entirely on out-of-pocket expenditures by its customers.

Community type is also a consideration when collecting baseline data on the market. The dominant community type in the market area—urban, suburban, or rural—has important implications for health status and health behavior. Consumer attitudes are likely to differ among community types, and the existence of submarkets in the market area may complicate the development of a marketing plan. The service area for a hospital serving a major metropolitan area, for example, would include all three community types.

Health Status

The health status of the market area population is the third dimension considered in a market profile. The level of **morbidity** in a population is a major concern for health services planners. **Incidence** and **prevalence** rates indicate the health problems that characterize a defined population. Health status includes measures of morbidity and disability indicators. To the extent possible, analysts should project future rates of incidence and prevalence to anticipate changes in the demand for health services.

A key objective in assessing health status is determining the level of morbidity among the population of the market area. In particular, the amount of sickness in different categories—such as acute conditions, chronic diseases, and reproductive health issues—must be determined. This allows researchers to profile a population in terms of the types of health conditions that are common, providing not only a picture of health status for the target population but also a basis for calculating a healthcare organization's market share (in the absence of other market share data). This information is used to create demand estimates for health services.

The primary challenge in determining health status is identifying and measuring the level of morbidity. Morbid conditions can be identified in a number of ways, and no single method adequately serves this purpose. The use of a variety of methods is required because, in the United States, no centralized registry of morbid conditions or systematic process exists for the comprehensive collection of morbidity data. Although the **Centers for Disease Control and Prevention (CDC)** has introduced the technological capability for reporting selected health conditions, no such mechanism is available for the majority of health problems. Exhibit 4.4 discusses the changing nature of health status.

alternative therapy
Therapeutic modalities used as alternatives or as complements to conventional allopathic medicine.

morbidity
The amount of sickness and disability characterizing a specified population.

incidence
The number of new cases of a disease, disability, or other health-related phenomenon in a population during a specified period; used to generate an *incidence rate*.

prevalence
The total number of cases of a disease, disability, or other health-related condition at a particular point in time; used to calculate a *prevalence rate*.

Centers for Disease Control and Prevention (CDC)
The federal agency charged with monitoring morbidity and mortality in the United States.

Efforts to measure health status began in the 1960s, as health professionals and policymakers became increasingly concerned about the persistence of poverty and its counterpart, poor health. No single indicator of health status existed at the time, so researchers focused on developing a health status index. The health status indices that were developed during the 1960s and 1970s took into account mortality rates and certain proxies for health status (e.g., poverty, educational level, unemployment). They also included process measures such as access to healthcare and hospital admissions; later, metrics such as obesity and physical activity were added.

No one was particularly happy with the health status indices that were developed, however, particularly analysts who emphasized the importance of quality-of-life measures. To them, whether people lived or died was not the critical issue—it was individuals' well-being while they were alive. By the 1980s, community health needs assessment methodologies were being used to comprehensively evaluate the health status of a community. Frustrated by the lack of meaningful measures of health status, analysts developed laundry lists of metrics in an effort to include every possible indicator of health status. However, the emphasis remained on traditional epidemiological data such as mortality rates.

Experts now agree that a more meaningful measure of health status is needed, for several reasons. First, the traditional approach to measuring health status relies on standard epidemiological measures. It assumes that health problems can be resolved by the healthcare system and considers health status in that light. However, this approach reflects the persistent perception that the healthcare system can cure what ails us.

Second, traditional health status indices emphasize the health of individuals rather than the health of populations. As a result, health status is considered the sum of individual health statuses, and the onus is on individuals to make the changes necessary to improve the health status of the entire community.

Third, measures of health status consider health from the perspective of epidemiologists rather than from the perspective of the communities being assessed—in other words, they are created from the top down rather than from the bottom up. Members of the population in question are likely to have much different perspectives on what constitutes "good" or "bad" health than analysts working within an epidemiological framework. For example, few people would be likely to name the heart disease death rate, or any other epidemiological measure, as their primary health problem.

The conceptualization of health status has not kept pace with changes in the social and cultural environment or with changes in healthcare.

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Although the healthcare industry has shifted from an emphasis on narrowly defined "medical care" to a focus on more broadly defined "healthcare," the notion of health status has remained the same. The health status indices developed in the 1960s included measures of income, education, and other demographic attributes as proxies for health status. Today, these factors would be considered *determinants* of health status. During this time, our notion of health has moved from narrow to broad; from being clinically based to nonclinically based; from being defined in biomedical terms to being defined in biopsychosocial terms; and from an emphasis on cure to an emphasis on health maintenance and disease management.

While the development of a new conceptualization of health status is still a work in progress, there is no doubt that a paradigm shift is underway with regard to the way we view community health.

Health Services Demand

The fourth dimension addressed in the market profile is the demand for health services. Identifying nongeographic-based markets involves a more complicated process. Typically, these markets are defined in terms of size and composition, and the geographic area provides only the context. Thus, a national market would consider the geographic boundaries of the United States as a framework within which to identify submarkets. An example would be the population of women who gave birth in the previous six months. With respect to a given service (e.g., mental health services for postpartum depression), the size of the **effective market** can be **estimated** at the national level.

The types of diseases and other health problems exhibited by the market area population should indicate the types of services needed. A market's need for childhood immunizations, for example, can be translated into demand for a specific number of health department clinics and clinic personnel. Similarly, the level of interest in vanity services such as facelifts or laser eye surgery, for example, can be translated into demand for plastic surgeons and ophthalmic surgeons.

In many cases, actual data on the market may not be available, and estimates of need must be calculated. Fortunately, a number of models have been developed for estimating and projecting the demand for a service using data on population characteristics and utilization rates. These modeling techniques require an understanding of the service area and way these models operate. Modeled data are never as good as actual data, but the estimates generated by methodologically sound models are adequate for most purposes. In any case, modeled data must be used if the level of need is being projected for a future period.

effective market
The portion of the potential business within a market area believed to be suitable for cultivation.

estimate
The calculation of a figure in a current or past period using a statistical method.

Typically, the level of need is expressed in terms of a percentage of the population or a rate. The most common measures of need are the prevalence and incidence rates used by epidemiologists and public health officials. For example, calculations may reveal that 20 percent of the adult population is affected by a clinically identifiable psychiatric condition or that the diabetes prevalence rate is 15 per 1,000 population. These measures of morbidity provide the baseline data for the analysis.

Once the level of need has been determined for the defined market area, the number of potential cases in that area can be estimated. A high prevalence rate, by itself, does not ensure a meaningful market. The potential demand indicated by observed morbidity rates must be adjusted to determine the effective market. Healthcare is a numbers game, and a critical mass is needed to support any service.

An alternative approach to assessing health services demand is to analyze the health behavior of the market area population. Health behavior includes both formal utilization of health services and informal actions taken to prevent health problems or to maintain, enhance, or promote health (e.g., diet management, exercise, oral hygiene). For formal utilization of health services, indicators might include hospital admissions, patient days, average lengths of stay, use of nonhospital facilities, physician office visits, visits to nonphysician practitioners, and drug use. The recent use of freestanding medical facilities and alternative therapies may also be an important indicator. Estimates of demand based on observed utilization patterns should be regarded with caution, as a number of factors—unrelated to morbidity—can affect the utilization of health services.

Availability of Resources

The fifth dimension of the market profile considers the availability of healthcare resources. Resources include healthcare personnel, facilities, and programs. The types of resources identified depend on the nature of the healthcare organization. A general hospital, for example, would want to determine the availability of resources comparable to its own—whether they are offered by a competing hospital or another healthcare organization. A medical specialty group, on the other hand, would be interested in a much narrower range of available resources in its specialty area.

Of the resources available to the community, healthcare organizations should focus on the competitors within their market "space." In the past, hospitals knew that other hospitals were their competitors, cardiologists knew that other cardiologists were their competitors, and so forth. The environment has changed, however, and today competition can take a number of forms. Many types of nonhospital organizations now compete with hospitals. These competitors are not always external to the hospital; in some cases, members of the hospital's own medical staff may set up rival services. The

boundaries of specialty practices have become blurred as specialists seek to expand the range of services they offer. Practitioners of alternative therapies are also competing with mainstream physicians.

In profiling the market area's resources and competition, the temporal dimension must be considered. Whether determining the needs of the target market or identifying competing services, marketers must take into account three time horizons: past, present, and future. Although the current characteristics of the market area are a good starting point, historical trends are also important: Is the population growing or declining? Are the characteristics of the population today different from five years ago? Is the number of competitors increasing? The most important time frame, however, is the future—whether two, five, or ten years down the road. The market profile should project the future characteristics of the population, the future health services needs of that population, and likely future developments of competing organizations.

From Mass Market to Micromarket

When the healthcare industry first began to recognize the importance of marketing, the total population was considered the market for most health services. Hospitals, for example, believed they provided all services to all people. They did not attempt to distinguish segments of the population and made only crude, geographic-based distinctions between markets.

Healthcare organizations operating in this mode typically take a mass marketing approach. *Mass marketing* involves developing generic messages and broadcasting them widely to the entire service area. No attempt is made to target specific audiences, identify best customers, or tailor the message to a particular group. This approach involves the use of **mass media** (e.g., newspaper, radio, television, internet) to blanket the market area. The **message** has to be general—it typically touts the merits of the organization rather than specific services.

As healthcare entered the marketing era, healthcare marketers adopted more targeted marketing techniques. *Target marketing* involves the identification and cultivation of segments of the market area population that have certain attributes. These segments of the population may reside in a geographic area that is being emphasized, they may be demographic or psychographic subsegments of the population, or they may be individuals otherwise classified as prospective customers.

The intent of target marketing is to deliver a particular message to a particular audience to attract members of a population segment as customers. Target marketing is an efficient and cost-effective means of communicating a message to a target audience. By eliminating irrelevant segments

mass media
Promotional techniques intended to reach a large audience (the mass of consumers), such as commercial television, radio, and newspapers.

message
The information a marketer is trying to convey; the content of a promotional piece.

of the population, marketing effort and expense can be minimized, offering the marketer more "bang for the buck." Although target marketing typically involves the use of traditional media, communication channels can be tailored to reach the target audience. Thus, wide-circulation newspapers and network television would be eschewed in favor of special-interest publications, radio stations appealing to specific audiences, and cable channels with certain viewer demographics.

In targeting audiences for specific goods and services, certain established rules should be applied. Target markets must be amenable to rating in terms of their potential, the markets must be realistic in size, the targeted customers must be reachable, and the targeted customers must have some minimum level of response potential. Assuming that the market is adequate in size, another consideration is the geographic distribution of prospective customers in the market area. The importance of customer distribution varies with the type of service and the characteristics of the population. Some services are supported by a local population and others by a more far-flung population. On the other hand, some populations are much more mobile than others or are otherwise more or less sensitive to travel times or distances.

In recent years, many healthcare organizations have gone a step further and adopted a micromarketing approach. *Micromarketing* involves identifying and soliciting specific individuals or households. In some situations, it may be more efficient and cost-effective to identify the individuals or households that are the best prospects for a particular service. For example, if an ophthalmic surgeon has determined that individuals with certain demographic and psychographic traits are better candidates for laser eye surgery than consumers with other traits, the most effective approach would be narrow rather than broad—that is, to contact people with those specific attributes through direct mail or telemarketing. Similarly, a hospital implementing a major fundraising campaign might target only households that have the resources and propensity to make a substantial contribution.

Determining the Effective Market

In healthcare, the potential market for a service may not correspond to the population that actually uses that service. Because the target population's level of need for a particular health service may or may not reflect its level of interest in that service, the best approach is to determine the extent to which members of the target population want the service. Although conducting a preliminary analysis of the market area population and developing an estimate of the level of interest in a particular service may suffice, many situations

require **primary research**. Ideally, no new program or service should be introduced without a consumer survey, and the newer the service or the less familiar the market, the greater the need for primary research. Many new programs fail because the target population's actual level of interest was much lower in reality than on paper.

Ascertaining the level of interest in a product or service may be relatively straightforward. Market surveys often query consumers about their interest in the availability of a service and whether they would use the service if it were available. Healthcare marketers found early on, though, that these survey responses must be carefully qualified. Typically, respondents express an interest in any new service that appears to benefit them specifically or the community generally. However, when their likelihood of using the service is qualified by introducing location or price considerations, the level of interest may change. For example, one survey found that a large share of consumers in a target area were interested in a hospital-sponsored fitness program. However, when the likely location was disclosed, interest waned somewhat. It waned even more when the proposed fee schedule was introduced. Obviously, the more elective the service under consideration, the more important these qualifiers become. Factors such as payer mix and the competition must be taken into consideration in determining the effective market. Case study 4.2 describes the steps involved in determining the effective market for a particular service.

primary research
The direct collection of data for a specific use.

Case Study 4.2
Determining the Effective Market

Southern Health Systems (SHS), a fictional organization, established a satellite hospital in a growing suburban area ten years ago. Since then, the hospital has become relatively successful. It has attracted adequate medical staff and gradually increased its occupancy rate. At the time it opened, SHS was not authorized to offer labor and delivery services. Now, however, a significant market for maternity services has emerged, as the population has reached a critical mass and many young families have moved into the community.

In 2019, the SHS marketing staff was instructed to assess the situation and determine the current and future potential for maternity services in the market area. Because the state requires a certificate of need to add any service, the organization needed data to make a case for adding obstetrics beds. The SHS market analysts recognized the need to identify the potential for maternity services but also to specify the effective demand.

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As in any marketing research project, the analysts began by delineating the service area likely to be served by the proposed obstetrics program. Once they were satisfied that a defensible service area had been specified, the analysts profiled its population. They determined the size and characteristics of the current population and developed projections that reflected anticipated changes in size and demographic characteristics.

According to the data available, the service area had approximately 42,000 residents. Estimates purchased from a demographic data vendor projected a population of 50,000 in ten years. The SHS analysts thought this figure represented the maximum population capacity of the area because virtually all available residential land would be built up by that time. The current demographic characteristics of the population were determined and projected ten years forward. The analysts focused on data on the population's age structure (especially the number of women in their childbearing years), marital status (unmarried suburban residents typically do not have children), and racial and ethnic composition. This last attribute was considered important given the disparities in birth rates among racial and ethnic groups in the area. The psychographic (or lifestyle) characteristics of the population were also analyzed on the grounds that people in different lifestyle clusters exhibit different attitudes toward childbearing.

The analysts also researched the insurance coverage situation of the market area. Because this information was not readily available, they had to conduct primary research. A **sample survey** of the area's households revealed that 75 percent of the population was covered by some form of commercial insurance. Small portions were covered by Medicare, Medicaid, or military insurance, and a negligible number of residents were uninsured. The high level of insurance coverage was a positive finding.

Satisfied that the number of women of childbearing age was adequate (23 percent of the population compared with 19 percent countywide) and that a significant proportion of households were married couples with or without children (55 percent compared with 35 percent countywide), the analysts calculated current and anticipated levels of fertility for the population. Because detailed data were not available on the area population's fertility patterns, known figures for a similar population were applied.

The analysts calculated a proxy estimate of the birth rate for this population (15 per 1,000 people), which turned out to be well above the county rate of 10 per 1,000. This estimate was not surprising, given that this population skewed toward women of childbearing age. The general fertility rate also was calculated to determine the fertility rate for women of

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sample survey
The administration of a questionnaire to a segment of a target population that has been systematically selected.

childbearing age (i.e., those aged 15–44), which turned out to be lower than that for the county overall (58 per 1,000 women aged 15–44 compared with 65 per 1,000). This calculation (rather than the crude birth rate) provided a more realistic estimate of the level of fertility for this population because it adjusted for the size of the childbearing-age population.

On the basis of these figures, the analysts estimated that the population would yield almost 700 births annually by the tenth year. Thus, 700 births became the base figure for calculating the effective market for obstetrics services. This figure was subsequently adjusted for factors that were likely to affect demand for SHS's proposed maternity services. One of the demographic factors considered was the projected growth in the number of African Americans in the service area. Given the higher fertility rate for the African American population, the anticipated number of births 10 years out was adjusted to 750. However, psychographic data indicated that the career orientation of many of the area's women was likely to lower the potential number of births. Thus, the anticipated number of births was adjusted back down to 725.

A major consideration was the drag on potential demand represented by competition from other providers of obstetrics services. After all, this service would be new, and with the exception of existing patients of SHS facilities who might transfer their business to the satellite facility, SHS would have to cultivate a new set of obstetrics customers. Realistically, many, if not most, of the women of childbearing age in the community were likely to have existing relationships with obstetricians and gynecologists (OB-GYNs). These patients would have to be convinced to change to an OB-GYN affiliated with the new facility, or SHS would have to convince their OB-GYNs to join the staff of the new facility. Further, many potential customers would be constrained in their use of facilities by the health plans that cover their obstetrics care. Lastly, some of these potential maternity customers had already delivered children at another facility (or had otherwise positive experiences with a competing hospital) and would not be inclined to change hospitals without a good reason.

The analysts believed the combined effect of these three factors (i.e., existing provider relationships, insurance steering, and previous experience) would reduce the potential market share to approximately 50 percent of the total in the short term and that SHS would grow its market share to 60 percent over 10 years. In the best-case scenario, the analysts believed that a market share of 75 percent 80 percent was the most they could hope for, so a 60 percent share in 10 years was considered a reasonable estimate.

On the basis of adjustments necessitated by these facts, the analysts estimated that SHS would capture approximately 285 births during its first

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year of operation and approximately 420 births annually by the tenth year. Given that a minimum of 200 annual births was required to justify the cost of establishing the facility, the analysts concluded that the effective demand was adequate to support the proposed maternity service.

Case Study Discussion Questions

1. Why did the market analysts have to assess the size of the market before going forward with the development of a new obstetrics service?

2. Why could the analysts not simply use the total population as the basis for determining the demand for obstetrics services?

3. To what extent might the lifestyle orientation of women in the market area influence their attitudes toward childbearing?

4. How important are the presence of other obstetrics service providers and the existing relationships between market area women and OB/GYNs in determining the effective demand for obstetrics services?

5. What challenges do marketers face in introducing a new service to a market area, particularly a service as personal as obstetrics care?

Payer Mix

payer mix
The combination of payment sources characterizing a population; the basis for payer segmentation.

reimbursement
In healthcare, compensation paid by a third-party payer to a provider or customer for the cost of services rendered or received.

payer
In healthcare, the individual or organization responsible for medical expenses.

A factor that has become increasingly important in developing a market profile is the consumer's ability to pay for health services. The analyst must determine the potential **payer mix** of the target population and estimate the expected level of **reimbursement** for a particular service. Given that different **payers** (e.g., commercial insurers, Medicare, Medicaid) offer different levels of reimbursement, the effective payer mix ultimately determines the actual level of payment.

The two bases for determining a target population's ability to pay are household income and type of health insurance coverage. For major health problems (i.e., problems requiring hospitalization or intensive services), the level of insurance coverage is the more important consideration. Employer-sponsored commercial insurance generally affords the highest level of reimbursement. Other forms of private insurance (e.g., Blue Cross) are also desirable. Although payments under Medicare and Medicaid are essentially guaranteed, reimbursement rates under these government insurance programs have historically been lower than those of commercial insurance plans. Because Medicaid reimbursement rates are state specific, reimbursement for medical care varies widely from state to state. For elective services, the patient's income is usually more important than the type of insurance coverage.

In some areas, underinsurance is an issue, especially during an economic downturn. Further, some **underinsured** segments of the population may have insurance coverage, but copayment provisions, restrictions on benefits, or limitations on reimbursement may reduce the coverage's value.

Since the implementation of the ACA, millions of additional Americans have obtained health insurance. The states, however, have taken different approaches to participation in ACA exchanges, with some states not participating and others obtaining waivers that affect the nature of Medicaid expansion. The ACA affects market areas differently, so it is important to determine the extent to which a specific market has been affected by increased health plan enrollment—through either a health insurance exchange or Medicaid expansion.

Competition

The potential market for health services must be adjusted to account for existing competitors. Except in rare cases in which a market is not served at all, competitors inevitably exist. Indeed, the proliferation of competition in the last quarter of the twentieth century marked a major development in US healthcare. Some of these competitors may already be entrenched in the target area or population. Others may be just entering the market to challenge institutions that are already active there.

Regardless of the nature of the **competition**, the available market must be adjusted to account for it. For example, a family practitioner opening an office in a community may face competition from other family practitioners, other primary care providers, public health clinics, urgent care centers, government-sponsored clinics, and even alternative therapists. A realistic assessment of the potential market must consider all of these factors.

One way of assessing competition is to calculate the organization's market share and, if possible, the shares for each of its competitors. The numerator in this calculation is the number of cases of a health condition recorded for the organization (or its competitors), and the denominator is the estimated total number of cases recorded for the market area. Internal records on procedures, discharges, and diagnoses may provide the numerator for market share calculations. The denominator may be derived from data made available in response to data reporting requirements. For example, hospital discharge data are often collected by state health departments and aggregated at geographic levels, such as the county level. A simple calculation divides the number of discharges from hospital X in county Y by the total number of discharges in county Y. Exhibit 4.5 provides an example of a market share calculation.

In the absence of a clearinghouse for health services utilization data, another approach is to estimate the number of procedures and discharges using population and incidence information. For example, the number of

underinsured
An individual who is insured under a health plan—either public or private—that provides inadequate coverage of healthcare expenses.

competition
The effort of two or more organizations acting independently to secure the business of the same customers.

Hospital	2019 Obstetrical admissions	Market share
Hospital X	200	14%
Hospital Y	400	29%
Hospital Z	600	43%
All Other	200	14%
Total	1,400	100%

diabetes cases in a market area can be estimated by multiplying national or regional incidence rates by population data specific to age or other enumerated factors known to differentiate the probability of a diabetes diagnosis. Estimates can be used as proxies for actual data when no market-specific count of procedures, discharges, or diagnoses is available that can serve as the denominator in a market share calculation.

The Changing Nature of Healthcare Markets

The healthcare arena used to be relatively stable and predictable—but not anymore. This dynamic has implications for identifying, profiling, and evaluating healthcare markets. An understanding of the changes occurring in the healthcare market is necessary for effective decision-making.

Several factors have contributed to the changing nature of healthcare markets. Many of these factors are characteristics of the market area and not directly health related. For example, market areas are constantly undergoing changes in demographic characteristics, population size, composition, and customer distribution; lifestyle changes are also common.

The demand for services in a particular market or population segment may be influenced by a variety of factors, such as changing consumer preferences or newly introduced technology. National or regional trends related to service usage, especially in the consumption of elective services (e.g., liposuction), also contribute to demand. Technological advances that make new procedures possible—and old procedures safer or more effective—can reshape the constellation of services offered or the way services are delivered (e.g., inpatient care versus outpatient care). Changing insurance arrangements can also affect the level of demand for services in a specific market.

Another factor that contributes to changing markets is the fluid state of competition. Competitors are constantly changing locations, services, or marketing strategies. New competitors are continually entering the market,

while other competitors are dropping out. This situation has been complicated by the emergence of national chains that may enter a market and, almost overnight, upset the competitive balance. National and state legislation that facilitates the creation of new partnerships (e.g., health alliances) or alters regulatory powers or procedures (e.g., for health maintenance organizations) may reshape markets and, in some instances, create new markets for services.

The ubiquity of change is one more reason to establish marketing research as an ongoing process rather than as an ad hoc activity. Identifying, profiling, and evaluating markets are not onetime activities to be returned to three, five, or ten years later. These three tasks should be part of an ongoing *process* used to continually search for market opportunities and reevaluate current strategies. Making these procedures routine, investing in the requisite hardware and software, and training personnel to perform these functions are essential tasks for nearly all health services providers. Case study 4.3 describes the steps involved in identifying true market potential.

CASE STUDY 4.3
Is There Really a Market for It?

The primary objective in analyzing any market is to determine the potential demand for a good or service being offered to that market. The market analysis typically determines the size and composition of the target market and profiles potential customers in terms of their demographic and socioeconomic characteristics. The market is also typically profiled in terms of health-related characteristics such as disease incidence, utilization rates, and referral patterns.

The initial market analysis attempts to estimate the market potential. The analyst will typically determine, for example, the age distribution, racial characteristics, and marital status of the target population along with socioeconomic characteristics such as income levels, workforce characteristics, and educational levels. Through this process, the analyst compiles all of the information necessary to determine the potential market for the goods or services being offered.

Such characteristics need to be verified from as many perspectives as possible and interpreted on the basis of any information on the community that may have a bearing on the market. An analyst must be able to read between the lines and capture the essence of the market, which may not be obvious from the raw data.

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In some cases, especially when entering a new market, the analyst may have only secondary data. The analyst should verify this information through ground-level research using whatever means available—even primary research. In fact, the analyst may not be able to determine the effective level of demand in a market without surveying the residents.

A case in point involved a growing suburban area outside a medium-sized southern city. The community had all the earmarks of an up-and-coming suburb. Its population was growing rapidly, and an increasing number of upscale housing units were being constructed. Income levels were rising, and the socioeconomic status of the resident population was steadily increasing. An examination of the available data suggested a highly attractive market in terms of its demographics.

Analysis of the secondary data revealed that the market was composed of an upwardly mobile population with a moderately high level of ambulatory care needs. The population appeared to be ripe for innovative programs (e.g., freestanding birthing centers), progressive services (e.g., behavioral healthcare), and even trendy services (e.g., fitness centers). In short, the community appeared to be a dream for marketers offering new services. Even better, virtually no competition had emerged in the community.

The analyst conducted a survey of community residents to confirm the conclusions drawn about the services this population would likely demand. However, early in the interviewing process, interviewers encountered high refusal rates and a generally hostile respondent population. The analysis of the survey data revealed that, contrary to the initial analysis, the population was anything but progressive. The residents of this suburb were traditional in their approach to healthcare and resistant to new or innovative services. They had little interest in such programs as women's services, fitness centers, or behavioral health programs, despite large numbers of residents who fit the profile for those services.

The high proportion of military personnel and retirees in the area also influenced the respondents' attitudes. These residents' situations were much different from those of typical suburban residents in that their military affiliation and retirement health plans influenced their health service utilization patterns.

Ultimately, the community was offered a basic package of primary care services. The gap between the residents' lifestyles and their socioeconomic status as well as the presence of a large military and retired population precluded the development of the types of services typically offered to a growing,

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upscale suburban population. The hospital's market analyst obtained the information necessary to prevent a serious strategic miscalculation based on the initial profile of the market area.

Case Study Discussion Questions

1. What characteristics of this fast-growing suburban population made hospital administrators envision a potential market?
2. When the suburb's population was initially examined, what types of services did the analyst think would appeal to the community?
3. What type of research was carried out to verify the conclusions based on secondary data for this population?
4. How did the findings from the consumer survey contradict what was deduced from the secondary data?
5. What did the analyst discover about this population that discouraged the development of innovative health services?
6. Rather than cutting-edge services, what types of programs did the analyst conclude were more appropriate for this population?

Summary

Understanding the market to be served is a critical requirement for marketing professionals in any industry. To appreciate the interface between healthcare and marketing, marketers must understand the societal framework in which both enterprises exist. Marketing professionals also must have a thorough knowledge of the social, political, and economic characteristics of the target population, along with its lifestyles, attitudes, and other traits.

The market for healthcare goods and services can be delineated in a number of ways. Markets can be conceptualized on the basis of geographic scope, population characteristics, level of demand, and market potential. With the emergence of the internet, markets without walls have also become common. The market area for an organization can be delineated in different ways, and the approach used depends on the circumstances. The geographic unit used to define the market (e.g., zip code, county) depends on the characteristics of the organization and the type of services provided. Over time, healthcare marketers have moved away from a mass marketing approach toward a target marketing or micromarketing approach in an effort to increase the precision of their marketing efforts.

Once defined, a market must be profiled in terms of its salient characteristics, including demographic and socioeconomic traits, psychographic or lifestyle attributes, health status, and patterns of health behavior. The population's ability to pay for care is an increasingly important consideration. Market characteristics are constantly changing, and market areas must be assessed in terms of past, present, and future traits.

A number of factors must be considered in determining the effective market for a healthcare organization. The total demand must be adjusted for such factors as ability to pay, consumer preferences, existing relationships with healthcare providers, and the presence of competitors. A distinction must also be made between consumer needs and wants when evaluating a potential market.

Key Points

- The decision to implement marketing implies that a market exists, but the word *market* has a different meaning in healthcare than it does in other industries.
- A healthcare market can be defined in a number of ways.
- A number of geographic units may be used to delineate a healthcare market.
- Large healthcare organizations are likely to have many different markets to consider.
- Healthcare markets can be profiled in terms of their size, population composition, health status, and level of demand for health services.
- Healthcare is unique in that not all people with a particular health condition are necessarily considered potential customers.
- Healthcare marketers must determine what portion of the total market represents the effective market for the organization's goods or services.
- Healthcare markets are often more dynamic than markets in other industries, as they must respond to developments in health conditions, treatment modalities, and reimbursement patterns.

Discussion Questions

1. What are some of the ways marketers define healthcare markets, and what determines how market delineation differs for types of healthcare organizations?

2. What are some of the bases on which markets can be delineated, and what determines which approach is used?

3. How can a start-up organization delineate a market in which it has no history?

4. What determines the geographic level (e.g., county, zip code, census tract) at which a market area should be delineated?

5. Why is it sometimes difficult to delineate a market area using standard political or administrative boundaries?

6. How can marketers identify unmet healthcare needs that may indicate an untapped market?

7. To what extent has the internet changed the way markets are organized?

8. What are the most salient demographic characteristics considered in profiling a population, and how may these traits differ according to the type of healthcare organization?

9. What arguments can be made for the use of psychographic analysis in healthcare marketing today?

10. Why is the ability to pay for healthcare an important factor to consider in a target market assessment?

11. What factors have prompted the transition from a mass marketing orientation to a target marketing orientation in healthcare?

Additional Resources

Dartmouth Atlas of Health Care. 2019. "Data by Region." www.archive.dartmouth atlas.org/data/region/.

Pol, L. G., and R. K. Thomas. 1997. *Demography for Business Decision Making*. New York: Quorum.

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HEALTHCARE CONSUMERS AND CONSUMER BEHAVIOR

I n any industry, the goods and services offered reflect the needs, desires, and preferences of that industry's consumers. Although this generalization is true to some extent in healthcare, the industry also defies this principle in many ways. In healthcare, distinctions are made among patients, clients, consumers, and customers—although all of these groups may be the purchasers or end users of healthcare goods and services. This chapter describes the categories of consumers of health services and discusses the implications of their attributes for healthcare marketing. In addition, this chapter addresses the nonconsumer purchasers of health services, such as health professionals and healthcare organizations. The unusual nature of consumer behavior in healthcare is discussed, along with the steps involved in the consumer decision-making process.

Who Are Healthcare Consumers?

Consumer, as the term is typically used in healthcare, refers to a person who has the potential to consume a good or service. As noted in previous chapters, anyone who has a need or want—and, presumably, the ability to pay—for a product (a good or service) can be considered a potential customer. According to this definition, the entire US population is a market for some type of healthcare good or service. Historically, healthcare organizations did not view consumers this way. Rather, they assumed that an individual was a prospect for health services only when that person became sick and sought care. Thus, healthcare providers made no attempt to develop relationships with nonpatients. Marketers in consumer goods industries, on the other hand, have always pursued potential customers aggressively, assuming that nearly everyone has a need (or at least a want) that can be met.

How Healthcare Consumers Are Different from Other Consumers
Healthcare consumers differ from consumers of other products in a variety of ways. First, healthcare purchases are largely nondiscretionary, in that serious consequences could result if no action is taken. Because of the nature of

most healthcare episodes, the factors that drive healthcare consumption are different from those driving other purchases.

Second, a health professional typically orders services for the good of the patient. This aspect of healthcare is unique: Goods or services are prescribed for the consumer, and then the consumer is expected to comply with the prescribed treatment.

Third, healthcare consumers often do not know the price of the services they consume—and neither do those prescribing the services. This fact reflects the unusual financing arrangements in healthcare and the patient's lack of access to pricing information. Unlike consumer behavior in other industries, the behavior of healthcare consumers is seldom affected by cost.

Fourth, healthcare consumers have little knowledge about the operation of the healthcare system, and they may have little or no direct experience with it. They have no basis for evaluating the quality of the services they receive and must make judgments about their treatment on the basis of nonmedical and often subjective criteria. When asked about the reasons for their hospital preferences, for example, it would not be unusual for consumers to cite free parking, large patient rooms, or a good cafeteria as criteria for choosing a hospital.

Finally, most healthcare episodes have an emotional component that is not present in other consumer transactions. Medical care involves a certain level of anxiety for both the patient and his or her family members. As noted in chapter 1, emotions such as fear, pride, and vanity influence the behavior and decisions of patients and their families. Exhibit 5.1 summarizes the differences between healthcare consumers and other types of consumers.

How Healthcare Consumers Are Similar to Other Consumers

Although much has been made of the unique characteristics of healthcare consumers, they share many similarities with consumers in other industries. Some healthcare episodes involve emergency or life-threatening conditions, but most do not. Thus, most healthcare episodes compel the end user or those involved in the decision-making process to exercise some discretion. Further, many types of health services are considered elective. Much like consumers in other industries, healthcare consumers are likely to distinguish between needs and wants when consuming services. Clearly, most healthcare consumers would view angioplasty to correct a heart condition as a need, but laser eye surgery to improve vision would be considered a want. The latter would typically be considered a **discretionary purchase**, whereas the former would be regarded as a nondiscretionary or medically necessary expense.

Healthcare consumers are like other consumers in that there is **elasticity** in the level of demand for healthcare goods and services. In the past, demand for health services was thought to be inelastic—that is, it was

discretionary purchase
A purchase of a good or service that is elective rather than required.

elasticity
The tendency of demand to rise and fall in response to factors inside and outside an industry.

Consumers of health services	Consumers of other services
Seldom determine their own need for services	Usually determine their own need for services
Seldom are the ultimate decision makers	Usually are the ultimate decision makers
Often make decisions subjectively	Usually make decisions objectively
Seldom have knowledge of price	Always have knowledge of price
Seldom make decisions based on price	Usually make decisions based on price
Are reimbursed by a third party for most costs	Are rarely reimbursed by a third party for most costs
Usually make nondiscretionary purchases	Usually make discretionary purchases
Usually require a professional referral	Rarely require a professional referral
Have limited choices	Have unlimited choices
Have limited knowledge of service attributes	Have significant knowledge of service attributes
Have limited ability to judge the quality of service	Are usually able to judge quality of service
Have limited ability to evaluate the outcome	Are usually able to evaluate the outcome
Have little recourse for an unfavorable outcome	Have ample recourse for an unfavorable outcome
Seldom are the ultimate targets for marketing	Are always the ultimate targets for marketing
Are not susceptible to standard marketing techniques	Are susceptible to standard marketing techniques

EXHIBIT 5.1
Healthcare Consumers Versus Other Consumers

assumed that those who were sick consumed health services and those who were well did not. This assumption reflected a dated notion of health and illness, and it failed to account for the vast number of elective services that are provided in healthcare.

Today, the demand for health services is considered extremely elastic. The level of healthcare utilization is influenced by a wide range of factors independent of health status, such as the availability of services, access to health insurance, and physician practice patterns. Furthermore, the demand for health services can be manipulated—for example, by physicians who order more or less of a particular service or by marketing campaigns that make consumers aware of a service they did not know existed. Pharmaceutical advertising, for example, has convinced many consumers that they suffer from a condition they had never heard of before.

A final similarity between healthcare consumers and other consumers has to do with the ability to pay for services. Most patients pay for healthcare

through some form of insurance. Those without insurance must pay out of pocket or resort to the healthcare **safety net**, which includes public health clinics and charity hospitals. Historically, healthcare was thought to be a necessity and that people would find a way to pay for required services, even if doing so meant going into debt. Many argued that community safety nets would ensure that all health problems were addressed in one way or another.

The ability to pay for care is a major consideration affecting the demand for healthcare goods and services. For elective procedures and other products that are not considered medically necessary, consumers may be unwilling to pay out of pocket, thus reducing the demand for services. During periods of economic prosperity, the volume of cosmetic surgery, laser eye surgery, and other vanity services increases; conversely, during periods of economic downturn, the volume of such discretionary expenditures decreases. Even medically necessary treatment may be cut back; for example, as a result of the Great Recession (2007–2009), the number of patient visits to physicians' offices decreased (American Academy of Family Physicians 2009).

The ability to pay for care has implications for health services utilization. Many patients are unable to obtain care because they do not have the resources to pay for it. Because most physicians and hospitals demand payment up front from patients without health insurance, the uninsured and those without financial means might be reluctant to seek treatment or to obtain care—even when that care is considered medically necessary. The inability to pay for healthcare is even more concerning when prescription drugs are involved. A critically ill patient may eventually be admitted to an emergency department, but necessary drugs cannot be obtained from a pharmacy without payment. Ultimately, healthcare consumers must weigh the economic implications of consuming goods and services, just like consumers in any other industry.

The Variety of Healthcare Customers

One important attribute of healthcare customers is their variety. The market for healthcare products includes not only individual consumers but also health professionals and health facilities. Although organizational needs may differ from individual needs, many of the same marketing issues pertain to both.

Individuals
Individual consumers fall into several categories, each of which has specific needs. In the eyes of the general public, the typical patient is someone requiring lifesaving services. Life-threatening situations, however, are rare; when they do occur, their management requires dedicated personnel, equipment, and facilities. Most healthcare encounters involve a second category

of individual consumer: people requiring routine services, such as those who present for treatment at a doctor's office, clinic, or therapy center. A third category includes consumers who desire elective goods or services that are not considered medically necessary.

A fourth category is those who practice self-care. Research indicates that self-care is much more prevalent than previously thought; many people access the formal healthcare system only after they have exhausted all other options. Thus, symptomatic individuals are likely to first self-diagnose (often with the aid of the internet) and then self-medicate using a wide range of do-it-yourself remedies in addition to over-the-counter products. Pharmacy shelves are stocked with products and devices for home testing and treatment; the internet has expanded the availability of and access to such products.

For these and other reasons, a variety of terms are applied to today's purchasers and end users of healthcare products, and *patient* is giving way to other terms that better reflect the contemporary healthcare environment. (Major terms are described in greater detail in chapter 2.) Exhibit 5.2 summarizes them for readers' reference. These terms for individual consumers are not mutually exclusive; rather, usage depends on the context. Someone who is a psychiatric patient could just as easily be called a *client*. This patient or client may also be referred to as the *end user* of the psychiatric service and the *enrollee* if he or she is a member of a health plan that pays for the treatment. Broadly speaking, this patient is considered a *customer* of the psychiatric clinic or practice.

Health Professionals and Facilities

Numerous other customers—beyond individual patients—use a wide range of healthcare goods and services. Two major groups are health professionals and health facilities.

Physicians

Physicians are thought of as providers of services, but they are also major consumers of healthcare goods and services. Hospitals invite physicians to join their medical staffs, and provider networks and health plans solicit the participation of physicians and other clinicians. Nursing homes, home health agencies, and hospices may depend on physicians for referrals; in turn, many physicians depend on referrals from other physicians.

Physicians are customers of a variety of entities that provide **support services**, including billing and collection services, utilization review companies, medical supply distributors, biomedical equipment companies, and biohazard management companies. Physicians are customers of information technology vendors who sell or maintain practice management systems, imaging systems, and electronic patient record systems. Physicians have also traditionally been the primary targets for pharmaceutical marketing because they determine the demand for prescription drugs.

support services
Nonclinical, operational activities that support the provision of medical care.

EXHIBIT 5.2
A Typology
of Healthcare
Customer Terms

Term	Meaning	Determinant	Application
Patient	Person under the care of a healthcare provider	Formal diagnosis by a medical practitioner	Traditional term for a person receiving medical care
Client	Person who has a formal relationship with a healthcare provider	Entry into a therapeutic relationship with a provider (with or without a formal diagnosis)	Most often applied to relationships with nonphysician providers (e.g., mental health professionals)
End user	Person who receives a service or consumes a good	Receiver of the product, regardless of who orders it or pays for it	Used to distinguish between the person receiving the care and other parties (e.g., the party that pays the bill)
Enrollee	Person who is enrolled in a health plan or other group arrangement that finances healthcare	Formal membership by qualifying and paying a premium	Enrollment status determines covered services, copayments, and deductibles
Consumer	Anyone in the population who might use a health service	Inclusion in the population under consideration	Universe of potential customers to be targeted by marketers
Customer	Person who uses a service or purchases a good	Receiver of a good or service in exchange for something of value	Consumer who has been converted into a buyer of a good or service

Other Clinicians

Other clinicians—such as dentists, optometrists, podiatrists, chiropractors, mental health counselors, and other independent practitioners—have many of the same needs as physicians and are cultivated by similar marketing entities. These providers require supplies, equipment, billing and collections, information technology, and other services, just as physicians do.

Hospitals and Other Institutions

Hospitals and other provider institutions are customers of a wide range of healthcare-specific goods and services, in addition to being users of the same consumer products as any other organization. These facilities or settings require medical supplies, biomedical equipment, and durable medical equipment (e.g., wheelchairs, hospital beds). They also need support services,

including billing and collections, physician recruitment, and marketing. By providing food service, gift shops, and parking services, hospitals are customers of the suppliers of a spectrum of non-healthcare-related goods and services. Hospitals and other healthcare facilities are routine (and even heavy) users of office supplies, janitorial goods and services, computer software and hardware, and information technology support, among many other goods and services.

Employers

Major employers are customers of health plans, managed care plans, providers, and provider networks. Most health plans are employer based, and competing health plans seek to contract with employers for the management of their employees' healthcare needs. Individual providers may seek to contract with employers that are self-insured or otherwise open to negotiated services. Employers are also customers of direct providers of care, including occupational health, employee assistance programs, fitness centers, and other services that healthcare organizations market directly to employers.

Other Consumers

Like companies in other industries, healthcare organizations have many other internal and external customers, including employees; the general public; the media; and federal, state, and local governments.

Every business should view the members of its workforce as its internal customers. In this regard, healthcare has generally lagged behind other industries. The mission, vision, values, goals, and objectives of the organization should be continually marketed to internal customers, and their input should be regularly solicited. The board of directors is another important group of internal customers. In most organizations, the board is charged with setting the enterprise's future direction and ensuring its progress toward this direction. This body also typically plays a critical role in determining the strategic direction of the organization.

The general public or the community is an external customer that must be considered during strategy development and program implementation. It is important to create and sustain a positive public image and corporate goodwill. At some point, the organization may need to demonstrate that it is a good community citizen. To justify their tax-exempt status, not-for-profit organizations specifically are required to document and report the community benefit they provide to their public constituents.

The media, whether local or national, are yet another category of external customer that the organization must cultivate to ensure that its story is told—and told in the right manner. Long before hospitals, health systems, and other healthcare delivery practices had a formal marketing function, they had public relations departments that dealt with the media.

Many healthcare organizations have one or more branches of government as customers. Healthcare facilities and health professions are regulated by government agencies, so they often maintain a separate government relations office to interface with these bodies. A not-for-profit's continued tax exemption depends on its good relationship with the appropriate government agency that certifies its status. The same goes for an organization located in an area where a certificate of need is required.

International Healthcare Consumers

International travel to obtain healthcare has surged since the turn of the twenty-first century. Many parts of the world, such as Europe, Asia, and the Middle East, have become rich sources of healthcare customers for US healthcare organizations. The fast-growing economies and populations of China and India, for example, are creating greater demand for health services than those countries can provide. Given the growth of the global economy and the excellent reputation of the United States, more and more American healthcare businesses are marketing their services to international consumers.

At the same time, a growing number of US citizens are crossing international borders to obtain health services and products. The relatively high cost of healthcare in the United States, especially pharmaceuticals, has driven consumers to seek products and services in other countries. Travel by Americans for health services may be as simple as crossing the border into Mexico or Canada for routine care or inexpensive drugs or as complex as traveling around the world for a major surgical procedure. As American healthcare facilities have adapted their operations to cater to foreign patients, healthcare providers in many foreign countries (often with government support) are also tailoring their facilities to meet the needs of healthcare consumers from the United States, Europe, and the Middle East.

medical tourism
The practice of traveling to another country to obtain medical care; also known as *global medicine*.

Medical tourism—also referred to as *global medicine*—experienced substantial growth during the first decade of the twenty-first century before leveling off after 2010. In 2009, according to the Organisation for Economic Co-operation and Development (2011), Americans spent an estimated $600 million on medical care overseas—a 13 percent increase from the 2004 estimate. Although growth in medical travel leveled off during the first decade of the twentieth century, a 2016 report projected 25 percent year-over-year increases through 2025 (*Medical Tourism Magazine* 2019).

The Market for International Health Services
Many US hospitals and health systems have developed institutional affiliations with facilities abroad or established independent operations in

foreign countries. These relationships take a variety of forms, such as a US organization's investment in a foreign-owned and -operated healthcare system, a partnership between an American and a foreign entity, or a US corporation's ownership of a healthcare facility or group of facilities abroad. Other forms of international interaction include clinical consultation, organizational management consultation, architectural design and engineering, regulatory and accreditation support, and staff training and development.

Many US-based not-for-profits—such as Johns Hopkins Medical Center, St. Jude Children's Research Hospital, and Harvard Medical School—have built healthcare facilities in South America, Asia, and the Middle East that are structured to resemble the hospitals and clinics in those countries. In addition, many large US for-profit healthcare organizations—including HCA Healthcare, Tenet Healthcare, Sun Healthcare, and Integrated Health Systems—have become multinational corporations by expanding their holdings overseas. Some US companies have even been set up exclusively to establish American-style healthcare facilities abroad.

Other healthcare organizations in the United States are discovering investment opportunities abroad. Health insurance, home health, and medical technology companies, for example, have experimented with exporting their expertise in exchange for new sources of revenue and growth. Another area of expansion involves clinical trials for new drugs. The US pharmaceutical industry has increased the proportion of its clinical trials that are conducted overseas to lower costs, expedite approval, and test drugs in the countries where they will eventually be sold. Approximately half the industry's spending on human drug testing takes place outside the United States, with more than 150,000 clinical trials underway overseas in 2019 (National Library of Medicine 2019). This figure is 23 times the number of clinical trials conducted in 1990. Pharmaceutical companies can significantly reduce the costs of human testing by conducting trials in Eastern Europe, Asia, and Central and South America. Some nations even request that drugs be tested on their populations before approving them for use, although many foreign countries do not have the same safeguards or mechanisms for legal redress as the United States.

Modern, state-of-the-art healthcare systems in Central and South America, Asia, and the Middle East are a relatively new phenomenon. Such facilities were established primarily to meet the needs of increasingly affluent populations in those countries as well as wealthy medical tourists. Even consumers from abroad who are not necessarily wealthy may be attracted to these healthcare operations. Increasingly, US residents who want elective surgeries and procedures are considering and often choosing doctors, surgeons, medical facilities, and hospitals abroad, where costs are a fraction of the costs at

home and the quality of care is the same or—some would argue—even better. Exhibit 5.3 presents data on the comparative costs of major procedures by key destinations.

According to Patients Beyond Borders (2019), the top destinations for international consumers seeking care are Costa Rica, India, Israel, Malaysia, Mexico, Singapore, South Korea, Taiwan, Thailand, Turkey, and the United States. The most common services sought by international medical travelers are as follows:

- Cosmetic surgery
- Dentistry (general, restorative, cosmetic)
- Cardiovascular (angioplasty, coronary artery bypass graft, transplants)
- Orthopedics (joint and spine, sports medicine)
- Cancer (often high acuity or last resort)
- Reproductive (fertility treatment, in vitro fertilization, women's health)
- Weight loss (gastric banding, gastric bypass)
- Scans, tests, health screenings, and second opinions

Patients Beyond Borders (2019) estimates that the market for international medical travel ranges from $65 billion to $87.5 billion, based on 20 million to 24 million cross-border patients worldwide spending an average of $3,410 per visit, including medically related costs, cross-border and local transportation, inpatient stay, and accommodations. An estimated 1.9 million Americans were expected to travel outside the United States for medical care in 2019.

The demand for international medical care appears to be growing. As the global population ages and becomes more affluent, the demand for health services will surpass the availability of quality healthcare resources in many countries. In addition, out-of-pocket medical costs for critical and elective procedures are continuing to rise, and nations that offer universal healthcare are faced with ever-increasing resource burdens. These factors are pushing patients to pursue cross-border healthcare options to save money or to avoid long wait lists for treatment. India is often considered the premier example of global medicine because of its quality of care and relatively low prices. Private entities have established facilities that cater to foreigners, despite the fact that the country's own healthcare needs outstrip its capacity. Some countries have developed facilities that specialize in certain conditions or procedures, such as cardiac surgery, orthopedic surgery, and cosmetic surgery.

EXHIBIT 5.3
Comparative Costs for Major Procedures by Medical Travel Destination, 2017

Procedure	US	Costa Rica	India	Malaysia	Mexico	South Korea	Taiwan	Thailand
Average savings vs. US		45%–65%	65%–90%	60%–80%	40%–60%	25%–45%	40%–65%	50%–75%
Coronary artery bypass graft	$92,000	$31,500	$9,800	$20,800	$34,000	$29,000	$27,000	$33,000
Valve replacement with bypass	$87,000	$28,000	$11,900	$15,000	$26,500	$38,000	$22,000	$19,000
Total hip replacement	$31,000	$15,300	$9,400	$12,500	$14,200	$21,600	$14,000	$16,500
Total knee replacement	$28,000	$14,200	$7,200	$7,800	$12,300	$16,250	$13,400	$13,200
Gastric bypass	$23,000	$10,500	$6,800	$9,250	$11,500	$14,500	$12,700	$12,600
Four-implant porcelain bridge	$21,500	$9,350	$6,850	$7,700	$9,300	$9,900	$8,700	$9,300
Full facelift	$11,500	$4,900	$2,800	$3,300	$4,750	$5,900	$5,250	$3,700
Rhinoplasty	$4,800	$2,600	$1,400	$2,800	$3,100	$3,800	$3,200	$1,600

Notes: Current data as of February 2017. US costs vary based on location, materials and equipment used, and individual patients' requirements. Figures are averages and reflect more common incidence of cost. International estimates do not include the cost of travel or accommodations.

Source: Patients Beyond Borders (2019).

Characteristics of International Healthcare Consumers

US consumers who are interested in medical tourism typically fall into one of four categories; most are driven by cost considerations. The first category comprises those who lack insurance coverage but need a major operation. Patients without insurance must pay out of pocket for the procedures they need, and going overseas could save them a significant amount because the costs are typically lower in foreign facilities. For example, by undergoing a total hip replacement in India rather than in the United States, the patient would realize $21,600 in savings—minus the cost of the trip (see exhibit 5.3).

The second category of medical tourists is composed of those who are underinsured. Despite having some insurance coverage, underinsured patients face high deductibles or cannot afford the portion of their medical expenses not covered by their health plan. As shown in exhibit 5.3, if a coronary artery bypass graft costs $92,000 in the United States and insurance pays 80 percent of the cost, a US patient will still owe $18,400; thus, the patient is better off undergoing this procedure in India, where the total cost for the procedure is $9,800.

The third category consists of those who are seeking elective surgery, following the example of Hollywood celebrities who routinely go abroad for cosmetic surgery. Because the US healthcare system does not consider elective procedures such as facelifts, tummy tucks, and hair transplants to be medically necessary, patients must pay for them out of pocket. Many patients look for ways to cut costs, including medical tourism. Even some procedures that would improve mobility (e.g., correction of tennis elbow) may not be considered medically necessary if the person's functional limitation is not deemed to be significant.

The fourth and final category includes those who are seeking services that are not available in the United States—the most common services are certain high-acuity or last-resort treatments for cancer. Some of these procedures may fail to meet US standards, while others may still be under review in the United States but are likely to be approved in the future. Although the use of such services involves some risk (e.g., lack of recourse in the case of malpractice), thousands of healthcare consumers choose to take advantage of treatments offered in other countries.

Patients who are encouraged by their health insurance companies or employers to partake in medical tourism represent a new category of international healthcare consumer. US insurers facing high costs of care may profit from referring their plan members to overseas medical facilities; some even enter into formal relationships with foreign hospitals. Similarly, some employers—concerned about rising healthcare costs—use financial incentives (e.g., subsidizing the cost of travel) to encourage employees to use less costly

services abroad. This practice is especially common in large firms that self-insure and pay directly for their employees' medical expenses. Recent reports, however, indicate that neither insurers nor employers have embraced medical tourism to the extent anticipated, and as a result, the volume of outbound medical tourism has leveled off since 2010 (Chambers 2015).

Some backlash has occurred in the United States in response to the increase in medical tourism. The proportion of US healthcare consumers traveling overseas is still small, and American facilities face a great enough challenge serving existing patients. Employee unions have raised concerns over the fact that their members are encouraged by their health plans to go to foreign countries for care—an apparent violation of some unions' "buy American" restrictions. These types of reactions are not unusual as people adapt to the globalization of healthcare.

Case study 5.1 provides an example of one country's global medicine marketing efforts.

CASE STUDY 5.1
Marketing Medical Tourism in Asia

In 2019, Ballistan—a fictional country based on a small Asian nation with a modern healthcare system and a strong economy—recognized that its healthcare system had features that would be attractive to medical tourists. The potential revenue that medical tourism could generate was large enough for the national government to take an interest in ensuring the success of this endeavor. To that end, Ballistan established an agency to attract international business and promote medical tourism. Funded by the national government, the agency was a ministry operated with the full cooperation of the country's healthcare organizations and directed by a high-ranking government official.

One of the first steps the agency took was to assess the current domestic need for health services and the availability of local facilities. It identified existing capacity, took an inventory of medical equipment, and determined the number and qualifications of existing clinical personnel. It also evaluated the system's ability to meet domestic needs and to serve an international clientele. Further, it estimated the size of the international market and calculated potential revenue.

Having determined that a large and growing market of consumers with substantial resources to spend on healthcare existed and that the system could absorb a substantial number of international patients, the agency developed a multipronged marketing initiative. The first campaign raised awareness

(continued)

about available services for the countries with the most potential customers (i.e., elsewhere in Asia, the Middle East, and the United States). A follow-up campaign promoted Ballistan and its healthcare resources. Related articles were published in newspapers, magazines, and journals. These print materials were supplemented by an interactive website that included a blog, a cost calculator, a map of the country's health facilities, and colorful infographics about medical tourism. Social media platforms were used to connect with prospects. Although some paid advertising was used, the agency felt that paid advertising was the least effective means of reaching the target market.

The agency put together comprehensive medical tourism packages with the help of the country's travel and hospitality industries. These packages offered a fixed price covering all charges for air or train travel, room and board, medical care, rehabilitation (if needed) and follow-up care, and local tours.

The agency installed liaison offices and staffs in several foreign countries to answer questions and coordinate arrangements for incoming customers. In addition, these satellite offices forged relationships with medical practitioners in these target countries to establish legitimacy and ensure a steady source of referrals. The agency negotiated with health insurance plans that agreed to refer some of their cases to these countries' practitioners.

In convincing potential customers to travel to Ballistan to obtain health services, the agency highlighted the following benefits:

- Fixed, competitive price
- State-of-the-art facilities staffed by English-speaking clinical experts trained in the United States
- Care and services of a quality equal to or better than that found elsewhere
- Personalized attention before, during, and after the treatment or procedure
- Cultural and sightseeing opportunities available to visitors and their families

The campaign to promote medical tourism in Ballistan was highly successful, particularly among consumers from the United States. People with medical needs or wants have flocked to its cities since. Customers with commercial insurance have been able to cover either the full or partial cost of care, but those who pay out of pocket are delighted to pay only a fraction

(continued)

of what the same care would cost in the United States. Notably, the agency's marketing research revealed that a high number of these medical tourists were satisfied with the outcomes of care and the delivery of the services—a critical finding in light of the importance of word of mouth to medical tourism.

CASE STUDY DISCUSSION QUESTIONS

1. What prompted officials in Ballistan to consider entering the medical tourism business?
2. What steps were taken to identify the current status and future potential of medical tourism?
3. What factors encouraged government officials to develop a marketing campaign to attract medical tourists?
4. What marketing techniques did the agency use to promote medical tourism?
5. What role did relationship development play in implementing the promotional strategy?
6. How effective was the campaign to Ballistan's thriving medical tourism?

What Is Most Important to International Healthcare Consumers?

Consumers have different motivations when using new and innovative services. Both US- and foreign-based healthcare organizations have identified the following as prerequisites for attracting an international clientele:

- **Excellent care.** High-quality service is a must for those hoping to compete in the medical tourism industry. Consumers will travel to another country for services only if they are assured that they will receive the best services possible and their needs will be fulfilled.
- **Physician skill set.** Most healthcare consumers, regardless of nationality, are looking for a physician who is capable of performing the basics of the job, is knowledgeable, has good bedside manner, is willing to answer questions and explain procedures, and personally guarantees the customer's satisfaction. All of these qualities signify that the doctor cares about the patient's health outcomes. This factor may be less important to US patients, who are not used to a consumer-driven orientation among clinicians.

- **Word-of-mouth reputation.** Word-of-mouth recommendations carry a lot of weight in the absence of objective information about a provider or an organization that is not yet established or has not yet built a reputation. This type of publicity is essential in the marketing of an unfamiliar service.
- **Physician recommendation.** Most people are not likely to be familiar with the medical facilities—or even the world-class hospitals or centers—in other countries. For this reason, few people will travel overseas for health services without a referral by a medical professional in their home country.

Market Segmentation for Healthcare Products

market segmentation
A process for grouping individuals or households who share similar characteristics for the purpose of target marketing.

segment
A component of a population or market defined on the basis of some characteristic that is relevant to marketers.

Market segmentation is used to single out and call marketers' attention to certain segments of the population. Not every subgroup in a population qualifies as a target market, and certain rules of thumb can help marketers identify a meaningful market **segment**. To be useful to a marketer, a segment should have the following qualities:

- **Measurable.** The data obtained on the segment's characteristics are accurate, complete, and detailed enough to allow for comparison, evaluation, and monitoring.
- **Accessible.** The segment can be reached by marketers effectively using standard marketing methods.
- **Substantial.** The segment is large enough to be considered worthwhile for a dedicated marketing activity.
- **Meaningful.** The segment includes consumers who have attributes relevant to the marketer's goals.

Furthermore, a viable market segment should demonstrate a desire for the product being marketed and have the ability to pay for it. The growing emphasis on consumer engagement has raised marketers' sensitivity to consumers' readiness for change.

In healthcare, marketers use market segmentation to better understand the unique traits of healthcare customers and of the healthcare delivery environment. The most common forms of market segmentation are described in this section (and considered in chapter 4).

demographics
The range of biosocial and sociocultural attributes of a population.

Demographic Segmentation
Market segmentation based on **demographics** is commonly used in consumer goods industries, and it is the best-known approach to identifying

target markets. This type of segmentation defines demographically distinct subgroups based on their need for a good or service. The links between demographic characteristics and health status, health-related attitudes, and health behavior are well established. For this reason, demographic segmentation is typically an early task in any marketing planning process.

Marketers typically segment the healthcare market in terms of age, sex, and race or **ethnicity**. Depending on the service to be offered, the market may be further segmented according to income level, educational level, or marital status. The population may be further classified according to region of the country or type of community (e.g., rural, suburban, urban). Research indicates, for example, that the demographic segment most likely to sign up for fitness programs is affluent women between 35 and 40 years old living in suburban communities. (Chapter 7 provides additional detail on the demographic characteristics of healthcare consumers.)

ethnicity
A common racial, national, tribal, religious, linguistic, or cultural trait or background of members of a population.

Geographic Segmentation

Understanding the spatial distribution of the target market is increasingly important as a result of healthcare's reorientation toward the consumer. One implication of this trend has been an increased emphasis on the appropriate location of health facilities. A market-driven approach requires providers to take their services to consumers wherever they live, and major purchasers of healthcare products insist on convenient locations for their members or employees. Understanding how the patient population is distributed across the service area and the links between **geographic segmentation** and other forms of segmentation is critical to the development of a marketing plan. (Geographic units used for geographic segmentation are described in chapter 4.)

geographic segmentation
A method of dividing a target audience on the basis of geographic location.

Marketers can segment the population in terms of geography in a number of ways. They can identify the geographic areas that constitute the market area for an organization (e.g., the zip codes from which a physician draws patients). They can segment the population by type of community—considering the area's rural, suburban, and urban residential components, for example, as separate markets. They can relate other variables (e.g., demographics, lifestyle) to particular geographic areas; for example, marketers commonly segment the market area geographically by income, identifying areas with low, medium, or high income levels. Exhibit 5.4 illustrates the geographic distribution of a demographic variable (race).

Psychographic Segmentation

For many types of goods and services, understanding the psychographics or **lifestyle** characteristics of the target population is essential. Lifestyle clusters in a population often transcend (or at least complement) that population's

lifestyle
The entirety of attitudes, preferences, and behaviors of an individual, group, or culture.
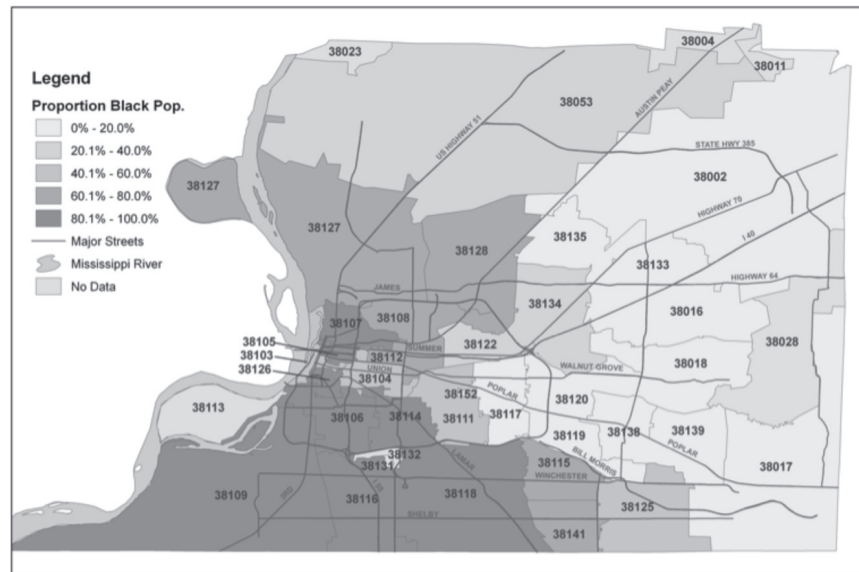
Source: Data from US Census Bureau. Prepared by the author.

demographic attributes. Psychographics can be linked to the attitudes, perceptions, and expectations of the target population as well as to its propensity to purchase certain products. Although the use of psychographic analysis in healthcare has lagged behind other industries, health professionals are finding a growing number of applications for this approach, and more healthcare data are being incorporated into psychographic segmentation systems.

Marketers can choose from a handful of psychographic segmentation systems for partitioning the market area by lifestyle. For example, the Mosaic system developed by Experian assigns one of 71 lifestyle clusters to most households in the United States. Knowing the assigned psychographic cluster of a household opens the door to a variety of other useful information, in addition to available lifestyle attributes. Exhibit 5.5 graphically presents the psychographic breakdown of a market area by major lifestyle grouping.

Health Risk Segmentation

An approach to market segmentation that is unique to healthcare involves partitioning the population by level of health risk. This approach enables marketers to determine the types of health services that are appropriate for a certain group and to craft marketing messages for those services. Health risk levels may be measured for a specific health condition (e.g., diabetes), a
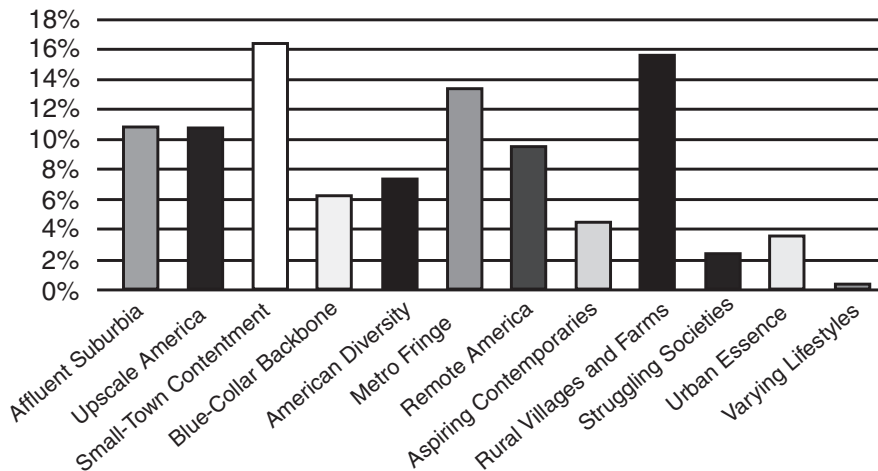
combination of conditions (e.g., obesity and hypertension), or a broad group of conditions (e.g., chronic disease). The risk level is quantified and presented numerically or, more commonly, ranked as low, moderate, or high.

From a marketing perspective, the level of risk affects the type of marketing message used and the timing of its delivery. Consumers with low risk need to receive information on prevention and health enhancement as well as the warning signs of health problems. Consumers with moderate risk need to be encouraged to take appropriate action and given related information. Consumers with high risk need to be persuaded to take urgent action, informed of the types of healthcare goods and services available, and encouraged to comply with their prescribed treatment.

Usage Segmentation

Usage segmentation, a common approach in other industries, is now being applied in healthcare. The market area population can be divided into categories based on the extent to which a particular service is used. In examining the use of **urgent care** clinics, for example, the population can be categorized as heavy users, moderate users, occasional users, and nonusers. This classification can be applied to many services, but it may be most useful for elective goods and services. Usage segmentation provides a basis for subsequent marketing planning that can be tailored, for example, to loyal customers versus noncustomers. Consumers' willingness to use certain services, especially elective procedures, often reflects the extent to which they are open to change. See exhibit 5.6 for a discussion of the adoption process for new healthcare services.

usage segmentation
A method of dividing a target audience on the basis of historical utilization of a product or an organization.

urgent care
Medical care for a condition that requires immediate attention but is not serious enough to warrant emergency care.

EXHIBIT 5.6
Who Adopts
Innovative
Services?

Despite their emphasis on research and innovation, healthcare organizations are relatively conservative. They adopt new techniques or treatment modalities only after extensive testing, and even then, practitioners may be reluctant to forsake tried-and-true procedures. Similarly, most healthcare customers tend to be conservative in their approach to care, preferring to stick with proven treatments rather than opt for more experimental approaches.

This perception of healthcare customers, however, masks the wide range of approaches to adopting health services. Baby boomers, for example, have been particularly open to innovative approaches. As a result, many novel health services have entered the market, such as urgent care and alternative and complementary therapies. Clearly, some segments of society have a greater predilection for innovation than others.

Marketers have studied the process by which individuals come to adopt a new procedure or therapeutic modality, tracking progress from the point an individual first hears about an innovation to final adoption. This process is similar in many ways to the consumer decision-making process. Studies indicate that the consumer population can be grouped into five categories (Rogers 2003):

1. **Innovators** represent, on average, the first 2.5 percent of all those who adopt. They are eager to try new ideas and products. They have higher incomes, are better educated, and are more active outside their community than non-innovators. They are less reliant on group norms, more self-confident, and more likely to obtain information from scientific sources and experts.

2. **Early adopters** represent, on average, the next 13.5 percent to adopt a product. They try the product early in its life cycle and—compared with innovators (who have a more cosmopolitan outlook)—are much more reliant on group norms and values and more oriented toward the local community. They are more likely to be opinion leaders because of their closer affiliation with groups. Because of its personal influence on others, this segment is regarded as the most important determinant of a new product's success.

3. **Early majority** members are the next 34 percent to adopt. They deliberate more carefully before adopting a new product; they collect more information and evaluate more options than early adopters do. Although they are slower to adopt, they are an important link in the

(continued)

EXHIBIT 5.6
Who Adopts
Innovative
Services?
(continued)

diffusion process because they are positioned between early and late adopters.

4. **Late majority** people are the next 34 percent to adopt. They are described as skeptics who eventually adopt an innovation because most of their friends have already done so. Subject to group norms, they adopt under the pressure to conform. They tend to be older, have below-average income and education, and rely on word-of-mouth communication rather than mass media messages.

5. **Laggards** are the final 16 percent to adopt. They are similar to innovators in their inattention to group norms. They make decisions based on their past experiences, independent of the opinions of others, and by the time they adopt an innovation, it has probably been superseded by another innovation. Laggards have the lowest socioeconomic status among all the adopter groups.

Healthcare marketers can improve their effectiveness by determining a product's level of innovation and using this information to target the segments of the population most likely to adopt it. Efforts directed toward those who are least likely to adopt innovative goods or services are likely wasted.

Sources: Adapted from Assael (1992) and Rogers (2003).

Payer Segmentation

Another form of market segmentation that is unique to healthcare involves targeting segments on the basis of their payer categories. The payer mix of the market area population is often one of the first considerations in profiling a target population. The existence of insurance coverage and the type of coverage available are major considerations in marketing most health services. Further, health plans cover some services and not others—an important consideration in marketing. For services that are routinely covered by insurance, a mass marketing approach may be appropriate. For elective services that are paid for out of pocket, a targeted marketing approach is typically more effective.

Market analysts typically categorize payers as follows: commercial insurers (sometimes managed care plans are a subcategory), Medicare, Medicaid, and other government programs (e.g., the US military's TRICARE program). Consumers who are not covered by insurance and pay for health services out of pocket belong to a category referred to as the *uninsured*. Exhibit 5.7 illustrates the payer mix of a target market area.
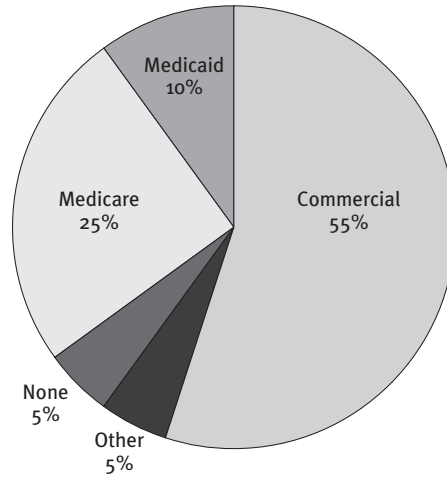
Benefit Segmentation

People buy the same or similar products for different reasons. **Benefit segmentation** is based on the idea that consumers can be grouped according to the principal benefit sought. The benefits that consumers consider when making a purchase decision include quality, convenience, value, and ease of access. As healthcare has become more consumer driven, marketing researchers have sought to determine how to make a product resonate with potential customers. The same service can be positioned in different ways, depending on the benefits sought by the target audience. Thus, a marketer might promote free, close-to-the-door parking to one segment, the quality of the staff to another segment, and competitive pricing to yet another segment. Exhibit 5.8 illustrates the results of a survey on benefits sought in a family practice clinic, and exhibit 5.9 summarizes the approaches to segmentation.

Attribute	Percentage of respondents seeking attribute
Convenient location	93
Extended hours	85
Same-day appointments	64
Free, nearby parking	63
Personal care manager	50
Online consultation	42
Low prices	31

Source: Thomas (2005).

Basis for segmentation	Focus	Example	Application
Demographic	Grouped by age, sex, race or ethnicity, or other demographic characteristics	Women of childbearing age	Conducting product development, target marketing
Geographic	Grouped by location, space, or other geographic dimensions	A fast-growing new suburb	Selecting a site
Psychographic	Grouped by a particular lifestyle	Generation X career women	Tailoring services or marketing messages to the lifestyle
Health risk	Grouped by level of health risk (low, moderate, high)	Obese men, women, and children	Targeting for prevention messages and social marketing initiatives
Usage	Grouped by level of use (heavy users, moderate users, occasional users, nonusers) of healthcare products	Single men who are heavy users of urgent care clinics	Tailoring marketing messages to level of usage
Payer	Grouped by payer or insurance categories (e.g., commercial, Medicare, Medicaid, other)	Medicare enrollees	Assessing the financial potential of a market segment
Benefit	Grouped by level of benefits desired	Consumers who demand speed and convenience	Determining the "hot buttons" of a targeted consumer group

EXHIBIT 5.9
Approaches to Healthcare Market Segmentation

Consumer Behavior

Consumer behavior refers to a customer's pattern of consumption of goods and services. This pattern encompasses the factors that contribute to the customer's behavior and the processes that lead to a **purchase decision**. It is essential for marketers to understand the behavioral dimension of any target population, and consumer behavior is what a marketing campaign seeks to influence. While the behaviors of health professionals and healthcare organizations are equally important to understand, this discussion focuses on individual customers.

purchase decision
A consumer's commitment to buy a good or to use a service.

Healthcare consumers' decision criteria can be classified in the same way as those of consumers in other industries. The factors that influence purchase decisions are technical, economic, social, and personal. Technical criteria include quality of care, clinical outcomes, the treatment environment, and the amenities associated with health services. Economic criteria—perhaps the least relevant in healthcare—include the price of goods and services, the payment mechanism (e.g., insurance), and the perceived value of the service rendered. Social criteria include the status of the professional, the facility, or the procedure performed, as well as the influence of the consumer's social group. Personal criteria include the emotional aspects of the service, self-image issues, and even moral and ethical considerations.

Hierarchy of Healthcare Needs

hierarchy of needs
The prioritization of personal needs, which range from basic survival to self-actualization.

Marketers traditionally think in terms of a **hierarchy of needs** in setting the context for analyzing consumer decision-making. Most refer to the theory of motivation developed by psychologist Abraham Maslow (1970), who contended that the first order of need for human beings is physiological—that is, the need for food, water, air, shelter, sleep, sex, and warmth. Once these basic needs are met, individuals can begin to pursue safety and security needs, including freedom from threats and the establishment of security, order, and predictability in their lives. Health is a dimension of safety and security.

With safety established, individuals can seek the next level in the hierarchy—social or companionship needs, which include friendship, affection, and a sense of belonging. Esteem or ego needs—such as self-respect, self-confidence, competence, achievement, independence, and prestige—are eventually added. Finally, at the top of the hierarchy is the need for self-actualization, which includes the fulfillment of personal potential through education, career development, and other goals. Only a few societies in the history of the world have achieved this top level.

The level at which an individual or a population functions says a lot about its healthcare needs (and the approach a marketer should take). At the lower levels, survival needs dominate, as the population faces health threats from pathological agents and a danger-filled environment. At the higher levels, the threats common at the lower levels have been moderated and, rather than attempting to preserve life and limb, the population can focus on maintaining and enhancing health. At the highest level, the population's healthcare needs shift from lifesaving procedures to public health considerations to self-actualization marked by such elective services as hair replacement, spa treatments, and cosmetic surgery.

From a marketing perspective, consumers who are at the survival level are likely to respond only to marketing initiatives that address their immediate healthcare needs. They are not going to respond to promotions

for services that may enhance their quality of life or require out-of-pocket expenditures (which explains the difficulty of convincing people in financially precarious positions that they should invest in a healthy lifestyle). As consumers progress up the hierarchy, they are more open to discretionary services and appreciate the importance of maintaining and enhancing their health status. At the self-actualization level, elective services such as plastic surgery, breast implants, and teeth whitening become a means of raising status and enhancing self-esteem.

The types of healthcare products that a person responds to, the communication method used to reach that person, and the message that resonates with that person reflect his or her position in the hierarchy of healthcare needs. Marketers are faced with the challenge of matching the product, medium, and message to the needs of the target audience. Case study 5.2 illustrates a marketing approach to a consumer behavior challenge.

CASE STUDY 5.2
Using Consumer Engagement to Encourage Wellness Behavior

Many companies have developed employee health management programs to control their healthcare costs and maintain a healthier, more productive workforce. They are encouraging employees to identify their health risks (by offering health risk assessments) and, when appropriate, to take actions to address those risks (by providing incentives to those who sign up for wellness classes, weight management programs, chronic disease management programs, etc.). The benefits of participating in employee health programs are well documented and improve not only the health of the employee but also the company's bottom line.

Despite their known benefits, these programs have been challenging for employers to implement. First, employees often resist completing health risk assessments. Employers cannot mandate participation, so they offer incentives to do so—but even then, presentation rates for assessments are low. This resistance creates a problem because an assessment is typically required for placement in a wellness program. Second, and more significant, if health risks have been identified, many employees fail to commit to a wellness program. In the same way that incentives have little influence on participation in health risk assessments, incentives have a limited effect on the initiation and continued use of fitness, chronic disease management, and other health and wellness programs.

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Many observers contend that an organization's inability to generate the desired level of employee participation in internal health programs is a marketing problem. Many, if not most people, they argue, would be willing to undergo a health risk assessment if approached in an effective manner. Similarly, most people who realize they are at risk for a health problem would be willing to change their behavior under the right circumstances. Ultimately, the question is how to engage employees in a way that elicits the desired results.

Heeding these facts, one company asked its marketing department to develop an approach to target groups of employees with messages that would resonate with them. The company believed that conveying the right message at the right time would go a long way toward engaging its workforce in its health improvement initiative.

To this end, the marketing department developed a questionnaire to be administered to all employees. Unlike the health risk assessment, the survey did not delve into the employees' health conditions but asked only a few questions about their knowledge of health risks, their attitudes toward improving their health status, and the actions they were taking or were willing to take to improve their health. From the survey results, the marketers were able to group the employees into four categories: (1) those who had limited knowledge of health issues and their own health status, (2) those who knew their own health risks but were reluctant to take appropriate action, (3) those who were willing to take appropriate action but were not sure how to do so, and (4) those who were already involved in some type of wellness program.

Armed with this information, the marketing department developed a consumer engagement initiative that targeted the needs of each group of employees but emphasized for all groups the core theme of living well. For the first group, the initiative focused on disseminating information to raise these employees' level of knowledge of health issues. The material created for the second group focused on changing these employees' attitudes and encouraging them to develop an appreciation of proactive measures. For the third group, the marketers cultivated these employees' awareness of available options and facilitated participation in those options. The marketing message for the fourth group was designed to reinforce desirable behavior. The overall intent was to progressively move employees in the first three categories to the fourth-category level using well-timed and stage-appropriate marketing messages.

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After the consumer engagement initiative had operated for a year, a follow-up survey indicated these achievements: (1) the level of awareness of health risks among all employees had increased, (2) an increased number of health risk assessments had been performed, (3) a higher proportion of employees had signed up for company-sponsored wellness programs, and (4) the dropout rate for existing programs had decreased. The employer is still refining its employee health program, but management concluded that a targeted consumer engagement approach influenced positive changes in knowledge, attitudes, and behavior among the employee groups. Although minor changes were made to make the program more attractive, the primary factor in its success was the implementation of an effective marketing initiative.

CASE STUDY DISCUSSION QUESTIONS

1. Why do employers think it is beneficial to assess their employees' health status and offer them health and wellness programs?
2. What factors prevent employees from reducing their health risks and taking steps to improve their health status?
3. What factors led the company to conclude that the ineffectiveness of the employee health program was a marketing issue?
4. Along what dimension(s) did the company marketers segment the employee population?
5. In what ways is this consumer engagement initiative an example of target marketing?
6. How was the effectiveness of this consumer engagement initiative evaluated?

Redefinition of the "Patient"

Of all the developments that occurred in healthcare during the 1980s and 1990s, perhaps the one with the most implications for healthcare marketing was the reconceptualization of the patient (see chapter 2 for a discussion). By the end of the twentieth century, fewer health professionals were using the term *patient* because of its narrow connotation. Patients came to be referred to as *clients*, *customers*, *consumers*, or *enrollees*. The major consideration, regardless of the label applied, was the fact that clients, customers, consumers, and enrollees all had different characteristics from patients. While *patient*

implies a dependent, submissive status, the other terms connote a more pro-active involvement in the therapeutic process. Ultimately, this development made healthcare marketing more similar to the marketing activities of other industries, as the consumer of the product became—for the first time—the focus of the healthcare marketer. The emphasis that healthcare marketers placed on consumer engagement in the early part of the twenty-first century reflects the growing need for marketing expertise.

Consumer Attitudes

attitude
A position that a person adopts in response to a theory, a belief, an object, an event, or another person.

Although patterns of consumer **attitudes** in US society tend to be com-plex, a new orientation toward healthcare emerged during the second half of the twentieth century. As the *patient* transformed into the *customer*, a new entity—one with the combined expectations of a traditional patient and a contemporary customer—was created. This healthcare customer was more knowledgeable about the healthcare system; more open to innova-tive approaches; and more intent on playing an active role in the diagnostic, therapeutic, and health maintenance processes than previous generations of consumers had been.

These attitudes were fostered by baby boomers (and, later, by gen-eration Xers and millennials), a cohort now facing the chronic conditions associated with middle and old age. Baby boomers have been influential in downplaying the importance of physicians and hospitals and provided the impetus for the rise of alternative therapy as a competitor to mainstream allopathic medicine.

Baby boomers favor a patient-centered approach to healthcare and are more likely to emphasize its nonmedical aspects. In general, they are less trusting of professionals and institutions, and they are control oriented to the point of stubbornness. They are more self-reliant, place greater value on self-care and home care, and are more outcomes oriented and cost sensitive. They pride themselves on getting results and extracting value for their expenditures. Although baby boomers began influencing the health-care system in the 1980s by "voting with their feet" (i.e., switching to new types of providers), they have now assumed positions of power that have allowed them to shape the healthcare landscape. Even now that the majority of baby boomers are seniors, members of this cohort continue to exhibit these characteristics.

To a certain extent, these new attitudes reflect the rise of consumer-ism that is affecting all segments of society. Seeing themselves as customers rather than patients pushed modern consumers to expect accurate and timely information, demand participation in healthcare decisions that directly affect them and their loved ones, and insist on receiving the highest-quality care

possible. They want health services to be delivered close to their homes, involving minimal interruption to their family life and work schedules, and they want maximum value for their healthcare expenditures.

Consumer Decision-Making

In healthcare, the end user of the product may not be the same person who makes the decision to purchase that product. Instead, another entity—a physician, a health plan representative, an employer, or a family member or guardian—may be responsible for this **decision-making**, determining the what, why, who, where, when, and how much related to the service. Therefore, the marketer must identify the appropriate targets and the best placement for a promotional initiative.

> **decision-making**
> In healthcare, the process of determining the need for a good or service, evaluating the available options, and making a choice.

Because the end user of a service may not be the ultimate target, healthcare marketers reach out to other types of audiences. These audiences include the following:

- **Influencers.** Family members, counselors, and other health professionals who encourage consumers to use a particular good or service
- **Gatekeepers.** Primary care physicians, insurance plan personnel, discharge planners, and others responsible for channeling consumers into appropriate services
- **Decision makers.** Family members, primary care physicians, and caregivers who act directly on behalf of the end users
- **Buyers.** Employers, business coalitions, and other groups that might indirectly control the behavior of customers

The role of women in healthcare decision-making illustrates the importance of understanding parties other than the end user. Data on health services utilization indicate that women use a disproportionate share of healthcare resources. Further, women generally make most of the healthcare decisions for their children and often for their spouses. They are also likely to be involved in decision-making for their parents, siblings, and other dependent family members (Lounsbery 2018).

Steps in Healthcare Decision-Making
A basic understanding of the decision-making process that consumers go through when purchasing a good or service is important for marketing planning purposes. The steps in the decision-making process are an

amalgam of approaches adapted for the healthcare environment and should be taken into consideration when developing a marketing plan (Berkowitz and Hillestad 2012). The approach marketers take depends on what step the consumer is in:

1. **Problem recognition.** The consumer acknowledges a problem or need. The marketer's task is to identify the circumstances or stimuli that triggered the need and to use this knowledge to develop marketing strategies that will spark consumer interest.

2. **Information search.** The consumer is interested enough in the problem to search for more information about it. The similarities and differences in information-gathering approaches between healthcare customers and other consumers are discussed in exhibit 5.10.

3. **Initial awareness.** The consumer is exposed for the first time to the good or service being marketed. This step could occur during the information search step, alerting the consumer to the options for addressing the problem.

4. **Knowledge emergence.** The consumer begins to understand the available goods or services and their advantages and disadvantages.

5. **Alternative evaluation.** The consumer evaluates all of the available options to make a rational, informed decision. The consumer may rule out some goods or services at this point to pare down the choices.

6. **Contract assessment.** The consumer considers whether his or her insurance plan covers the options being weighed or whether the service provider accepts his or her insurance. The decision stops here for options that conflict with the customer's insurance plan.

7. **Preference assignment.** The consumer develops a preference for a good or service over another (e.g., a podiatrist versus an orthopedic surgeon) or for one provider over the others (e.g., podiatrist A versus podiatrist B or C).

8. **Purchase decision.** The consumer (or someone else) selects, among his or her preferences, the good or service to be purchased or used.

9. **Product usage.** The consumer buys the good or uses the service. This step could be as simple as applying the product acquired at a pharmacy or a medical supply store or as complex as undergoing a heart transplant.

10. **Postpurchase behavior.** The consumer, along with family members and other parties involved, assesses whether the purchase is satisfactory. If satisfied, the consumer becomes an advocate for the product or service (or, if dissatisfied, a detractor).

The information search process, historically carried out by healthcare consumers, differs considerably from the process followed by consumers in other industries. In healthcare, a lack of information is typical, and the structure of the healthcare delivery system is complicated—even for seasoned health professionals. Accurate and updated information and data on provider and organizational quality, value, outcomes, and other indicators—which cannot be fully conveyed by promotional material—are not often easily accessible to the public. Faced with this lack of information, where can the healthcare consumer turn?

Healthcare consumers turn to two primary sources of information—one informal and one formal. The primary, informal source comprises family members, friends, relatives, neighbors, coworkers, and contacts on social networks (e.g., Facebook, Twitter). These sources offer insights based on their own experiences, word of mouth, and other information they have gathered. The formal, secondary source of information includes physicians, other clinicians, and healthcare personnel. Because of their position in their organization and their training and knowledge, these sources can give authoritative advice and point the consumer to more resources.

Information from these two major sources can be supplemented by reports, findings, and announcements from the media. Historically, magazines, newspapers, books, and even newsletters, as well as radio and television programs and news, were the primary print and electronic media sources. These sources of information continue to be important today.

With the introduction of Medicare and Medicaid in the 1960s and the emergence of managed care in the 1980s, healthcare consumers turned to their health plans as a source of information on providers (mostly in response to the restrictions health plans imposed on the use of practitioners, facilities, and programs). Managed care plans have been particularly aggressive in establishing call centers and encouraging their enrollees to seek information before making health-related decisions.

In the 1990s, the internet came to the fore and since then has become a major source of information for all consumers, with purportedly more websites related to healthcare than any other topic. Most healthcare consumers with internet access have, at some point, researched a medical condition, a healthcare service or facility, or a clinician or provider organization online. Today's consumers are increasingly armed with internet-generated information and questions when they visit their doctors. Although the information

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EXHIBIT 5.10
Information Search by Healthcare Consumers

and data available on the internet are not always reliable (or high quality), they can jump-start the consumer's research. The internet—whether social media, online newspapers, healthcare blogs, healthcare association and provider websites, or private or governmental quality rating and reporting systems—has progressively narrowed the gap between how healthcare customers and other consumers search for product information.

In addition to these steps in the decision-making process, marketers must consider in their marketing planning how consumers decide to change their behavior when they are ready. Exhibit 5.11 describes the five stages of behavioral change.

EXHIBIT 5.11
A Behavioral
Change
Approach
to Market
Assessment

Marketers in any field spend much of their time trying to get potential customers to change their knowledge, attitudes, and behavior patterns. In healthcare, these efforts may involve educating customers to persuade them to switch to the service being marketed, to adjust their attitudes toward a particular provider, or to encourage them to change their lifestyles to improve their health. For this reason, marketers strive to understand the factors that cause individuals to modify their behavior.

One classic approach to understanding behavioral change was developed by Prochaska, Norcross, and DiClemente (1994). Based on their study of initiatives aimed at changing behaviors that are detrimental to health (e.g., smoking), they developed a model that marketers can easily apply to promotional purposes. According to these researchers, individuals go through five stages of behavioral change:

1. **Precontemplation.** The individual has not yet thought about taking action. For example, this individual could have a healthcare condition but is unaware of it (e.g., high cholesterol).
2. **Contemplation.** The individual becomes aware of the problem and is considering doing something about it. For example, an individual with high cholesterol found out about this condition at a health fair.
3. **Preparation.** The individual has decided to start taking steps to address the problem. For example, the person has become convinced that some action is required and begins to examine options to lower his or her cholesterol.

EXHIBIT 5.11
A Behavioral
Change
Approach
to Market
Assessment
(continued)

4. **Action.** The individual proactively faces the problem with whatever resources are available. For example, the person with high cholesterol visits a primary care physician or a nutritional counselor.

5. **Maintenance.** The individual continues the course of treatment that has been prescribed. The person with high cholesterol, for example, regularly eats a low-fat diet and takes prescribed medication.

Marketers target groups of people at different stages of behavioral change. For example, individuals in the precontemplation stage clearly need awareness and information, so the marketer will use educational approaches to reach this audience and get them to move to the next stage. The marketer can tailor this approach depending on the stage being targeted.

Summary

Although the consumer is the primary concern of almost every industry, only in recent years has healthcare come to think in terms of consumers rather than patients. Most healthcare providers in the past gave no thought to consumers until they entered the system as patients. Consumers were neglected before and after they became patients, and healthy people were not considered candidates for health services.

As healthcare became more market driven, the importance of the consumer was increasingly recognized. Healthcare organizations redefined patients as customers and came to appreciate the variety of customers they serve. Today, healthcare constituents encompass consumers, customers, clients, patients, and enrollees, all of which have unique characteristics. Other customers cultivated by healthcare organizations include employers, board members, government agencies, the media, and the general public.

Because of the unique characteristics of the healthcare industry, healthcare consumers are different from consumers in other industries. At the same time, these two types of consumers share some common characteristics. To reach the massive healthcare market efficiently, marketers can segment the population on the basis of demographics, geography, psychographics, health risks, usage, payers, and benefits.

Along with healthcare's increased emphasis on the consumer came increased attention to consumer behavior. Healthcare consumers generally follow the same steps as other consumers when making purchase decisions; they begin by recognizing a need and end with an assessment of their purchase. However, healthcare consumers' purchasing behaviors are influenced by aspects unique to healthcare that do not concern consumers of other products.

Key Points

- Healthcare providers were not used to thinking of patients as consumers. Redefining the patient as a consumer has encouraged wider use of marketing in healthcare.
- Marketers should be sensitive to the ways healthcare consumers differ from consumers of other products. At the same time, healthcare consumers share many of the attributes of consumers of other products.
- Although the patient is typically thought of as the primary consumer of health services, large healthcare organizations must satisfy a wide variety of customers.
- Users of health services are called by different terms, depending on the context (e.g., *patient*, *client*, *customer*, *consumer*, *enrollee*, *end user*).
- Healthcare organizations (e.g., hospitals, physician practices) are also customers for a wide range of goods and services.
- The healthcare market can be segmented in a number of ways—by demographics, geography, psychographics, health risks, usage, payers, and benefits.
- The consumer decision-making process for healthcare is similar to the process for other goods or services.
- Healthcare consumers seek information from a variety of sources, and the internet has become an important resource.
- The consumer decision-making process in healthcare is different in that someone other than the end user may make the decision about or pay for the services.
- The consumer decision-making process is influenced by an individual's readiness to change and willingness to innovate.

Discussion Questions

1. Why is everyone in society considered a potential consumer of health services?
2. Why did the healthcare industry not historically view customers or patients as consumers?
3. In what ways are healthcare consumers different from consumers of other goods and services?
4. In what ways are healthcare consumers similar to consumers of other goods and services?

5. How are different healthcare customers distinguished from one another (e.g., patients, clients, end users, enrollees)?

6. What are some examples of institutional customers for healthcare goods and services?

7. Why do healthcare organizations often have a much wider range of customers than organizations in other industries?

8. What are some of the dimensions along which the market for health services can be segmented?

9. What are the major steps in the decision-making process for healthcare consumers, and how do these steps differ from the process in other industries?

Additional Resources

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HEALTHCARE PRODUCTS

I n developing a marketing initiative, the marketer's first task is to understand the product to be promoted. In healthcare, the product may be as simple as a bottle of aspirin or as complex as heart transplant surgery. Whether simple or complex, the product must be conceptualized in a way that is conducive to effective promotion. This chapter covers the product mix of healthcare organizations and discusses the different ways of conceptualizing healthcare products. The range of healthcare products is also surveyed.

For the purposes of this discussion, *goods* and *services* are considered two different types of products. Unlike marketers in other industries, who tend to promote clearly defined products, healthcare marketers expend a great deal of effort determining exactly what they are marketing.

The marketer is likely to start with two questions in developing a marketing initiative: What is the product? How is it being sold? In most other industries, the answers would be straightforward and relatively easy to provide because the product is its reason for existence; an executive who cannot specify his or her company's product is not likely to succeed in today's environment. The situation is not so simple in healthcare, as health professionals do not think in terms of products. A health professional's response to "What is your product?" may be along the lines of "quality care," "improved health," or "treatment and cure." Although these answers sound great, they are not helpful to marketers.

Product Mix

An organization's *product mix* refers to the combination of goods, services, and ideas that it promotes to consumers. Large healthcare organizations, such as hospitals, offer a wide range of goods and services. They perform hundreds of intangible services and procedures and dispense or sell hundreds of tangible goods (e.g., drugs, supplies, equipment) in the course of their normal operations. At the same time, they often promote ideas to plant a particular perception in the consumer's mind. The organization's brand image, for example, is an idea that can be promoted through marketing. Quality care, professionalism, value, or other subjective but desirable attributes may

also be promoted. Ultimately, the product mix determines the focus of marketing activities.

Goods Versus Services

The purchase of goods tends to involve a single episode, whereas the purchase of services may be an ongoing process. Although healthcare is generally perceived as a service, the sale of goods is ubiquitous in the industry—goods that range from consumer health products to pharmaceuticals to home-testing kits to durable medical equipment. A physical examination, a flu shot, and open heart surgery are all examples of health services. Most people would recognize each of these activities as a service, but the nature of services is often difficult to describe.

The primary distinction between goods and services is their tangibility—the extent to which the product can be examined, touched, or experienced before purchase. Goods and services can also be distinguished by their durability. Services tend to be consumed at the time they are administered (e.g., immunization), whereas goods tend to last for an indefinite time (e.g., a blood pressure monitoring device). These distinctions clearly determine the marketing strategy developed for each category.

Healthcare is unlike other industries in that the stakeholders for a service tend to have diverging perceptions of it, depending on the role they play in the service rendered. In the case of childbirth, for example, the mother may see it as a natural experience, the physician could view it as a medical episode, and the hospital administrator could regard it as an accounting event. Alternatively, the mother could see it as a one-time experience, the physician as a series of discrete activities, and the administrator as a group of billable and nonbillable items; the healthcare marketer might view it as yet something else. The marketer's task is to conceptualize the product and package it appropriately—that is, present the service in a manner to which the consumer can relate.

Consumer Goods Versus Industrial Goods

Goods can be classified by their users and buyers. *Consumer goods* are purchased by the end user of the items. In most industries, these items are divided into three categories: convenience goods, shopping goods, and specialty goods.

convenience good
A product that consumers purchase frequently without forethought.

Convenience goods are items that people purchase regularly and as needed, such as cold or headache remedies, dental floss, and tissues. Because the consumer engages in little deliberation when purchasing such items, name recognition and product distribution are critical concerns for the marketer. The manufacturers of over-the-counter drugs, for example, expend considerable effort establishing brand identity and prominently displaying their products in retail outlets.

Shopping goods are products that require the consumer to search for and compare competing brands on attributes such as price, style, or features. Fitness equipment, computers, and cameras are common examples of shopping goods. Marketers of shopping goods must differentiate their brand from competitors' brands by emphasizing features that are important to their customers. Salespeople often play a major role in helping consumers learn about alternative brands.

Specialty goods are specific items that a consumer seeks. Often, a consumer is loyal to a particular brand and will go to great lengths to find that brand among a multitude of others. Common specialty items include exclusive brands of jewelry, perfume, or electronic equipment, as well as one-of-a-kind or imported food or drink. Few goods in healthcare are included in the specialty category.

Industrial goods are products purchased for use in the manufacture of other products, which will be purchased by the ultimate consumer. (Note the distinction between consumer goods for personal use and goods purchased for professional or institutional use.) Industrial products can be divided into two broad types of goods. **Production goods** are made into a final product; raw materials (e.g., the chemicals that make up a prescription drug) fit into this category. **Support goods** are used to enable the production of goods or the provision of services. Examples include a computed tomography (CT) scanner, an examination table, and the printer used to generate patient bills.

Nondurable Versus Durable Goods

A **nondurable good** is a product that should be consumed within a defined time frame (e.g., unprocessed or fresh foods, drugs, bandages). A **durable good** is a product that lasts for an extended period (e.g., hospital beds, wheelchairs, computer hardware).

The differences between goods and services and between nondurable and durable goods are important considerations in any marketing initiative. Nondurable products are often heavily advertised because they are perishable and purchased frequently. Marketers prominently display them in stores to sell them directly to consumers. Durable products usually cost more than nondurable products and are often more complicated to use. For these products, a personal sales approach is often used to answer questions and explain the intricacies of the product.

Product or Service Lines

In the 1980s, following the lead of other industries, healthcare organizations began to develop *product* or *service lines*. Most industries have product lines, but in healthcare, the term **service lines** is more in keeping with the mission of healthcare providers. To establish service lines, a hospital's programs are organized into vertical groupings based on specific clinical areas. Specialty

shopping good
A product consumers compare to competing brands (on price, style, and features) before purchasing.

specialty good
A product—often expensive—that carries a brand name.

production good
A product or raw material used to produce other goods.

support good
A product used to supply or support the provision of goods and services.

nondurable good
A product used once or a few times and then disposed of.

durable good
A product used repeatedly over an extended period.

service line
A bundle of unique, related services.

areas frequently selected for service lines include women's services, cancer care, cardiology, orthopedics, and pediatrics. Each service line is considered semiautonomous, and the service line manager is charged with the vertical integration of the relevant clinical services and necessary support functions. Thus, the service line administrator has broad control over the range of activities (including marketing) that support the service line.

packaging
The presentation of the physical attributes or the positioning of a good or service.

Some observers contend that service lines are little more than **packaging** of services for marketing purposes. Although the service line relates more to packaging than to substance in some cases, typically a certain level of reorganization occurs around the clinical area. Exhibit 6.1 presents a discussion of the service line approach.

EXHIBIT 6.1
Healthcare
Service Lines
and Marketing

Since the 1980s, many hospitals have adopted the service line management concept, which has long been established in other industries. Service line management appeared attractive to hospitals looking for ways to become more agile, move closer to their customers, strengthen relationships with physicians, become more profitable, and move beyond cost cutting and reengineering to develop more innovative and effective ways of serving their patients.

A service line is a tightly integrated, overlapping network of semiautonomous clinical services and a business enterprise that bundles needed resources to provide specialized, focused care and value to a patient population. Common service lines are cardiovascular services, orthopedics, rehabilitation, women's services, children's services, and oncology services. Service lines can be virtual in that all components may not be under one roof; some services are horizontal and cross departments and disciplines. A service line may be created around a business that is already well established, or the concept may be used to focus on a new service or niche.

The product line concept was developed by organizations in other industries—most notably, Procter & Gamble, General Electric, and General Motors—to decentralize decision-making; make strategic planning more effective; improve cost management and productivity; improve communication and collaboration; and, most important, help their product line management teams better understand the needs of their customers. The product line management concept emerged in the healthcare industry in the 1980s in response to prospective reimbursement, a tight economic environment, declining revenues, and intense competition—all of which drove the need to improve the way hospitals did business. In healthcare, this concept

(continued)

has probably been carried furthest by pharmaceutical companies, which organize their business enterprise by product lines.

Many of the gains from service line management were erased with the emergence of managed care and other innovative financing structures in the late 1980s. Although many hospitals maintained their service line orientation throughout the 1990s, the concept was latent and reemerged only around 1997, when hospitals began to renew their patient focus. This revitalized service line management model defines a hospital's clinical services; allocates organizational resources—human, financial, and strategic—to those service lines; and clearly assigns accountability for performance to a service line leader.

This service line platform integrates clinical and support services on a matrix management grid to create horizontal integration of clinical services along a traditional continuum of care along with the vertical integration of support services. Also built into this platform are education and wellness programs, retail models, business development tactics, and a strong focus on physician relationships—all with an increased emphasis on creating enhanced quality and value for patients.

Because the service line is sensitive to its costs and operational dynamics, its customers, and its competition, hospitals and health systems are able to decentralize accountability for strategic, operational, and financial performance from the corporate or executive office to the clinical service line. This shift in accountability to the service line maximizes hospital capacity by focusing on the best use of space and resources and provides more flexibility in managing growth.

Whether the service line concept is an effective approach to healthcare strategy development is still open to debate, and little hard evidence of the merits of this approach exists. Service line management does facilitate the marketing of services in many ways, and the close relationship between operations and marketing that can develop is an advantage.

Around 2005, another wave of interest in service line management in healthcare emerged (Litch 2007). This renewed interest reflected a growing emphasis on quality control, integrated services, and physician collaboration. From a marketing perspective, the growing need to establish an advantageous market position appeared to drive the revival.

The significance of service lines to customers is not clear. Ideally, service lines are designed to address consumer needs, but most consumers probably think about healthcare as a continuum of services that extend across clinical lines, not in terms of vertical silos of care. As service lines become more entrenched in healthcare, a better understanding of their meaning for consumers should be established.

Ways to Conceptualize Products

A marketer must be able to conceptualize the products offered by the healthcare organization to promote them effectively. That is, the marketing approach must reflect the nature and complexity of the product, and the marketer must understand who uses the product and how they use it. This section discusses the differences among product categories.

Level of Care

primary care
Basic, routine health services, including preventive care.

Primary care refers to basic health services (i.e., general examination or physical, taking medical history, physician consultation, preventive services) and the treatment of minor, nonurgent problems. Primary care may involve some self-care and the services of a nonphysician health professional (e.g., pharmacist); for some ethnic groups, primary care could involve a folk healer.

Formal primary care services are generally provided by physicians who have been trained in family practice, general internal medicine, obstetrics and gynecology, and pediatrics. These practitioners are typically community based (rather than hospital based), rely on direct first contact with patients rather than referrals from other physicians, and provide continuous rather than episodic care. Physician extenders, such as nurse practitioners and physician assistants, are taking on more responsibility for primary care. In the mental health system, psychologists and other types of counselors provide the primary level of care. Medical specialists may also provide some primary care.

Primary care is generally delivered in a physician's office or in some type of clinic. Hospital outpatient departments, urgent care centers, neighborhood clinics, and other ambulatory care facilities also provide primary care services. For certain segments of the population, the hospital emergency department is a source of primary care. In addition, the home has become a common site for the provision of primary care. This trend has been driven by the financial pressures on inpatient care, changing consumer preferences, and improved home care technology. Case study 6.1 addresses the marketing of primary care services for an urgent care center.

emergency care
Emergency treatment or services provided in response to an urgent medical need.

In terms of hospital services, primary care refers to services that can be provided at a general hospital. Hospital primary care typically includes routine medical and surgical procedures, diagnostic tests, and obstetrics services, as well as **emergency care** (although not major trauma) and many outpatient services. Hospital-based primary care tends to be unspecialized and requires a relatively low level of technological sophistication.

secondary care
Services provided for conditions that are moderately complex and need a moderate level of resources and skills.

Secondary care involves a higher degree of specialization and technological sophistication than primary care because of the increased severity

Case Study 6.1
Marketing an Urgent Care Center

During the 1980s, some enterprising healthcare professionals saw the need for an alternative to the traditional physician's office. While they conceded that many patients desired a long-term relationship with a physician and were willing to accept the deficiencies of the typical physician practice to obtain it, they also thought a significant portion of the population did not have an established physician relationship but occasionally required some type of care. Some of these consumers were new to their community and had not found a regular physician, while others had become disillusioned with their physician but had not yet found a replacement. Still others were dissatisfied with the conditions under which care had to be obtained—long waits for an appointment, time spent in the waiting room, short time (often only five minutes) spent with the doctor, and a big bill afterward. Out of this frustrating situation, the urgent care center was born.

The concept behind urgent care centers was to develop conveniently located (i.e., in the community) walk-in clinics staffed by the same types of physicians encountered in a doctor's office. Each center would offer only basic services and refer patients with anything more than a minor condition to another facility. Although the urgent care center would accept insurance, it would charge a low fee to attract patients without insurance and patients with insurance who did not wish to see their regular physicians. The center would not maintain medical records beyond the basics, assuming most visits were one-time events. They would have the advantage of quick service with none of the hassle associated with a typical physician's office.

Convinced of the demand for this type of service in a highly mobile, convenience-oriented society, physician entrepreneurs in a midsize southern city established a network of seven urgent care centers at strategically located sites. They chose fairly new suburban areas close to high-traffic commercial and retail centers, believing that these locations would attract the customers they were seeking. Having gambled on location, they faced the challenge of marketing the new concept. They brought in marketers to survey consumers to determine the best prospects for urgent care centers.

Upon reviewing the surveys, the physicians developed a fairly clear idea of their prospective customers. The best prospects were 25- to 40-year-old men and women who were highly mobile (often new to the community), fairly well educated, and, more often than not, in a two-income family without

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children. Whites appeared to be more open to the idea than nonwhites. Those in the middle- to upper-middle-class income categories were great prospects; the more affluent were not attracted, and less affluent populations were intimidated by this practice model and concerned about having to pay cash up front. In terms of lifestyle, the survey showed that those who were progressive, innovative, highly mobile, and more focused on the present than the future were more likely to use the service.

This information confirmed the developers' intuition about locating the centers in newly emerging affluent suburbs, and they set out to market this service to the target population. Taking advantage of a variety of data sources, the developers targeted households that displayed the desired characteristics within a five-mile radius of each site. Of the seven urgent care centers established, five were successful and two significantly underperformed. The only discernable differences between the successful and unsuccessful ones were the lower visibility and lower drive-by traffic characterizing the latter.

The developers' ability to target the most likely prospects helped them launch a successful promotional campaign that quickly resulted in a high volume of business. Without knowledge of the most likely prospects, the marketers' efforts would have been ineffective and the growth of the urgent care center clientele would have been much slower.

Case Study Discussion Questions

1. What factors encouraged the entrepreneurs to develop an alternative to traditional primary care?
2. What characteristics of the urgent care center concept might make it unattractive to mainstream healthcare consumers?
3. What assumptions did the developers make at the outset about the demand for such a service and the types of consumers who might use it?
4. From their marketing research, did the developers find that the urgent care center model would appeal to the general population or that some segments of the population would find it more attractive than others?
5. What was the profile of the best prospects for utilization of an urgent care center?
6. How did knowledge of the characteristics of the best prospects contribute to an effective marketing campaign?
7. Given the characteristics of the best prospects, what attributes of the urgent care centers should be highlighted in promotional material?

of the health problems encountered. Physician care is provided by more highly trained practitioners, such as specialized surgeons (e.g., urologists, ophthalmologists) and specialized internists (e.g., cardiologists, oncologists). Problems requiring specialized skills and more sophisticated biomedical equipment are included in this category. Although much of secondary care is still provided in a physician's office or clinic, these specialists tend to spend a large share of their time in the hospital setting. Secondary hospitals can provide more complex technological backup, physician specialist support, and ancillary services than primary care hospitals. These facilities can handle moderately complex surgical and medical cases and serve as referral centers for primary care facilities.

Tertiary care addresses the most complex surgical and medical conditions. The practitioners tend to be subspecialists housed in highly complex and technologically advanced facilities. Complex procedures, such as emergency care for a heart attack or reconstructive surgery, are performed at facilities that provide extensive support services in the form of personnel and technology. Tertiary care cases are usually handled by a team of medical and surgical specialists who are supported by the hospital's radiology, pathology, and anesthesiology physician staffs. Tertiary care is generally provided at a few centers that serve large geographic areas. Single hospitals are often not sufficient for the provision of tertiary care; a medical center may be required. These centers typically support functions not directly related to patient care, such as teaching and research.

tertiary care
Services provided for conditions that are highly complex (or serious) and need specialized clinicians, equipment, and facilities.

Some procedures performed at tertiary facilities may be considered **quaternary care**. Organ transplantation—especially involving vital organs such as the heart, lungs, and pancreas—is one example of quaternary care. Complicated trauma cases are another example. This level of care is restricted to major medical centers, often in medical school settings. These procedures require the most sophisticated equipment and are often performed in association with research activities.

quaternary care
Specialized services provided in large medical centers for complex conditions.

The level of care plays an important role in determining the type of marketing technique to use. Consumers often have more discretion in decisions about primary care than about specialized forms of care. They can typically choose their primary care physician (although their insurance plan may limit their choices), and they can obtain primary care through urgent care centers or emergency departments if necessary. However, specialists—especially those involved in tertiary or quaternary care—are more difficult to access. Specialists typically require a referral from another physician or health professional, and insurance plans are reluctant to reimburse for the services of a specialist if the proper procedures have not been followed.

Because of these factors, consumers are a more viable marketing target for primary care services than for more specialized services. Marketing

tertiary or quaternary care to the general public is not likely to be effective because someone other than the patient typically makes the treatment decision. Nevertheless, consumers need to be made aware of all available services, even if they cannot access them directly. Exhibit 6.2 summarizes the levels of healthcare in the United States.

Level of Urgency

Health problems are generally classified as routine, urgent, or emergency. Routine health problems make up the bulk of primary care episodes, and many, if not most, urgent care episodes involve routine care that is provided during off-hours. Emergency care typically involves at least secondary care, if not tertiary or quaternary care.

Although marketing can influence the use of all three categories of care, some types of care are more amenable to marketing than others. In general, routine care—such as primary care—allows the most discretion by the consumer. Therefore, marketing for routine care is relatively

EXHIBIT 6.2
Levels of Healthcare in the United States

Complexity

Severity

Specialization

Procedures	Location	Practitioner
Quaternary care		
Organ transplantation, complex trauma	Multi-institution medical centers	Teams of subspecialist physicians
Tertiary care		
Specialized surgery, complex medical cases	Large-scale, comprehensive hospitals with extensive technological support	Physician subspecialists
Secondary care		
Moderately complex medical and surgical cases	Moderate-scale hospitals, some freestanding surgery and diagnostic centers	Physician specialists
Primary care		
Routine care, standard tests, simple surgery, prevention, counseling	General hospitals, clinics, physicians' offices, urgent care centers, counseling centers	Primary care physicians, extenders

Source: Adapted from Pol and Thomas (2013).

straightforward and typically focuses on promoting services directly to potential customers.

In some ways, potential urgent care patients may be more amenable to marketing than even routine care patients. Potential customers of urgent care centers may not have a regular source of care, and thus they are likely to be responsive to marketing messages when the need for care arises. Marketing for urgent care is not as straightforward, however, as it is for routine care. Although most consumers will need urgent care at one time or another, its unpredictable nature and the segments of the population that prefer traditional primary care services pose a challenge for healthcare marketers. A marketer tasked with promoting an urgent care center must be aware of the attributes that lead consumers to choose an urgent care center rather than their private practitioner or a hospital emergency department.

Emergency services are perhaps the most difficult to market to the general population. Emergency department use is a rare event, and decisions about emergency care are often made under duress. In situations in which people choose the hospital emergency department, their physician's affiliations and health plan restrictions are likely to be important considerations. For example, a patient who is taken to an emergency department at a hospital that is not in his or her network would have to be transferred to an in-network facility for insurance to cover the charges.

In most cases, someone other than the patient is likely to make the choice about emergency care when the need arises. For serious conditions, emergency medical technicians will make the decision based on the proximity of an emergency department or the type of emergency services required. Thus, emergency services may be more appropriately marketed to ambulance companies, emergency medical technicians, police dispatchers, and other decision makers rather than to the general public.

Inpatient Versus Outpatient Care

Inpatient care requires at least an overnight stay and is typically provided in hospitals. **Outpatient care** (also called ambulatory care) includes less than 24 hours' stay in a health facility. Outpatient services typically allow more consumer discretion than inpatient services. Consumers may present themselves for many outpatient services without a prior relationship or even an appointment. The use of inpatient services requires at minimum a referral or admission by a physician, and possibly authorization by the patient's health insurance plan. While the general public can be directly targeted for outpatient care, the marketing approach for inpatient care should focus on establishing and cultivating a loyal medical staff and negotiating favorable contracts with health plans.

inpatient care
Medical care provided by a hospital to patients who are admitted for at least one night.

outpatient care
Medical care provided outside a hospital or an inpatient facility; also known as *ambulatory care*.

Medical Versus Surgical Services

Medical procedures involve treatments based primarily on drug therapy, and surgical procedures are therapies that primarily involve surgery of some type. Of course, when any surgery is performed, some drugs are administered, and when drug therapy is administered, some surgical procedures, however minor, may be required.

These two approaches to care are obviously different, and they are implemented by different specialists. Medical therapy is typically carried out by internists and internal medicine specialists (e.g., nephrologists, gastroenterologists), and surgery is performed by general surgeons or surgical specialists (e.g., ophthalmic surgeons, orthopedic surgeons). Although risk is inherent in both types of therapies, the general public usually attributes greater risk to surgical procedures. In either case, the marketer must emphasize the benefits and minimize the risks of the procedures involved.

Diagnosis Versus Treatment

Diagnostic procedures are used to assess health status and to test for the presence of a pathological condition. Treatments (or therapeutic procedures) are used to treat a condition once it has been diagnosed. Many diagnostic procedures are routine and administered at regular intervals to asymptomatic individuals; these procedures are usually referred to as *screening tests.* Tests administered in response to observed symptoms are usually referred to as *diagnostic tests.* For example, there are screening mammograms and diagnostic mammograms. This distinction is important because the same test might be marketed in a different way according to its use. Clearly, the approach to marketing differs on the basis of whether the product is a diagnosis or a treatment. With diagnostic procedures, the emphasis is on prevention and early detection, and the intent is to maintain health. With treatment procedures, the emphasis is on treatment and cure, and the intent is to restore health.

Clinical Versus Nonclinical Services

Clinical services involve the administration of a formal medical procedure. Examinations, diagnostic tests, and therapeutic procedures administered by a clinical practitioner are examples of clinical services.

Healthcare providers have added a number of nonclinical services to complement their clinical services. Some hospitals, for example, provide valet parking, food services for nonpatients, and senior discount programs. In addition, some practitioners link their patients to support groups, while others offer childcare or transportation. Some physician practices have even launched **concierge services** that allow them to provide a smaller number of patients with superior service at a premium price.

Obviously, nonclinical amenities are marketed differently than clinical services are. Although clinical care may seem to be the most important

concierge services Customized health services offered to customers who pay a premium for the personalized attention.

(it generates the most revenue), consumers are more likely to evaluate their experiences on the basis of the nonclinical aspects. Thus, marketers need to give nonclinical services adequate attention.

Nonelective Versus Elective Procedures

Nonelective procedures are those considered medically necessary, although they do not always deal with life-threatening conditions. **Elective procedures**, on the other hand, are those that patients voluntarily choose to undergo, such as a nontherapeutic abortion, laser eye surgery, facelifts, and hair transplantation. Some surgery (e.g., for tennis elbow) might not be considered medically necessary and thus be classified as elective. Nonelective services are considered to be nondiscretionary, while elective services are considered to be discretionary.

    Although nonelective and elective procedures may be marketed in much the same manner, there are significant differences between them. For one thing, the decision maker is likely to be different. Nonelective surgery is generally prescribed by a medical practitioner and, being medically necessary, is covered under a health insurance plan. On the other hand, the decision to undergo an elective procedure is generally made by the patient, perhaps on the advice of a medical practitioner. Because of their elective nature, these procedures are typically not covered by insurance. For these reasons, marketers have to promote nonelective procedures and elective procedures differently. For nonelective procedures, demand cannot be influenced by marketing to a great extent. Thus, the emphasis must be on influencing the choice of provider when a condition arises. On the other hand, a hospital seeking patients for nonelective procedures may target its marketing toward admitting and referring physicians to channel referrals into its system.

    The marketing of elective procedures has a lot in common with the marketing of nonmedical services. Providers of these services are much more prone to advertise their services and often compete on the same basis as providers of other types of services. Thus, eye surgeons and plastic surgeons may advertise their low prices, convenient locations, and efficient customer service. In addition, creating demand for these services may be possible. Most balding men probably suffered in silence with their hair loss until they saw promotions for a hair restoration clinic; this introduction of a new service essentially established a market where one did not exist before.

    Another way to categorize products is in terms of their point in the product **life cycle**. A product may be in the introductory, growth, maturity, or decline stage. A product's position in the life cycle is significant in that it shapes the marketing strategy that should be pursued. An innovative service is likely to be marketed differently, for example, from a mature service. Exhibit 6.3 describes the product life cycle and its implications for marketing.

nonelective procedure
A clinical service considered medically necessary.

elective procedure
A clinical service not considered medically necessary and obtained at the discretion of the customer.

life cycle
The maturation of a population, a product, or an industry from birth to death.

EXHIBIT 6.3
The Product Life
Cycle

introductory stage
The first phase
of a product's life
cycle, in which the
product or industry
is launched.

early adopter
An individual or a
group willing to try
new products and
services before
they are accepted
by the general
public.

growth stage
The second phase
of a product's life
cycle, in which the
product or industry
gains dominance
in the market.

maturity stage
The third phase
of a product's life
cycle, in which the
product or industry
reaches its apex
and ceases to
grow.

Healthcare products, like other products, experience a natural life cycle that comprises four stages: introduction, growth, maturity, and decline. Marketers need to understand these four stages to craft an effective marketing strategy. If an organization is primarily involved in providing inpatient services, for example, marketers need to recognize where inpatient services can be placed in the life cycle. Or, if a marketing plan is being developed for a specific procedure, marketers must determine where that procedure resides in the life cycle.

The first stage in the product's life cycle is the **introductory** (or market development) **stage**. A new product is likely to be innovative, so most of the marketing effort is directed toward creating awareness and cultivating the **early adopters** in the market. At this stage, there are relatively few competitors, and products are not yet standardized. The market is relatively easy to enter because the established players are few, although in healthcare, regulatory requirements often must be met (e.g., US Food and Drug Administration approval). New pharmaceuticals are one example of a healthcare product subject to regulation.

At the **growth stage**, the product has become established and the market has accepted it. Expansion is rapid, as new customers are attracted and more competitors enter the arena. Products become increasingly standardized, although enhancements may continue to contribute to product evolution. Marketing planning at this stage emphasizes differentiation of the organization, product, or service. The rapid growth of cosmetic surgery during the 1990s is an example of this type of expansion.

By the **maturity stage**, the product has matured, most of the potential customers have been captured, and growth is beginning to taper off. Because few new customers are available, competition for existing customers increases. Product features and pricing are highly standardized, and little differentiation remains between competitors. The number of competitors decreases as consolidation occurs, and it becomes increasingly difficult for new players to enter the market. Marketing activities emphasize retaining existing customers and capturing customers from competitors. Traditional hospital inpatient services are an example of a product that has reached the maturity stage.

When a product reaches maturity, it must adapt to its new state to remain viable. At this point, three strategies may be used to stretch the lifespan of the product: (1) modify the product, (2) modify the market, or (3) reposition the product. Hospitals use all of these strategies by adding goods or services to their existing product mix, promoting their services to

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new markets, and shifting some services from the inpatient to the outpatient setting.

In the **decline stage**, the number of customers decreases as consumers substitute new products or services. Typically, a shakeout occurs among industry players as the dominant competitors squeeze out the less entrenched and as other competitors adopt a different strategic direction. Competition among the remaining players for existing customers becomes even more heated. Because no innovations are being introduced and the customer base cannot be expanded, the remaining competitors tend to emphasize cost reduction to maintain profitability.

The role of marketing depends on the product's stage in the life cycle. The stage influences the packaging of products, the promotional techniques, the approaches to competitors, and the relationships with other organizations.

During the introductory stage—when the product represents an innovation—the marketer's primary task is to educate consumers about the product while facilitating a first-to-market approach. During the growth stage, marketers focus on differentiating the product from those of competitors by capitalizing on its attributes and penetrating new markets. During the maturity stage, the role of marketing shifts dramatically. There are few new customers for the product, so marketers focus on retaining existing customers and capturing customers from competitors. Market consolidation is likely to occur at this stage, and the marketer may be involved in enhancing the organization's image during this period of turmoil. During the decline stage, the marketer must focus on maintaining current customers and presenting the product in creative new ways to extend its life span.

decline stage
The fourth phase of a product's life cycle, in which the product or industry decreases in importance and is supplanted by another.

Common Healthcare Products

This section elaborates on the types of healthcare goods and services and the types of healthcare organizations that provide them. The marketing team generally focuses its campaign on a specific service rather than the organization in general, so it is critical for marketers to understand how to classify healthcare products.

Categories of Goods
Healthcare organizations and providers sell a significant number of goods. For example, hospitals not only provide their patients with medication, food, home-monitoring kits, and sundry supplies but also sell crutches, braces, prosthetics, and other durable goods. They may also sell goods

through a gift shop, a resource library, or another retail-type enterprise. Some hospital service line extensions may sell goods on a retail basis. For example, the fitness center might sell nutritional supplements, athletic attire, and exercise equipment, while the cardiac rehabilitation program may sell DVDs, books, and other resources and tools. Exhibit 6.4 describes the emergence of retail medicine.

The concept of *retail medicine*—healthcare available to consumers outside the traditional institutional setting—is a relatively new **niche** in the elective outpatient healthcare marketplace. Retail medicine involves a variety of goods and services—some routine or commonplace and others representing a collection of personalized products. Patients often pay for these products and services out of pocket rather than through their insurance company. In its broadest sense, retail medicine includes a range of activities, from selling products in physicians' offices, clinics, and hospitals to establishing comprehensive body imaging centers. Some of the more common goods and services sold include dietary supplements, wellness programs, cosmetic medical products and services, and diagnostic and imaging tests.

By the turn of the twenty-first century, retail medicine had gathered significant momentum as entrepreneurs sought to profit from high consumer demand that traditional medicine had failed to meet (Gardner 2013). The immediate gratification that consumers derive from social media and internet shopping drives additional demand for convenient health services.

Aging baby boomers—the vast majority of whom consume retail medicine—are more concerned about their health than any previous American generation, and as a result, they are driving the interest in retail medicine. In addition, retail medicine introduced to the healthcare community new buzzwords and phrases, including *medical entrepreneurs*, who market their services to consumers known as the *worried well* and the *worried wealthy*.

One trend in retail medicine is the development of walk-in primary care clinics in nontraditional settings. Many large retail stores have added primary care services to supplement optometry and dental services on-site. For example, the Walgreens drugstore chain introduced in-store walk-in clinics that are staffed by nurse practitioners and cater to customers who are not interested in long-term physician relationships, have an immediate healthcare need, or may not have the insurance to cover a more expensive visit to a traditional healthcare setting.

(continued)

By 2014, 2,734 retail clinics were in operation in the United States (RAND Corporation 2016). CVS and Walgreens operated three-quarters of them. A number of other retail medicine chains have installed primary care outlets in shopping malls and in big-box stores such as Walmart and Target. Even some hospital systems have set up branded clinics in retail stores in their market areas.

Other examples of retail medicine include healthcare organizations building fitness and wellness programs and opening them up to the general public and providers selling consumer goods related to their specialty straight out of their offices. Obstetrician and pediatrician practices, for example, might sell books or DVDs on childbirth and parenting, or dermatologists may offer products for skin care, sun protection, or hair growth.

Other types of institutions providing inpatient care may sell similar goods, although none is likely to match the range that a hospital offers. Nursing homes, residential treatment centers, and assisted living centers typically provide supplies, medication, food, and other nondurable goods to their patients or residents. Some of these goods are considered part of the room charge or surgical fee, and others are itemized on the patient's bill.

Many of the same procedures performed on hospital patients are now carried out in physicians' offices, so physicians provide many of the same goods, such as wound dressings, casts, disposable supplies, and medications. These goods are typically not itemized separately but are included in the overall cost of the professional services. Some physicians have become increasingly involved in the retail aspect of healthcare, offering their patients a range of related goods. For example, a cardiologist may sell exercise DVDs, educational CDs, heart-healthy cookbooks, or medical alert wristbands. Although these retail activities are not endorsed by the American Medical Association, they have become entrenched in a number of medical practices.

Among other independent practitioners, some sell many goods and others sell relatively few. A major part of an optometrist's business (and, to a lesser extent, an ophthalmologist's) is the sale of eyeglasses and contact lenses. Likewise, although dentists and dental specialists primarily provide services, a considerable portion of their revenue may be derived from the sale of dentures, braces, and even high-end toothbrushes. (The range of goods demanded by consumers results in a steady flow of new products; exhibit 6.5 discusses this process.)

EXHIBIT 6.5
New Product
Development

As the healthcare industry evolves, new goods and services, such as drugs and surgical procedures, are introduced. The range of products available to healthcare consumers is constantly expanding. The growth of consumerism in healthcare and the greater involvement of individuals in the management of their health has resulted in a thriving market for "new and improved" healthcare products.

This phenomenon raises a number of interesting questions: What inspires the development of a new product? How do product developers determine what products are needed? Which products are desired? What determines the likelihood of success of a new good or service?

Product development is an important part of the marketing planning process. Marketers must determine the extent to which current goods and services are meeting the needs of the market and what new products might be desirable. New products are not developed and introduced overnight—this long and tedious process is often the responsibility of the marketing staff.

A variety of approaches to developing a new product can be taken. In the course of completing a community assessment, for example, a gap analysis may indicate a need for a particular service—one that is not being met by existing resources. Or consumers may express dissatisfaction with an existing product or frustration that a certain good or service is not available. Service providers may discover a more effective way to treat a health condition and suggest a new service. Pharmaceutical and consumer health product companies may have people on staff who are responsible for identifying new products.

Ideas for a new product come from a variety of sources. Some impetus may be derived from customers' satisfaction with existing products. In other cases, patients' changing characteristics may spur new product development. For example, the shift from a preponderance of acute conditions to a preponderance of chronic conditions has necessitated a major change in the types of products that patients require. The movement away from disease cure to disease management also has implications for product development.

Similarly, the changing characteristics of the consumer population have contributed to the demand for new products. Home-testing products are a good example of a category of goods that were unknown a generation ago. As lifestyles have changed over time, consumers have come to demand products that suit their way of living and their emerging pursuits. The burgeoning senior market has resulted in the development of a wide range of

(continued)

products geared not only to seniors in general but to subcategories of that demographic—for example, the frail elderly, active seniors, and so on.

The product development process begins with marketing research—whether assessing an existing product, determining consumer product needs, or "testing the water" when it comes to an entirely new product. Newly developed pharmaceuticals, medical equipment, or surgical procedures typically have to undergo extensive testing prior to approval, providing an opportunity to gauge consumer acceptance.

For a new product, extensive marketing research is typically required to determine the appropriate characteristics, packaging, and pricing for the proposed product. New product ideas are usually subjected to analysis by focus groups that provide feedback on what consumers are looking for, their preferences, or their opinions on a new product idea. Marketing research must be geared to the target audience—for example, what seniors are looking for in a product is likely to be different from what young, childbearing-age women are looking for.

Each product development initiative will have its own challenges. From marketing research to product conceptualization and testing to the development of a product introduction plan, marketing professionals are uniquely positioned to guide this process.

Categories of Services

The primary function of a healthcare provider is to offer services that address a particular healthcare need. A hospital's fee schedule, for example, includes thousands of individual services. It is not practical to itemize all of these services; therefore, only the major categories are noted in this section.

Health services can be considered in terms of clinical areas. Services may be classified as obstetrics, pediatrics, cardiac, oncology, orthopedics, and so forth. The services provided to obstetrics patients, for example, are grouped together, as are those in the other clinical categories. Medicare's prospective payment system recognized these categories and made them the industry standard. Clinical support services, such as radiology and laboratory services, are generally provided independent of a particular specialty and serve patients in all clinical categories.

Another way of classifying the services provided by hospitals (and certain other facilities) is to distinguish between facility-based services and professional services. Items associated with a hospital stay include the room, nursing services, technical services, and some overhead. Charges for these and other services are bundled in the per diem room rate, but services that involve variable costs (e.g., breathing treatments) may be charged

separately as part of the facility fee. Hospital-based physicians (e.g., radiologists, anesthesiologists, hospitalists) also submit separate bills, which may be combined with the facility charges. Attending and consulting physicians typically bill separately for their professional fees because they are not employed by the hospital.

The services a hospital provides may be divided into diagnostic and therapeutic categories involving different **coding systems**. Routine diagnostic procedures (e.g., X-rays, blood tests, urinalyses) and specialized diagnostic tests (e.g., mammograms, CT scans, bone density tests) are offered in the hospital setting. Hospitals, out of all healthcare organizations, typically provide the widest array of diagnostic capabilities; other clinicians offer few diagnostic tests that are not available in hospitals.

Therapeutic procedures account for the widest range of treatments provided in hospitals. They take the form of simple treatments, such as administration of medication or intravenous fluids, as well as most complex procedures, such as open heart surgery or organ transplantation. These procedures are typically grouped into clinical categories and supervised by administrators dedicated to that clinical area.

It is impossible to understand the range of diagnostic and therapeutic services without a working knowledge of the way conditions and procedures are classified. Marketers need to have at least a basic knowledge of the classification or coding systems used in healthcare. Exhibit 6.6 provides an overview of these systems.

coding system
A structure for classifying and recording medical diagnoses, procedures, and other events.

EXHIBIT 6.6
Coding Systems in Healthcare

The following is a brief introduction to the common classification or coding systems used in healthcare. Additional research into each is recommended for marketers or anyone seeking a more comprehensive discussion.

INTERNATIONAL CLASSIFICATION OF DISEASES

The most widely recognized disease classification system is the **International Classification of Diseases (ICD)** developed by the World Health Organization. The ICD is used to classify medical conditions and procedures that occur in hospitals and certain other healthcare settings. The ICD-10 classification system now in use in the United States includes two components: diagnoses and procedures. A set of codes is assigned to each component. These codes are detailed enough that fine distinctions can be made among different diagnoses and procedures. (A different system is used for recording procedures in physicians' offices and other outpatient settings.)

International Classification of Diseases (ICD)
The standard coding system that medical practitioners use to classify diseases.

(continued)

The diagnosis component comprises 17 disease and injury categories and 2 supplementary classifications. In each category, major specific conditions are listed in detail. A basic three-digit number is assigned to the major subdivisions with a total of seven digits possible. The three-digit numbers are extended to indicate a subcategory within the larger category (to add clinical detail or isolate terms for clinical accuracy). A fifth digit is sometimes added to specify factors further associated with the diagnosis. For example, in the ICD-10, Hodgkin's disease—a form of malignant neoplasm or cancer—is coded C81. Hodgkin's sarcoma, a particular type of Hodgkin's disease, is coded C81.90. If Hodgkin's sarcoma affects the lymph nodes of the neck, it is coded C81.91.

Current Procedural Terminology

Although the ICD focuses on procedures performed under the auspices of a hospital or clinic, the **Current Procedural Terminology (CPT)** system relates exclusively to procedures and services performed by physicians. Physician-provided procedures and services are divided into five categories: medicine, anesthesiology, surgery, radiology, and pathology and laboratory services. In the fourth edition of this classification system—CPT-4—each procedure and service is identified by a five-digit code.

Examples of coded procedures include surgical operations, office visits, and X-ray readings. The provider determines the most accurate descriptor from the CPT guidebook and assigns that code to the procedure. Modifiers may also be appended to the five-digit identifying code. Modifiers may indicate situations in which an adjunctive service was performed. Approximately 7,000 variations of procedures and services are cataloged.

Another set of codes has been developed to supplement the CPT codes. The Healthcare Common Procedure Coding System, administered by the Centers for Medicare & Medicaid Services (CMS), lists services provided by physicians and other providers that are not covered under the CPT coding scheme. This includes certain physician services and nonphysician services, such as ambulance, physical therapy, and durable medical equipment rental.

Diagnosis-Related Groups

In an attempt to contain costs under the Medicare program, the federal government introduced a prospective payment system as the basis for

Current Procedural Terminology (CPT)
The coding system used to classify medical procedures for recordkeeping purposes.

EXHIBIT 6.6
Coding Systems
in Healthcare
(continued)

**diagnosis-related
group (DRG)**
The coding
system used to
classify inpatient
diagnoses and
procedures.

reimbursement for health services provided to Medicare beneficiaries. Prospective payment limits the amount of reimbursement for services provided to each category of patient on the basis of rates determined by CMS.

The basis for prospective payment is the **diagnosis-related group (DRG).** Using the patient's primary diagnosis as the starting point, CMS developed a mechanism that assigns every hospital patient to one of more than 700 DRGs. The idea was to link payment to the consumption of resources, assuming that a patient's diagnosis is the best predictor of resource utilization.

To refine the more than 700 diagnostic categories, the primary diagnosis is modified by such factors as coexisting diagnoses, the presence of complications, the patient's age, and the usual length of hospital stay. For situations in which DRGs represent too fine a distinction among conditions, the nearly 1,000 DRGs are grouped into 23 major diagnostic categories based on the different body systems and other factors.

Although it was introduced for use in federal healthcare programs, the DRG system was quickly adopted by other health plans as a basis for reimbursement. This system has become the standard classification scheme for hospitalized patients in the United States and has been adopted by other countries around the world.

Ambulatory Payment Classification

In response to rising outpatient costs, CMS developed a system for the outpatient environment called the *ambulatory payment classification (APC)*. Like the DRG system, APC focuses on the facility component of healthcare costs and not on physician charges. The basis for the fee is the patient visit rather than the entire episode of care, as in the case of DRGs. APC-specific diagnosis codes have been developed, and CPT codes continue to be used to classify procedures and ancillary services. Introduced in August 2000, APC codes are now widely used in outpatient facilities.

Diagnostic and Statistical Manual

*Diagnostic
and Statistical
Manual of Mental
Disorders (DSM)*
The primary
reference used to
classify mental
health problems.

The definitive reference for the classification of mental disorders is the ***Diagnostic and Statistical Manual of Mental Disorders (DSM)***, which is currently in its fifth edition (*DSM-5*). Published by the American Psychiatric Association, the *DSM* remains the last word on mental illness classification despite long-standing criticism of its scheme. Its 18 major categories of

mental illness and more than 450 identified mental conditions are considered exhaustive.

The *DSM* is derived in part from the ICD. Like the ICD, it is structured around five-digit codes. The fourth digit indicates the variety of the disorder under discussion, and the fifth digit refers to any special consideration related to the case. Unlike the other classification systems discussed, the *DSM* guide contains detailed descriptions of the disorders categorized therein and thus serves as a useful reference.

Hospitals provide another distinct category of services: emergency care. The emergency department is designed to handle cases urgent enough that they cannot be processed through normal admission procedures. Theoretically, this department handles serious injuries and health conditions that require immediate attention. Emergency departments are staffed with physicians and nurses trained in emergency medicine and are backed up by a full range of hospital personnel. Emergency departments maintain or have access to diagnostic equipment that expeditiously determines a patient's condition. Services provided in the emergency department are charged separately from those for inpatients. Like inpatients, emergency patients are charged both a facility fee and a professional fee.

Hospitals are likely to offer spin-off services related to their inpatient activities. For example, many hospitals have established occupational health programs and sports medicine programs to serve their patients and the community. Some hospitals offer home health, rehabilitation, and hospice programs as extensions of their core activities. These programs may contain some unique services, but for the most part they repackage existing services. For example, a fitness program targeting the hospital's employees and community residents might combine existing services, such as physical examinations, stress testing, cardiac rehabilitation services, and recreational therapy; the services might be provided by nonmedical fitness personnel such as personal trainers and aerobics instructors.

Other categories of services that hospitals are likely to offer include prevention, education, and community outreach programs. Health educators may teach prevention to patients while they are hospitalized or may provide educational programs outside the hospital to patients or the general public. Nurses may provide educational services to postsurgical and obstetrics patients, and nutritionists may offer guidance to a wide range of patient types. Some of these prevention and education services are built into the facility fee; others are billed separately to the patient. Community outreach programs involve information and referral, health education, and wellness

training generally geared toward the general public. They could also include home visits by hospital staff for purposes of monitoring health problems.

Categories of Settings and Providers

Earlier chapters have enumerated the practitioners and providers in healthcare, and that information is reviewed here to put it in the context of the healthcare product. No other institutional setting provides the range of services that a general hospital does, although some specialty hospitals may provide unique services. General hospitals offer the full range of services considered under primary, secondary, and tertiary care. Only the most advanced general hospitals, however, provide complex tertiary and quaternary care. Specialty hospitals may be dedicated to a particular population (e.g., women, children) or to a specific condition (e.g., substance abuse, mental illness). In the case of the former, services similar to those provided in a general hospital are likely to be offered, although the emphasis is on specialized services for the population in question. On the other hand, a psychiatric hospital is likely to provide services not found in other clinical settings.

Hospitals provide support services of which patients are seldom aware, such as janitorial, landscaping, and parking services. Even less obvious, hospitals provide such services as medical records management, information systems operation, research services, and marketing services. Fees for these services are bundled into per diem or overhead charges.

Other facilities that house patients on an inpatient basis include nursing homes and residential treatment centers. Assisted living facilities may also provide health services. The term *nursing home* is a misnomer in that nursing homes typically provide a limited amount of medical care. Most of the services provided in a nursing home are custodial and involve the personal care of residents. As required, nursing personnel administer medication, monitor chronic conditions, and provide other forms of routine care. Physicians are on call but are not typically in residence. Unlike charges for hospital services, the charges for most services provided to nursing home residents are included in the monthly fee. Nonroutine health services are usually covered by a third-party payer, such as private insurance, Medicare, or Medicaid.

Residential treatment centers provide a narrower range of services than do hospitals but a broader range than nursing homes. Unlike nursing homes, they are involved in the active treatment of most of their residents. Facilities for treating addictions or mental disorders, for example, provide services that are usually folded into the per diem charges of the treatment center.

Physicians are the most common type of practitioner the public encounters when seeking health services. The range of services physicians provide varies with the specialty involved, although most specialists provide a core group of routine medical procedures and diagnostic tests such as X-rays,

blood tests, and urinalyses. Primary care physicians (i.e., family practitioners, obstetricians and gynecologists, pediatricians, general internists) provide the bulk of routine care and, increasingly, are taking on the management of chronic patients. Specialists, as the term implies, focus on particular health problems. Patients are typically referred to specialists by their primary care physician, although some patients, depending on the health problem, may go straight to a specialist.

The services offered by nonphysician practitioners vary depending on the profession. For example, optometrists offer vision exams and a limited range of eye-related therapies, chiropractors perform examinations and provide a narrow range of procedures aimed at spinal manipulation, and podiatrists perform examinations and offer a range of medical and surgical procedures for the treatment of foot problems.

The services of mental health and behavioral health professionals are focused on the treatment of emotional and mental disorders, including counseling, psychotherapy, and drug therapy. The range of conditions for which treatment is available has expanded over time; mental health professionals may also treat such conditions as substance abuse, eating disorders, and Alzheimer's disease. Mental health services generally have been viewed separately from the treatment of physical health problems. This separation prompted the creation of a disease classification system unique to the mental health field. (See exhibit 6.6 for a discussion of the *DSM* classification system.) The most serious mental disorders are likely to be treated by a psychiatrist—a medical doctor with specialized training in mental disorders.

Alternative (or complementary) therapy practitioners offer services that take diverse therapeutic approaches to health problems. This category includes practitioners of acupuncture, massage therapy, homeopathy, naturopathy, and other nonmainstream therapies. The use of alternative therapies has grown in popularity, and many insurance plans now cover alternative therapy interventions. Many of these services are still considered elective, however, so they must be paid for out of pocket. Alternative therapists have been some of the more aggressive marketers among health professionals. Their efforts have raised consumers' awareness of—and created niche markets for—alternative products.

One other category of service providers that should be considered in this context is social service organizations. Although most of these organizations do not provide medical care, many do perform services that are health related and are often reimbursable by third-party payers. For example, agencies addressing HIV/AIDS issues may provide diagnostic tests for HIV, and a family planning agency might provide physical examinations and perform clinical procedures. As the definition of health expands, the boundaries between healthcare providers and social service agencies can be expected to blur.

Summary

The first task of any marketer is to develop an understanding of the products being marketed. The healthcare industry, however, is not used to thinking in terms of products, and marketers often have to help health professionals define the goods and services they are offering to their customers. The complexity of the product mix in healthcare creates a challenge for marketers. Because of this complexity, healthcare organizations often market ideas, concepts, or images in addition to discrete goods and services.

Healthcare marketers must be able to distinguish between the variety of goods and services offered, recognize the relationship between products and the relevant market segment, and develop marketing initiatives accordingly. Healthcare is complicated in that products may reflect different levels of patient need, different clinical settings, and varying clinical skills. The marketing approach will be dictated, for example, by whether the treatment is routine or urgent, elective or medically necessary, or performed in an inpatient or outpatient setting. Some healthcare organizations have adopted service line management to help organize the management of types of care.

The operation of the healthcare system is complicated by a diversity of practitioners who provide an overwhelming variety of services. Physicians, other clinicians, and auxiliary personnel all provide care. In the hospital setting, the types of service providers are even more diverse. Traditional practitioners have also been joined by alternative therapists, further complicating the picture. Practitioners use a bewildering array of coding systems with which the marketer must become familiar. Furthermore, healthcare is provided in numerous settings, including clinicians' offices, community clinics, mental health centers, hospitals, nursing homes, and residential treatment centers.

Key Points

- The healthcare field is characterized by a bewildering array of goods and services, resulting in a complex product mix.
- The product offered in healthcare varies with the type of practitioner and healthcare setting, and healthcare organizations use complicated coding systems to classify their products.
- Many goods and services in healthcare are marketed to the end user (typically the patient), but institutional customers in healthcare, such as clinics and hospitals, are also major purchasers of goods and services.
- Health professionals have not traditionally thought in terms of products, and marketers have to help them define what they are trying to market.

- The delivery of services in healthcare—and the marketing thereof—is complicated in that consumers may be characterized by differing levels of need, problems with differing levels of urgency, and a wide range of health conditions.
- Healthcare products are dispensed by a great diversity of practitioners in a wide variety of settings.

Discussion Questions

1. Why were healthcare organizations not concerned about carefully defining their products in the past?
2. What makes healthcare products difficult to clearly define?
3. What are the distinctions between healthcare goods and services, and what are the implications of these distinctions for marketing?
4. How do the challenges involved in marketing health services to consumers differ from the challenges involved in marketing products to healthcare organizations?
5. In what ways is the complexity of the product mix of large healthcare organizations a challenge for marketers?
6. Given the complexity of a hospital's service offerings, what dangers exist with regard to marketing services at cross-purposes (e.g., simultaneously marketing the urgent care center and the emergency department, or the outpatient mental health center and the psychiatric ward)?
7. What is service line management, and what are the pros and cons of using a service line management approach in healthcare?

Additional Resources

American Medical Association Store: https://commerce.ama-assn.org/store/catalog/categoryDetail.jsp?category_id=cat1150004&navAction=jump.

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Washington, DC: American Psychiatric Publishing.

Centers for Medicare & Medicaid Services: www.cms.gov.

Kalorama Information. 2007. *Retail Clinics: The Emerging Market for Convenience and In-Store Healthcare*. Rockville, MD: Kalorama Information.

Synovitz, L. B., and K. L. Larson. 2012. *Complementary and Alternative Medicine for Health Professionals*. Sudbury, MA: Jones & Bartlett.

FACTORS IN HEALTH SERVICES UTILIZATION

The decision to offer a health service is generally predicated on the anticipated level of demand for that service. Once the service is offered, almost all decisions related to its continued provision are driven by demand. For this reason, healthcare marketers spend a great deal of time and effort determining current and future levels of demand for the totality of services or for the specific services offered by their organization. Calculating demand is challenging—particularly in healthcare—and requires an understanding of the many factors that influence the utilization of health services. As a result, it is one of the most critical aspects of the marketing process.

The factors that influence health services utilization have become increasingly complex, and past utilization patterns are seldom predictive of future demand. The demographic, socioeconomic, and psychographic attributes of a population all play important roles in influencing demand. At the same time, managed care arrangements and financing trends may artificially influence demand. These developments have made projecting the demand for health services increasingly difficult at a time when the ability to do so is critical to the survival of most healthcare organizations.

Conceptualizing Demand

In the context of health services, *demand* is an imprecise concept. The term is often used interchangeably with other terms (e.g., healthcare needs, wants, utilization), and no one definition is universally accepted. Because it is so vague and used in so many different ways, demand is difficult to define operationally. Part of this dilemma stems from a lack of agreement regarding *who is* the customer for health services.

Customer identification is seldom an issue in other industries, but it is a paramount concern in healthcare. Typically, the end user (usually the patient) is the primary customer, and his or her demand is thought of as consumer demand. However, there are other customers—such as physicians, health insurance plans, and employers—that are equally (if not more) influential in determining demand. In addition, organizations serve myriad other customers in the industry beyond healthcare consumers. For a health plan, the customer may be the manager of an employer-sponsored benefits

package. For a medical supply or equipment company, the customer may be a retail distributor. Physicians may determine patient demand for hospital care and pharmaceuticals, insurance companies may dictate the demand for services because of the treatments they cover, and so forth.

It may be surprising to find that in healthcare—as in other industries—it is possible to create demand for services. Creating demand, perhaps where none existed before, is an important function for marketers. While artificially generating demand may seem inappropriate, if not unethical, it can be carried out legitimately in many situations—for example, when introducing a new drug or a treatment for a recently discovered disease. The elasticity of demand for health services opens the door to marketer-generated demand. Exhibit 7.1 illustrates this process.

EXHIBIT 7.1
Creating
Demand for
a Healthcare
Product

Healthcare products are generally introduced to a market in response to a demonstrated demand, and providers develop their products in response to an established health condition or other perceived need. However, it is not unusual for healthcare organizations to proactively identify new conditions to which their existing product can be applied and to call on marketers to create demand for that product. Pharmaceutical companies, for example, have been particularly aggressive in their attempts to define new health conditions that could benefit from their products, and they promote those products to consumers and to physicians who write prescriptions. To create demand, however, an organization must demonstrate to the public and to the medical community that (1) an identifiable health problem exists and (2) the company has a product that can treat that problem.

Marketers create demand for a healthcare product in several ways, including classifying ordinary bodily functions (e.g., menstruation) or ailments (e.g., gastric reflux) as medical problems, portraying mild symptoms as signs of a serious disease, defining personal or social problems as medical problems, conceptualizing risks as diseases, or maximizing disease prevalence estimates to enhance the perceived size of a medical problem. A key strategy used by pharmaceutical companies is to target the news media with stories designed to create awareness of a condition or disease and draw attention to the latest treatment. Company-sponsored advisory boards often supply the "experts" for these stories, consumer groups provide the "victims," and public relations firms are employed to put a positive spin on the latest medical "breakthrough."

For example, on the basis of research conducted in Australia, analysts identified a concerted effort by a pharmaceutical company to generate

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demand for a product it had developed to treat irritable bowel syndrome (IBS). IBS is considered a common functional disorder and a "diagnosis of exclusion" covering a range of symptom severity. Many people with the condition are severely disabled by their symptoms, but the arrival of new drugs for IBS prompted drug manufacturers to change the way the world thought about IBS.

In this case, a communications company was engaged to formulate a medical education program to promote the perception of IBS as a "credible, common, and concrete disease." The educational program was part of a leading manufacturer's marketing strategy for a drug designed specifically to treat IBS. The aim of the campaign was to establish in the minds of physicians that IBS was a significant and discrete disease state. Further, the campaign sought to convince consumers that IBS was a recognized medical disorder for which there was a new, clinically proven therapy.

The process for generating demand involved establishing an advisory board to provide key parties with current opinions about gastroenterology and best practice guidelines for diagnosing and managing IBS. In addition, the board produced a newsletter in the prelaunch period to "establish the market" and convince medical specialists of the condition's seriousness and credibility. This newsletter was accompanied by a series of **advertorials** published in medical journals and distributed to general practitioners by pharmaceutical sales personnel. Pharmacists, nurses, and patients were targeted with promotional material.

Although the marketing campaign was portrayed by the pharmaceutical company as a medical education plan, it was intended to create demand for a drug it was selling. This marketing strategy has become common among pharmaceutical companies and adopted by other healthcare organizations.

Source: Adapted from Moynihan, Heath, and Henry (2002).

EXHIBIT 7.1
Creating Demand for a Healthcare Product *(continued)*

advertorial
An advertisement that is designed to look like an editorial or news report.

Perhaps the best way to approach the demand concept is to examine its components. From a marketing perspective, demand can be conceptualized as the combined effect of (1) healthcare needs, (2) healthcare wants, (3) recommended standards for healthcare, and (4) observed utilization patterns (Thomas 2003b).

Healthcare Needs

Healthcare needs, the first component of demand, can be defined in terms of the overall health status of a population or, more specifically, the number of health conditions affecting the population that require medical treatment.

These conditions are ones that an objective evaluation—for example, a physical examination—would uncover. The services required to address these conditions might be considered *absolute needs* (e.g., trauma requiring emergency care or a life-threatening illness), which exist independently of any other factors. These epidemiologically based needs that a team of health professionals would identify in a sweep through a community are thought to reflect the true prevalence of illness in the population. All things being equal, the absolute level of need should not vary much from population to population.

The existence of clinically identified health problems—at least in contemporary societies—does not translate directly into demand for health services. In fact, the mismatch between identified needs and the utilization of health services is substantial. Many conditions go untreated (indeed, even undiagnosed), for a variety of reasons. Treatment obtained for many other conditions would not be considered medically necessary using objective criteria. For example, no team of epidemiologists assessing the healthcare needs of a community would likely identify sagging facial skin as a health problem. Yet tens of thousands of facelifts are performed in the United States every year by medical doctors. Thus, demand for a health service might exist even though no argument for medical necessity can be made.

Healthcare Wants

Healthcare wants, the second component of demand, arise from a population's wishes or desires for health services. Unlike needs, however, wants would not necessarily be uncovered by public health investigators. Desired services are determined less by the absolute needs of a population than by the factors that influence the consumption of nonhealthcare goods and services. Many desired services are considered medically unnecessary or elective and thus are considered wants rather than needs. Tummy tucks and laser eye surgery are examples of such services.

Healthcare wants are determined less by the level of biological morbidity in the population and more by nonmedical factors. Wants may be determined by personal traits, such as fear and vanity; by social characteristics, such as group pressure or family influence; or by cultural factors, such as societal trends. For this reason, the level of wants is likely to be elastic and more susceptible to the influence of marketers than needs. The US healthcare system has evolved to accommodate the wants of the consumer, and many healthcare organizations cater to people desiring elective services that might be considered medically unnecessary.

The type of organization and the services it offers dictate whether needs or wants are the main consideration in marketing efforts. For example, a clinic for people with HIV/AIDS deals with basic needs, and few elective procedures are relevant to the treatment of that disease. On the other hand,

a plastic surgeon specializing in body sculpting is likely to focus on the want-driven demand generated by those motivated by vanity. (Exhibit 7.2 presents a discussion of marketing approaches for an elective procedure.) At the same time, if a plastic surgeon also maintains a reconstructive surgery practice for trauma victims, then both wants and needs would be addressed.

With the emergence of consumerism driven by the baby boom generation, the emphasis on alternative therapies, and the wellness and fitness movement, consumers started making more of the decisions regarding health services. As they assumed a greater role in decision-making, consumers became an increasingly important target for healthcare marketers.

One area ripe for the application of direct marketing methods is elective surgery. *Elective procedures*—that is, those not considered medically necessary and thus not reimbursable through health insurance plans—constitute a significant proportion of the procedures performed by medical practitioners. Procedures from elective knee surgery to laser eye correction to facelifts are included in this category. These procedures are elective in that the consumer, not the physician or the health plan, usually makes the decision.

Candidates for many types of elective surgeries are characterized by a particular profile and do not represent a cross-section of the population. The most effective approach to developing a consumer profile involves gathering patient data that specify the characteristics of the best prospects for the service. Aggregate data on patients obtaining facelifts or elective knee surgery, for example, could be used to identify others in the population who have similar characteristics. Even better data, however, are the actual names and addresses of patients who have obtained these services. This information can be used to link the patients to consumer databases to develop a more in-depth profile of the typical candidate for a procedure. Thus, patients for a particular service can be profiled in terms of their demographic characteristics, lifestyle orientation, and consumer behavior, among other characteristics.

Laser eye surgery has grown in popularity as new techniques have been perfected and outcomes have improved. This procedure is almost always elective, requires out-of-pocket expenditures by the patient, can be expensive, and appeals disproportionately to certain segments of the population.

To support the development of a marketing campaign, researchers obtained patient data from a successful laser surgery clinic. Names and addresses were requested for those who had undergone the procedure,

(continued)

those who had presented themselves for surgery but turned out to be clinically ineligible, and those who had indicated an interest in laser eye surgery at some point but had never undergone the procedure. The analysis included approximately 700 laser eye surgery patients (and medically ineligible prospective customers) and another 1,200 prospective customers who had inquired about the surgery but never followed through. In addition, a random sample of 1,000 consumers was drawn from the zip codes associated with the patient and prospect sample.

Researchers gathered the data necessary for the analysis by matching the compiled names and addresses to consumer data maintained by Experian Marketing Services. The data obtained from Experian included the following:

- **Individual-level data**, such as age, marital status, and gender
- **Household-level data**, such as home ownership, estimated household income, and presence of children
- **Geographic-based data**, such as the median household income of the consumer's census block group, the racial and ethnic profile of the block group, the median home value, and the Mosaic lifestyle cluster assigned to each household (discussed in exhibit 7.4)

To ensure that the patient sample and the random sample represented the same underlying population, any consumer whose zip code was outside the primary service area of the ophthalmic surgery practice was removed from the study population.

When the characteristics of the patients, prospects, and matched subjects from the general population were compared, significant differences were found in the demographics and household characteristics of the three groups. Differences were found in age, gender, race, marital status, income levels, and rates of home ownership. When the groups were compared on the basis of Mosaic lifestyle clusters, four of the clusters—typically assigned to neighborhoods of low socioeconomic status—were determined to be negatively associated with interest in laser eye surgery.

Based on these comparative data, a logistic regression model was derived to predict the probability that a given consumer would fit the profile of previous laser eye surgery patients. The **predictive model** demonstrated reasonable predictive validity. Overall, 63 percent of the sample was correctly classified as either a patient or nonpatient. Although a logistic regression model yields both false positives and false negatives, the overall result—with 60 percent of the positives correctly classified and 66 percent

predictive model
A statistical method for identifying and quantifying the likely future need for health services for a defined population on the basis of known utilization patterns.

of the negatives correctly classified—indicated that this model could be used to significantly increase the probability of identifying prospects for laser eye surgery within a defined population. In the final analysis, the characteristics that had the most predictive power (in no particular order) were race, age, gender, marital status, and income. Although these factors all contributed to a person's likelihood of pursuing laser eye surgery, certain occupational statuses and lifestyle categories reduced a person's likelihood of becoming a patient.

The ability to predict classification of an individual as a patient rather than a nonpatient was improved dramatically by using this model. Careful use of the model as a basis for identifying targets for direct mail (i.e., targeting those falling into the top three deciles of customer potential) would significantly increase the "hit rate" and could drive up marketing effectiveness by 300 percent. As a result, the bottom-line impact on an ophthalmic surgery practice could be significant.

Source: Adapted from Barber, Thomas, and Huang (2001).

EXHIBIT 7.2
Marketing an Elective Procedure: The Case of Laser Eye Surgery *(continued)*

Recommended Standards for Healthcare

Recommended standards for the provision of services are the third component of demand. These standards primarily involve diagnostic procedures and disease management activities recommended for patients who display certain symptoms or are at risk for a specified health problem.

The medical community has developed recommendations for how often diagnostic tests should be performed, the circumstances under which a medical procedure should be performed, and the proper implementation of certain treatment plans. These standards differ on the basis of health condition, age group, population segment, health risk, and so forth. For example, the American Cancer Society recommends an annual mammogram for all women of a certain age and a prostate exam for all men after a specified age. The National Cholesterol Education Program recommends cholesterol testing every five years after a certain age or more frequently if other risk factors are present. According to the Centers for Disease Control and Prevention, most healthy adults should have their cholesterol checked every four to six years. Children and adolescents should have their cholesterol checked at least once between ages 9 and 11 and again between ages 17 and 21 (Grundy et al. 2018).

As health professionals and providers have become more attuned to disease prevention and health maintenance, the number of guidelines and recommendations has increased, along with the number of diagnostic and screening procedures available. Many of these standards serve a public health purpose,

so they may be promoted through social marketing efforts by the American Cancer Society, the American Heart Association, and other public and private groups. The rise in the number of physician-ordered or recommended diagnostic tests may also reflect a trend toward *defensive medicine,* or the practice of overtesting or overtreating patients to avoid malpractice liability.

Utilization Patterns

The fourth component of demand is conceptualized as the level of utilization of health services. This measure reflects the combined effect of the first three components, along with certain structural considerations (e.g., the availability of services). The amount of services consumed is frequently used as a proxy for demand because utilization rates can be calculated for almost any type of healthcare good or service. More data are available on utilization than on the other components of demand, primarily because utilization data are routinely collected for administrative and billing purposes whenever a service is provided or a good is sold. Utilization rates thus indicate the actual level of activity as opposed to theoretical demand.

Because of the perceived relationship between demand and utilization, analysts sometimes work backward, using utilization levels as a basis for determining demand. However, utilization does not equal demand; depending on the circumstances, the perceived level of demand may exceed observed utilization or, conversely, utilization levels may exceed reasonable demand as objectively measured. For example, there may be less utilization than expected for a certain treatment because of limited access to services. On the other hand, some services may be overutilized for reasons unrelated to the level of demand (e.g., insurance coverage, physician practice patterns).

Likewise, identifiable demand may not directly translate into utilization. Because marketers are concerned with what consumers actually do, situations in which the level of demand exceeds actual utilization may represent marketing opportunities. (See Pol and Thomas [2013] for a detailed review of the relationship between demographic characteristics and health status and health behavior.) Health services researchers commonly compare the assumed level of need with the observed level of utilization. Exhibit 7.3 discusses the use of proxy data to create health status indices.

Factors Influencing Demand

Many factors influence the level of health services demand, and their interactions are complex. Although biological characteristics may predispose a person to certain health problems, other factors may ultimately determine the type and amount of goods and services consumed. Biological factors are

Because data on the propensity to use health services for the residents of a particular geographic area are unlikely to exist, inferences based on knowledge gained from analyses of other population segments may have to be made. For example, if the likelihood of the presence of HIV among Latinos is a function of Puerto Rican ancestry, a specified level of education and income, and residence in a highly mobile urban area, then developing a propensity score for the presence of HIV in Latino populations should be possible. Thus, the propensity score for Latinos in parts of New York City might be 250, while in Miami this score might be only 45. (A propensity score of 100 indicates average presence of a condition.)

To use another example, the propensity for undergoing laser eye surgery might be related to certain psychographic or lifestyle segments. Thus, five lifestyle segments might be found to have a propensity score for laser eye surgery of 300 or more (or three times the average), in contrast to ten other lifestyle segments who almost never undergo laser eye surgery. Determining the potential market becomes possible by using such an approach to the extent that the distribution of lifestyles can be specified for a target area.

EXHIBIT 7.3
Proxy Data for Health Status Indices

comparable to the healthcare needs and may or may not translate into utilization. Nonmedical factors, on the other hand, may have a greater influence on wants than on needs.

Knowledge of a population's characteristics (e.g., cultural background, lifestyle patterns) and structural factors (e.g., health insurance, financing arrangements, healthcare providers) may offer more clues to the type and level of services demanded than knowledge of the actual level of morbidity. This section describes some of the factors that influence the level of demand for health services.

Population Characteristics

The population characteristics that influence the demand for health services can be categorized in terms of their effect on health status and health behavior. These categories include biological factors, psychological factors, demographic factors, lifestyle and psychographic factors, and other, mostly structural factors.

Biological Factors

In the context of the medical model, health and illness are defined by a person's biological state. Illness is indicated by the presence of symptoms indicating a biological pathology. Genetic factors are the most easily identified

contributors to morbidity. Among these factors, heredity is the one that cannot be intentionally altered.

This view of health and illness remains widely accepted, since it is the view supported by mainstream medical practitioners. The way most health problems are conceptualized and managed reflects this orientation, and both medical education and the organization of the healthcare system reinforce this view. Health insurance provides an excellent example: No treatment is covered without a physician's diagnosis.

All human populations share certain biological traits, and thus they have the same susceptibility to particular diseases because of their exposure to similar pathogens. Therefore, differences in the morbidity patterns among populations are a function of time and place. All else being equal, one could expect to find the same level of morbidity from one population to another in terms of the number of extant conditions; the differences are a function of the types of conditions common to the respective populations.

Historically, there was a reasonable correlation between the presence of symptoms and the use of health services. Simply put, people with symptoms consumed health services, while people without symptoms did not. That correlation is much weaker today as chronic conditions and mental disorders with less distinct symptoms have become common. One consequence of this development is an increase in want-driven services at the expense of need-driven services.

Psychological Factors

The psychological factors correlated with demand include emotional responses, personality types, and attitudes evoked by health problems. The relationship between these factors and health behavior can be exceedingly complex—as in the case of a hypochondriac or when the fear of dying, for example, pushes one person to seek treatment but prevents another from consulting a physician. Fear, pride, vanity, and other emotion-based responses play a large role in the demand for many elective procedures (e.g., breast augmentation, liposuction).

In industries in which marketers pay more attention to psychological motivations, personality traits are often thought to drive consumer behavior. In healthcare, however, the individualized nature of personality makes directly correlating personal traits with utilization difficult, and data on the relationship between psychological characteristics and health behavior are limited.

In healthcare, customer attitudes toward the healthcare system, physicians, facilities, treatments, and so forth influence the decision to obtain healthcare goods and services. The preference, choice, or willingness to use an urgent care center rather than an emergency department, a health maintenance

organization rather than a traditional health plan, or a chiropractor rather than an orthopedic surgeon may be a function of a person's attitude.

Attitudes are not restricted to patients or clients; they also apply to other customers such as physicians and other health professionals. The attitudes of physicians, for example, have been shown to affect which types of services they provide to which types of communities and which types of individuals. The wide variation in medical procedure rates from community to community and the absence of some services in certain communities may be partly attributed to provider attitudes.

Despite the significance of psychological factors at the individual level, such information is particularly hard to acquire. While some psychology-based patterns of health behavior may be identified for certain segments of a population, psychological traits are so idiosyncratic as to limit their usefulness as predictors of health behavior. Other characteristics that are more closely associated with social groups in the population are better predictors of both health status and health behavior and, hence, the demand for health services.

Demographic Factors

Demographic characteristics exert a powerful influence on the utilization of health services. Among demographic attributes, age is one of the best predictors of health services use. In the United States, for example, utilization increases with age, reflecting the onset of chronic conditions and more frequent hospital care. The rate of hospitalization for people younger than 45 is low, and the lowest rate of admissions to US hospitals is recorded for the 6–17 age cohort. After age 45, however, admission rates increase dramatically; the rate for the 45–64 age cohort is more than double that of the 15–44 cohort. In terms of emergency department utilization (for true emergencies), teens and people in their early twenties (particularly men) account for a disproportionate share as a result of injuries and accidents. The elderly also account for a large share of emergency department utilization (National Center for Health Statistics [NCHS] 2012).

The sex or gender of the consumer is another influential factor. In the United States, women are more involved than men in the healthcare system and are heavier users of health services in general. Women tend to visit physicians more often, take more prescription drugs, and use most other facilities and personnel at a higher rate. They also are more aware of available health services and quicker to turn to health professionals when symptoms arise. Perhaps more important from a marketing perspective, women influence others' use of health services. They often are in charge of making healthcare decisions for their spouse or children, with 78 percent claiming to be the primary healthcare decision maker for their families (Lounsbery 2018).

Racial and ethnic backgrounds also influence health services demand in the United States. Clear-cut differences have been identified between African Americans and non-Hispanic whites in terms of their use of health services. Certain Asian populations and many other ethnic groups display distinctive utilization patterns. In general, whites tend to use physicians at a higher rate than the rest of the population, but African Americans are significantly more likely to use emergency department services. Additionally, some minority groups are more likely to use alternative therapies (e.g., folk medicine and acupuncture). Differences in utilization may be traced to the types of health problems experienced by minority populations and reflect variations in their lifestyle patterns and cultural preferences. Perceptions and expectations of the healthcare system also likely differ among races and ethnicities (NCHS 2012).

Marital status is related not only to the level of demand but also to the types of services used and the circumstances under which they are consumed. Married people in the United States tend to have fewer health problems than the unmarried, widowed, or divorced, but they use health services at a higher rate. The lifestyles sometimes associated with unmarried status are believed to prompt more health problems, while the social support provided by a marital relationship is thought to contribute to more diligent use of health services (NCHS 2012).

A population's income level is probably one of the best predictors of utilization. A correlation exists between income level and the amount of health services used as well as between the types of services used and the circumstances under which they are received. Despite the health penalty that accompanies low income, the unhealthy poor tend to use fewer services than the healthy affluent. This is true whether the indicator is for inpatient care, outpatient care, tests and procedures performed, or any other measure of utilization (NCHS 2012). In the past, a lack of health insurance or coverage under the Medicaid program was typically a reflection of poverty-level income, but this is no longer necessarily true since passage of the Affordable Care Act (ACA), which aimed to expand coverage to the previously uninsured or underinsured poor.

The relationship between educational level and utilization is similar to that for income. The distribution of health problems in a population is associated with educational status, making it one of the better predictors of demand. The rate of hospitalization for the least educated segments of the US population is low, despite the higher prevalence of health problems in this group. More educated segments, although less affected by health problems, have higher rates of health services utilization. These higher rates are thought to be a function of a greater appreciation of the benefits of healthcare and greater access to insurance coverage (NCHS 2012).

The relationship between religious affiliation or degree of religiosity and health behavior is the most idiosyncratic of the demographic associations. Research on this relationship is limited, so clear patterns are hard to discern. Further, in the United States, religious affiliation and participation are associated with so many variables that isolating the influence of religious involvement on utilization is difficult. Nevertheless, evidence indicates that health status (and the subsequent use of services) is correlated with measures of religiosity. This factor may be an important consideration for marketers in communities where faith-based healthcare organizations are common (Benjamins 2003).

Health demographers argue that "demographics are destiny" when it comes to health services utilization. Beginning with age, they see changing demographic traits driving changes in the demand for health services—in terms of both volume of services and types of health services demanded.

Psychographic or Lifestyle Factors

Psychographic or lifestyle factors have a significant influence on a population's healthcare wants, needs, and behaviors. In fact, health behavior and the propensity to use health services may be more highly correlated with lifestyle characteristics than with other variables. If the lifestyle classification of members of a population can be determined, the types of health problems that group will experience, as well as likely utilization patterns, can be estimated. To a certain extent, lifestyles override, or at least refine, differences in health services utilization based on demographic traits.

There are pros and cons to using psychographic attributes of predictors of health behavior. On the one hand, contemporary lifestyle segmentation systems assign a lifestyle cluster to virtually every US household, making lifestyle assignment easy. A wide range of attributes are assigned to each lifestyle cluster and provide useful insights into the attitudes, lifestyles, and behavior of members of those clusters. On the other hand, limited work has been done to link psychographic traits to health status and health behavior. While there is some benefit to examining the lifestyle attributes of a target population, more research is required to make this approach useful for predictive analysis. Exhibit 7.4 discusses lifestyle segmentation systems.

Structural Factors

Other influential factors—mostly structural—often operate independently of the characteristics of the population. Advances in technology usually lead to higher levels of utilization of the services supported by the new technology. Some operations, such as laser eye surgery, could never be performed without technological advances. Technological advances have also contributed to the shift from inpatient care to outpatient care and facilitated the emergence

segmentation
The process of dividing a population into meaningful segments for the purposes of market analysis and strategic planning.

Lifestyle segmentation systems have been used for decades in other industries but have never received widespread acceptance in healthcare. Historically, provider organizations depended on physicians or health plans to channel patients to them. For this reason, they did not need to know much about the characteristics of their patients.

Today's healthcare environment, however, demands increased attention to customer **segmentation**. The market has become consumer driven, and individuals are taking a more active role in healthcare decision-making. The pharmaceutical industry has led the way with heavy investment in research on market segmentation. Healthcare providers who perform elective procedures—such as plastic surgeons, orthopedic surgeons, and eye surgeons—also need such information. As the health insurance landscape changes (particularly as a result of the ACA), growing numbers of health plans, providers, and other organizations are expressing an interest in customer segmentation and target marketing.

The first lifestyle segmentation systems—also referred to as psychographic segmentation systems (see chapter 5)—were developed in the 1970s. This approach to segmentation was developed in response to some of the perceived deficiencies of demographic profiling. Marketers realized that people in the same demographic category could be grouped on the basis of lifestyle. For example, all senior citizens used to be grouped into the 65 and older category. Lifestyle research discovered that this demographic category contained at least two major subgroups: (1) active, financially secure seniors and (2) frail elderly with limited resources.

The concept behind all segmentation systems is the use of geodemographic data in conjunction with data on consumer behaviors, attitudes, and preferences. This information is used to generate distinct lifestyle clusters that cover the entire population. A specific set of attributes can then be assigned to each cluster. Marketers and researchers can attach health characteristics to each cluster on the basis of these unique attributes.

The Mosaic lifestyle segmentation system, for example, includes 71 lifestyle clusters grouped into 12 major categories. This system has been used by Experian to assign psychographic clusters to more than 135 million households. Such systems can be used to perform lifestyle analyses and, depending on the database, provide a wide range of demographic, socioeconomic, and consumer data linked to each psychographic cluster. Vendors of psychographic segmentation systems continue to expand the range of data, and the healthcare industry is slowly beginning to embrace a psychographic segmentation approach to marketing research.

of home healthcare as a major aspect of healthcare delivery. The impact of technology has been particularly notable in the area of diagnostic testing. The variety of tests that can be performed has increased dramatically; the expanded use of home testing is just one example.

Another structural factor is the type and extent of health insurance coverage available to individuals and families. The availability of insurance has been identified as one of the best predictors of the demand for health services. Access to health insurance enables access to care, and changes in insurance provisions can have a significant effect on the demand for health services. For example, when insurers introduce copayments or higher deductibles into their plans, the use of health services often declines in response. When insurance reimbursement is authorized for a service or increased, use of that service tends to rise as well. Before the enactment of the ACA, the growing number of uninsured led to decreased demand for basic health services, an unfortunate consequence at a time when health problems and chronic conditions were increasing.

Reimbursement arrangements also influence practice patterns. To limit claims payments, health plans may impose restrictions on the hospital services for which they will reimburse costs. Similarly, changing reimbursement and regulatory pressures force physicians to change their practice patterns, which, in turn, leads to changes in utilization levels for certain procedures. ACA provisions, however, are changing this dynamic, making high-quality, coordinated care—rather than financial considerations—the driver of utilization and reimbursement. Increased Medicaid payments to primary care doctors took effect in 2013, and insurers are now required to spend 80 percent to 85 percent of all premium dollars collected on medical care (Centers for Medicare & Medicaid Services 2019b).

The availability of health services in the form of facilities and personnel has an understandable impact on the level of health services utilization. In some situations, the demand for services may not be met because of a lack of facilities or personnel. In other cases, an oversupply of facilities or personnel may result in overutilization of health services. When new facilities or equipment are acquired, healthcare organizations face financial pressure to generate as much utilization as possible to recoup the cost of the new resources.

One final factor to consider is the practice patterns that characterize different health service providers. Far from being an exact science, medicine involves frequent value judgments on the part of physicians and other practitioners. The volume and types of services provided by physicians in the same market area may vary widely, and even more striking differences may be observed from market to market (Fisher 2008). Local practice patterns may account for significant variations in utilization among groups of patients with similar health problems.

The recorded level of utilization reflects a combination of a population's needs, wants, and recommended standards, as well as the impact of structural factors. Each component of demand poses a different challenge for healthcare marketers—but the real challenge is determining the correct combination of factors relevant for a particular situation. Identifying demand is a multifaceted process that involves many dimensions. Considering only one dimension of needs, wants, recommended standards, or utilization as a proxy may be appropriate in a particular situation, but ultimately a blended concept must be developed to more precisely determine the level of demand. Exhibit 7.5 discusses the elasticity of the demand for health services.

EXHIBIT 7.5
The Elasticity of
Health Services
Demand

Historically, economists considered medical care to be the one service for which demand was inelastic. The assumption was that if individuals were sick, they would consume health services, and if individuals received health services, they must be sick. Today, this assumption is understood to apply only to rare, life-threatening situations for which treatment is almost invariably given, regardless of other characteristics of the patient or the healthcare system. For every episode requiring lifesaving efforts, there are thousands of situations in which healthcare is consumed—many involving individuals who are not technically sick. Therefore, the demand for most health services is now considered to be relatively elastic.

There is ample historical evidence of elasticity in healthcare demand. For example, in the factory system of the former Soviet Union (and certainly many other places), the amount of sickness allowed among workers depended on whether the factory was meeting its quota. If the quota was being met, the factory doctor may have been fairly liberal in diagnosing sickness among workers. If the quota was not being met, few cases of sickness were identified.

Military recruitment offices provide another example: If there was demand for soldiers on the front lines, few recruits were dismissed for medical reasons (even when they should have been). On other hand, during peacetime, many more cases of illness were recognized, even though people with the same conditions were previously inducted. A contemporary example is offered by the Great Recession of 2007–2009, when the demand for healthcare—as measured by utilization—declined significantly at a time when observable symptoms were increasing.

A substantial body of evidence indicates that differences in demand exist among people with similar health conditions; indeed, one of the major

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factors that drove (and continues to power) passage of the ACA was the disparity in utilization of health services. In reality, demand rises and falls in response to a variety of factors. In areas where few health services are available, for example, demand appears to be low. Conversely, in areas with an abundance of healthcare resources, demand appears to be high. A change in physician practice standards is likely to affect the demand for health services. At one time, for example, it may have been "fashionable" among obstetricians to perform cesarean sections on a larger proportion of their pregnant patients; as more scientific evidence accumulated, fewer C-sections were performed.

Perhaps the best example of the elasticity of demand is when the demand rises and falls commensurate with the availability of health insurance. Indeed, because insurance coverage is one of the best predictors of demand, those who are adequately insured demand more health services than do those who are poorly insured.

Measuring Utilization

Healthcare marketers should have a working knowledge of the measures of health services utilization, because a large part of their role is to influence utilization levels. Health services researchers have developed a number of indicators for measuring utilization. Commonly used indicators are discussed in this section.

Facility Indicators

The hospital admission rate is one of the most frequently used indicators of utilization, since the hospital remains the focal point for treatment. The terms *admissions* and *discharges* refer to episodes of inpatient utilization. The hospital **admission rate** counts patients at the time of admission to the facility; patients require at least one overnight stay to be included in this measure. The hospital **discharge rate** counts patients when they are released from the facility. All patients are eventually discharged even if they are classified as expired. The number of discharges generally equals the number of admissions, although there are a few situations in which this is not the case—for example, in the case of pregnant women, one person is admitted and two or more people—assuming a successful delivery—are discharged. Both measures are important to marketers, especially in light of the growing interest in the characteristics of patients both before they are admitted and after they are discharged. Exhibit 7.6 describes a situation in which marketers may have an impact on admission patterns.

admission rate
For a healthcare market area, the number of patients admitted to a hospital in a specified year per 1,000 population.

discharge rate
The number of patients discharged from a hospital in a specified year per 1,000 residents.

In an effort to contain healthcare costs, the Centers for Medicare & Medicaid Services (CMS) is constantly researching factors that contribute to higher costs to the federal government. CMS found that one of the main contributors to excessive Medicare and Medicaid costs was the frequent readmission of hospital patients within a short time after discharge. This research suggested that hospitals were not appropriately managing the care of these patients, resulting in frequent readmissions and additional costs. This led CMS to levy penalties on hospitals with high rates of readmission.

Subsequent research found, however, that the likelihood of readmission actually had little to do with the quality of care received. Numerous studies, in fact, found significant differences in hospital readmissions among patients who were hospitalized for the same condition and received the same type of care.

These findings led CMS and other researchers to look for other causes of readmissions. A number of studies explored the role of nonclinical factors in shaping rates of rehospitalization. A 2014 study published in *Health Affairs* compared hospital performance on 30-day readmissions and found that adjusting for patients' socioeconomic status significantly reduced the rates of variation in readmissions among hospitals in Missouri (Hu, Gonsahn, and Nerenz 2014).

For patients discharged between 2009 and 2012, analysis using a model enriched with census tract socioeconomic data found that the range of variation in readmissions among hospitals decreased to 1.8 percent from 6.5 percent for patients with acute myocardial infarction; to 7.4 percent from 14.0 percent for those with congestive heart failure; and to 3.7 percent from 7.4 percent for those with pneumonia, compared with rates unadjusted for socioeconomic factors. Another study in the same journal conducted by researchers at an urban teaching hospital found that patients living in high-poverty neighborhoods were 24 percent more likely to be readmitted to the hospital within 30 days, after adjusting for demographic and clinical characteristics.

The preponderance of evidence now suggests that nonmedical factors are the primary drivers of hospital readmissions. The characteristics of the patient and the patient's environment determine the attributes that the patient carries to the hospital. Similarly, the characteristics of the patient and the patient's environment determine to a great extent what happens to the patient after discharge. Thus, a range of factors—poverty, housing insecurity, lack of social support, and community safety—play a greater

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role in hospital readmissions than the acuity of the condition or the type or quality of care received.

Marketers can play a role in reducing readmissions by developing knowledge about the characteristics of patients and their social and cultural contexts. Using this knowledge, marketers can profile patients in terms of their likelihood of a successful hospital stay and likelihood of readmission. Hospital administrators, then, can take actions to ameliorate the adverse impact of these characteristics and thereby decrease the likelihood of readmission. This information can form the basis for predictive modeling that will enable a proactive approach to the challenge of hospital readmissions.

The hospital admission rate is a proxy for other indicators, as admissions correlate with tests conducted, surgeries performed, and the allocation of other resources. Hospital care is both labor and capital intensive, so one admission represents a significant healthcare expenditure. Admissions may be measured for an entire community or for one facility, or they may be broken down into components of utilization (e.g., clinical specialty, demographic attribute, geographic origin, payer category).

The term **patient days** refers to the total number of hospital days that a set of patients spends in a facility during a year, often expressed in terms of the number of patient days accrued per 1,000 residents. This measure refines hospital admissions as an indicator by reflecting the total utilization of resources on the basis of patient days to adjust for variations in length of stay. Like the admission rate, patient days may be calculated by diagnosis, type of hospital, patient origin, or payer category. Changes in reimbursement procedures have made patient days a more effective indicator of resource utilization.

The **average length of stay** is a measure of the average number of days patients remain in the facility during a specified period. This indicator is also a good measure of resource utilization. Because Medicare and many other health plans reimburse hospitals on a per diem rate, a facility's average length of stay is an important financial consideration.

Several other facility indicators, each important in its own way, might also be used. Utilization rates may be calculated for nursing homes, hospital emergency departments, hospital outpatient departments, freestanding emergency centers, minor medical centers, surgery centers, and freestanding diagnostic centers.

As home healthcare has become more important, so has the number of *home healthcare visits* as a measure of utilization. Although this measure is not facility based, the scope of home care has expanded and now encompasses a broad range of services. Home healthcare utilization is typically measured by

patient days
The total number of days recorded by an organization or population that patients spent hospitalized during a specified year.

average length of stay
The average number of days patients spent hospitalized in a facility during a specified year (i.e., the total number of patient days for the year divided by the number of patients).

the number of visits made by different types of personnel. Thus, a population's utilization might be considered in terms of the number of home health nurse visits or home health physical therapist visits recorded. Alternatively, the number of residences (i.e., the rate per 1,000) receiving home care visits might be calculated.

Personnel Indicators

One of the most useful indicators of utilization is the volume of physician encounters. This volume is typically measured in terms of *physician office visits*, although telephone or e-mail contact and physician visits to hospitalized patients are sometimes considered. The physician is the gatekeeper for most types of health services, and physician visits are a more direct measure of utilization levels than are hospital admissions, as most people avail themselves of a physician's services at some time but may never be admitted to a hospital. Physician utilization rates are often broken down by specialty, since utilization among specialties varies dramatically.

Utilization rates also might be calculated for other types of personnel—typically independent practitioners who, like physicians and dentists, are not supervised by other medical personnel. Examples include optometrists, podiatrists, chiropractors, and mental health counselors and therapists. Other healthcare personnel—who generally cannot operate independently, but for whom utilization rates might be calculated—include home health nurses, physician assistants, nurse practitioners, and technical professionals. Physical therapists and speech therapists are other personnel for whom utilization rates might be developed if, for example, the analyst is involved in marketing rehabilitation services.

Drug Dispensing and Prescribing

Drug dispensing and prescribing have become important indicators of health services utilization, as the consumption of drugs has increased at the expense of other forms of treatment. Although patient care providers typically have limited use for drug utilization data, analysts representing entities such as pharmaceutical companies find this information valuable because prescription drugs (rather than over-the-counter medicines) are thought to more accurately reflect utilization of the healthcare system. Although the level of prescription drug utilization can be determined from physician and pharmacist records, the rate of nonprescription drug utilization must be determined in more indirect ways. Important recent research has demonstrated that patterns of drug prescribing can serve as a proxy for chronic disease prevalence (Cossman et al. 2010).

Exhibit 7.7 presents examples of the health services utilization rates discussed here, along with sample calculations for obtaining these rates.

Formula   *Example*

EXHIBIT 7.7
Commonly Used
Health Services
Utilization Rates

Hospital Admission Rate

Admission rate per 1,000 population	=	Number of hospital admissions in specified year ÷ Total population at midpoint of year	× 1,000

1,000 hospital admissions in 2019 ÷ 10,000 population estimate for midyear 2019	× 1,000 = 100

Patient Days

Hospital patient days	=	Hospital patients admitted in specified year × Average length of hospital stay

1,000 patients admitted in 2019 × Average length of stay of 5 days	= 5,000 patient days

Physician Utilization Rate

Physician office visits per 1,000 population	=	Number of physician office visits in specified year ÷ Total population at midpoint of year	× 1,000

30,000 office visits in 2019 ÷ 10,000 population estimate for midyear 2019	× 1,000 = 3,000

Emergency Department (ED) Utilization Rate

ED visits per 1,000 population	=	Number of ED visits in specified year ÷ Total population at midpoint of year	× 1,000

4,500 ED visits in 2019 ÷ 10,000 population estimate for midyear 2019	× 1,000 = 450

Implications of Utilization Rates for Marketers

An obvious goal of healthcare marketers is to increase utilization of the services provided by their healthcare organizations. However, doing so, like much else in healthcare, is not always straightforward. As a general rule, increased volume results in increased revenue—and, presumably, increased profit for the organization providing the services. However, organizations are often required by regulations, community standards, or consumer demand to provide services that may not generate enough revenue to cover costs. Further, ACA provisions require not-for-profit hospitals to demonstrate that they are meeting community needs regardless of cost. In addition, because the fee schedules adopted by insurance companies and health plans limit the reimbursement amounts that providers receive for many services, these organizations may provide services for which the reimbursement is less than the actual cost. To further complicate matters, a service that is profitable under normal circumstances may cause an organization to lose money if it attracts patients with no or limited ability to pay.

This situation has numerous implications for healthcare marketers. They must be familiar with the variety of services offered, the mechanisms for reimbursement, and the most "desirable" types of patients. In some situations, the sickest patients may be considered desirable, and in others, the target market may consist of healthy individuals. In some circumstances, a service might be provided at a loss to establish a customer relationship, and in other circumstances, services may be offered at a loss because volume in this service area has implications for down-the-road profit in a related service. Clearly, marketers in healthcare must be more intimately aware of the inner workings of their organizations than marketers in any other industry.

Predicting Demand

The current level of demand, however it is measured, is important information for marketers. Even more important is the anticipated future level of demand characterizing the population under study. Three techniques for projecting future demand are described in this section.

Traditional Model

The simplest and most straightforward prediction approach involves straight-line projections based on historical trends. For example, in the past, it was common to review several years of hospital admissions and then extrapolate the observed trend into the future. This approach was intuitive in that if the trend was rising, the assumption was that it would continue to rise. On the

other hand, if the trend was declining, the assumption was that the decline would persist into the future.

Few market analysts use this approach in today's healthcare environment. Because developments outside of healthcare have had a significant effect on the demand for services and patterns of utilization, simply extrapolating from the past into the future is not practical. As a result, more sophisticated approaches to the **projection** of utilization were developed.

projection
The use of a statistical technique to calculate a future estimate.

Population-Based Model

The most significant factor in predicting demand is the size of the population. The number of people an organization serves has the greatest effect on demand. Because of the importance of population size, and because population projections are likely to be readily available and fairly reliable, approaches based on the population-based model have become the most common techniques for forecasting demand.

The simplest approach involves multiplying the projected population by known utilization rates. Thus, all population-based approaches depend on two components: (1) accurate and timely population estimates and projections and (2) accurate and timely utilization rates. This methodology seldom relies on total population figures for projection purposes, since utilization is influenced by so many other factors.

Changes in age distribution can have a major effect on utilization. Utilization patterns for males and females vary significantly and must be taken into consideration. To the extent that data are available, the population may be examined in terms of the influence of race and income on demand. In some cases, profiling the population by health insurance status may also be possible.

It is common to decompose the population into its age and sex components and apply rates specific to each subset (e.g., males aged 20–24). When data are available, projections may be refined based on race, income, insurance coverage, or some other factor. Federal agencies provide population estimates and projections as well as information on utilization rates. Commercial data vendors also provide population estimates and projections.

Projected utilization rates may be expressed in terms of hospital admissions or physician visits per 1,000 residents per year, patient days per 1,000 residents per year, live births per 1,000 women aged 15–44 per year, and so forth. These rates can be adjusted to account for regional differences when appropriate. Utilization rates can be applied to different age and sex categories and adjusted for other attributes to the extent that such information is available.

Although population-based models provide an intuitive, appealing approach, some caveats apply. The mobility of the population in contemporary America introduces uncertainty into the projection process. The cohort effect (e.g., the changing characteristics of an age group as it grows older) also plays a role in determining differential utilization patterns. It is no longer safe to assume, for example, that the utilization patterns of 65-year-olds today are the same as the patterns of 65-year-olds 20 years ago. Thus, applying an age-specific rate based on past experience to today's elderly may be risky.

Utilization rates are also subject to change, for a number of reasons. Many of these factors have already been discussed, including availability of services, financing arrangements, and level of managed care penetration. Who could have predicted, for example, the decline in hospital admissions that resulted from the introduction of the Medicare prospective payment system and the emergence of managed care in the 1980s? Likewise, the ACA has introduced a new paradigm. The frequency with which paradigm-changing developments occur makes predicting levels of utilization even more challenging.

Econometric Model

The econometric model comprises a variety of techniques for projecting future phenomena in complex situations. In its simplest form, the model is a type of time-series analysis, attempting to statistically improve on projections that extrapolate past trends into the future.

forecast
A form of projection that incorporates likely future developments into the calculations.

Econometric approaches use equations that project utilization as a function of the interplay of independent variables. With a complex phenomenon such as the utilization of health services, **forecasts** based on multiple factors make more sense than forecasts based on a single factor. Theoretically, the more factors that are used in predicting future utilization, the more accurate the prediction will be. Econometric prediction addresses these factors in a series of mathematical expressions. The equation ultimately used is the one that best "fits the curve" of historic demand.

For this complex form of econometrics to work, projections are needed for numerous independent variables in the equation. While many analysts have attempted to apply the econometric model to predicting demand, it has limited usefulness today because of the unpredictability and instability of the healthcare environment. Case study 7.1 presents an example of the use of lifestyle analysis to predict the use of behavioral health services.

Case Study 7.1
Using Lifestyle Analysis to Predict the Use of Behavioral Health Services

During the last quarter of the twentieth century, behavioral health services emerged as an important sector of the US healthcare system. This umbrella term covered many conditions, including psychiatric problems, emotional disturbances, substance abuse, hyperactivity in children, and other conditions considered treatable by mental health professionals. Behavioral health services were considered to be in a different category from the treatment of physical illness, and a separate industry developed for the management of behavioral health problems. Many health plans carved out behavioral health services, and, eventually, national managed care plans specializing in such services emerged.

By the late 1990s, the primary purchasers of behavioral health services—that is, major employers—were facing growing financial pressure because of increasing healthcare costs. Behavioral health services were particularly problematic because of the open-ended nature of many behavioral health conditions. At the same time, however, regulations that mandated parity between physical health coverage and behavioral health coverage were being enacted. Employers who wanted to offer behavioral health coverage to their employees were faced with a major cost-containment challenge.

ABC Health Services was a major player in the behavioral health arena, reporting an enrollment of more than three million members in its managed care plans. ABC was faced with the same issue other behavioral health plans had to address: customers who could not distinguish between plans and were shopping for the lowest price. As a result, ABC was losing clients to other, sometimes less efficacious plans that quoted lower prices.

In response to this situation, ABC developed an innovative approach to the market using lifestyle segmentation analysis. On the basis of records maintained on enrollees who participated in its behavioral health plans, ABC believed the likelihood of using behavioral health services could be linked to certain lifestyle categories among employees. ABC also thought that the type and intensity of services used could be correlated with lifestyle cluster.

ABC subsequently profiled existing clients in terms of its Mosaic lifestyle clusters (see exhibit 7.4). It found that approximately a dozen lifestyle clusters (of the 60 Mosaic clusters at that time) were associated with a high propensity to use behavioral health services. Another ten lifestyle clusters

(continued)

were almost never associated with the use of these services. The remaining clusters did not appear to correlate with use or nonuse.

The cluster populated by middle-class suburban families tended to be characterized by high utilization levels, whereas the cluster populated by low-income rural families was characterized by low utilization levels. Furthermore, the older, affluent suburban household cluster had a high propensity for using alcohol abuse services but not drug abuse services. On the other hand, the single, affluent, urban, high-rise cluster had a high propensity to use drug abuse services but not alcohol treatment services. Some clusters were characterized by episodic use of services (e.g., in response to some stressful event), while members of other clusters were characterized by recurrent use of services, indicating deeper problems.

ABC was able to use this information in marketing its behavioral health plan to existing customers and prospective clients. ABC representatives offered to profile the employees of existing customers, for example, to determine the extent to which the package of services offered by ABC was meeting their employees' needs. Profiling not only allowed ABC to more efficiently serve the existing client population but also helped the organization to predict future use of behavioral health services. The service mix could be subsequently adjusted to serve existing enrollees more efficiently and more cost-effectively.

To attract prospective clients, ABC distinguished itself from other behavioral health plans by determining a configuration of needs for the target group of employees. By serving in a consultative role, ABC demonstrated greater expertise than its competitors in managing behavioral health clients. Further, ABC could offer a package of services tailored to the needs of its clients, rather than the one-size-fits-all plans offered by other firms. By developing an in-depth knowledge of the target population using lifestyle segmentation analysis, ABC was able to provide more effective services at competitive prices while raising the satisfaction level of employers and employees.

Case Study Discussion Questions

1. What is the conventional wisdom regarding the distribution of mental health problems in the population? Is it surprising to find that mental health problems are concentrated in different segments of the population?
2. What are the implications of this irregular distribution for marketing?

3. Which sensitivities surrounding the marketing of mental health services should the marketer be aware of?

4. Does the fact that hospitals often lose money on mental health patients mean they should not market to the affected population?

5. Is this health problem one for which healthcare organizations might find social media marketing useful?

Summary

Determining demand in healthcare is a complex task that requires marketers to develop an understanding of the many factors that influence the ultimate utilization of health services. From a marketing perspective, demand can be conceptualized as the result of the combined effect of (1) healthcare needs, (2) healthcare wants, (3) recommended standards of care, and (4) utilization patterns.

The demand for health services is surprisingly elastic. A number of factors influence the level of demand, including population characteristics (e.g., demographics, psychographics, and social group affiliation) and structural factors (e.g., availability of and access to health personnel and health facilities; financial arrangements, especially the availability of insurance; technological resources; physician practice patterns). Some of the factors that contribute to demand have been affected by provisions of the ACA.

A variety of indicators can be used to measure utilization rates. For hospitals, these indicators include use rates for admissions, patient days, and length of stay. Other indicators include use rates for physician office visits, procedures performed, and drugs prescribed. The utilization indicators chosen depend on the type of organization and the product being marketed. In healthcare, increased volume is not always desirable, and marketers must have enough knowledge about the organization's operations to know which services to promote and which to avoid.

Information on the demand for a service is typically unavailable, so marketers must develop ways to determine potential demand. Similarly, data on utilization rates for different types of services may not be readily available. Marketers must also be able to generate estimates and projections of the demand for services and likely utilization rates to develop an effective marketing plan. A number of methodologies are available for this purpose, including population-based and econometric models.

Key Points

- The demand for health services reflects the combined effect of healthcare needs, wants, recommended standards, and utilization patterns.
- Because demand is hard to quantify, the level of utilization is often used as a proxy for demand.
- The amount of sickness in a population influences demand but may be less important in determining demand than other factors.
- Because of the many factors influencing utilization, demand in the United States is relatively elastic.
- Frequently, a mismatch exists between service demand and actual service utilization; some needs go unmet, while some services are overutilized.
- Besides biological factors, demand is influenced by psychological, demographic, sociocultural, and economic factors.
- Psychographic (or lifestyle) attributes may exert significant influence on demand by affecting health status and health behavior.
- In healthcare, demand can be created where it did not previously exist by introducing new procedures or drugs, modifying diagnostic criteria, or identifying new health problems.
- Extrinsic factors—such as availability of services, technological developments, physician practice patterns, and insurance reimbursement rates—also influence the demand for health services.
- A variety of indicators can be used to measure utilization, including use rates for hospitals, physicians, other practitioners, and pharmaceuticals.
- Health services researchers have developed a variety of techniques for predicting utilization, including population-based and econometric models.

Discussion Questions

1. Why is demand in healthcare a complicated issue, and what are some components that might contribute to the level of demand?
2. What is the difference between healthcare needs and healthcare wants, and to what extent do the two overlap?
3. Why is the correlation between demand and utilization imperfect?
4. What are some demographic factors that influence demand?
5. What role do psychographic or lifestyle factors play in influencing demand?

6. Why may the mere presence of health services increase demand?

7. Can demand for health services be created?

8. What is the role of health insurance in determining demand?

9. Why do patterns of utilization vary widely from community to community when the communities generally share the same characteristics?

Additional Resources

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Sekhri, N., R. Chisholm, A. Longhi, P. Evans, M. Rilling, E. Wilson, and Y. Madrid. 2006. "Principles for Forecasting Demand for Global Health Products." Published September. https://pdfs.semanticscholar.org/62fd/bc205 c561c9f53eb98e03a27ec3eb28c9ad8.pdf.

III

HEALTHCARE MARKETING TECHNIQUES

Because marketing in healthcare encompasses a wider range of activities than marketing in most other industries, the topic is covered in the broadest possible sense in this book. Part III begins with a review of developments that provide the context for healthcare marketing in the twenty-first century. This is followed by an introduction to health strategy development, then by chapters on the marketing techniques used in healthcare and on the growing significance of social media for healthcare marketing.

THE CHANGING ENVIRONMENT FOR HEALTHCARE MARKETING

As the US population has changed, the American healthcare system has undergone a major transformation of its own. Both of these developments have had major implications for healthcare marketing. The primary goals of the US healthcare system are to manage illness and advance the health status of the population. Some believe, however, that the healthcare system was diverted from these goals as the profit motive increasingly influenced the course of American medicine. In fact, some argue that the needs of the patient became subordinated to the needs of the healthcare system.

These developments unfolded over many decades in the context of a changing society. The convergence of a number of trends created a dynamic and unprecedented situation. Developments inside and outside healthcare have prompted a reconsideration of a number of aspects of our healthcare system.

The Medical Model of Health

The impetus for the ascendancy of Western medicine was the adoption of germ theory as the basis for modern medicine. The adoption of this theory led to the establishment of what became known as the *medical model* of health and illness, which was the traditional paradigm of Western medicine for much of the twentieth century. The medical model emphasized the existence of clearly identifiable clinical symptoms, reflecting the conviction that illness represented the presence of biological pathology. The medical model assumed that illness could be reduced to disordered bodily (biochemical or neurophysiological) functions, and it failed to account for any social, psychological, and behavior dimensions of illness (Engel 1977). As a result, disease was located within the individual body, without considering any external factors such as the effect of the individual's social or emotional life or the characteristics of the individual's community on physical health.

Proponents of the medical model deliberately discarded most previous models of ill health. "Bedside manner," an important practice for traditional healers and one of the few tools available to early twentieth-century physicians, was eschewed in favor of efficient, impersonal patient management.

Natural remedies that had been used for centuries (and later became the basis for many prescription and over-the-counter drugs) were derided as "home remedies," if not outright quackery. The contributions of patients and their social support networks to the therapeutic process—another important resource for traditional healers—were also discounted.

As for-profit insurance companies became dominant in the healthcare industry, the aims of the system shifted. Health insurers were less concerned with the needs of their plan members than with the needs of their shareholders. The involvement of insurers in healthcare increased the cost of care by diverting resources away from patient care to administrative activities. This focus on profits over people, together with the growing political influence of the powerful insurance industry, led to a wide range of abuses that went unaddressed. This situation ultimately influenced the enactment of the Affordable Care Act (ACA) of 2010, which contained provisions intended to address the worst of the abuses on the part of the insurance industry. Health insurers were firmly entrenched as intermediaries between patients and the healthcare system. For better or worse, the ACA ensured that this role would continue.

The last quarter of the twentieth century also saw the emergence of the pharmaceutical industry as a major force in healthcare. The private pharmaceutical industry became a major player on the healthcare scene. Success in the creation of vaccines and lifesaving drugs gave the pharmaceutical industry a level of credibility that is now considered unwarranted. By the beginning of the twenty-first century, drug therapy was the fastest-growing component of healthcare delivery, and pharmaeutical companies were among the most profitable of American industries.

Americans increasingly turned to healthcare institutions in the late twentieth century, despite their obvious deficiencies, to solve a wide range of social, psychological, and even spiritual concerns. Physicians came to be regarded as experts on almost any human problem. This expansion of scope is evidenced by the fact that less than half the people in a primary care practitioner's waiting room suffer from a clear-cut medical problem. Rather, they are there because of emotional disorders, sexual dysfunction, social adjustment issues, obesity, or other conditions unrelated to biological pathology. Even though physicians generally are not trained to deal with these conditions, the healthcare system has come to be seen as an appropriate place to seek solutions to these and other nonmedical maladies.

The impact of care became diluted as competing interests shifted the emphasis in healthcare away from patient care. These factors led to the reallocation of resources as healthcare organizations focused on specialty care rather than primary care, extensive diagnostic techniques, and expensive but not necessarily more effective treatments.

The medical model, despite its flaws, was effective at addressing many health problems during the twentieth century. Indeed, the health status of the US population improved steadily over the course of the century. Using 1900 as a convenient starting point, it is possible to trace a continuous decline in mortality, an increase in life expectancy, the reduction or elimination of many communicable diseases that were the major causes of death at the beginning of the twentieth century, and an overall improvement in health status based on both objective and subjective measures. Americans reported lower mortality rates overall and higher levels of health. Over the course of the twentieth century, Americans became generally healthier.

In this context, marketing emerged as a core function in healthcare organizations. Marketers were tasked with the promotion of their organizations and products, with little thought to the nature of the care being given or the appropriateness of the services provided. Marketers were playing the game by the rules as written and contributed to the movement toward a more profit-oriented system.

An Evolving Environment

The growth of the US population during the postwar period was accompanied by the development of the American healthcare system. The "golden age" of American medicine beginning in the 1960s witnessed an expansion of the healthcare institution in every conceivable way. Lifesaving drugs supplemented the vaccines that had been introduced in earlier years, and the medical experience that physicians had gained during World War II allowed the introduction of advanced surgical techniques to general hospitals. The scope of medical care expanded dramatically as new procedures and new technologies allowed clinicians to treat a range of problems—problems that extended beyond routinely treated illnesses to conditions historically thought to be beyond the purview of medical doctors.

For several decades after World War II, there was a comfortable fit between the US healthcare system and the needs of the population it served. The healthcare system practiced what could best be described as "white middle-class medicine," with increasingly standardized protocols for ensuring consistent quality of care. Health insurance became widespread, and there was a cozy relationship between health service providers and the health insurance industry. The health status of the US population steadily improved, and much of the credit went to the healthcare system. In fact, public health measures were responsible for much of the improvement in health status during this time, although they were seldom accorded the same accolades as feats of "heroic" medicine.

While this one-size-fits-all healthcare system was effective at responding to the healthcare needs of the majority of the population, many minority groups were excluded from the advances of modern medicine. African Americans, in particular, were often excluded from the modern healthcare system—either deliberately early on or de facto during later years. Those with limited ability to pay for services were also excluded from the healthcare system or diverted to public services that were often inferior. The healthcare marketing enterprise was established against this backdrop—an environment showcasing the white, middle-class population to which marketers catered.

By the turn of the twenty-first century, the characteristics of the US population had changed dramatically. The diversification of the population was reflected not only in the changing racial and ethnic composition but also in household structures and lifestyles. The audience for healthcare marketing became an increasingly moving target.

Changing Patient Characteristics

The demographic trends that played out over the last quarter of the twentieth century dramatically reshaped the patient population in the United States, with major consequences for healthcare marketing. By the second decade of the twenty-first century, seniors accounted for nearly one-third of patients, and the children who had been ubiquitous in physicians' offices 20 years earlier now represented a declining proportion of the patient population. The proportion of the US population that is non-Hispanic white had shrunk considerably, and a majority of school-aged children were now from minority populations. While the greatest increase has been recorded for the Hispanic population, the proportion of citizens from all nonwhite racial and ethnic groups has increased dramatically, bringing considerable diversity to physician waiting rooms. Women continue to outnumber men (by more than six million), meaning that the majority of patients are female.

Notably, the proportion of adults who are married has declined dramatically since the baby boom generation. Not only are fewer people marrying, but those who do are having fewer children. Thus, fewer patients live in traditional nuclear families or are even part of a family household. Nevertheless, the healthcare system still operates on the assumption that people live in families—and are covered by family health insurance plans—and that patients have household support to assist with their healthcare needs.

The Epidemiologic Transition

The epidemiologic transition—that is, the process by which acute conditions were displaced by chronic disorders—has played a major role in changing patient characteristics. As acute conditions waned in importance and chronic and degenerative conditions became more prevalent, the medical

model became less salient. Once the cause of most health conditions ceased to be environmental microorganisms and became aspects of lifestyle, a new model of health and illness was required. The chronic conditions that once accounted for most health problems did not respond well to the treatment and cure approach advocated by the medical model. Chronic conditions could not be cured but rather had to be managed over a lifetime, and this called for a different approach. Exhibit 8.1 traces the epidemiologic transition that occurred over the course of the twentieth century.

EXHIBIT 8.1
The Epidemiologic Transition

During the twentieth century, the United States, as well as most other developed countries, experienced an *epidemiologic transition*. This transition involved a shift from a predominance of acute conditions to a predominance of chronic conditions in the population. This phenomenon was primarily a consequence of two factors: The first was a demographic transition early in the twentieth century, as the aging of the US population caused a dramatic change in the types of health conditions affecting Americans—driving increases in the prevalence of high blood pressure, diabetes, respiratory conditions, and arthritis, among other conditions. The second was advances in the ability to manage health problems, as the introduction of public health measures and advances in clinical medicine eliminated certain acute health conditions at the same time that chronic conditions became more prevalent.

Acute conditions typically result from pathogens in the environment or from accidents, whereas chronic diseases are characterized by a much more complex etiology. Acute conditions affect a cross-section of the population, sometimes seemingly at random, but chronic diseases are typically more concentrated among certain population segments. In the twentieth century, emergent chronic diseases reflected the combined effect of heredity, environment, lifestyle, and access to healthcare. As a result, demographically related disparities in health status became common.

Prior to the epidemiologic transition, the most common health conditions were respiratory conditions, gastrointestinal conditions, infectious and parasitic diseases, and injuries. Even today, in traditional societies and in populations with a younger age structure, cholera, yellow fever, skin diseases, nutritional deficiencies, and similar acute conditions are common. In the wake of the epidemiologic transition, populations in developed countries and those with older populations are more likely to be affected by heart disease, cancer, diabetes, arthritis, chronic respiratory

(continued)

EXHIBIT 8.1
The
Epidemiologic
Transition
(continued)

diseases, and similar chronic conditions. As a practical matter, most members of traditional societies did not live long enough to contract chronic conditions; when they did, these conditions could not be managed and likely caused early death.

The focus in medical science did not begin to shift away from acute conditions to chronic conditions until the epidemiologic transition was well underway. This shift has presented new challenges for the US healthcare system because of the complex etiology of chronic disease, its unpredictable progression, and its management challenges. Physicians are now paying more attention to disease etiology (and, as a consequence, disease prevention), disease progression and management, and especially the demographic disparities associated with chronic disease. For those involved in the provision of care and others concerned about the population's morbidity profile, the epidemiologic transition has been momentous, creating an environment that was conducive to a new paradigm—the population health model.

The Shift from Patients to Consumers

The changing patient profile has been accompanied by the transformation of *patients* into *consumers*. By the end of the twentieth century, few health professionals were using the term *patient* because of its narrow connotation. Patients came to be referred to as *clients*, *customers*, *consumers*, or *enrollees*—all of which had different characteristics than patients. While the term *patient* implies a dependent, submissive status, the other terms connote a more proactive involvement in the therapeutic process.

The new healthcare consumer was more knowledgeable about the healthcare system, more open to innovative approaches, and more intent on playing an active role in the diagnostic, therapeutic, and health maintenance processes. As a result, patients today are no longer passive recipients of healthcare but take an active role in the management of their health. These new attitudes were fostered by members of the baby boom generation (and, in turn, by generation Xers and millennials), who have been influential in downplaying the importance of physicians and hospitals and providing the impetus for the rise of alternative therapy as a competitor to mainstream allopathic medicine. Baby boomers favor a patient-centered approach to healthcare and are more likely to recognize the nonmedical influences on health and illness.

The Need for Cultural Competency

These changing patient characteristics have had important implications for the operation of the healthcare system and for the marketing of health

services. Healthcare providers now realize that children are different from adults, men are different from women, whites are different from nonwhites, the affluent are different from low-income individuals, and so forth. For this reason, the one-size-fits-all healthcare system has become a thing of the past. Today, adult medicine (particularly older adult care) has become more important than pediatric care. Geriatric medicine has become a distinct specialty, and the healthcare system has expanded to encompass long-term care, home healthcare, and end-of-life care. Much of the emphasis in female healthcare has shifted from obstetrics to gynecology, and "men's health" has emerged as a specialty area. *Cultural competency* has become a buzzword as the healthcare system works to meet the needs of an increasingly diverse American population.

The increased diversity of healthcare consumers has brought attention to significant **health disparities** among segments of the population. Researchers have documented that members of racial and ethnic minority groups often suffer from more health problems, lack access to care, and, when they receive care, are often treated inappropriately. Pursuing "business as usual" runs the risk not only of alienating a large segment of the patient population but of delivering ineffective care when ethnic perspectives are not taken into consideration. The failure of the healthcare system to accommodate the needs of a diverse patient population contributed to the emergence of the population health model.

health disparity
Observed difference in health status or behavior between various groups in society.

Changing Disease Etiology

The epidemiologic transition was accompanied by a significant change in the conception of disease causation, or **etiology**. The major causes of death a century ago (and throughout human history) could almost invariably be attributed to a single factor. Today, however, physicians understand that diseases result from the interaction of a variety of factors, made possible by long lives that allow prolonged exposure to carcinogens and pollutants and the emergence of chronic and degenerative conditions. The contemporary approach to etiology argues for a more complex view of disease causation, one that considers interdependence of biological and nonbiological factors.

etiology
In epidemiology, the cause or causes of an identified disease.

The Role of Lifestyle

The epidemiologic transition was accompanied—and, to a great extent, driven—by the changing lifestyles of the US population. Although the population was aging, it was also experiencing a shift in its lifestyle characteristics. Perhaps no other societal trend has had as much influence on the search for a new health paradigm as changes in the way Americans live. The term *lifestyle* refers to a pattern of behavior or way of life characterizing a

population. (References can also be made to an individual's lifestyle, but group patterns of living are of interest in this analysis.) A lifestyle typically encompasses the attitudes, values, and worldview of members of a particular group as well as the behavior patterns that reflect these characteristics. A group's lifestyle provides a means of forging a sense of self for group members and includes cultural symbols that resonate with personal identity. While individual lifestyles are sometimes considered voluntary, members of groups tend to have their attitudes and behaviors shaped and even constrained by group norms.

disease of civilization
A health condition that is thought to be a product of the conditions of modern society.

The diseases that have become dominant in the US population in the twenty-first century are increasingly referred to as **diseases of civilization**, reflecting the notion that our lifestyles are contributing to our health problems. These diseases tend to become more prevalent as countries become more industrialized and as more people live to old age. Chronic conditions of this type are attributable to the combined effects of a lifetime of stress and wear and tear and of unhealthy lifestyles. Diseases of civilization include conditions such as Alzheimer's disease, atherosclerosis, asthma, cancer, chronic liver disease and cirrhosis, chronic obstructive pulmonary disease, type 2 diabetes, heart disease, metabolic syndrome, Crohn's disease, nephritis and chronic renal failure, osteoporosis, stroke, depression, obesity, and sexually transmitted infections.

The impact of lifestyle becomes evident when the health status of immigrants is tracked. As new immigrants spend more time in the United States, their health status declines as they adopt an American lifestyle. As second- and third-generation immigrants become increasingly vested in the American way of life, they develop morbidity patterns comparable to those of the native-born population.

The growing importance of lifestyle as a determinant of health status illustrates the extent to which the etiology of disease has changed as a result of the epidemiologic transition. Throughout much of the twentieth century, individuals were thought to be "innocent bystanders" when it came to disease causation. After all, physicians believed, biological pathogens in the environment were responsible for most health problems. Exposure to communicable disease was haphazard, and disease distribution in the population was regarded as random.

The recognition of the role of lifestyle has had significant implications for the marketing of health services and contributed to the acceptance and expansion of healthcare marketing in the late twentieth century. This reconceptualization of the end user of health services as a consumer implies much greater volition on the part of the individual—the consumer as decision maker. This development has limited the discretion of healthcare

providers (and particularly physicians) with regard to decision-making. Consumers demand more information than patients, and the internet is happy to oblige—healthcare websites are among the most visited sites on the internet. Marketing directly to consumers has represented a major shift in strategy for many healthcare organizations.

These developments all contributed to a transformation of the role of the healthcare marketer. At the turn of the twenty-first century, marketers were forced to take a more expansive view of their responsibilities. They were faced with a much more diverse audience with ever-changing needs, including many nontraditional patients who had different perspectives on health and healthcare and responded differently to promotional materials.

The Shift from Medical Care to Healthcare

It is helpful at this point to distinguish between medical care and healthcare. *Medical care* is defined narrowly in terms of the formal services provided by the healthcare system and refers primarily to those functions of the healthcare system that are under the direction of medical doctors. This concept focuses on the clinical or treatment aspects of care and excludes the nonmedical aspects of healthcare. *Healthcare* refers more broadly to any function that might be directly or indirectly related to preserving, maintaining, or enhancing health status. This concept includes not only formal activities (e.g., visiting a health professional) but also informal activities such as preventive care (e.g., brushing teeth), exercise, proper diet, and so forth.

The decades since the 1970s have seen a steady movement of activities and emphasis away from medical care and toward healthcare. Despite the ever-increasing sophistication of medical technology, the nonmedical aspects of care have become increasingly important. The growing awareness of the connection between health status and lifestyle and the realization that medical care is limited in its ability to control the disorders of modern society have prompted a shift from a strictly medical model of health and illness to one that incorporates a social and psychological perspective (Engel 1977).

A number of factors have contributed directly or indirectly to this shift in orientation. Clearly, the epidemiologic transition played a major role. Independent of this trend, many patients have become increasingly dissatisfied with the operation of the healthcare system. Further, the rising costs of healthcare have led observers to question the wisdom of pursuing a one-size-fits-all approach to healthcare.

Demographic factors have played no small role in this process. The baby boom generation has been particularly influential in changing the orientation of healthcare. More than any other population, baby boomers have

led the movement toward a value reorientation in healthcare by emphasizing convenience, value, responsiveness, patient participation, accountability, and other attributes not traditionally found in the US system of healthcare delivery. This cohort has also been instrumental in the emergence of urgent care centers, freestanding surgery facilities, and health maintenance organizations as standard features of the healthcare system.

Despite this shift in orientation, the allocation of resources in healthcare remains unbalanced. Treatment still commands the lion's share of healthcare expenditures, and most research is still focused on developing cures for diseases rather than identifying preventive measures. The hospital remains the focal point of the healthcare system, and the physician is its primary gatekeeper. Nevertheless, these traditional components of medical care were substantially weakened during the 1980s, and a definitive shift toward a healthcare orientation became evident during the 1990s. By that time, references to medical care in the press—both public and professional—had become fewer, as references to healthcare came to dominate. As those financing care become more convinced of the value of health measures over medical measures, this trend can be expected to continue.

The Role of Marketing

Some question whether healthcare marketing has contributed to the lack of progress in improving community health. Although marketers have been active—intentionally or not—in promoting the paradigm shift from medical care to healthcare, they may have inadvertently contributed to the healthcare system's failure to achieve its primary goals by encouraging the overutilization of healthcare resources. While it is hard to determine the "right" amount of utilization, healthcare marketers have typically been concerned with generating more volume, without much consideration of other factors or the ramifications of their promotional efforts. Thus, some contend that the US population is overtested and overtreated—efforts that may not contribute to improved patient care or community health status and may actually cause harm in the form of overly aggressive or incorrect diagnoses or unnecessary treatments. Exhibit 8.2 discusses the relationship between health services utilization and health status.

Marketers might also be accused of promoting high-end and complex (read: expensive) services rather than more appropriate and less expensive treatments. Healthcare administrators face pressure to generate as much revenue as possible and to prevent expensive equipment from remaining idle. In fairness, this criticism cannot be laid on marketers, who are primarily carrying out the wishes of their managers.

EXHIBIT 8.2
Does More Care
Mean Better
Health?

The US healthcare system historically operated on the assumption that more care means better health and that the health status of the population can be improved simply by providing greater access to health services. This approach has been applied at the individual patient level as well, as physicians traditionally preferred overtreatment to undertreatment. The potential harm from therapeutic "overkill" was considered preferable to the perceived danger of limiting diagnosis and treatment. Today, however, some doubt the benefits of incremental "doses" of care, while others regard overdiagnosis and overtreatment as health threats in their own right.

The United States has seen a steady increase in the expenditure of resources on healthcare. One of the most straightforward measures of resource allocation is per capita expenditures. According to the American Medical Association (2019), per capita expenditures on health services almost doubled between 1990 and 2000, and then almost doubled again between 2000 and 2010. Per capita spending on healthcare increased from around $5,000 in 2000 to nearly $11,000 in 2017. While there is some evidence that the rate of increase in healthcare costs has slowed, an increase of 21 percent was recorded between 2010 and 2017 (from $2.8 trillion to $3.4 trillion).

Researchers have found that enrollment in the Medicaid program in the United States led to increased access to services as well as greater utilization of services. Compared with uninsured adults, adults covered by Medicaid were 25 percent more likely to report they were in good to excellent health (versus fair to poor health), 40 percent less likely to report health declines in the past six months, and 10 percent more likely to screen negative for depression. In addition, access to Medicaid markedly improved adults' mental health. However, Medicaid's impact on physical health was not conclusive. Multiple factors may mitigate the impact of coverage on clinical outcomes, including unmeasured barriers to access, missed diagnoses, inappropriate medication, patient noncompliance, and ineffectiveness of treatments (Paradise and Garfield 2013).

A study conducted in Canada found that lower-income populations used more healthcare services than their counterparts with higher levels of income and education (Cooper 2016). However, their clinical outcomes appeared to worsen over time, leading patients to record more primary healthcare visits. Overall, patients' use of health services had little cumulative explanatory impact on the association between mortality and socioeconomic status. The greater use of services by disadvantaged patients simply reflected their worse health status and did not make up for

(continued)

EXHIBIT 8.2
Does More
Care Mean
Better Health?
(continued)

the effects of their lower socioeconomic status. A review of the relationship between amount of care received and health status suggests that access to health services alone cannot eliminate historical health and social disparities (Alter et al. 2011).

This relationship can be examined more broadly using the one consistent measure of health status that is available over time—self-reported health status. Per capita healthcare expenditures have been increasing since the 1950s. Looking at self-reported health status for this period, however, the improvement in health status is not commensurate with the growth in expenditures. In fact, since 2010, there appears to have been no improvement—and perhaps even some decline—in self-reported health status for the US population overall. According to the Behavioral Risk Factor Surveillance System, a series of health-related telephone surveys conducted by the Centers for Disease Control and Prevention, the share of the population reporting poor or fair health increased from 8.9 percent in 2000 to 10.1 percent in 2010 and remained stable at this higher rate through 2014. Therefore, the claim that the population's health status improved over this period is not clear-cut.

Epidemiologists contend that the health status of the US population is actually *declining* (Thomas 2016). Although no definitive measure of health status exists, evidence indicates that, at the very least, the trend toward improved health status observed during the twentieth century has stagnated and, on some measures, has been reversed despite greater utilization of health services. This finding provides additional support for the argument that more care is not necessarily correlated with improved health status.

Sources: Alter et al. (2011); Cooper (2016); Thomas (2016).

Marketers could also be charged with promoting misplaced priorities—again at the behest of healthcare administrators. Despite the proven benefits of prevention and efforts to address health problems "upstream," most marketing efforts are directed toward encouraging consumers to seek treatment for existing conditions. Today, we realize that those efforts reflect the emphasis on quantity rather than quality and the historical emphasis of payment based on volume.

Finally, some argue that a broad-based approach to marketing that casts a wide net risks promoting the wrong services to the wrong consumers. Despite the emergence of target marketing, with its more specific targeting methodologies, marketers still tend to promote services to audiences that may not benefit from the services or may actually be harmed by them. This

danger is obvious in the aggressive marketing to consumers on the part of pharmaceutical companies, which have convinced consumers they have health problems that they did not know they had and demand unnecessary prescriptions from their physicians.

The Failure of the Healthcare Paradigm

While the emergence of the healthcare paradigm bolstered the marketing function, it was not successful at achieving one of the healthcare system's primary goals—population health improvement. The shift from medical care to healthcare that began during the late twentieth century was aimed at addressing many of the issues plaguing the US healthcare system. The healthcare paradigm recognized the significance of changes in the health problems affecting the US population and therefore encouraged a holistic approach to improving the effectiveness of care while emphasizing prevention and positive lifestyle choices.

With regard to the goal of community health improvement, however, the healthcare paradigm was not much of an improvement over the medical model. Emphasis remained on the individual patient rather than the community. While recognizing that patients have different characteristics than they did in the past, and thus should be treated differently, the healthcare paradigm still attempted to address health problems one patient at a time. The failure of this approach soon became evident: After a century of improvement, the health status of the US population began to decline. As early as the 1980s and 1990s, some observers pointed to signs that the trend of continuously improving health was at risk of stalling.

Further, many have argued that the healthcare system itself has played a role in the failure to improve the health of the population and may even have contributed to the deterioration of Americans' health status. The system's sins of omission—for example, the failure to provide access to care for large segments of the population—have contributed to poor community health. Similarly, the system's sins of commission—such as misdiagnoses and hospital treatment errors—have contributed to the declining health status of the US population. In fact, research shows that the healthcare system is now the third-leading cause of death after heart disease and cancer (Sipherd 2018).

One reason the healthcare paradigm has failed to improve population health is that it continues to treat health conditions rather than the root causes of those problems. It has become increasingly clear that most health problems represent *symptoms* of some deeper issue. Researchers have found that individuals do not define health problems the same way that health

professionals do. When clearly sick populations are surveyed about their health status, they often conceptualize health and illness differently from those performing the survey. The public may point to a different set of health problems from those conventionally identified by health professionals, classifying nonmedical problems as medical problems—citing poverty, lack of housing, and a lack of access to healthy food or open space.

The conclusion that emerges from these realizations is that the US healthcare system—really, any healthcare system—is not up to the task of improving population health in today's environment. This can be demonstrated in a number of ways. The emphasis of healthcare remains on treatment and cure rather than prevention, maintenance, and enhancement of health. The focus on acute conditions lingers, despite the predominance of chronic conditions. In considering the reasons people present themselves for treatment, we find a mismatch between the skills of the practitioner and the problems brought by the patients. Perhaps less than half of patients present with a physical health problem; large numbers exhibit emotional, psychological, addiction, or dietary or nutritional problems or some other nonmedical concern.

At the same time, society's health problems are driven by factors outside the purview of the healthcare system. These forces—which have become apparent to health professionals—affect groups of people as much as individuals. Poverty does not affect individuals one at a time, nor does a toxic environment. The extreme health disparities that have been observed do not reflect individual morbidity but unfavorable health status at the group level.

The inescapable conclusion is that the approach taken by the US healthcare system, emphasizing the treatment of one patient at a time, is not an effective model in the face of current health problems. While the shift in emphasis from medical care to healthcare improved the management of patients, it still focused on individual patients, albeit in a different way. Another paradigm shift is needed to focus on populations rather than individuals. These populations may be groups of consumers, plan members, or employees—and even groups of patients—who are assessed and managed in terms of their group attributes.

Under provisions of the ACA, not-for-profit hospitals must develop strategies and tactics to address the needs of the entire service area population, not just their current patients. The emphasis on better access to care, improved quality of care, and cost-effectiveness requires healthcare providers to gain an in-depth understanding of not only their existing patients but all healthcare consumers. Reimbursement models that emphasize pay for performance reinforce this emphasis by rewarding providers based on their impact on groups of patients or consumers and not individual success stories. Providers with capitated patient populations are similarly rewarded based on the health status of an entire panel rather than any individual outcomes.

The Population Health Paradigm

In the face of the failure of the healthcare paradigm to solve our healthcare problems, the concept of *population health* has gained popularity among health professionals, policy analysts, and government agencies. This approach assesses health from the perspective of an entire population rather than individual patients; therefore, it represents an opportunity to develop a better understanding of the health status of populations—regardless of whether they are patients—and innovative approaches to improving population health status.

The term *population health* has been used in many different ways. Healthcare providers describe using a population health approach to more efficiently manage their patients; consultants have rebranded themselves as "population health experts" to capitalize on this trend; and vendors claim to be able to support their clients' population health needs.

Deprez and Thomas (2017) attempted to clarify the concept of population health by developing a more useful definition. They view population health as having two dimensions. First, *population health* refers to the totality of a population's health and well-being, as measured by population-based measures such as housing stability, food security, and personal safety, taking into account both medical and nonmedical factors.

Second, *population health* refers to an approach to improving health status that operates at the population level rather than the individual (or patient) level. This approach focuses on social pathology rather than biological pathology and involves the "treatment" of conditions in the environment and policy realms in addition to the provision of clinical services to individual patients. It seeks to address the root causes of ill health and structural impediments to good health rather than focusing exclusively on treating the symptoms and conditions of individuals. While a population health approach aims to improve health status by focusing on the healthcare needs and resources of populations, not individuals, it does not rule out specific patient-based medical treatment but views healthcare as one component of a health improvement initiative.

The application of the population health model, or *population health management*, can be explored at two levels: a micro-level view that considers population health as it relates to the delivery of care and a macro-level view that considers population health from a societal perspective. At the micro level, one approach is to identify individuals who are at high risk of a disease or condition and to intervene to reduce their risk. At the macro level, the population health approach might involve reducing the average risk level for the entire population through initiatives or policies addressing the social determinants of health.

Intervening with individuals who are at high risk is generally the domain of clinical medicine, although public health authorities often coordinate certain clinically implemented programs to achieve population health objectives. Some programs such as breast cancer screening and childhood vaccinations involve individual encounters but have population-level objectives. Some initiatives targeting individuals at the micro level will have macro level implications, while others will not.

Attributes of the Population Health Model

The following attributes characterize the population health approach. Each attribute has implications for healthcare marketing.

- **Recognition of the social determinants of health problems.** Social factors are powerful determinants of health status and health services utilization, accounting for 40 percent to 60 percent of the variation in health status among subgroups of the population. The population health model emphasizes understanding the social determinants of health and recognizing the importance of social pathology over biological pathology. If social factors are considered the root cause of observed health problems, health improvement initiatives should take these factors into consideration.

- **Focus on populations (or subpopulations) rather than individuals.** Application of the population health model involves measuring the health status of the total population rather than simply assessing the clinical readings (e.g., reduction of A1C, blood pressure) of individual patients. As regulators, payers, and other evaluators increasingly reward healthcare providers for their effectiveness at managing groups of patients, consumers, or plan members, the social contexts of those targeted populations become more important.

- **Focus on consumers rather than patients.** Once the healthcare industry was introduced to marketing in the 1980s, it was inevitable that patients would come to be seen as consumers. This trend was already underway among baby boomers, who wanted the benefits of quality care as patients coupled with the efficiency, convenience, and value that they had come to expect as consumers. This shift represented a significant conceptual leap for healthcare providers and signaled the future direction of the healthcare industry and the emergence of a population health model.

- **Recognition of geography as a strong predictor of health services use.** Geography is now recognized as an important contributor to health and ill health. One of the most significant findings from decades of health services research is that the utilization of health services varies

significantly by geography. Where an individual lives is a powerful determinant of the kind and amount of medical care received. Rates for procedures may vary widely, reflecting factors such as local physician practice patterns, insurance coverage, availability of services, and consumer lifestyles. Research has shown that an individual's zip code of residence is the best predictor of health status and, by extension, health behavior (Roeder 2014). Exhibit 8.3 discusses the role of geography in influencing health status.

- **Measurement of health status at the community level.** A community-based (participatory) understanding of critical health issues is a key feature of population health. While some argue that community health status represents the sum of the health status of the individuals in the community, the population health model posits the existence of a state of health that is independent of the health of the individuals who make up the population. This view would explain why certain communities exhibit persistent health problems over time regardless of who resides there. Even personal lifestyles are thought to reflect the influence of the social groups with which the individuals are affiliated.

- **Acceptance of the limited role of medical care.** Although the cost of healthcare to consumers influences the amount of care that is consumed, there is no evidence that more care translates into better health. Indeed, a premise of the population health model is that health services make a limited contribution to the overall health status of a population. Even as the US population consumes increasingly more healthcare resources per capita, overall health status is not improving and may, in fact, be declining.

- **Emphasis on changes in health behavior at the group level.** According to the population health model, health status and health behaviors are not the result of individual volition but reflect the impact of an individual's sociocultural context and life circumstances. The model recognizes that improvement in personal health status must be addressed in the context of the social or community environment (i.e., the root causes of health problems) so as to leverage group pressure for health improvement.

- **Emphasis on new ways of measuring health status.** Health status has historically been measured using biomedical indicators, which have the most relevance for health professionals. However, any assessment of health status should reflect the perspectives of the community rather than those imposed by health professionals. The problems identified through community input are not likely to correspond with those recognized by the healthcare establishment. Even the public health department's criteria for assessing health may differ from those of the general public.

- **Involvement of the community in health improvement.** Because the healthcare system alone cannot improve the health of the population, the responsibility falls to the community. No one organization can have a significant impact on the health status of a community's population, especially in light of the variety of factors that are known to influence health. The involvement of a wide range of community organizations—supported by but not led by the healthcare system—is necessary for community health improvement. This community involvement must include representatives of the education, housing, economic development, criminal justice, and transportation sectors. The involvement of government agencies that make policy is also critical for creating the collective impact necessary to improve community health.

EXHIBIT 8.3
The Impact of Geography on Health Status

Where individuals live, learn, work, and play has an effect on how healthy they are. According to the Robert Wood Johnson Foundation (2011), a range of factors, such as education, employment, income, family and social support, community safety, and the physical environment, impact a population's health. In many communities, healthy choices are easy for residents to make. These communities have plenty of gyms, safe places to jog, and community recreation centers with high-quality swimming pools and sports fields. Children play and exercise in well-maintained parks and have access to affordable, nutritious foods.

But many other American communities face obstacles to healthy living: Parks and playgrounds are littered, broken, or unsafe, and some communities do not even have sidewalks for walking. School meals are low in nutritional value, school vending machines sell junk food, and students do not get regular physical education classes. Access to fruit and vegetables is limited because supermarkets are far away. Dilapidated housing, crumbling schools, abandoned factories, and freeway noise and fumes cause illness and injury. These poor conditions cause higher levels of obesity and chronic disease, including diabetes, heart disease, and cancer, leading to higher healthcare costs. One major factor in the health of a community is whether a strong public health system is in place.

Public health departments should play an important role in improving the health of communities, as they are responsible for addressing the systemic factors that determine why some communities are healthier than others and for developing policies and programs to remove obstacles to health. However, healthcare observers are increasingly concerned about the ability of public health agencies to fulfill this function. Addressing such large-scale

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concerns requires a population health approach, but some doubt whether public health is positioned to play a major role in implementing such an approach given, among other factors, the field's dwindling resources.

Healthcare marketers are often charged with identifying the location and characteristics of prospective customers. Under provisions of the ACA, hospitals are required to demonstrate an understanding of the connection between geography and health status. The ability to identify the health-related characteristics of residents will be an increasingly important skill for marketers.

The Social Determinants of Health

As the impact of social factors on health status has become clearer, proponents of the population health model argue that the health conditions exhibited by a population are in fact *symptoms* of underlying problems. Thus, the morbidity level of a population reflects the social determinants of health and illness—that is, the root causes of illness—and the presence of disease can be seen as a manifestation of these social factors. This perspective is supported by research indicating that disadvantaged populations are likely to identify as health problems factors such as a lack of food, inadequate housing, and unsafe streets.

Indeed, some segments of the population seem to place a low priority on health—not because they do not desire to be healthy but because other, more pressing concerns take priority. For example, research by the US federal government found that for people living in poverty, basic expenses for necessities exceed their available income (US Department of Health & Human Services 2015). While limited information is available on the priorities of the poor in the United States, international research (World Bank 2001) has found that the urban poor worldwide are most concerned about access to jobs, unsanitary environments, meeting basic needs, food insecurity, and lack of education. Health and healthcare are regarded as subordinate concerns. This finding is supported by a study of low-income residents of Washington, DC (Danis et al. 2011), in which researchers found that the most important factors thought to contribute to health were health insurance (95 percent), housing vouchers (82 percent), dental care (82 percent), job training (72 percent), adult education (63 percent), counseling (68 percent), healthy behavior incentives (68 percent), and job placement (67 percent). Medical care was not considered a major contributor to health status, as respondents focused on social factors when amelioration was discussed.

Critics of the US healthcare system argue that it treats the symptoms of disease but fails to address the root causes of health problems. Just as

putting a bandage on a wound will be of limited usefulness if the underlying infection is not treated, an approach to healthcare that addresses only symptoms without treating the underlying problems will be ineffective at improving population health. Indeed, research has found no correlation between expenditures on health resources and health status. Further, access to health insurance does not guarantee access to care, and, in turn, access to care does not ensure utilization of health services. Finally, utilization of services does not necessarily foster better patient outcomes and, by itself, does not contribute to improved population health.

It is hard to ignore the flaws of the treatment-focused perspective. Providers are well aware of the high rate of recidivism despite the best efforts of the medical community. Patients return for care repeatedly because their symptoms were treated but not the underlying disease. Research on hospital readmissions has found, for example, that readmission has little to do with the care that a patient received but almost everything to do with the characteristics of the patient prior to admission and after discharge (Hu, Gonsahn, and Nerenz 2014).

Improvement in population health will require attention to the root causes of ill health. As early as the 1980s, healthcare analysts posited the social determinants of health and illness (Evans, Barer, and Marmor 1994). This view was described as a "common focus on trying to understand the determinants of health of populations." Foreseeing the breadth of the population health approach, this work brought together research findings from epidemiology, biomedical science, psychology, sociology, economics, political science, and history. Although our understanding of the social determinants of health and illness has advanced significantly since then, the healthcare industry still has much to learn about the connections between social conditions and health status. Exhibit 8.4 summarizes the social determinants of health.

Population Health Disparities

As social factors have supplanted biological and genetic determinants of health and illness, patterns of morbidity for the US population have changed significantly. These "modern" causes of health problems have not only shifted the nature of the health conditions faced by the population but also contributed to the emergence of distinctive patterns of morbidity. While biologically generated illnesses did not necessarily correspond with age, sex, race, or other demographic attributes, the diseases of civilization affect narrower, more specific segments of the population. Thus, contemporary patterns of morbidity are associated with variations in the demographic attributes of subpopulations.

The emergence, persistence, and even augmentation of dramatic disparities in health status among segments of the US population has become a

EXHIBIT 8.4

The Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks			Discrimination	Quality of care
Medical bills	Playgrounds	Vocational training			
Support	Walkability	Higher education			

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

Source: Artiga and Hinton (2018).

growing concern for health professionals. The changes observed in morbidity patterns during the second half of the twentieth century included the redistribution of disease within the population along demographic lines. Clear patterns of distribution demonstrated the concentration of specific health problems among specific demographic subgroups.

Diseases of civilization tend to follow patterns of distribution corresponding to race and ethnicity, income and education, and even sociocultural factors such as marital status, occupation, and religion. Thus, a distinctive disease configuration could be identified for most demographic subgroups. The morbidity profile for low-income African Americans, for instance, is much different from that of affluent white Americans; the health conditions of poor white rural residents differ from those of upwardly mobile urban residents; and the health status of second- and third-generation immigrants diverges from that of newly arrived immigrants.

The patterns of morbidity distribution that have emerged are so significant that they are viewed not just as differences but as disparities. The latter term reflects the fact that members of some groups are increasingly affected by certain diseases. The social determinants of health have a disproportionate impact on certain subpopulations—the poor, minorities, immigrants, the poorly educated, and other vulnerable populations. These disparities have

contributed to the bifurcation of the population by health status: While one portion of the population maintains relatively high health status, the other portion of the population faces an inordinate share of chronic diseases and adverse health conditions.

While these patterns of disease distribution by themselves are not inherently discriminatory, the fact that certain disadvantaged groups are characterized by higher rates of most contemporary conditions than other groups is noteworthy. As a result of persistent health disparities, it is now reasonable to *expect* that certain subgroups will suffer from differential morbidity and mortality rates. Once these disparities are established, they tend to be self-perpetuating.

A consequence of these developments has been the establishment of a demographic profile for most health conditions. While most chronic conditions in contemporary societies are widespread throughout the population, they are likely to be concentrated among certain groups, creating a unique disease-specific pattern. For example, although diabetes affects all demographic groups, higher rates of prevalence and mortality can be seen among certain subgroups than others. Similarly, heart disease as the leading cause of death is widespread throughout the population, but it has a greater impact on certain subpopulations. The populations most affected by these disparities are minorities, the poor, and the least educated.

Factors Driving the Adoption of the Population Health Approach

A number of developments have encouraged healthcare providers to apply population health approaches at the micro level to the delivery of care. The following are major developments that have implications for healthcare marketing:

- **Emphasis on group outcomes.** Increasingly, providers are no longer evaluated and rewarded for the successful management of individual patients. Although the successful treatment of serious conditions is important, the Centers for Medicare & Medicaid Services (CMS) and other third-party payers are more concerned with how a clinic's 100 patients or a health plan's 1,000 enrollees are faring—and not just in terms of a specific health condition but in terms of their overall health status, thereby minimizing the significance of clinical outliers. Organizations evaluating effectiveness or paying for services are now looking for across-the-board improvements rather than individual successes. Hospital executives' efforts to improve the overall health of a managed population are increasingly being considered in their evaluations.
- **Emphasis on quality rather quantity.** Likewise, providers are no longer rewarded based on the *number* of cases treated, diagnostic

tests run, or procedures performed but rather on the *quality* of the services provided and their impact on the health of patient populations. Quality, although hard to define and measure, is thought to provide a broader indication of the effectiveness of the care provided to a group of patients, plan members, or employees.

- **Deficiencies in disease management initiatives.** Since the early twenty-first century, health plans and employers have attempted to control costs through the implementation of initiatives such as disease management and patient management, which micromanage care for a select number of high-cost patients. Individuals with diabetes have been a common target for such efforts; some programs go so far as to assign case managers to ensure timely access to services and patient adherence to treatment. However, such programs have yielded limited financial benefits and failed to contribute to the overall health of the targeted population. Micromanaging a small number of patients has been found to have little impact on overall health, whereas focusing on at-risk populations, for example, has tended to produce better results. Ultimately, any initiative that attempts to improve population health one patient at time will not be effective in today's healthcare environment.

- **Emphasis on community benefits.** There is growing concern that healthcare providers are focusing on existing patients to the detriment of the community's health. Not-for-profit hospitals in particular face pressure to generate **community benefits** beyond the services they provide to their patients. Indeed, the ACA mandated that not-for-profit hospitals conduct a comprehensive community health needs assessment at least every three years. The legislation emphasized the extent to which these providers served the entire community and not just their own patients. In fact, existing regulations require that a plan be developed for addressing any identified gaps in services in the community, regardless of whether the provider is involved in the delivery of these services.

- **Emphasis on nonclinical factors.** The population health movement has put a spotlight on nonclinical factors and their impact on health status and health behavior. Demographic, socioeconomic, and psychographic attributes of populations are now recognized as playing an important role in the health problems that populations exhibit and subsequent health behavior. These nonclinical factors often outweigh any impact of the healthcare delivery system. These attributes determine who gets sick and with what disease, the likelihood of seeking treatment or complying with doctor's orders, and what happens to them after they leave the doctor's office or hospital.

community benefits
Under the Affordable Care Act, the benefits presumed to accrue to a community through the actions of not-for-profit hospitals.

- **Emphasis on patient, plan member, and employee engagement.**
  The ineffectiveness of care delivery has been traced to the failure to
  engage patients, plan members, employees, and consumers in positive
  health behaviors. Social marketing efforts have been primarily geared
  to mass audiences, and interventions typically involve one-size-fits-all
  initiatives. A population health approach would involve identifying
  subpopulations and their attributes and then customizing engagement
  efforts to the needs of targeted populations. Population health
  emphasizes the segmentation and profiling of defined populations
  in terms of their salient characteristics, allowing for more informed
  intervention efforts.

Population Health Management

population health management
A process for proactive clinical and financial management of a defined population using population health principles.

The term **population health management** is used to refer to the applica-
tion of the population health model in the context of healthcare delivery.
Population health management emphasizes serving clinical patients (even
when they are considered as a group), managing service utilization, and con-
trolling costs. Efforts to improve the individual experience of care, reduce
the per capita cost of care, and improve the health of populations over
which providers have some control can all benefit from a population health
approach. Many clinicians and medical managers, in fact, have begun using
the term *population health management* to describe "the iterative process of
strategically and proactively managing clinical and financial opportunities to
improve health outcomes and patient engagement, while also reducing costs"
(Kindig 2015).

Alternatively, the Agency for Healthcare Research and Quality
(AHRQ) uses the term *practice-based population health* to describe the appli-
cation of population health principles to patient populations (Cusack et al.
2010). The AHRQ defines practice-based population health as "an approach
to care that uses information on a group of patients within a primary care
practice or group of practices to improve the care and clinical outcomes of
patients within that practice."

While efforts geared to improving the effectiveness of care continue
to emphasize the care of individual patients, population health principles can
be applied to healthcare delivery in many ways. Exhibit 8.5 describes situa-
tions facing healthcare organizations that would benefit from a population
health approach.

The following population health principles can be applied to health-
care delivery. All require the attention of healthcare marketers:

- **Segmenting and profiling populations and subpopulations.** Rather
  than focusing on the characteristics of individual patients, population

The following scenarios illustrate issues that are increasingly common among healthcare organizations:

- A hospital is penalized for unacceptably high rate of readmissions within 28 days.
- A hospital realizes that its outcomes vary widely based on the demographic characteristics of its patients.
- A provider loses its capitated panel of patients from a managed care plan because it failed to meet health status benchmarks.
- An employee assistance program provider loses money because of the high level of overutilization of some services and underutilization of other services.
- A behavioral health organization loses its contract with a state insurance plan because of its inability to effectively communicate with its covered plan members.
- A Medicaid managed care organization loses money because of its inability to manage the utilization of services by its enrollees.
- A hospital is reprimanded by the Internal Revenue Service for failure to take the needs of the service area population into consideration in the preparation of its community health needs assessment.
- A county government is faced with escalating healthcare costs because of excessive preventable admissions and inappropriate use of the emergency room at its public hospital.
- An accountable care organization fails to qualify for "shared savings" under its contract with CMS.

What all of these organizations have in common is the need to address issues affecting an entire *population*—a need that cannot be addressed by more traditional approaches to care. These challenges cannot be met simply by providing clinical care to individual patients. And they cannot be met without a much more in-depth understanding of the characteristics of the affected population.

The challenges facing these organizations include cost containment, patient management, community health improvement, appropriate utilization, and member retention. Despite these disparate challenges, all organizations face the need to adopt a population health approach. This approach allows them to view the challenges they face in terms of groups of people—whether they be patients, consumers, plan members, employees, or others—who can be profiled in terms of their salient characteristics and can be served, managed, assessed, or enhanced using methods that address those groups as a whole.

health emphasizes the attributes of groups, whether they are patients, employees, plan members, or consumers. The first step is identifying meaningful segments in any targeted population. Segmentation can be based on demographic or psychographic characteristics, levels of utilization, at-risk status, or a variety of other attributes. Once population segments have been identified, they can be profiled in terms of their salient characteristics.

- **Implementing "group therapy."** While traditional clinical medicine is designed to manage one patient at a time, population health emphasizes the management of groups of patients. Doing so could be as simple as creating a group diabetes education management program or as complex as developing an advanced treatment strategy for a defined set of patients. All plan members who are at risk of developing diabetes, for example, could be singled out for attention. Efforts to introduce interventions, educational programs, or marketing initiatives can take the characteristics of population segments into consideration in a targeted fashion.

- **Implementing patient education.** An activity that most healthcare organizations are already engaged in that fits the population health approach is health education. Social marketing is a well-established method of educating consumers, and providers have attempted to implement patient education activities for groups of patients who exhibit similar characteristics. Patients, plan members, and employees may be at different stages of health improvement and may exhibit different levels of health literacy. Some may only be realizing they have health issues, some may be informed but unmotivated, and others may actively be involved in positive health behavior and require ongoing support. Marketers can play a role in tailoring educational programs to the needs of the population segments and developing engagement plans that take these differences into consideration.

life circumstances
Adverse conditions that individuals and households face on a daily basis that influence their health status and health behavior.

- **Accounting for life circumstances.** Nonclinical factors can have an important impact on health status and health behavior. **Life circumstances** can be thought of as the everyday manifestations of the social determinants of health, such as low health literacy, joblessness, food insecurity, housing insecurity, and unsafe neighborhoods. We now realize that what happens to patients before they enter treatment and what happens to them after they leave treatment have a greater impact on clinical outcomes than the actual clinical care provided. Providers that understand the characteristics of their patients will be able to provide better care. Exhibit 8.6 describes the use of predictive modeling for population health management.

EXHIBIT 8.6
Using Predictive
Modeling in
Care Delivery

The growing popularity of personalized medicine and its transformation into predictive modeling offers the prospect of improved patient care. By combining patient and community data with evidence-based healthcare practices, predictive modeling can make a significant contribution to population health management. Predictive medicine replaces the traditional paper-and-pen approach to collecting patient data by simplifying and personalizing the process. Combining stored data about the patient, massive amounts of evidence-based medical information, and a user-friendly data infrastructure, predictive medicine can estimate when patients are likely to become ill or be at risk for dangerous health conditions. Including information on patients' life circumstances brings additional depth to this effort.

In addition, predictive medicine allows physicians to catch conditions *before* they turn into medical emergencies or cause lasting damage. Patient alerts allow primary care physicians to handle preventive care in the office, freeing up emergency department doctors' time and workloads. It also cuts down on the amount of care needed to improve the health of individual patients. Predictive medicine empowers patients to be more proactive by educating them about which symptoms qualify as medical emergencies, thus preventing unnecessary trips to the emergency department.

When care providers are armed with information before patients come into the office, they can pinpoint possible diagnoses. While this information may not always lead to a final diagnosis, it can give providers some direction, helping them narrow down possible ailments. This capability not only cuts down patient wait time but also frees up time for providers to help other patients.

While predictive medicine is concerned with individual patients, predictive modeling combines individual patients' data to give a picture of a health system's entire patient population. Expanding the principles of personalized medicine to hospitals and clinics, predictive modeling allows healthcare administrators to transform data into insightful guidelines for managing future demands on the healthcare system. For example, predictive modeling could help administrators more accurately forecast the number of patients who will arrive at the emergency department on a given day. This insight can help administrators make more informed decisions about everything from staff scheduling to supply ordering.

Predictive modeling has already been used to lower wait times in healthcare facilities. For example, administrators at Johns Hopkins Hospital

(continued)

EXHIBIT 8.6
Using Predictive
Modeling in
Care Delivery
(continued)

used predictive modeling and interactive software to reduce the average patient wait time in the emergency department from 10 hours to 4 hours in just one year. Research conducted at the Massachusetts Institute of Technology on applying predictive parameters to hospital waiting rooms has been proven to lower emergency department wait times by 10 percent (approximately 40 minutes).

Source: Saxena (2015).

- **Community health needs assessment.** Progressive healthcare organizations have historically conducted community health needs assessments, typically for their own strategic planning purposes. Now, however, the ACA requires not-for-profit hospitals to conduct comprehensive community health needs assessments at least every three years. Even providers that have routinely conducted community health assessments are not likely to comply with this new provision of the ACA. Tax-exempt hospitals must demonstrate an understanding of the healthcare needs of the total community (even those segments that they do not serve), identify gaps in services (even those that they do not provide), and formulate a plan for addressing the gaps that have been identified. The emphasis of these efforts is on *consumers*, not just existing patients. Thus, a major hospital has to look beyond its walls to the broader community to identify issues that need to be addressed, even if they are not related to a service the hospital provides. For example, suppose that a hospital does not provide behavioral health services, but its community health needs assessment uncovers a significant gap between the needs of the community and the behavioral health services that are available. This hospital must quantify these gaps, demonstrate to the federal government that it has a plan to address them, and document through subsequent assessments its effectiveness in helping close the identified gap. Case study 8.1 presents an example of the use of community health needs assessment for population health management.
- **Creating financial efficiencies and maximizing revenue.** The financial welfare of healthcare providers is a primary concern, and population health management efforts often focus on introducing financial efficiencies and maximizing revenue. Measures of success are increasingly focused on the extent to which providers or health plans are providing cost-effective services. To compete in today's healthcare environment, providers must be able to control costs

and maximize revenue. CMS is increasingly offering financial incentives to Medicare providers that manage patients efficiently. A number of vendors have developed methodologies (often under the label "population health") for helping providers, health plans, and accountable care organizations improve their financial performance. CMS has encouraged such activity through its "shared savings" initiative. Exhibit 8.7 discusses the role of marketing in advancing the population health model.

CASE STUDY 8.1
Using a Community Health Needs Assessment to Improve Patient Care

A major hospital system in a medium-sized southern city conducted a comprehensive community health needs assessment in compliance with the ACA. In conducting the assessment, the analysts discovered that the residents of one zip code accounted for a large proportion of the hospital's uncompensated care. Additional research was conducted to understand the high use of healthcare resources by residents of this community.

The research found a significant number of residents with comorbid chronic conditions who were frequent users of the hospital's emergency department and regularly admitted for inpatient care. These high utilizers were clustered in certain locations, suggesting that the local environment was having an impact on health status.

The research also found that a significant portion of the population was at high risk of developing a chronic condition, particularly diabetes. The remainder of the population was at moderate risk, but, given the attributes of the community, the analysts expressed concern about their future health status. Each of the three populations—high utilizers, high risk, and moderate risk—were profiled in terms of their demographic, socioeconomic, and psychographic characteristics. This information was used to inform the development of customized programs for each group.

As a result of this analysis, the hospital developed a three-tier approach to addressing the health issues facing this community. For the 100 chronically ill high utilizers, a case management program was established to manage each patient's care. Efforts were made to ensure that they received timely treatment, adhered to their medical regimen, and, to the extent possible, maintained a healthy lifestyle. For the estimated 4,000 at-risk residents, an

(continued)

intensive patient education effort was developed that targeted their area of residence. Like the high utilizers, the at-risk populations also tended to cluster together. For the relatively healthy moderate-risk population, a social marketing program was developed to provide general information on healthy lifestyles and prevention.

Although the impact of such programs is difficult to quantify, the case management efforts for the high utilizers paid significant dividends in terms of reduced emergency department utilization and inpatient admissions. Many of the 4,000 at-risk patients who received screening and prevention materials actually entered treatment programs for chronic conditions, although it is difficult to determine the impact of the hospital initiative in this regard. Follow-up surveys found that members of the general population (the moderate-risk segment) were exposed to health education materials, and many participated in health fairs located in areas with concentrations of high-risk residents.

CASE STUDY DISCUSSION QUESTIONS

1. What activity on the part of the hospital raised the question of uncompensated care?
2. What conditions contributed to high utilization of health services?
3. What was the basis for segmenting the target population?
4. What was the impact of the "intervention" on the targeted segments?

EXHIBIT 8.7
Advancing Population Health: Medicine or Marketing?

Despite the apparent success of clinical medicine in the United States, there is growing concern that the historical approach to care that emphasizes individual treatment has ceased to be effective at improving community health. In response to these concerns, population health has emerged as a methodology for refocusing the healthcare system on the health status of groups of people rather than individual patients. This perspective may be foreign to healthcare providers, who may not recognize the social determinants of health or the implications of life circumstances that affect their patients. The failure of the healthcare system to address population health is less a function of structural deficiencies—although these certainly play a part—and more a function of the allocation of resources.

What is the role of healthcare marketing in promoting population health? Some argue that from a population health perspective, the past

(continued)

EXHIBIT 8.7
Advancing
Population
Health:
Medicine or
Marketing?
(continued)

efforts of marketers have been misdirected and have contributed to the deterioration of population health status. Healthcare marketers have been accused of promoting the wrong services to the wrong populations, of marketing products that do not contribute to community health, and even of marketing services that may be detrimental to health.

The standard approach to marketing health services involves marketing to individuals rather than groups, marketing to patients rather than consumers, marketing downstream rather than upstream, and marketing to sick people rather than well people. In view of the historical incentives related to the healthcare system, this is exactly what marketers would be expected to do. However, none of these marketing activities contributes to population health improvement. In some cases, they do not even contribute to personal health improvement and may, in fact, exert a negative pressure on health status.

To adapt to the demands of the population health approach, a major rethinking of healthcare marketing is necessary. First, marketers must use their in-depth community knowledge as a foundation for population health initiatives. Marketers know the characteristics of patients and consumers much better than clinicians—yet this knowledge is often underutilized. Even more important, marketers are likely to be familiar with the nonmedical factors that contribute to health status, such as life circumstances, lifestyle, and social context—factors that are now considered as important to patient outcomes as the clinical treatment they receive. Marketers are also likely to be familiar with the motivations that characterize different groups of consumers.

Second, marketers are well acquainted with methods of influencing *groups* of consumers. Most marketing is geared toward the entire population or toward major subsets of the population. Marketers have the expertise to profile these populations and develop appropriately designed marketing initiatives.

Third, marketers recognize the importance of differences in the population and can segment the population into meaningful subgroups. Not only is this a necessary step in developing an informed marketing plan, but careful segmentation allows for efficient allocation of marketing resources.

Finally, marketers understand how to engage target populations in desired behaviors. Most population health initiatives call for active participation of targeted populations. Indeed, the failure of many initiatives promoting improved health status can be attributed not to flaws in the proposed intervention but to the inability to engage members of the

target audience in appropriate behaviors. Providers are evaluated (and rewarded) based on the extent to which their patient pool demonstrates more positive health behaviors and the extent to which they contribute to overall improvement in the health status of the community (a requirement of the ACA).

The marketer of the future can play an important role in promoting community health status by acting as a bridge between the healthcare system and the community. The marketer is in a position to view healthcare both from the perspective of the provider and from the prospective of the consumer. No one else is in a better position to reconcile these two perspectives and encourage the confluence of personal health and population health.

Barriers to Population Health Management

Healthcare providers are naturally drawn to population health management because it is a comfortable fit with activities that are familiar to them. Despite this affinity for population health management, a number of factors present challenges to applying this methodology in the context of healthcare delivery:

- **Limited appreciation of population health and its usefulness.** Despite growing interest in population health, many, if not most, healthcare providers have a limited understanding of what it involves. Few providers appreciate the macro-level application of population health, although more are beginning to appreciate its micro-level application to the delivery of care. When health professionals consider challenges related to the delivery of care, they most frequently consider the efficient processing of patients, controlling utilization, and maximizing revenue. These are pressing concerns for healthcare administrators, but the usefulness of population health management is not likely to be obvious under the pressure of delivering care.

- **Lack of appreciation for the nonclinical contributors to health status.** To the extent that the population health approach can be applied to the delivery of care, a major benefit is its emphasis on the nonclinical aspects of care. Few providers are unaware of the influence of poverty, inadequate housing, food insecurity, and domestic violence on the health of the population. Yet acknowledging these factors does not necessarily create a connection to the practice of medicine or the delivery of care. Part of the failure to acknowledge the importance of social determinants is the notion that those factors are beyond the influence of healthcare providers. To a great extent, this is true—how

much better care could be provided if providers were armed with information about the life circumstances of their patients and the importance of social factors on their health status.

- **Lack of incentives to incorporate population health management.** Historically, healthcare providers have faced pressure to process as many patients as possible as efficiently as possible. In fact, the pressure to do so has only increased as managed care arrangements have become widespread and increasing numbers of physicians are working under quotas as employees. This environment does not encourage the thoughtful introduction of population health management, and financial incentives do not encourage many of the activities that would be promoted through population health. Not only do financial considerations influence consumer and patient behavior, they also influence the practice patterns of physicians. If financial incentives encourage physicians to see more patients, conduct more tests, or provide more services, physicians will respond rationally by increasing volume. Certainly, incentives are changing rapidly as healthcare organizations shift their emphases to ensuring greater access, more effective outcomes, and lower costs, but these incentives must be incorporated into the healthcare system before many providers embark on radical restructuring.

- **Discontinuity with other types of nonmedical services.** Medical care alone cannot advance population health. A comprehensive range of services is required to supplement the benefits of clinical medicine. Given the extent to which nonclinical factors contribute to health status, the healthcare system must be able to link healthcare providers with the providers of services independent of medical care, such as dentists, eye care specialists, mental health counselors, and social workers. Often, formal and informal relationships exist between health services providers and these sources of care. However, the wide range of services thought to have an impact on clinical outcomes are not typically considered in the healthcare system, such as services related to housing, food security, personal safety, environmental threats, and the range of social determinants of health. The disconnect between providers of clinical services and these external service providers and the absence of financial incentives to establish relationships among them are clear barriers to the implementation of population health management.

- **Lack of data to support population health management.** Although significant advances have been made in accessing and analyzing the vast amount of clinical data available to healthcare providers, gaps remain with regard to the data required for population health management.

Most data focus on historical utilization patterns for existing patients but are not very helpful to clinicians and administrators seeking to apply population health management. Actionable data that would allow practitioners to appreciate the factors that influence the health status and clinical outcomes for their patients, plan members, or employees are lacking. Providers have limited information, for example, on life circumstances affecting their patients' health status and their ability to benefit from treatment—information that is unlikely to be obtained from a medical history. For example, clinicians are unlikely to know the economic circumstances of their patients and may not even know what type of insurance coverage patients have. Similarly, clinicians are unlikely to know the living arrangements of their patients, although these affect the ability to adhere to a medical regimen.

- **Lack of tools for population health management.** The amount of knowledge and expertise required of physicians has increased exponentially. But it is impossible for even the most informed physician to be knowledgeable about all the factors that contribute to health status and health behavior. Further, in a population health framework, physicians need access to information—particularly nonmedical information—to support their decision-making. For the population health model to be effective, this type of information needs to be readily accessible to physicians. Practitioners lack both data and tools for applying population health management. To effectively apply this model, practitioners need tools that allow them to use the available data to anticipate health problems and challenges to care on the part of their patients. These same needs exist with regard to insurance plan members and employees.

Marketing and Population Health

The changes taking place in healthcare as a result of the population health model suggest a changing role for the healthcare marketer. As the focus shifts from the individual consumer to *communities* of consumers, the knowledge and skills of marketers take on new significance. Marketers must incorporate the following functions:

- Understanding the patient population
- Understanding consumer populations
- Understanding health services utilization and financial management
- Strategic planning
- Understanding community health needs assessments
- Understanding and measuring the social determinants of health

- Reconceptualizing the notion of health status
- Adapting to an increasingly diverse patient population

The evolving healthcare environment offers challenges and opportunities for healthcare marketers. The challenges arise from the need to adjust to situations that are unprecedented in the industry. Doing so requires a radical rethinking of the goals and objectives of the healthcare system and, by extension, the marketing function. The opportunities arise from the expanded role of marketing and the many ways that marketing skills might add value. As with most changes in the healthcare industry, the changing environment offers the opportunity for marketers to use their skills for the benefit of healthcare organizations and the health of the community.

Summary

As the US population has changed, the American healthcare system has undergone a major transformation of its own. Both of these developments have had major implications for healthcare marketing.

Among the developments that have implications for healthcare marketing are the changing nature of the US population, the changing characteristics of patients, the changing nature of disease (and, especially, disease causation), and changes in the healthcare system. Of particular importance is the growing recognition that the US healthcare system is not meeting the goal of improving the health of the population and, in fact, may be contributing to declining health status.

Since the end of the twentieth century, healthcare has undergone two paradigm shifts. The first shift, which took place in the last years of the twentieth century, saw a transition from medical care to healthcare. This shift entailed a movement away from a narrow perception of health based on the medical model to a more expansive view of health that considered the social and psychological determinants of health in addition to the biological ones. As a result of this shift, the patient came to be redefined as a consumer. This more expansive wholistic approach was better suited to address the challenges facing the US population. However, its continued emphasis on individual patients limited its ability to affect community health.

Healthcare marketers have been instrumental in promoting the aims of the prevailing healthcare paradigm. In this regard, they have unwittingly contributed to the need for paradigm change. Marketers have aggressively promoted the goods and services offered by healthcare organizations on the assumption that more care means better care. The tendency to overdiagnose and overtreat health conditions has resulted in an expansion of the healthcare industry, along with its costs, and contributed to the failure to improve community health.

The second paradigm shift, which has emerged since the beginning of the twenty-first century, is the population health movement. The term *population health* can be used to describe the overall health of a population or a method for improving the health of a population. The population health approach represents a radical departure for the healthcare system, as it prioritizes well people over sick people, consumers over patients, populations over individual patients, and an upstream focus over a downstream one. This model calls for a rethinking of health status and focuses on the social determinants of health. This model is gaining widespread acceptance, and its implementation has significant implications for marketers.

Population health management refers to the application of the population health model in the context of healthcare delivery. It focuses on defined populations (e.g., patients of a clinic, employees, insurance plan members) rather than on consumers at large or broad population groups. Favored by hospitals, population health management employs careful clinical and financial management of patients and other defined populations to control health service utilization to contain costs. The advancement of the population health model, some argue, is as much a marketing function as a medical function.

Key Points

- Marketing emerged as a core function for healthcare organizations during the late twentieth century, a period that was dominated by the medical model of health.
- Despite the limitations of the medical model, it remained the dominant paradigm into the twenty-first century; however, it has limited relevance for today's healthcare environment.
- Continued reliance on the medical model resulted in a decline in the health status of the US population, which was influenced by the operation of the healthcare delivery system.
- Two new paradigms emerged to address problems with the healthcare system.
- The first paradigm involved a shift in emphasis from medical care to healthcare, as the narrow view of health promoted by the medical model was replaced by a more expansive view emphasizing holistic health.
- The healthcare paradigm ultimately failed to improve Americans' health status because, like the medical model, it focused on the individual patient.

- The second paradigm was the population health model, which focuses on populations rather than individuals and shifts the emphasis of healthcare from sick people to well people, from patients to consumers, from defined populations to communities, and from a downstream emphasis to an upstream one.
- Population health management refers to the application of the population health model to healthcare delivery; it focuses on the management of defined populations to control health services utilization and reduce costs.
- Population health principles are being employed by health systems to adapt to the pay-for-performance environment.
- As these developments have unfolded, the role of the healthcare marketer has continued to evolve.
- The population health model requires a wide range of skills that are unique to marketers as the industry adapts to the changing healthcare environment.

Discussion Questions

1. How did the rise of scientific medicine contribute to the improvement of Americans' health?
2. How did the rise of scientific medicine create barriers to the promotion of good health?
3. How did the field of medicine expand and establish a growing influence over American life?
4. What factors contributed to the shift from an emphasis on *medical care* to an emphasis on *healthcare*?
5. How did changes in population characteristics contribute to the changing nature of health problems?
6. What were some of the implications for marketers of changing health characteristics?
7. How did lifestyle contribute to changing morbidity profiles?
8. What factors led to the emergence of the population health movement?
9. How does the population health approach differ from previous approaches to community health improvement?
10. How does marketing need to change its approach to adapt to the population health model?

Additional Resources

Bailey, J. 2014. *The End of Healing.* Memphis, TN: The Healthy City.

Deprez, R., and C. Manchester. 2018. "Improving the Health of Communities Through Population Health Assessments." *Maine Policy Review* 27 (2): 51–59.

MARKETING STRATEGIES

Healthcare organizations are often tempted to rush a marketing campaign into the field in response to a perceived need. However, few initiatives will be successful without a well-thought-out strategy to guide the organization's marketing activities. A marketing initiative should never be considered an emergency; rather, it should be crafted against the backdrop of a strategic plan. This chapter describes healthcare marketing strategies and highlights the relevance of the four Ps of marketing—product, price, place, and promotion. Factors influencing strategy development are reviewed, and the steps involved in developing a marketing strategy are outlined.

What Is Strategy?

The term **strategy** is used in a variety of ways by students of marketing. For the purposes of this book, strategy refers to the general approach taken by a healthcare organization to meet market challenges. The strategy establishes the tone for marketing activities and sets the parameters within which the marketer must operate. The strategy that is chosen influences the development of the organization's marketing plan and guides its marketing initiatives.

Marketers often think of strategy in terms of levels. For example, they might create a *corporate strategy* that deals with the overall development of an organization's business activities, a *business strategy* that outlines how to approach a particular product or market, and a *marketing strategy* that focuses on one or more aspects of the marketing mix. The marketing strategy spells out how an organization intends to achieve its objectives. The marketing strategy is reflected in the initiatives an organization develops to approach a target market, the marketing mix it selects, and the marketing expenditures for which it budgets.

Ideally, strategies are carefully thought out and deliberately formulated through enterprisewide strategic planning. The absence of an articulated strategy, however, does not mean that no strategy exists. Acts of commission or omission ultimately create a strategy, and even the absence of a strategy could be considered a strategic approach. As a result, many healthcare organizations end up with strategies that are not formulated intentionally. This situation may result from the lack of a formal strategic plan, the failure to

strategy
A general approach taken by a healthcare organization to meet market challenges.

link marketing efforts to an existing strategic plan, or the failure to articulate marketing strategies clearly. In most cases, this situation results when the organization neglects to engage in formal market strategy development.

Unplanned strategies are referred to as *emergent strategies*, and they derive from a pattern of behavior that is not consciously imposed by senior management. They are the outcome of activities and behaviors that occur unconsciously but nevertheless fall into a pattern. Although many healthcare administrators would concede that they do not have a strategy in place, some form of strategy, even if it is unstated, usually exists. Exhibit 9.1 graphically depicts the role of strategy in an organization.

Why Is Strategy Development Important?

Strategies are generally developed for the same reasons any type of planning activity is carried out. All strategies should accomplish the following functions:

- **Provide direction for the organization or program.** The strategy should constitute the "which way" aspect of organizational development.
- **Focus efforts on one of many possible options.** Because there will always be many strategic options from which to choose, focusing on a particular strategy prevents confusion of purpose and diffusion of efforts.
- **Unify the organization's actions.** The strategy should give the organization a purpose and unify the actions of its members.
- **Differentiate the organization.** The strategy should reinforce the organization's identity and distinguish it from competitors.
- **Channel the organization's promotional materials.** The strategy should guide the development of promotional documents, and all materials should present a distinct **image**.
- **Marshal the organization's resources.** The strategy should guide the allocation of resources to focus them on one approach rather than many.
- **Support decision-making in the organization.** The strategy should implicitly establish criteria for framing issues that require decisions.

image
The perception an organization wants to project about itself, its products, and its services.

EXHIBIT 9.1
The Role of Strategy in an Organization

Corporate strategy → Marketing strategy → Marketing plan → Marketing campaign
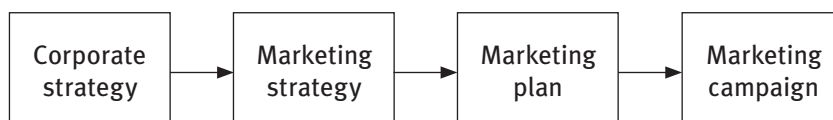
- **Provide the organization with a competitive edge.** Ultimately, strategy development is about positioning the organization in relation to the market, capitalizing on the organization's strategic assets, and creating a strategic advantage.
- **Demonstrate competence to key external stakeholders.** Funders and regulators need to be assured that the organization is taking a systematic approach.

What Is the Context for Strategy Development?

Strategic planning is a well-established activity in most industries. It is often synonymous with corporate planning. The **strategic plan** is the primary mechanism through which an organization adapts to an ever-changing environment. A strategically oriented organization is one whose actions are aligned with the realities of its environment. The organization's strategic mind-set should foster a marketing mind-set among its members or stakeholders (e.g., board of directors, leaders, employees, physicians, and other clinicians).

strategic plan
A comprehensive guide to action developed by an organization for carrying out a specific strategy.

The strategic plan should guide the allocation of marketing resources, particularly when resources are scarce. The strategic plan should also serve as the basis for relationship development in an environment that is increasingly driven by provider networks, integrated delivery systems, and referral relationships. The strategic planning process should address the appropriateness of existing links and identify potential new relationships.

Most important, the strategic plan should be a **call to action**. The strategic plan should not only embody the organization's strategy but also convey the organization's vision and the kind of organization it wants to be. This vision should help marketers plan the activities that are necessary to support the organization's strategic initiatives.

call to action
A statement, usually at the end of a marketing piece, that encourages the audience to take initiative regarding the good or service being promoted.

Healthcare administrators are sometimes tempted to rush headlong into marketing campaigns without regard for the strategic implications of their actions. The tendency is to address immediate marketing needs without concern for the broader implications of these actions. This all-too-common scenario underscores the need for a strategic orientation at all levels of the organization.

The Strategic Planning Process

Although the steps and sequencing of the strategic planning process may differ, the approach outlined here is a common one. The marketing planning process is described in greater detail in chapter 16 (see also Thomas 2003a).

Step 1: Plan for Planning

A good starting point for the strategic planning process is reviewing the organization's **mission** and **goals**. Many organizations spend considerable effort defining their mission and establishing goals, so the strategic planning process should confirm the validity of those concepts or provide a rationale for modifying them. If an organization has not articulated a clear mission, doing so is a prerequisite to strategic planning.

Much of the activity at this stage is organizational in nature and focuses on identifying the key stakeholders, decision makers, and internal resources that should be involved in the planning process. A planning team should be established that includes representatives from all constituent groups, including stakeholders, key decision makers, and opinion leaders, as well as representatives from key departments in the organization.

Step 1 focuses on clarifying the nature of the organization and the business it is in. (An overview of the organization, its mission, and its current operations will be developed in step 4.) For example, toward the end of the twentieth century, hospitals that continued to think of themselves as being in the hospital business rather than the healthcare business found themselves at a competitive disadvantage compared with hospitals that embraced a broader mission. Indeed, the redefinition of the mission of healthcare organizations during the late twentieth century contributed to the emergence of marketing as an essential healthcare function.

mission
The overarching purpose of an organization; the reason an organization exists.

goal
The ideal state or position the organization strives to achieve.

Step 2: State Assumptions

It is essential to frame the strategic planning process within the healthcare organization's current reality, and this typically begins by stating assumptions. Assumptions might be made about the players involved in the local healthcare arena, the nature of the market area (and its population), the political climate, the position of other providers, and any other factors that might affect the strategic development process. As noted in chapter 8, assumptions should be appropriate to the *anticipated* healthcare environment.

Many of these assumptions are likely to have a marketing dimension; they may relate to the organization's position in the market, the nature of the competition, the distribution of the organization's facilities, and so forth. Although the planning team will undoubtedly refine its assumptions during the planning process, it should begin with some general ones. Examples of general assumptions include the following: "Managed care will continue to exert a major influence on the local market"; "The industry will see a growing emphasis on pay for performance and a focus on quality over quantity": "We are number four in market share, and there is no way we will ever be number one."

Step 3: Gather Initial Information

The planning team begins the data collection process by gathering general background information on the organization, drawing from available organizational materials such as the following:

- Annual reports, press releases, and marketing materials
- Resumes of management and key clinical and technical personnel
- Reports filed with regulatory agencies
- Business plans presented to funding sources
- Grant applications and certificate-of-need applications
- Executive committee minutes, planning retreat summaries, and evaluation studies
- Previous strategic planning and marketing planning documents

In addition, the planning team should conduct an inventory and assessment of current marketing activities. Marketing initiatives that are already underway need to be cataloged, and existing marketing themes should be identified. Healthcare organizations that are new to formal marketing efforts may have more marketing initiatives underway than they realize. For example, an organization may offer perks to admitting physicians or conduct community health fairs without considering these initiatives marketing activities. Case study 9.1 describes an example of a marketing inventory.

CASE STUDY 9.1
A Marketing Inventory

In the early days of healthcare marketing during the 1980s, a major hospital in a southern city began to address the need for marketing. Despite the interest of some administrators in this function, the chief executive officer was opposed to any marketing activities, and in fact, the word "marketing" was never to be uttered in his presence.

Nevertheless, concerned about growing competition, some staff pressed on to explore marketing options. Their first step was to take an inventory of existing marketing activities. The exploratory committee was surprised to find that a number of marketing activities were already underway. The hospital had a well-established public relations department that regularly held press conferences, issued press releases, and worked with the media when crises arose. The public relations department also produced a print newsletter for patients and another for the general public.

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Individual departments in the hospital published newsletters for their department staff and, in a few cases, for the general public. For example, the human resources department produced a newsletter for hospital employees and developed promotional materials to recruit employees. It also regularly held training sessions on customer service.

The hospital employed a physician recruiter who marketed the hospital to targeted specialists, and hospital administrators networked with referring physicians at professional and social events. A newly formed network of urgent care centers employed a salesperson to call on local employers to encourage referrals, and the hospital's rehabilitation facility aggressively sought referrals from its patients.

The hospital conducted regular patient satisfaction surveys and occasional community surveys. The hospital also had a government relations department that lobbied government officials at the federal, state, and local levels and advocated for certificate-of-need applications. As managed care plans began to emerge, the hospital employed a sales force to solicit managed care relationships and negotiate contracts.

Ultimately, more than 120 marketing-related activities were identified in an organization that had once claimed to eschew marketing. This exercise makes clear that a wide range of activities in support of marketing may be taking place that might not be recognized as marketing.

Case Study Discussion Questions

1. Why did the hospital face resistance to taking an inventory of existing marketing activities?
2. What unexpected finding did the inventory discover?
3. What did the inventory tell the marketers about the state of marketing activities at the hospital?
4. What are examples of the variety of marketing activities that were underway?
5. What did the research tell us about perceptions of what constitutes marketing?

Initial information should be gathered through interviews with knowledgeable people in the organization representing a diversity of functional areas, vested interests, and perspectives. In large organizations, these interviews may be restricted to key administrators and medical staff and individuals with a perspective on institutional history. In small organizations, such as

physician practices, interviews with people further down the organizational structure may be necessary.

This step in the process should also identify the key constituents of the organization. To whom does it report? What stakeholders does it have to satisfy? If it is tightly held and private, a few entities outside the organization may matter. On the other hand, a private, not-for-profit organization is likely to be accountable to its board members, regulators, major donors, and other interested parties. A public entity (e.g., a charity hospital) will have these same stakeholders as well as others, such as advocacy groups. In a publicly held company, the board and the shareholders are important constituents.

Other constituents to consider are patient groups, referring physicians, employee benefits managers, advocacy groups, insurance plan representatives, and political officials. The list should include the full range of constituents that could conceivably be addressed by any type of marketing initiative, such as consumers (who need to be made aware of the organization's services), existing customers (whose loyalty needs to be strengthened), medical staff (whose continued support must be ensured), and the media (who must be kept up to date on the organization's activities).

The information gathered during this phase should be used to generate a description of the organization's **corporate culture**. This culture defines the organization's character, sets the tone for employee interaction, influences the organization's operations, and determines the extent to which the organization is amenable to the planning process. It also typically determines the ease with which a marketing mind-set can be established in the organization.

corporate culture
The values, beliefs, and attitudes that characterize an organization and guide its practices.

The planning team will not likely have all the answers to every question raised at this point, and typically more questions than answers are generated. Nevertheless, during this step, knowledge begins to accumulate, and promising options and potential roadblocks begin to emerge.

Step 4: Profile the Organization

In this step, the general description of the organization created in step 3 is fleshed out in more detail. In profiling the organization, three important questions must be addressed:

1. **What are the organization's products?** This question may seem easy to answer, but few healthcare organizations can readily respond to this question. Organizations historically have not had to think in terms of discrete products. Furthermore, healthcare products are often complex and, unless their sole business is selling a healthcare widget, healthcare organizations offer products that may be difficult to classify. How can public health or occupational medicine, for example, be conceptualized

as goods and services? Regardless of the complexity involved, specifying the organization's products is an important step in developing both general and marketing-specific strategies. (Healthcare products are discussed in detail in chapter 6.)

2. **Who are the organization's customers?** In other words, who does the organization have to convince to purchase its services? The more purposes an organization serves, the broader the range of customers it will have. For a hospital, the list of customers includes patients, family members and other decision makers, staff physicians, referring physicians, major employers and business coalitions, insurance companies, and managed care plans. With the emergence of provider networks and integrated delivery systems, other care providers are also customers. The list does not stop there, particularly if the hospital is tax exempt (because of its not-for-profit status); in that case, its customers may include consumer advocacy groups, policymakers, legislators, regulators, and the press.

3. **What are the organization's resources?** While an in-depth examination of the organization's resources will be conducted in step 8, it is worthwhile to develop an initial inventory of the organization's capabilities. The types of resources identified will depend on the type of organization. As a starting point, the types of services provided, staffing capabilities, financial resources on hand, and any other worthwhile information related to assets or resources should be noted.

While this phase does not involve in-depth data collection, the information gathered in step 4 will begin to provide a sense of the nature of the organization and a framework for further analysis.

Step 5: Collect Baseline Data

Step 5 encompasses an intensive data collection agenda involving both internal and external data audits. Although the primary driver of strategy development is the external environment, a thorough organizational and internal self-analysis is critical.

internal audit
The examination of internal data to assess organizational efficiency and effectiveness.

The intent of the **internal audit** is to determine who does what in the organization, when and where they do it, how they do it, and even why and how well they do it. This self-analysis covers a wide variety of organizational features and can be incredibly detailed. The following aspects of the organization might be addressed in an internal audit:

- Policies and procedures
- Existing services and products
- Nature, number, and characteristics of customers

- Utilization patterns for services
- Sales volume
- Staffing levels and personnel characteristics
- Management processes
- Financial situation
- Fee and pricing structure
- Billing and collection practices
- Marketing arrangements
- Location of service outlets
- Referral relationships

The internal audit for a strategic plan typically involves some type of operational analysis. This analysis is likely to include, at a minimum, an evaluation of patient flow, paper flow, and information flow. The operational analysis may also examine staffing patterns, physical space considerations, and productivity. Although this information might not apply directly to most marketing initiatives, it is critical to any internal marketing effort.

The scope of the **external audit** (or *environmental assessment*) is determined by the nature of the organization and the issues under consideration. Macro-level trends are more important than micro-level trends for organizations that are engaged in regional or national marketing initiatives. For most healthcare organizations, however, the external audit typically focuses on the local market because most marketing takes place at that level. The needs and assets of the local market area provide the context for strategy development.

external audit
The examination of the outside environment in which an organization operates; also known as an *environmental assessment*.

For marketers, the most important component of this step is market identification and description. The organization's market can be defined in a number of ways, and the definition used depends on the purpose of the analysis, the product or service being considered, the competitive environment, and even the type of organization involved in the marketing effort. Markets may be defined on the basis of geography, demographics, consumer demand, disease prevalence, and so forth. (The identification of healthcare markets is discussed in chapter 4.)

In a typical strategy development initiative, the service area is delineated. A number of methods can be used to determine the boundaries of the organization's service area. A common approach is to examine the origins of existing patients. Typically, a primary service area is identified that accounts for about 60 percent of the patients and a secondary service area that accounts for another 20 percent to 25 percent of patients. For a new organization, other methods might be used to determine the likely service area.

Once the service area has been delineated, the population of the market area is profiled. The type of information needed on the market

area population varies with the nature of the project. Demographic data, including biosocial and sociocultural traits, are typically compiled first. At a minimum, the analyst would examine the population in terms of age, sex, race and ethnicity, marital status or family structure, income, and education; insurance coverage is also typically assessed. Furthermore, the role of migration is increasingly important in community analysis, and information on the volume and traits of migrants—particularly newcomers to the market area—may be useful. (Additional details on useful types of community data are provided in chapter 7.)

The demographic analysis is often accompanied by an assessment of the psychographic or lifestyle characteristics of the market area population. Information on lifestyles can be used to determine the likely health priorities and behaviors of a target audience and any relevant subgroups. The attitudes that consumers display, often a reflection of their lifestyle, are likely to have considerable influence on the demand for almost all types of health services. Marketers must also consider the attitudes characterizing other constituents, such as referring physicians and policymakers.

A key component of the external audit is the competitive analysis. Organizations do not operate in a vacuum. Marketers must consider the healthcare environment and the other players in the arena. Any strategy must reflect the organization's position in the market and in relation to its competitors. Competitors include providers in the same specialty or providers offering the same services as well as those outside the area that perform competitive services. For physicians, competitors include hospitals, freestanding clinics, and specialists who may "poach" patients from another specialty. Exhibit 9.2 lists examples of data collected during internal and external audits.

EXHIBIT 9.2
Data Collected Through Internal and External Audits

Subjects for internal audit	Subjects for external audit
Organizational structure	Market area
Corporate culture	Target market
Decision-making process	Consumer characteristics
Key influentials	Key influentials
Staffing patterns	Utilization patterns
Sales volume	Competitors
Customer characteristics	Market positioning
Pricing structure	Market shares
Sources of revenue	Reimbursement trends
Referral sources	Profitability by service
Existing marketing initiatives	Consumer perceptions

Step 6: Identify Health Status

The salient health characteristics of the target market are identified during the course of the external audit. Data on health characteristics offer insights into the health status of the population and, ultimately, into the types of health services the population requires.

Not all healthcare providers deal directly with reproductive health issues, but local fertility patterns influence current and future patterns of demand, and a wide range of needs revolve around childbearing. Childbearing also triggers the need for such down-the-road services as pediatrics. Demand in this area may also encompass infertility treatments and treatments for conditions related to the male and female reproductive systems.

Determining the level of morbidity in a population is a critical task during this step, since morbidity attributes can be converted into demand data. For this reason, the incidence and prevalence rates for health conditions in a population provide a context for strategic development. To the extent possible, analysts must project incidence and prevalence rates into the future to anticipate service needs. Likewise, the level of disability in the population should be identified.

Knowledge of the levels of acute conditions, chronic conditions, reproductive health issues, mental health problems, and other health conditions is vital to understanding the healthcare needs of the market area population. The level of mortality and the leading causes of death in the market area population should also be studied. Market researchers are typically less interested in a population's death rate than its disease profile because the latter is more closely linked to service demand. Nevertheless, mortality data are almost always examined during this step because these data serve, to some extent, as a proxy for morbidity. Exhibit 9.3 describes the implications for healthcare marketing of the community health needs assessment provision of the Affordable Care Act (ACA) of 2010.

Step 7: Convert Health Status to Health Service Demand

Once the population's health status has been identified, marketers must then convert these characteristics into demand for goods and services. Demand can be conceptualized by service utilization (e.g., inpatient services, ambulatory care), diagnostic and therapeutic procedures, drug prescriptions, and other utilization indicators. Goods and services required by the population are a function of the needs identified in that population, such as care for acute conditions, chronic illnesses, reproductive issues, and mental and behavioral problems. The amount of goods and services actually consumed, however, is determined by a variety of factors (see chapter 7 for a discussion of health services utilization). For this reason, the actual health behavior of the target population needs to be considered.

**community health
needs assessment
(CHNA)**
An in-depth
assessment of
a community's
population, health
status, health-
related issues, and
unmet needs.

The ACA included provisions that have significant implications for not-for-profit hospitals and, ultimately, for the marketing of those entities. Beginning in 2012, all not-for-profit hospitals were required by the Internal Revenue Service (IRS) to complete a **community health needs assessment (CHNA)** once every three years. In addition, not-for-profit hospitals were required to develop, adopt, and implement a *community benefits* plan to address documented health needs in their service areas. The CHNA must include input from people representing the broad interests of the community served by each hospital, such as those with knowledge of public health. The results of the CHNA must be made widely available to the general public.

For nearly 100 years, not-for-profit hospitals in the United States have enjoyed exemption from taxes by virtue of their charitable status. Exemption from federal, state, and local taxes was initially allowed when community hospitals were funded through charitable donations and operated primarily with uncompensated staff to provide free care to indigent populations. In 1956, the IRS began to require not-for-profit hospitals to promote the overall health of the community and to provide services for members of the community who are not able to pay.

Today's not-for-profit hospitals are much different from those in operation when the charitable provisions were first enacted. These hospitals provide secondary and tertiary care services that use advanced medical technology to perform complex diagnostic and therapeutic procedures. The role of hospitals in the treatment of chronic diseases, acute care, and trauma has expanded, and over time many have become wealthy institutions with a level of power and influence in the community that belies their almshouse roots. The failure of some of these institutions to meet their community benefit expectations in the past led to increased oversight by regulatory agencies.

IRS revenue rulings in 1969 and 1983 established and clarified the community benefit standard requirements. These requirements were meant to ensure that adequate health services were available to members of the community who needed them. Bipartisan congressional interest in the issue increased over time and resulted in the ACA provision on "Additional Requirements for Charitable Hospitals."

This provision imposed new requirements for not-for-profit hospitals, including the CHNA requirements. The ACA requires not-for-profit hospitals to systematically evaluate the health needs of community residents. They must identify medical and behavioral health needs, the health services currently available, important health service gaps, and unmet health needs. Consumer interviews, focus groups, and surveys must be conducted to

(continued)

EXHIBIT 9.3
Implications of
the Affordable
Care Act for
Marketing
(continued)

ensure community participation and to incorporate the perspectives of residents into the availability of and access to health services. Projecting future health needs is an essential step in determining health service gaps, unmet health needs, and public assistance issues for the market area.

The ACA requirements go beyond previous expectations in that the hospital must not only document the extent to which the organization is addressing the known healthcare needs of the community but also determine the unmet needs and then submit a plan for meeting these needs. If a CHNA reveals a gap in the services available to the community, the hospital must document that it has a plan to address that deficiency even if it is not a service offered by the hospital.

The CHNA has three major implications for marketing:

1. To the extent that the hospital or health system is adequately providing a community benefit, the CHNA is a public relations boon—particularly if competitors are *not* meeting their obligations. Marketers can then present the hospital as a responsible community citizen that offers a wide range of benefits to the market area. The results of the CHNA should support the marketers' claim.

2. The hospital or those it engages to conduct the CHNA are given the opportunity to collect information from a wide variety of sources, including parties who may not have had a voice in hospital decision-making in the past. More important, the organization is given the opportunity to demonstrate that it is sincerely concerned about the overall needs of the community and is committed to meeting those needs.

3. The type of information generated by a CHNA should be compiled by marketers even in the absence of this requirement. This form of marketing research should reveal opportunities and threats in the environment and guide the development of the marketing strategy and targeted marketing initiatives. Marketers have every reason to support the CHNA and should encourage ongoing monitoring of market trends between assessments.

Since the enactment of the ACA, the federal government has taken a lax approach to enforcing its community benefit provisions. Standards for conducting community health needs assessments have been very general, and only on rare occasions has a hospital been censored for failing to meet the requirements for maintaining its not-for-profit status. At the time of this writing, there appears to be increased interest on the part of regulators and policymakers in pursuing the aims of the ACA provisions.

Health behavior (introduced in chapter 7) refers to any action aimed at restoring, maintaining, or enhancing an individual's (or a population's) health status. From a marketing perspective, information on health behavior provides insights into consumer behavior and the consumer decision-making process. Health behavior includes formal activities, such as physician visits, hospital admissions, and prescription drug consumption, and informal activities, such as wellness and fitness activities aimed at preventing disease or illness and maintaining, enhancing, or promoting well-being. Organizations employing social marketing, for example, are likely to require information on unhealthy lifestyles or risky behavior exhibited by the population.

An understanding of the population's health behavior should supplement previously developed knowledge of the market area's health needs and consider the social and cultural factors that influence health behavior. Decisions related to health behavior are now understood to be made within a social context, reflecting group norms as much as individual volition.

Utilization data are often the best source of information on health behavior. Healthcare organizations consider indicators of health behavior that are most relevant to their operations. In step 7, hospitals are likely to examine the broad set of utilization indicators described throughout this book, while other organizations with limited operations are likely to focus on a narrower range of utilization indicators.

Step 8: Conduct a Resource Inventory

A *resource inventory* identifies the facilities, personnel, and other resources of the organization that are available or may be used to address the healthcare needs of the target population. Sometimes the full range of available resources in the market area must be identified, but typically the focus of step 8 is on resources likely to make the organization competitive. Given the role of marketing in countering the competition, the resource inventory is a critical piece of the strategy development process. The following are some examples of resources commonly included in the inventory:

- Facilities
- Equipment
- Personnel
- Programs and services
- Funding sources
- Networks and relationships

The final category—networks and relationships—is important to managed care and negotiated contracts, and it is crucial in the new environment of the **accountable care organization** (see exhibit 9.4). Such connections

cannot be overestimated, and many organizations have come to view relationship building and **relationship management** as the responsibilities of the marketing department. The relationship building and management effort extends to organizations, medical personnel, and consumers.

In the future, patients are likely to use a provider because of their existing relationships (i.e., patients will form a relationship with their provider or health plan *before* they become sick rather than *after* they use the service or experience a medical episode). The existence of networks, integrated delivery systems, and strategic partners in the community should be fully addressed during strategic planning.

relationship management
An approach to cultivating long-term relationships rather than short-term or one-time transactions.

EXHIBIT 9.4
Accountable Care Organizations: The Future of Healthcare?

According to the Centers for Medicare & Medicaid Services (2019a), accountable care organizations (ACOs) are "groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high quality care to their Medicare patients." ACOs are intended to make healthcare delivery more efficient, lower cost, better coordinated, and higher in quality. This organizational structure is intended to address the long-standing problems in the US healthcare system of uneven quality, unsustainable costs, and fragmented care.

ACO implementation began in 2012, when Medicare established the Pioneer ACO Model and the Medicare Shared Savings Program through contracts with fledgling ACOs. Today, many organizations have begun commercial payer ACO contracts, and several states have begun negotiating or implementing ACO contracts under Medicaid programs. At this early stage, it is too soon to know whether ACOs will spur systemwide transformation of healthcare delivery. However, evidence from Medicare's Physician Group Practice Demonstration suggests that the ACO model holds promise. Still, many have raised doubts about the model's ability to achieve its aims and concerns about the high cost and technical difficulty of establishing ACOs; the number of provider organizations that will sponsor or form ACOs is unclear at this point. Communities that have preexisting managed care or health maintenance organizations or pay-for-performance guidelines appear to be fertile ground for ACO development, but little else is known about the factors that contribute to ACO formation.

The implications of ACOs for healthcare marketing are yet unknown, but marketers may begin preparations in several areas in the event that their organization launches or joins an ACO initiative:

(continued)

EXHIBIT 9.4
Accountable
Care
Organizations:
The Future of
Healthcare?
(continued)

- **Marketing the ACO.** Few providers, consumers, or other customers will understand the concept initially, so marketers must make ACO information available to a wide range of existing and potential constituents. Marketers must adhere to the National Committee for Quality Assurance (NCQA) guidelines for promoting the ACO. According to the NCQA guidelines, only accredited ACOs can advertise their accreditation status. Participating providers and other entities associated with the accredited ACO are not allowed to advertise the accreditation status or use the accreditation seal. However, the accredited ACO can list its participating providers and mention its accreditation status.

- **Involving potential partners.** To convince potential partners to join an ACO, they must be given adequate data and information specific to the market area to convince them of the benefits of partnering. Marketers must recognize that in some communities, competition for partners may already be ongoing between two or more ACOs. These partnerships may be regarded as "unholy alliances," but they can unite organizations that may have had a history of a lack of cooperation at best and competition at worst.

- **Competing for customers.** Whether the marketers are attracting individual patients participating through a health insurance exchange, employees of a particular organization, or other groups of consumers, they must promote the benefits of ACO participation. If competition is intense, marketers must detail the merits of enrollment in their particular ACO plan. This situation makes an understanding of the market area population even more important.

- **Internal marketing.** All personnel of an organization participating in an ACO must be made aware of this innovative organizational structure and what it means for customer service. Ongoing communication is necessary to ensure that all parties are fully informed and that misinformation does not rule the day.

Although some progress has been made in introducing ACOs into the healthcare arena, this movement has not achieved the momentum that was predicted. Today, some of the developments noted in chapter 8 may influence the future course of the ACO movement.

Step 9: The State of the Organization

By step 8, the marketer has compiled a great deal of valuable data. On the basis of the information available, the marketer should be able to determine the following:

- Overall societal, healthcare, and service trends
- Market area delineation
- Market area population profile
- Market area population health characteristics
- Level of demand for health services
- Current position of the organization or product
- Profile of current customers
- Resources available in the service area
- Gaps between needs and resources
- Future developments that will affect the organization

The state of the organization can now be frankly described and its position in the market assessed. Thus informed, all parties can revisit the initial assumptions stated in step 2 and plan for strategy development. Case study 9.2 describes a state-of-the-practice report for healthcare administrators.

CASE STUDY 9.2
The State of the Practice

A world-class orthopedic practice affiliated with a large private hospital had dominated a regional market of one million residents for a number of decades. The hospital counted on the practice for a large share of its admissions at a time when most surgery was performed on an inpatient basis. Changes in the local healthcare environment were creating uncertainty for the hospital, and its administration insisted that the orthopedic practice participate in a strategic planning initiative. Subsequently, a comprehensive assessment of the practice and its position in the market was carried out.

When it was time for the planning staff to present their "state of the practice" report, the executive team expected to hear what a successful and

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profitable operation they were overseeing. The executive team was surprised to hear the results of the strategic analysis, which revealed the following:

- The practice had become isolated in the traditional medical center, while much of its population had moved to the suburbs.
- Competing practices with less skilled surgeons and poorer reputations were capturing the growing suburban population because of their convenient locations and superior customer service.
- Competing practices were early adopters of new outpatient techniques, while the practice continued to emphasize inpatient procedures.
- A market had developed for sports medicine and elective surgery, but the practice was excluded from this market by more entrepreneurial providers.
- The clinic's practice of assigning patients to surgeons based on the preferences of the practice rather than those of the patients was viewed negatively.
- Long-established referral networks—primarily among surgeons who had trained at the clinic—were no longer effective, and the clinic's graduates had increasingly established competing practices in the surrounding area.

The results of the analysis prompted a number of changes to the structure and operations of the clinic. Satellite clinics were opened in growing suburban areas, extended hours and walk-in clinics were offered, patient preferences were taken into account in physician assignment, most inpatient procedures were transformed into outpatient procedures, and the range of orthopedic specialties was expanded to take advantage of consumer demand.

The resulting strategic plan reflected the attributes of the market and anticipated future changes that would affect the practice. Within several years, the clinic had regained its prominence in the local area and the region and reestablished itself as a world leader in orthopedic surgery.

Case Study Discussion Questions

1. What prompted the implementation of an in-depth assessment of this successful specialty practice?
2. What were the results of the strategic analysis?
3. What were some of the unexpected findings from the assessment?
4. How did the practice respond to this information?
5. What was the long-term impact of the practice assessment?

Developing the Strategy

When should the strategy be developed? The development of strategy should occur when adequate baseline data have been acquired and analyzed. It is not unusual for a strategy to begin to develop early in the planning process, and then be finalized after all information has been collated and analyzed. The sequencing of the strategy development process, as described in this section, depends on the nature and circumstances of the organization. The actual process of specifying a strategy is discussed later in the chapter.

Setting Goals

The goals established during strategy development should reflect the information that has been compiled to date and should align with the organization's mission statement. As defined earlier, a goal depicts an ideal state and indicates where the organization would like to be at some point in the future. For example, the goal of a national medical products company may be to position itself as the low-cost provider of a certain product. For a local health services provider, the goal may be to establish itself as a niche player to take advantage of specified market opportunities. For the purveyor of a specific service, the goal may be to become the provider of choice for a particular segment of the market.

Setting Objectives

Each goal should encompass a number of **objectives** that support its achievement. Objectives are the tactics that support the strategic initiatives. Whereas goals are typically broad statements, objectives should be specific, concise, and time bound. For example, in support of its goal of expanding its orthopedic product lines, a hospital might set an objective that its orthopedic practice will recruit a sports medicine specialist within the next 12 months.

objective
A specific, concise, time-bound, formally designated target in support of a goal.

Having multiple objectives for a single goal is common, because action will likely be required on a number of different fronts. As the planning team establishes objectives, any barriers to accomplishing the organization's stated objectives should be noted, described, and assessed.

The possibility that pursuit of the objectives will bring about unanticipated consequences should also be considered. For example, a successful marketing campaign may overwhelm the service providers or otherwise strain resources. If the organization cannot deliver on the marketer's promises, negative consequences will likely result. A marketing campaign may alert competitors to the organization's strategic direction, or the campaign might alienate a party that had been a strong supporter of the organization. Although negative consequences cannot be eliminated completely, planning for them is the first step toward minimizing their impact.

Selecting a Strategy

In selecting a strategy, analysts must consider the organization's nature and mission, the market's characteristics (specifically, those of the customers), and the nature of the existing competition. The chosen strategy will influence the public's perception of the organization and carry long-term implications. Unfortunately, no standard list of strategies exists from which the organization can choose. Each situation is unique and will call for creative design.

SWOT Analysis

SWOT analysis
An assessment of an organization's strengths, weaknesses, opportunities, and threats.

One technique that provides guidance in conceptualizing the state of the organization is SWOT analysis. A **SWOT analysis** examines the strengths, weaknesses, opportunities, and threats related to markets, organizations, or products. It considers several dimensions of the organization simultaneously, establishing a basis for strategy development.

SWOT analysis has become a common technique for assessing the position of a healthcare organization in its market. SWOT examines the organization, its environment, and the ways the organization and environment interact. It is an important tool for strategists and marketers, and it has numerous applications in healthcare. SWOT analysis can be done for an entire organization or for subdivisions of the organization. Factors related to both the macroenvironment (societal) and the microenvironment (local) should be considered.

The four dimensions of the SWOT analysis are as follows:

1. **A strength is a distinctive skill, attribute, or competence that helps achieve stated objectives.** Strengths can include marketing capabilities, management skills, image or reputation, and financial resources.
2. **A weakness is an attribute that indicates a vulnerability of the organization that hinders the achievement of its stated objectives.** Weaknesses might include inadequate working capital, poor management skills, lack of services, and personnel shortages.
3. **An opportunity is any feature of the external environment that has the potential to be a benefit during the pursuit of stated objectives.** Opportunities may take the form of gaps in the market, new sources of reimbursement, demographic shifts, weaknesses among competitors, and other potential areas for exploitation.
4. **A threat is an environmental condition or trend that may present problems with or prevent the achievement of stated objectives.** Threats may take the form of competitive activity, unfavorable

demographic shifts, reimbursement changes, and other external developments.

The SWOT analysis should involve quantitative research and qualitative research. The former should include community or patient surveys, while the latter should include **personal interviews** with key personnel (e.g., stakeholders, key decision makers, opinion leaders). Because the identified strengths, weaknesses, opportunities, and threats guide further development of the plan, consensus needs to be reached on these attributes before proceeding with the planning process. Case study 9.3 presents an example of a SWOT analysis for a medical clinic.

personal interview
A data collection technique that involves face-to-face interaction and the administration of a survey by the interviewer to the respondent.

Case Study 9.3
A SWOT Analysis for a Medical Clinic

A faith-based clinic embarked on the development of a strategic plan to guide its operations over the next five years. As part of the process, the planning team conducted a SWOT analysis. This analysis involved identifying the strengths and weaknesses of the organization, the opportunities that existed in the current and future environments, and any threats that might hinder its success. To obtain a diversity of opinions on these issues, the process was carried out with clinic staff, patients, and with representatives from the community.

The clinic's location, quality of staff, caring philosophy, and willingness to accept all patients were identified as strengths. Weaknesses that were noted included overcrowding, a lack of after-hours services, and few medical specialists. Not surprisingly, clinic staff and patients identified different weaknesses.

When opportunities were enumerated, the stakeholders agreed that the clinic could benefit from additional locations, extended hours, expanded service offerings, and more modern facilities. While the staff, patients, and community members agreed that the clinic faced limited threats because of its near monopoly on Medicaid and uninsured patients, some expressed concern about the defection of increasingly dispersed customers to clinics with more convenient locations.

The results of the SWOT analysis informed the development of the clinic's five-year strategic plan and helped set the parameters for the organization's future development.

The assessment of strengths revealed attributes on which the organization should capitalize. The weaknesses indicated aspects that should be minimized or ameliorated. The threats indicated aspects that should be neutralized or countered. Of the four dimensions, opportunities were the most salient for

strategy development, because an implicit goal of the strategy chosen should be to exploit opportunities in the marketplace.

Case Study Discussion Questions

1. What is a SWOT analysis designed to discover?
2. What sources of information were identified to inform the SWOT process?
3. What were the findings of the SWOT analysis?
4. How were these findings used by the clinic?

second-fiddle strategy
A marketing approach that concedes the lead position in the market in favor of being an effective runner-up.

flanking strategy
A marketing approach that seeks to avoid confrontation with better-positioned competitors by bypassing their captive audiences and cultivating neglected target audiences.

market penetration strategy
A marketing approach that emphasizes extracting more product sales or greater service utilization from an existing customer base.

market development strategy
A marketing approach that emphasizes introducing an existing product to a new or poorly cultivated market.

Strategic Approaches

Ideally, the marketing strategy will support the organization's mission and reflect the strategies embodied in the organization's strategic plan. Thus, if the strategic plan calls for positioning the organization as a caring organization, the marketing strategy should advance this plan. If the organization seeks to promote itself as a technologically advanced facility, the marketing strategy should support this position. Sometimes, of course, a marketing strategy may call for a departure from this established approach. For example, a hospital that has adopted a "we're number two" position against a powerful competitor may develop a world-class program and decide to take a much more aggressive marketing approach to promote this new service. In light of this development, the hospital's **second-fiddle strategy** may be displaced by a **flanking strategy,** whereby the organization takes a parallel track with the goal of outflanking the market leader.

Other approaches may involve a specific target market and a market-oriented strategy, while still others may revolve around a product or service line and a product-oriented strategy. Thus, one healthcare system may position itself as the premier clinic for women's services (a population-focused approach), while another's strategy may focus on cardiology services (a service-based approach). One approach may address an aspect of the marketing mix, as in the case of a pricing strategy, while another may cut across the marketing mix and be broader in scope.

A **market penetration strategy** (existing market and existing product) focuses on efforts to extract more sales and greater utilization from existing markets by acquiring customers from competitors and by converting nonusers into users. A **market development strategy** (new market and existing product) focuses on discovering new market sectors on the basis of different benefit profiles, establishing new distribution channels, developing new marketing

approaches, and identifying underserved geographic areas. For example, a market niche strategy might be pursued by a healthcare organization that serves small segments of the healthcare market that competitors overlook or ignore.

A **new product strategy** or *service development strategy* (existing market and new product) focuses on modifying existing services by introducing different levels of quality or developing entirely new products. A **diversification strategy** (new market and new product) involves such actions as horizontal or vertical integration (or sometimes both) to extend the organization's operations into additional services not previously offered.

The relationship between the product and the market is another way to view strategic development. This relationship can take one of five distinct configurations: (1) full service, (2) product/market specialization, (3) production specialization, (4) market specialization, and (5) selective specialization. These configurations are illustrated in exhibit 9.5. Examples of each of these relationships can be found in healthcare (although the term *service* should be substituted for *product* in most cases). The *full-service approach*

new product strategy
A marketing approach that introduces different levels of quality or entirely new products into an existing market.

diversification strategy
A marketing approach that emphasizes the introduction of a new product into a new market.
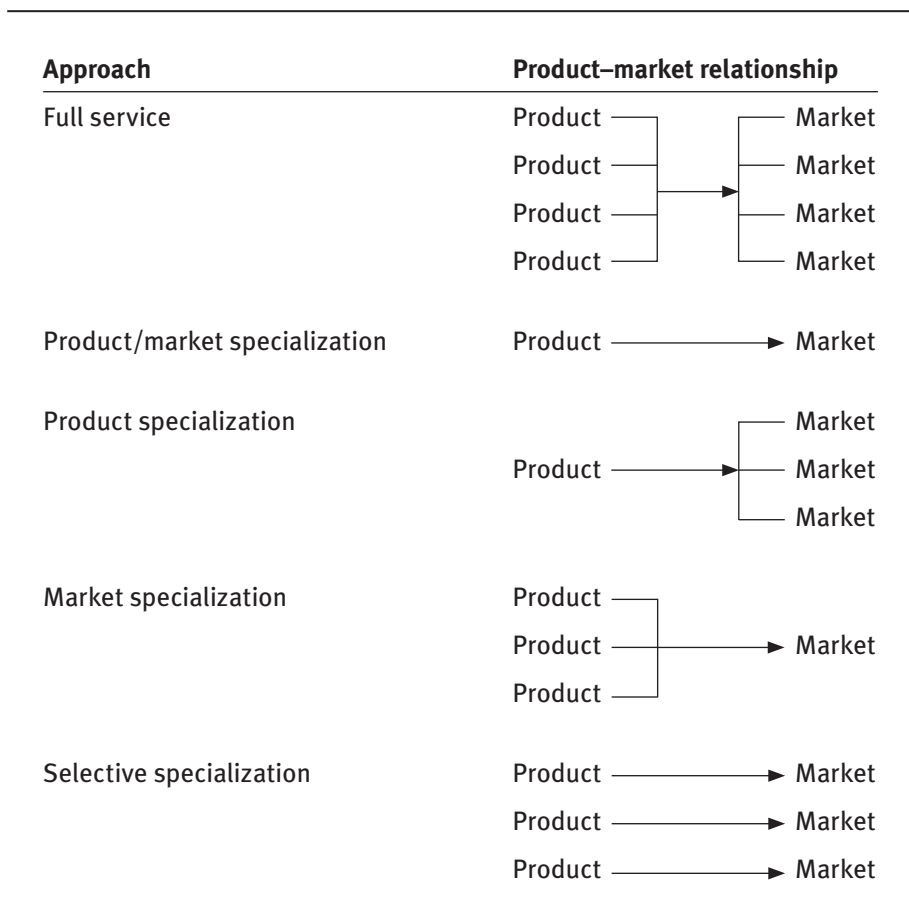
EXHIBIT 9.5
Product–Market Relationships

Approach	Product–market relationship
Full service	Product → Market (Product, Product, Product, Product linked to Market, Market, Market, Market)
Product/market specialization	Product → Market
Product specialization	Product → Market, Market, Market
Market specialization	Product, Product, Product → Market
Selective specialization	Product → Market; Product → Market; Product → Market

was typical of most hospitals in the past, particularly during the production-focused era following World War II. General hospitals attempted to be all things to all people, and their strategies reflected this orientation. A *product/market specialization approach* is typically adopted by an organization that supports a single service or service line for a defined market, such as in the case of a home infusion company that provides a discrete set of services to a narrowly defined market of home-bound pediatric patients.

Firms in the business of *product specialization* offer a distinct set of products that can be promoted to a number of markets in which consumers have one characteristic in common. For example, a firm specializing in assistive equipment (e.g., wheelchairs, walkers, home monitoring devices) promotes its products to consumers who have physical limitations and thus require assistance with daily living. The diverse market for these products would include the frail elderly, individuals suffering from congenital conditions or childhood illness, injury victims, and those undergoing rehabilitation from surgery—distinctly different subpopulations requiring similar services.

market specialization
A marketing approach that emphasizes the introduction of a range of products into a particular market.

Organizations emphasizing **market specialization** typically develop a range of products geared to a certain market. Organizations that offer senior services or that specialize in women's healthcare goods and services are examples of enterprises pursuing market specialization. Pharmaceutical companies are probably the best-known example of firms engaged in **selective specialization**. Each drug constitutes a product line that is targeted to a specific market. For example, ABC Pharmaceutical's hypertension drug is marketed to the hypertensive population, its diabetes drug to the population affected by diabetes, its arthritis drug to the population with rheumatoid arthritis, and so forth.

selective specialization
A marketing approach that emphasizes the customization of a line of products (e.g., pharmaceuticals) to meet the needs of different target populations.

Another approach to strategy development examines the combination of market attractiveness and competitiveness found in the situation under study. For example, an area characterized by high market attractiveness and high competitiveness might call for a strategy involving investment and growth or, more likely, a strategy emphasizing selective growth in vulnerable areas. Different combinations of market attractiveness and competitiveness call for different strategies.

The following are examples of market-oriented strategies typically used in healthcare:

- **Dominance strategy.** The number-one player in the market focuses on maintaining its position.
- **Second-fiddle strategy.** The runner-up in the market accepts its second-place status and acts accordingly (also called a *market-follower strategy*).

- **Frontal attack strategy.** The organization confronts the market leader or major competitors head-on.
- **Niche strategy.** The organization concedes that it cannot successfully compete for the mainstream market but instead concentrates on niche markets based on geography, population groups, or selected services.
- **Flanking strategy.** The organization outflanks the competition by entering new markets, cultivating new populations, or offering fringe products.

A sample strategy development process is presented in case study 9.4 to illustrate these approaches.

CASE STUDY 9.4
Hospital Strategy Development

A hospital management company acquired a 150-bed general hospital in a medium-sized city in the southeastern United States. Although the company had little knowledge of the local market when it acquired the facility, its intention was to continue to run the facility as a general hospital. However, the hospital had not been profitable in offering general care, and it faced competition from three large facilities that had access to almost unlimited resources. For these reasons, the new managers performed a situational analysis to determine the most appropriate strategy.

The managers commissioned a study of the immediate market area—the five-mile radius surrounding the hospital. This market area was examined in the context of overall trends for the metropolitan area. The analysts reviewed demographic trends to determine the future size and composition of the population as well as trends in service utilization. This information was used to develop projections of the future demand for health services in the urban area and in the immediate market area. Particular attention was paid to the hospital's competitors, to determine the services offered by other facilities, the existing market shares for those services, and the nature of existing managed care contracts and other negotiated relationships.

The analysis determined that the immediate service area was not likely to support a general hospital. The payer mix was not favorable, and other facilities controlled significant portions of the local market. Further, most area employers were tied to the provider networks of the two dominant health systems in the community. The hospital did not have a large or strong

(continued)

medical staff. Given the existing provider networks involving competing hospitals, attracting additional physicians to the facility would have been difficult.

Conceding that it could not operate effectively as a general community hospital and that confronting large, established competitors head-on was not practical, the managers considered other strategies. After analyzing the data, the managers decided that a niche strategy was appropriate for the hospital. It would identify niche services, and the corporate focus would be on exploiting those niches.

The hospital had previously developed an occupational health program that catered to the employers in the area. Facilities were available, a basic program was in place, and adequate personnel were available to expand the program. Because no other entity was offering this service in the community, expansion of this program seemed like a logical next step. In addition, the hospital had a long-standing behavioral health program that had experienced some success in attracting patients, and some of the area's leading substance abuse experts were affiliated with the hospital. Thus, because a program was already in place, key personnel were available, and the market was underserved, the hospital also identified behavioral health (including substance abuse treatment) as a promising niche. Finally, in view of the large Medicare population in the area and the lack of geropsychiatric services in the community, the hospital decided to add psychiatric services for seniors to its behavioral health program. This niche strategy focused on services that were not being adequately provided to the community.

One other niche was considered but eventually rejected. Market research indicated that minority group members—primarily African Americans—made up a large proportion of the surrounding community. The Hispanic population in the area was also growing rapidly. Further, mainstream providers historically had neglected these populations. A niche strategy focusing on these target populations was considered that would convert the hospital into a facility specializing in minority care. Because of the many unknowns surrounding this concept and the potential controversy such a strategy might generate, this idea was rejected.

After carefully assessing the situation, the managers conceded that the facility could not successfully operate as a general hospital and therefore chose to pursue a niche strategy. The approach has—in the short run at least—been relatively successful. The hospital has maintained a significant share of the occupational health and behavioral health markets in the city and earned a reputation as a facility that does not offer a lot of services but does a good job with the services it provides.

Case Study Discussion Questions

1. What factors raised concerns among the hospital's managers about the viability of the facility as a general community hospital, and how did the market analysis validate those concerns?
2. What steps were taken to determine the most appropriate focus for the hospital's services?
3. Which strategic approach did the managers choose, and to what types of services did it direct them?

The Four Ps

A traditional approach to selecting a strategy that is used in other industries considers the role of the marketing mix in establishing the strategic direction. The marketing mix is the set of controllable variables that an organization uses to influence the target market. The mix includes the four Ps: product, price, place, and promotion (see chapter 2). The strategy could focus on any dimension of the four Ps, or it could cut across all four. Strategic approaches based on the four components of the marketing mix are addressed in this section.

Product Strategies

A *product strategy* focuses on one good (or product line) or service (or service line). The strategy is built around the attributes of the product, and the marketing approach attempts to capitalize on those product attributes (e.g., quality, durability).

A product strategy may involve a preemptive approach in which only limited differences exist among products in the same class. A preemptive approach attempts to convey something about a product that competitors are reluctant to repeat because of the risk of being labeled imitators. Another product-oriented approach focuses on the unique selling proposition, in which an organization establishes and communicates a product benefit that competitors cannot make or refuse to make. Marketers might also adopt a brand image strategy, which emphasizes psychological rather than physical differences among products. The aim in this case is to associate the product with symbols and characters that resonate with the target audience.

A product strategy may use *positioning* to draw comparisons between one product and another in the consumer's mind. The organization's task is to identify weaknesses in competing products and strengths in its own that can be reinforced to gain a competitive edge. Positioning indicates to

customers how the company differs from current or potential competitors. A positioning approach can support a product strategy through the following steps:

1. Identify competitors and competing products in the defined product category.
2. Determine consumers' perceptions of competing products.
3. Determine the relative position of competing products using a perceptional positioning map that graphically depicts the market.
4. Identify the gap in the market by assessing customer needs in relation to existing product offerings.
5. Select desired positioning.
6. Implement a promotional strategy.
7. Monitor and control the positioning process.

Pricing Strategies

Healthcare providers seldom use pricing strategies because end users typically do not know the prices of health services before receiving them, and physicians (the primary decision makers on healthcare purchasing) generally make care decisions without taking pricing into consideration. Further, the amount of reimbursement from third-party payers is often established irrespective of the price set by the provider. For these reasons, healthcare has few opportunities to compete on the basis of price. On the other hand, purveyors of healthcare consumer products—such as personal health product manufacturers—are likely to use pricing strategies in much the same manner that producers of other consumer goods do.

Insurance companies represent another sector of the industry for which price may be a factor. Although insurance premiums have been established according to the perceived risk to the insurer and typically are regulated at the state level, the emergence of managed care plans and the establishment of the ACA marketplace have prompted unprecedented competition. Because their products are essentially the same, price became a rational basis for competition. The health insurance exchanges introduced by the ACA have forced insurance companies to review their pricing practices.

A major drawback to the use of pricing strategies in healthcare is that organizations and practitioners have not been able to determine the actual cost of providing a service. The development of an intelligent pricing strategy requires some objective basis. Further, restrictions related to price fixing have prevented healthcare providers from using the fee schedules of other organizations as models. Without a systematic means for determining costs, it is almost impossible to develop a rational pricing schedule.

Despite these barriers, a growing number of providers—particularly those performing elective procedures—are competing on price for services that are discretionary and typically paid for out of pocket. Most cosmetic surgery would be included in this category, and as competition has increased among ophthalmic surgeons, ophthalmologists performing laser eye surgery have also begun to compete on the basis of price.

Place Strategies

Place focuses on the way a good or service is distributed. In healthcare, place refers to the location where services are rendered. An important aspect of place is the **channel** of distribution—the path that a good or service takes as it travels from the producer to the consumer. Although this concept has traditionally been applied to consumer goods, it can also be applied to health services.

channel
The mechanism used to distribute a promotional message, good, or service.

A variety of distribution channels are used to deliver health services. Primary care centers are typically located near potential patients (e.g., neighborhoods, heavily populated residential areas), whereas tertiary services are concentrated in medical centers, regardless of the proximity to population centers. Emergency services are delivered through a combination of distribution methods; ambulances travel to the patient and then take the patient to the hospital for treatment.

During the production-focused era in healthcare, little emphasis was placed on the location of service outlets. Most intensive care was provided by hospitals, and patients were expected to travel to where the hospital was located. Physicians (particularly specialists) had the same attitude. Although primary care providers may have sought locations in the community that were close to patient populations, the overriding attitude was "if you build it, they will come."

Since the 1970s, healthcare systems have attempted to control the primary care market through **channel management.** The intent was to control referral sources by purchasing and "controlling" physician practices. However, hospital administrators failed to consider that the product—physician practice patterns—could not be easily controlled. As a result, such attempts largely failed. Although hospitals controlled the distribution of physician practices, they were unable to control the products or prices these practices offered, and therefore they failed to benefit from their control of the distribution outlets. Since 2010, however, the number of practice acquisitions has increased as hospital systems have become more astute at managing outpatient services and as physician practices have faced severe financial constraints. This wave of practice acquisitions has been accomplished by purchasing, partnering with, or otherwise exerting influence over primary care providers in the community.

channel management
A formal program for reaching and servicing customers through a particular marketing channel.

As the focus of healthcare shifted from the inpatient setting to the outpatient setting, healthcare providers were forced to pay attention to the location of services. Hospitals were largely immobile, but outpatient services could be established almost anywhere. Organizations that sought to compete with hospitals took advantage of their relative immobility and established facilities in proximity to target markets.

The emergence of place strategies was driven by a new generation of healthcare consumers (baby boomers) with different expectations of healthcare providers. These patients brought a consumer orientation that demanded convenience of location and easy access to services. They placed a high value on their time and expected the same of service providers. The healthcare industry responded to this emerging consumerism by offering urgent care centers and freestanding diagnostic and surgery centers as convenient alternatives to traditional sources of care.

The emphasis on place has also been encouraged by the employers and business coalitions that are paying a large share of the healthcare bill. Employers want their employees to have convenient access to services, not only to ensure patient satisfaction but to limit the time they are away from work using these services. In addition, one of the bases for competition among managed care plans is the convenience they provide to enrollees. To succeed, health plans found they had to establish networks of providers that were distributed in a manner that would meet the needs of their enrollee populations.

The combined influence of these developments—particularly the shift from inpatient care to outpatient care—has encouraged providers to take healthcare to the community. Expecting patients to come to the source of care is no longer a viable approach. The contemporary consumer demands convenient locations, and, in cases in which locations cannot be changed, healthcare providers are working to improve the value of an existing location through more efficient patient-processing methods or redesign to create more appealing facilities.

Promotional Strategies

The most visible type of strategy used by healthcare organizations involves the promotion of the organization or its services. As healthcare marketing came into its own during the 1980s and 1990s, it focused on advertising, direct mail, and other traditional promotional strategies. The limitations of competition based on product, price, and place encouraged healthcare providers to differentiate themselves through promotional strategies.

Promotional strategies should reflect the organization's overriding strategic orientation. If, for example, a hospital adopts a niche strategy, its promotional efforts should be focused on a narrow range of services or a

targeted population. On the other hand, a hospital pursuing a full-service strategy should develop an approach that promotes the organization as a desirable choice for almost any service.

Similarly, a promotional strategy should reflect the organization's chosen approach to the market. If the organization has adopted an aggressive, hard-sell approach, the promotional strategy should reflect it. Conversely, if the organization has adopted a soft-sell approach, it would be reflected in initiatives such as educating the market.

A promotion-oriented strategy can take a variety of forms. A *resonance strategy* strikes a chord with the consumer. The intention is to portray a lifestyle orientation that is synonymous with the target group and easily recognizable. For example, this approach might be used to promote a hospital-based fitness center. An *emotional strategy* plays on (and to) consumers' feelings—as in the case of children's health services. A second-tier oncology practice may differentiate itself by providing superior emotional support services for cancer patients and their families.

In the contemporary healthcare arena, promotional strategies involve far more than advertising. Increasingly, healthcare providers have turned to personal selling and sales promotions to compete more effectively. To develop an effective promotional strategy, marketers must understand the media (including social media) available to them and be able to craft a message with appropriate content and tone. (Promotional strategies are addressed frequently throughout the remainder of the book.)

The marketing mix concept discussed earlier has been adopted from other industries and applied to healthcare. Critics suggest, however, that the four Ps of marketing have never fit comfortably in healthcare. As healthcare providers become more service oriented, they, too, are criticizing this concept. Some have suggested the need to revise the four Ps and replace them with some other set of attributes that are more appropriate for contemporary healthcare. These conflicting views on the importance of the four Ps are a source of ongoing debate among health professionals.

Branding as a Strategy

Branding as a strategy is a relatively recent phenomenon in healthcare. A **brand** is a name, term, symbol, or design (or combination thereof) that signifies the goods or services of one seller or group of sellers. *Brand identity* refers to the visual features that create awareness in the mind of the consumer; these features include the brand's name, image, typography, color, package design, and slogans. The intent of the brand identity is to distinguish in the eye of the user a company's product from competing products

branding
The creation of a brand for a company, service, or product.

brand
A name, term, symbol, or design (or combination thereof) that signifies the goods or services of one seller or group of sellers.

(Mangini 2002). The brand image indicates what business the company is in, what benefit the company provides, and why the company is better than its competition. Thus, brand identity is the visual, emotional, rational, and cultural image that a consumer associates with a company or product.

Corporate branding is often confused with corporate identity or corporate image, but these three terms have different meanings:

- *Corporate identity* refers to a company's name, logo, or tagline.
- *Corporate image* is the public's perception of a company—whether that perception is intended or not.
- *Corporate branding* is a business process that is planned, strategically focused, and integrated throughout the organization. It establishes direction, leadership, clarity of purpose, and energy for a company's corporate brand.

Brand associations are attributes of a product or company that consumers think of when they hear or see a brand name. An effective brand name evokes positive associations with the company. Therefore, the logic behind branding is simple: If consumers are familiar with a company's brand and perceive it positively, they are more likely to purchase the company's products.

A company's brand also has significant internal value. A strong corporate brand generates and sustains internal momentum. Employees have been shown to be more committed to the brand's promise if it is understood and supported by the organization's leadership (Lake 2019). To maximize the effectiveness of its brand, a company must ensure that it is understood by all relevant audiences: customers, prospective consumers, business partners, the media, and employees. Corporate communication should reinforce the branding effort.

Branding is most effective for products that command a mass market, can benefit from advertising, and can be effectively evaluated by consumers. Few healthcare services have these characteristics. Because most healthcare is provided locally, few healthcare organizations need to develop national brand recognition. Furthermore, many organizations have been around for a long time, and efforts to rebrand them are often met with resistance. The national hospital chain HCA, for example, went through a period of renaming all of its hospitals with the HCA brand, only to have to revert to the hospitals' old names in some cases because of local resistance. The Mayo Clinic and the Cleveland Clinic are examples of healthcare organizations that successfully established national brands, but few organizations are in their league.

The lag in adopting branding strategies in healthcare has had both negative and positive consequences for healthcare marketing. The negative consequences include a lack of expertise and success in healthcare branding efforts. The positive consequence is that the healthcare industry can learn lessons from other industries. The emergence of the new healthcare consumer has prompted increased interest in branding among healthcare providers. This revitalized consumerism is being driven by well-informed consumers who demand choices.

For established retailers of healthcare products (e.g., pharmaceutical and personal health products companies), branding has been an inherent part of their strategy. In these cases, consumers are more likely to be familiar with the brand (e.g., Claritin, Band-Aid) than they are with the corporation that created it. The development of branding strategies in this segment of the industry reflects the relative ease of branding consumer products. According to Mangini (2002), three steps must be followed to establish a brand identity:

1. **Decide what to brand.** The organization must carefully consider the services it offers, the people who provide those services, the competition for those services, and the population the organization serves. Branding can focus on the entire health system, outpatient services, a prominent department, or a particular medical group. In addition, an institution may choose to focus on goods and services that are in high demand but difficult to emulate. No matter what the focus, effective brands are almost always linked to a target audience, such as women or senior citizens.

2. **Define the brand message.** The organization must decide what information to communicate about the service it wants to brand. For example, the focus may be on quality of care, convenience, or technology capabilities. Any of these approaches can be effective if the brand message relates to the target audience and the service being branded.

3. **Communicate the brand both internally and externally.** Internal communication is important to encourage and gain the staff acceptance and enthusiasm necessary for brand success. Staff members can be brought on board by giving them ownership of the branding initiative and rewarding them for their involvement in the campaign. External communication can take place through such channels as promotional materials and advertising. Most important, however, is that the message—both internal and external—is clear, consistent, and continuous.

The true test of a brand is the institution's performance. An organization must be confident that it can fulfill the promise of its brand. Every customer interaction must reinforce the brand identity, and that identity must be used to establish a relationship with consumers. If consumers have a positive interaction with the organization and are satisfied, they are potential sources of new business. Thus, information is key in determining how the institution is implementing its brand. It must develop a systemwide data collection, analysis, and reporting network so that it can continually assess the success of its brand and make necessary adjustments.

Once a brand is built, it must be constantly updated and revitalized. Brand revitalization does not simply mean creating a new logo or repackaging a product but also examining the company's point of differentiation. A successful branding process provides a framework that links the branding strategy to the business strategy. This linkage is essential because the commitment and involvement of executive management are key components of a successful branding strategy. Finally, once all key players understand the institution's brand identity and framework, documentation of the branding system can begin.

A number of important lessons about the healthcare branding process must be mentioned here:

- A branding strategy must build consensus and ensure concurrence with the business strategy.
- An organization's marketing department must be cautious about making changes to long-standing brand franchises. A strong brand, once tarnished, is difficult to reinstate.
- An organization must follow a set of guidelines when developing its branding strategy, but it should also be flexible and allow carefully chosen exceptions to those rules.
- An organization must consider its competitors' current and future brands.
- To prevent inconsistency, an enterprise must secure commitment from every organizational level and all key players must reach consensus.
- An organization must align its values with the values of its branding strategy.

Case study 9.5 provides an example of a successful branding initiative.

Case Study 9.5
Establishing a Brand

One example of a successful branding initiative is the one developed by the Cleveland Clinic Foundation in Cleveland, Ohio. The outcome of its efforts demonstrates what branding can do for a healthcare organization and how a small outpatient practice can be transformed into a national brand.

The Cleveland Clinic was founded in 1921 by four veterans of World War I medical units, and it is now a leading American healthcare organization. From its start, the clinic was highly regarded for the quality of its specialty care, basic science research, and medical innovations. The clinic's initial marketing approach—typical of healthcare organizations in the premarketing era—targeted the physician audience in an effort to increase patient referrals. Promotional activities consisted of developing and distributing fundraising brochures and disseminating press releases to the media.

In the 1990s, the clinic realized that healthcare consumers were looking for a trusted brand name, and thus it expanded its marketing research. This research indicated that local consumers highly respected the Cleveland Clinic name, so the organization focused on maintaining and protecting its brand through an integrated marketing effort. The 1990s also marked a period of hospital mergers and acquisitions in the healthcare industry, and the clinic played a significant role in this development. Over a two-year period, it merged with ten local community hospitals and formed the Cleveland Clinic Health System. The formation of this system presented a challenge in that the clinic had to decide how much it could share its brand identity without diluting it.

To address this challenge, the clinic established a four-tiered marketing approach that applied to all organizations using the Cleveland Clinic brand. Tier 1 members represent the core organizations—the conservators of the brand and directors of all marketing efforts. Tier 2 members include entities owned by the clinic but that have their own brand equity; in their advertisements, they are allowed to use only the words "Cleveland Clinic Health System" in half size under their own hospital name. Tier 3 includes clinic departments housed in hospitals the clinic does not own. They are not part of the clinic or the system, and the appropriate relationships are outlined in their advertising; they are prohibited from using the Cleveland Clinic name, logo, or tagline. Finally, Tier 4 includes organizations to which

(continued)

the clinic belongs. In these relationships, the clinic's logo may be used only in visual arrangement with the logos of other participating hospitals.

As this case shows, the Cleveland Clinic has been successful in supporting the integrity of its brand while extending the brand's positive image to other entities without diluting existing brand equity. Although not all healthcare organizations can be expected to have the same success as the clinic, this case illustrates how, with sound market intelligence and thoughtful planning, a successful branding initiative can be undertaken.

Case Study Discussion Questions

1. What changes in the marketplace led the Cleveland Clinic to reassess its marketing strategy?
2. What were potential negative consequences of expanding the brand umbrella too widely?
3. How did the clinic adapt its marketing strategy to the new organizational structure?
4. How is the clinic able to preserve its commitment to its mission while at the same time marketing a complex organization?

Summary

A well-thought-out marketing strategy is essential for any healthcare organization that hopes to compete in today's environment. The strategy sets the tone for marketing activities and establishes the parameters within which the marketer must operate. The strategy that is chosen influences the development of the organization's marketing plan and guides its marketing initiatives. Emergent strategies arise in the absence of a formal corporate strategy. Strategies may be developed at different levels, from an overall corporate strategy to a specific marketing strategy.

The marketing strategy should be developed during the strategic planning process so that it reflects the organization's overall corporate strategy. Strategy development follows a series of steps, from initial data collection through data analysis and the identification of strategic options. All key stakeholders should participate in the strategy development process. A SWOT analysis may be used to inform strategy development.

A number of strategic approaches are available to healthcare organizations; the type of organization and environmental circumstances will determine

the best approach to use. The chosen strategy should reflect the organization's position in the market. Most strategies consider the product–market relationship; options range from matching a specific product to a narrowly defined market to dispersing a range of products to a broad market. Branding as a strategy has become increasingly important in healthcare, although many healthcare organizations still face challenges in applying this approach.

Strategies are often geared to one of the four Ps of the marketing mix—product, price, place, and promotion. Customer relationship building and relationship management have become increasingly important in shaping strategy.

Key Points

- Every healthcare organization should choose a strategy to guide its marketing activities.
- The marketing strategy should support the overall corporate strategy and guide the development of the organization's marketing plan.
- The chosen strategy performs a number of functions, the most important of which is to focus the entire organization on a common goal.
- If the healthcare organization does not proactively develop a strategy, a default strategy is likely to emerge that may not be in the best interest of the organization.
- Strategies can exist at different levels of the organization, from an enterprisewide strategy to specific strategies for individual departments or products.
- As with any strategy, the development of a marketing strategy should follow fairly rigid steps.
- Both internal and external data must be collected to develop an informed marketing strategy.
- Marketing strategies may reflect the organization's desired position in the marketplace, emphasize one or more of the four Ps of the product mix, or focus on the relationship between the organization's products and the market.
- Branding as a strategic approach has become more common among healthcare organizations, although certain attributes of the healthcare industry militate against a branding strategy.
- Although the ACA focuses primarily on health insurance reform, it also has implications for the marketing of health services.
- The ACA also has many implications for the marketing and pricing of health insurance products.

Discussion Questions

1. What are some of the different functions that a strategy performs for an organization?
2. What is meant by "the absence of an articulated strategy does not mean that no strategy exists"?
3. What is meant by "acts of commission or omission ultimately create a strategy, and even the absence of a strategy could be considered a strategic approach"?
4. What are the steps involved in the strategic planning process?
5. How should an organization's marketing strategy be linked to its strategic plan?
6. What types of strategies might an organization use, and what determines the best type of strategy for a particular situation?
7. What are some ways in which the product and market interface during strategy development?
8. What is the relationship between strategy development and the four Ps of the marketing mix?
9. What determines which of the four Ps is most relevant to strategy in a particular case?
10. Why is a branding strategy not universally employed by healthcare organizations?
11. Under what circumstances does a branding strategy work best?

Additional Resources

Bashe, G. 2000. *Branding Health Services: Defining Yourself in the Marketplace*. Sudbury, MA: Jones & Bartlett.

Hillstead, S. G., and E. N. Berkowitz. 2012. *Health Care Market Strategy*, 4th ed. Sudbury, MA: Jones & Bartlett.

Zuckerman, A. M. 2005. *Healthcare Strategic Planning*, 2nd ed. Chicago: Health Administration Press.

10

HEALTH COMMUNICATION

Health professionals have developed an appreciation for the critical role that communication plays in healthcare. The communication of information among the many players in healthcare has always been assumed. However, nuances and unspoken interactions may have serious implications for the communication process. Examples of the pivotal role of communication in healthcare can be found everywhere—communication between doctors (and other clinicians) and patients, between health educators and their clients, between pharmaceutical companies and consumers, and between parents and children.

Just as important as the positive contribution that communication can make to healthcare is the negative impact that ineffective or misleading communication can have. We only have to note the contribution of poor communication to malpractice suits, misdiagnoses, failures in patient compliance, and cross-cultural misunderstandings to see the crucial role that communication plays.

Many of the challenges facing healthcare today, in fact, reflect failures in communication. The headlines are full of stories about issues surrounding medical errors, patient confidentiality, patient compliance, and the effective delivery of care. The common theme running through these headline-grabbing issues is communication.

The need for stepped-up efforts in the area of health communication is growing in all areas. Fortunately, the resources available for improving health communication are increasing as well. The base of healthcare knowledge—that is, the information that is being communicated—has increased exponentially over the past few years. The body of research on which treatments and therapies are effective and which are not has grown dramatically, and health professionals are benefiting from advances in communication theory. The number and range of available communication techniques has greatly expanded, providing health communicators with an ample toolbox of approaches. The dramatic impact of the internet on our everyday lives has also broadened the opportunities for those who seek to communicate health-related messages to both the general public and narrowly targeted audiences.

This interest in communication is also reflected in funding initiatives on the part of federal agencies. Driven by concerns about issues such as access to care, disparities in treatment, and increasing patient dissatisfaction, many federal programs now prioritize research on health communication.

The Nature of Communication

Communication refers to the transmission or exchange of information and implies the sharing of meaning among those who are communicating. Communication serves a number of purposes: (1) initiating actions; (2) making needs and requirements known; (3) exchanging information, ideas, attitudes, and beliefs; (4) fostering understanding, and (5) establishing and maintaining relationships (US Office of Disease Prevention and Health Promotion 2019). Thus, communication plays an integral role in the delivery of healthcare and the promotion of health. Health communication encompasses the study and use of communication strategies to inform and influence individual and community decisions that enhance health. It links the domains of communication and health, and it is increasingly recognized as a necessary element of efforts to improve personal and public health.

health promotion
Promotional activity geared toward influencing the knowledge, attitudes, and behaviors of healthcare consumers.

The most obvious applications of health communication have been in the areas of **health promotion** and disease prevention. Research has shown that interpersonal and group interactions in clinical situations (e.g., between provider and patient, between provider and provider, and among members of a healthcare team) can be improved by training health professionals and patients in effective communication skills.

Almost all Americans have been exposed to health messages through public education campaigns that seek to change the social climate to encourage healthy behaviors, create awareness, change attitudes, and motivate individuals to adopt recommended behaviors. Campaigns traditionally have relied on mass communication (e.g., public service announcements on billboards, radio, and television) and educational messages in printed materials (e.g., pamphlets) to deliver health messages. Other campaigns have integrated mass media with community-based programs or incorporated social marketing techniques.

Increasingly, health improvement activities are taking advantage of digital technologies to target audiences, tailor messages, and engage people in interactive, ongoing exchanges about health. As population-based approaches to healthcare become more common, the role of health communication is expanding. Community-centered prevention efforts shift attention from the individual to group-level change and emphasize the empowerment of individuals and communities to effect change at multiple levels.

Federal healthcare officials have emphasized the importance of health communication through the Healthy People 2020 initiative. This effort by the federal government to foster good health habits includes among its objectives facilitating decision-making among patients and providers, delivering targeted health information, and increasing health literacy (US Office

of Disease Prevention and Health Promotion 2019). Movement toward the achievement of these objectives depends to a great extent on effective health communication. The promotion of regular physical activity, healthy weight, good nutrition, and responsible sexual behavior all require a range of information, education, and advocacy efforts, as does the reduction of tobacco use, substance abuse, injuries, and violence. Effective counseling and patient education geared to behavior change require healthcare providers and patients to have good communication skills. Public information campaigns are used, for example, to promote increased fruit and vegetable consumption, higher rates of preventive screenings, higher utilization rates for clinical preventive services, and greater rates of adoption of risk-reducing behaviors.

Communication, of course, is at the core of any marketing initiative. Regardless of the goal of the marketing campaign, the intent is to communicate information to a target audience in a way that is understandable, resonant, and persuasive. The principles discussed in this chapter should underlie any marketing effort, regardless of its intent, approach, or target audience.

Levels of Communication

Health communication can take place at a number of levels. The Centers for Disease Control and Prevention (CDC 2000) identifies the following levels of impact:

- **Individual.** The individual is the primary target for health-related change, since individual behaviors affect health status. Communication can affect individuals' awareness, knowledge, attitudes, self-efficacy, and skills for behavior change. Activity at all other levels ultimately aims to affect and support individual change.
- **Social network.** Individual relationships and the groups to which individuals belong can have a significant impact on health. Health communication programs can work to shape the information that a group receives and may attempt to change communication patterns or content. Opinion leaders in a network are often a point of entry for health programs.
- **Organizations.** Organizations include formal groups with a defined structure, such as associations, clubs, and civic groups; worksites; schools; primary healthcare settings; and retailers. Organizations can deliver health messages to their membership, provide support for individual efforts, and make policy changes that enable individual change.

- **Communities.** The collective well-being of communities can be fostered by creating structures and policies that support healthy lifestyles and by reducing or eliminating hazards in social and physical environments. Community-level initiatives are planned and led by organizations and institutions that can influence health: schools, worksites, healthcare settings, community groups, and government agencies.
- **Society.** Society as a whole has many influences on individual behavior, including norms and values, attitudes and opinions, laws and policies, and the physical, economic, cultural, and information environments. Campaigns may use communication methods to influence health behavior at the societal level.

The more levels at which a communication program has influence, the greater the likelihood of creating and sustaining the desired change. While health communication alone cannot change systemic problems related to health, such as poverty, environmental degradation, or lack of access to healthcare, comprehensive health communication programs should include a thorough exploration of all the factors that contribute to health and the strategies that could be used to influence these factors. Well-designed health communication activities can help individuals better understand their needs and their communities' needs so that they can take appropriate actions to maximize health.

The Role of Communication

Health communication can play an important role (for good and bad) in determining individual and community health status. Effective communication can help improve health outcomes for acute and chronic conditions; reduce the impact of racial, ethnic, disease-specific, and socioeconomic factors in care; and improve the effectiveness of prevention and health promotion efforts. The large gap between expected and achieved quality in healthcare can often be attributed to ineffective communication between providers and patients and their families, among providers, or between healthcare organizations and providers (Institute of Medicine 2001).

Health communication is a basic tool used to promote public health initiatives. Health communication principles are often employed today for disease prevention and control strategies such as advocating for health issues, marketing health plans and products, educating patients about medical care or treatment choices, and educating consumers about healthcare quality issues. At the same time, the availability of new technologies and computer-based media is expanding access to health information and raising questions about the equality of access, the accuracy of information, and how to use new tools most effectively.

The many roles that health communication can play are highlighted by the CDC (2000). These roles include the following:

- Increase knowledge and awareness of a health issue, problem, or solution
- Influence perceptions, beliefs, attitudes, and social norms
- Prompt action
- Demonstrate or illustrate skills
- Show the benefits of behavior change
- Increase demand for health services
- Reinforce knowledge, attitudes, or behavior
- Refute myths and misconceptions
- Help coalesce organizational relationships
- Advocate for a health issue or a population group

Despite the acknowledged benefits of effective communication, significant gaps in communication between patients and healthcare professionals are evident. These gaps are more pronounced among marginalized groups, such as those with disabilities, low literacy, limited English proficiency, or low socioeconomic status; stigmatized groups, such as those with HIV infection, obesity, or mental illnesses; and minority populations such as African Americans and refugees.

Factors Affecting the Evolution of Health Communication

A downside of the medical model of healthcare—the dominant paradigm in Western medicine for most of the twentieth century—was its inattention to health communication. As the field of healthcare became more science based, it became increasingly reductionist, as all health problems were reduced to the lowest level, from the person to the body system to the organ to the cellular structure. With each successive step, the patient as a whole person receded further into the background.

The Changing Doctor–Patient Relationship
A direct implication of the medical model was the diminution of the importance of communication. Bedside manner became less important, since the answer to health problems was to be found under the microscope and not within the patient. Although some physicians developed an effective bedside manner, organized medicine came to see this as an unnecessary skill, and only in recent years has communication become recognized as a skill required of

practitioners. As medicine became more scientific, the importance of objectivity came to the fore. Rather than understanding the totality of the patient, physicians were trained to remain distant and uninvolved, so that their personal feelings would not interfere with medical progress.

Since it was impossible to totally avoid communication with patients and their families, physicians' conversations became filled with medical jargon. Their newfound scientific knowledge allowed them to demonstrate the level of skill they possessed *and* created a clear separation between the practitioner and the patient. Thus, physicians began to use scientific terminology that was unfamiliar to their patients. Further, the asymmetric nature of the doctor–patient relationship discouraged patients from asking questions, lest they appear to doubt the knowledge and authority of their doctor. These developments were detrimental to effective doctor–patient interaction.

By the end of the 1970s, doctor–patient relationships were beginning to change. Some refer to this change as beginning of the *patient education movement*; others see it in the broader context of *consumerism* that affected all institutions in society, not just healthcare. This movement reflected increasing criticism of the healthcare system and its operation. The consumer movement found that patients in particular and healthcare consumers in general were ignorant of the nature of health and illness and unable to contribute to their own health in a meaningful way.

This failure of communication has been attributed primarily to the healthcare system and particularly to its central practitioner, the physician. Critiques cite the deliberate efforts of physicians to hamper communication, deter the transfer of knowledge, and confuse patients about their health status. The wholesale shift to scientific medicine had nearly eliminated the doctor–patient link. Protests by practitioners that patients could not talk intelligently about their health problems were refuted by research indicating reasonable knowledge on the part of patients, even patients considered to be disadvantaged.

Changing Patient Demands

These developments occurred in a context of growing concerns about many aspects of American society. Although certain groups were acknowledged to face discrimination in terms of jobs, education, housing, and other benefits of society, it became increasingly clear that the healthcare system also discriminated against many groups in society. While medical practitioners related well to well-educated, affluent patients who could more or less "speak their language," they did not relate at all to minority populations or those from different socioeconomic backgrounds. Differences in the communication modalities of medical professionals have contributed to the now

well-documented disparities among groups in society with regard to health status, health behavior, and treatment received.

Another emerging trend has been the understanding that prevention can play a greater role in the improvement of health status than treatment. This led to the realization that the standard approach—repairing broken bodies—was not as effective at improving health status as preventive measures. A growing body of research on the potential of preventive measures has drawn attention to this dimension of healthcare and dampened enthusiasm for more aggressive treatments and cures.

One consequence of consumerism with implications for marketing was the insatiable demand for information on the part of consumers. Baby boomers in particular began demanding more information and reacted strongly when their doctors refused to communicate even basic health information, such as their own vital signs. In response, they turned to the internet to find information on diseases and their treatment and on the characteristics of practitioners. Subsequent generations of healthcare consumers have turned to social media to create virtual forums on health-related issues. (For example, PatientsLikeMe is an online forum for patients with various health conditions and their caregivers.)

The Acceptance of Marketing in Healthcare

Healthcare adopted marketing approaches well after most other industries—the marketing era did not begin in healthcare until the 1980s. While marketing was noticeably absent from the functions of most healthcare providers until that time, precursors to marketing had long been established. Every hospital and many other healthcare organizations had well-established public relations functions. Public relations involved disseminating information about the organization and announcing new developments. Public relations staff mainly interacted with the media, by which they disseminated press releases, responded to requests for information, and dealt with reporters when a negative event occurred.

Large provider organizations also typically had communication staff for developing materials for the public and for the employees of the organization. Internal newsletters and, later, patient-oriented educational materials were frequently developed by communication staff. Some larger organizations (and certainly major retail firms and professional associations) established government relations offices. They served as the interface for communication with government officials and other stakeholders.

In addition to these formal precursors of marketing, healthcare organizations of all types were involved in informal communication activities to a certain extent. For example, hospitals sponsored health education seminars, held open houses for new facilities, and supported community

events. Hospitals marketed themselves by making their facilities available to the community for public meetings and otherwise attempting to be good corporate citizens. Physicians marketed themselves by networking with colleagues in social and professional settings. All of these activities relied on effective communication.

During this period, health communicators began looking at audiences in an entirely different way. The importance of consumers was heightened by the introduction of the prospective payment system. Hospitals began to think of medical care in terms of product or service lines, a development that would have major consequences for the marketing of health services. Hospitals realized that marketing directly to consumers for services such as obstetrics, cosmetic surgery, and outpatient care could generate revenue and enhance market share.

As healthcare became market driven in the 1990s, the communication function grew in importance in healthcare organizations. The institutional perspective that had long driven decision-making gave way to market-driven decision-making. Hospital policies and procedures that had been established for the convenience of the hospital staff, not for the benefit of the patient, were reexamined from the point of view of customers and other external audiences. The popularity of guest relations programs during the 1990s solidified the transformation of *patients* into *customers*. Every hospital was now trying to win the "hearts and minds" of healthcare consumers.

The emergence of the internet as a source of health information furthered the rise of consumerism. Newly empowered consumers were taking on an increasingly influential (if informal) role in reshaping the US healthcare system. Consumers began to challenge physicians and their health plans armed with unprecedented knowledge.

The acceptance of marketing as a legitimate function in healthcare had at least two important implications for health communication. First, it brought heightened attention to all types of "promotional" activities, including communication. Health professionals became sensitized to the need for meaningful ongoing communication with their employees, customers, and constituents. Second, once promotional materials are created, methods are required for their dissemination.

The Variety of Healthcare Customers

As discussed in chapter 5, a number of terms are applied to the purchasers or end users of healthcare goods and services. At the practitioner level,

the term *patient* is giving way to other terms that more clearly reflect the contemporary healthcare environment, with each exhibiting different communication needs.

Consumer, as the term is usually used in healthcare, refers to any individual or organization that is a potential purchaser of a healthcare product. Theoretically, everyone is a potential consumer of health services. *Consumer behavior* refers to the utilization patterns and purchasing practices of the population of a market area.

The *customer* is typically thought of in healthcare as the actual purchaser of a good or service. While a patient may be a customer for certain goods and services, the end user (e.g., the patient) may not always be the customer, as someone else may make the purchase on behalf of the patient.

A *client* is a type of customer that consumes services rather than goods. A client relationship implies personal (rather than impersonal) interaction and an ongoing relationship (rather than an episodic one). Professionals typically have clients rather than customers.

While the term *patient* is used rather loosely in informal discussion, a patient is technically defined as someone who has been admitted into the formal system of healthcare. A prerequisite for becoming a patient is being defined as "sick" by a physician.

While health insurance plans have historically conceptualized their customers as *enrollees*, this concept has only recently become common among healthcare providers. As managed care has become a major force in healthcare, other healthcare organizations have begun to adopt this term.

The ultimate consumer of healthcare services, as in other industries, is referred to as the *end user* or the patient who is the direct recipient of a healthcare service or the eventual consumer of an over-the-counter drug. The end user could also be a health plan enrollee who eventually files a claim for compensation for medical care.

This does not exhaust the list of potential targets for health communication. To this number could be added provider organizations, government agencies and other regulatory bodies, and healthcare policymakers. Employers, who pay for a large share of healthcare costs, are increasingly communicating health information to their employees.

Characteristics of Healthcare Consumers

Healthcare consumers differ from the consumers of other goods and services in many ways. To a great extent, healthcare purchases are nondiscretionary. That is, they are often "ordered" by a health professional for the good of the patient. In almost no other situation in any industry would a good or service be "prescribed" for the consumer and then pressure placed on the

consumer to comply with the prescription. For that reason, the communication patterns associated with patient care are often one-sided and dominated by practitioners.

Healthcare consumers are also distinguished from the consumers of other goods and services by their insulation from the price of the products they consume. Because of the unusual financing arrangements characterizing healthcare and the lack of access to pricing information, healthcare consumers seldom know the price of the services they are consuming until after they have consumed them. In the typical case, in fact, the physician or clinician providing the service is also unlikely to know the price of the services being provided. Representatives of other industries would be shocked at the lack of communication with regard to pricing.

Few consumers are knowledgeable about the operation of the healthcare system or have direct experience with many aspects of its delivery. Typically, no basis for the evaluation of the quality of services is provided by health facilities or practitioners, leaving the consumer with no way to make meaningful distinctions. Consumers must make judgments based on the provider's reputation or on superficial factors such as the appearance of the facility, the available amenities, or the tastiness of the hospital's food. The consumer is left with no way of comparing services and the marketer with no real basis for differentiation.

Another factor setting healthcare consumers apart from other consumers is the personal nature of the services involved. While most healthcare encounters are not matters of life or death, almost all involve an emotional component that is absent in other consumer transactions. Every diagnostic test is fraught with the possibility of a positive result, and every surgery, no matter how minor, carries the risk of complications. Whether this emotionally charged and personal aspect of the healthcare episode prevents the affected individual from seeking care, influences the choice of provider or therapy, or leads to additional symptoms, the choices made by the patient or other decision makers are likely to be affected. Emotions such as fear, pride, and vanity come into play. In the past, clinicians were notorious for their failure to communicate with their patients. Information was considered power, and clinicians were reluctant to share that power with patients, often to the detriment of clinical outcomes. (Refer to exhibit 5.1 in chapter 5 for differences between healthcare consumers and other types of consumers.)

While much has been made of the unique characteristics of healthcare consumers, they are perhaps more similar to consumers in other industries than the foregoing discussion would suggest. While some healthcare episodes involve emergency or life-threatening conditions, the overwhelming majority do not. Indeed, if the incredible volume of self-care episodes are considered, what is considered a true medical episode is relatively rare.

A large proportion of healthcare episodes involve some discretion on the part of the end user or those involved in the decision-making process, and the consumption of many types of services is elective. For this reason, health-care consumers are similar to other consumers in many ways. For example, healthcare consumers are likely to distinguish between needs and wants when it comes to the consumption of services. Clearly, most healthcare consumers would consider angioplasty to correct a heart condition a need, while laser eye surgery would be considered a want. The latter might be considered a discretionary expenditure, while the former would be nondiscretionary. Similarly, cardiac care would be considered a necessity, while for most consumers laser eye surgery would be considered a "luxury" purchase.

Healthcare consumers are like other consumers in that the level of demand for goods and services is elastic. Years ago, the demand for health services was believed to be inelastic. It was assumed that those who were sick consumed services and those who were well did not. This assumption reflects a dated notion of health and illness and fails to account for the vast number of discretionary transactions that occur in healthcare. The demand for health services is now recognized to be extremely elastic, and the level of demand to be influenced by a wide range of factors, including the characteristics of the consumers, the availability of services, and access to health insurance.

Further, the demand for health services can be manipulated through marketing. Throughout this book, many cases are cited in which consumers are made aware of a service that they did not know existed. Indeed, many consumers have been convinced that they have a condition they did not know they suffered from. In the former case, individuals with emotional disorders may be made aware of the availability of counseling services. In the latter situation, parents may realize that their child has attention deficit disorder, or an individual may realize that indigestion is actually a gastric reflux disorder as a result of health communication.

Health Communication and Health Behavior

Health communication is often used to influence health behavior. Numerous attempts have been made to develop explanatory frameworks for understanding health behavior. Models are geared to the individual, the group, and the community (National Cancer Institute 2003). Although no single model is generally accepted, the most important ones are described here.

Individual Level
One set of models of health behavior focuses on the individual level and considers how individuals make decisions with regard to health behavior.

According to these models, effective communication requires an in-depth understanding of individual traits and attributes.

Behavioral Intentions

Studies of behavioral intentions suggest that the likelihood of intended audiences adopting a desired behavior can be predicted by assessing (and subsequently trying to change or influence) their attitudes toward and perceptions of the benefits of the behavior, along with how they think their peers will view their behavior. Research by Fishbein and Ajzen (1975) supports the idea that individuals' and society's (perceived) attitudes are an important predecessor of action. Therefore, an important step toward influencing behavior is assessing intended audiences' attitudes, and subsequent tracking is necessary to identify any attitudinal changes. Case study 10.1 describes an initiative addressing obesity among a disadvantaged population.

Case Study 10.1
Determining Consumer Perceptions of Obesity

To determine the perceptions of high-risk populations with regard to obesity and its causes and remedies, four town hall meetings were convened by a consortium of healthcare organizations in communities in Memphis, Tennessee. The healthcare providers felt they had a poor understanding of perceptions of obesity in these communities. The town hall meetings were intended to elicit input from low-income African American residents about how to address obesity. Although those providing the input did not represent a scientifically drawn sample of residents of the targeted communities, they were thought to represent a reasonable cross-section of community residents.

The following questions were posed to the community residents in attendance:

- What can family, friends, and other associates do to help address the issue of obesity in the community?
- What can the community do to help address the issue of obesity among its residents?
- What can medical professionals do to help address the issue of obesity?

(continued)

The recordings of the meeting proceedings were transcribed and conclusions were drawn with regard to the participants' knowledge of the obesity situation, attitudes toward obesity, factors contributing to the obesity "epidemic," and barriers to addressing the problem.

The following findings were derived from the town hall meetings:

- Participants had a reasonable knowledge of the problem of obesity, its causes, and its associated dangers.
- Participants were generally aware of the importance of exercise and healthy dietary habits for good health.
- Participants generally accepted the notion that there is no "quick fix" for obesity.
- Participants expressed a genuine concern about obesity for themselves and their families and a willingness to address the issue.
- Participants felt that obesity (and health in general) was an issue that could be addressed if the necessary resources were available.
- Participants felt that there was a gap between the needs of the population and the health personnel and facilities available to meet those needs.
- While participants felt that most community residents were aware of the problem of obesity, they believed that many did not have the knowledge, skills, or resources necessary to effectively address the issue.
- While regular exercise was recognized as an important means of addressing obesity, participants contended that a lack of access, prohibitive costs, and a lack of guidance with regard to exercise facilities were deterrents.
- Participants expressed concern that cultural factors in the community were deterrents to effectively addressing obesity.

The primary conclusion drawn from these meetings was that the residents' ability to address obesity was not a function of a lack of knowledge or detrimental attitudes but a reflection of the lack of resources and effective support structure to facilitate the changes that the residents knew they needed to make. The information gathered through these town hall meetings was used to design a grassroots program to address obesity in the disadvantaged African American population.

(continued)

Case Study Discussion Questions

1. What prompted health professionals to seek additional information on perceptions of obesity?
2. What means were used to research the issue with this high-risk population?
3. To what extent were the researchers' preconception borne out? Refuted?
4. What unexpected findings did the researchers discover?
5. What implications did the findings have for the planning of interventions designed to reduce obesity within this population?

Stages of Change

stages of change
A construct that delineates five stages that healthcare consumers may exhibit vis-à-vis their health—precontemplation, contemplation, decision/determination, action, and maintenance.

The premise of the **stages of change** construct is that behavior change is a process and not an event (Prochaska, Norcross, and DiClemente 1994). Further, individuals are considered to have varying levels of motivation, or readiness, to change. The extent to which people are responsive to change will depend on their stage at that time.

Knowing an individual's current stage of change allows communicators to set realistic program goals. Messages, strategies, and programs can be tailored to the appropriate stage. The stages of change construct comprises five stages:

1. Precontemplation
2. Contemplation
3. Preparation
4. Action
5. Maintenance

health belief model
A model of health behavior that emphasizes the influence of consumers' perceptions on their health behavior.

It is important to note that this model is circular, not linear: Individuals can enter or exit at any point and recycle back through the model.

Health Belief Model

The **health belief model** was designed to explain why people do not participate in programs to prevent or detect diseases. The core components of the health belief model include the following:

- **Perceived susceptibility**—the subjective perception of the risk of developing a particular health condition
- **Perceived severity**—feelings about the seriousness of the consequences of developing a specific health problem
- **Perceived benefits**—beliefs about the effectiveness of various actions that might reduce susceptibility and severity (taken together, perceived susceptibility and severity are labeled *threat*)
- **Perceived barriers**—potential negative aspects of taking specific actions
- **Cues to action**—bodily or environmental events that trigger action

More recently, the health belief model was amended to include the notion of self-efficacy as another predictor of health behavior (LaMorte 2018), especially more complex behaviors in which lifestyle changes must be maintained over time. A wide variety of demographic, social, psychological, and structural variables may also affect people's perceptions and, indirectly, their health-related behavior. Some of the most important variables are educational attainment, age, gender, socioeconomic status, and prior knowledge.

Consumer Information Processing Model

The consumer information processing model was not developed specifically to study health-related behavior or to be applied in a health communication context, but it has many useful applications in the health arena. Information is a common tool for health education, and it is an essential foundation for health decisions. The conveyance of information can increase or decrease people's anxiety, depending on their information preferences and how much and what kind of information they are given.

Illness and its treatments can interfere with information processing. By understanding the key concepts and processes of consumer information processing, health educators can examine why people use or fail to use health information and subsequently design more effective communication strategies. This theory reflects a combination of rational and motivational ideas. The use of information is an intellectual process; however, motivation drives the search for information and how much attention people pay to it.

The central assumptions of this model are that individuals are limited in the amount of information they can process; to increase the usability of information, they combine bits of information into "chunks" and create decision rules, known as heuristics, to make choices faster and more easily. According to basic consumer information processing concepts, before people will use health information, it must be available, seen as useful and new, and processable, or format-friendly.

Interpersonal Level

Another type of model posits that behavior is a function of the influence of interpersonal relationships. These relationships provide clues—if not outright direction—for individual behavior. Effective communication must take into consideration the different forces that are generated through interpersonal transactions.

social cognitive theory
A theory of social behavior that emphasizes the role of interpersonal and environmental factors in determining behavior.

Social cognitive theory explains behavior in terms of triadic reciprocality (also referred to as *reciprocal determinism*), in which behavior, cognitive and other interpersonal factors, and environmental events all operate as interacting determinants. This theory describes behavior as dynamically determined and fluid, influenced by both personal factors and the environment. Changes in any of these factors are hypothesized to result in changes in the others.

Social cognitive theory views the environment not just as a variable that reinforces or punishes behaviors, but as one that also provides a milieu in which an individual can watch the actions of others and learn the consequences of their behaviors. Processes governing observational learning include the following:

- **Attention**—gaining and maintaining attention
- **Retention**—being remembered
- **Reproduction**—reproducing the observed behavior
- **Motivation**—being stimulated to produce the behavior

Thus, cognitive theory supports the increasingly accepted notion that healthcare decisions are not made in a vacuum but are a function of a variety of influences.

Organization, Community, and Societal Level

A third type of communication model operates at the macro levels of organization, community, and society. Communication activities at these levels may be geared to influencing organizational change, modifying the environment of the community, or influencing public policy. Given this, communication efforts under this model are likely to take a variety of forms and be particularly complex.

Organizational Change Theory

Organizations represent complex social systems composed of many components. Organizational change can best be promoted by working at multiple levels in the organization. Understanding organizational change is important for establishing policies and environments that support healthy practices and create the capacity to solve new problems. While there are many theories of

organization behavior, two are especially of interest here: stage theory and organizational development theory.

Stage theory is based on the idea that organizations pass through a series of steps or stages as they change. Strategies to promote change can be matched to points in the process of change. An abbreviated version of stage theory involves four stages:

1. Problem definition (awareness)
2. Initiation of action (adoption)
3. Implementation
4. Institutionalization

Organizational development theory grew out of the recognition that organizational structures and processes influence worker behavior and motivation. This theory concerns the identification of problems that impede an organization's functioning, rather than the introduction of a specific type of change. A typical organizational development strategy involves process consultation, in which an outside specialist helps identify problems and facilitates the planning of change strategies.

Stage theory and organizational development theory have the greatest potential to produce health-enhancing change in organizations when they are combined. That is, organizational development strategies can be used at various stages as they are warranted. Simultaneously, the stages signal the need to involve organization members and decision makers at different points in the process.

Community Organization Theory

Community organization theory has its roots in theories of social networks and support. It emphasizes active participation and developing communities that can better evaluate and solve health and social problems. Community organization is the process by which community groups identify common problems, mobilize resources, and develop and implement strategies for reaching their goals. It is grounded in several theoretical perspectives: the ecological perspective, the social systems perspective, social networks, and social support. Some approaches to community change include the following:

- **Locality development** (also called *community development*) uses a broad cross-section of people in the community to identify and solve its own problems. It stresses consensus development, capacity building, and a strong task orientation; outside practitioners help coordinate and enable the community to successfully address its concerns.

- **Social planning** uses tasks and goals and addresses substantive problem-solving, with expert practitioners providing technical assistance to benefit community consumers.
- **Social action** aims to increase the problem-solving ability of the community and to achieve concrete changes to redress social injustice that is identified by a disadvantaged or oppressed group.

Although community organization theory does not use a single unified model, several key concepts are central to the approaches. The process of empowerment is intended to stimulate problem-solving and activate community members. Community competence is an approximate community-level equivalent of self-efficacy plus behavioral capability, which are the confidence and skills to solve problems effectively. Participation and relevance involve citizen activation and a collective sense of readiness for change. Issue selection concerns identifying "winnable battles" as a focus for action, and critical consciousness stresses the active search for root causes of problems. Of course, health communication is a basic component of each of these dimensions of social intervention.

Diffusion of Innovations Theory

Diffusion of innovations theory addresses how new ideas, products, and social practices spread in a society or from one society to another. The challenge of diffusion requires approaches that differ from those focused solely on individuals or small groups. It involves paying attention to the innovation (a new idea, product, practice, or technology) as well as to communication channels and social systems (networks with members, norms, and social structures).

A focus on the characteristics of innovations can improve the chances that they will be adopted and hence diffused. It also has implications for how an innovation is positioned to maximize its appeal. The following are some of the most important characteristics of innovations:

- **Relative advantage**—is it better than what was there before?
- **Compatibility**—fit with intended audience
- **Complexity**—ease of use
- **Trialability**—can it be tried out first?
- **Observability**—visibility of results

Communication channels are another important component of diffusion of innovations theory. Diffusion theories view communication as a two-way process rather than one of merely "persuading" an intended audience

to take action. The two-step flow of communication—in which opinion leaders mediate the impact of mass media—emphasizes the value of social networks (or interpersonal channels) over and above mass media for adoption decisions.

The stages of the consumer decision-making process were described in chapter 5. That chapter explains the role that communication plays in consumer decision-making. Exhibit 10.1 discusses the role of communication throughout the patient "career."

The patient "career" can be viewed as a linear phenomenon in which an individual proceeds through a number of stages. If individuals are assumed to be naturally in a state of "health," then prevention, screening, and routine self-care represent the initial stage. Following the onset of symptoms, the individual transitions to the point of diagnosis and treatment at an outpatient facility. At this point, the symptomatic individual is defined as a patient and enters the formal care system, which may encompass a variety of settings and practitioners for addressing the identified health problem.

Assuming the patient survives the illness episode, he or she may move out of the patient care model back into the community as a "well" person. Alternatively, the patient may require follow-up care or chronic disease management (e.g., by a home care agency), temporary institutionalized care (e.g., a subacute facility), long-term nursing care (e.g., a nursing home), or rehabilitative services of some type (e.g., physical or occupational therapy). These post-patient services extend the model horizontally. This **patient career** can be thought of as involving three stages: pre-patient, patient, and post-patient.

The characteristics of health communication vary depending on the stage of the patient career in terms of sources, contexts, channels, messages, and timing. Early in the process, the symptomatic individual, even before disclosing symptoms to anyone, seeks out information from a variety of sources. The individual may pick up literature at a healthcare facility, a social service office, or a health fair or research the symptoms at the library. Increasingly, healthcare consumers are accessing the internet at the first appearance of symptoms.

Whether or not these sources of information are adequate, the symptomatic individual then typically turns to informal sources of information related to his or her condition, such as family members, friends, and associates. Indeed, these informal sources of health information remain mainstays

(continued)

EXHIBIT 10.1
The Role of Communication During the Patient "Career"

patient career
The stages through which an individual passes in transitioning from wellness to sickness and (ideally) back to wellness.

EXHIBIT 10.1
The Role of
Communication
During the
Patient "Career"
(continued)

for those seeking knowledge about a health condition. Individuals place considerable confidence in this form of communication, as it comes from people who are trusted and can be expected to have the best interests of the individual at heart. Personal forms of communication complement the impersonal sources of data accessed earlier.

As the patient career progresses, increasingly formal sources of input are sought, and the communication process takes a different form. In addition, information on the healthcare system is required beyond information on the health condition. Information seeking at this stage may involve communication with a professional known to the affected individual or an accessible health professional such as a pharmacist.

The affected individual may now seek information on sources of care for the particular problem. Many of the same sources of communication may be accessed—the internet, the library, friends and relatives, and health professionals. A surprisingly large number of affected individuals contact their health plans to determine what resources are available for treatment of their condition (and which providers are covered under their plans).

During the next phase (the patient phase), most of the encounters take place at the practitioner's office or in another ambulatory care setting. As the context for communication shifts to a more formal setting, information is transmitted between the symptomatic individual and an authoritative source of information, such as a physician or other practitioner. The nature of communication may change dramatically at the point that the individual is defined as a patient. The communication becomes more one-way and authoritative, reflecting the asymmetric power relationship between the provider and the patient.

In the healthcare setting, other sources of information come into play, such as communication with other health professionals or the dissemination of print materials. Directives may be issued by the physician (and others) to guide the behavior of the patient after the clinical episode.

Communication in the clinical setting with regard to diagnosis, treatment, and subsequent medical regimens is often problematic. The source of information is clearly authoritative and carries the weight of "doctor's orders." However, physicians often are not trained in communication methods, and research has documented the extent to which adequate information is not transmitted in this context. This defect in the communication process has been held responsible for problems encountered in the management of health conditions such as noncompliance with the prescribed treatment regimen, misuse of prescription drugs, and failure to obtain follow-up care.

Communication Sources

Communication can originate from a wide variety of sources, and the source is often critical to the message's acceptance. Sources can be grouped into three major categories: informal sources, formal sources, and impersonal sources. Each category is discussed in this section.

Informal Sources

Consumers obtain much of their healthcare information from informal sources, such as family, friends, and associates. These ad hoc sources of information are important because of their convenience and their credibility. Even today, healthcare consumers point to individuals in these categories as their primary sources for health information.

Informal sources may also take the form of groups, with many consumers obtaining their information concerning health and healthcare in some type of group context. Church groups, social groups, or similar groups may provide a context for the effective transfer of information. Indeed, in US society, attitudes toward health and healthcare are more likely to reflect the attitudes of individuals' dominant social groups than of specific individuals.

Formal Sources

Formal sources of health information include those entities that communicate with consumers as part of their job, such as physicians and other providers. Historically, consumers have placed physicians at the top of the list as their main source of health information. Other types of healthcare providers may serve this function, supplemented by the input of pharmacists in many communities.

Other categories of providers such as social workers, psychologists, and counselors maintain as part of their job an information and referral function. Unlike physicians, they may be trained in the transfer of information. Some of the information transmission by these providers takes place in group settings in which both the facilitator and the group influence the communication process.

All healthcare organizations offer some type of information, and even if they are not in the information business, most healthcare organizations have to make referrals, conveying information in the process. Healthcare organizations are constantly talking to their customers about the who, what, where, and how of health services.

Increasingly, consumers report that health plans are a primary source of information about health and healthcare. This is not surprising, since

consumers may contact their insurance carrier frequently to determine the level of benefits available to them or the status of their claims. With the establishment of provider networks with limited access, health plans have become primary sources of healthcare information.

Impersonal Sources

As mass media became pervasive, an increasing proportion of the population came to receive its information—on healthcare and other topics—from newspapers, magazines, radio, and television. These modes of information transfer are the hallmark of modern society, with the internet now the king of mass media. The amount of space in both print and electronic media devoted to healthcare has increased dramatically in recent years. Health is a favorite topic of traditional media, and cable television has served to multiply the opportunities for health and healthcare programming. Popular books on healthcare have also become a major source of information on the topic.

While traditional print and electronic media have taken over some of the role of family, friends, and even health professionals in the transfer of health-related information, the internet has become a growing source of information on health and healthcare. Many healthcare consumers turn first to the internet to understand a symptom, find a doctor, or research a drug. Despite the sometimes questionable nature of information available online, the internet is arming consumers with information to take to their physician, pharmacist, or other practitioner.

Whatever the source, the effectiveness of a message depends to a large extent on the audience's perception of the source. *Perception* is critical, since perceptions rather than reality may determine the way a message is received. The communicator's job is to control and determine the audience's perceptions. Students of communication have identified several dimensions of source credibility (O'Keefe 1990), listed here in order of their importance:

1. Competence
2. Trustworthiness
3. Goodwill
4. Idealism
5. Similarity

Thus, the extent to which a message is accepted, attitudes are changed, and a behavior is modified hinges on the perceived validity of the source of information.

Components of Communication

Communication involves a number of components, each of which is critical for a successful communication effort. The major components of the communication process are discussed in this section.

Context

Context is a consideration in the examination of any communication event. The context or environment is the situation in which the communication occurs and includes the physical context, social context, number of people involved, relationship of participants, surrounding events, culture, rituals, and noise.

The physical context is the place in which the communication actually occurs. This could be in the receiver's home, in the workplace, in the physician's office, or any number of other physical settings. For example, the context would be quite different for a preacher delivering a sermon from a pulpit, on the street corner, or on television. The temperature, time of day, nearby people, and any concurrent activities all contribute to the establishment of the context.

The social context represents a major influence on communication. The context may be a group of friends, work associates, or strangers. The context may be familiar or strange. If someone is offering a toast, the approach would be different depending on whether the context is the neighborhood pub, a child's wedding, or the Nobel Prize award banquet. Factors such as the level of formality, use of appropriate language, familiarity with the audience members, use of humor, content of the message, and appropriate dress may be influenced by social context.

The context for the transmission of health information is an important consideration. The same information conveyed by the physician in his or her office, around the water fountain at work, with a close family member, or on the internet will have different degrees of impact. Some contexts are more conducive to the transfer of health-related information than others.

Message

In the communication field, a message represents information that is sent from a source to a receiver. Information includes any thought or idea expressed briefly in a plain or secret language prepared in a form that is suitable for transmission by any means of communication. The message is an explanation, response, set of instructions, or recommendations that helps accomplish the aim of the communication process.

Much of the development of a communication initiative focuses on what to say and how to say it. Health communicators must determine what information will be provided, the style and tone in which it will be presented,

and what the message will convey. If the message does not resonate with the target audience, the communication effort will likely fail.

Channels

Communication occurs through a specific channel or channels. A channel is also referred to as a *medium*, hence references to *mass media* or to *the media* as a collective term for journalists working in any form of mass media. The channel determines the means by which the communication is delivered and received. Channels differ in terms of attributes, attention getting, and volume of information conveyed. A book, for example, has more credibility than television. More information can be communicated in a newspaper article than a television newscast. On the other hand, television has live pictures that make the communication more engaging.

Each type of channel has benefits and drawbacks. Factors to be considered, and questions to be asked, include the following:

- The intended audience(s)
  - Will the channel reach and influence the intended audiences?
  - Is the channel acceptable to and trusted by the intended audiences?
- Compatibility with the message
  - Is the channel appropriate for conveying information at the desired level of simplicity or complexity?
  - If skills need to be modeled, can the channel model and demonstrate specific behaviors?
- Channel reach
  - How many people will be exposed to the message through this channel?
  - Can the channel meet intended audience interaction needs?
  - Can the channel allow the intended audience to control the pace of information delivery?
- Cost and accessibility
  - Is this a cost-effective channel given the objectives?
  - Are the resources available to use the channel and the specific activity?
- Activities and materials
  - Is the channel appropriate for the activity or material you plan to produce?
  - Will the channel and activity reinforce messages and activities you plan through other routes to increase overall exposure among the intended audiences?

Timing

The expression "timing is everything" applies especially to communication. Timing can be thought of in a variety of ways. In a mechanical sense, timing could refer to the day of the week or the time of the day at which communication occurs. It could also refer to the frequency of exposures established. Radio and television advertising is carefully planned to take advantage of the habits of listeners or viewers, and information is available on the timing that is appropriate for different target audiences. (Public service announcements may run at 3:00 a.m. because that is when a time slot is available that paying advertisers may find unattractive.)

Timing may also refer to the state of readiness on the part of the target audience with respect to the message that is being conveyed. Different audiences are amenable to receiving information at different times—not in terms of clock time but in terms of their current situation. It is difficult, for example, to interest teenagers or young adults in the risk of chronic disease since their age and health status make this topic irrelevant. A woman may only be interested in information on pediatricians around the time that her baby is due to be delivered. It is difficult to talk about HIV and AIDS in some church settings, and this type of situation is particularly difficult in health communication, since many topics are unpleasant or make the recipient uncomfortable.

The Communication Process

A number of communication models have been developed for application to marketing, and Berkowitz (2016) has adopted one of these for healthcare. While Berkowitz focuses on marketing communication, this model can be readily applied to health communication. An understanding of each of the model's nine components is important for effective communication.

1. The **sender** is the party sending the message to another party. Also referred to as the *communicator* or the *source*, the sender is the "who" of the process and takes the form of a person, company, or spokesperson for someone else.
2. The **message** refers to the combination of symbols and words that the sender wishes to transmit to the receiver. This is the "what" of the process and indicates the content that the sender wants to convey.
3. **Encoding** refers to the process of translating the meaning to be transmitted into symbolic form (words, signs, sounds, etc.). At this point, a concept is converted into something transmittable.

4. The **channel** refers to the means used to deliver a marketing message from sender to receiver. This indicates the "how" of the process or what connects the sender to the receiver.

5. The **receiver** is the party who receives the message, also known as the *audience* or the *destination*. It is the receiver toward whom the communication effort is directed.

6. **Decoding** refers to the process carried out by the receiver, who converts the "symbols" transmitted by the sender into a form that makes sense. This process assumes that the receiver is using the same basis for decoding that the sender used for encoding.

7. The **response** refers to the reaction of the receiver of the message. At this point, the effect of the message is gauged; it relates to the meaning that the receiver attaches to it.

8. **Feedback** refers to the aspect of the receiver's response that the receiver communicates back to the sender. The type of feedback will depend on the channel, and the effectiveness of the effort is gauged in terms of the feedback.

9. **Noise** refers to any factor that prevents the decoding of a message by the receiver in the way intended by the sender. Noise can be generated by the sender, the receiver, the message, the channel, or the environment.

Barriers to Communication

The communication process could be unsuccessful for any number of reasons. Factors that might influence this process include selective attention on the part of the receiver; selective distortion on the part of the receiver, whereby the receiver changes the message to fit preconceptions; selective recall, whereby the receiver only absorbs part of the message; and message rehearsal, whereby the receiver is reminded by the message of related issues that distract the receiver from the point of the message. Any of the aspects of communication discussed previously—the source of the information, context, message, channel, and timing—can have barriers associated with them. Although public access to interactive media has helped overcome some barriers to communication, many of the barriers discussed here remain unaffected by technological solutions to information transfer. Some of the types of barriers are discussed in this section.

Transmission Barriers
Things that get in the way of message transmission are sometimes called *noise*. Communication may be difficult because of noise and associated

problems. A bad mobile phone line or a noisy restaurant, for example, can hinder communication. If an e-mail message or letter is not formatted properly, or if it contains grammatical and spelling errors, the receiver may not be able to concentrate on the message because the physical appearance of the communication is sloppy and unprofessional.

Conflicting Messages

Messages that cause a conflict in perception for the receiver may result in incomplete communication. For example, if a person constantly uses jargon or slang to communicate with someone from another country who has never heard such expressions, mixed messages are likely to result. Another example of conflicting messages might be if a supervisor requests a report immediately without giving the report writer enough time to gather the proper information. Does the report writer emphasize speed in writing the report, or accuracy in gathering the data? An example of conflicting messages in healthcare is the debate over the health benefits of moderate alcohol consumption: Moderate alcohol consumption is recommended in the general case, but it is strictly proscribed for certain health conditions.

Information Overload

In reality, people do not pay attention to all communications they receive but selectively attend to and purposefully seek out information. A received message that contains too much information is likely to create a barrier to effective communication. If information is transmitted too fast, it becomes difficult to interpret the information. For example, if a topic has 25 salient points, it may be possible to communicate only two or three of them at a time; otherwise, the receiver will be overwhelmed by the avalanche of information.

Channel Barriers

The choice of channel is critical for effective communication. If a sender chooses an inappropriate channel of communication, insurmountable barriers may be imposed. Detailed instructions presented over the telephone, for example, may be frustrating for both communicators. Some consumers may be so resistant to direct mail (read: junk mail) that they refuse to deal with any organization that sends them unsolicited communications. The credibility (or lack thereof) of a channel will determine the extent to which the message is acceptable to the receiver.

Social and Cultural Barriers

Effective communication with people of different cultures can be challenging. Culture provides people with ways of seeing, hearing, and interpreting the world. Thus, the same words can mean different things to people from

different cultures, even when they talk the "same" language. When the languages are different and translation is used to communicate, the risk of misunderstanding increases.

Ting-Toomey (1994) describes three ways in which culture interferes with effective cross-cultural understanding. The first type of interference is *cognitive constraints*. These are the frames of reference or worldviews that provide a backdrop that all new information is compared to or inserted into. This framework facilitates one's interpretation of the information that is transmitted.

The second type of interference is *behavior constraints*. Each culture has its own rules about proper behavior that affect verbal and nonverbal communication. Whether people look each other in the eye or not; whether people say what they mean overtly or talk around a subject; and how close people stand to each other when they are talking are practices that differ from culture to culture.

Ting-Toomey's third type of interference is *emotional constraints*. Cultures regulate the display of emotion differently. In some cultures, people get very emotional when they are debating an issue: They yell, cry, and exhibit their anger, fear, frustration, or other feelings openly. In other cultures, people try to keep their emotions hidden, exhibiting or sharing only the "rational" or factual aspects of the situation.

Literacy Level

health literacy
The level of understanding exhibited by a healthcare consumer with regard to health and healthcare.

The literacy level of the target audience must be taken into consideration. **Health literacy** is defined as the ability to read, understand, and act on health information. People of any age, income, race, or background can find it challenging to understand health information. Low health literacy has been identified as a serious barrier to health communication, yet presenting material to well-educated audiences that is well below their level of comprehension can also have a negative effect on the communication process.

Health literacy represents a crisis of understanding medical information rather than one of access to information. In fact, the health of 90 million people in the United States may be at risk because of the difficulty that some patients experience in understanding and acting on health information.

Medical information is becoming increasingly complex, and all too frequently, physicians do not explain this information in a way that patients can understand. Physicians face increasing time pressures in today's clinical setting, and they may not even recognize when patients do not understand medical information or care instructions. If patients do not understand their medication and self-care instructions, a crucial part of their medical care is missing, which may have an adverse effect on their clinical outcomes. Exhibit 10.2 discusses low health literacy as a major barrier to communication in the US healthcare system.

EXHIBIT 10.2
Low Health
Literacy

Low health literacy—the inability to read, understand, and act on health information—is an emerging public health communication issue that affects people of all ages, races, and income levels. Research shows that most consumers need help understanding healthcare information (Mahoney 2016). Regardless of reading level, patients prefer medical information that is easy to read and understand. For people who do not have strong reading skills, however, easy-to-read healthcare materials are essential (US Department of Health & Human Services 2019).

Limited health literacy increases the disparity in healthcare access among exceptionally vulnerable populations, such as racial and ethnic minorities and the elderly. Low health literacy is an enormous cost burden on the American healthcare system. Annual healthcare costs for individuals with low literacy skills are four times higher than for those with higher literacy skills. Problems with patient compliance and medical errors may be based on poor understanding of health information. The fact that only about 50 percent of all patients take their medications as directed illustrates the downside of low health literacy.

Patients with low health literacy and chronic diseases such as diabetes, asthma, or hypertension have less knowledge about their disease and its treatment and fewer self-management skills than literate patients. Patients with low literacy skills face a 50 percent higher risk of hospitalization compared with patients with adequate literacy skills.

Research on literacy levels indicates that people with low literacy:

- Make more medication or treatment errors
- Are less able to comply with treatment regimens
- Lack the skills needed to successfully negotiate the healthcare system
- Are at higher risk for hospitalization than people with adequate literacy skills

Approaches to Effective Communication

Communication experts indicate that effective communication requires certain attributes. The communication must contain value for the receiver; it must be meaningful, relevant, and understandable; and it must be capable of being transmitted in a few seconds. Further, the communication must lend itself to visual presentation if possible, be relevant to the lives of "real" people, and stimulate the receiver emotionally. The communication should also be interesting, entertaining, and stimulating.

Research shows that effective health promotion and communication initiatives adopt an audience-centered perspective, with promotion and communication activities reflecting audiences' preferred formats, channels, and contexts. These considerations are particularly relevant for populations that speak different languages or rely on different sources of information. Public education campaigns must be conceptualized and developed by individuals with specific knowledge of the cultural characteristics, media habits, and language preferences of intended audiences. Direct translation of health information or health promotion materials should be avoided. Credible channels of communication need to be identified for each major group. Television and radio serving specific racial and ethnic populations can be effective means to deliver health messages when care is taken to account for the language, culture, and socioeconomic situations of intended audiences.

An audience-centered perspective also reflects the realities of people's everyday lives and their current practices, attitudes and beliefs, and lifestyles. Audience characteristics that are relevant include gender, age, education and income level, ethnicity, sexual orientation, cultural beliefs and values, primary language(s), and physical and mental functioning. Additional considerations include experience with the healthcare system, attitudes toward different types of health problems, and willingness to use certain types of health services. Particular attention should be paid to the needs of underserved audience members.

These factors indicate the complexity of developing effective health communication. One of the main challenges in designing effective health communication programs is identifying the optimal contexts, channels, content, and reasons that will motivate people to pay attention to and use health information. Exhibit 10.3 outlines the attributes of effective health communication.

The Health Communication Process

The health communication process can be complicated but, like any complex process, can be broken down into discrete steps. The following sections outline the steps involved in the health communication process. Although they are presented in a sequence, situations may arise that require the sequence to be changed or, in some circumstances, require a step to be eliminated.

The health communication process can be divided into four stages: planning, development, implementation, and evaluation. Each stage will be discussed in turn. Exhibit 10.4 describes one formal planning technique developed for use in healthcare.

According to documents produced by the US Department of Health & Human Services, effective communication is defined by several attributes:

- **Accuracy.** The content is valid and free from errors of fact, interpretation, or judgment.
- **Availability.** The content is delivered or placed where the audience can access it.
- **Balance.** When appropriate, the content presents the benefits and risks of potential actions or recognizes different and valid perspectives on the issue.
- **Consistency.** The content remains internally consistent over time and is consistent with information from other sources.
- **Cultural competence.** The design, implementation, and evaluation processes take into account special issues for select population groups as well as their educational levels.
- **Evidence based.** Relevant scientific evidence that has undergone comprehensive review and rigorous analysis to formulate practice guidelines, performance measures, review criteria, and technology assessments is included.
- **Reach.** The content gets to or is available to the largest possible number of people in the target population.
- **Reliability.** The source of the content is credible and the content is kept up to date.
- **Repetition.** The delivery of and access to the content is continued or repeated over time, both to reinforce the impact with a given audience and to reach new generations.
- **Timeliness.** The content is provided or is available when the audience is most receptive to, or most in need of, the specific information.
- **Understandability.** The reading or language level and format are appropriate for the target audience.

Source: US Department of Health & Human Services (2019).

The PRECEDE-PROCEED framework is an approach to planning that examines the factors that contribute to behavior change:

- **Predisposing factors**—the individual's knowledge, attitudes, behavior, beliefs, and values before intervention that affect willingness to change
- **Enabling factors**—factors in the individual's environment or community that facilitate or present obstacles to change
- **Reinforcing factors**—the positive or negative effects of adopting the behavior (including social support) that influence continuing the behavior

These factors require that individuals be considered in the context of their community and social structures, and not in isolation, when planning communication or health education strategies.

Phase 5	Phase 4	Phase 3	Phase 2	Phase 1
Administration and Policy Diagnosis	Educational and Organizational Diagnosis	Behavioral and Environmental Diagnosis	Epidemiological Diagnosis	Social Diagnosis

Health Promotion

Health education

Policy regulation organization

Predisposing factors

Reinforcing factors

Enabling factors

Behavior and lifestyle

Environment

Health

Quality of life

Phase 6	Phase 7	Phase 8	Phase 9
Implementation	Process Evaluation	Impact Evaluation	Outcome Evaluation

Once health communication planners identify a health problem, they can use a planning framework such as PRECEDE-PROCEED. A planning framework can help identify the social science theories that are most appropriate for understanding the problem or situation. Thus, planners use theories and models within the construct of a planning framework.

Using a planning system such as PRECEDE-PROCEED increases the odds of program success by examining health and behavior at multiple levels. Planning system perspectives emphasize changing both people and their environment.

Source: National Cancer Institute (2003).

The Planning Stage

Planning is critical to the development of an effective health communication project. A carefully devised plan will enable the project to produce meaningful results. Taking the time to carefully plan the project will ultimately save time by defining program objectives and outlining the steps for meeting those objectives. Even if the project is part of a broader health promotion effort, a plan specific to the communication component is necessary. Indeed, any health communication effort should fit within the context of the organization's overall marketing plan and be informed by its strategic plan.

The Development Stage

Stating the Problem or Issue

Defining the problem or the issue is the critical first step in the plan development process. It involves identifying the "real" issues at hand and the specific information required for the development of the communication initiative. Unless the issue is properly defined, the chances of developing a successful campaign are low. Time spent initially isolating the issues is a good investment.

Stating Assumptions

A critical step at the outset is stating assumptions. Assumptions are the understandings that drive the planning process; if they are not specified early in the process, the communication team may find itself holding conflicting notions of what the project is really about. Assumptions can also relate to demographic trends, reimbursement practices, and any other aspects of the healthcare system. Assumptions should be made about the target audience. These assumptions include the nature of the population, the political climate, other options for services, and so forth.

Some assumptions can—and should—be stated at the outset of the planning process. Others will be developed as information is collected and more in-depth knowledge is gained concerning the community, its healthcare needs, and its resources. Although assumptions will undoubtedly be refined as the planning process continues, it is important to begin with at least general assumptions.

Reviewing Available Data

Gaps in available information should be noted and sources of additional information identified. The types of sources of information will be determined by the type of issue addressed in the communication project. The types of information that are useful at this stage include descriptions of the incidence or prevalence of the health problem; the characteristics of those affected by the identified problem; the consequences of the health problem

for individuals, communities, and the healthcare system; likely causes of the conditions; and possible solutions, treatments, or interventions.

Both published and unpublished reports may be available from internal and external sources. A number of federal health information clearinghouses and websites also provide information, products, materials, and sources of further assistance for specific health subjects. A helpful first step in assessing the problem may be to contact the appropriate websites or the relevant health department to obtain information on the health issue being addressed.

Often, health professionals rely on health communication alone and set unrealistic expectations for what it can accomplish. It is important to identify all of the components necessary to bring about the desired change and then carefully consider which components are being—or can be—addressed. It is important to determine what aspect of the problem is amenable to change.

Conducting Additional Research

Research on intended audiences' culture, lifestyle, behaviors and motivations, interests, and needs is key to the success of a health communication program. As noted in chapter 4 on communication audiences, an understanding of the target population should include information on demographics, lifestyles, health status, and health behavior, as well as information on the channels, messages, and timing appropriate for the target audience. In some cases, primary research may be required to gather the information needed to develop a campaign.

Defining Communication Objectives

Defining communication objectives will help set priorities among possible communication activities and determine the message and content required for each. Objectives refer to the specific targets to be reached in support of goal attainment. Once communication objectives have been defined and circulated, they serve as a kind of contract or agreement about the purpose of the communication and establish the types of outcomes to be measured.

Realistically Assessing the Health Communication Approach

In some cases, health communication alone may accomplish little or nothing without changes to policy, technology, or infrastructure. Sometimes, effective solutions may not yet exist for a communication program to support. For example, no treatment may exist for an illness, or a solution may require services that are not yet available. In these cases, the health communication program may be easily redirected to support the importance of research on this issue.

Raising awareness or increasing knowledge among individuals or the organizations that serve them can be accomplished through the communication process. However, accomplishing such an objective may not necessarily lead to behavior change. For example, it is unreasonable to expect communication to cause a sustained change in complex behaviors or compensate for a lack of healthcare services, products, or resources.

Profiling the Intended Audience(s)

The identification of the intended populations for a program starts with a review of the epidemiology of the problem. This effort will determine who is most affected, who is at greatest risk, and what other factors contribute to the problem. Intended populations are often defined very broadly, using just a few descriptors (e.g., women over age 50). These audiences are often carved out of broad population groups and defined more narrowly based on characteristics such as attitudes, demographics, geographic region, or patterns of behavior.

Formulating a Strategy

Somewhere during this process, the choice of strategy must be considered. The strategy refers to the generalized approach to communication that is to be taken in response to the challenges identified. This may mean choosing between a public health approach, a free market approach, an educational model, or a public-private consortium approach, to name a few. Any one of these approaches could be the basis for a strategy and serve as the framework for communication planning. The strategy should provide overall direction for the initiative, fit the available resources, minimize resistance, reach the appropriate targeted groups, and, ultimately, accomplish the goals of the communication initiative.

While the precise strategic approach taken may not be specified at this point, the options can be narrowed. This will focus subsequent planning activities by eliminating strategies that are considered unproductive. For example, it may have been determined that the target population must be educated on the issues prior to attempting behavioral change. In that case, the strategy would focus—initially at least—on education and information dissemination.

Choosing the Type of Appeal

There are a variety of ways to capture the intended audience's attention. Appeals might be made to their emotions, their intellect, or their pocketbooks. The best approach depends on the intended audience's preferences, the type of information being communicated, and what the project hopes to

accomplish. In any case, the choice of type of appeal should reflect the strategy that has been chosen.

Determining the Channels

Message delivery channels have changed significantly in recent years (National Cancer Institute 2003). Today, channels are more numerous, they are often more narrowly focused on an intended audience, and they represent changes that have occurred in healthcare delivery, the mass media, and society.

Interpersonal channels (e.g., physicians, friends, family members, counselors, parents, clergy, and coaches of the intended audiences) put health messages in a familiar context. These channels are more likely to be trusted and influential than media sources. Group channels (e.g., brown bag lunches at work, classroom activities, church group discussions, neighborhood gatherings, and club meetings) can help an initiative reach more of the intended audience, retaining some of the influence of interpersonal channels. Health messages can be designed for groups with specific things in common, such as workplace, school, church, club affiliations, or favorite activities, and these channels add the benefits of group discussion and affirmation of the messages.

The Implementation Stage

Planning is ultimately only an exercise, albeit a meaningful one. The payoff comes in the implementation of the plan. The planning process creates a road map that the communication staff will use to move the initiative forward. However, the process often breaks down during the implementation stage. The oft-repeated maxim that "the last plan is still sitting on the shelf" reflects a failure of implementation rather than any flaw in the plan itself.

The transition from planning to implementation involves a handoff from the planning team to the management team. Implementation must occur at several different levels and in different sectors of the community or divisions of the organization. For this reason, the implementation of the plan requires a level of coordination that few organizations and certainly few communities have in place.

Developing Materials

Developing and pretesting messages and materials can help indicate early in the process which messages will be most effective with the intended audiences. Knowing this information will save time and money. Positive results from pretesting can also generate early buy-in from others in the organization. It is beneficial to start with existing materials, if possible, and determine what is appropriate for the particular project rather than reinventing the wheel.

The development of new materials is a major expenditure. Affordable formats should be chosen. Knowledge of the intended audience should

be used to combine, adapt, and devise new ways to get the message across. Input should be sought from the intended audience or partners with regard to decisions about materials. Exhibit 10.5 explains concept testing.

EXHIBIT 10.5
Concept Testing

Concepts can be presented for testing in a number of ways. A health communication concept should convey the major characteristics of the appeal along with the action that a program wants the intended audiences to take and the benefits they will receive as a result. Concept testing typically involves initially testing a message, testing draft materials incorporating that message, and testing final materials before they are sent to production.

Once the intended audiences have been defined and communication strategies developed, testing the concepts with intended audiences can help determine message appeals (e.g., fear arousing versus factual), spokespeople (e.g., scientists, public officials, or members of the intended audience), and language (determined by listening to the research participants' language). Testing is especially important if the program deals with a new issue, because it will help clarify where the issue fits within the larger context of the intended audience's life and perceptions. Messages and materials should be pretested in a context that approximates real life. Theater-style testing, for example, can approximate reality using a simulated television-viewing environment. Using multiple methods can help produce an accurate picture of the intended audience members and their likely responses to the initiative.

Concept testing can help save time and money because it identifies which messages work best with the intended audiences. Concept testing can be used to identify the following:

- The concept with the strongest appeal and potential for effect
- Confusing terms or concepts
- Language used by the intended audience
- Weaker concepts that should be eliminated
- New concepts

Message concept testing often asks participants to rank a group of concepts from most to least compelling and then to explain their rankings. Participants then discuss the benefits and drawbacks of each concept. Health communicators often use a sentence or brief paragraph to describe a

(continued)

EXHIBIT 10.5
Concept Testing
(continued)

concept to participants. For example, two antismoking concepts for teenagers can be articulated as following:

1. Smoking harms your appearance.
2. Cigarette advertisers have created a myth that smoking makes a person more attractive. They are lying.

Both concepts address attractiveness, but the first concept uses it as the focal point of a negative appeal (to avoid becoming less attractive, do not smoke), whereas the second concept uses a factual approach and a different benefit—avoid being manipulated by the tobacco industry—designed to appeal to teens' strong desire for independent thought.

In each of these concepts, both the action that the intended audience members should take and the benefit are implied, not stated. This approach works best in situations in which the desired behavior is obvious. In other situations, the behavior or benefit should be mentioned.

Source: National Cancer Institute (2003).

Launching the Campaign

Before the launch of a communication initiative, it is important to plan for distribution, promotion, and process evaluation. In this step, the communication staff develop a launch plan, produce sufficient quantities of materials, and prepare for subsequent tasks. Some projects might benefit from a quiet, low-key launch, while others may mandate a major kickoff event. A kickoff event can create broader awareness of the program and promote community involvement. Kickoff events are an excellent way to develop relationships with people who may be willing to get involved in the program. Scheduling an event also creates a deadline, which will help the program avoid unnecessary lag time or protracted preparations.

Managing the Campaign

The primary tasks involved in managing a health communication program include monitoring activities, staff, and budget; problem-solving; process evaluation; measuring audience response; and revising plans and operations. The plan developed to manage the campaign should indicate how and when resources will be needed, when events will occur, and at what points efforts will be assessed. Ongoing process evaluation will determine whether activities are being completed on time, whether the intended audiences are being

reached, which activities or materials are most successful, and which aspects of the program need to be altered or eliminated.

The Evaluation Stage

Evaluation of the communication project should be top of mind from day one, and the means of evaluation should be built into the health communication process. Evaluation is necessary to determine the efficiency of the process and the effectiveness of the initiative. Evaluation techniques focus on two types of analysis: process (or formative) analysis and outcome (or summative) analysis. The former evaluates systems, procedures, communication processes, and other factors that contribute to the efficient operation of a program. Outcome evaluation focuses more on end results or what is ultimately accomplished. Process evaluation essentially measures efficiency, whereas outcome evaluation measures effectiveness.

Summary

Health professionals have developed an appreciation for the critical role that communication plays in healthcare. Just as important as the positive contribution that communication can make to healthcare is the negative impact that ineffective or misleading communication can have. Many of the challenges facing healthcare today reflect failures in communication.

Communication refers to the transmission or exchange of information and implies the sharing of meaning among those who are communicating. Communication serves a number of purposes: (1) initiating actions; (2) making needs and requirements known; (3) exchanging information, ideas, attitudes, and beliefs; (4) engendering understanding; and (5) establishing and maintaining relationships.

The most obvious applications of health communication have been in the areas of health promotion and disease prevention. Communication can take place at several levels: individual, social network, organization, community, and society. The more levels at which a communication program has influence, the greater the likelihood of creating and sustaining the desired change. Barriers exist with any communication campaign. These barriers need to be recognized and addressed.

A number of audiences exist for health communication, including patients, clients, enrollees, employees, and other end users, as well as the general consumer population. In addition, a number of professional and institutional targets can be identified for communication initiatives. All of these audiences are affected by the context, message, channel, and timing of communication.

Regardless of the target audience, the health communication process comprises a number of steps: planning, development, implementation, and evaluation.

Key Points

- Effective communication is the basis for any successful marketing initiative.
- Health communication has evolved along with the changing healthcare system.
- Communication serves a number of purposes: initiating action, indicating needs and requirements, exchanging information, engendering understanding, and establishing and maintaining relationships.
- Communication can take place at many levels, ranging from the individual to the society.
- Communication that takes place at multiple levels is more likely to be successful.
- The audiences for health communication include individual consumers (patients, clients, enrollees, etc.) and professional and institutional consumers.
- Healthcare consumers share similarities and dissimilarities with consumers in other industries; their attributes have implications for health communication initiatives.
- A number of communication theories can be applied to healthcare.
- Healthcare consumers rely on informal, formal, and impersonal sources of information; the type of source has implications for the effectiveness of the communication.
- Barriers to communication must be identified and addressed.
- The health communication process comprises four stages: planning, development, implementation, and evaluation.

Discussion Questions

1. Why should communication be considered more important in healthcare than in any other field?
2. Why is effective communication often absent in healthcare settings?
3. What are the different levels of communication, and what are the implications of each level for addressing health-related issues?

4. What roles does communication play in healthcare beyond simply conveying information?
5. How does the nature of the target audience affect health communication efforts?
6. What are the effects of low health literacy for populations that suffer disproportionately from health problems?
7. What are some of the theories that guide the development of health communication initiatives, and how does each theory influence the nature of communication?
8. What are the sources from which healthcare consumers receive information, and how does the nature of the source influence the acceptance of information?
9. What barriers prevent effective communication of health information?
10. What are the steps in the process of developing a communication plan?

Additional Resources

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11

TRADITIONAL MARKETING TECHNIQUES

This chapter provides an overview of traditional marketing techniques as they are applied to healthcare. The promotional mix and media options are discussed, along with social marketing and integrated marketing. The pros and cons of each technique are discussed in turn.

The Promotional Mix

The promotional component of the marketing strategy can be considered the action component through which the marketing plan is implemented. *Promotions* refer to the techniques used to communicate with customers and potential customers for the purpose of promoting an idea, an organization, or a product. Traditional promotional activities include public relations, advertising, personal sales, and sales promotion; direct marketing is also included in this discussion. Each of these techniques is carried out through different means. The term *promotional mix* refers to the combination of techniques used for a given marketing campaign. The following sections discuss these techniques and their applications to healthcare.

A marketing plan typically includes a combination of promotional activities, since a single activity is seldom adequate to achieve the marketing goal. For example, issuing a press release or holding a press conference may be useful for announcing the opening of a new facility or the inauguration of a new service. However, this type of "soft" promotion is not likely to bring customers in the door.

An advertising campaign may be necessary to drive home the availability of the new resources. This advertising may be accompanied by incentives to entice customers to a new facility or service. Depending on the project, networking may be employed, or even personal sales. Ultimately, an effective product launch requires a carefully thought-out combination of promotional activities.

Public Relations
Public relations (PR) is a form of communication management that uses publicity and other forms of promotion to influence consumers' feelings,

opinions, or beliefs about an organization and its offerings. PR typically involves unpaid promotional activities, with marketing, communications, or other personnel carrying out PR activities as part of their job responsibilities. The organization, therefore, does not incur additional expenses or overhead costs. PR activities include writing and distributing press releases (see exhibit 11.1 for a sample press release), scheduling and holding press conferences, writing feature stories, and producing public service announcements.

EXHIBIT 11.1
Sample Press
Release

US Department of Health & Human Services   HRSA NEWS ROOM
Health Resources and Services Administration   http://newsroom.hrsa.gov

FOR IMMEDIATE RELEASE   CONTACT: HRSA PRESS OFFICE
Tuesday, October 29, 2013   301-443-3376

HHS Awards $1.9 Billion in Grants for HIV/AIDS Care and Medications

More than $1.9 billion in grants have been awarded to cities, states and local community-based organizations, the US Department of Health & Human Services (HHS) announced today. This funding will ensure that people living with HIV/AIDS continue to have access to critical health care services and medications. The fiscal year 2013 awards were funded through the Ryan White HIV/AIDS Program.

"The Ryan White HIV/AIDS Program plays an important role in the fight against HIV/AIDS," said Secretary Kathleen Sebelius. "These grants will help make a real difference in the lives of Americans coping with HIV/AIDS, especially those in underserved urban and rural communities."

The Health Resources and Services Administration (HRSA), an agency within HHS, oversees the Ryan White HIV/AIDS Program, which provides funding for health services for people who lack sufficient health care coverage or financial resources to pay for treatment.

"The Ryan White HIV/AIDS Program helps more than half a million individuals each year obtain clinical care, treatment and support services," said HRSA Administrator Mary K. Wakefield, Ph.D., R.N. "The key to its success is the cities, states and community groups who know their populations and decide how best to allocate the funding they receive."

A total of $594 million was awarded to 53 cities to provide core medical and support services for individuals living with HIV/AIDS under Part A

(continued)

of the Ryan White HIV/AIDS Program. These grants are awarded to eligible metropolitan areas with the highest number of people living with HIV/AIDS and to areas experiencing increases in HIV/AIDS cases and emerging care needs. See a list of the Part A awards.

Approximately $1.16 billion was awarded in FY 2013 to 59 states and territories under Part B of the Ryan White HIV/AIDS Program. Part B grants include grants that can be used for home and community-based services, AIDS Drug Assistance Program (ADAP) assistance, and other direct services. In FY 2013, $309 million was awarded in Part B base funding and $782 million was awarded for ADAP. In addition, 16 states received Emerging Community grants based on the number of AIDS cases over the most recent five-year period. Thirty-six states and territories were also awarded $10.1 million in Part B Minority AIDS Initiative grants. See a list of the Part B awards.

In FY 2013, approximately $178 million was awarded across the country to 357 local community-based organizations to provide core medical and support services to individuals living with HIV/AIDS under Part C of the Ryan White HIV/AIDS Program. Currently, 351 Part C grantees are providing ongoing services. Part C grant recipients provide comprehensive primary health care in outpatient settings to people living with HIV disease. See a list of the FY 2013 Part C awarded grants.

These funds also will support states and communities in their ongoing efforts to pursue the goals of the National HIV/AIDS Strategy, particularly efforts to increase access to HIV care and reduce HIV-related health disparities.

To learn more about the Ryan White HIV/AIDS Program, visit hab.hrsa.gov. For more information about HIV/AIDS prevention, testing, treatment, and research, visit AIDS.gov.

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The Ryan White HIV/AIDS Program is administered by the US Department of Health & Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Bureau (HAB). Federal funds are awarded to agencies located around the country, which in turn deliver care to eligible individuals under funding categories called Parts. First authorized in 1990, the Ryan White HIV/AIDS Program is currently funded at more than $2 billion.

Source: Reprinted from US Department of Health & Human Services (2013).

Publicity refers to any type of promotion that draws general attention to an organization without targeting a specific audience. This traditional form of promotion predates advertising and other marketing techniques. Forms of publicity include the following:

- **Collateral materials.** These materials are developed for the organization, program, or product being promoted. They include brochures, letterhead, business cards, social media content, and websites. A potential customer may be first exposed to the organization, program, or product through such materials. In addition, collateral materials serve as a foundation for materials developed for future or subsequent marketing efforts; are an inexpensive means of generating and maintaining **visibility** for the organization's activities; and convey basic information, such as location and directions, pertinent phone numbers, and e-mail addresses.

- **Public service announcements.** A no-cost advertisement that supports a public service campaign, a **public service announcement (PSA)** may be aired on radio or television, printed in a newspaper or magazine, featured on a billboard, or posted on the internet. Although the no-cost aspect of PSAs is appealing, the downside is that the advertising organization often has no control over the placement or timing of PSAs. Further, this method is not entirely free, as time, effort, and money are required to produce the radio or television spot, internet banner advertisement, or printed notice.

- **Internal and external publications.** Staff of the communications department (or an overlapping function like marketing or community outreach) develop internal employee newsletters, annual reports, patient education pamphlets, and other publications geared to relevant groups within the organization (internal marketing) and outside of it (external marketing).

- **Sponsorships. Sponsorship** involves support by an organization for a community project or event. Sponsorship may include direct financial support through contributions or sponsorship of concessions (e.g., refreshment booth) or in-kind contributions such as volunteer time, food and beverages, and gift items (e.g., water bottles, T-shirts). The sponsor typically does not run an advertisement but may be mentioned in a "brought to you by" message. Although sponsorships may be driven by altruistic motives, they typically bestow goodwill and favorable attention on the generous organization. Additionally, sponsors receive substantial media coverage and improve their employees' morale. Unlike most forms of PR, sponsoring or underwriting a project or an event usually requires financial output.

publicity
Any promotion that draws general attention to an organization but does not target a particular audience.

visibility
A marketing campaign goal that raises the public's awareness of the organization, program, or product to increase consumers' top-of-mind recall.

public service announcement (PSA)
A no-cost advertisement that supports a community program or public initiative.

sponsorship
Organizational support—typically financial—of a community project or event.

- **Spokespeople.** A **spokesperson** may be a national or local celebrity—such as an athlete, an actor, a community leader, or some other influential personality; a well-known mascot could also be a spokesperson. By associating the organization with a recognizable person or character, the organization hopes to be perceived in a positive way.

- **Community outreach programs.** Community outreach presents the organization's programs to the community and seeks to establish relationships with other community organizations. They may take the form of episodic activities, such as health fairs or educational programs, or ongoing initiatives such as "parish nurses" (fielded by churches to provide home visits and staff health fairs). This type of publicity emphasizes the organization's commitment to the community and its support of local interests. Although the benefits of community outreach activities are not as easily measured as the benefits of direct marketing activities, the organization often gains customers as a result of its health screenings, educational seminars, and referrals. Many consumers are not aware of the healthcare services offered in their own communities; outreach efforts are an effective way to raise **awareness**.

> **spokesperson**
> An individual—usually a celebrity—paid to deliver the organization's message or to speak publicly on its behalf.

As noted in earlier chapters, healthcare organizations are typically regulated by state and federal government agencies. Decisions related to reimbursement rates and adding, eliminating, or changing services may be controlled by government agencies. Organizations often must cultivate and maintain relationships with politicians and other policymakers and government agencies—as well as initiate lobbying activities. In a large organization, the PR function is typically assigned responsibility for these activities or shares it with the government relations office.

> **awareness**
> Recognition of or familiarity with an organization or its product; the ultimate goal of a public relations effort.

Advertising

Advertising refers to any paid form of nonpersonal presentation and promotion of ideas, goods, or services by an identifiable sponsor, typically using mass media as the communication vehicle. The objectives of advertising are as follows:

- Promote products, services, organizations, and causes
- Increase product use
- Remind consumers of the organization or product
- Build customer loyalty
- Introduce new products
- Offset competitors' advertising

- Support sales personnel in the field
- Alleviate sales fluctuations
- Educate consumers
- Maintain visibility

Not all of these objectives are relevant for every healthcare organization, and they are likely to be pursued according to the type of marketing being undertaken.

Advertising is typically classified as institutional (or corporate) advertising or product advertising, depending on what is being promoted. **Institutional advertising** promotes the organization—its image, people, ideas, political issues, and any other traits or features, but not its products. It may introduce or announce a new facility, present comparative information, or explain a public policy stance. **Product advertising**, on the other hand, promotes specific goods or services, not the institution itself. Historically, this type of advertising was less attractive to healthcare organizations, which tended, at least initially, to promote awareness of the institution rather than its products. At some point, large healthcare organizations realized they could not be all things to all people and began to focus their advertising on specific services or service lines. Providers offering elective services, for example, shifted their advertising to tout the availability of laser surgery, facelifts, or pain management rather than the attributes of the organization.

Advertising is much more flexible than other traditional promotional techniques. An advertising campaign could be as simple as print ads in a local shoppers' newsletter or as complicated as a series of commercials that air on national television. This wide range of options comes with a wide range of costs, varying degrees of exposure to consumers, and varying degrees of effort from the organization. Ultimately, the scope of the advertising campaign is determined by the objectives of the effort, the type of product being promoted, and the nature of the target audience.

institutional advertising
Promotion of an organization rather than its products.

product advertising
Promotion of an organization's goods and services rather than the organization itself.

Personal Sales

Another tool in the promotional mix is personal sales—the conversation between a marketer or salesperson and one or more prospective purchasers for the purpose of generating sales. A primary difference between personal sales and advertising is that the former involves two-way rather than one-way communication. The objectives of personal sales are to find prospects, convince prospects to buy a product, and keep existing customers engaged. These objectives involve researching prospects, closing sales deals, providing after-sales service, forecasting future sales, and maintaining relationships with customers. Thus, the role of the salesperson requires not only selling but also

developing relationships with customers and serving as the organization's eyes and ears in the marketplace.

One advantage of personal sales is that the salesperson can get direct feedback from existing and prospective customers. If customers express any misunderstandings or difficulties interpreting the information they are given, the salesperson can correct the situation on the spot. Another advantage of personal sales is that the healthcare organization has more direct control over who receives the message.

Well-established personal-selling activities in healthcare include solicitation of physicians by pharmaceutical and medical supplier representatives, solicitation of consumers by insurance salespeople, and solicitation of hospitals by biomedical equipment representatives. Healthcare providers have become active in personal sales, and hospital representatives may solicit referring physicians, employers, and other organizations to promote the hospital's emergency department, sports medicine program, or a particular service line. These activities have become increasingly important as interactions between individual physicians and individual patients have been displaced by interactions between groups of providers and groups of purchasers.

As with any promotional tool, however, personal sales has several limitations. First, personal sales can be costly. In addition to salary and benefits for sales staff, the costs include travel expenses, promotional materials, and technical support. Second, the number of customer visits that a salesperson can make in one day is limited, as each visit can be time-consuming. Third, the strength of the interpersonal connections made vary from one salesperson to the next. The sales message's "punch" (effect on the consumer) depends on the salesperson's training, disposition, and salesmanship, as well as customer attributes.

The more technologically sophisticated the service, the greater the need for personal sales. For example, a salesperson might be needed to explain the intricacies of a diagnostic or therapeutic technique (to the point of being present in the operating room). Personal sales are also important when a variety of decision makers (especially with differing perspectives) are involved or when the decision carries some risk (e.g., committing to a managed care contract).

The pharmaceutical industry represents the epitome of personal sales. With tens of thousands of sales representatives (called detailers) calling on health professionals and facilities, the industry represents an extreme example of personal sales incorporating aggressive marketing techniques and incentives.

Personal sales can involve a combination of sales presentations, sales meetings, incentive programs, sample distributions, and participation in fairs and trade shows. Regardless of the personal sales mix, the selling process involves specific steps. Exhibit 11.2 outlines the steps in the personal sales process.

Salespeople typically follow seven steps when promoting an organization or a product.

Step 1: Identification of the Prospective Customer

This first step in the personal sales process is identifying qualified potential customers. In healthcare, for example, salespeople may identify potential referring physicians, organ donors, or purchasers of biomedical equipment. In some cases, the prospects are obvious—for example, when contacting a hospital's purchasing office to promote routine products. In other cases—for example, when selling marketing research services to hospitals—the prospects may be located in a variety of departments (e.g., marketing, research, business development) or at different levels within the organization, from research analyst up to vice president.

Step 2: Pre-Approach

The second step requires the salesperson to learn as much as possible about the prospects identified before approaching them. If the salesperson is offering supplies to a hospital, for example, he or she should find out the hospital's level of supply use and its current suppliers. Likewise, a pharmaceutical sales representative must first become familiar with physicians' prescribing practices and the drugs they typically prescribe.

Step 3: Approach

In the third step, the salesperson meets the prospective buyer to establish a relationship. Healthcare sales are not typically characterized by the "wining and dining" that often accompanies promotional activities in other industries. Because sales situations in healthcare vary, no standard approach to clients exists.

Step 4: Presentation and Demonstration

In the fourth step, the salesperson describes the attributes and benefits of the healthcare product to the prospects. The salesperson faces two common challenges: many healthcare providers are not used to receiving sales calls or visits, and salespeople may have difficulty meeting with the right person in a large healthcare organization. Exhibiting at professional meetings is one way for salespeople to gain exposure to supplement presentations, demonstrations, and other information channels.

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EXHIBIT 11.2
Steps in the
Personal
Sales Process
(continued)

STEP 5: HANDLING OBJECTIONS

In this step, the salesperson seeks out, clarifies, and overcomes the customer's objections to buying. Because of the nature of healthcare, the sales representative is likely to take a consultative rather than hard-sell approach. Instead of trying to out-negotiate the customer, the salesperson is likely to address the customer's objections in a mutually beneficial manner.

STEP 6: CLOSE

In this step, the salesperson asks the customer to order the product or otherwise consummate the sale. Establishing an agreement among the parties initiates the fulfillment process. Closing a sale is often less straightforward in healthcare than it is in other industries, as many parties may have to participate in the purchase decision.

STEP 7: FOLLOW-UP

After the sale, the salesperson follows up to ensure the customer's satisfaction and repeat business. In healthcare, relationship management is equally—if not more—important than in other industries, and ongoing contact with the customer is necessary.

Fundraising is an aspect of personal sales that characterizes many not-for-profit healthcare organizations. Such organizations often rely on donations to support their programs or fund capital improvements, so organizations typically market themselves to potential donors to secure contributions. Although this effort may involve direct mail or telemarketing, major contributors typically must be contacted in person—that is, by a high-level representative of the organization acting as a "salesperson." Thus, many large not-for-profits maintain development staff dedicated to soliciting funds directly from large donors.

While many sectors of the healthcare industry look askance at the wining-and-dining activities in other industries, a certain amount of networking is both inevitable and desirable for the purpose of the sale. Healthcare administrators (e.g., hospital administrators, physician practice managers) interact with those in similar positions to exchange information, flesh out ideas, and "do deals." Perhaps more so in healthcare than in other industries, administrators are likely to know each other and network in the same social or professional circles. Likewise, physicians commonly network with other physicians; this is understandable, given the importance of referral

relationships in channeling patients to other physicians. Hospital and physician practice administrators also network with physicians.

Sales representatives of for-profit healthcare organizations are active networkers. They seek out prospects at professional meetings, in civic organizations, and at social events. Relationships developed at healthcare conferences or in social settings may be used to a salesperson's advantage at some point in the future. The salesperson may offer to sponsor a meeting or a reception or may provide lunch to the employees of a networking partner or practice. A representative will be present at such an event to answer questions and to get to know the people involved in decision-making at the practice.

Sales Promotion

trade show
A convention at which vendors present their products to attendees.

Sales promotion refers to any activity or material that directly induces resellers, salespeople, or consumers to buy a good or use a service. Enticements are offered to achieve a specific sales or marketing objective. The sales promotion mix includes health fairs and **trade shows**, exhibits, demonstrations, contests and games, premiums and gifts, rebates, attractive financing terms, and trade-in allowances.

Although sales promotion methods have less application in healthcare than in most other industries, both "pull" and "push" incentives are frequently used. Pull incentives used to promote consumer goods also apply to personal healthcare products. They include discounts on the customer's next purchase, cash refunds, coupons, buy-one-get-one-free promotions, consumer contests, loyalty cards, free trials (or samples), free products, price reductions, and merchandising and point-of-sale displays. Manufacturers and service providers use push incentives to influence intermediaries to carry or deliver a product. For example, an optometrist might be offered incentives to carry (and presumably promote) a particular brand of contact lens solution.

Pharmaceutical companies use both pull and push strategies to promote drugs to their target audiences. By using a pull strategy, they appeal directly to the consumer, recognizing that the consumer creates the demand for the product and pulls the product through the channel. In other words, the consumer asks the physician to write a prescription for the product, which ensures that at least one intermediary is distributing the product. When the consumer asks the pharmacy to fill the prescription, the consumer is again pulling the product through the supply chain because the pharmacy must order the drug from the manufacturer to fill the prescription. At the same time, pharmaceutical companies offer samples and make sales calls to physicians to get them to push their products out to consumers.

For many provider organizations, holding or participating in health fairs is a form of sales promotion. Providers may offer diagnostic tests and distribute health education materials at these fairs, and the fairs give providers an

opportunity to attain greater visibility and interact with patients who might not be familiar with their services. Consumers who attend these health fairs, in turn, get the chance to enroll in local wellness programs, sign up for or obtain disease screening or tests on the spot, learn about medical risks and conditions, and (for those who test positive in screening tests) get a referral for diagnosis or treatment.

Exhibits at trade shows, professional meetings, and conferences are another form of sales promotion. These displays give organizations an opportunity to interact with hard-to-reach prospects, such as physicians and hospital administrators. The decision to exhibit and the type of display developed depend on the nature of the organization and its products as well as the characteristics of its target audience. In addition, an exhibit provides a unique avenue for conducting market research, as many of the best prospects are assembled in one location. Organizations that are not accustomed to or opt out of exhibiting may miss out on this sales promotion format. Exhibit 11.3 presents ten tips for effective exhibit marketing.

EXHIBIT 11.3
Ten Tips for Effective Exhibit Marketing

Little guidance is available for healthcare organizations that want to exhibit at trade shows or professional meetings and conferences—perhaps because of the variations in marketing strategies and techniques used by healthcare organizations. Nevertheless, general dos and don'ts are relevant to any organization that plans to exhibit. Here are ten of them.

1. DEVELOP A FORMAL EXHIBIT MARKETING PLAN
Having both strategic exhibit marketing and tactical plans of action is a critical starting point. To make trade shows a powerful aspect of an organization's overall marketing operation, strategic marketing must be aligned with the exhibit marketing plans. Trade shows should not be stand-alone ventures. Organizations should know and understand exactly what they wish to achieve at the show (e.g., shore up relationships with existing users, introduce new products and services to new markets).

2. DEVELOP A WELL-DEFINED PROMOTIONAL PLAN
An important component of exhibiting is promotion, including pre-show, at-show, and post-show activities. Most exhibitors fail to develop a plan that encompasses all three areas. The organization's budget naturally plays a major role in deciding what and how much promotional activity is possible.

(continued)

EXHIBIT 11.3
Ten Tips for
Effective Exhibit
Marketing
(continued)

Developing a meaningful theme or message that ties into the organization's strategic marketing plan helps guide promotional decisions. Exhibitors should know whom they want to target and develop different promotional programs customized for the different groups they want to attract. Target audiences can be reached through direct mail, advertising, public relations, sponsorships, social media, and the internet.

3. Use Direct Mail Effectively

Direct mail is still one of the most popular promotional vehicles that exhibitors use. From postcards to multipiece mailings, attendees are deluged with invitations to visit booths. Many of the mailings are based on lists of registrants, and as a result, every attendee receives every piece of direct mail. To target the people they want to attract to their booth, exhibitors should use their own lists of customers and prospects. Starting about four weeks before the show, exhibitors should mail materials to conference attendees at regular intervals. Distribution via first-class mail is recommended so that the mailing does not arrive after the show is over. Increasingly, e-mail and other social media are used to supplement, if not replace, direct mail for boosting exhibit attendance.

4. Give Prospects an Incentive to Visit the Booth

Regardless of the type of promotional vehicles used, exhibitors need to give visitors a reason to visit their booth. Limited by time constraints and distracted by a hall overflowing with fascinating products and services, people need an incentive to visit a particular booth. First and foremost, visitors are primarily interested in new offerings. They are eager to learn about the latest technologies, new applications, or anything that will help them save time or money. If an organization does not have a new product or service to introduce, it should put a new twist on an existing product or service.

5. Offer Giveaways That Work

Exhibitors can give visitors an incentive to visit their booth by offering a premium item. The giveaway item should be designed to make the exhibit memorable and to communicate, motivate, promote, or increase recognition of the company. Developing an effective giveaway takes thought and creativity. The company should consider items that members of its target audience want, help them do their jobs better, and are not regularly available

elsewhere. It should think about offering different gifts to different types of visitors. The company can use its website to tell visitors that they can obtain important information, such as an executive report, if they visit the booth. Giveaways should be used as a reward or token of appreciation for visitors who participate in a demonstration, presentation, or contest or as a thank you for providing information about their specific needs.

6. Use Press Relations Effectively

Public relations is one of the most cost-effective and successful methods for generating large volumes of direct inquiries and sales. Before the show, exhibitors should ask show management for a comprehensive media list to find out which publications are planning a special show edition. The company should send out newsworthy press releases focusing on what is new about its product or service or highlighting a new application or market venture. Press kits—including information about industry trends, statistics, new technology, or production—should be compiled for the press office. High-quality product photos and key company contacts should also be included in the kits.

7. Differentiate Products or Services

In shows that attract hundreds of exhibitors, few stand out from the crowd. Because memorable exhibits are an integral part of a visitor's show experience, exhibitors should think about what makes their company different and why a prospect should buy its products or use its services. Every aspect of the exhibit marketing plan, including promotions, the booth, and the people working in the booth, should make an impact and generate curiosity.

8. Use the Booth as an Effective Marketing Tool

An organization's exhibit makes a strong statement about what it is, what it does, and how it does it. The purpose of an exhibit is to attract visitors so that the organization can achieve its marketing objectives. In addition to being an open, welcoming, friendly space, the exhibit needs to have a focal point and strongly communicate the benefit that the exhibitor is offering to prospects. Displays that use large graphics are more effective than those that use reams of copy. Pictures paint a thousand words, and few attendees take the time to read lengthy copy. Presentations and demonstrations are critical parts of exhibit marketing. Exhibits should create an experience that gets visitors to use as many of their senses as possible.

(continued)

EXHIBIT 11.3
Ten Tips for
Effective Exhibit
Marketing
(continued)

9. CHOOSE EXHIBIT PERSONNEL CAREFULLY

Exhibit personnel are a company's ambassadors, so they should be carefully selected. Before the show, they should be briefed on why the company is exhibiting, what it is exhibiting, and what it is expecting from them. Exhibit staff training is essential for a unified and professional image. The objectives of exhibit personnel should reflect the marketing plan, and staff should know how to close the interaction with a commitment to follow up. At the same time, the booth should not be crowded with company representatives, and specific tasks should be assigned to company personnel working the show.

10. FOLLOW UP PROMPTLY

The key to trade show success is effective lead management. The best time to plan for follow-up is before the show. Follow-up often takes second place to other management activities that occur after sales staff are out of the office for several days. The longer leads are left unattended, the colder they become. Exhibitors should develop an organized, systematic approach to follow-up. They should establish a lead-handling system, set timelines for follow-up, use a computerized database for lead tracking, make sales representatives accountable for leads assigned to them, and track the results of these efforts.

Source: Adapted from Friedmann (2009).

Direct Marketing

Direct marketing involves an interactive system that uses one or more advertising media to effect a measurable response or transaction from consumers. Categories of direct marketing relevant to healthcare include direct mail, direct-response advertising, mail order, telemarketing, internet marketing, and home-shopping television.

Direct mail is a means of promotion whereby selected customers are sent advertising material addressed specifically to them. Direct mail traditionally has been distributed through the US Postal Service, but contemporary approaches may use e-mail or social media. Junk mail, e-mail spam, and unsolicited faxes are all products of direct mail promotion.

Although many people find these types of solicitations annoying, they are considered effective marketing tools. Marketers like direct mail because it can target specific audiences and be personalized to the prospect's needs. Even if a campaign achieves as little as a 2 percent response rate, marketers

find direct mail to be reasonably cost-effective. Research has found that certain segments of the population are relatively responsive to mailed solicitations, and incoming correspondence related to healthcare is less likely to be discarded than others (Thomas 2008).

Healthcare marketers find that direct mail works best when promoting an event, such as a patient education program or an open house. This approach probably does not work as well to stimulate action that does not have to be completed by a certain date (e.g., scheduling an elective procedure). Marketers of some elective procedures (e.g., laser eye surgery), however, have had reasonable success with direct mail. Case study 11.1 presents an example of direct-to-consumer marketing in healthcare.

CASE STUDY 11.1
Using Direct-to-Consumer Advertising to Increase Drug Sales

After the US Food and Drug Administration relaxed its rules on mass media advertising of prescription drugs, pharmaceutical companies began to engage in direct-to-consumer marketing. Rather than rely strictly on the prescribing activities of physicians, these companies believed that direct appeals to consumers would increase overall pharmaceutical sales and, at the same time, convince consumers to request particular drugs.

To take advantage of this opportunity, GoodDrugs, Inc. shifted a portion of its advertising budget to direct-to-consumer marketing. This advertising supplemented existing marketing approaches: visits by sales representatives to physicians' offices, advertising in medical journals, and the presentation of educational seminars to physicians.

GoodDrugs planned and implemented a six-month television campaign to promote its best-selling (and most profitable) drug for indigestion. Because the drug was available only by prescription, the intent of the campaign was to raise awareness of the drug and get consumers to ask their doctors to prescribe it.

At the end of the six-month campaign, GoodDrugs conducted a telephone survey of consumers in the media coverage area. The results were encouraging. Consumers were aware of the drug: Half of the survey respondents remembered the advertisement for the drug, and one-quarter of them recalled the drug's name. About 25 percent of those who had seen the advertisement said they had asked their doctor about using this drug

(continued)

for indigestion, and physicians wrote prescriptions for 71 percent of those who asked for one. Therefore, approximately 6 percent of the consumers who were exposed to the advertisement received a prescription for the drug.

GoodDrugs marketers and sales executives were encouraged by the results of the television campaign. It generated greater consumer awareness of their product, an increase in consumer preference for the drug, and an increase in desired physician prescribing behavior. As a result, GoodDrugs reworked its marketing budget, shifting resources away from personal sales and journal advertising and toward direct-to-consumer advertising.

Case Study Discussion Questions

1. What limitations were historically placed on pharmaceutical advertising, and what development encouraged drug companies to take more aggressive action?
2. What factors prompted pharmaceutical companies to shift some of their marketing efforts from physician-prescribers to consumers?
3. According to the GoodDrugs marketing team's evaluations, what were the results of the campaign?
4. What did the GoodDrugs marketers do as a result of this campaign?
5. How appropriate is it for pharmaceutical companies to market directly to consumers who may not be in a position to judge the merits of a particular drug?

Direct-response advertising involves promotions distributed through print or electronic media that provide an e-mail address or telephone number (typically a toll-free number) to potential customers. Consumers who want to order a product or obtain more information are instructed to access the website or call the sponsor. This approach has been used successfully in other industries, and it is now being used in healthcare. Physicians performing elective procedures, for example, may have an answering service to field such calls and provide information on laser eye surgery, hair transplants, weight loss programs, or whatever service the practitioner is offering. Fitness equipment is also commonly promoted through television advertisements using this approach.

telemarketing
Sales conducted by telephone, through either outbound or inbound calls.

Telemarketing is another common form of direct marketing. Direct-response advertising is a form of telemarketing that involves inbound calls, but most people are more familiar with outbound telemarketing in

which solicitors operating from a bank of telephones—often equipped with computer-assisted interviewing software—call people on a prospect list to offer a good or service. Telemarketing has faced considerable backlash from consumers, and in 2013, legislation was passed establishing the Federal Trade Commission's National Do Not Call Registry.

Such legislation has done little, however, to deter the use of outbound telemarketing, and telemarketers are now developing increasingly sophisticated mechanisms for getting around the restrictions. Since passage of the Affordable Care Act (ACA) in 2010, telemarketers promoting health insurance plans have become ubiquitous.

Some telemarketing involves cold calls to individuals or households for which the demand for goods and services is unknown. More likely, the telephone numbers drawn from a sampling frame or randomly generated are keyed to certain characteristics of the target audience. Consumer data companies can provide contact information for consumers that are targeted to a specified geography or screened for selected respondent characteristics (e.g., age, marital status, income).

A more benign form of telemarketing in healthcare involves follow-up calls to people who have expressed interest in a program or topic. Healthcare organizations assume that these people will be willing to receive calls describing such programs because of their implied previous interest and thus will not consider such calls an imposition. Hospital **call centers** frequently use this approach to follow up with existing customers or prospects.

call center
A centralized communication hub established to capture incoming customer inquiries and generate outgoing marketing messages.

Telemarketing is more expensive than direct mail initiatives, but the costs are not unreasonable. Telemarketers' wages are relatively low, and the benefits gained by attracting a new patient are likely to be significant. Not all healthcare products lend themselves to this approach, but a surprising number do.

Distribution of mail-order catalogs has long been used to reach consumers, but it has not been a traditional means of promoting healthcare goods and services. However, as the market for alternative therapies and home testing and treatment has grown, catalogs have become an important vehicle for promotion. In many parts of the country, if a consumer wants to purchase herbal supplements, natural remedies, or other unconventional treatments, mail order may be the only way to obtain some products. People are also turning to mail-order catalogs and the internet in search of better prices for prescription drugs. Although mail-order catalogs are unlikely to become a mainstream promotional medium in healthcare, the use of catalogs does have advantages. It puts product exposure directly in the hands of targeted consumers, and it can be relatively cost-effective because of economies of scale.

Venues for electronic marketing include the internet and home-shopping television channels. Home-shopping channels capitalize on the

fitness and wellness movement by selling goods such as fitness equipment, workout supplies, and skin treatments. Internet marketplaces, on the other hand, traffic in a variety of healthcare products, and aggressive e-mail and social media marketing can rapidly carry messages about these products far and wide. Healthcare consumers frequently turn to the internet as a first resort to locate and price consumer health products. They also turn to the internet for healthcare information, and the content posted online influences consumer decision-making. Once considered a mechanism only for providing information about hospitals, health plans, pharmaceutical companies, and consumer products companies, the internet has also become a medium for aggressive marketing of a wide range of healthcare goods and services.

Exhibit 11.4 summarizes the role of promotional techniques in healthcare marketing and the advantages and disadvantages of their use.

Media Options

Because advertisers and other promoters typically use different types of media as a means of communication, the media options available are an important consideration. For this discussion, media are categorized into print media, electronic media, and display advertising.

Marketers today have a wide variety of outlets for promotional activities and an abundance of publications (both print and online) in which they can advertise. In the 1950s, the advent of electronic media (television and radio) introduced marketing efficiency by facilitating the dissemination of information. In the 1980s, the emergence of cable and satellite television allowed marketers access to almost unlimited transmission outlets. Now, the internet links billions of people worldwide, creating endless opportunities to interact with consumers. Marketers also have access to vast databases of information they can use to profile markets and target consumers.

media plan
A document that outlines the objectives of a marketing campaign, its target audience, and the media to be used.

To capitalize on these media options, marketers need to develop a **media plan**. The media plan involves a systematic assessment of the channels available for promotion. The choice of media, as well as the combination of media employed, is influenced by the objective of the marketing campaign, the nature of the product being promoted, the characteristics of the target audience, and the cost involved.

print media
Any ink-on-paper medium used for promotional purposes.

Print Media

Print media is the traditional vehicle for promoting organizations and products. Magazines, newspapers, journals, newsletters, and directories are common forms of print media. Although the "death" of print media has

been widely reported, these reports are premature. Newspaper readership has indeed declined, but some demographic groups continue to be loyal readers of print media, and magazine readership has remained steady.

Magazines—including popular magazines aimed at the general public (e.g., *Self*, *Men's Health*) or trade publications aimed at professionals in a particular field (e.g., *Modern Healthcare*, *Healthcare Executive*, *Scrubs*)—offer many advantages to advertisers. First, they allow color production and ample space for images and words. Second, they have high potential readership, and readers expect them to include advertisements. Third, they have a relatively long "shelf life" and can be read at the subscriber's leisure. Fourth, advertising in magazines can be cost-effective, depending on the audience.

On the other hand, the use of magazines for promotion has some disadvantages. Advertisements may appear in a magazine's "desert areas"—occupying spaces seldom noticed by readers or lost in the surrounding clutter of a page. Monthly distribution is also problematic if marketers want to promote their products or services more frequently or have time-sensitive offerings. "Shoppers' magazines"—periodicals distributed to local consumers at no cost—are available in many communities and provide opportunities for promotions. Ad placement in these magazines is relatively inexpensive, but it may not be effective because these publications are considered "throwaways."

Newspapers are typically published daily or weekly and have a national, regional, or local distribution. The advantages of newspaper advertising include extensive market coverage, timing flexibility, and the ability to use illustrations. On the other hand, newspaper advertising is a mass marketing approach that attempts to reach all audiences and does not differentiate among groups of readers, making it difficult for the advertising content to attract attention. Newspapers have recently suffered from declining readership, retaining the loyalty of few demographic groups. Depending on the market, newspaper advertising can be relatively expensive, so marketers need to ensure that the objectives of the marketing plan lend themselves to this medium.

Alternative newspapers are usually weeklies that cover aspects of the news neglected by the mainstream press. In some communities, the readers make alternative newspapers appropriate vehicles for promoting healthcare products. These readers may support progressive causes or use alternative and innovative goods and services, such as holistic medicine or alternative therapies. Special-interest newspapers devoted to health and wellness have emerged, and some regular newspapers chronicle developments in the local healthcare arena or reserve sections for topics such as fitness and alternative

EXHIBIT 11.4
Matrix for Promotional Decision-Making

Promotional technique	Uses	Audience	Time frame	Relative cost	Advantages	Disadvantages
Public relations	Awareness Visibility Service rollout	General public Stakeholders Decision makers Influentials	Short term within a longer-term strategic context	Primarily staff time with low out-of-pocket costs	Broad reach Low cost Short lead time	Not targeted Short shelf life
Communication	Awareness Visibility Education Relationship development/maintenance	General public Stakeholders Existing customers Employees	Ongoing with periodic flurry of activity	Primarily staff time with moderate out-of-pocket costs	Direct to target Low cost	Narrow focus Staffing costs
Community outreach	Awareness Visibility Education Relationship development/maintenance	General public Targeted consumer groups	Ongoing with periodic flurry of activity	Primarily staff time with moderate out-of-pocket costs	Ongoing presence Personalized Localized	High effort Long lead time

Networking	Awareness Business development Relationship development/ maintenance Intelligence gathering	Key stakeholders Potential partners Potential referrers	Ongoing	Little additional cost	Ongoing Targeted	Time commitment
Direct marketing	Exposure Product introductions Call to action	Targeted consumer groups	Short term but with some lead time	Moderate costs	Focused Customized Multiple exposures	Low response rate High unit cost Short shelf life
Personal sales	Visibility Close contacts Relationship development	Influentials Potential customers	Regular periodic contact	Moderate to high costs	Face-to-face Ongoing Feedback on market	Sales force maintenance Cost
Advertising	Awareness Visibility Image enhancement	General public Targeted customer groups	Typically long term with long lead time	High costs	Many options Design options Easily targeted	Cost Negative connotation Short shelf life

Source: Thomas and Calhoun (2007).

medicine. Special-interest newspapers serve as advertising venues for many healthcare goods and services.

Journals are possibly more ubiquitous in healthcare than in any other industry. Every medical specialty and all allied health fields generate one or more journals, and most associations for health professionals publish at least one journal for their members (e.g., *Journal of Healthcare Management*, *Physician Executive Journal*). Some journals are highly specialized and do not carry advertisements, but others are mainstream—though still academic—and do feature ads (e.g., *Journal of the American Medical Association*, *New England Journal of Medicine*). Industry journals are effective vehicles for advertising because their audiences are targeted and effectively prescreened. Pharmaceutical companies are heavy advertisers in these publications, as are medical supply, equipment, and information technology vendors.

Change occurs rapidly in healthcare, and the lead time required to produce publications such as magazines and journals does not accommodate last-minute revisions or additions to advertising content. Newsletters, therefore, have become an alternative but equally valuable vehicle for publicizing new programs, services, or organizational changes. Although advertisements are rare in printed newsletters, e-newsletters (electronic or online) often accept product notices and promotional postings.

Directories have become an increasingly important means of gaining visibility. Some directories, such as state physician directories or hospital directories, are compiled for bureaucratic recordkeeping purposes. Such directories generally are not intended for commercial use, and an organization's inclusion may or may not be mandatory. Some directories are compiled for administrative purposes but subsequently shared with a larger audience (e.g., a health plan's provider directory).

Another category of directories includes those commercially produced for distribution, including directories of physicians, hospitals, information technology vendors, and so forth. Increasingly offered online, directories make their listed organizations more visible, and organizations may even pay a fee to be listed. These directories are typically sold to customers who need the information. A number of publishers compile and distribute directories as their primary business activity, and many such directories are posted on the internet. Consumer-oriented print directories are being replaced with online directories. An online listing represents a form of advertising, but these web-based directories also post promotional content. For example, the website of a nursing home directory may feature ads by nursing facilities, home health agencies, pharmaceutical companies, and insurance plans.

Exhibit 11.5 compares the costs of several promotional vehicles, including print and electronic media.

EXHIBIT 11.5
Comparison of
Promotional
Media

Medium or vehicle	Promotion type	Cost
Billboard	Artwork Installation	$3,000 $5,000–$500,000, with a minimum 16-week contract
Cable television	30-second commercial, prime time	$5,000–$8,000
Local network television	30-second commercial, off-peak time 30-second commercial, prime time	$1,000 $200,000
Direct mail	4- by 6-inch postcards, including postage	$1,000–$1,500
Internet ad	Pay per click Banner ad Search engine optimization	$0.60 cents; $1,200–$1,000 per month for an aggressive campaign $200–$1,200 per year $15,000+
Magazine	Ad	$1,200–$5,000 per month or per issue, depending on ad size and readership demographics
Newspaper	2- by 2-inch ad	$1,300 per week
Radio	60-second commercial on a rotator (with higher prices for selective time slots)	$100–$1,000

Note: Costs vary from market to market. These figures should be used only for comparative purposes and should not be considered absolute rates.

Sources: Black Swamp Media Group (blackswampgraphics.com); Inland Empire Small Business Development Center (www.iesmallbusiness.com); Pole Positioning Web Marketing (www.polepositioning.com); Thomas (2008).

Electronic Media

Electronic media include television, radio, the internet, and cinema; each can be used for promotional purposes. Television is the prototypical electronic marketing medium. Using television advertising, healthcare organizations can build a high level of awareness of their offerings, reach large audiences, and demonstrate their products (using sound and visuals). In addition, television is accessible to almost everyone, and 24-hour programming is the norm,

making advertisements highly visible. Viewers are likely to experience multiple exposures of an advertisement, creating greater impact for the advertiser.

Promotion using television has its downsides, however. First, viewers may find commercial breaks irritating, to the point that they lose interest or stop viewing altogether. Second, the medium is considered transient with a limited shelf life. For example, advertising associated with a program that airs only once a week is not likely to make a lasting impression on the viewer. Third, the ability to target specific audiences is limited. Fourth, television advertising is expensive, particularly given its unpredictable outcomes and its drawbacks.

Historically, television advertising was concentrated on the national networks (ABC, NBC, CBS, and Fox). However, this has changed with the advent of cable television and satellite broadcasting. These channels and their programs developed their own following, which became conceptualized as market segments. Marketers learned the demographic traits of these segments on the basis of their viewing preferences. This development has enabled marketers to target television audiences much more precisely. For example, viewers of travel and food channels tend to be college educated (or higher), have creative or academic careers or white-collar jobs, have more disposable income, live in cities, and so forth. Advertisers seeking to target this segment would find travel and food channels attractive. Advertising time is much less expensive on cable than on network television (see exhibit 11.5).

Radio is often considered by listeners as a companion (as it is often turned on when one is driving or doing tasks around the house). The most important attribute of radio advertising is that it can precisely target an audience because it airs at a specific time of day and on a specific station. Further, radio advertising time and production costs are relatively low, especially compared to television commercials. However, radio has no visual attribute and is a transient medium. If listeners miss a commercial, they may not experience another exposure. In addition, the growth in number of radio stations has caused radio audiences to become fragmented and reduced in size.

infomercial
An in-depth advertisement that mimics the look and feel of a daytime talk show, news report, documentary, demonstration, or other presentation format.

One trend that electronic media has spawned is the **infomercial**, a portmanteau of information and commercial. Infomercials are advertisements that vary in length—from 30 seconds to one hour—and air on television or radio. They give a good or a service in-depth treatment, educating viewers on its features and benefits and often accompanied by testimonials from fans, success stories, and corroborative data—all often in a casual, entertaining, upbeat, and easy-to-understand manner. Their forms vary widely, ranging from daytime talk shows to news reports to documentaries and demonstrations.

Whatever the format, infomercials focus on the product, not the advertiser (which is recognized but not directly discussed). Their intent is to soft-sell the good or service by implying that the advertiser (provider, supplier, or manufacturer) is the authority on the topic, thus attracting customers without having to overtly solicit them. "As seen on TV" infomercials are common examples, and a quick Google or YouTube search yields more examples (from both television and radio) that feature consumer health products and provider organizations.

Healthcare marketers have also entered the world of streaming television as the industry shifts away from traditional television broadcasting. Consumers are replacing their older television sets with internet-connected smart televisions (Nguyenova 2019) or streaming television on their computers or mobile devices. Some streaming services, such as Netflix, are ad-free and therefore of little interest to marketers. Ad-based video on demand is the fastest-growing streaming category. New "aggregators" are entering the field and offering opportunities for healthcare marketers seeking to reach a younger, more technology-savvy audience. The increase in service providers offers a growing range of options for marketers, including nonskippable commercials and targeting capabilities based on demographics, geography, interests, and so on.

Healthcare organizations are also becoming increasingly involved in **video advertising**. Healthcare organizations of all types and sizes are producing high-quality videos using emerging technologies. Videos are used to connect with patients and educate them on a variety of health topics while promoting the interests of the sponsor (522 Productions 2019). Videos are used to humanize healthcare organizations; testimonials are a favorite video subject. They can be used to educate patients and introduce them to a hospital or physician's office, with physician profiles providing a useful marketing tool. Video presentation is not limited to an organization's website but can also include a YouTube channel or placement on other sites. Organizations that have made effective use of video marketing include the Mayo Clinic, Mount Sinai Medical Center, Nicklaus Children's Hospital in Miami, Aetna Insurance, and Walgreens (MDG Advertising 2017).

As mentioned in earlier chapters, most healthcare organizations—particularly those involved in direct patient care—were slow to adopt internet advertising. Consumer health products companies, on the other hand, were quick to take advantage of web-based or internet marketing. Today, many healthcare marketers have a web presence, using not only **banner ads** and pop-up ads but also online directories, social media (see chapter 13), mobile apps, and search engine optimization, among many other technology-enabled tactics.

video advertising
Display advertising that incorporates video.

banner ad
A small, rectangular promotional graphic that appears in printed material or on a website.

Goods and services are used on film sets or appear on-screen as props or background scenery; this is why cinema has long been part of the electronic medium of advertising. Cinema advertising is not commonly used for healthcare products—at least not yet. However, as healthcare becomes even more consumer driven, as healthcare becomes a priority for the government and the public (as shown by passage of the ACA), and as in-theater advertising spots become more common, healthcare marketers will most likely enter the cinema arena.

Display Advertising

display advertising
A promotional approach using posters, billboards, and other eye-catching signs.

Display advertising includes outdoor advertising, transportation advertising, and posters. Outdoor advertising primarily involves billboards, although other types of signage (e.g., banners, portable signs) are also used. While billboard advertising has its critics, it is popular with hospitals, health plans, voluntary associations, and other healthcare organizations. Transportation (or transit) advertising consists of graphics, signs, or plaques placed on buses, taxis, and other commercial vehicles. Posters are bills displayed in public places to attract attention to an organization, a service, or an event.

Using display advertising, marketers can reach large numbers of people and build a high level of awareness for a product or an organization at a relatively low cost. Display advertising can be short or long term, can support local or national marketing campaigns, and can be strategically located. On the downside, display advertising is often subject to the effects of weather and criticized for spoiling natural settings.

Exhibit 11.6 presents the advantages and disadvantages of print, electronic, and display media.

Social Marketing

In healthcare, *social marketing* can be defined as the application of commercial marketing techniques to the development and implementation of programs that influence the attitudes, knowledge, and behavior of target audiences for the purpose of improving individual and community health status. Social marketing is used most often by not-for-profit healthcare organizations and government agencies seeking to change consumer behavior. It is considered *social* in the sense that the organizations involved typically do not engage in these efforts for their own benefit but for the benefit of the general public or some subgroup of the public.

EXHIBIT 11.6

Matrix for Media Decision-Making

Medium	Uses	Audience	Resource requirements	Relative cost	Advantages	Disadvantages
Television	Exposure Service introduction Call to action		Production skills Creative skills	High	Consumer appeal Multiple exposures	Cost Negative connotation Short shelf life Competing ads
Network		General public			Broad reach	Diffuse impact
Cable		Targeted consumers			Targeted reach	Narrow impact
Radio	Exposure Service introduction Call to action	General public Targeted consumers	Production skills Creative skills	Moderate	Broad or narrow reach	Cost Short shelf life
Newspapers	Exposure Service introduction Call to action	General public		Moderate	Broad reach Low unit cost Frequent exposure	Cost Competing ads Short shelf life
Magazines	Exposure Service introduction Call to action	General public (but higher end)		Moderate	Moderate shelf life Design options	Cost Competing ads
Internet		General public Targeted consumers		Low	Appealing medium Interactive Ongoing	Incomplete coverage Spam annoyance
Display advertising	Public notice of products	General public	Limited production skills	Low to moderate	Mass exposure	Untargeted or downscale perception

A key difference between social marketing and direct marketing is the target audience and goals. Social marketing has a population health orientation and thus aims to affect the knowledge, attitudes, and behavior of large segments of the population rather than one consumer at a time. In contrast to the top-down approach of traditional marketing, social marketing uses a bottom-up approach, listening to the needs and desires of the target audience and building the marketing campaign on that basis.

in-depth interview
A data collection technique in which the interviewer asks probing questions to elicit detailed information from the interviewee.

This focus on the consumer requires the use of **in-depth interviews** to understand consumer attributes and reevaluate messages for a target audience that is constantly changing. Social marketers research their target audience and then segment it on the basis of common risk behaviors, motivations, and information channel preferences. The marketing mix is continually refined on the basis of consumer feedback. Instead of a sales pitch, the target audience might be exposed to an intervention (e.g., educational program, health screening initiative) aimed at changing attitudes or encouraging healthy behavior.

Social marketing takes advantage of different types of media to target audiences, tailor messages, and engage people for the purposes of increasing knowledge, influencing attitudes, and changing behaviors. As population-based approaches have become more common, the role of health communication has expanded. Community-centered prevention shifts attention from the individual to the group and emphasizes the empowerment of individuals and communities to effect change at multiple levels.

The functions of social marketing in healthcare include the following:

- Increase knowledge and awareness of a health issue, problem, or solution
- Influence perceptions, beliefs, attitudes, and social norms
- Prompt a desired response
- Demonstrate or illustrate health-enhancing skills
- Show the benefits of behavior change
- Increase demand for health services
- Reinforce knowledge, attitudes, and behaviors
- Refute myths and misconceptions
- Coalesce organizational relationships
- Advocate for a health issue or a population group

Exhibit 11.7 describes the steps involved in developing a social marketing campaign. These steps are illustrated in case study 11.2.

Most successful social marketing campaigns can be broken down into these 10 steps:

STEP 1: DEFINE YOUR AUDIENCE

Be specific and learn as much as possible about the target audience. One way to define the target audience is to describe their demographics (e.g., heterosexual males between the ages of 14 and 18 who smoke). In addition, paint a vivid picture of the individuals *within* the group; understand their attitudes, feelings, beliefs, values, motivation, and culture—all the factors that might influence their behavior.

STEP 2: IDENTIFY EVALUATION MEASURES

Evaluation is a big part of all prevention efforts: This is no exception. Evaluate whether the campaign was implemented as intended and if the specific goals were met. Start developing the evaluation strategy early in the planning process. Think carefully about the evaluation questions, the best ways to collect the necessary information, and the type of people to bring on board to help in the process.

Establishing a direct correlation between the campaign and any observed outcomes may be difficult because a communications campaign does not exist in a vacuum. However, it's possible to evaluate broader, population-level changes in behavior and compare them to a baseline before the marketing campaign began. For example, Massachusetts has conducted a large-scale, multi-million-dollar antismoking campaign, funded solely by a tax on tobacco products. To assess change, [the state] measures the difference in the number of cigarette packs sold before and since the campaign began.

STEP 3: IDENTIFY CHANNELS

It's important to think about how to communicate the intended message. One option is to deliver the message *directly* to the target audience. Common marketing channels include television or radio commercials, interviews, and public service announcements. They include newspaper or magazine articles, editorials, and print ads; billboards; and banners across main streets. In addition, websites; electronic mailing lists; bulk mailings; and special events, contests, and awards can also be used. In selecting appropriate dissemination channels, consider the costs involved. Think

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about where the target audience gets its information, and which channels they consider most credible. Also, keep in mind that the most effective campaigns combine mass media with other efforts, such as community events and small-group discussions.

Another option is to deliver the message *indirectly*, through intermediaries associated with the target audience. Intermediaries include people who work with these groups, such as coaches, teachers, and counselors, or other people who are respected, such as athletes, clergy, and community and political leaders. Intermediaries can also be credible organizations, such as citizens' advocacy groups and local agencies.

STEP 4: IDENTIFY BENEFITS

The exchange principle asserts that in order for people to voluntarily give something up or try something new, they must benefit in some way. Ask the following question: Why would the target audience want to adopt the behavior promoted in the campaign? Think about this question from the audience's perspective. For example, to convince people over 50 to start exercising, highlight benefits such as increased energy and protection against osteoporosis. But to convince young adults to exercise, "sell" the idea that going to the gym is a great way to get in shape and increase your sex appeal.

It is also important to differentiate between long- and short-term benefits. People tend to gravitate toward short-term benefits: They're more immediate and enticing. Therefore, in the example above, increased energy—a short-term benefit—may be a far more compelling reason for people to exercise than developing stronger bones. However, only solid research will tell for sure.

STEP 5: IDENTIFY OBSTACLES

To achieve an exchange, it is also important to identify any *obstacles* that might prevent members of the target audience from adopting a given behavior. For example, when promoting treatment for alcohol and drug problems, find out whether treatment slots are, in fact, available; whether members of the target audience have insurance coverage; and if the programs can be reached using public transportation. Another example is encouraging a group of adults to quit smoking. The sheer power of nicotine addiction, plus the strength of the habit of smoking, are both big obstacles that prevent many people from quitting. The prevention message must thus be

EXHIBIT 11.7
Ten Steps for
Developing
a Social
Marketing
Campaign
(continued)

compelling, and salient enough to overcome these barriers. In order for the "exchange" to work, the benefit of adopting (or giving up) a behavior must be greater than the cost.

STEP 6: DETERMINE THE MESSAGE

This is a critical step. When creating a message, be very clear about the behavior you want to elicit. Do you want the audience to make a telephone call? Send for information? Stop doing something—like smoking—or start doing something—like talking to their children about drugs? People who see or hear the message must be clear about what is expected of them.

Next, create a message that builds on what has been learned about the audience: their existing knowledge, concerns, and interests. Try to emphasize positive behavior change rather than negative consequences. For example, the message "use a designated driver" offers people concrete information for how to get home safely, whereas "don't drink and drive" simply tells people what not to do.

Finally, determine the tone and the style of the message. Tone is an elusive quality but is very important in a social marketing campaign. Determine if the message is intended to be informative? Emotional? Humorous? A combination of the above?

Remember: All the "pieces" of the message—headlines, illustrations, and copy—should work together to immediately establish what is being offered, what the benefits are, and who is advertising it. People should know at a glance what the message is about.

STEP 7: TEST AND REFINE

It's very important to "pre-test" the message. The best way to do this is to test the message on focus groups that represent the target audience. Present them with several message samples and record their impressions and reactions. Then use their feedback to refine the message. Test the message for comprehension, attention and recall, strong and weak points, personal relevance to the target audience, and sensitivity to cultural and/or audience-specific characteristics.

STEP 8: COLLECT DATA

Collect data to determine whether the message is having an impact. Data collection might involve conducting more focus groups, administering

(continued)

EXHIBIT 11.7
Ten Steps for
Developing
a Social
Marketing
Campaign
(continued)

surveys, or doing telephone interviews. Data collection methods should be dictated not only by cost, but also by the questions you want answered and the kind of information you want to collect. Whenever possible, work with an evaluator to design and implement your data collection efforts.

Step 9: Modify Your Work, Based on the Data

Even the best-researched campaign often needs some tweaking once it has been launched. Use the data collected to refine and adjust the message, communication channels, and promotion strategies. If something isn't working, a small alteration is often enough to improve it significantly. If unsure, go back to the target audience and ask them what they think.

Step 10: Write an Evaluation Report

This is often required by the funder. Yet, even when it is not, creating a report is a helpful way to organize the information collected so that it can be shared with others and garner support for future efforts. In the report, present the intended campaign accomplishments, broad lessons learned, and remaining tasks or recommendations for follow-up. Try to be concise, avoid jargon, and present a balanced set of findings.

When moving through each of these steps, always keep a clear picture of the target audience. The most valuable asset is knowledge of the audience. Don't ever underestimate just how critically important that knowledge is to the success of any social marketing campaign.

Source: Reprinted from Substance Abuse and Mental Health Services Administration (2018).

Case Study 11.2
The Texas WIC Program

During the mid-1990s, a social marketing program was implemented to increase enrollment and improve customer and employee satisfaction with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in Texas. (Although this case is 20 years old, the approach used here is still relevant in today's environment.)

Participant observation, in-depth interviews, **telephone interviews**, focus groups, and surveys were used to identify the needs, preferences, and characteristics of four target audiences: (1) families eligible but not participating in the program, (2) program participants, (3) program employees, and (4) professionals who refer people to the program.

The results of this research were used to develop a comprehensive social marketing plan that included policy changes, service delivery improvements, staff and vendor training, internal promotion, public information and communications, client education, and community-based interventions. This plan was designed to change families' perceptions of WIC as a welfare program that provided free food to low-income people by emphasizing nutrition education, health checkups, immunizations, and referrals. It included recommendations for lowering costs by repositioning the program as a temporary assistance nutrition and health program—"WIC—Helping Families Help Themselves"—in which families can maintain their pride and self-esteem as they earn their WIC benefits and learn about nutrition and other ways to help their families.

Because many women did not know they were eligible for the program or had trouble enrolling, the marketing plan also emphasized ways to help families understand eligibility guidelines, to streamline the certification process, and to make it easier for health and social service professionals to refer eligible women. Placement strategies recommended locating WIC clinics outside of government assistance venues, and professional training programs were developed to enhance employees' skills in dealing with customers and teach grocery store cashiers to process WIC purchases more efficiently and respectfully. Promotional efforts included a community outreach kit to reach referral sources as well as the use of mass media to reach eligible families.

The Texas WIC Program was launched in the fall of 1995. Program data were used to monitor the number of families who called the toll-free number for more information after the program was launched and, more important, the number of people participating in Texas WIC. When results showed that increases in program enrollment were not sustained, mid-course revisions were made to improve program delivery. The program's caseload then grew from its baseline level of 582,819 in October 1993 to 778,558 in October 1998—an increase of almost 200,000 participants.

Source: Grier and Bryant (2005).

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telephone interview
A data collection technique in which a survey instrument is administered by an interviewer to a respondent over the telephone.

Integrated Marketing

Given the number of available marketing techniques and the fragmentation of media distribution channels, determining the most appropriate tactic for a particular marketing campaign is a challenge. One approach that may help tie some of the parts together is integrated marketing. **Integrated marketing** (or integrated marketing communication) emphasizes a consistent overarching approach to the organization's promotional strategy. The aim is to achieve synergy among the components of the strategy to make the effort more effective.

> **integrated marketing**
> A marketing approach that emphasizes consistency in the promotional strategy to achieve synergy among its components.

Integrated marketing involves strategically choosing elements of marketing communication that effectively and economically influence transactions between an organization and its existing and potential customers or clients. Marketers coordinate advertising campaigns across types of media, supplementing television advertisements with marketing messages communicated through other media vehicles, such as print. For example, a print advertisement might capture a frame from a television commercial and include a tagline that summarizes the 15- or 30-second message, or a radio station may air an excerpt from the dialogue and the announcer's product claims from that same commercial. An integrated approach ensures that all elements of the marketing campaign are delivered synergistically.

Many factors have encouraged the use of integrated marketing. Tighter marketing budgets have squeezed available resources, and the fragmentation of the media has demanded unification. The shift from mass marketing to target marketing and the rise of electronic media (especially the internet and social media) have contributed to this development. Although integrated marketing appears to be an obvious step toward more effective marketing, it is inconsistent with traditional patterns of marketing behavior and cumbersome to implement in some organizations.

If resistance can be overcome, however, an organization can derive major advantages from the marketing integration process. Its strategies will reinforce each other; its messages will be consistent and their delivery synergized; cost savings will ensue; and it will sustain a competitive advantage. Case study 11.3 presents an example of an integrated marketing strategy.

CASE STUDY 11.3
Integrated Marketing Strategy

Many people who might benefit from hearing aids do not wear them. Further, those who might benefit from surgery are even more unlikely to present for treatment. Among adults aged 18 years or older with impaired hearing, 78 percent do not own a hearing aid. As the US population ages, the need for hearing assistance will become nearly universal—but even today among the hearing impaired aged 65 years or older, 61 percent do not wear hearing aids. Research has found that although people readily agree to wear eyeglasses to correct their vision, take pain relievers to alleviate aches, or walk with a cane, the prospect of wearing a hearing aid is difficult for them to accept.

The hearing and speech communications literature suggests that use of a hearing aid carries a stigma that implies the wearer is old, feeble, and incompetent (Wallhagen 2009) and describes the denial and depression that people associate with hearing loss (American Psychological Association 2015). In addition, hearing loss, if not addressed with hearing aids, can lead to greater dependence on a spouse and withdrawal from social events. People do not want to admit their hearing loss to themselves because it connotes aging; they do not want to admit it to others for fear of being viewed as incompetent.

Given all these considerations, when *Business Week* featured a hearing aid manufacturer in its Annual Design Awards, the product receiving acclaim was tiny and said to "nestle discreetly in the ear canal." Hearing aid sales surged when a prominent person publicly acknowledged that he had begun wearing one, as hearing aids were perceived as more acceptable when associated with a popular and virile individual rather than one who was old and feeble.

A product with such a negative image as hearing aids clearly presents a challenge for marketers interested in stimulating sales. Research conducted to determine how to induce more favorable attitudes toward these personal, stigmatized products assessed the applicability and effectiveness of integrated marketing communication in the promotion of hearing aids. In

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addition, the research looked at whether a stigmatized product might best be approached through multimodality approaches, thereby reinforcing the advertising message.

A panel of respondents was established as a **test market**. The researchers contacted 4,344 participants at time 1, before exposing them to any marketing communications. The attitudes of 3,351 participants were then measured at time 2, after they were exposed to a combination of synchronized materials. Finally, the attitudes of 3,049 respondents were measured three months after being exposed to the marketing materials, at time 3.

Three advertising themes were tested in this study: warm and emotional, educational, and wedge of doubt. The warm and emotional print advertisement began with the question, "Honey, can you pick up some nails?" A response of "Sure" was printed in the middle of the page, with a photograph of a can of escargot. The tagline printed at the bottom of the page inquired, "Is it any wonder hearing loss can frustrate those around you? Have your hearing checked. For you. For them."

The copy in the educational message stated, "Use your head once a year," and it was placed above a photograph of headphones. The advertisement's closing copy read, "Annual hearing checkups help you spot changes in your hearing. Hear today. Hear tomorrow."

The wedge of doubt advertisement began with copy that warned, "If you think it's difficult admitting your hearing problem, imagine admitting all the mistakes you've made because of it." At the bottom, the advertisement read, "When you can't hear clearly, it's easy to misunderstand someone. And before you know it, people start thinking you've lost your mental edge."

Once these messages had been tested with different audiences, they were adapted for delivery through other media vehicles: mass media (including print and television ads) and private media customized to appeal to targeted individuals (including telemarketing phone calls and direct marketing mailings).

The analysis showed that consistent combinations of media (both mass or both private) were more effective than mixed media; the two private media (telemarketing combined with direct marketing) outperformed any two mixed media (telemarketing and print, telemarketing and television, direct marketing and print, or direct marketing and television). In addition, the private media combination outperformed the public media combination. Learning more about the product in a private setting appeared to increase acceptance.

Finally, the content of the message affected the impact of the particular class of media (mass or private). The integrated private media (telemarketing

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test market
A group or population on which a marketing theme or concept is tested.

and direct marketing) performed best, first with the wedge of doubt content and then with the warm and emotional content. The combination of two private exposures did not perform well in all cases—the combination with the educational advertising message was not effective. The wedge of doubt content, which worked best when delivered via the two private media, did not perform well in all cases either; it performed the worst when delivered through a mass medium.

Marketing health services can be complicated. As this investigation demonstrates, rarely can a marketer choose a medium or an advertising message without considering the big picture. Media cannot be simply pasted together to achieve some seemingly critical threshold of ad weight; many mixed media can perform worse than fewer exposures of sensibly integrated media. Similarly, the choice of media outlets depends on both the product and the content of the ads. A well-thought-out combination of media and messages appears to have greater influence on consumers than a haphazard collection of media and messages.

Source: Adapted from Iacobucci et al. (2002).

Case Study Discussion Questions

1. What challenges are faced by those trying to promote hearing aids to the consumer market?
2. How do marketers test the effectiveness of a promotional message?
3. What type of message appeared to resonate most with consumers and why?
4. Did mass media or private media fare better in terms of promotional results?
5. What characteristics of integrated marketing contributed to the success of this campaign?

Summary

A variety of established marketing techniques are available to the healthcare industry. All of these approaches are commonly used in other industries and have been adopted to varying degrees by healthcare organizations. Traditional approaches to reaching an organization's constituents include public relations (e.g., publicity, communications, government relations),

advertising, personal sales, and sales promotion. Direct marketing is a recent addition to the healthcare marketer's arsenal of techniques.

The technique of choice depends on the type of organization involved and the product being marketed, among other factors. Of special importance is the objective of the promotional initiative. Objectives vary with the situation; different aims (e.g., raise visibility, retain existing customers, change consumer attitudes, increase market share) call for different marketing techniques. A common theme among all promotional objectives, however, is effective communication.

Likewise, different circumstances call for different types of media. Marketers have the option of using print media (e.g., magazines, newspapers), electronic media (e.g., radio, television, internet), and display media. Each type of media has advantages and disadvantages. Display media, such as billboards, are not as applicable to healthcare as most other promotional techniques but are nevertheless employed by many healthcare organizations.

Healthcare organizations are increasingly recognizing the importance of integrated marketing. This systematic approach to promoting an idea, an organization, or a product instills consistency in the marketing initiative and facilitates the coordination of a potentially broad range of promotional activities.

Key Points

- Healthcare marketers have access to a variety of promotional techniques that historically have been used in other industries, although some have been modified for use in healthcare.
- Long before most healthcare organizations embarked on formal marketing initiatives, they relied on forms of publicity for promotional purposes.
- Promotional activities that are not always recognized by health professionals as marketing include community outreach, networking, and government relations.
- Advertising has been the most visible form of marketing by healthcare organizations, although arguably not the most important.
- Although some health professionals have a negative view of advertising, it can serve a number of positive functions.
- As healthcare organizations became more involved in ancillary endeavors (e.g., fitness centers) and business-to-business marketing, personal sales became more important.

- Sales promotion is not typically associated with the marketing of healthcare services, but it is commonly used to promote consumer health products.
- As the consumer has become more important in healthcare, the use of direct-to-consumer marketing has become more common.
- Direct mail and telemarketing are often employed to deliver the message directly to the consumer.
- Available print media include newspapers, magazines, journals, and other publications.
- Available electronic media include radio, television (network and cable), and the internet.
- Available display advertising includes posters, billboards, and other outdoor media.
- The promotional technique and medium a marketer chooses to use depend on the type of organization, type of product, and characteristics of the target audience.
- Integrated marketing involves the coordination of all promotional activities to communicate a consistent and uniform marketing message.

Discussion Questions

1. What role does the nature of the product play in determining the promotional vehicle to be used?
2. How important is the culture of the community when choosing a promotional technique?
3. Why is PR often a preferred form of promotion for healthcare organizations?
4. Can it be argued that a major function of promotional activities in healthcare is educating the healthcare consumer?
5. Why do many health professionals and even members of the general public resist the idea of using advertising to promote health services?
6. What steps are involved in the personal sales process, and under what circumstances is personal sales the most effective promotional technique?
7. What is the difference between a push and a pull approach in the context of sales promotion?
8. What developments in healthcare have encouraged the use of direct marketing?

9. What are the pros and cons of using different print media?

10. What are the advantages and disadvantages of using electronic media as opposed to print media?

11. What factors are encouraging the growing emphasis on integrated marketing among healthcare organizations?

Additional Resources

Advertising Age: http://adage.com.

American Marketing Association: www.ama.org.

Kotler, P., and G. Armstrong. 2017. *Principles of Marketing*, 17th ed. Upper Saddle River, NJ: Prentice Hall.

Society for Healthcare Strategy & Market Development: www.shsmd.org.

12

CONTEMPORARY MARKETING TECHNIQUES

The changes that occurred in the field of marketing as it evolved eventually filtered down to healthcare. By the 1990s, healthcare marketing had adopted techniques from other industries and developed new healthcare-specific approaches. These program-based and technology-based techniques enabled healthcare marketers to take advantage of contemporary technology. Despite their seemingly impersonal technical basis, these approaches focused on customer relationship development and management, not just the sale of goods and services.

The healthcare industry has never been a leader in the development of marketing techniques, and trends outside the field have influenced the form that healthcare marketing has taken. The emergence of electronic modes of communication has led to a new paradigm, which had made traditional marketing techniques—at least as they were employed in the past—obsolete or, at best, outdated. As David Meerman Scott (2015) indicated in *The New Rules of Marketing and PR*, marketing is no longer about selling but about disseminating information. One-way "interruptive" marketing is no longer effective or even acceptable. Traditional media no longer control the playing field when almost anyone can become a new media expert armed with a free means of information distribution. In today's environment, content trumps style, and information sharing replaces information hoarding.

The New Approaches

As noted in chapter 8, healthcare has experienced a number of trends that have affected marketing, including a shift in emphasis from image marketing to service marketing in recent years, from mass marketing to target marketing, from a one-size-fits-all philosophy to personalization and customization, and from a focus on single healthcare episodes to long-term relationships. The immediacy of social media has introduced an additional dimension (see chapter 13). These developments in healthcare, as in other industries, continue to benefit from the application of ever-changing contemporary technology.

The marketing techniques that have gained momentum in healthcare can be divided into two categories: (1) techniques that involve programmatic

changes that support marketing and (2) techniques that capitalize on information management. The former implies an innovative approach at a conceptual level and the latter a technology-based approach that may be applied to traditional or innovative marketing techniques.

Common to both types of techniques is an emphasis on *relationship management*. Relationship management is the process of getting closer to customers by developing long-term relationships through careful attention to service needs and high-quality care. It succeeds by keeping existing customers happy, ensuring repeat business, and recognizing the revenue potential of long-term relationships. The attributes of relationship management include the following:

- Focus on customer retention
- Orientation toward product benefits rather than product features
- Long-term view of customer relationships
- Development of ongoing relationships
- Multiple employee/customer contacts
- Emphasis on key account relationship management
- Emphasis on trust

All of the techniques discussed in this section incorporate at least some of these attributes.

Program-Based Techniques

Program-based marketing techniques require organizations to rethink the programs they offer in the context of the new marketing reality. These techniques include direct-to-consumer marketing, business-to-business marketing, internal marketing, and affinity marketing.

Direct-to-Consumer Marketing

As mentioned in chapter 1, the customer—the ultimate end user of healthcare products—was initially written off as a marketing target. The physician made most medical decisions for the patient, and the health plan controlled its enrollee's choice of provider and the services obtained from that provider. The choice of drug typically depended on the physician's prescription, and the supply channels for medical goods and services generally focused on intermediaries rather than the end user. With the emergence of the healthcare consumer, these practices have undergone dramatic change. Aided by access to state-of-the-art technology, customers are now able to express their preferences for everything—from physicians and hospitals to health plans and prescription drugs.

Pros	Cons
Meets increasing demand for medical information	Interferes with the physician–patient relationship and pressures physicians to prescribe
Informs consumers about new treatments	Confuses the patient
Encourages people to seek medical attention for conditions or symptoms that might otherwise go untreated	Emphasizes pharmaceutical treatments when other treatment options may be preferred
Decreases the cost of healthcare	Increases the cost of drugs
Promotes patient compliance	Results in unnecessary drug use

EXHIBIT 12.1
The Pros and Cons of Direct-to-Consumer Pharmaceutical Advertising

Source: Adapted from Craig (1998).

The direct-to-consumer movement was jump-started by the pharmaceutical industry. Pharmaceutical companies have spent more money and have been the most visible among healthcare organizations in attracting current and potential customers to their brands. (Exhibit 12.1 lists the pros and cons of direct-to-consumer marketing in the pharmaceutical sector.) Health insurers have followed this trend, albeit at a safe distance, by offering policies online and increasing the number of health plans available to individuals rather than groups. The implementation of the Affordable Care Act (ACA) has led to a surge in **internet marketing** and telemarketing by insurance companies.

internet marketing
A marketing approach that uses the internet to promote an idea, an organization, a good, or a service.

The direct-to-consumer movement has not been lost on providers: Hospitals, physicians, and other practitioners have launched technologically sophisticated websites to maintain contact with existing customers and to entice prospective customers. These sites are not only informational but also interactive—for example, patients can bid online for elective procedures (e.g., a facelift by a plastic surgeon). Such features offer direct negotiating and communication links between providers and consumers.

A number of factors have driven direct-to-consumer marketing:

- New regulations for drug companies
- Introduction of **defined contributions**, which increased health plan enrollees' latitude in choosing and customizing menus of services
- Providers' chase of discretionary patient dollars (e.g., elective procedures)
- Use of the internet as a direct path to the hearts, minds, and pocketbooks of healthcare consumers

defined contributions
The set of covered services whose combination and value are chosen by individual plan members and not the insurer.

Consumers, for their part, have eagerly accepted this onslaught of direct marketing attention, taking advantage of the information available to tailor offers to their needs. The internet has become a favored vehicle for engaging individual customers, but print and electronic media have played a part, too. Direct mail appears to have made a comeback from its junk mail reputation as well.

In this consumer-driven market, healthcare marketers have had to rethink their approaches. As discussed in previous chapters, marketers today must be in touch with end users to gain in-depth knowledge of their target audience's wants, needs, and preferences. To determine which groups or individuals want a particular good or service and to what extent they want standardization over customization, marketers must study consumer characteristics and behaviors at the household level, as they have historically done in other industries. They must understand the interrelationship between psychographics (lifestyle traits), consumer behavior, and demand for services.

Business-to-Business Marketing

Much of the discussion about healthcare marketing focuses on patients and other end users, but a significant amount of healthcare marketing involves business-to-business transactions. The corporatization of the industry means that more and more relationships are forged between two or more corporate entities. Traditional doctor–patient relationships have been supplanted by contractual arrangements between groups of buyers and sellers of health services. Many hospital programs now target corporate customers rather than individual patients. Healthcare delivery also has been employing a business-like approach. All of these have contributed to the growth of **business-to-business marketing**.

business-to-business marketing
The process of building profitable, value-oriented relationships among businesses.

Clearly, business-to-business marketing in healthcare is nothing new. Healthcare organizations are major purchasers of a wide variety of goods, and large organizations do business with hundreds of vendors. Business-to-business marketing involves building profitable, value-oriented relationships between two businesses and their staffs. Business marketers focus on a few customers, and the sales transactions are usually larger in scope, more complex, and more technically oriented.

Business-to-business marketing has become integral to selling products or services to business, industrial, institutional, and government buyers. In past decades, innovative products, superior engineering, or great salesmanship alone might have been enough to close a sale, but healthcare organizations no longer have the luxury of "build it and they will come" thinking. Statistical tools, data mining techniques, and marketing research techniques

that work so well in the consumer product arena must be fine-tuned for business-to-business marketing in healthcare.

The factors involved in marketing to businesses are significantly different from those involved in marketing to individuals. Business customers and traditional customers do not buy in the same way; they are driven by different impulses and respond to different approaches. Business-to-business purchases are often considered group decisions, whereas business-to-consumer purchases are more personal. (Affinity programs, discussed later in this chapter, are one tool used in business-to-consumer marketing.)

Much of the business-to-business marketing in healthcare is fairly routine and resembles the process in other industries. Hospitals and other large healthcare institutions have purchasing departments with established procedures for dealing with vendors of goods and services. Those marketing nonroutine services to a hospital or health system face several challenges:

- **Finding the right contact.** A marketer trying to promote an innovative technology solution, an organizational engineering initiative, or a customer relationship marketing system may run into difficulty identifying the right person to talk to. Depending on the organization, the person handling this type of proposal may be in a marketing, administration, operations, or even clinical department.
- **Tailoring the proposal to the needs and preferences of the prospect.** While physician group practices might have much in common with other group practices and hospitals have much in common with other hospitals, there is no standard approach to resource acquisition. Each healthcare organization is likely to have its own approach to dealing with vendors, often dictated by the corporate culture.
- **Arranging a meeting with or a presentation to the identified contact.** Hospital administrators are notorious for their crowded schedules. Waiting six weeks or more for an appointment—common in healthcare—would seem ludicrous in most other industries.
- **Waiting for a decision.** The initial contact person may not be the primary decision maker, so that individual may have to discuss the proposal with someone further up the chain of command. That could take many weeks or even months. The final decision may not be made until much later, especially if the proposal concerns a project that is not a priority.

Case study 12.1 presents an example of business-to-business marketing in healthcare.

Case Study 12.1
Using Business-to-Business Marketing to Promote an Occupational Health Program

Meridian Medical Center (MMC) was a 100-bed hospital located in a suburb of a medium-sized city. In its 40 years of operations, it had undergone several changes in ownership and was currently an investor-owned for-profit facility. MMC offered a wide range of services, but its survival had depended largely on its ability to identify niches that were not being filled by larger, better-financed providers in the area. MMC had become the major local provider of inpatient psychiatric and substance abuse treatment as well as weight management services. Its business was driven by personal referrals, word of mouth, and the reputation of its clinicians.

For five years, MMC had operated a fledgling occupational health program, primarily in response to the needs of nearby industries. Hospital staff treated minor injuries and illnesses (mostly on an urgent care basis) and the occasional emergency case. They also administered drug tests, tuberculosis tests, and other tests required for certain classes of employees. MMC administrators recognized a growing market for employee health programs in the area and planned a promotional campaign to pursue additional occupational health business. Before initiating the campaign, MMC took advantage of some of its unused space to create an occupational medicine center with a dedicated entrance. The intent of the program was to provide high-quality care in a comfortable setting and efficiently return employees to their job.

A much different means of attracting businesses was required for the occupational health program because clients were not likely to be self-referred but sent to the facility by their employers. Thus, this initiative required business-to-business marketing. MMC hired a salesperson to call on area employers and familiarize them with the program and its services. The salesperson's ultimate goal was to establish relationships with local employers, which would guarantee they would use MMC for their occupational health needs.

The salesperson had a clinical background and thus could discuss occupational health services intelligently. The challenge was to use personal sales to convince employers that MMC was the best choice in the area. Fortunately, the occupational health field was not well organized in

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the city, so presenting MMC's program as a dedicated resource generated a favorable response. In addition, the salesperson had to convince employers that sending their sick or injured employees to the emergency department or a private physician was not cost-effective or practical. Once MMC gained a foothold in a couple of companies, others began to express an interest in signing on.

While personal sales became the primary means of promoting the program, other traditional promotional techniques were used as well. Before the first sales call, MMC held a grand opening and invited human resources staff from area businesses. MMC earned an endorsement from the local chamber of commerce, which recognized the unmet need for occupational health services. The salesperson gave presentations to business groups and service organizations to highlight the benefits of the program. MMC sponsored local events put on by the chamber of commerce and community development groups. It offered discounts for seasonal services (e.g., flu shots, allergy shots) and lifestyle-related services (e.g., cholesterol testing, smoking cessation, weight management).

Through personal sales, public relations, sales promotion, and other marketing techniques, MMC established itself as the first choice for occupational health services in the area. Because of the program's growth, MMC added more clinical staff and two salespeople.

Case Study Discussion Questions

1. How did MMC attract clients for its traditionally offered services (e.g., substance abuse, weight management)?
2. Why did occupational health require a different means of promotion from MMC's traditional services?
3. Who were the actual customers for occupational health services?
4. What preparations were required of MMC prior to promoting its occupational health services?
5. Why was personal sales the method of choice for this business-to-business marketing initiative?
6. What other promotional techniques were used to supplement personal sales?
7. How did MMC differentiate its services from those provided by other health facilities?

Internal Marketing

Internal marketing refers to a provider's efforts to effectively train and motivate its customer service and support staffs to work as a team to generate customer satisfaction. It strives to get everybody in the organization working toward common objectives. Internal marketing is based on the premise that the relationships among people who work together mirror the relationships between customers and suppliers. Its goal is to increase communication among staff members to coordinate marketing initiatives and reinforce messaging.

Internal marketing is a combination of marketing, human resources, training, and behavioral science. It redefines employees as valued customers, with the rationale that anticipating, identifying, and satisfying employee needs lead to greater employee commitment. Greater commitment, in turn, improves the quality of services provided to external customers.

The marketing department is a logical focal point for internal marketing because of its knowledge of the organization's resources and overall strategy and its appreciation of external customers' needs. It has the expertise to deploy these tools with regard to internal customers and the budgets and financial resources to do the job. Internal marketing begins with communication, and communication is the marketing staff's primary responsibility. For internal marketing to be successful, employees must be made fully aware of the organization's aims and activities. Amazingly, employees of large healthcare organizations are often unaware of the services or programs their own organization offers. Although such lack of awareness is evident to some degree in any organization, it appears to be an inherent characteristic of healthcare.

A deliberate effort is required to instill requisite knowledge about the organization and its services and to ensure that all employees are working toward the same goal. Employees must develop a basic understanding of the nature of their customers, especially as they are often isolated from the service delivery aspects of healthcare operations. They may have little knowledge of the customer interaction process or, at best, only a partial understanding of service delivery.

Unfortunately, investment in internal efforts has always been a paltry fraction of most marketing budgets and is probably even smaller in healthcare than in other industries. Internal marketing is typically overshadowed in the budgeting process. Organizations that are frantically trying to boost revenues and cut costs may not appreciate the need to spend money on marketing to their employees. However, this attitude misses the point: Employees are the ones who deliver on and carry out the promises made by the organization. A lack of investment in internal marketing may also result from a conscious

decision by executives who dismiss internal efforts as feel-good pseudoscience, even though research consistently demonstrates that poor service (which stems more from people problems than from product problems) is what pushes customers away and into the arms of competitors.

Furthermore, internal marketing is an important implementation tool. It facilitates communication and helps counter resistance to change. It informs and involves all staff in new initiatives and strategies. Internal marketing initiatives are relatively simple to develop if the marketer is familiar with traditional principles of marketing. Internal marketing is based on the same rules that govern external marketing, and it is similarly structured; the main difference is that the customers are staff and other internal stakeholders. Simply, internal marketing is nothing mysterious; most of it is common sense. Among the most common features of internal marketing programs are workshops, special events, company anniversary celebrations, appreciation dinners, brown-bag lunches, off-site or satellite office visits, internal newsletters, bulletin boards, e-mail newsletters, intranets, and broadcast e-mails. Case Study 12.2 describes an example of internal marketing.

Case Study 12.2
Internal Marketing at SouthCoast Rehabilitation Center

SouthCoast Hospital operated 240 licensed beds, 30 of which were devoted to inpatient rehabilitation. The rehab facility was located in a separate building and primarily provided services to patients discharged from critical care units of the hospital who had been admitted for stroke, heart attack, or trauma. The facility was the only one of its kind operating in the market area, and thus it had no competition.

As Medicare and other insurers attempted to reduce the cost of care, restrictions were placed on the provision of rehabilitation services on an inpatient basis. As with many other health conditions, the emphasis (and the reimbursement) was shifted to outpatient care. This development created a challenge for SouthCoast, as it had historically focused on inpatient care and left outpatient rehabilitation services to other providers in the community. Now, the organization was forced to expand the limited outpatient services it offered and compete with other providers; the good thing was that it was known as the premier provider of rehab services in the region and had an

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excellent facility. However, it had not yet developed its outpatient program, which would require a marketing effort. The marketing staff embarked on a research initiative to determine the perception of SouthCoast's rehab services both in the market area and within the organization. They anticipated that much of the hospital's outpatient business (like its inpatient business) would come from internal referrals.

The goals of internal marketing research were to discover whether the physicians and staff (i.e., administrators, staff physicians, other clinicians, social workers, and discharge planners) knew of SouthCoast's rehabilitation services (both inpatient and outpatient), to assess whether they were using the services or otherwise referring patients to the facility, and to determine what was needed to generate more patients from internal sources. Marketing personnel had never conducted internal research before and were somewhat stunned by their findings from **surveys**, interviews, and **focus groups**.

First, some administrators were unaware of the availability and nature of the organization's rehab services. While many specialists routinely referred their recovering patients to the facility, many did not. Other staff members also were not aware of these services; this group included discharge planners who influenced the disposition of patients once their inpatient care was completed. Second, among those who did know about the facility, few actually referred their patients to it. For example, the two major orthopedic surgery groups operating at the hospital seldom referred patients to the facility. Third, because of the limited outpatient rehab services in SouthCoast, many staff had established relationships with other rehab providers in the community.

Clearly, an internal marketing initiative was needed, so marketing developed a plan for increasing awareness and utilization of the outpatient rehab services. The following activities were planned for this purpose:

- Grand opening of the outpatient services center, including tours of the space, for all staff and physicians
- Informational sessions for those within the hospital who could be making referrals—including physician staff, patient advocates, social workers, and discharge planners—as well as admissions and financial services staff
- Monthly employee newsletter describing the activities of the rehab facility, spotlighting key staff, and featuring successful rehab stories
- Promotional materials (e.g., keychains, refrigerator magnets, sticky notes) bearing the outpatient rehab center's contact information

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survey
A data collection technique that involves the use of a questionnaire administered in any number of ways.

focus group
A data collection technique that involves eliciting opinions and perspectives from a panel of individuals who interact under the direction of a leader.

After the introduction of the internal marketing campaign, SouthCoast rehab staff conducted an assessment of the effectiveness of the initiative every six months. At the first six-month mark, the outcome evaluation found that the level of awareness had risen substantially, the willingness to refer had increased, and the perception of the service had become positive. The real proof, however, was the utilization level. Independent of any external marketing, the number of internal referrals had increased dramatically in a matter of months. Subsequent research revealed that all of these indicators continued to trend upward, and SouthCoast was able to carve out a significant share of the outpatient rehabilitation market.

Case Study Discussion Questions

1. What development led to a need for SouthCoast to shift its emphasis from inpatient rehabilitation to outpatient rehabilitation?

2. Why did SouthCoast now face a competitive situation that had not been an issue in the past?

3. Because the rehab facility was well established, marketing staff made certain assumptions about the internal awareness of the rehab services. What surprises awaited them when they conducted internal research?

4. What possible reasons could there be for the lack of awareness (and subsequent lack of referrals) of the rehab services?

5. What steps were taken as part of the internal marketing campaign?

6. What other activities might have contributed to the internal marketing effort?

Affinity Marketing

Affinity marketing is a technique that is used to formally link an organization with its customers, partners, or constituents. It may involve a partnership between a company and an organization or between an organization and people sharing the same interests. The intent is to establish a larger consumer base for the organization's services and products.

Referred to as *affinity programs*, these arrangements merge the notion of group identification and membership benefits with the opportunity to satisfy the wants and needs of customers. An affinity group attempts to establish a solid connection with a group of consumers, creating an opportunity to target them more effectively than through standard and less personal marketing

affinity marketing
A marketing approach that involves a partnership between an organization and people sharing the same interests that is intended to expand the organization's consumer base.

techniques. Hospitals and other healthcare organizations may establish affinity groups that are open to all existing patients and customers or, more frequently, subsets of consumers—for example, seniors, pregnant women, or heart patients. At the institutional level, hospitals may become part of an affinity group by joining a group purchasing organization.

According to a leading advocate of affinity groups (Cassling 2019), belonging to a "club" with members who share common interests creates a strong bond of fellowship and loyalty. Hospitals and other health facilities have used such groups to generate patient affinity. Membership programs, also known as loyalty or wellness programs, create opportunities for healthcare organizations to become involved in the community while reinforcing the organization's position as a leading healthcare resource. Such programs can lead to valuable and ultimately profitable patient relationships.

The most popular hospital membership clubs are geared toward consumers over age 50. Older adults who make decisions for their children and their parents, as well as for themselves, represent a fertile target for such programs. Fostering a sense of commitment among this cohort will likely lead to increased patient volume later when they need healthcare. However, boomers tend to avoid products or services with a "senior" label and may not be attracted to programs branded for older audiences. One way to overcome this barrier is to offer programs tailored to both the younger and older segments of this population. For example, providing both yoga classes and estate planning workshops would allow the affinity group to span the age group.

Health and wellness clubs can also be tailored for children, men, and women, with special events and member perks customized for each audience. Women are favorite targets of affinity programs since they account for two-thirds of hospital procedures, 61 percent of physician visits, and 59 percent of prescription drug purchases. As women are the drivers of healthcare expenditures, presenting the hospital or physician's practice as a "healthcare information broker" may be helpful for women who frequently care for their spouses, children, and parents, in addition to themselves.

The following list, though not exhaustive, encompasses the range of membership "perks" offered by hospital affinity programs:

- Weight loss and nutrition counseling
- Men's health programming
- Specialized programming for women
- Discounts at local businesses
- Hospital cafeteria and gift shop discounts
- Products not covered by insurance
- On-site fitness classes or gym memberships
- Group outings and travel opportunities

- Exercise programs
- Golf tournaments
- Health screenings and fairs
- Cooking classes
- Lifestyle counseling
- Art classes and book clubs
- Wine, cookie, and coffee tastings
- Computer classes
- Finance, insurance, or medical claims workshops
- Kids clubs

The programs offered should be driven by the needs of members and their communities. Event ideas can be drawn from area businesses, pharmaceutical and medical supply companies, local academic institutions, community organizations, government agencies, and retirement and independent living facilities. Input from members through online polls can help generate program ideas.

Affinity groups offer an opportunity to proactively cultivate future customers. Such programs may target noncustomers as well as existing customers with the intent of converting "members" into "customers" at some point in the future. For example, an affinity group for healthy seniors who do not require much healthcare at the moment may lay the groundwork for the development of future users of health services. The assumption is that members will naturally use services of the organization they are affiliated with.

The marketing resources required for an affinity program include logos, collateral materials, direct mail, regular newsletters (print or electronic), and an interactive website. In addition, a systematic internal marketing initiative should be implemented to ensure that everyone in the organization is aware of the program and prepared to service its members. Exhibit 12.2 offers guidance on the development of a successful affinity program.

Technology-Based Techniques

Technology-based techniques take advantage of state-of-the-art technology to support marketing efforts. Pioneered in other industries, these techniques are increasingly being adopted by healthcare marketers, who recognize the contributions technology can bring to the marketing effort.

Database Marketing

Database marketing is a well-established component of marketing in most industries, but it is relatively new to healthcare. Although patient care does not easily lend itself to the retail-oriented applications of this marketing

In light of the growing emphasis on population health and the increasing senior population, healthcare organizations must take an active role in practicing preventive medicine to keep seniors healthy. Many factors are at play in the creation of a successful senior affinity program. These suggestions can help guide initial conversations with leadership to determine whether a senior affinity program is an initiative worth committing to for the long-term benefit of the organization and its community.

Articulate an Objective (Internal) and Mission (External)

Before developing and launching a senior affinity program, leadership should understand why the organization is investing time and resources in this initiative. Senior programs are shifting their emphasis from simply building loyalty and awareness to improving the health of seniors in the community. That shift in purpose necessitates a shift in the way programs are structured and supported by the organization. Once an internal purpose is determined, a mission statement should be created to share with the community. Developing a clear mission will help seniors understand what affinity program they are joining and why. A clear mission to benefit the community's senior population will also help gain community support.

Identify and Articulate Program Benefits

Focus on the benefits the program will be able to offer members. Consider what the organization and area businesses already do to accommodate and attract senior patients and visitors and incorporate those existing items into program benefits along with new benefits. From senior discounts at local restaurants and the hospital gift shop to warm blankets and valet parking at the hospital, making members and potential members aware of what is offered is critical.

Community businesses should be actively involved in the program. Many want to support a healthy and active senior community through discounts, giveaways, and other incentives. A senior program will succeed by offering more benefits, and local businesses will win by gaining another opportunity to market directly to seniors.

Develop Membership and Welcome Kit

After joining the program, the welcome packet or informational content that is provided to members is their first impression of the value of the program. These first few impressions will likely drive whether they share the details of the program with their friends. Whether it is a directory of benefits, an

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online health library, or an upcoming calendar of events, the initial welcome communication should inform and build excitement.

Programs, Events, and Screenings

Before launch, the organization should plan three months of senior-targeted events, programs, screenings, or other social activities to offer for members. Activities do not need to be available daily or even weekly, but giving insight into what is available and how to get involved from the time of enrollment will help ensure that seniors become engaged and stay engaged in the program. Existing senior-targeted events and programs should be incorporated into the affinity program's events calendar.

Launch and Ongoing Logistics

Once the program is launched, many logistics need to be handled on an ongoing basis. It is important to discuss resources needed for ongoing support prior to launch to ensure the program continues to grow without unnecessary obstacles. The following issues should be considered:

- How will the membership database be maintained?
- How often will the organization communicate with members, and how—by mail, e-mail, or both?
- Will the organization communicate based on specific requests and interests or generally to all members?
- Which annual community events will the program have a presence at or sponsor?
- Will the program host large events annually? Twice per year?
- Will the program need an ongoing paid media buy to recruit new members and announce events?
- How will the organization generate content to provide health education to members?
- Which staff and volunteers will drive the direction of the program on an ongoing basis?
- Will operations and clinical teams support requests for ongoing free or discounted screenings?

The development of a senior affinity program is an iterative process and the program should have the flexibility to adapt to changing member preferences and local community needs.

Source: Adapted from RCM&D (2019).

EXHIBIT 12.2
Five Keys for a Successful Senior Affinity Program
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technique, health professionals are increasingly recognizing the ways healthcare can benefit from some aspects of database marketing.

Database marketing involves collecting, storing, analyzing, and using information about customers and their past purchase behaviors to guide future marketing decisions. Ultimately, database marketing involves two main activities: (1) building a comprehensive database of customer profiles and (2) launching direct marketing initiatives based on those profiles.

The direct marketing that results is considered database marketing if it is response and outcomes oriented. The integrated data set created through this process can be analyzed to discern consumer-related patterns relevant to the marketing process. This knowledge can be used to create a communication vehicle that allows the healthcare organization to target relevant prospects and deliver the appropriate message. Increasingly, data mining using "big data" is being employed in healthcare to support healthcare marketing.

A number of constraints are implicit in database marketing in healthcare. These constraints are legal or ethical and often relate to customers' privacy, confidentiality, and data security. The repercussions from disclosing the medical condition of a customer can be much greater than those from disclosing grocery store purchases or even financial transactions. The enactment of the **Health Insurance Portability and Accountability Act (HIPAA)** in 1996 focused the spotlight on the issue of patient data confidentiality (see chapter 17 for the implications of HIPAA for healthcare marketing).

The application of database marketing to patient care is challenging because the healthcare customer's decision-making process is much different from that of other consumers. For one thing, patients may not be well informed about the attributes of healthcare goods and services. Further, products must generate adequate margins to be candidates for database marketing, and some health services do not qualify in this respect. Even the establishment of a database marketing system may be hindered by the fact that healthcare is much more complex than most other enterprises and includes numerous data collection points.

Adapting database marketing to healthcare requires a certain level of sophistication and a potentially expensive technology solution capable of handling these complexities. The ideal system for healthcare database marketing is difficult to conceptualize, however, because of the convoluted decision-making and financing arrangements in healthcare. The variety of coding systems (summarized in chapter 6) alone presents challenges to the development of database marketing applications. Healthcare providers must invest a lot of effort in the process, which is a challenge when many healthcare executives are not attuned to direct consumer marketing. In the past, the limitation was the technology itself, but today the impediment is the complexity of healthcare.

Health Insurance Portability and Accountability Act (HIPAA)
Legislation enacted in 1996 that limits access to and protects individuals' protected health information.

Database marketing cannot be imported from another industry without extensive modification, as patients and clients cannot be treated the same way as fast-food customers or car buyers. Nevertheless, the potential applications of database marketing to healthcare are almost unlimited. While the complexities pose numerous challenges, they can also be viewed as an opportunity or a reason to develop a database structure. The data mining potential of a well-designed customer database is considerable. Any choice-driven program—whether it is an affinity program (e.g., senior program), a concierge service, or a fundraising initiative—is a natural candidate for database marketing. Pharmaceutical companies already use a version of database marketing in their direct-to-consumer advertising campaigns. Health plans also are using this approach to segment their enrollee populations, and hospitals may introduce new programs to a "captive audience" through their customer databases.

Customer concerns about privacy can be addressed by having an opt-in/opt-out feature and letting patients indicate their preferred means of contact. With these features in place, database marketing appears ideal for a number of healthcare applications. Two obvious—but different—examples include the operation of wellness programs and the promotion of retail goods and services.

In other industries, database marketing is used for **cross-selling**, **upselling**, follow-up sales, and so on. Overt solicitation in healthcare may be a turnoff for an organization's customers, but if it is conducted in the right way, it can be an effective means of increasing customer uptake. For example, patients who register for an educational program (and give consent for subsequent contact) may be offered follow-up resources. Likewise, many healthcare organizations promote ancillary goods and services (e.g., pediatric services to obstetrics patients), and patient data inform the bundling of services that benefit the patient. The degree to which healthcare customers will accept more aggressive database marketing depends on how the technique is implemented. Clearly, the call to action that pharmaceutical companies have issued through their direct-to-consumer marketing has been well received by patients (if not by physicians). If database marketing is employed to help customers obtain more information, then it is likely to be perceived as a positive outreach. Still, the potential for backlash exists—whether it is as simple as a customer asking to be removed from a solicitation list or as serious and complex as a customer feeling anxious about their sensitive medical information.

cross-selling
A sales approach that encourages the purchase of additional products and services related to the initial purchase.

upselling
A sales approach that encourages the purchase of an upgraded (and more expensive) product over a lesser and cheaper option.

Customer Relationship Management

Well-developed and well-executed *customer relationship management* (CRM) programs can generate substantial returns for many businesses,

and new technologies only add to the possibilities. Healthcare organizations are beginning to recognize the benefits of CRM and are expected to increase spending on CRM activities. At the same time, CRM is still largely misunderstood by many health professionals and provider organizations; they must significantly change their mind-sets to realize the true benefits of CRM.

The most important benefit of CRM for the organization is its contribution to the ways in which the organization defines its customers, segments them into meaningful categories, determines their needs, and provides services to them. Organizations need to balance the value they provide to customers with the value CRM generates for the organization. For patients, the benefit of CRM derives from access to information and the benefits of a "partnership."

Marketers should identify which of the organization's goals can be addressed using CRM and, based on those goals, create subsequent internal plans and implementation activities. Some common goals and objectives of technology-driven CRM programs include the following:

- Improving customer service and satisfaction
- Reducing the number of negative customer experiences
- Allocating resources more efficiently
- Reducing expenses related to customer interaction
- Attracting prospects and retaining existing customers
- Anticipating customers' needs and building stronger relationships over time
- Improving clinical outcomes
- Increasing profitability

Customer satisfaction is a key metric for defining the organization's success, and a CRM strategy can contribute to that goal. Given that most hospitals already use patient satisfaction as a key performance indicator, it should not be a big leap for management to see the value of CRM strategies, which enhance customer satisfaction in all areas of the system. Marketers can then introduce the more aggressive objectives of increased patient volume, revenue, and profitability.

Existing businesses often have difficulty changing their institutional mind-set from one that is driven by sales or operations to one that is driven by customers. Healthcare organizations in particular seem to have difficulty making this shift. For this reason, healthcare marketers are often unable to integrate every aspect of their organization into a CRM program, and they probably should not try to do so.

The success of CRM programs hinges not on how comprehensive or complex a program is, but on how well coordinated and orchestrated it is. CRM strategies could be applied to the following areas:

- Disease management for a group of chronically ill patients
- Physician-to-physician marketing
- Community health screening or prevention
- Specific product lines, such as cardiology, oncology, women's health, maternity, or sports medicine
- Urgent care services
- Promotion of the organization's website or establishment of an online community
- Call center or customer service functions
- Identification and servicing of the organization's top-ten referring physicians
- Identification and servicing of the organization's top-ten leading accounts or clients
- Frequent customer programs or other affinity programs

Case study 12.3 describes an effort to promote heart health using CRM.

Case Study 12.3
Promoting Heart Health Using Customer Relationship Management

The Customer Potential Management Marketing Group (CPM) was a pioneer in applying CRM to the cardiology market. This company developed a program for three hospitals that were part of a national healthcare system comprising more than 100 acute care hospitals in 17 states. The three participating hospitals (hospital A, hospital B, and hospital C) ranged in size from a small local hospital to a large regional medical center.

The overall objective of the CRM marketing campaign was to educate the hospitals' customers about the early warning signs of a heart attack and to encourage them to take a proactive role by determining their heart health. It also was designed to build awareness of the national healthcare system's local cardiology services and to drive early intervention and service utilization. It used the Consumer Healthcare Utilization Index (CHUI), a

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predictive index developed by CPM to select the individuals in each market area most likely to benefit from the campaign information. Targeted people were referred for a heart health exam, for which they paid a fee. The campaign also included a matched control group that did not receive any promotional material or services.

The area's referring physicians and providers were briefed about the campaign and encouraged to participate in screening patients. This was in keeping with the campaign's aim to involve physicians while promoting the hospitals' cardiology services and extending information to more patients. The study was designed to do the following:

- Identify people at risk for a heart attack and initiate an early intervention (i.e., low-cost heart health exam)
- Provide consumers with beneficial education (regarding heart attack signs and symptoms)
- Strengthen relationships with primary care physicians and cardiologists
- Increase total charges attributed to cardiac-related services

The CRM approach involved delivering segmented messages to male and female prospects drawn from the databases of the three facilities. Solicitations were limited to one per household and targeted to people aged 35 or older living in households reporting at least $30,000 in annual income. The campaign material consisted of a 7.5-inch by 5-inch, four-color informational brochure with two versions—one for males and one for females. The primary offer was a heart health check, which included an electrocardiogram (EKG) screen with a free EKG wallet card, body mass index measurement, lipid screen, and cardiac education booklet. The secondary offer was a free take-home health risk assessment. The cost per package (including printing and postage of the material) differed for each hospital—according to how many pieces were printed and how many pieces were mailed—and ranged from $0.71 to $1.39. Package prices for hospitals B and C were higher because they printed large quantities for future mailings.

CPM staff maintained a complete record of organization-initiated communications—outbound dialogues with customers and prospective customers through direct mail. These communication records were matched to individuals and households in the database to assess activities, behaviors, and service utilization regarding the product line being promoted. Respondents were

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tracked through their appointment activity, and a response was tallied when a member of the target audience scheduled a heart health exam.

A 5 percent sample of the system's CRM database was flagged as a control group for each hospital. The control group was selected using the same criteria for selecting the organization-initiated communications groups. Members of the control group did not receive the mailing, but their activity was tracked in the database to compare activities, behaviors, and service utilization with those of the people who did receive the mailing.

The list of individuals with high predictive index scores compiled by Hospitals A and B returned significant positive results. Although hospital C also reported positive results, fewer data were available for this site (e.g., EKG results were not available). At hospital A, nearly half of those who signed up for the heart health exam had abnormal EKG readings. When combined with those whose EKG showed minor abnormalities, the percentage of people with some sort of abnormal reading rose to 54 percent. At hospital B, 61 percent of those who signed up for the heart health exam had abnormal EKG readings.

The real measurement of success is a simple value proposition that demonstrates dollar for dollar the revenue received for revenue spent. Furthermore, an accurate calculation of return on investment (ROI) must take into account utilization (among the control group) that might have occurred without the campaign. The use of CHUI methodology to target potential cardiology patients clearly benefited the participating hospitals. The combined results for the first six months of this campaign are as follows:

- Patient response rate: 5.36 percent; control group response rate: 1.61 percent
- Marketing response increase: 333 percent
- Net profit: $1,868,711
- Marketing lift after factoring out the control group: $1,684,643
- ROI: $44.78 for every $1 spent on marketing

The results for the first six months demonstrated that this health system was successful in identifying the most appropriate individuals for cardiology services and generating a high return on the marketing investment. These results demonstrated that ability of the CHUI to target at-risk people for intervention by offering appropriate education, health maintenance, and wellness programs.

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> ## Case Study Discussion Questions
>
> 1. What was the organization's objective in applying the CRM approach to its customer pool?
> 2. In what ways did the initiative intend to change the knowledge, attitudes, or practices of the hospital's customers?
> 3. What were the characteristics of the promotional package used for this initiative?
> 4. How receptive were the organization's patients to this initiative?
> 5. What tangible benefits did the organization derive from this initiative?
> 6. How was ROI measured, and what did the evaluation reveal?

Internet Marketing

This section introduces internet marketing; further explication is provided in chapter 13 on social media. Although healthcare providers were slow to jump on the internet marketing bandwagon, some healthcare organizations have led the way in certain aspects of online marketing. Hospital websites, for example, have become important sources of health information, and increasing numbers of healthcare consumers search online. Patients and caregivers alike use the internet as a resource both before and after a physician visit. Because internet users are seeking information, an internet-based promotion can be more customized than, say, a television advertisement.

Observers have noted a progression in healthcare organizations' internet marketing initiatives over time. The first stage simply involved a brochure-type website that identified the organization and described its work. The next stage introduced more service line and health content and more interactive features and applications. Websites became increasingly integrated with their organization's marketing efforts or other information technology applications. A growing number of health systems began pushing customized health information and medical records out to consumers, allowing e-mail communication with physicians, and carrying out some level of disease management online. Some health systems are now using their websites as tools for establishing and maintaining customer relationships. Today, many healthcare organizations' websites include unique, sophisticated features. *Hospitals & Health Networks* magazine's Most Wired Survey (www.hhnmostwired.com) is a useful indicator of what health systems are doing with information technology. Some of the early pioneers in this arena were Columbia/HCA, Kaiser Permanente, United Healthcare, and academic medical centers such as the University of Alabama at Birmingham and the University of Iowa.

Most healthcare organizations devote part of their marketing budget to online brand promotion. To assess the value of providing information online, many are attempting to determine their ROI by measuring whether physician visits are increasing, more prescriptions are being written, more coupons are being redeemed, and more products are being sold. Answering the ROI question enhances the appeal of internet marketing (over offline marketing) for those who are skeptical about this methodology.

According to Scott (2015), the best websites focus on content that pulls customers, markets, media, and products together in a common location. A website should be the point where all of an organization's online initiatives intersect, including podcasts, blogs, news releases, and other online features (see chapter 13 for a discussion of social media). A content-rich website should mesh the organization's resources in a cohesive and interesting way that efficiently informs the audience.

The internet is also a major channel in direct-to-consumer marketing. By providing free online information, education, advice, summaries of scientific studies, tools, and shared experiences, pharmaceutical companies are communicating better with consumers. Well-established sites include Schering-Plough's claritin.com and Medtronic's medtronicdiabetes.com. In another notable effort, the National Headache Foundation and AstraZeneca teamed up to create the Migraine Mentors at Work program (migrainementors.com). Consumer advocacy organizations have been particularly aggressive in establishing sites for the benefit of consumers, such as HIVTribe (hivtribe.com) and the American Cancer Association (cancer.org). These sites—online extensions of a workplace-based education and disease management program—provide users with information on how to manage their illness.

Healthcare marketers are successfully using offline techniques to draw consumers to their sites to search for information or respond to specific offers. They invite consumers to their sites to find a physician, view photos of newborns, sign up for a health screening, or take advantage of other features. Once consumers are online, marketers can convert internet surfers into prospects by capturing personal information in a customer database and encouraging them to sign up for interactive health news and medical reminders. This tactic enables hospitals to extend their marketing reach in a more personal way than just advertising on television or through the mail.

While healthcare organizations have typically not been on the cutting edge of online approaches, many are taking advantage of contemporary technology. For example, Second Life (secondlife.com) is a virtual community and gaming system that uses state-of-the-art technology to enable users to develop a cyberpersona and an accompanying world, interact and socialize with other users, create group activities, trade virtual properties and services, and so forth. The application has a three-dimensional modeling tool for

"sculpting" objects and introducing animation. Case study 12.4 describes a hospital's employment of Second Life for marketing purposes.

Many developments in healthcare internet marketing are expected to continue. Contemporary technology allows marketers to do the following:

- Better integrate online initiatives with more traditional marketing programs
- Leverage targeted marketing campaigns to generate new referrals and patient encounters for service lines such as cardiology, oncology, and orthopedics
- Focus on online customer relationship management strategies
- Increase direct-to-consumer online marketing
- Increase multicultural marketing as the industry gains a better understanding of the healthcare needs of diverse populations
- Better integrate the entire media mix
- Position the internet as the ultimate relationship management tool

Employing a website for marketing purposes is by far the most common example of internet marketing on the part of healthcare organizations. However, some hospitals and health systems—not to mention pharmaceutical companies and insurance plans—place advertising on other websites. Depending on the advertiser, these websites may be totally unrelated to healthcare but offer exposure to a wider audience. These are typically organizations that have national and even international reach (e.g., Cleveland Clinic, St. Jude Children's Research Hospital), although with the ability to target internet advertising more accurately, some healthcare organizations are placing internet advertisements.

Case Study 12.4
Hospital Takes Its Grand Opening to Second Life

In partnership with Cisco Systems, Palomar Pomerado Health in San Diego, California, was able to hold a grand opening three years before it started operations by creating a simulated version of the real-life Palomar West Medical Campus using Second Life. The health system claimed that the facility was the first US hospital to be unveiled in this manner.

By entering Second Life, virtual visitors could tour the facility and see some of the amenities of the $810 million, publicly financed hospital. Under the direction of Palomar Pomerado's chief innovation officer, the facility was

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designed from the ground up to be integrated with leading-edge technology, including medical technology. Its Second Life presence offered patients and the healthcare community a chance to explore these innovations in the virtual world years before the physical facility opened.

Virtual visitors also helped Palomar Pomerado test some of its ideas regarding the use of leading-edge technology at the new facility and the opportunities futuristic concepts present for the healthcare industry at large. The system even used Second Life to test some technology proposed for deployment in Palomar West, such as radio frequency identification (RFID). Virtual patients taking the tour could wear RFID-enabled bracelets that not only tracked them but also guided them to areas of the facility in which their services or treatments were scheduled to take place. Thus, a virtual patient slated for day surgery could automatically have the hospital elevator land on the correct floor, according to the information programmed into the RFID bracelet. The idea behind the testing was that if the technology worked in a virtual setting, it could be adopted in the real world. Some of the concepts tested were not yet considered feasible in today's environment, but they were explored in advance.

Looking ahead, Palomar Pomerado planned to use Second Life to host industry events and meetings with healthcare leaders, policymakers, and others to discuss a variety of topics, including clinical and operational issues as well as the design and architecture of technology that could apply to the physical Palomar West setting.

Case Study Discussion Questions

1. Why have hospitals and other healthcare organizations been slow to adopt contemporary technology for nonmedical purposes?
2. What are the advantages and disadvantages of opening up development plans to the public and encouraging their feedback?
3. By using Second Life technology for the hospital's virtual grand opening, was Palomar Pomerado in danger of creating unrealistic expectations among future customers?
4. How do you think Palomar Pomerado's cutting-edge approach is likely to be perceived by the traditional healthcare community?
5. How likely are other healthcare organizations to adopt this approach in presenting themselves to the public?

Source: Adapted from McGee (2008).

Consumer Engagement

consumer engagement
The process of identifying and profiling consumers and subsequently involving them in desired behaviors.

Consumer engagement refers to the process of establishing relationships with customers or prospective customers and involving them in bringing about a desired behavior change. The growing interest in consumer engagement stems primarily from the perceptual shift from *patient* to *consumer*. For example, a physician or other clinician might engage a patient to encourage compliance with a proposed treatment, a health plan might engage an enrollee to encourage a healthier lifestyle that would reduce healthcare use, and a wellness practitioner might engage a client to encourage active participation in a fitness program.

In each case, engagement is built on the provider's understanding of the background, needs, and motivations of the customer; the most effective means of communicating with the customer; and the type of relationship that facilitates the customer's movement through the phases of awareness, action, and maintenance. (See Prochaska, Norcross, and DiClemente's stages of change model later in this section.)

Patients' participation in their own care is clearly a key to reducing health risks, improving outcomes, and lowering costs; without this involvement, the efforts of the healthcare providers are likely to be wasted (Demchak 2007). Noncompliant patients are not only detrimental to their own health but also costly for the healthcare system. Managing to improve or eliminate prediabetes symptoms is much less expensive than a lifetime treatment for diabetes. Regular visits to a primary care office are more effective healthwise and costwise than any visit to an emergency department. A prevention check-up and screening are preferable to a hospital stay, and purchasing and taking prescription drugs as ordered by a physician is obviously better than going without.

Implementing effective consumer engagement efforts involves considerable rethinking on the part of both healthcare customers and providers. Patients and clients were told for decades to turn their healthcare and decision-making over to physicians and hospitals. Physicians, on the other hand, were trained to look at patients as separate from their environments and to rely on laboratory results and other tests rather than listen to patients' stories. Providers, in general, were not paid for preventive care but rewarded for "downstream" clinical care. Health insurance companies discouraged the use of services rather than ensure that each plan member received the right care at the right place at the right time. Much of this thinking has evolved and continues to evolve (albeit gradually)—thanks to many direct and indirect factors, including federal and state regulations, influential studies and reports, quality improvement and safety initiatives, the patient and

family involvement movement, public demands for provider transparency and accountability, and the ACA.

Encouraging Engagement

Healthcare researchers and experts have found that customer participation is fundamental to transforming the healthcare system. Patients today are encouraged to engage in a number of ways, such as selecting their own providers and health plans, monitoring and managing their symptoms and illnesses, adopting and maintaining healthy behaviors, and interacting more deeply with their providers. Healthcare organizations, practitioners, insurers, and employers are offering incentives to urge patients, enrollees, and staff to get involved in supporting consumer-directed health plans.

The most promising approaches to supporting consumer engagement are those that are participatory rather than didactic, involve family members, and have multiple dimensions. Interventions tailored to the individual's ability to initiate change yield good results. If members of targeted populations are asked to take small but realistic steps (e.g., reduce the number of cigarettes per day rather than quit smoking cold turkey), they have a greater chance of succeeding and moving on with confidence to the next step.

Segmenting customers into groups based on their capacity to change could prove beneficial, especially if the segmentation is based on clinical risk factors. Segmentation can enable marketers to customize their strategies to address the unique challenges associated with each stage of engagement in a particular group. If engagement strategies are implemented before risks increase or health worsens, patients could require less acute care as their self-management skills improve and they gain confidence. Other stakeholders, such as providers and employers, could use similar techniques. Together, insurers, providers, and employers can help increase engagement by addressing the specific challenges customers face as they begin to manage their health. Outreach at the community level could help provide the local momentum needed to activate a specific population. Reaching out to those who are more motivated to become role models and opinion leaders may help to hasten change in the community.

The capacity to change depends on the customer's state of knowledge, attitudes, access to support resources, and other factors. The potential to change status determines the approach an organization may take to engage that person. One such approach was developed by Prochaska, Norcross, and DiClemente (1994), who identified five stages of change: precontemplation, contemplation, preparation, action, and maintenance. (These stages are the same as the stages of the consumer decision-making process, discussed in chapter 5.)

A consumer in the precontemplation stage is not ready to use a service and needs to be educated about it. A consumer in the contemplation stage may be aware of a service but needs to adjust his or her attitude toward it. A consumer in the preparation stage is ready to take action and needs to be exposed to the service options available. A consumer in the action stage has committed to address the issue but needs supportive services. A consumer in the maintenance stage needs reinforcement. Thus, the stage of change becomes a major determinant of the type of marketing activity pursued. Exhibit 12.3 presents a graphical depiction of Prochaska, Norcross, and DiClemente's stages of change model.

What Must Marketers Know?

Effective consumer engagement requires meeting customers where they are and progressively moving from a generalized approach to an individualized approach. As long as marketers continue to use a one-size-fits-all approach, they are likely to see little response from target audiences. Marketers need to recognize that customers are unable to make these changes on their own and that the entire healthcare system needs to engage them. An essential task in this process is educating providers on the different levels of engagement and the ways to tailor messages accordingly. Marketers also need to understand the following:

- The types of interventions that have the greatest effect on outcomes
- How different interventions affect customers at each level of engagement
- How populations with low literacy or without health insurance (who tend to have lower health status) can be engaged.

Financial incentives are commonly used to motivate consumer behaviors, although different consumer segments are likely to respond differently to such enticements. Even more important, marketers need to determine whether responsiveness to incentives leads to sustained behavior change and increased engagement.

EXHIBIT 12.3
Stages of
Change Model

Source: Adapted from Prochaska, Norcross, and DiClemente (1994).

Although much more research is required before the consumer engagement endeavor is thoroughly understood, some early conclusions can be drawn with regard to what makes an engagement approach effective. For a customer to benefit, he or she must:

- Possess adequate knowledge about health problems and preventive measures
- Be motivated
- Have the capacity to change
- Be offered meaningful incentives
- Be provided appropriate pathways for action
- Receive reinforcement for positive behavior

For those involved in fostering consumer engagement, the tools for change include an in-depth understanding of the target population, meaningful segmentation of this population, a proactive intervention package, targeted communications, ongoing support, and regular monitoring of consumer activity.

Limitations of Contemporary Marketing Techniques

Certain barriers limit the application of some of the more innovative and technology-based techniques discussed in this chapter.

First, adopting these techniques to healthcare may not be practical. Many healthcare organizations do not have the personnel or technical resources necessary to implement such techniques. They may lack the information technology infrastructure needed to support these approaches, or they may be unable to access the data on which these techniques depend. They are not likely to know how to implement database marketing or CRM without bringing in outside consultants.

Second, in healthcare, not only are the necessary data often lacking, but also concerns exist about the confidentiality of the patient data used in some of these contemporary marketing techniques. HIPAA restrictions have made many healthcare organizations reluctant to use—even legitimately—personal health data. Questions about the appropriateness of using patient data for marketing purposes reinforce these concerns. The conservative nature of health professionals poses a barrier to the use of data, while professionals in other industries would have no qualms about doing so.

Contemporary marketing techniques are being slowly but surely incorporated into healthcare—particularly into areas that have fewer reservations about the use of data (e.g., pharmaceutical sales). The demands of

a competitive and consumer-driven system need to be approached through new marketing techniques, and contemporary consumers are likely to insist on having more and more access to, and interaction with, healthcare providers. Ultimately, the challenge for healthcare is to use modern marketing techniques to establish and maintain customer relationships without violating or even giving the appearance of violating patient confidentiality.

Summary

Contemporary program-based techniques include direct-to-consumer marketing, business-to-business marketing, internal marketing, and affinity marketing. Those that are technology based include database marketing, customer relationship management, and internet marketing. Techniques that involve information technology and intensive use of data have tremendous applications in healthcare but remain controversial. The enactment of HIPAA legislation, for one, has made many healthcare organizations reluctant to use personal health data for marketing purposes. The internet has changed healthcare marketing, just as it has revolutionized marketing in other industries. That is expected to continue in the future.

Contemporary approaches to healthcare marketing emphasize customer relationships, and consumer engagement is its most recent incarnation. Experience has shown that promoting health services to consumers is becoming increasingly challenging. Customers and consumers are now at the stage where they understand the importance of availing themselves of a service. Although many are already engaged in their own healthcare and decision-making, others must be convinced to proactively participate in managing their health and interacting with their providers. That task falls on healthcare marketers.

Key Points

- Healthcare has moved beyond traditional marketing techniques and adopted more sophisticated techniques that take advantage of information technology.
- Much of this shift has been driven by the need to develop and maintain relationships rather than simply sell products and services.
- Electronic forms of communication—mainly the internet—have revolutionized the marketing of healthcare goods and services.

- To employ contemporary marketing techniques, marketers require in-depth knowledge of the target audience.
- Direct-to-consumer marketing recognizes the importance of the consumer as the end user and targets identifiable segments of the population.
- As healthcare becomes even more corporatized, organizations' transactions with other businesses have increased, necessitating business-to-business marketing approaches.
- Internal marketing focuses on internal customers to create a culture that fosters customer service and turns all employees into marketers.
- Database marketing takes advantage of information technology to create a repository of customer data that can be used for relationship development and management and in follow-up sales efforts.
- Customer relationship management builds on database marketing to establish intensive relationships with customers.
- Internet marketing has become healthcare marketers' main medium of interface with target audiences.
- Consumer engagement is a way to positively influence customer behavior, and the task of promoting that engagement falls to healthcare marketers.
- The conservative nature of healthcare is a barrier to using contemporary marketing techniques, and the fear of violating HIPAA and patient confidentiality limits the use of personal health data for marketing purposes.

Discussion Questions

1. What marketing or healthcare factors are encouraging the adoption of contemporary marketing techniques?
2. In the pharmaceutical industry, why is direct-to-consumer marketing a radical departure from traditional approaches to marketing?
3. What developments in healthcare have encouraged the growth of business-to-business marketing?
4. In what ways can healthcare organizations use customer databases?
5. What factors have influenced the trend toward establishing long-term relationships, as opposed to securing an immediate sale from the healthcare consumer?
6. Why are healthcare marketers cautious about using patient data or even applying technology-based marketing techniques?

7. As internet marketing has matured, how have healthcare marketers taken advantage of it?

8. Why has consumer engagement become such a concern in healthcare, and what is the marketer's responsibility in promoting it?

Additional Resources

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SOCIAL MEDIA AND HEALTHCARE MARKETING

I n the twenty-first century, **social media** revolutionized communication in contemporary society. Although no concise definition of *social media* exists, the term is an umbrella description for a variety of communication modes enabled and supported by internet technology. It includes social networking, blogging, tweeting, texting, and podcasting (to name just a few). Social media are distinct from traditional media (television, radio, print—also known as "industrial media") in that they connect people and allow direct interaction among a community of users, offering immediacy and flexibility. The widespread adoption of social media in American society has had major repercussions for marketing. This chapter discusses the basics of social media and their application to healthcare marketing.

social media
A variety of communication modes that use internet technology to support innovative forms of interaction between people.

The Basics of Social Media

Social media were developed for the purpose of person-to-person interaction and have been primarily popularized by young, technology-savvy consumers. With roots in new-generation cell phone and internet applications, social media technology allows individuals to maintain contact with friends, family, and other associates at any time from anywhere. Social media thus represented a revolution in communication, and its growth has been phenomenal.

The social networking numbers alone are remarkable. According to Pew Research Center (2019), 72 percent of American adults regularly use social networking platforms: YouTube and Facebook are the leading sites, followed by Instagram, Pinterest, and LinkedIn. The use of social networking platforms is skewed toward younger cohorts, although around one-third of those aged 65 and older report using one or more social media. The choice of platform varies by age, race, sex, education, and community type. Most users access social media platforms on a daily basis. Hootsuite (2019a) reported 3.48 billion social network users worldwide (nearly half the world's population), up from 1.7 billion in 2012.

New social networking platforms are constantly emerging, and they immediately attract millions of users. Social media users, with their desktops, tablets, or smartphones, can also create and post content, including comments,

pictures, videos, audios, or blog posts. Such **user-generated content** powers sites, such as YouTube and Wikipedia, that rely on visitor submissions and responses. In addition, social media host a variety of peer-to-peer activities, from news updates to online collaboration to viral marketing to entertainment sharing. Social media have not eliminated the need for information gatekeepers in most industries, including healthcare, but they have helped shift the control of information from those gatekeepers to consumers.

Each type of social media allows its users to create a "community," and that community is given a forum to contribute perspectives and knowledge on a wide range of topics, encompassing current events, politics, religion, pop culture, society, economics, commerce and consumerism, history, science, and healthcare, just to name a few. These forums allow real-time (and often unfiltered) inputs or discussions that readers and other virtual community members can freely access in perpetuity with an internet search or a visit to social media sites. Exhibit 13.1 describes the common types of social media.

EXHIBIT 13.1
Types of Social Media

> New types of social media (along with their specific platforms) are constantly emerging. Here are the most common types at the time of this writing.
>
> - **Social networks.** These websites require every user to create a profile that showcases basic data (e.g., name, gender), interests, and other information the user wants to share; attaching pictures to a profile is highly encouraged. A profile then becomes the "face" of the user, allowing him or her to connect with the profiles of friends, family, colleagues, and even total strangers; to communicate with this network; and to share updates, media, content, and so on. Leading social networking platforms include Facebook and LinkedIn.
> - **Blogs.** One of the oldest and most popular forms of social media, a blog is an online journal whose entries are organized by categories or by *tags* (codes that help search engines find entries easily and thus make them a marketing tool). Blogs have evolved over time. They are no longer used exclusively for personal thoughts but are now a tool and medium for instructors and professors, marketers, and other professionals and businesses. They are no longer text-only but are multimedia. Many websites—from those posting news to those selling goods and services—have a dedicated blog. Vlogs (video blogs) have
>
> *(continued)*

EXHIBIT 13.1
Types of
Social Media
(continued)

emerged as well. Popular blogging platforms include WordPress, Blogger, and Tumblr.

- **Microblogs.** Microblogs feature short posts—usually restricted to a few lines of text, an image or photo, a short video, or a link. They are particularly suited for quick updates and distributing content via mobile devices. Notable microblogging platforms include Twitter (for text and video) and Instagram (for photographs and video). Facebook and LinkedIn also have microblogging features.

- **Content communities.** Content communities present text, images, and videos submitted by their users or members. These users also comment on or discuss the content. YouTube, Flickr, and Scribd are examples of content communities.

- **Wikis.** Wikis are user-generated websites. One of the best-known wikis is Wikipedia, an online encyclopedia. Another site is WikiLeaks, a controversial wiki that posts information from whistle-blowers that is often linked from confidential sources.

- **Podcasts.** Podcasts comprise audio and other content that can be downloaded or streamed either for free or through a paid subscription. The term is a portmanteau of "pod" (from iPod) and "broadcast" (as the content is "aired" or transmitted electronically). Increasingly, webinars built on the podcast model are being presented to replace on-site meetings. Popular podcast venues include iTunes, Spotify, and Stitcher.

Other types of social media include (but are certainly not limited to) rating and review sites (e.g., Yelp, Angie's List); social bookmarking (e.g., Pinterest, Digg); forums and discussion boards (e.g., Reddit, Craigslist); 3D virtual worlds or gaming (e.g., Second Life, World of Warcraft); music and movie streaming (e.g., Pandora, Spotify, Netflix); and media, science and technology, and pop culture aggregators (e.g., Mashable, BoingBoing, BuzzFeed).

A Healthcare Consumer's Tool

Not surprisingly, social media have become popular with people interested in health-related issues (Sarasohn-Kahn 2008). It is hard to imagine a healthcare consumer today (even someone who is not technologically savvy) who would not research a health condition or diagnosis on WebMD, watch a related video on YouTube, find more information about a physician or another clinician by using Google or Healthgrades or by asking friends on Facebook,

or check out posts by those undergoing similar experiences on Twitter or PatientsLikeMe. Online forums focused on specific diseases are burgeoning (e.g., Diabetes Daily), along with countless general healthcare and personal journey blogs (e.g., *The Health Care Blog*, *Heart Sisters*).

Healthcare and social media are natural partners. Social networks are user-friendly, and the posts are in real time, which helps when a patient and a doctor are trying to make a healthcare decision on the fly. Blog entries (video, audio, and text), online articles, and forum discussions are stamped with a time and date, allowing healthcare consumers to disregard old and obsolete (and thus possibly dangerous) information. Because healthcare information is fluid or ever-changing, it is disadvantageous to rely on only industrial media as sources; a printed brochure or an aired program cannot be instantaneously updated once new information emerges. Social media, on the other hand, are not meant to be permanent and thus are better suited to the dissemination of updates and other new material.

Exhibit 13.2 and case study 13.1 discuss social media's application in a healthcare setting.

The following statistics illustrate social media's role in healthcare:

1. 42% of individuals viewing health information on social media look at health-related consumer reviews.
2. 32% of US users post about their friends and family's health experiences on social media.
3. 29% of patients viewing health information through social media are viewing other patients' experiences with their disease.
4. Of all the individuals viewing healthcare information on social media, 24% are viewing health-related videos and images posted by patients.
5. 74% of internet users engage on social media. 80% of those internet users are specifically looking for health information, and nearly half are searching for information about a specific doctor or health professional.
6. Information on social media can have a direct influence on patients' decisions to seek a second opinion or choose a specific provider.
7. Some of the most engaged and active audiences on social media are individuals coping with a disability or chronic condition.

(continued)

EXHIBIT 13.2
Social Media
and the
Healthcare
Industry
(continued)

8. 81% of hospitals said service lines expressed an interest in participating in the hospital's social media strategy.

9. 60% of consumers say they trust doctors' posts versus 36% who trust posts from a pharmaceutical firm.

10. 50% of healthcare applications available to consumers can be downloaded for free and are produced by a variety of developers.

11. 27% of patients comment or post status updates based on health-related experiences.

12. Among the 165,000 health and medical applications now on the market, nearly two-thirds are focused on general wellness issues such as fitness, lifestyle and stress, and diet. The remainder are focused on specific health conditions.

13. Mobile health applications generated $392 million in revenue 2015.

14. California, New York, and Texas hospitals use social media more than hospitals in other states.

15. 88% of physicians use the internet and social media to research pharmaceutical, biotech, and medical devices.

16. Out of the 5,624 hospitals in the United States, only 1,501 (or 26%) are using a form of social media.

17. Healthcare marketers use social media less often than other marketers.

18. On average, healthcare marketers spend 23% of their total marketing budget on content marketing activities, compared to 31% for all marketers.

19. Healthcare marketers tend to use print (e.g., magazines, newsletters) at higher rates than marketers in other industries.

20. There are 695 hospitals on YouTube and 1,116 hospitals on 4Square.

21. 72% of all internet users are active social media users.

22. 43% of baby boomers leverage social media for healthcare-related information.

23. There are 27.4 million people in the United States over the age of 55 engaged in social networking, and 19 million of those use Facebook.

24. 53% of physician practices in the United States have a Facebook page.

25. There are at least 967 hospitals on Twitter, and around 3,000 hospitals have a company page on LinkedIn.

26. 16% of Facebook users post reviews of medication, treatments, doctors or insurers.

27. 18- to 24-year-olds are more than twice as likely as 45- to 54-year-olds to use social media for health-related discussions.

28. 30% of adults are likely to share information about their health on social media sites with other patients, 47% with doctors, 43% with hospitals, 38% with a health insurance company, and 32% with a drug company.

29. 23% of drug companies have not addressed security and privacy regarding social media.

30. YouTube traffic to hospital sites has increased by 119% year over year.

Source: Adapted from Warden (2017).

CASE STUDY 13.1
Virginia Blood Services' Facebook Events

When the legal age for donating blood in Virginia was lowered from 18 to 16, Virginia Blood Services (VBS) began to explore new methods of communicating with potential donors—particularly first-time donors—and attracting them to blood-collection events. VBS consulted with a marketing firm on how to use social media to reach those audiences.

It quickly became apparent that using social media was appropriate for reaching not only those as young as 16 but also college-aged students. Upcoming blood drives on college campuses signaled an opportunity to market the events in a way that would be applicable to both demographics. With a target population of high school and college students, the challenge of drawing interest and engagement was significant.

VBS developed a strategy of using a Facebook event to organize and promote a series of blood drives on campuses across the state. The events were linked to VBS's Facebook profile, which was already disseminating content and news. The success of this strategy was measured through the RSVP feature, which indicated who and how many would be attending, might be attending, or would not be attending a specific event. A related measure was the visibility of the feature. People without Facebook profiles could not see the event information unless it was made available to the public. People with profiles, in contrast, not only could see the event but also could follow and RSVP to the event; the user's timeline would then publicize this intention to attend or participate.

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In a circle of friends, the more people planning to attend, the more people are influenced to attend or would know about the event. In the case of VBS, even if just 1 in 20 people invited to the blood drive says "yes" or "maybe" to participating (which endorses the activity), then hundreds—if not thousands—of people who were not even invited would find out and could sign up themselves. In this way, the RSVP would likely take on a life of its own.

The immediate success of VBS's Facebook event strategy was evident: In just one week, several hundred people had viewed the promoted events, and more than one-third of them responded using the RSVP feature. For a blood drive at the University of Virginia, for example, VBS received 165 yes, 64 maybe, 56 no, and 247 no responses. More than 500 people viewed the event page in less than seven days.

But the real results came after the blood drives, when the initiative was evaluated. Data were compiled on people who actually attended (as opposed to those who merely said yes), who were viable donors, who donated "double-reds" (i.e., a certain type of blood), and who were new donors. Because people generally use their real names on Facebook, VBS was able to develop a small programming script that matched donors in the database with the Facebook Event log of names. The final tally was a remarkable 28 percent increase in new donors, all solicited through Facebook. For some of the events, the double-red total increased more than 20 percent.

Case Study Discussion Questions

1. What demographic did VBS seek to penetrate, and why did it think an innovative method would be required to do so?
2. In addition to Facebook, what other forms of social media might VBS have employed?
3. What characteristics of Facebook and other social networks make them ideal for this type of campaign?
4. How effective was the VBS campaign, and how do the results compare with what might be expected using traditional marketing methods?

A Modern Marketer's Medium

The growth and popularity of social media have revolutionized marketing in all industries. This form of communication can target audiences (assuming they are online) anywhere and at any time. They represent a conduit that can

rapidly and widely spread a marketing campaign's message. Modern marketers realize that social media are part of contemporary communications' ecosystem that includes television, radio, and print; thus, most marketers have integrated a variety of media to capture consumers with seamless promotions that are visible on the web, on mobile devices, on television and the radio, and in print.

social media marketing
The promotion of an idea, a good, a service, or a brand using social media.

viral
The rapid, epidemic-like dissemination of content on the internet.

earned media
The free exposures, publicity, or word of mouth that a brand, product, initiative, or content receives.

paid media
Ads or sponsorships purchased to promote a brand, product, initiative, or content.

owned media
Online channels that an organization develops, maintains, and cultivates for marketing and other purposes.

Social media marketing usually involves creating content and feeding it to appropriate online channels (e.g., social networks, blogs, news aggregators) to attract enough attention that it is shared across platforms or goes **viral** (i.e., an epidemic-like dissemination of content). When a brand's corporate message is posted and then passed on from user to user on a social network (by being reposted or retweeted, for example), it resonates because it appears to come from a trusted third-party source rather than generated by the brand or company itself. Obviously, this repetition increases the visibility of the message and its creator. The greater the number of people it reaches, the greater the likelihood it will bring more traffic or visitors to the company's website.

For a post to go viral, the process usually starts on a social network, so marketers tend to first post promotions on their organization's Facebook page and follow it up with an announcement on Twitter. Word of mouth becomes "word of mouth on steroids" (also known as electronic word of mouth or eWoM) when social networks are employed because of their capability to reach and attract even those who are not direct followers or fans. This is why social networks are referred to as earned media rather than paid media.

Earned media refers to the free exposures, publicity, or word of mouth (likes, reposts, retweets, favorites, up votes, shares, recommendations, and other mentions) that a brand, product, initiative, or content benefits from. **Paid media**, on the other hand, refers to ads or sponsorships purchased to promote a brand, product, initiative, or content. A related term is **owned media**, which refer to online channels (e.g., websites, blogs, Facebook pages, Twitter feeds) that the organization develops, maintains, and cultivates for marketing and other purposes. These terms are illustrated throughout this chapter.

Innovative healthcare marketers have long appreciated the advantages of social media for promoting healthcare organizations and their products. If the key functions of healthcare marketing are to inform and educate current and potential customers, then there is no better vehicle than social media to facilitate these activities. To this end, marketers have persuaded hospitals, health systems, and other healthcare organizations not only to launch their own websites, actively participate in social networking, and offer online courses but also to continue cultivating their web presence to disseminate information, encourage information sharing, support customer involvement and interaction, and encourage customer feedback. Furthermore, many have initiated blogs, sponsored content, published online advertorials and white papers, engaged in e-commerce, posted videos, created podcasts related to

certain medical conditions or procedures, and so on—all to attract and retain healthcare consumers. Pharmaceutical companies have been at the forefront of these social media efforts, but even government agencies have done their part to support their missions and increase their online visibility.

Social media allow all users—whether individuals, groups, or organizations—to choose whom and what to follow. By choosing accordingly, marketers can narrow down a target audience. While this strategy may not be particularly helpful to providers of patient care, it could benefit individuals and groups practicing retail medicine or offering elective procedures as well as companies selling consumer health products.

An equally important advantage of social media for healthcare is that it gives organizations an opportunity to interact directly with their constituents or stakeholders. This personal interaction between the hospital and patient, for example, can promote loyalty among patients and their family and friends. It communicates that the organization cares whether individual patients are happy or sad, satisfied or angry, well or ill. A social network account (assuming it is run ethically and carefully) humanizes the organization and makes it relatable—that is, makes it seem as if it is listening to customer concerns. Exhibit 13.3 describes the use of search engine optimization (SEO) as a marketing tool to drive users to a website.

EXHIBIT 13.3
SEO as a
Marketing Tool

Search engine optimization, or SEO, is critical for tapping into the largest traffic source online—searches. SEO is a method for increasing the quantity and quality of traffic to a website through organic search engine results. This exhibit explains how different types of searches influence the effectiveness of certain SEO practices for reaching a healthcare organization's target audience. A search engine's goal for every search is to return results that are exactly what the user is looking for.

To do this, the search engine customizes the order of retrieved sites using a variety of factors (i.e., an algorithm) to determine how well a search result matches the query based on the user's intent and location. For example, imagine a searcher is looking for a doctor that specializes in feet. Searching for "doctor that specializes in feet" will return vastly different results than "doctor that specializes in feet Knoxville."

For this reason, the following factors should be considered when developing an SEO strategy:

- Is the user looking for something nearby?
- Is the user searching for general information?

(continued)

- Is the user searching for an image?
- Is the user looking for products?

The answers to these questions will influence the way results are ranked and affect the results supplied by a search engine such as Google. Google looks at more than 200 ranking factors, but the factor that has the greatest impact on SEO efforts is whether the searcher is looking for local or national information. Local searches are queries in which the users are searching for information specific to a certain area, such as a town or neighborhood. To retrieve more useful information, Google and other search engines look for keywords and phrases that indicate local search intent and return local results. For example, searches for a keyword such as "doctor" or "dentist" will return local search results that depend on the user's location.

In addition to specific keywords that typically imply local intent, Google uses local modifiers to trigger local searches. For example,

- "Near me," as in "podiatrists near me"
- Addition of town names, as in "ophthalmologists Nashville TN"
- Addition of location names such as "urgent care clinic near Walt Disney World"

When it comes to more general topics such as conditions or treatments, there is not much difference in the expected results for a searcher in the Midwest compared with one on the East Coast. Results for these searches are typically similar nationwide. While ads and some local information may appear, the results for someone searching "varicose vein symptoms" in Las Vegas and Philadelphia will be similar.

The purpose of distinguishing local and national searches is to provide users with the most relevant results for a given query. When users are expecting to find something nearby, such as a doctor's office, the best results are local, but if a user is searching for the most authoritative answer to something like "varicose vein symptoms," the best result might be a nationally ranked specialist instead of the general practitioner up the street.

To customize searches, search engines now include vast amounts of data about users besides their location. For example, Google now offers snippets that directly answer questions, it can find the date of your next doctor's appointment by searching your e-mail for an appointment confirmation, and so much more. These types of queries go hand in hand with local and national searches, allowing search engines to provide better

EXHIBIT 13.3
SEO as a
Marketing Tool
(continued)

information, for example, to a physician practice's potential patients. For this reason, crafting a solid SEO plan is vital for generating the best return from this marketing channel.

Regardless of which type of searches are being targeted, the building blocks of SEO are consistent. Each healthcare organization will use these components differently based on its marketing strategy. Every SEO plan, whether national or local, should include three basic elements:

1. Keyword-optimized content, page titles, descriptions, and other elements (e.g., image names and alt text)
2. Correct and consistent contact information, including the organization's name, address, phone number, and e-mail address
3. Consistent updates with quality content, such as blog posts, social media updates, or new topic pages

The intent is to make sure that search engines can understand and process the organization's content and that the business appears to be open and active. These elements come together to create a sense of authority on a given topic, yielding higher rankings and more traffic. Further, the heavier the activity on the site, the higher priority it will receive in future search results.

When it comes to local SEO, targeted keywords and phrases ensure that the organization shows up in location-based search results. When working on local SEO, the focus is not only on big search engines such as Google but also on directories and other local listings and maps.

A local SEO plan comprises three main components:

1. General search optimizations (e.g., keywords embedded in site documents)
2. Directory citation optimizations (e.g., listings on directory sites like Healthgrades)
3. Map search optimizations (e.g., listings on Google Maps and other online mapping applications)

The benefits of a local SEO campaign are typically more tangible compared with a national SEO campaign. In addition to benefits such as increased search rankings and more web traffic, local SEO can drive more physical traffic to the organization. According to Google, 76 percent of people who search on their smartphones for something nearby visit a business

within a day, and 28 percent of those searches result in a buying decision, such as purchasing a product or service or scheduling an appointment.

One of the biggest shifts in SEO over the last few years has been the consistent growth of the share of internet traffic from mobile devices. To capitalize on SEO, it is important to be mobile ready. With mobile devices now surpassing 50 percent of the market share, search giants such as Google have begun to roll out mobile-first listings and increasingly rely on mobile device location services to provide location-specific results that are far more accurate than previous geolocation methods.

Source: Adapted from Baker (2018).

Healthcare Consumers' Use of Social Media

Healthcare consumers who rely on social media to address their healthcare issues currently outnumber the healthcare organizations that have a social media presence. This is understandable—not only because there are obviously more people than businesses but also because organizations (unlike private citizens) face legal and regulatory risks if they make false or careless claims online. For example, a hospital could be fined under the privacy rules of the Health Insurance Portability and Accountability Act (HIPAA) for transmitting or sharing **protected health information** (online or offline) without the patient's consent.

Consumers, on the other hand, are not daunted by social media. They use these channels to find answers to their health-related questions and commiserate about their conditions. They look up symptoms and treatments, specialists and practitioners in their communities, and reports on other patients' experiences. They are eager to share information with (as well as obtain information from) those they trust, and they are willing to give out their personal and medical data *if* doing so would benefit them. Their expectations of providers mirror the instant gratification of social media: They want a response (or at least an acknowledgment) from individual practitioners and organizations within a short time. If they feel ignored, slighted, or unfulfilled, they are likely to broadcast this negative perception to their social media followers (and those people's followers and beyond), generating bad publicity for the provider.

Clearly, not all members of US society are users of social media, and different segments of the population adopt new technology at different rates. The same can be said of healthcare consumers. When all factors are taken into consideration, the segment of society that is most active in engaging social

protected health information
A patient's identifiable healthcare data, including physical and mental health status, treatment record, and insurance and payment information.

media for healthcare purposes is women between the ages of 18 and 34 who have no college degree and earn between $25,000 and $50,000 annually.

Part of facilitating the use of social media by healthcare consumers is understanding who they trust online. According to PricewaterhouseCoopers Health Research Institute (2012), consumers are most willing to share health-related information online with providers (physicians, nurses, and organizations), patient advocacy groups, and other patients they know. They are least likely to share health information with patients they do not know, a gym or fitness center, a drug company, or an alternative care provider. Exhibit 13.4 summarizes healthcare consumers' willingness to share their health data online.

Patient-Oriented Websites

Patient-oriented websites are online communities dedicated to health and wellness. They offer robust resources on myriad diseases and illnesses, symptoms and risk factors, treatments and cures, and medications and side effects—usually written in easy-to-understand language, organized alphabetically, highly searchable, and laid out in a simple and attractive way. Collectively, these sites offer patient stories, health and industry news, expert medical insight, health apps and other tools, patient and provider blogs, educational literature (from

EXHIBIT 13.4
Healthcare Consumers' Willingness to Share Health Data Online

Share data with . . .	Percentage of willing consumers
Other patients you know	46
Other patients you don't know	25
Hospital	55
Doctor	60
Nurse	56
Health insurance company	42
Drug company	36
Retail pharmacy	48
Patient advocacy organization	54
Government organization	45
Gym or fitness center	34
Alternative healthcare setting	36

Source: Data from PricewaterhouseCoopers Health Research Institute (2012).

newsletters to articles to research studies), links to other resources, support groups, discussion and chat forums, e-learning or webinars, advocacy opportunities, disease prevention and health monitoring guides, interactive social media platforms, and much more.

Patient-oriented websites empower patients and their family members or caregivers by equipping them with credible information, putting them in touch with those who have similar conditions, connecting them with health professionals, and giving them tools for self-management. (Similar digital communities are available for physicians and other health professionals, such as Sermo.com and Imedex.com).

Patients research medical and health information, treatment options, provider attributes and locations, and many other factors. Their research guides decisions about treatment options and the choice of practitioner or facility. Further, patients do not hesitate to post reviews of physicians and hospitals online.

Astute social media marketers have learned that the patient's time is just as valuable as the physician's time. With the emphasis on patient-centered care, convenience is paramount. Patients want convenient and timely appointment scheduling, and they have little patience for waiting days or weeks for an appointment—not to mention long waiting room times. Today's patients demand a retail consumer experience from their healthcare providers.

Many patient-oriented sites are accessible to casual internet searchers, but others—because of the need for confidentiality—require users to sign up for an account to take advantage of all the site's features. Exhibit 13.5 presents an example of a patient-oriented website.

EXHIBIT 13.5
PatientsLikeMe

PatientsLikeMe was cofounded in 2004 by three Massachusetts Institute of Technology engineers after a family member of two of the founders was diagnosed with amyotrophic lateral sclerosis (ALS, also known as Lou Gehrig's disease) at an early age. Wanting to help other ALS patients manage their condition, the trio conceptualized and built PatientsLikeMe, a health data–sharing platform designed to transform the way patients manage their own conditions and the way the healthcare industry conducts research, as well as to improve patient care overall.

Members of PatientsLikeMe can share and learn from real-world, outcome-based health data. The organization's partnerships with trusted nonprofit, research, and industry leaders give members access to information that can improve products, services, and care. In addition, users can

(continued)

EXHIBIT 13.5
PatientsLikeMe
(continued)

search the site's database, monitor their health, and connect with others who know firsthand what they are going through.

According to the company, "We are passionate about bringing people together for a greater purpose: speeding up the pace of research and fixing a broken healthcare system." Because much of healthcare data are private or proprietary, the development of breakthrough treatments takes decades and patients are unable to get the information they need to make important treatment decisions. To this end, PatientsLikeMe created a depository to which patients can add their specific symptoms, diagnoses, treatments, medications, and stories and from which other patients, caregivers, physicians, researchers, and pharmaceutical and medical device companies can learn to ease and enrich the lives of those afflicted with a condition.

PatientsLikeMe currently has more than 350,000 members, who report their real-world experiences with more than 2,000 diseases—from the rare conditions such ALS to common ones such as depression, fibromyalgia, multiple sclerosis, and psoriasis. Through health profiles, members can manage their health between doctor or hospital visits, document the severity of their symptoms, identify triggers, note their responses to new treatments, and track medication or treatment side effects. They also learn from the aggregated data of others in the same situation, getting and giving support in the process. As a result of the site's success, it was acquired by United Healthcare in 2019.

Source: Adapted from "About Us" and "Our Philosophy," www.patientslikeme.com.

The Value of Social Media Engagement

In healthcare organizations, social media activities are typically assigned to the marketing or communication department. Such a department appears to be the logical place from which to run social media initiatives, but relegating the effort this way suggests that top management has not bought into the value of social media.

Gleaning Benefits from Inbound Messages

Typically, "outbound" messages (posts that originate from the organization and are transmitted to followers) get more attention than "inbound" messages (posts from followers directed either at the organization or to other followers), but both are equally important because they are critical sources of information.

One benefit of inbound messages is that they provide an opportunity to hear honest opinions, identify concerns, and counter negative or incorrect perceptions. Consumers are talking honestly online about products and people—and the organization must listen. For example, one plastic surgeon found out that some of his former patients were giving him poor reviews on Yelp and Healthgrades. It had never occurred to the surgeon to check review sites or that his practice was being discussed in front of millions of people. After investigating the claims, he found that the reviewers were not downgrading him but another physician with an identical name. Providers cannot ignore this type of feedback, and they should incorporate what they have learned into their marketing efforts.

Another benefit of inbound transmissions is that they contain additional details about patients. Despite the incredible amount of clinical data collected and stored by healthcare organizations, providers really do not know their customers. For many reasons, patients are not reluctant to share many aspects of their lives on social media. Their social media posts give marketers (and providers) a glimpse into patients' life circumstances and other personal factors, providing insights that can be used by providers to better serve their customers.

Developing a Social Media Strategy

As noted by the PricewaterhouseCoopers Health Research Institute (2012), business strategies that include social media can help healthcare organizations take a more active role in managing an individual's health. Thus, organizations need to coordinate internally to effectively use the information gleaned from the social media space and to connect with their customers in ways that build and increase trust. Trying to do this, however, is filled with pitfalls; to avoid them, organizations must provide the right leadership and invest adequate resources. Exhibit 13.6 lists the areas in which organizations may need to invest money and staff (Sargent 2011).

Marketers can transform customer comments and testimonials posted on social media (earned media) into relevant content that may be used for personal sales, advertising (paid media), and other promotional techniques. Additionally, marketers may tap into social media chatter to gauge public perceptions of the organization, its staff, and its services and to de-escalate any bad publicity.

The quality of the content disseminated through social media is important. It needs to be authoritative, interesting, and shareable. As patients are now responsible for a greater share of their medical costs, they want information that will guide their decision-making. However, patients are not interested in just any content; increasingly they desire content that is tailored to their particular needs and interests. Contemporary marketing efforts can identify user interests and deliver timely, personalized, and relevant content

Social media consultation may be helpful in the following areas:

- **Social media strategy.** What are your goals? Where will you invest your time on social media? What is your message? How can you monetize your social media efforts? Are you looking for a hard or soft return on investment (ROI)? A social media strategist can work with you to address these questions and formulate a plan that works for your business.
- **Social media policies.** Once you have a plan in place, you need to establish social media policies. These are guidelines for your staff that cover appropriate use, showing employees where they are empowered in social channels, and where they need to exercise caution. Well written policies can be priceless, so it's worth investing in a custom policy for the organization.
- **Social communications calendar.** When do you post on your blog? What goes on Facebook? How often should you tweet? What do you say? A communications calendar can help you plan social media content that aligns with your strategy, enabling staff to express your messages in the right way at the right time.
- **Outsourced engagement.** Hiring someone to tweet and post on your behalf may sound good, but this is an area where caution should be exercised. There are many risks if you outsource the voice of your business, and the cost to your reputation can be high when things go wrong. With that in mind, if you choose to outsource your tweeting, posting, and blogging, hire someone you can work closely with to collaborate on plans and create content.

Source: Reprinted with permission from Claravon Consulting Group.

EXHIBIT 13.6
Social Media Areas That Require Resource Investment

on a one-on-one basis. This represents an opportunity to direct display ads to users who have expressed an interest in a topic or activity.

Social media strategies must be optimized for mobile phone use. The majority of Americans use smartphones as well as computers and tablets for enhanced connectivity. For most, however, the smartphone is the first point of contact. The phone is always in hand, offering the opportunity for sending and receiving e-mail, text messages, and other social media communication, as well as to perform immediate internet searches. The use of smartphones adds another dimension involving location-based marketing. Patients and

prospective patients can be alerted to options that are located near them, allowing providers to detect and adapt to the personal preferences of their target audience.

This section provides guidance on the steps involved in developing a social media strategy (see Hootsuite 2019b). The process of developing a social media strategy is similar to the planning processes discussed elsewhere in this book. The sequence of steps should be taken as a guideline, with the option of modifying the sequence to suit the organization's needs.

Set Goals and Objectives

The first step in developing a social media strategy is to establish goals and objectives for the initiative. Without setting goals, it is impossible to measure success or ROI. These goals should align with the organization's overall marketing strategy, and different goals may be established for each social media platform. Doing so not only makes it easier to gain buy-in from administrators for social media initiatives but also allows the project to contribute to organization-wide marketing objectives. A common approach to establishing objectives is based on the SMART model: Objectives should be specific, meaningful, actionable, relevant, and time-bound.

Understand the Audience

Understanding the audience and what its members want to see in social media is key to creating content that will generate a positive response. This information also provides guidance on converting social media followers into customers. Administrators need to be engaged with social media to learn from people talking about the organization and the industry online.

Create Audience "Personas"

Knowing who the organization's audience is and what they want to see on social media is key to creating content that they will like, comment on, and share. This knowledge is also critical to converting social media followers into customers. Assumptions should not be made about the audience, as they are often incorrect.

One approach is to create audience "personas" based on demographics, buying motivations, buying objections, and the emotional needs of customers. Such personas can help the organization create campaigns that speak to the real desires and motivations of buyers.

Social media analytics can also generate valuable information about who followers are, where they live, which languages they speak, and how they interact with the organization's brand on social media. Using these insights, the social media strategy can be refined, and social media ads can be targeted more effectively.

Understand the Competition

A competitive analysis allows the organization to understand who the competition is and what they are doing well (and not so well). It provides a sense of what is expected in the industry and offers guidance in setting social media targets. It may be advantageous to focus on networks in which the target audience is underserved, rather than trying to win followers away from a dominant competitor.

"Social listening" is another way to keep track of the competition. This involves monitoring traffic on social media sites. By tracking competitors' accounts and relevant industry keywords, strategic shifts in the way competitors use their social media accounts can be observed.

Conduct a Social Media Audit

Conducting a social media audit can help the organization assess the effectiveness of its social media initiatives. For social media tools already in place, it is important to step back and look at what has already been accomplished. Once this information is gathered in one place, it will offer a starting point for refining the strategy.

The audit should provide a clear picture of the purpose that each social media account serves. If the purpose of an account is not clear, its value should be reconsidered. It may be a valuable account that just needs a strategic redirection, or it may be an outdated account that is no longer worth your while.

Set Up Social Media Accounts

When choosing which social channels to use, a strategy should be defined for each network. For example, Twitter might be used for customer service, Facebook for customer acquisition, and Instagram for engaging existing customers. A mission statement for each network allows the developer to focus on a specific goal for each account on each social network.

Capitalize on Best Practices

While it is important that a brand be distinctive and unique, the experiences of other businesses should not be ignored. All social networks feature success stories that highlight how brands are using their tools effectively. Examples of brands that are at the top of their social media game can be found among winners of the Facebook Awards or Shorty Awards.

Create a Social Media Content Calendar

A schedule should be in place for adding content to achieve the maximum impact. A social media content calendar needs to account for the time that will be spent interacting with the target audience.

The social media content calendar lists the dates and times for posting new content on each channel. The calendar ensures that posts are spaced out appropriately and published at the optimal times. It should include both daily posts and content for social media campaigns.

The calendar should reflect the mission statement assigned to each social profile, so that all content supports the organization's business goals. For example, a social media content calendar might specify the following:

- 50 percent of content will drive traffic back to the organization's blog
- 25 percent of content will be curated from other sources
- 20 percent of content will support enterprise goals
- 5 percent of content will be about the organization's employees and company culture

Once the calendar is set, scheduling tools (e.g., Sprout Social, Kronos, Zoho) can be used to prepare postings in advance rather than updating constantly throughout the day. This gives staff time to focus on crafting the language and format of the posts, rather than writing them on an ad hoc basis.

Test, Evaluate, and Adjust the Strategy

The social media strategy is an important document for the organization, and it is not likely to be exactly right on the first try. As the plan is implemented and results are tracked, the organization may find that some strategies do not work as well as anticipated, while others work even better than expected.

In addition to using the analytics tools available in each social network, tracking parameters can be used to monitor visitors as they move through the website to determine exactly which social media posts drive the most traffic to the website.

Reevaluate and Refine

Once data start coming in, the social media strategy should be reevaluated. This information can be used to test different posts, campaigns, and strategies against one another. Constant testing reveals what works and what does not work, allowing for strategy refinement in real time. Surveys are an effective way to gauge how well a strategy is working. Social media followers, e-mail correspondents, and website visitors can be asked whether their needs and expectations are being met and what types of content they would like to see more of.

The social media strategy should be a living document that is monitored and adjusted regularly. Developers should not hesitate to make changes so that the strategy better reflects the organization's changing goals, tools,

and plans. Changes should be shared with everyone on the social media team so that they can work together to make the most of the organization's social media accounts. Case study 13.2 presents an example of one organization's social media strategy.

Case Study 13.2
Hello Health: A Successful Cybermedicine Model

Hello Health, a Brooklyn, New York–based primary care practice, is a virtual concierge service that eschews the limitations of insurance-based medicine. It is popular and successful, largely because it employs powerful social media tools and web-based technology. Patients can go to their doctor's Facebook page to read about his or her personal interests. Patients who need a consult but cannot visit the office can send an instant message to their physician for quick and free advice. For complicated issues, patients are asked to come into the office. Appointments are booked online, and most communication is done electronically.

Many of the services that Hello Health offers require a nominal signup fee, which allows patients to participate in "cybervisits" with their personal physician. More than 300 patients enrolled in the year it launched, and the high demand forced the practice to open another office. Because it was a software company first and a healthcare entity second, it ensured that its participating practices were at the cutting edge of cybermedicine. The Canadian software company Myca, which established Hello Health and markets its products, provides practices with back-office support, such as billing for remote care.

Hello Health has found that important by-products of using social media and web capabilities are patient-centered healthcare and patient happiness. For healthcare consumers who do not have health insurance or are underinsured, the Hello Health model has particular appeal. For a fraction of the cost of an insurance premium, an enrollee can get easy access to a physician but pay only when care is rendered.

Source: Adapted from Hawn (2009).

Case Study Discussion Questions

1. How is the Hello Health practice different from most physician practices?
2. What unusual services does the practice offer?
3. How does the practice employ social media for customer service?
4. What are the benefits of this innovative practice arrangement?

Monitoring Social Media

Social media monitoring entails tracking the content of social media channels, especially those controlled by the organization (owned media). Monitoring is important for determining the volume and general sentiment of online chatter about a topic or the organization's brand, products, services, staff, or providers. Media monitoring has a long history in marketing, and it is now being applied to social media.

In addition, social media can be "mined" to assess a brand's visibility, measure the impact of promotional campaigns, identify opportunities for engagement, discover competitor activity, and curb or anticipate crises. It can also alert marketers to emerging trends—the goods and services prospective customers might be interested in, what technologies they are using or prefer, the questions and concerns they are raising, and so on. Understanding these buying signals can help marketers and salespeople target relevant audiences and design the most appropriate campaigns.

Because of the volume of activity and the many social media conversations that are private, monitoring social media has become a challenge and a full-time activity. However, marketers may use free or proprietary monitoring and analytics tools, such as Hootsuite, Klout, SDL, Argyle Social, and Back-Tweets, to name just a few. The data and insights gleaned with the help of these tools can influence and shape future business decisions.

Social Media and Ethical Issues in Healthcare

As a result of social media and internet technologies, patients are becoming more informed and increasingly engaged in their own care. Digital media and technologies allow users to exchange information and create media content individually or in community with others. These media are increasingly becoming a tool for supporting healthcare processes, gathering and sharing information, bringing patients and healthcare consumers together, and encouraging social networking and communication about health topics. The evolution of the internet from a limited, technical resource to today's dynamic platform where people are able to share information means that increasing numbers of people living with chronic conditions are now putting personal health information into the public domain, on discussion boards, social network sites, blogs, videos, and virtual environments.

A number of ethical questions arise when it comes to the use of social media in healthcare settings. If a consumer has a Facebook page with 600 friends, is that page considered a private page or a public document? What do researchers need to consider when developing social media monitoring

applications for healthcare? What do health providers have to consider with respect to ethical questions of social media use?

How ethical principles should be applied to online health research is a challenge for researchers as well as for health professionals and patients. *Medical ethics* concentrates on the relationship between patients and doctors. *Public health ethics* deals with the specific moral questions regarding public actions for disease prevention, life elongation, and psychological and physical well-being. Ethical issues in healthcare related to social media include the management of data on children, communications between doctors and patients, the use of patient-reported data, data collected from online surveys, and the recruitment of patients for clinical trials. Underlying all of these ethical issues is the confidentiality and privacy of personal health data.

Some organizations have created institutional policies on the use of social media, but no universal policies are available. Maintaining a respectful and safe environment for patients, the public, and physicians should be the primary goal of all researchers, physicians, and commerce. With respect to the doctor–patient relationship, the information gained from the use of social media technologies must be balanced against the possible misuse or misinterpretation of data. Physicians could conduct social media searches for patients to learn more about their behavior or social circumstances. However, it is unclear how that information should be used in healthcare and how it affects the doctor–patient relationship.

For people in the healthcare industry, the line between professional and personal is particularly difficult to navigate in the digital realm (Canosa 2019). It is natural to want to use social media as a platform to complain, to source new opinions on a difficult subject, or even to brag about a job well done. Social media conduct is a thorny issue in healthcare, where HIPAA rules and patient confidentiality are extremely important, and the rules are easy to break. Sometimes, violations are obvious and egregious, such as a doctor who posted photos of a young female patient being treated for extreme intoxication on Facebook and Instagram, or nursing home staff who sent Snapchat photos of residents in private moments to friends while on the job.

A social media post may seem benign or even friendly but still breach protocol. For example, several emergency department staffers at one hospital were fired for offering their condolences on Facebook for a police officer killed in the line of duty—before his family had been notified. A nurse who posts a selfie with a favorite patient without the patient's consent or makes an identifying comment in a Tweet about a patient who had a heart attack or a young girl who attempted suicide—all of these posts are all HIPAA violations, even if the user's account is private. In most cases, the First Amendment does not protect employees from being fired for social media activity. The right to freedom of speech allows individuals to express themselves

without interference or constraint by the government. However, speech is not protected from private sector disciplinary action.

Social media is just that: social. It is meant to be a public forum, and it should be treated as one. Workers in the healthcare industry need to be especially careful about how they discuss work-related issues online, and they should be aware of how their actions might reflect their ability to inspire trust in a public that requires dependable, quality care. Exhibit 13.7 describes an example of the abuse of social media to spread misinformation.

EXHIBIT 13.7
Social Media
Misinformation
and the
Antivaccination
Movement

Health-related misconceptions, misinformation, and disinformation can be spread on social media, posing a threat to public health. Although social media allow the dissemination of much factual information, it also can be abused to spread harmful health content, including unverified and erroneous information about vaccines. Misinformation about vaccines has the potential to reduce vaccine uptake rates and increase the risks of global pandemics, especially among the most vulnerable patients. Some vaccine skeptics use online platforms to advocate vaccine refusal. Antivaccine advocates have a significant presence in social media, with as many as 50 percent of tweets about vaccination expressing antivaccine beliefs.

The proliferation of such content has consequences: Exposure to negative information about vaccines is associated with increased vaccine hesitancy and delay. Indeed, vaccine-hesitant parents are more likely to turn to the internet for information and less likely to trust healthcare providers and public health experts on the subject. Exposure to the vaccine debate may suggest that there is no scientific consensus, shaking confidence in the efficacy of vaccinations. Recent resurgences of measles, mumps, and pertussis and increased mortality from vaccine-preventable diseases such as influenza and viral pneumonia underscore the importance of combating online misinformation about vaccines.

One commonly used online disinformation strategy seeks to create impressions of false equivalence or consensus through the use of bots and trolls. Bots are accounts that automate content promotion, and trolls are individuals who misrepresent their identities with the intention of promoting discord.

Despite the ubiquity of this phenomenon, the role of bots and trolls in the proliferation of vaccine misinformation is unclear. However, an observational study assessing the impact of bots and trolls on online vaccine

(continued)

discourse on Twitter examined nearly 2 million tweets from 2014 to 2017. This analysis was supplemented by a qualitative study of the hashtag #VaccinateUS, intended to promote discord using vaccination as a political wedge issue. Tweets including the #VaccinateUS hashtag were uniquely identified with Russian troll accounts linked to the Internet Research Agency—a company backed by the Russian government specializing in online influence operations. Thus, health communications have become "weaponized," used to spread misinformation and disinformation by foreign powers. In addition, Twitter bots distributing malware and commercial content (i.e., spam) masqueraded as human users to distribute antivaccine messages, with a full 93 percent of tweets about vaccines generated by accounts whose provenance could not be verified as either bots or human users while tweeting antivaccine misinformation.

Source: Broniatowski et al. (2018).

Summary

The emergence of social media as a communication mode has revolutionized marketing in healthcare and in other industries. Social media have become the primary means of interaction for many segments of society, in the United States and abroad. In addition, social media have proven to be a promising marketing tool. Social networking alone is expected to amass 3.5 billion users by 2019, so marketers cannot ignore social media's wide reach. Perhaps the greatest benefit of social media marketing does not lie in the number of people a marketing message reaches but in the amount of consumer insight those people can impart about a brand, product, or initiative.

The common types of social media are social networks, blogs, microblogs, content communities, wikis, and podcasts. Other types of social media include but are not limited to ratings and reviews, social bookmarking, forums and discussion boards, virtual worlds or gaming, music and movie streaming, and information or data aggregators.

Healthcare consumers' use of social media has exploded. It ranges from exchanging information and sharing experiences on Facebook and disease-specific chatrooms to watching videos on YouTube to reading hospital, provider, or patient blogs to participating in online support groups to researching symptoms and treatments on websites. Social media enable consumers to interact directly with other consumers, physicians and other clinicians, and other resources in real time and from any place. Although still a

controversial use of social media, sharing personal health information online has become a practice for some social media users.

Pharmaceutical companies and consumer health product manufacturers have embraced this mode of communication, creating online communities around their products. Healthcare delivery organizations have started to do the same, going as far as posting professionally produced videos that show their top physicians and staff performing surgeries or explaining available treatments. At the very least, many providers rely on social media to promote their services and upcoming events and to encourage consumers to participate in their programs.

A brand, product, initiative, or content promoted on social media could go viral and garner exposure to millions of social media users all over the world. For this reason, social media channels are viewed as earned media, not paid media. Earned media are the mentions, likes, recommendations, and reposts gained by a campaign that cost nothing but could mean everything, while paid media are ads or sponsorships a campaign buys to attract attention or maintain visibility. Healthcare marketers who employ social media marketing could leverage their owned media (website, blog, Facebook page, Twitter feed, and other channels created, cultivated, and controlled by organizations) with both earned and paid media.

Healthcare marketers should develop a social media strategy that integrates social media with other components of the marketing effort. This strategy should be well thought out and may require the involvement of a social media consultant. Part of this strategy is tracking and analyzing social media activities related to the campaign. Doing so can determine the impact of social media on the initiative's goals and objectives.

Key Points

- Social media revolutionized communications among consumers and between customers and businesses in all industries, including healthcare.
- Social media have the advantage of being free, accessible to all—and in real time and from anywhere—and flexible enough to support content in different formats (e.g., text, images, video).
- On social media, users themselves can provide content, making the traditional gatekeepers of information unnecessary.
- The common types of social media are social networks, blogs, microblogs, content communities, wikis, and podcasts.
- Social media marketing has taken hold in healthcare and other industries.

- Social media are widely used by not only healthcare consumers but also healthcare organizations, including providers, vendors of consumer health products, health insurance companies, and drug manufacturers.
- Different demographic groups use social media at different rates, thereby affecting the marketing strategy.
- Healthcare marketers benefit from being able to push information to social media users and to receive instantaneous feedback from members of online communities.
- Healthcare marketers should develop a social media strategy that integrates social media with other components of the marketing plan.

Discussion Questions

1. Define social media. How does social media marketing differ from traditional marketing techniques?
2. What are the attributes of social media that account for their widespread popularity?
3. What types of healthcare organizations have most rapidly incorporated social media into their marketing efforts?
4. What are some of the barriers to applying social media to healthcare issues and activities?
5. What are the common types of social media, and how do they differ from each other?
6. Why is the notion of user-generated content attractive to users of social media?
7. How have social media shifted the control of information away from traditional gatekeepers of information to the consumers of information?
8. Why is a social media strategy important, and what factors need to be considered in developing such a strategy?
9. What ethical issues are raised when health-related information is shared on social media?

Additional Resources

Healthcare Social Media Monitor: http://hcsmmonitor.com.

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IV

THE MARKETING ENDEAVOR

It is one thing to come up with a marketing idea, but another to develop and implement a marketing plan or coordinate a marketing campaign. To carry out these activities, marketers must understand the entire marketing process and demonstrate campaign management skills. The chapters in part IV address the nuts and bolts of organizing, developing, and implementing marketing initiatives. The marketing process is described from beginning to end, and the support activities that make effective marketing possible—such as marketing research, marketing planning, and marketing data management—are explored.

MARKETING MANAGEMENT

Numerous activities are involved in developing and implementing a marketing campaign. The process begins with a decision to carry out a marketing effort and ends with an evaluation of that effort. This chapter provides a guide through the steps involved in this process. It identifies the players involved and describes how the many components of the process come together to create a marketing campaign.

The Importance of Marketing Management

Marketing management is both an art and a science, and it is particularly challenging in healthcare (see, e.g., Kotler and Keller 2011). Marketing management encompasses the analysis, planning, implementation, and control of programs designed to create, build, and maintain beneficial exchanges with target buyers for the purpose of achieving organizational objectives. In short, it is about overseeing the marketing process from start to finish. Control includes, among other things, measuring and evaluating the results of marketing strategies and plans.

Marketing management has two aspects: (1) managing the process (e.g., forecasting, planning, monitoring, and controlling) and (2) managing the people inside and outside the organization who are involved in the process. The first aspect emphasizes oversight of the structures and resources that support and carry out the functions of the marketing campaign. The second aspect focuses on the direct management of the personnel who perform these functions. Neither aspect is likely to be in place in most organizations, but they are both necessary for marketing to be integrated into the organization's corporate structure.

Marketing management is usually better carried out by a marketing consulting firm or a full-service agency. While specific aspects of a campaign may seem achievable, the absence of an overarching management entity could lead to a marketing disaster.

Strong marketing management is particularly important in healthcare because most organizations have limited marketing experience. They often have diffuse objectives and a range of customers, and they may have a variety of stakeholders with competing agendas. Because healthcare administrators

may be skeptical about the efficacy of marketing, strong controls are required. The negative potential of marketing is also a growing concern in healthcare. Organizations must be careful not to convey the wrong image or appear to be irresponsibly expending resources on marketing. The damage done by a poorly conceived, targeted, or implemented campaign may be hard to rectify.

The form that a marketing initiative takes depends on a number of factors. First, is the intent to develop a comprehensive plan or a specific marketing campaign? Second, is the marketing initiative meant to provide a framework for ongoing marketing efforts, or is it a one-time campaign? Third, is the marketing initiative meant to influence the general public (or at least a broad swath of it) or a narrowly defined target population? The answers to these and other questions should be reflected in the design of the marketing campaign.

Steps in a Marketing Campaign

All marketing campaigns should operate under the assumption that the following conditions are in place:

- The organization is promoting well-defined products that lend themselves to marketing.
- The initiative fits within an established overarching strategic plan.
- Adequate information is available on the potential target audiences.
- The marketers have an in-depth understanding of consumer behavior.

Marketing is not an act but a process. As such, it involves a series of activities or steps that are integrated and appropriately sequenced. These steps must be followed regardless of who is responsible for the marketing function:

1. Organize the campaign.
2. Define and profile the target audience.
3. Determine the marketing objectives.
4. Determine the resource requirements.
5. Develop the message.
6. Specify the media plan.
7. Implement the marketing campaign.
8. Evaluate the marketing campaign.

This section discusses each of these steps and considers their relevance for developing the marketing plan and implementing the marketing campaign.

Step 1: Organize the Campaign

The first step is the planning phase—the foundation on which the rest of the process is built. This step typically involves pulling together appropriate personnel from inside and outside the marketing department. This team is responsible for conceptualizing the marketing campaign. Since marketers often do not have in-depth knowledge about a particular clinical area being marketed, they need input from professional and technical staff. Regardless whether the campaign is long term or short term, a campaign *champion* must be identified—someone who understands the value of and the ideas behind the initiative and thus supports it in the face of obstacles and opposition from within the organization.

To create an effective marketing plan, marketers must understand the problem being addressed, the audiences being targeted, and the environment in which the campaign will be implemented. Marketing research is used to analyze these factors and develop a workable strategy for effecting behavior change. As noted earlier, marketers are assumed to already have a body of relevant knowledge on the service area and its population.

Step 2: Define and Profile the Target Audience

A marketing campaign has, at its core, the wants and needs of its consumers. As discussed in other chapters, these wants and needs are determined through market segmentation analysis and marketing research, which identify the target audience and its thoughts, feelings, and behaviors about the service being offered. These methods include quantitative research (which generates objective data on the target population) and qualitative research (which provides insight into why people think what they think or do what they do). The actions taken to complete this step depend on whether an overall marketing plan or a specific marketing campaign is being pursued.

Healthcare marketers face a challenge that is unknown to marketers in other industries: Not all customers are created equal. Realistically, some have a greater ability to pay for health services than others. Thus, any effort to identify a target audience for a marketing campaign must be tempered by the need to *not attract* certain types of customers. Obviously, this is tricky because many healthcare organizations have not-for-profit status that requires them to provide a certain amount of charity care. Further, all hospitals and medical facilities are ethically required to treat any individuals who present themselves for care. While this is not always observed in practice, marketers must be aware of the danger of appearing to court some patients at the expense of others.

The process of profiling the target market has been discussed in considerable detail. The marketing staff should already possess a general understanding of the characteristics of customers and potential customers in the

service area. For a particular marketing campaign, however, that information may need enhancement so to focus the initiative on the target audience. In addition to demographic attributes and health status measures, the lifestyle attributes of the target audience should be considered, since attitudes, preferences, and desires are likely to feed into purchase decisions.

It is important to judge the readiness of targeted groups to adopt the service or make the purchase. This means determining where in the purchase decision-making process the population is: totally unaware of the product, somewhat aware of the product but not at the decision stage, open to product purchase but not ready to make a decision, current customer who requires reinforcement, and so forth.

Finally, the communication preferences of the target audience should be determined. Doing so involves acquiring information about the types of media the audience responds to, the content that resonates with the audience, the time of week or time of day when the audience is more responsive, and any themes that might reflect the audience's lifestyle (e.g., innovators versus traditionalists; see chapter 5).

Step 3: Determine the Marketing Objectives

The objectives of a marketing plan should be determined within the broad context of the organization's strategic plan. If the focus is on a specific marketing initiative, the objectives that are set should be aligned with those of the overall marketing plan. Here, as elsewhere, the objectives should be specific, include quantifiable concepts, and be time limited. The marketing objectives should be based on where in the purchase decision-making process consumers are or the point in the product life cycle that the particular service is located. The introduction of a new, innovative service illustrates both points—no one is familiar with the new service, and everyone needs to be educated. At the same time, consumers are at the point of information search and nowhere near making a decision about utilization because they are still unfamiliar with the new service.

Step 4: Determine the Resource Requirements

The marketing budget is the part of the overall marketing plan or project plan that projects revenues, costs, and profits. The marketing budget for a specific initiative should consider direct costs such as personnel expenses, marketing research costs, creative costs, production costs, media expenses, and other resource requirements. For initiatives built around advertising, media costs are likely to be the main expense and include the cost of advertising through communication channels such as print, electronic, outdoor, and direct mail. The marketing budget should include the dollars necessary not only for items

such as creative development and media time, but also for personnel, production facilities, and other resources required to carry out the campaign.

Indirect costs may also be significant, although they are often difficult to quantify. Even if the campaign is outsourced, the marketing agency requires some time with internal staff, and some overhead costs are involved. (Budgetary issues are covered later in this chapter.)

Step 5: Develop the Message

The message is a combination of symbols and words that the **sender** transmits to the **receiver**. It is typically based on the results of the research conducted in the planning stages of the campaign. The message embodies the campaign *theme*—the primary topic, motif, or idea around which a promotion is organized—as well as the campaign slogan that the sender wants the receiver to identify with the good or service.

The concepts and materials that are part of the message are usually tested on a group of target consumers to determine how well they resonate with the audience. This information is used to determine the best approach to achieving the campaign's objectives. Focus groups, consumer panels, and other methods can be used to test messages, materials, and proposed tactics. Marketers may have to go back and forth several times between development and testing before the message is finalized.

A positioning concept that reflects how the target audience perceives the product compared with similar products must be developed by the marketing staff and evaluated by members of the target audience. Generally, positioning is based on the product's key selling point(s). Marketers typically select the best positioning statement that emerges after testing different concepts in focus groups or in-depth interviews.

Using the information obtained from concept testing, marketers then create the "final" materials—such as slogans, posters, news clips, videotapes, brochures, public service announcements, and product packaging—and test them through different executions. Members of the target audience can test the materials for memorability, impact, communication effectiveness, comprehension, believability, acceptability, image, ability to persuade, and other key attributes.

With printed materials, the readability of the text is crucial, particularly for audiences with low health literacy. Using short words and sentences can improve readability; word processing programs have built-in readability calculators that measure the readability of text. Readability testing is recommended for materials that include a lot of text, such as long print advertisements, brochures, and information kits. Asking health communication peers and representatives of intermediary organizations to review the text can be helpful.

sender
In communication theory, the party that generates and disseminates a message to the target audience.

receiver
In communication theory, the target audience of a message.

As part of this step, marketers develop a **marketing brief** that lays out the specifics of the campaign (see exhibit 14.1 for an example). A brief is essential if the organization is going to seek bids from external marketing agencies, as they will base their proposals and presentations on the brief. Even if most aspects of the campaign are to be handled in-house, a brief is critical for getting every organizational stakeholder to buy in to the initiative and its objectives.

Step 6: Specify the Media Plan

Campaigns differ in the extent to which they use media. Some initiatives do not even plan on a media component. However, even those that do not involve advertising are likely to distribute press releases or other communiqués that end up in the media (especially in the era of the internet and social networking). Thus, a media plan is essential. The media plan outlines the objectives of the advertising campaign, the target audience, the media vehicles for reaching that audience, and the schedule for communicating the message. The steps of the media planning process are as follows:

1. Define the objectives.
2. Identify the audience.
3. Establish a media budget.
4. Evaluate media options.
5. Select the type of medium.
6. Determine the specific form of that medium.
7. Negotiate media relationships.
8. Develop the media schedule.
9. Implement the plan.
10. Evaluate the plan.

This step applies more directly to a specific marketing campaign than to overall plan development. For example, if the intent is to advertise a service, the marketer needs to consider whether print or electronic advertisement will work best. If electronic, will radio, television, or the internet be used? If television, will the advertisement appear on network or cable channels? If cable, which channel(s) and time slots will be appropriate?

In addition, the media plan must consider—and balance—the reach, frequency, and waste involved. *Reach* refers to the number of people exposed to an ad. *Frequency* refers to the number of times a person sees the ad within a defined time frame. *Waste* refers to the number of people the ad reaches who are not part of the target audience. This last issue is particularly important in healthcare marketing, given that the healthcare organization may not want to encourage the patronage of patients with limited ability to pay for care.

> Amarketing brief contains the details of the campaign to the extent that they are known. The marketing sophistication of the healthcare organization determines the sophistication of its marketing brief. However, even a bare-bones brief gives a marketing agency (if the organization opts to hire an external firm) something to which it can respond.
>
> A marketing brief typically includes the following components:
>
> - Description of the good or service to be marketed
> - Situational information on the organization and the product
> - Objectives of the marketing campaign
> - Proposed marketing strategy
> - Anticipated marketing budget
> - Campaign timelines or target schedule
> - In-house personnel involved and their potential contributions
> - Planned methods of evaluating the campaign's effectiveness
>
> An agency bidding for a campaign will address each of the components listed in the brief. It will offer insights into the marketing challenge, suggest creative and media strategies, indicate the control mechanism it will use, and show how it will assign responsibilities. Further, it will state the terms and conditions under which it will carry out the campaign.

EXHIBIT 14.1
Creating a
Marketing Brief

Step 7: Implement the Marketing Campaign

Campaign implementation turns strategies and plans into actions to accomplish objectives. This is when the initiative is introduced to the target audience and the process shifts from the planning function to the implementation function and from concept to operations. (Note that marketing planning is different from other types of planning in that the same people are likely to be involved in both planning and implementation.) The implementation of the marketing campaign must be monitored to ensure that every element proceeds as planned.

A systematic implementation requires marketers to develop a project plan and an implementation matrix. The *project plan* details the steps in the process and the exact sequence they should follow. It also indicates the relationships between tasks and the extent to which completing some tasks is a prerequisite to accomplishing others. The *implementation matrix* lists every action and breaks down each action into tasks, if appropriate. For each action or task, the responsible party is identified, along with any secondary parties involved in the activity. Resource requirements (e.g., staff time, money) and the start and end dates for each activity are specified as well.

Resource requirements should be priced and added together to determine the total cost of implementing the campaign. This information feeds back into step 4, where required resources are estimated. Once identified, the resource requirements may have to be adjusted in response to available funds and any other fiscal constraints. (See chapter 16 for further discussion of marketing plan implementation.)

Step 8: Evaluate the Marketing Campaign

Evaluation of the initiative should be top of mind from the beginning of the process and, in fact, should be built into the process. Campaign evaluation should include ongoing monitoring, using benchmarks or milestones along the way. Although evaluation is important for all types of planning, it is particularly important in marketing planning. Because the objectives of a marketing campaign are usually highly focused and there is likely to be concern over the return on investment, measures of marketing effectiveness are essential.

Marketing campaigns may be evaluated using two types of techniques: process evaluation (or formative analysis) or outcome evaluation (or summative analysis, which is particularly important for the marketing process). **Process evaluation** assesses the efficiency of the marketing effort, while **outcome evaluation** addresses effectiveness. Effectiveness can be measured in a variety of ways, and most campaigns involve more than one means of evaluation—particularly in healthcare, where the intangible benefits of a marketing initiative may be as important as the tangible benefits.

process evaluation
An assessment of how efficiently a marketing initiative is carried out.

outcome evaluation
An assessment of how effectively a marketing initiative reached its objectives.

While the campaign is underway, process evaluation should take place at each step. It involves media monitoring and analysis as well as assessment of program activities. The key indicators to track include consumer knowledge of the product being marketed, advertising awareness and recall, attitudes and perceptions, images of the product and users, experience with the product, and behaviors (trial and repeat). The target audience should be asked specific questions about the product or campaign (in addition to general questions about attitudes and behaviors regarding the marketing approach) to determine the message's level of penetration. For example, how many consumers can recall seeing the television commercial or reading the newspaper ad? How often have they seen it? What image did the ad convey? While some of these factors will be revisited during outcome evaluation, they serve as markers for process evaluation itself.

Outcome evaluation measures the extent to which the campaign induced the desired change (e.g., an increase in consumer approval or greater patient volume). Impact is often difficult to assess accurately, however. For example, can one public service announcement cause a drop in morbidity and mortality from heart disease? Probably not, but several such efforts may

combine synergistically to contribute to health status improvement. Because campaigns are relatively short-lived, the effect of a particular spot on overall trends cannot be determined. However, one can at least compare mortality and morbidity rates before and after the implementation of, say, a social marketing initiative.

When marketers seek mass media coverage for their promotional activities, they need to be able to evaluate the outcomes of these activities. The most effective way to determine media "hits" is by subscribing to a clippings service. In addition, a media monitoring service—Nielsen Audio, for example—may be used to track the frequency with which a program's public service announcements are broadcast on radio or to monitor television viewing patterns. Today, access to the internet makes tracking media attention much easier, and monitoring social media activity has itself become a business (e.g., customscoop.com).

The most effective way of establishing a cause-and-effect relationship between healthcare marketing campaigns and changes in behavior and health outcomes is to conduct an intervention study in one or more communities, using matched communities as controls. Assuming that no significant differences exist between the intervention and control communities, marketing activities may be linked with precision and reliability to changes in the communities.

Impact evaluation is not often used in the assessment of marketing campaigns in healthcare, especially since their objectives are typically immediate and short term, mitigating the possibility of long-term impact. However, impact evaluation may be used to assess, for example, the long-term consequences of a five-year marketing plan for a social marketing program. Impact evaluation may involve tracking of changes in health knowledge, attitudes, and practices of community residents; assessment of progress toward goals for improved health outcomes; or assessment of the cost-effectiveness of social marketing initiatives. In light of the emerging population health approach and the mandate under the Affordable Care Act to conduct comprehensive health needs assessments, impact evaluation will become increasingly important.

A factor that makes evaluating healthcare marketing campaigns particularly problematic is the difficulty of isolating the campaign's effects. In most industries, changes in knowledge, attitudes, or behaviors can be linked or attributed, with a certain level of confidence, to the introduction of a campaign. For example, an increase in the number of people signing up for the National Do Not Call Registry is the direct result of a multichannel promotional effort. This is not typically the case in healthcare, because so many factors are at play that are outside the control of the marketer or even the healthcare organization. For example, a decrease in the number of obese

children in one community does not necessarily mean that a hospital's family fitness and nutrition campaign was effective; rather it could be the result of a health insurance plan's new restrictions on coverage, inaccurate reporting, changes in the national body mass index standards, parental or physician interventions, school district incentives, competitors' weight loss programs, and so on.

Participants in the Marketing Management Process

The extent to which staff members of the healthcare organization participate in the marketing function or a marketing campaign reflects the extent to which marketing is internalized in the organization. This participation influences how the marketing initiative is carried out. If the function is not internalized, an organization has a number of marketing arrangements to choose from, each with different implications.

One option is to outsource the marketing function. Outsourcing was typical in the early years of healthcare marketing, and it is still common in small organizations—such as physicians' offices—that cannot support an in-house marketing resource. In this case, all of the activities related to the marketing process are handled by an external entity or entities. The process can never be fully outsourced, however; the organization still must provide information on the product to be marketed, offer feedback on marketing strategies, and approve the concepts and materials developed by the marketing agency. Even when marketing activities are outsourced, the organization has to invest time, energy, and money in the process. For example, if key internal staff members have to spend two person-days explaining a complicated service to an external marketer, the organization incurs considerable direct and indirect costs. Unanticipated opportunity costs may also result when an organization diverts resources to participate in the marketing campaign.

A second option is to outsource most of the marketing function and carry out some activities in-house. Organizations that choose this arrangement typically have a marketing professional (a marketing director) on staff but no one else who can perform the required marketing tasks. In this case, the marketing director is responsible for coordinating the process and overseeing the tasks delegated to the contracted agency. Conversely, a large hospital may have full-time personnel to perform marketing tasks in-house but no formal marketing function. The in-house staff may consist of copywriters, designers or graphic artists, website developers, printers, and support personnel but no director to guide the work.

A third option is to farm out aspects of the process that require specialized skills. For example, the in-house marketing department may not have

the know-how or experience in negotiating media purchases or implementing a direct mail campaign. Few organizations can support nearly all of the marketing tasks, and only multifacility health systems can typically support a centralized marketing department. This department coordinates the marketing activities and ensures that all corporate entities convey a consistent message. Even these organizations, however, may rely on outside parties for certain specialized functions such as film production.

The marketing process involves a variety of personnel and departments, depending on the extent of outsourcing. If marketing is fully internal, most of these marketing players are in-house. If it is partially outsourced, some are in-house and others are contractors. If it is entirely outsourced, nearly all are external.

This section discusses some of the entities involved in the marketing process.

Agencies

The term **agency** covers many different entities in the marketing industry. It could refer to a full-service marketing firm; specialty shop; à la carte operation; or any other entity that offers the creative, production, media, account management, or planning services needed to support marketing. It could even apply to an in-house group that carries out agency functions. Although an agency may be referred to informally as an *advertising agency*, it usually provides a wide range of services beyond generating ads. A full-service agency delivers start-to-finish marketing; a specialty agency performs a certain function such as social media branding or internet marketing; and an *à la carte agency* offers a menu of on-demand services customized for the client and provided by separate, independent agencies.

agency
An independent organization that supports one or more marketing functions on behalf of a client.

Some of the functions that marketing agencies perform are as follows:

- Plan marketing campaigns
- Design creative components
- Schedule and buy media
- Design and produce promotional materials
- Provide administration and accountancy functions
- Implement marketing campaigns
- Monitor and evaluate marketing campaigns

Choosing the appropriate agency is an important step and thus should not be taken lightly. Healthcare organizations that want to outsource all or some of their marketing functions must conduct meaningful research on available options. Exhibit 14.2 presents guidelines for selecting an agency.

Many healthcare organizations and their staffers have limited experience dealing with—let alone searching for and hiring—marketing agencies. Although much of the decision involved in selecting an agency is a matter of common sense, the unique aspects of healthcare make this decision a critical one. The following are suggestions that may help in this regard.

Prepare to Engage in an Informative Discussion with Prospective Agencies

The client (the organization), at the very least, must be able to describe the product to be marketed, articulate the goal of the campaign, and talk about other organizational components involved. Some health professionals might argue that they know little about marketing and thus rely on the agency to propose guidelines for the campaign. Even so, the client should drive the marketing process and be able to ask and answer any pertinent questions from agencies.

Specifically, the client should present prospective agencies with a marketing brief. This brief, discussed earlier, contains situational details, objectives, proposed strategy and tactics, target market data, budget and time frames, and evaluation plans. Conversely, the client should request qualified agencies to present their credentials—including examples of current or past projects and descriptions of staff or company experience and capabilities—and other information for the client's review.

Consider Only Agencies That Have Experience in Healthcare Marketing

Remember that the healthcare marketing function is different from marketing in other industries. If an agency does not understand how healthcare operates, the likelihood that it will cause a highly visible marketing gaffe is great. In addition, the client is very likely to spend precious time and use busy staff members to explain basic concepts about health services, payers, and regulations to an uninformed marketing professional.

Seek Agency Recommendations from Other Healthcare Organizations

Healthcare organizations tend to be followers rather than leaders, and in this situation, it is warranted because so few agencies have healthcare

EXHIBIT 14.2
Guidelines
for Selecting
a Marketing
Agency
(continued)

experience. Approaching tried-and-true agencies is more beneficial than vetting inexperienced ones. The client should solicit ideas and recommendations from other organizations because their positive previous experience with an agency may be the best indicator that the agency could work well with the client.

Considering several qualified agencies before selecting the best one is ideal. However, given the nature of healthcare and the services being marketed, this practice seems like a waste of everyone's time. Nine times out of ten, the healthcare client does not need the best agency but a good one that can meet its needs. Here again, recommendations from other organizations ought to assist in the decision. Because healthcare marketing resources are likely to be limited, the client should broach the topic of costs as soon as possible.

DEVELOP AN AGENCY WANT LIST

Some of the traits a healthcare client should want (maybe even require) from an agency include the following:

- Understanding of the client's product and market
- Strong research and planning skills
- Knowledge of the current media landscape
- Creativity
- Adequate internal resources
- Ability to develop effective campaigns

For health professionals in particular, the agency must be easy to work with. Easy, in this case, means the agency's willingness to accommodate the constraints of healthcare marketing, to be considerate of the time demands on health professionals, and to appreciate the client's overall mission.

Some agency characteristics may be more important in healthcare than in other industries. A number of concerns apply here. One is how the agency's culture and management style (which are typically corporate or business driven) fit with that of the client (which are typically not-for-profit and service oriented). Another is potential conflicts between the client's business and the business of the agency's other clients. For example, a hospital that incurs significant costs as a result of treating smoking-induced health problems may not find a comfortable fit with an agency that promotes cigarette manufacturers.

(continued)

> ## NEGOTIATE CONTRACTUAL TERMS
>
> A variety of factors must be considered in developing the project budget, and this net should be cast widely. The client needs to be aware of any hidden costs, especially if it is new to the marketing arena. Agencies without healthcare experience may assume that all organizations already know about hidden or unanticipated expenditures, but that may not be the case with healthcare entities (which cannot easily adjust their budgets). The contract should cover not only the amount of remuneration but also the terms and timing of payments, issues of nonperformance and termination, and ultimate decision-making authority. In most cases, a confidentiality agreement is also a critical component of the contract.

Clients

The healthcare organization is typically the *client* in the marketing process. If the marketing function is internal, the client is typically another department in the organization. The client should not be considered a passive customer but should play an important role in the following functions:

- Stating the justification for the marketing campaign
- Selecting and briefing the marketing agency
- Providing input into and approving campaign plans
- Integrating promotional planning into marketing planning
- Evaluating and controlling the campaign
- Financing the campaign

The needs of the client, of course, drive any marketing campaign, so the involvement of the client at the outset is crucial.

Media Suppliers

media supplier
An entity
that provides
communication
channels for
marketing
campaigns.

Media suppliers include commercial television companies, commercial radio companies, newspaper and magazine owners, creators of posters and other artwork, and other organizations that make media available to the campaign. A complex marketing campaign may require the marketing team to coordinate the activities of a variety of media suppliers.

Promotional Materials Suppliers

A number of other specialty suppliers exist, including printers, promotional gift makers, exhibition organizers, and corporate event planners. These specialty services are bought directly by client companies or managed through the advertising agency.

Marketing Consulting Firms

Marketing consulting firms vary in the services they offer. Some handle one or a few specialty services (e.g., marketing research, media planning, evaluation), while others perform a comprehensive set of activities. Their input may be narrow (e.g., providing a targeted mailing list) or broad (e.g., determining the overall strategic plan).

For a healthcare organization that is new to marketing, hiring a consulting firm should be a foremost consideration. Such a firm will help the organization understand its marketplace, marketing planning capabilities, evaluation skills, and ability to marshal the resources required for a marketing campaign.

marketing consulting firm
An external agency that provides various services to support an organization's marketing function.

Departments in the Marketing Function

Even if the healthcare organization outsources its entire marketing function or a marketing campaign, it should familiarize itself with the common departments of an agency. This section briefly describes the responsibilities of each department.

Creative

The **creative department** houses the "idea people" who write the words (or copy), design the visuals (e.g., pictures, logos, spatial and color placement), and conceptualize all the artistic elements of a campaign or brand. Slogans, promotional websites, catalogs and brochures, jingles, print and electronic posters, interactive computer games and apps, product labels, viral images and videos, television and radio commercials, and multimedia displays are among the myriad creations of this department. Typically headed by an art director or a creative director, this influential department employs both full-time and freelance copywriters, web designers, graphic artists, and other professionals with relevant skills and training. It works closely with the production department (either in-house or contract) to bring some aspects of its artistic vision to fruition.

creative department
The marketing function that generates ideas for a campaign and translates them into words, images, and other artistic content.

Production

The **production department** is responsible for converting marketing ideas into tangible outputs. It is responsible for producing the creative department's ideas, whatever form they may take. Its tasks include laying out posters, printing catalogs, photographing a scene, filming a video that features musicians or actors, and building a website. Like media buying, production is difficult and expensive to fully implement in-house because of the specialized equipment and expertise this function requires.

production department
The marketing function that converts ideas into tangible outputs, such as posters, catalogs, videos, and websites.

Media Planning and Buying

The dual job of determining media needs and negotiating for ad placement is an industry in its own right. This area is fairly specialized and thus may be difficult to effectively bring in-house. The **media planning and buying department** knows the landscape and makes arrangements for the most suitable medium, the best time slots, and the fairest prices for all forms of advertisement. The more central media are to the campaign, the more important this function becomes. If most of the marketing eggs for a particular campaign are placed in the advertising basket, then identifying the appropriate medium, determining how to best use it, and negotiating a favorable contract are critical tasks.

Account Management

The **account management department** consists of account managers who serve as the primary contact for an internal or external client during a marketing campaign. Account managers attend all planning meetings, write activity reports, coordinate tasks, present marketing research findings, and communicate feedback or comments to their clients. They are ultimately responsible for the client's satisfaction with the agency and the marketing management process.

Traffic

The **traffic department** is responsible for delivering the copy, image, film, audio, poster, and other promotional content to the media channel (e.g., radio station, movie or television studio, website, publishing office, printer) on time. When the campaign is distributed through multiple types of media, traffic coordination becomes complicated, requiring several modes of transmission or transportation.

The Marketing Budget

Budgeting is tricky in marketing because all the costs of achieving marketing objectives can be difficult to accurately and fully determine. Numerous factors affect the **marketing budget**. Many of them are obvious, but others are not and thus may be overlooked by those not familiar with marketing planning. In addition to direct costs, indirect costs and opportunity costs are likely to be incurred.

Two types of marketing budgets need to be set by a healthcare organization to support its marketing efforts: annual and campaign specific. The annual budget comprises the expected expenditures for the entire fiscal year on *all* marketing activities. The campaign-specific budget includes the expected expenses for just one campaign. The cumulative campaign budgets

media planning and buying department The marketing function that researches, selects, and negotiates with media channels to increase a campaign's media exposure.

account management department The marketing function that interacts and builds a relationship with a marketing client throughout a campaign.

traffic department The marketing function that delivers promotional content to the appropriate media channels on time.

marketing budget The itemized allocation of financial resources to the department or a campaign.

for the year should approximate the annual budget amount. Both budgets help with the following:

- Setting milestones for accomplishing tasks
- Putting all activities in financial terms
- Keeping activities on budget
- Motivating staff members to control their spending
- Making managers accountable for their actions
- Communicating objectives
- Increasing coordination among all business units, departments, and relevant staff members

In general, a healthcare organization or an agency budgets for the following marketing expenses:

- Salaries and benefits for marketing personnel
- Marketing research
- Creative development
- Production of promotional materials
- Printing (if applicable)
- Postage (if applicable)
- Promotional giveaways (if applicable)
- Media time/space purchase
- Evaluation

Expenses that are indirectly attributable to a campaign may include the following:

- Administrative (management, secretarial, accounting, and other similar services):
  - Salaries of directors, managers, and office staff
  - Rent and associated costs
  - Insurance
  - Telephone and postage
  - Printing and stationery
  - Heating and lighting
  - Distribution and selling
  - Salaries of marketing and sales directors and managers
  - Salaries and commissions of sales staff
  - Travel and entertainment used by salespeople

As noted in previous chapters, nonmarketing staff devote a considerable amount of their time to working with marketing personnel to develop the marketing plan or marketing campaign. As a result, the organization not only incurs direct costs of nonmarketing staff's involvement in the marketing function but also experiences considerable disruption in its operations.

Other factors that could affect the size of the marketing budget include the following:

- Geographic market to be covered
- Type of product (e.g., industrial, consumer durable, consumer convenience items)
- Distribution of consumers
- External factors (e.g., competitors' promotional budgets)

Return on Investment

return on investment (ROI)
The value and benefit received in exchange for the resources given.

Healthcare administrators have been concerned about the costs and perceived benefits of promotional activities since marketing was introduced into healthcare. Of particular concern is the **return on investment (ROI)** for marketing dollars. This concern is heightened when a national economic downturn (e.g., the Great Recession of 2007–2009) exacerbates the ongoing financial pressures facing healthcare organizations. The 2018 results of an annual survey conducted by the American College of Healthcare Executives indicate that finance-related challenges have long been top of mind for hospital and system leaders. The survey identified the following financial concerns of healthcare organizations: increasing costs for staff, supplies, and other necessities; Medicare and Medicaid reimbursements; operating costs; bad debt; competition from other providers; and government funding cuts, among other concerns (ACHE 2018).

ROI is the value received in exchange for the marketing dollars and other resources invested. It is typically calculated as a percentage return on the use of specific assets (financial or otherwise). Consider, as an example, the concept of depositing money in a bank account and receiving interest for that deposit. If the annual interest rate paid by the bank is 5 percent, a deposit of $100 accrues $5 in interest by the end of the year. Thus, the ROI is 5 percent.

Of course, ROI calculation is much more complicated in healthcare marketing. For example, consider the ROI of a direct mail campaign for an urgent care center. In this case, ROI is calculated by subtracting the direct costs of implementing the campaign (e.g., advertising agency fees, printing charges, postage and handling expenses) from the value gained from

the campaign (e.g., revenue increase, patient volume growth). Thus, if the campaign cost $10,000 and generated $20,000 in new business, the ROI is 100 percent. Remember that in some cases, the return may be less than the investment, resulting in a negative ROI. This straightforward example, however, involves a number of ambiguities and thus reflects the complications of determining the ROI in an actual healthcare setting.

First, the calculation includes the direct costs but not the total investment, including indirect costs. Indirect costs are expenses associated with marketing research previously conducted, the time and salary of staff who worked with the agency to design promotional materials and profile the target audience, the time of staff who evaluated the effectiveness of the campaign, the overhead of the office space and equipment used, and so on. Typically, the full costs allocated to a campaign greatly exceed the direct costs.

Second, the time frame in which the ROI should be calculated is not defined. Should the marketer wait to measure changes in revenue or other proxy of revenue until the end of the campaign, do so regularly during the campaign, or allow some time to pass after campaign implementation? The last approach suggests that the promotional piece will likely attract only a few consumers immediately after the mailing, but it could spread and attract more people nine months down the road, and thus its effect might be better measured then.

Third, the ROI of a healthcare marketing campaign is difficult to isolate. If the urgent care center recorded an increase in revenue after the direct mail campaign, how much of that increase can be attributed to the campaign? Many factors influence a healthcare consumer's choice of provider (and thus patient volume and revenue), such as changes to health plan provisions, an increase or a decrease in competition, or even demographic changes in the service area.

The indirect benefits of a marketing campaign are additional factors to consider in calculating ROI in healthcare. At first, the urgent care center may concede that, at best, it will break even as a result of the campaign. However, in looking at the bigger picture, the hospital that owns the urgent care center may be counting on the facility to make referrals to hospital specialists, which could result in subsequent hospital admissions by these specialists. Thus, a considerable amount of time may pass before the effects of the campaign unfold. Case study 14.1 illustrates ways in which ROI might be determined for a marketing campaign.

In summary, the following factors affect the marketer's ability to calculate ROI in healthcare:

- Often, significant time elapses between implementation of a marketing campaign and utilization of the service promoted in the campaign.

- Routine checkups aside, most utilization of services is not planned but is a spontaneous response to an unanticipated health need.
- The accounting systems many healthcare organizations use are not designed to generate the type of data necessary to accurately measure ROI.
- Healthcare marketers typically have limited knowledge of financial management and accounting systems.
- Because of the complexity of healthcare, the impact of marketing on operations and utilization is almost impossible to isolate.
- Healthcare involves so many intangibles that traditional measures of ROI may not be applicable.

CASE STUDY 14.1
Measuring ROI for a Marketing Campaign

Southwest Regional Medical Center (SRMC) believed it could boost its orthopedic presence by establishing a service line called the Orthopedics Center of Excellence. To support the center, SRMC recruited three new physicians; bought state-of-the-art equipment; renovated a nursing unit; added nurses and technicians; developed a dedicated web page and linked it to the enterprise website; conducted educational programs for referring physicians; made sales calls to primary care physicians; published articles in local publications; and advertised on radio, on television, in newspapers and magazines, and on the internet and social media. The total investment in the first year for programmatic changes and marketing was $1.6 million.

    To determine ROI for the center, SRMC compared the increase in the center's first-year income with the incremental revenue the orthopedics services generated. In the 12 months before the center was established, orthopedics-related services generated $4.5 million in net revenue. In the 12 months after the center's launch date, the center generated $7.9 million in net revenue. On the basis of incremental gain and net revenues, SRMC realized ROI of 76 percent. This figure assumes that the gain resulted from the center's creation and would not have occurred otherwise.

    Some argued that in addition to direct investment in the service line, indirect contributions (e.g., spillover services provided by other departments) should be figured into the calculation and added to the total cost. SRMC's

(continued)

administrators asked the marketing team to isolate ROI for the programmatic investments and marketing expenditures. The team found this task extremely difficult, given the extent to which the different aspects of the service line were intertwined. The marketing team determined that it would need to employ more sophisticated accounting processes to factor out ROI for specific components of the service line.

This case highlights the pitfalls of taking ROI analysis too far. Calculating ROI for the entire investment makes sense, but attempting to calculate ROI for every element probably does not. SRMC concluded that its evaluation efforts would be better spent developing other indicators of tangible and intangible benefits of the service line initiative, such as the public's top-of-mind awareness of the center, new referral sources, consumer inquiries, and so forth. Although SRMC was pleased with the overall ROI generated through enhanced operations and the multipronged marketing effort, it was justifiably cautious about carrying ROI analysis too deep into the program.

Case Study Discussion Questions

1. What factors influenced SRMC to consolidate its orthopedic services under the service line model?
2. What programmatic changes were made to establish the center?
3. What marketing options could SRMC have considered, and why do you think it chose the options it did?
4. Aside from net revenue, were there other tangible and intangible measures that SRMC could have used to evaluate the campaign?
5. What caveats must be observed when trying to isolate ROI for program components?

Summary

Developing and implementing a marketing campaign comprises a number of steps. The process begins with a decision to embark on a marketing initiative and ends with the evaluation of that effort. The extent to which the staff members of the healthcare organization are involved in the process depends on the extent to which the marketing function is internalized.

A healthcare organization has a number of options when faced with having to perform marketing, ranging from total outsourcing to developing

the full range of marketing capabilities in-house. Each option has different implications. The organization's circumstances determine the extent to which these tasks are internalized. The extent to which the process is incorporated into the operations determines the amount of control and responsibility the organization retains. Even in the case of an outsourced marketing function, staff can expect to spend substantial time interacting with marketing personnel.

The marketing function and campaign involve a variety of personnel and departments, depending on the extent of outsourcing involved. Health professionals and organizations should become familiar with marketing agencies, marketing consulting firms, and marketing departments and their responsibilities. Every marketing initiative requires interaction with at least some of these entities.

Managing a campaign requires coordinating a sequence of activities: establishing a planning team (and identifying a champion), defining the product, identifying the target audience, specifying marketing objectives, and developing a marketing strategy. Subsequent steps include developing the message and identifying the mechanism for delivering it. Finally, the marketing concept needs to be pretested and modified as appropriate before the campaign is implemented.

Evaluating the marketing initiative should be top of mind from the outset of the process and, in fact, should be built into the process. There are two primary evaluation functions: process evaluation and outcome evaluation. Both have a role to play in the project, although outcome evaluation is particularly important in that it assesses how the campaign induced the desired change. Impact evaluation may be employed to measure the long-term impact of a marketing initiative on the target audience.

The organization sets two kinds of marketing budget: an annual budget for the general function and a campaign-specific budget for a single initiative. Both budgets should consider direct, indirect, and hidden costs. In healthcare, indirect costs are often significant, especially if personnel are pulled away from their core functions to work on the marketing campaign, thereby disrupting the regular operation of the organization.

Campaign effectiveness can be measured in a number of ways. Most projects need more than one means of evaluation—particularly healthcare projects, in which evaluation of the intangible benefits of a campaign is often as important as evaluation of the tangible benefits. The ability to measure ROI has become increasingly important in today's financially challenged environment. Healthcare marketers must be able to demonstrate the value and benefits (both tangible and intangible) that result from marketing activities.

Key Points

- The marketing of any product is not a single activity but involves a set of sequential activities.
- Healthcare organizations have a variety of marketing options—from outsourcing the entire function to developing an in-house capability to outsourcing certain aspects of the function. Because the organization's staff must be involved in designing and implementing a marketing campaign, the function can never be fully outsourced.
- The eight steps in a marketing campaign include organizing the campaign, defining and profiling the target audience, determining the marketing objectives, determining the resource requirements, developing the message, specifying the media plan, implementing the marketing campaign, and evaluating the marketing campaign.
- During the implementation step, the marketer should develop a project plan to integrate the disparate activities of the campaign and an implementation matrix to facilitate the effort.
- Campaign evaluation is an important but often neglected aspect of the marketing process.
- Process evaluation assesses the campaign's efficiency, while outcome evaluation assesses the campaign's effectiveness.
- The healthcare organization and health professionals must interact with a variety of marketing personnel and departments, so they must familiarize themselves with these players' responsibilities.
- An in-house marketing function should have capabilities that are similar to the departments of a marketing agency or consulting firm.
- The marketing budget—whether for the overall marketing function or for a particular campaign—should be carefully thought out and managed.
- Marketing activities typically involve considerable direct, indirect, and hidden costs.
- Marketers should be familiar with the concept of calculating ROI and the factors that could affect ROI.
- Marketing management involves managing both the marketing process and the people involved in this process.

Discussion Questions

1. Why is the careful planning of a marketing campaign considered so important?

2. What is a marketing brief, and why is it important to the marketing process?

3. What role might the marketing agency play in developing and implementing the marketing plan?

4. How active a role should the healthcare organization play in the marketing process if the actual marketing activities are outsourced?

5. What departments are usually included in a marketing function, and what responsibilities do they have?

6. What indirect costs must an organization factor into its marketing budget?

7. Why is strong marketing management probably more important in healthcare than in other industries?

8. In what ways are process evaluation and outcome evaluation in healthcare somewhat different from those in other industries?

9. Why should marketers use a variety of means to evaluate a marketing campaign? To evaluate different marketing techniques?

10. Why is measuring ROI more of a challenge in healthcare than in other industries?

Additional Resources

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MARKETING RESEARCH

Any marketing effort inevitably involves marketing research. Marketing research encompasses market, product, pricing, promotional, and distribution research. Its purpose is to identify the nature of the product to be marketed, the characteristics of consumers, the size of the potential market, the nature of competitors, and other relevant factors. This chapter discusses the marketing research process and its role in healthcare.

Marketing research should be distinguished from *market research*. Although these terms are often used interchangeably, they have different meanings. Marketing research is a broad concept that refers to *any* research performed in support of a marketing plan. Market research is a narrower concept, referring to research on a particular market. Market research is one component of marketing research, which also includes activities such as locational analysis, competitive analysis, pricing research, environmental scans, and other research-related activities that support the marketing planning process.

The Scope of Marketing Research

Marketing research should provide the foundation for any marketing endeavor. While health professionals have come to appreciate the role of marketing, they have been slower to appreciate the importance of marketing research. Yet marketing research is critical for every aspect of the marketing process.

In the past, a qualified researcher needed to be only somewhat familiar with demographic data and able to conduct a patient satisfaction survey. That is no longer the case, however; modern researchers now must be knowledgeable of the extensive array of tools, techniques, and technology needed to carry out a broad range of research activities. Researchers today are asked to address issues that would have been considered beyond their expertise and purview decades ago.

Marketing research is intended to answer a range of questions, from a focused query such as "How will customers react if we raise our monthly fitness program fee from $40 to $60?" to a broad query such as "How will the integrated delivery system planned by a competitor affect our market share?"

Research is expected to contribute to narrow and broad marketing functions, such as the following:

- Determining the appropriate location for a facility
- Identifying employers' needs for the healthcare of their employees
- Discovering whether a particular market could support a certain service
- Evaluating the level of demand among providers for a new type of equipment
- Measuring patient or customer satisfaction with a health plan or service
- Identifying appropriate market niches for a facility in a highly competitive market
- Ascertaining the potential business for a national chain on the local level
- Discerning the types of services desired by a community
- Determining the size and characteristics of the audience amenable to marketing
- Determining the impact of the Affordable Care Act (ACA) on the local market

Today, it seems that most (if not all) components of healthcare can benefit from the application of marketing research. Exhibit 15.1 presents contemporary examples of healthcare marketing research initiatives.

EXHIBIT 15.1
Healthcare
Marketing
Research
Vignettes

The following are snapshots of the types of research activities undertaken in today's healthcare environment.

IDENTIFYING UNMET HEALTHCARE NEEDS

To plan its services, a faith-based clinic engaged a market researcher to identify segments of the population affected by untreated health problems. The researcher collected demographic data and health-related statistics on the service area to identify high-risk populations and their healthcare needs. On the basis of this information, the researcher determined the level of health problems among the sample and the extent to which the problems were being treated. (Today, of course, the impact of the ACA would have to be taken into account.)

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EXHIBIT 15.1
Healthcare
Marketing
Research
Vignettes
(continued)

Evaluating a Market's Potential

A clinical psychologist was interested in establishing an outpatient eating disorders program. The psychologist engaged a marketing researcher with expertise in behavioral health to explore the market potential for such a program. The researcher identified the characteristics of the people most likely to be affected by eating disorders, developed an estimate of the number of potential cases in the community, and assessed the strength of competitor programs.

Monitoring Changing Market Characteristics

Physicians in an obstetrics and gynecology practice noticed a decrease of younger obstetrics patients but an increase in older gynecologic patients, so the practice engaged a market researcher to identify the reasons. The researcher found that the community demographics were changing along with the national trends: The birth rate among people of childbearing age—in the community and nationally—was the lowest in decades, and more seniors were moving into the practice's service area. The researcher provided the information that helped the physicians determine the feasibility of switching from an obstetrics-oriented to a gynecology-oriented practice.

Conducting a Feasibility Study

Many members of a hospital's medical staff had relocated to a distant suburb to take advantage of an emerging market there. The hospital's administrators began to consider establishing a satellite facility there, so they requested the market research department to assess the feasibility of this idea. Using computer-based algorithms to project demand, the researchers were able to determine the numbers and types of physicians this population required and the potential business a new facility could bring in.

Predicting the Changing Demand for Inpatient Care

The inpatient census at one hospital had been steadily declining, and some nursing units had already been closed. The hospital's administrators wondered whether the downward trend would be short term or the "new normal," so they engaged the market research department to review past utilization patterns. The data indicated a short-term decline in inpatient

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EXHIBIT 15.1
Healthcare
Marketing
Research
Vignettes
(continued)

demand but projected a steady increase in the near future as the population ages and develops chronic conditions.

DETERMINING A SOCIAL MEDIA TACTIC

A local public health agency wanted to use social media to reach out to youth aged 13 to 21 in an effort to reduce the rate of HIV infection among that population. The agency hired an expert in market research to determine the extent of social media use and the specific types and platforms preferred by young people in the community. Results of this research would dictate what the message should be and how it would be transmitted so that it could quickly spread and resonate with the target population.

Changes in Society and Healthcare

The expansion of the scope of healthcare marketing research reflects a number of changes in American society and the healthcare environment. First, the "customers" for marketing research have grown in number and type. Historically, the main users of health-related data and information have been hospitals, health systems, and some for-profit entities (e.g., pharmaceutical companies). Today, any group that provides or is involved in direct patient care—such as clinics, physician practices, home health agencies, urgent care center networks, and managed care organizations—can be considered users. Demand for market data has soared; for example,

- Human resources departments need information on the future labor pool.
- Finance departments need demand projections to forecast future revenue.
- Managed care departments need detailed data to negotiate contracts with employers.
- Patient care departments need anticipated future volumes for planning purposes.
- Facilities planning departments need future demand estimates to allocate floor space appropriately.
- Physician relations departments need information for medical staff development purposes.

Second, the scope of strategic planning has broadened. Gone are the days when marketing research focused primarily on measuring the corporate

image or supporting advertising campaigns. Research now covers analysis of human resources, assessment of managed care, evaluation of facilities for acquisition, assessment of the impact of competitor activities, and justification of the organization's tax-exempt status among others. Involvement of researchers is limited only by the organization's range of services and salient issues.

Third, the subjects for healthcare marketing research have multiplied. At one time, patients and the general public were the primary targets of market researchers. Today, the subjects include patients or end users, families, employers, employees, medical staff, other clinicians, and caregivers. Almost every segment of the service area is relevant to researchers in one way or another.

Fourth, new research techniques continue to be developed and implemented, while old techniques are constantly revised to keep up with industry developments and technological advances. Contemporary geographic information systems, for example, have transformed the simple mapping of health-related phenomena into increasingly sophisticated spatial analyses. In addition, social media, data collection and data analysis software, online surveys, and other technology-based methods have become available.

Fifth, the disciplines from which market researchers are drawn have increasingly become diverse. Healthcare, more so than other industries, demands a multidisciplinary approach to research. Qualitative techniques often require a different type of expertise than quantitative research, and as more innovative methods emerge, the need for analysts with training in sociology, anthropology, demography, epidemiology, and organizational development (to name a few disciplines) will increase.

Contributions to Healthcare Decision-Making

Healthcare has become more market driven, and data generated through market research drive marketing. The characteristics of the market can no longer be ignored. In this context, *market* refers to much more than the target population, including the social and cultural milieu, community health conditions, policies, and reimbursement practices. More and more, the market's needs are determining the types of healthcare goods and services offered.

Today's healthcare environment calls for a more aggressive approach to research. Marketers must be constantly on the alert for new market opportunities and aware of threats to the organization's market share or financial viability. In addition, researchers must have monitoring capabilities in place that will flag any out-of-range statistics. For example, if a researcher maintains a database on physicians in the market area, the researcher should be able to identify a community in which a shortage of physicians is emerging.

The growing diversity of US consumers—including healthcare users—has made research central to marketing. Once the importance of consumers

was recognized in healthcare, they were subjected to the same segmentation processes as consumers in other industries. The US population has become more racially and ethnically diverse, has maintained and even accentuated regional differences, and has adopted lifestyles disparate enough to be daunting to any marketer (Thomas 2003b). As a result, the characteristics of the healthcare customer have changed, and health behavior has become less predictable.

For many types of services, the market is no longer growing. A good example is the slumping demand for inpatient care and the rise of outpatient care (Kutscher and Evans 2013). The success of inpatient programs, therefore, will rely on retaining existing customers and requiring providers to know more about them than ever before. However, anticipating future demand is also important. For example, newly insured individuals (as a result of the ACA) who may not have had previous primary or preventive care are entering the healthcare system. The needs of these healthcare consumers should be factored into the marketing equation.

Other factors also make research an essential fixture in healthcare decision-making. Organizations can incur tremendous costs if they locate a facility at a problematic site, undertake a marketing initiative at the wrong time, overlook a key niche market, or develop misleading product packaging. The costs involved in building and outfitting a clinic, mounting a marketing campaign, and developing a product are growing. Similarly, failure to discern the causes of expensive readmissions could result in serious consequences for hospitals. Losses associated with one bad decision may need to be countered with ten good decisions for the organization to recover.

Even more important in an environment of increasingly scarce resources are the opportunity costs of a wrong decision. Situating a clinic in one place means that other potentially more favorable sites were not selected. Money spent on one promotion cannot be spent on another that may yield higher returns. Product development resources spent on one service could have been spent on another possibly more profitable service. By overlooking a critical niche, an organization may have invited a competitor to outposition it in the market.

Healthcare decision-making relies heavily on accurate, timely, detailed, and complete data. Data supplement the knowledge that the decision maker has acquired through training and experience. Marketing research should be a complement to, rather than a substitute for, an administrator's direct knowledge of the marketplace. The researcher should work closely with the administrator to build the knowledge base for decision-making.

Finally, marketing research should drive marketing strategy. Marketing initiatives should not exist in a vacuum but should support an overarching marketing strategy, which, in turn, should support the organization's

long-range strategic plan. If, for example, research indicates that the organization is a niche player (and the public perceives the organization as such), the marketing strategy should capitalize on this positioning. On the other hand, if the organization is perceived as the leader in its service area, the marketing strategy should likewise capitalize on this view.

Steps in the Marketing Research Process

Any type of information gathering on the marketplace constitutes marketing research, so a formal, expensive research process is not always necessary. Although this chapter focuses on a more formal approach, healthcare organizations may also pursue a less formal approach based on observation and data collection through networking.

In an ideal world, marketing research is an ongoing organizational function. It is not practical to initiate discrete research projects from scratch to support each new campaign. By the time an organization implements a data collection process, the campaign is likely to be over. However, with ongoing monitoring systems in place, the organization could, for example, track changes in physician referral patterns, admission trends, or emerging market niches as they occur.

Marketing research is a multistep endeavor, much like every other marketing activity. While the exact number of steps depends on the campaign and the preferences of the researcher, all research designs include the same basic elements. The process begins with an initial inquiry (e.g., is the management of eating disorders a service worth pursuing?) and ends with a decision (e.g., a pilot program for eating disorders should be initiated). No two research experts completely agree on the steps involved, and some of the limitations that are unique to healthcare (e.g., the sanctity of patient records) distinguish the research conducted in healthcare from that conducted in other industries. The following steps reflect the typical sequence of research activities, although this order is not set in stone. The steps may be iterative and often occur simultaneously, and should in any case be modified to fit the circumstances.

Define the Issues
A marketing initiative is often triggered by some event or situation. The introduction of a new service in the market area, a competitor's anticipated or unannounced move, or the identification of a new market for an existing service are all examples of triggers. Thus, the main task in this step is to isolate the relevant issues connected to the event by developing a precise statement of the situation. This statement may reveal a concern altogether different from the one that initiated the effort, and it could dictate whether the scope

of the market research is broad or narrow. If problems or challenges are not properly defined at this point, the information subsequently generated by the research is unlikely to have much value.

At this point, the marketer should state some assumptions to guide the research design. Are certain audiences more important than others? What issues or questions are off limits? What are the time constraints, if any? These initial assumptions should be refined as more information becomes available.

This step requires a general understanding of the organization and its characteristics, the product, and the market area. Reviewing the literature—journals, magazines, newsletters, government reports, technical papers, presentations from professional meetings, annual reports, and other relevant documents—is an obvious place to start. Unfortunately, healthcare marketing has yet to develop a body of literature comparable to that of marketing in other industries. Marketers, however, have access to bibliographic databases, literature reviews, online archives, blogs, and other references as sources of relevant information (with most sources now available on the internet).

Set Research Objectives

To determine the objectives of the intended research, a number of questions must be asked. For example, what body of knowledge does the organization want to establish through the research process? Who can provide the information needed to inform this initiative? What does the organization want to learn from the research? Answers to these and similar questions determine the research objectives and design.

The objectives that are specified determine the research design. Four general categories of research—exploratory, descriptive, causal, and predictive—should be considered when formulating the design.

exploratory research
Research that discerns the general nature of a problem or an opportunity to identify factors of importance.

descriptive research
Research that describes (but does not explain) the characteristics of a community or population.

1. **Exploratory research** is characterized by a high degree of flexibility and usually relies heavily on reviews of the literature, small-scale surveys, informal interviews and discussions, and subjective evaluations of available data. Its goal is to discern the general nature of the problem or opportunity under study and the associated factors of importance. Exploratory designs are commonly used for initial information gathering at the outset of a marketing initiative. The objective is to gain insights and information, even if anecdotal, that may reveal the usefulness of other categories of research.

2. **Descriptive research** is aimed at the development of a factual portrait of the components of the community or organization. These portraits do not attempt to explain the "why" of the researcher's observations but rather to profile the salient characteristics of the topics under study. Market profiles, community assessments, and resource inventories are

products of descriptive research. Any source of information can be used in descriptive research, although it relies heavily on secondary data sources and survey research. Carefully designed descriptive studies are the bread and butter of marketing research and provide the basis for any subsequent analysis.

3. **Causal research** (also known as *inferential research*) identifies the relationship between two or more variables in the situation under study. For example, a cause-and-effect analysis may be used to discover the link between place of medical training and physician referral patterns. Likewise, a study of the market response to a promotional campaign may isolate and identify how increased advertising, for example, fostered the growth of outpatient visits. Causal research designs infer relationships, given that a direct causal relationship usually cannot be demonstrated. Little of the research conducted in healthcare in the past could be characterized as causal. Although this category has contributed to an understanding of consumer behavior and motivation in other industries, it is only now reaching a level of sophistication to do the same for healthcare.

4. **Predictive research** uses findings from previous research as a basis for forecasting future events and conditions. Predictive modeling is a form of predictive research that has been adopted by some healthcare organizations. For example, health plans and managed care organizations can benefit from identifying at-risk enrollees and predicting (and even influencing) their future utilization of services. Forecasting the utilization of employee health services on the basis of the known characteristics of service users is another example.

causal research
Research that identifies the specific functional relationship between two or more variables.

predictive research
Research that forecasts future characteristics or actions on the basis of known present characteristics.

Develop the Research Plan

The categories of data to be considered, the means of collecting the relevant data, and the indicators and analytical techniques to be used, among other attributes, are included in the research plan. The research plan specifies the sequence in which tasks (of data collection and statistical analysis) are to be carried out, the responsible party or parties, the resources required, and the time frames to be followed.

At this point, decisions must be made regarding which category of data to use—primary, secondary, or a combination of the two. If primary research is deemed necessary, the data collection technique will have to be specified and the questionnaire design, sampling, interviewer training, and other tasks will have to commence.

Because most research is essentially descriptive, the analytical methods used are usually fairly straightforward. Data analysis entails converting a series of observations, however obtained, into information—descriptive statements

or inferences about relationships. The type of analyses that can be performed depends on the sampling process, the measurement instrument, and the data collection method. Analytical approaches can be applied to convert raw data into information that supports the marketing process. An effective marketer is familiar with demographic analysis techniques, epidemiologist-developed methods, and other evaluation approaches.

Estimate Resource Requirements

Time, money, and personnel are required to implement the research plan. If the research is to be performed in-house, resources can be broken down into direct expenses (e.g., the cost of hiring additional interviewers) and in-kind contributions (e.g., staff time, office space, supplies). Time refers to the days, weeks, or months needed to complete the process, as well as to the time commitment required of the responsible parties. Money refers to the financial investment and the monetary equivalent of personnel time, materials and supplies, and other tangible and intangible organizational resources to be expended. Personnel, the largest cost, refers to both internal staff (including those inside and outside the marketing department) and external professionals or contractors who participate in the implementation of the plan. In addition, research imposes opportunity costs that must be estimated to the extent possible. If the process is outsourced to a marketing consultant or firm, the costs are calculated differently.

Project management tools—such as the program evaluation review technique (PERT) and critical path method (CPM)—help in estimating the resources needed and clarifying the manner in which the process is managed. PERT divides the total research plan into its smallest component activities, identifies the sequence in which these activities must be performed, attaches a time estimate for each activity, and presents these details in a flowchart. Marketers can use these same time estimates for CPM, which establishes the critical path for accomplishing the plan objectives. They can then create a chart that indicates the interdependence of the plan's components and the sequence for performing the tasks.

Collect Data

secondary research
The analysis of data originally collected during primary research and for some other purpose.

In selecting the best data collection technique for a particular analysis, the researcher must weigh the advantages and disadvantages of each approach and consider only the methods that will return reliable and valid data. Data collection typically generates both primary and secondary data. Primary research is likely to be used to gather data that cannot be acquired through **secondary research** using existing resources. Secondary data are almost always collected first because they are likely to be readily available at little or no additional expense.

Often, the necessary data are not available, and primary research must be carried out. It may be necessary to conduct interviews to find out current consumer attitudes about such a service, interview key informants to obtain expert opinions and perspectives, or launch a pilot study to measure consumer reception of the proposed service. (The use of secondary data in marketing research is discussed in more detail in chapter 17.)

Because an unlimited amount of data can be collected on an infinite number of topics, the marketer must ensure that the information collected is relevant to the issues defined and that it is actionable, not just interesting. If the data do not contribute to the achievement of research objectives, the time, money, and personnel dedicated to the collection process are wasted. Specifically, the marketer should list the questions that need to be answered by the end of the research period, structure the data collection process accordingly, and determine the actual and potential uses for any information collected.

Analyze Data and Draw Conclusions

The main objective in analyzing collected data is to generate conclusions about the issues defined earlier in the research process. Properly chosen analytical techniques should generate useful findings—whether they are related to market share, utilization trends, or changing consumer characteristics. These conclusions should provide the basis for subsequent marketing activities. Some of them, in fact, become part of the assumptions stated and restated throughout the process. Acquiring and maintaining a desired share of the patient market are always a top priority for healthcare providers. Market share information not only indicates the position of an organization or a service in the market but also serves as a basis for evaluating the success of a marketing initiative. This critical piece of information is often difficult to calculate in healthcare. Case study 15.1 provides an example of a market share analysis.

CASE STUDY 15.1
Market Share Analysis for a Physician Practice

Southeast Orthopedic Clinic (SOC) had long been the premier orthopedic practice in a midsize southern city. Over time, however, competition had become increasingly fierce, and concerns were growing over the perceived erosion of SOC's market share in the community. SOC asked its marketing consultant to analyze the practice's and its competitors' current market share. Because the consultant did not routinely calculate market share, it was necessary to

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gather data for this task. The calculation of market share is relatively straight-forward *if* the required data are available. The formula for calculating market share is as follows:

$$\text{Volume for the practice} \div \text{Total volume for the service area} = \text{Market share}.$$

The numerator could be presented as volume (e.g., office visits or hospital admissions), utilization (e.g., number of diagnoses or procedures), or revenue reported for the practice. The denominator could be the combined figure for the numerator selected (e.g., volume, utilization, revenue) for all providers in the service area. The figure for the practice is then divided by the total figure to generate the percentage of the market controlled by the practice.

The consultant did not know whether the data needed for the calculation were readily available. SOC was presumed to have reasonable data on its own volume, utilization, revenue, and so forth. Comparable data on competing practices were not likely to be available, but data on volume for the total service area likely were. Fortunately for SOC, data on hospital admissions were reported to the state annually, allowing the consultant to determine the overall volume of orthopedic admissions for the service area as well as admissions for types of orthopedic diagnoses. Equipped with data from the state's repository, the consultant was able to determine that 10,000 orthopedic cases were admitted in the previous year. SOC had admitted 2,000 cases during that time, so its market share of the area's orthopedic patients was calculated to be 20 percent.

For confidentiality reasons, the state would not release data on the hospital admissions recorded by other area orthopedic practices. However, this information was available for individual hospitals, and the consultant was able to develop a reasonable estimate of the market shares of hospital patients for the players in the orthopedic arena. Had these data not been available, the consultant would have had to assess the relative status of SOC on the basis of the relative size of the practices (e.g., was the 20 percent market share for SOC commensurate with the size of the practice relative to its competitors?). The consultant was able to further refine the estimate of market share by comparing revenue figures reported to the state by the practices.

The data acquired from the state were useful for refining the market share estimate of the types of patients treated. The hospital data categorized orthopedic admissions by the types of problems seen (e.g., fractures, back pain, torn ligaments). The consultant was able to calculate the practice's

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market share for each of the major categories of orthopedic services. The data indicated that SOC maintained a market share of more than 25 percent for traditional orthopedic services (e.g., hip replacement and back surgery) but controlled less than 15 percent of the market for newer services (e.g., arthroscopic surgery, sports injuries, and knee replacement).

Despite the usefulness of this information, the consultant was concerned that these data did not capture the market share for ambulatory services (i.e., office visits). Office visits for orthopedic services were much more common than hospital admissions, especially because orthopedic care had largely shifted from the inpatient setting to the outpatient setting. In this community, as elsewhere, no repository of data existed for ambulatory services. The consultant was forced to turn to a colleague who provided software-generated estimates of the utilization of different types of services. Using algorithms developed on the basis of known utilization rates, the consultant determined the *expected* volume of office visits for the community, along with the breakdown of those visits by diagnosis. SOC's share of office visits was 18 percent and, as with the hospital data, the share was higher for traditional services and lower for contemporary services.

The consultant reported back to the SOC that, overall, its market share for hospital care was consistent with the size of the practice, but its share of ambulatory patients was lower than anticipated. On both the inpatient and outpatient sides, SOC was more prominent among patients with traditional problems but less prominent among those who sought contemporary treatments.

Case Study Discussion Questions

1. Why do healthcare organizations need to understand market share, and what developments in healthcare are increasing the significance of market share data?

2. What are some of the challenges healthcare organizations face in calculating their market share?

3. Why is it important to go beyond overall market share and disaggregate data by patient type or procedure?

4. How did the SOC market share stack up against its competitors, and in what area was SOC found to be relatively strong? Relatively weak?

5. In the absence of actual data, what approach might be used to develop proxy data as a basis for determining market share?

6. What did the consultant conclude about the position of SOC in its market?

Historically, marketing research was seen as a technical support function. The researcher's role was to turn numbers over to administrators, who would then make the appropriate decision. As marketing issues have become more complex and research methods more sophisticated, decision makers are increasingly asking marketers to offer recommendations. Instead of providing the decision maker with three objectively compared options for review, the researcher is likely to be asked to indicate the best choice based on the results of the analyses. Exhibit 15.2 discusses the interpretation of data gathered through research.

EXHIBIT 15.2
The Pitfalls of Interpreting Research Data

Data interpretation is as much an art as a science, and certain skills and experiences are required to perform it. Interpreting objective data drawn from 1,000 survey forms necessitates an approach that is different from the approach to interpreting observation notes or in-depth interview transcripts. The following are some dangers that analysts should avoid when interpreting data.

First, results are easy to misinterpret. Often, the analysis compares data from two or more groups or for two or more time spans. For example, the satisfaction of a senior program's members may be compared with the satisfaction of nonmembers, or consumers' awareness of a service before a promotion may be compared with that after a promotion. Accepting *any* difference as evidence that a consequential difference exists or that a change has occurred is tempting. In reality, however, only *some* change may be observed. As statisticians are fond of pointing out, there are many types of change—statistically significant change, meaningful change, and so on. Thus, analysts should first determine if change has occurred, then test for statistical significance, and then assess the meaning of the change.

Second, observed change is difficult to fully attribute to the intervention or initiative applied. Cause and effect works well in controlled environments, but in healthcare—even more so than in other industries—many factors are at play (including chance) that influence results. For example, evaluating a campaign to increase admissions for a regional hospital starts out at a disadvantage because audience responses to the promotion are not immediate (i.e., they will not use the hospital right after they see an ad, for example). If this is a six-month campaign, when does the analyst start counting admissions—at the end of the six months, a year after the campaign, or two years later? Even when a reasonable time frame is identified, it is not possible to distinguish one factor's effects from another's. Such factors may include the arrival or departure of physicians, the acquisition

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EXHIBIT 15.2
The Pitfalls of
Interpreting
Research Data
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or loss of a managed care contract, or the opening or closure of a facility in the service area. In addition, determining what constitutes a successful outcome is difficult. Sometimes, simply maintaining the current level of admissions might be considered a success.

Third, failure to qualify the responses generated from a sample survey is equivalent to not getting relevant information. This is a common issue faced by researchers. Take, for example, the overwhelmingly positive response to a proposed hospital-sponsored fitness center. A survey or research initiative that introduces or suggests *any* new service tends to be met with support and agreement. Thus, these responses must be qualified with follow-up questions that give details about the new facility's location, operating hours, amenities, fees, incentives, and so on. When provided some specifics, survey respondents tend to give more practical answers and their level of interest tends to be more tempered.

Fourth, finding that one piece of information that could make or break a decision is complicated. Research yields findings, some of which are more salient than others. For example, a survey that asks health plan members to rate the attributes and offerings of hospitals in the service area may uncover interesting facts, but ultimately, those findings are not relevant. Why? Because plan members usually do not choose the hospitals they use— that is the one piece of information analysts must recognize. Among the hundreds of variables that researchers analyze, only one variable may be deemed useful. For example, a large health system considering the acquisition of an underperforming rural hospital was conducting a feasibility study. Researchers for the system examined all the usual variables: characteristics of the service area population, the state of the facility and its equipment, the referral patterns of the medical staff, and so forth. Researchers found, however, that only one number mattered for the system's purpose: The hospital's market share was more than 85 percent. This variable was crucial because it was not possible to increase that market share and it would be difficult to maintain it in a highly competitive area. In the end, the system decided that the proposed acquisition was not viable.

Present Marketing Research Results

Findings are largely useless unless they are presented to the intended audience or appropriate decision makers in an understandable, actionable fashion. Many executives and administrators cannot easily ascertain the quality of the research plan, methodology, or instrument. They can, however, easily recognize the quality of the report presented. Thus, the quality of the report is often used as an indicator of the quality of the research. Visual displays, such

geographic information system (GIS)
A computer application that collects, analyzes, and organizes data geographically for the purpose of spatial analysis and map generation.

as charts and maps, are particularly useful in painting a clear picture. Exhibit 15.3 describes the **geographic information system (GIS)**, a tool for collecting, analyzing, and presenting data that has been used by market researchers in other industries for decades and is now applied to the healthcare arena. (Visit https://www.cdc.gov/gis/index.htm to see how the Centers for Disease Control and Prevention applies the technology.)

Effective communication of research findings is a challenge for marketers. Typically, marketers present written or oral reports to hospital leaders (including executives and the board), physicians, department heads, financial analysts, venture capitalists, and other health professionals. These are individuals who are well educated and trained in their respective fields and are at the height of their careers, but they do not necessarily have the research background to discern the nuances in the data presented to them. The marketer's job is to explain, clarify, and illustrate the findings as well as possible, keeping in mind each audience's perspectives, biases, and need for information.

EXHIBIT 15.3
Using GIS in Healthcare

Few marketing analyses in other industries would be complete without maps illustrating the distribution of markets, consumer segments, usage rates, and other essential data. Furthermore, the use of spatial analysis techniques in decision-making and developing sales territories is not uncommon in other industries. These functions are made possible by geographic information systems (GIS). Although this technology has been available to healthcare organizations for decades, most organizations have failed to incorporate it into their strategies and operations. That is surprising, given the importance of the spatial dimension for many aspects of healthcare.

Unlimited opportunities exist for adopting GIS in healthcare. GIS-generated maps can display a wide variety of health-related information, including distribution of resources (e.g., hospitals, physicians, urgent care centers), patterns of patient flow, demand for health services, and market share. From a marketing perspective, nothing depicts concentrations of potential customers better than a map. Beyond mapping, GIS can track trends in population growth and demographic patterns, determine drive times to healthcare facilities, compare potential facility sites on the basis of several variables simultaneously, and monitor the progression of disease through the service area. In addition, GIS can be used for specialized applications, such as accessibility analysis for managed care plans.

As GIS becomes more sophisticated but less expensive and easier to use and as the ACA's focus on population health management becomes integrated into providers' operations, the adoption of GIS can be expected to increase.

Primary Research Methods

An industry that undergoes constant changes—new regulations, consolidations, technological advancements, service area expansions, demographic shifts, product introductions, to name a few—requires current, accurate, and comprehensive data. Primary research is used to gather such data.

Primary research is the collection of data for a specific use. One advantage of this type of research is that the data gathered are relevant and current. Another advantage is that the findings remain proprietary (i.e., the organization "owns" the results), which is not the case with data collected through secondary research because the instrument used is from another party and for a different purpose. The disadvantages are that it is an expensive and time-consuming process and the administration of the tools requires sophisticated skills that staff members may not have.

Before primary research activities can begin, marketers need to determine the means of collecting the data. Many methods are available (including the ones described in this section) that fall under the quantitative and qualitative categories. **Quantitative research** (e.g., sample surveys) is considered objective and readily lends itself to statistical analysis, while **qualitative research** (e.g., focus groups) is considered subjective and not amenable to rigorous statistical analysis. Exhibit 15.4 compares the quantitative and qualitative research approaches.

quantitative research
A data collection technique that uses objective methods, such as experiments and sample surveys.

qualitative research
A data collection technique that uses subjective methods, such as observations, interviews, and focus groups.

EXHIBIT 15.4
Quantitative and Qualitative Research

In the past, researchers and managers were enamored with quantitative research (surveys) and statistical analyses. Because quantitative research was a well-established science, healthcare administrators regarded (often erroneously) surveys as easy to conduct. Some administrators even argued against the use of qualitative research, claiming that the data generated were neither scientific nor rigorous.

Quantitative methods present some advantages. They can be subjected to statistical analyses, and their findings can be generalized or applied to other populations. The data collected using quantitative methods are easy to analyze and definitive (at least within a known range of error), instilling confidence in decision-making. The backlash against quantitative methods pushed qualitative approaches to center stage. Some have argued that surveys may yield misleading results, a direct contrast to the reliable data generated through more in-depth qualitative methods (e.g., focus groups, in-depth interviews, and observations). Researchers hail qualitative research for the richness of detail it provides and prefer it (over quantitative)

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EXHIBIT 15.4
Quantitative
and Qualitative
Research
(continued)

in situations in which opinions, choices, and perceptions are sought. Focus groups and interviews with naturally occurring groups are conducted on a regular basis, and observations and content analyses are employed to supplement quantitative research. Qualitative data are analyzed and interpreted in many ways, often using specially developed software.

Admittedly, qualitative methods have their limitations. They cannot be subjected to statistical analysis, nor can they be generalized and applied to other populations. Their contributions are limited to generating broad conclusions and hypotheses. In this sense, they can serve as a guide for designing quantitative research initiatives.

Researchers today recognize the value of both quantitative and qualitative approaches. They may be conducted simultaneously to obtain data that supplement each other. Both also have evolved over the years. Surveys, for example, are no longer composed of closed-ended, yes/no questions; they now pose open-ended questions that encourage respondents to volunteer more detail. Often, the use of both qualitative and quantitative data allows the researcher to triangulate the findings for better-informed conclusions. Case study 15.2 discusses the application of quantitative and qualitative research to a community health initiative.

Case Study 15.2
Applying Quantitative and Qualitative Research to a Community Health Initiative

On the advice of a marketing consultant, a network of faith-based clinics opened a new clinic in a low-income community. This community had once received widespread acclaim for its level of home ownership, the stability of its households, and the achievements of its residents. After one year of operation, the clinic still was not receiving the support it expected from the local community. Area residents were not taking advantage of the services offered by the clinic, even though demand clearly existed. The network's marketing department designed and sent a sample survey to 200 of the community's 3,000 households. It conducted in-depth interviews with key informants, who either lived in the area or had a long history of working with its residents. It

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facilitated focus groups and carried out observational research—all involving local residents.

Findings from the sample survey essentially reinforced the results of the previous market analysis: Respondents reported a high level of morbidity (particularly chronic diseases), a high level of psychiatric morbidity and substance abuse, and a low level of treatment or medical intervention. In addition, more health problems and greater unmet needs were revealed than anticipated.

Observational research added critical layers of information. While the community had a high rate of home ownership, it also had many empty, dilapidated, or abandoned single-family dwellings; trash-filled vacant lots; and crumbling buildings (including the low-rated elementary and high schools). Furthermore, residents had little or no social interaction, even among neighbors. Few adults walked and talked on the streets, and few children played outside. The sight of residents sitting on their porches or working in their yards was rare. Even vehicular traffic was light. The churches that dotted every corner had low attendance and did little community outreach. Many grocery stores and restaurants had boarded up their doors and moved out, creating a "food desert."

The in-depth interviews and focus groups helped qualify the findings from the sample survey and observations. The observed social dysfunctions were primarily rooted in the decline of the quality of housing, which encouraged detachment from the community. Longtime residents felt marginalized, isolated from their neighbors, and afraid to leave their homes. The community's educational system, once the pride of the neighborhood, faltered partly as a result of young families leaving the area.

The marketing researchers concluded that health problems were symptoms of a bigger problem. Faced with so many environmental concerns, the residents accorded their medical conditions and general health low priority. As a result of the disintegration of face-to-face interactions and word-of-mouth promotion between neighbors, most people were unaware that a new clinic had been built in the area. Leaders of the network and the clinic realized that at least some of these underlying issues must be fixed before the community could focus on its health problems.

The combined quantitative and qualitative research methods applied in this case, as well as the triangulation of the findings, did not yield a solution. However, they enabled a community health clinic to peel back the layers to reveal social and health issues that need immediate—even urgent—attention.

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Observation

In *observational research*, marketers watch and take notes of the actions and attributes of research subjects, who are typically in their "natural" setting (e.g., an employee performing a daily task). In this way, information is not elicited directly from the subjects but captured through structured **observation**—with specified rules based on stated objectives. Three conditions must be met to ensure that observation is a successful endeavor:

observation
A data collection technique in which the actions or attributes of those being studied are recorded by either an individual or a recording device.

1. **The activity must be observable.** Motivations, attitudes, opinions, views, and other inclinations are internal and are not visible. Behavior or action, however, can be observed and recorded.
2. **The activity must be generalizable.** Observing one exasperated patient in the physician's waiting room is not a basis for making a generalization about all waiting patients; ten such patients might be. The activity must be one that is repeated, frequent, and predictable.
3. **The activity must not take a long time.** Researchers are usually restricted to observing activities that can be completed in a relatively short time (e.g., a doctor visit) or short segments of activities that take a long time (e.g., an emergency department visit).

Observations are typically used when data cannot be obtained through interviews or secondary sources and when analyzing a process. For example, a trained observer may sit in the admissions waiting area to watch the intake process, or he or she may follow a patient from an emergency department bed to the radiology table to an inpatient room. Some organizations, in fact, hire

mystery shoppers to carry out observational research. The mystery-shopping method often reveals more information than passive forms of observation.

The type and amount of marketing research undertaken are dictated by several factors, such as the nature of the organization, the objectives of the campaign, the available resources, and the intended use of the findings. A critical skill any marketer should possess is the ability to identify the type and scope of research appropriate for a particular campaign. Other industries (e.g., restaurant, retail, hotel) are more accustomed to heated competition, so they frequently use **mystery shoppers** to collect market intelligence. Although blatant efforts to acquire intelligence on competitors meet resistance in healthcare, mystery shopping (though the term *shopper* is not quite accurate) can work to reveal interesting insights. Exhibit 15.5 discusses the use of mystery shoppers in healthcare.

mystery shopper
An individual hired by an organization to pose as a customer to covertly collect information on its own or a competitor's operations, goods, or services.

EXHIBIT 15.5
Mystery Shoppers in Healthcare

To better understand their processes, products, and other offerings, some healthcare organizations have employed mystery shoppers. These are patients or consumers with limited knowledge of the organization or existing employees of the organization. Mystery shoppers may arrive at a facility's front desk, emergency department, doctor's office, outpatient clinic, cafeteria or gift shop, or some other healthcare setting to observe typical procedures, sample certain services, engage employees and other staff, or perform tasks as ordered by the organization. They may call an advertised phone number, helpline, or hotline to assess the level of customer service and the quality of response. They may visit the organization's website and test its features (e.g., appointment scheduling) and ease of use (e.g., whether a person who is not tech savvy can navigate or find information without help). They may pose questions or seek help on the organization's Facebook, Twitter, YouTube, or other platforms to gauge how well social media are incorporated into operations.

Mystery shoppers provide organizations with honest feedback and objective findings about the overall service experience, processes, staff skills and behavior, customer service, quality, wait times, technology, and other aspects examined. The organizations then use these data to revise procedures, develop orientation and training programs, implement new policies, and institute other changes.

Aggressive organizations engage mystery shoppers to collect information on their competitors, such as operational details, volume of services performed, and sources of customers or patrons. To gather this intelligence,

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shoppers may pretend to visit a hospitalized patient, call to inquire about a service and its cost, or attend a patient education session offered by the competitor. They may participate in online discussions as well to monitor popular opinions or perceptions.

This type of qualitative data collection is not likely to provide all the data necessary for a thorough market analysis. More often, mystery shoppers provide provisional information on which more formal data collection activities can build. Although the use of mystery shoppers is not widespread and has critics in healthcare, this method of research could become more common as organizations weigh what works and does not work.

Observation is classified as either participatory or nonparticipatory. In *participatory observation*, the researcher becomes part of the group or activity being observed (e.g., mystery shopper). It allows the observer to analyze the group, situation, or process as an insider. By being part of the group, the researcher minimizes the impact of the observation process on the group's behavior; of course, the researcher's presence could still alter the behavior of the subjects. The drawback of participatory observation is that the researcher typically cannot take notes or otherwise record observations at the time they are made. Thus, the observer must rely on memory to record observations at a later date.

In *nonparticipatory observation*, the researcher is detached from the individuals, situations, or processes being observed. The passive observer may view the subjects from afar or, in more controlled environments, through a one-way mirror in an observation booth. The advantage to this approach is that the researcher typically does not affect the behavior of the subjects because they do not know they are being observed. On the other hand, such an indirect approach makes it harder to interpret the meaning of the observed actions.

Although observational research is good for documenting *what* people do, it does not address *why* people do so. Thus, this method often needs to be supplemented with personal interviews or some other data collection methods.

In-Depth Interviews

In-depth interview, *one-on-one interview*, and *key informant interview* are terms used interchangeably to mean one person posing probing and often ad hoc questions to another. Complicated questions—those that cause the respondent to pause or demand more than simplistic explanations—are best asked through an in-depth interview. The interviewer does not necessarily pose a predetermined set of questions in a set order; rather, the interviewer

elicits the information by listening to the responses and asking follow-up questions as necessary. The entire activity typically lasts 30 to 45 minutes, but sometimes it can last several hours. Note the distinction between an in-depth interview and the administration of a survey form: The former takes time because it is meant to be exploratory, while the latter is short both in duration and on content.

Anyone presumed to have knowledge of the topic under study can be interviewed. However, in healthcare, *key informants* are usually interviewed. Key informants are those who have a particular set of knowledge (e.g., technical innovators), have a broad perspective on the study issues (e.g., administrators), hold a position that familiarizes them with the perspectives of many groups of people (e.g., human resources manager), or are opinion leaders (e.g., medical staff members). As discussed earlier, one of the first steps in marketing research is to define the issues the organization is facing; in-depth interviews are an excellent means of accomplishing this task. In fact, typically the survey instruments used in subsequent quantitative research are based on in-depth interviews with key informants.

The in-depth interview method does have some limitations. It must be carried out by a skilled interviewer. The potential for interviewer bias or respondent misrepresentation is great. Key informants or experts may go off on tangents. An opinionated physician interviewee, for example, may be difficult to rein in; valuable time may be wasted discussing irrelevant topics.

Group Interviews

Group interviews have become a popular qualitative research technique in healthcare. They can be structured (as in the case of focus groups) or informal (as in the case of naturally occurring groups). *Focus groups* consist of people who are assembled to discuss a topic of interest under the direction of a professional moderator. The objective is to have people express their feelings or views on a range of topic components. *Naturally occurring groups*, a subset of focus groups, consist of people who share an interest; in healthcare, such a group may include employees in one department working the same shift or family members of patients admitted at the same time.

Focus groups, and the information they yield, serve several purposes, such as the following:

1. **Be the basis for questions in a survey.** For example, generalized perceptions of a hospital's image may be converted into specific survey items.
2. **Identify customer needs and wants.** For example, a physician focus group may reveal what programs or services referring physicians would like their health system to offer.

3. **Test ideas.** For example, parents of orthopedic patients aged 6 to 18 may assess the feasibility of an orthopedic practice's plan to establish a pediatric sports medicine program.
4. **Examine the underlying meaning of survey results.** For example, recent emergency department users may be asked, as a follow-up, why 50 percent of them indicated the service they received was unsatisfactory.

Group interviews impart valuable insights that can jump-start subsequent action steps, research, and other activities. Therefore, they are a great supplement to other data collection methods. However, they should never be used as a primary tool.

Surveys

Many, if not most, marketing campaigns use surveys for data collection. Some healthcare organizations conduct survey research themselves, while others contract with an outside consultant. Survey data may also be obtained via a syndicated survey or an omnibus survey. In conducting a *syndicated survey*, a number of organizations band together to share the cost of the research. The participating organizations may have the option of including a few custom questions in the survey, but for the most part, all will receive the same information back. *Omnibus surveys* are ongoing (often panel) surveys in which organizations can participate. The survey firm regularly asks questions of a panel of several thousand respondents, and healthcare organizations can submit questions to pose to the pool of respondents.

Survey research presents a number of challenges that may not be obvious to healthcare administrators. First, developing an effective questionnaire requires a great deal of professional skill. When respondents fail to provide the desired information, often the reason is that they were given a defective survey instrument. Second, the intent of the survey should dictate the population to be surveyed; otherwise, the survey will ask the right questions of the wrong respondents. Thus, an appropriate sampling frame must be established. Third, the set of respondents almost never represents the profile of the originally defined sample. For example, it is almost inevitable that more women and more seniors will respond to a typical survey. The sample may be affected by other factors as well. Although the sample may be statistically adjusted, after a certain point this adjustment could lead to misleading results. All of these complicated considerations reiterate the importance of using professional surveyors.

Survey research typically takes one of these forms: mail survey, personal interview, telephone interview, and online survey. This section describes these four methods for surveying target populations.

Mail Surveys

Mail surveys involve self-administered questionnaires sent to a selected sample of respondents; they are often used in healthcare to collect patient satisfaction data. One advantage of mail surveys is they are relatively inexpensive. Typically, costs include staff compensation (for survey design and data analysis), printing, and postage (including return postage). Another advantage is that they allow respondents to remain anonymous and eliminate the potential for interviewer bias. Mail is also an efficient way to contact people who are dispersed over a large geographic area and have no access to electronic communication (e.g., e-mail). Returned survey forms are analyzed according to predetermined analytical techniques.

mail survey
A data collection technique that uses a self-administered paper questionnaire mailed to a sample of respondents.

This method has several disadvantages. Response rates to mail surveys are often low and skewed toward certain categories of respondents. The surveys are self-administered, leaving the questions open to the respondent's interpretation. Turnaround time may be lengthy, and therefore the short time frames of healthcare marketing campaigns may preclude the use of mail surveys.

Personal Interviews

Personal (or face-to-face) *interviews* are ideal when the questions are tough or complicated to answer. In contrast to in-depth interviews, face-to-face interviews are completed quickly, involve many respondents, and require that respondents be representatives of the population being studied. If the survey instrument is well designed, interviewers who are not experts on the topics being discussed may suffice, but they still have to have basic interviewing skills. Because marketing research targets specific audiences, on-site interviews are often desirable. Waiting rooms of clinics, emergency departments, and other public spaces in a healthcare facility can serve as sites for these interviews.

Community surveys—wherein a sample of households is selected and then interviewed in their homes—used to be routinely conducted, but they have been largely replaced by on-site interviews. The costs of community surveys have become prohibitive, and many research organizations are reluctant to use this approach because of the perceived danger of sending interviewers into certain neighborhoods. Potential respondents also are unlikely to be home during the day, and people are now reluctant to open their doors to strangers.

A drawback to the use of personal interviews is the potential for interviewer bias. Poorly trained interviewers may condition responses by their reactions to answers or by their mannerisms, or they may fail to accurately follow the wording of a survey. In terms of cost, the personal interview is the most expensive survey method. Even the most basic surveys involve training and monitoring expenditures—and sometimes travel costs.

Telephone Interviews

Telephone interviews involve the collection of data directly from subjects via the telephone. Generally, telephone interviewers who have a "hook" (e.g., the respondent is a current patient) can obtain a high response rate. They also can do a reasonable amount of probing over the phone. On the other hand, respondents can terminate a telephone interview more easily (by hanging up, "accidentally" dropping the call, or declining the call altogether) than they can a face-to-face interview.

Sampling bias is inherent in this approach because only people with access to a telephone can participate. Landlines have become almost obsolete, with just 7 percent of US households having only a landline in 2016 (Blumberg and Luke 2017). Another 39 percent reported having both a landline and a cell phone, and 50 percent reported owning only a cell phone. Only 3 percent of households were phone-free. In addition, many smartphone owners prefer text messages over voice calls, helping make traditional telephone use a thing of the past. Prohibitions against accessing cell phones for telemarketing purposes, the National Do Not Call Registry (which now covers cell phones), unlisted numbers, fear of phishing scams, and blocking are additional barriers between potential respondents and telephone interviewers. Software with multiple capabilities has enabled interviewers to bypass some of these barriers, however.

The use of computer-assisted telephone interviewing (CATI) is common among telephone surveyors. CATI is a program that enables the interviewer to read questions on the screen and type the answers into the system as the respondent speaks. The responses are automatically entered into the database to be analyzed. This software can flag out-of-range answers, adjust subsequent questions on the basis of earlier answers, and lead the interviewer through a series of branching questions.

Online Surveys

online survey
A data collection technique that uses a self-administered questionnaire that can be completed and submitted on the internet.

Online surveys are self-administered questionnaires that respondents can complete on the internet. Their use in healthcare is wide-ranging. They could be completed by patients, employees, administrators, senior management, physicians and other clinicians, segments of the service population, or vendors. They could be deployed for many purposes and conducted off-site or on-site. After a doctor's appointment, for example, a patient may be asked to sit at a workstation to fill out a brief survey shown on the computer screen. Each answer to a question item is selected with a touch of the screen, a click of the mouse, or a few keystrokes. When completed and submitted, the responses populate a database for analysis. The questionnaire itself may solicit general feedback, an evaluation of the clinic and its staff, or an opinion on a planned change.

Well-designed surveys are user-friendly; include clear, simple instructions; and require no technical or even internet proficiency from respondents.

More advanced designs may even modify the questions during the course of the survey, autocorrect or edit the responses, and perform immediate analysis. The design possibilities are endless. Many free tools—such as Zoomerang and SurveyMonkey—are available to marketers and other staff members who want to create simple online surveys from a template and perform simple analyses. For complicated purposes or large data collection initiatives, however, marketers may purchase a proprietary, customizable system or consult with a professional surveyor.

The online approach offers several advantages. If done on-site, it captures information while it is still fresh in the respondent's mind. It allows researchers to collect responses from nearly every patient instead of a sample. Whether completed on-site or off-site, it saves resources by eliminating the time and staff involved in mail or telephone interviews and the cost of paper, printing, and postage of a traditional survey form. It can be tabulated in hours, if not minutes. It is generally inexpensive and convenient (especially when a link to the survey is included in an e-mail). It is inherently attractive to those who are technologically savvy.

There are also disadvantages to online surveying. It requires access to a computer and an internet connection, which some people do not have. It could be intimidating to people who are unfamiliar with computers—and that fear could translate to a refusal to participate, an on-the-spot crash course or handholding from staff, or an incomplete survey. It could be a source of resentment for already overburdened staff, for technologically averse leaders and clinicians, or for patients who are not feeling well. It is so painless to create and implement that some marketers may be lured into developing unnecessarily lengthy questionnaires.

A related research method involves the collection of data generated through social media devices. Since mobile phones are always linked to a location, market researchers can monitor traffic on Twitter, Instagram, Facebook, and other social media platforms to mine health-related data. Thus, it is possible for researchers to determine what consumers are saying about health-related issues, practitioners, and facilities and identify the locations from which they are transmitting this information. Sophisticated programs have been established to track health-related chatter on social media that can be then sold to healthcare organizations and their associated entities.

Summary

Marketing research encompasses market, product, pricing, promotional, and distribution research. Its scope has expanded as the demand for market data has soared; data requests now come from an ever-growing variety of users.

The opportunity costs of a wrong strategic decision in an increasingly competitive market are prompting some of this demand.

Marketing research should be an ongoing function in healthcare, not just an episodic action undertaken when an urgent need arises. It can take a variety of forms and does not always have to be a formal, expensive process. Marketing research is a multistep process, and the exact number and order of steps varies from one analyst to the next and from one campaign to another. Generally, the process begins with defining the issues at hand, involves developing a research plan, and ends with presenting the results to decision makers.

A number of primary research methods, each with advantages and disadvantages, can be used. The qualitative approach includes observation, interviews, and focus groups. The quantitative approach constitutes surveys, which may be conducted face-to-face, by mail, by telephone, or online.

Key Points

- Any type of information gathering about the marketplace constitutes marketing research.
- Many marketing research methods applied in healthcare are borrowed from other industries.
- Strategic decisions in healthcare are more data driven today than ever before.
- Marketing research involves both primary and secondary types. The data collection technique chosen depends on the research topic, available resources, and the available data.
- Quantitative research uses objective means, such as experiments and sample surveys.
- Qualitative research uses subjective means, such as observations, interviews, and focus groups.
- Marketing research, like other aspects of marketing, benefits from contemporary technology (as evidenced by GIS and online surveys).

Discussion Questions

1. What developments have made marketing research increasingly important in healthcare?
2. In what ways has the scope of marketing research in healthcare broadened, and what accounts for the expanded scope?

3. What is the explanation for the growing influence of market research on the decision-making process in healthcare?

4. What are the relative advantages and disadvantages of primary research and secondary research?

5. Why has most research in healthcare been descriptive rather than causal or predictive?

6. What are the relative merits of quantitative and qualitative research, and why are both important to marketing researchers in healthcare?

7. How has contemporary technology improved the effectiveness of marketing research in healthcare?

8. What are the advantages of using more than one method to research a topic?

Additional Resources

Academy Health: www.academyhealth.org.

Aday, L. A., and L. J. Cornelius. 2006. *Designing and Conducting Health Surveys: A Comprehensive Guide*, 3rd ed. San Francisco: Jossey-Bass.

American Marketing Association Special Interest Groups: www.ama.org/academics.

Quirk's Marketing Research Media: www.quirks.com.

MARKETING PLANNING

Although most healthcare organizations have some level of marketing expertise, they are not necessarily skilled in marketing planning. Even today, healthcare marketers are often brought in at the eleventh hour to implement a marketing campaign in which they had no previous involvement. This chapter examines the marketing planning process and its importance in the development of any marketing initiative.

Marketing planning refers to the development of a systematic process for promoting an organization, good, service, or program. This straightforward definition masks the wide variety of activities and the complexity that characterizes this endeavor. Marketing planning may be limited to a short-term promotional project or a component of a long-term strategic plan. Because the systematic implementation of a marketing initiative is not possible without a marketing plan, a plan should be in place before any marketing activities begin, regardless of whether they are intended to be broad or narrow in scope or long or short in duration. This chapter explores the importance of marketing planning and its role in the marketing endeavor. (For additional information on marketing plans, see Thomas [2003a].)

The Nature of Marketing Planning

Of the types of planning that healthcare organizations undertake, marketing planning is most directly related to the consumer. Whether the targeted consumer is a patient, a referring physician, an employer, a health plan, or another category of consumer, the marketing plan is built around the needs of someone or something. Although internal factors are often considered (internal marketing is a component of many marketing plans), the marketing plan focuses on the characteristics of the external market with the objective of influencing change in one or more of those characteristics.

Marketing plans geared toward changing the image of an organization are often broad in scope, while plans that focus on a particular good or service are typically narrow in scope. All planning activities should be time delimited, and marketing plans are often rigid in this regard. Clear-cut target dates are almost always included, as the content of a marketing campaign is usually time sensitive. A marketing plan that seeks to establish consumer

awareness before the opening of a new clinic, for example, does not allow much margin for error in terms of timing.

The approach to marketing planning varies depending on the focus of the project and whether the plan is being developed for a new or an existing organization or product. In the case of a new organization or product, the intent of the marketing plan is to create awareness, generate initial business, and establish a customer base. The primary emphasis is on attracting new customers. In the case of an existing organization or product, the intent may be to enhance or improve the organization's image. Objectives may include changing behaviors by, for example, convincing customers to switch their business to the organization or product or by encouraging them to use more services. Generally, information on existing customers is readily accessible, so the planner can capitalize on this resource not only to generate as much additional business as possible but also to expand the customer base.

Although marketing planning is often considered a stand-alone activity, it should fit within the context of the organization's overall strategic initiatives. Thus, the objectives of the marketing plan should correspond to those outlined in the organization's strategic plan. A marketing plan should be a component of any formal business plan as well, even if the organization has an established customer base. Potential funders of a healthcare project are not likely to consider a business proposition that does not include a marketing plan.

Levels of Planning

Marketing planning can take place at different levels, the highest of which is the facility or the health system. A hospital branding itself might develop a master marketing plan that encompasses most aspects of its marketing effort. Such a plan is comprehensive in approach and broad in scope, and its time horizon may be relatively long—say, a multiyear implementation period. Plans formulated at the highest level are likely to be strategic (rather than tactical) in that they aim to effect large-scale change.

Large healthcare systems may develop multilevel marketing plans that address a range of audiences. A systemwide marketing plan may overlay separate marketing plans for individual facilities in the system. At the facility level, marketing plans are likely to be in place for specific divisions in the organization.

Most marketing plans are geared toward the operational level, focusing on a good, service, program, or event. Such plans are developed to introduce a new product, office site, piece of equipment, or series of patient education seminars; these plans aim at increasing patient volume or market

share and are narrow in scope and short in duration. Low- or middle-level plans are considered tactical (rather than strategic) because they support specific marketing goals. Their objectives are more restrictive than those of a facility-level plan, and they are measured, for example, by consumer awareness of the new product, attendance at patient education sessions, or increased patient volume.

The Marketing Planning Process

Although the marketing planning process is similar for both the facility and operational levels—and those in between—it varies slightly for each level. These differences are noted in this section, along with the steps involved in the marketing planning process. The sequence of steps is depicted in exhibit 16.1. (Note that these steps are similar to those of the strategic planning process described in chapter 9—as marketing and organizational strategies should be aligned—as well as those of the marketing campaign outlined in chapter 14.)

EXHIBIT 16.1
Steps in the Marketing Planning Process

Plan for planning
↓
State assumptions
↓
Gather initial information
↓
Audit the market
↓
Determine the strategy
↓
Set goals
↓
Set objectives
↓
Prioritize objectives
↓
Specify actions
↓
Implement the plan
↓
Evaluate the plan

Plan for Planning

The first step in any planning process is to identify the mandate under which the planners are to operate. A marketing campaign may be initiated for any number of reasons. It may be driven by competitors' actions, a political motive, or an immediate financial consideration.

Much of early marketing planning activity is organizational in nature. After specifying the "why" of the initiative, the planning team must identify the key stakeholders, decision makers, and existing resources. If the organization has an established marketing department, much of the initial work (e.g., background research) may be completed, and the key players may already be in place. However, in the case of a newly installed marketing function or the marketing of an unfamiliar service, additional organizational effort is likely to be required.

Although there is no foolproof combination of team members that will ensure success, certain categories of participants should be involved. The first category includes those familiar with the service, the market, and the distribution channels. Representatives of the target audience should be involved—whether they be patients, physicians, or employers.

Internal participants in the planning process should be drawn from different functional areas, starting with management. Certainly, the marketing department should play a key role and its efforts should be combined with those of the research department (if such a unit exists). Other key departments may participate, including the finance, human resources, and clinical departments (depending on the issues at hand). The planning process is also unlikely to run smoothly without the cooperation of the information systems department.

At this point, the mechanics of the planning process must be specified. Mechanics include the process format, objectives, and the frequency and purpose of team meetings (e.g., progress reporting, decision-making). Note that the objectives here are the items expected to be achieved during the planning process, not during the implementation process.

State Assumptions

Marketers must identify and articulate assumptions that have potential consequences for the marketing initiative. This must be done not only at the outset but throughout the planning process. The assumptions made at the outset reflect the degree to which a service has already penetrated the market. The extent to which marketing activities have previously been initiated for the service affects the assumptions under which the planner operates. The approach or appeal to be used in the campaign is another element about which assumptions might be made. The intent—whether to educate, motivate, entice, or frighten the target audience—determines the nature of the appeal.

Gather Initial Information

If a healthcare organization has a marketing function in place, the tasks associated with initial information gathering may have already been completed. Typically, the marketing staff examine most aspects of the environment as part of ongoing marketing research; at best, the staff just need to update some of the data collected. A newly formed marketing department or an external marketing consultant, however, may have to undertake a significant data collection effort.

This step requires planners to assemble and review general background information on the organization or the product to be marketed for a number of reasons. First, planners need to identify and then differentiate the salient attributes of the organization or product from others in the market. Distinctive features should be highlighted in the plan. Little or no differentiation creates a challenge for the marketer.

Second, planners need to be familiar with all of an organization's existing services—especially those that have not been marketed in the past. Hospitals and other large organizations frequently add new services and tend not to promote all of their offerings. Thus, marketers need to conduct an inventory of existing services.

Third, planners must understand the history of the organization or product being marketed. Planning is futuristic by nature, and the future is often inextricably intertwined with the past. Current relationships, for one, evolved from old experiences, occurrences, decisions, and so on; these relationships will develop in the future on the basis of events and choices that take place in the present (which quickly turns into the past). The same can be said of an organization's past, present, and future trajectory. History is both instructive and influential for the future.

To minimize duplicate effort, planners typically inventory marketing resources and determine the extent to which current marketing activities relate to the proposed project. Ongoing marketing activities are easy to overlook, especially if they are informal or not labeled as marketing. At the same time, planners should determine whether the new initiative would contradict or otherwise conflict with existing marketing activities.

Planners need to note barriers to plan development—both known and potential. First, immutable patterns of behavior in the organization should be identified, particularly if the campaign is to involve internal marketing. Second, problems may crop up if the campaign pits two organizational entities against each other. For example, the director of the emergency department may not react favorably to a marketing campaign that is focused on directing patients away from the emergency department to urgent care centers affiliated with the hospital. Third, regardless of the type of organization, any environmental constraints likely to affect the organization and the provision

of its services need to be identified. Some barriers may be surmountable, but others might not be. This understanding can be used to refine the assumptions previously stated.

Planners may benefit from information on similar marketing initiatives in other markets, especially if the initiative involves a product, a market, or an approach with which the marketer has limited familiarity. Planners should be able to incorporate information about marketing approaches that have and have not worked when similar organizations or services were marketed in other contexts.

As the planning process moves forward, formal data collection is likely to be required. The extent of this data collection effort will depend on the nature of the organization and the type of marketing initiative. A national organization courting a mass market (e.g., a pharmaceutical company promoting an over-the-counter product) probably would perform a detailed, national-level market analysis. On the other hand, a home health agency licensed to practice in a single county is not likely to need detailed, national home health trends to develop a marketing plan. If appropriate to the initiative, marketers may identify relevant societal developments, lifestyle trends, changes in consumer attitudes, health industry trends, and industry or product life cycle information. They may also consider regulatory, political, legal, and technological developments.

Audit the Market
Typically, planners gain an in-depth understanding of the organization's products, customers, and marketing practices through internal and external audits. An internal audit reveals the answers to the following questions:

- **Products.** What goods or services does the organization produce and distribute? What are the characteristics of these products?
- **Customer characteristics.** How many customers does the organization serve, and what are their characteristics? What demographic characteristics are most pertinent? Where do these customers live, and what is the organization's market area? What is the case mix of current customers? What are the financial circumstances of the patient base?
- **Utilization patterns.** What volume of services do the organization's customers consume? How does this volume break down by service line or procedure?
- **Pricing structure.** How does the organization set prices for its products? How does this price structure compare to that of competitors or the industry average? How price sensitive are the products offered?

- **Marketing arrangements.** What marketing programs are currently in place, and how is marketing structured? What type and level of resources are available for marketing? Are processes in place for internal marketing?
- **Locations.** To what extent are operations centralized or decentralized? How many satellite locations are in operation, and how were the locations chosen? Are there markets that existing outlets are not serving?
- **Referral relationships.** How are customers referred to the organization? To what extent are there formal referral relationships?

Meanwhile, an external audit provides information about the environment in which the healthcare organization operates, including the following factors:

- Social, economic, and political environment
- Demographic, psychographic, and socioeconomic characteristics of the target population
- Health status of the target population
- Health service utilization patterns
- Characteristics and offerings of competitors in the market

Determine the Strategy

The strategy developed during the planning process sets the tone for subsequent planning activities and the parameters in which the planner must operate. Ideally, the strategy used in a marketing initiative will support the organization's mission statement and align with the organization's strategic plan. For example, if the organization's strategy is to position itself as a "caring" organization, marketing initiatives should support this approach.

Likewise, strategic considerations should guide the marketing planning process. The marketing strategy could, for example, be framed as an educational initiative, a public relations rather than an advertising approach, or a soft-sell versus a hard-sell approach, ultimately reflecting the overall corporate strategy.

Set Goals

The goal(s) of the marketing plan should reflect the information generated by the initial research, align with the organization's mission statement, and be broad in scope and limited in detail—for example, "to establish hospital X as the most prominent inpatient facility in this market area." Alternatively, for a product-oriented initiative, the goal might be "to dominate the niche for occupational medicine in this market area." Organizational goal setting is

The mission of a healthcare organization is likely to be different from that of an organization in another industry. A healthcare organization may emphasize its charitable mission or service orientation rather than profits. Its mission is also likely to be more diffuse. A mission of improving the health status of the community, for example, is much different from the profit-maximization goals of corporations in most other industries.

The goals of a healthcare organization are also likely to be much more diverse than those of an organization in another industry. Hospitals, with their many functions and interests, are the epitome of the multipurpose organization. A marketing plan for an organization this complex must include a wide range of perspectives given that health services are often established without consideration of the potential profit.

The constituencies of healthcare organizations are different as well. Although a growing number of healthcare organizations must satisfy stockholders, most are more directly accountable to other types of constituencies. For example, a public hospital may have to cater to politicians, consumer interest groups, the medical community, and other entities. A church-affiliated hospital may be accountable not only to its board of directors but also to the denomination's leadership.

Furthermore, healthcare organizations are different in that they often provide mandated services. In other industries, an unprofitable product line can simply be eliminated. Hospitals and certain other healthcare organizations, however, may not be able to compete on equal terms unless they are comprehensive in their service offerings. If a hospital drops an unprofitable obstetrics service, other aspects of the organization may be negatively affected. State regulations may even mandate the existence of the unit, in which case eliminating it would not be an option.

somewhat problematic given the diffuseness of healthcare goals. Exhibit 16.2 discusses the variety of marketing goals in healthcare.

Set Objectives

Goals are general statements, whereas objectives are specific. Objectives should be clearly and concisely stated. They must be time-bound, and clear deadlines for accomplishing objectives must be established. Finally, objectives must be measurable, given that the marketing plan is typically evaluated on the extent to which its objectives have been achieved. For example, an objective of the goal stated for hospital X (see the previous step) might be as follows: "To establish expertise in three new specialty areas over the next 12 months." A number of objectives may be specified for each goal, as each is likely to require action on several different fronts.

Any barriers to accomplishing the organization's stated objectives should be identified and assessed at this point. A lack of resources or talent is a common barrier to any type of plan. Ethical or legal considerations may be associated with some types of marketing—for example, certain health professionals may be prohibited from using advertising. Issues of appropriateness and taste may also pose problems. For example, the educational level of the target audience might be a barrier to introducing a new high-tech procedure, or the public perception that a new procedure is experimental could make potential patients apprehensive.

Prioritize Objectives

The objectives specified to support a goal are likely to address different dimensions of the initiative. Although all of the objectives may be considered important or even essential, pursuing all of the objectives may not be feasible—at least not all at the same time. Some objectives could even operate at cross-purposes.

As an example of a potential dilemma, imagine a situation in which a project has multiple objectives that support the goal of establishing a new facility as the dominant provider in a market area. One objective involves increasing public awareness of the facility and another focuses on increasing patient volume. Although these efforts might overlap, the approach the facility would take to make its name a household brand would likely be different from the approach it would take to induce patients to try the new facility. If the facility does not have the resources it needs to pursue these two objectives simultaneously, it may need to prioritize its marketing efforts.

To prioritize the objectives of a marketing plan, planners might envision the initiative according to the four Ps: product, price, place, and promotion. For example, they could decide to focus on the product dimension of the marketing mix at the expense of price, place, and promotion. Thus, objectives most related to promoting the characteristics of the product would receive priority. Alternatively, they might capitalize on the price advantage of the product, thereby prioritizing objectives that focus on the pricing dimension.

One last consideration is the possibility of unanticipated consequences resulting from the pursuit of stated objectives. However tedious the job may be, planners need to specify both the intended and unintended consequences of carrying out each objective. Too often, planners examine only the intended outcomes, neglecting the potential negative ramifications.

Specify Actions

Actions might range from securing postage for a direct mail initiative to enlisting a celebrity spokesperson. For example, if the objective of a specialty practice is to increase public awareness of its new sports medicine program by 50 percent, actions might include selecting an advertising agency, allocating

funds for marketing, packaging the program, and scheduling press conferences. Or, in keeping with the goal and objective stated earlier, an action might involve instructing the human resources department to identify and recruit physicians prominent in the three targeted specialty areas. Many actions fall naturally into a sequence, so planners may want to refine the plan by specifying the timing of each action. Case study 16.1 presents examples of plan goals, objectives, and actions.

CASE STUDY 16.1
Sample Goals, Objectives, and Actions

Southern Neuroscience Center (SNC) completed a strategic plan and set this goal: to be recognized as the premier neurological specialty group in the region. To that end, SNC developed a marketing plan that detailed the objectives and actions to support the achievement of this goal.

MARKETING GOAL
To establish SNC as the premier neurological specialty center in the minds of consumers in its market area.

MARKETING OBJECTIVES
- Increase awareness of SNC from 40 percent to 60 percent of consumers within 12 months.
- Improve patient satisfaction ratings of "excellent" from 80 percent to 90 percent within 12 months.
- Increase the number of physicians regularly referring to SNC by 25 percent within 12 months.

MARKETING ACTIONS
For objective 1, actions include the following:

- Develop an advertising campaign for local television.
- Increase SNC event sponsorship from two events to four events within the next 12 months.
- Distribute an SNC newsletter to all relevant members of the medical community.

(continued)

> - Establish an interactive website featuring consumer-oriented information on neurology and neurosurgery.
>
> **CASE STUDY DISCUSSION QUESTIONS**
>
> 1. What prompted SNC to initiate marketing planning?
> 2. How did SNC use the marketing planning process to address its goal?
> 3. What indicators did SNC use to measure the success of its marketing initiative?
> 4. What potential barriers might SNC encounter in pursuing its marketing objectives?

Implement the Plan

Planning is ultimately only an exercise, albeit a meaningful one. The payoff comes when the plan is implemented. To a certain extent, planning is talk, but implementation is action. Fortunately, the handoff from planning to implementation is typically smooth in that the same parties are likely to be involved in both functions.

In addition to a detailed marketing project plan, an **implementation matrix** is essential. The implementation matrix lists every action specified in the previous step and, if appropriate, breaks each action down into tasks. For each action, task, or activity, a number of details need to be specified, such as the following:

- Primary party responsible, along with any secondary parties
- Resources required (e.g., staff time, money)
- Start and end dates
- Prerequisites
- Benchmarks

implementation matrix
The list of specific actions, tasks, or activities needed to accomplish goals and objectives.

The resource requirements from the implementation matrix should be combined to determine total project resource requirements.

Evaluate the Plan

Evaluation of the plan should be top of mind from the beginning of the planning process. It should be ongoing and should use benchmarks and milestones to measure progress toward goals and objectives. As discussed in chapter 15, both process evaluation and outcome evaluation are used to assess marketing efforts.

Also discussed in chapter 14 is the practice of calculating return on investment (ROI) to justify a marketing initiative. To determine ROI, marketers must not only carefully construct a marketing plan but also keep a detailed record of expenditures and revenues associated with the initiative. Some type of cost–benefit analysis should be conducted before the project is initiated, and every effort should be made to track the benefits (e.g., visibility, perception, market share, volume, and revenue) that accrue to the organization as a result of the campaign. Case study 16.2 presents a simple marketing plan that includes these elements.

Case Study 16.2
Marketing Planning for a New Program

SouthCoast Institute, a rehabilitation hospital, perceived an opportunity to expand its outpatient capabilities. Among SouthCoast's options was to develop an aqua therapy program that would supplement its existing inpatient services and allow it to serve a wider range of customers on an outpatient basis. The hospital's staff recognized the need to engage in the marketing planning process to successfully design, launch, and evaluate this new service.

Step 1

In organizing the process (identifying the key stakeholders, decision makers, and resources necessary), the planners had an advantage in that the development of an aqua therapy program was a proposal derived from SouthCoast's major strategic planning initiative. Many of the organizational issues had been addressed within the context of the strategic plan. A team was already in place, and a planning framework had previously been established.

Step 2

The planning team stated the following assumptions about the aqua therapy program and its relationship to the market:

- Adequate demand for aqua therapy services was present in the service area.
- SouthCoast had a captive audience for this service—its existing rehabilitation patients.
- Aqua therapy was generally unknown to the public and medical community.

(continued)

- Considerable outreach was required to educate the public and raise awareness and acceptance of aqua therapy.
- If properly informed, health insurance companies would be willing to reimburse aqua therapy services.
- Potential spillover benefits existed as a result of the introduction of the aqua therapy program (e.g., provide trainers for school swim teams and thereby attract student athletes needing aqua therapy).

Step 3

The team members collected background data on existing aqua therapy services in other markets. In addition, they assessed the availability of internal resources and the degree to which the general public and the external medical community were open to the idea of a new program. They also developed a general idea of what was involved in operating an aqua therapy program.

Step 4

The team performed a preliminary internal audit. Data were compiled on the types of rehabilitation procedures and services offered by most internal programs, the types of patients typically served, the reimbursement prospects, and so forth. The analysis examined the existing staff's ability to take on more responsibility, the need to add staff and to train them in aqua therapy, the available pool and the need for other equipment, and the general attitude of the staff regarding the proposed aqua therapy program.

The team also conducted an external audit. It identified potential referral sources and interviewed them to gauge their interest in the program. The team contacted local health plans to ascertain their willingness to reimburse for the service. Finally, the team conducted a competitive analysis and learned that no medically supported aqua therapy program was being offered in the community.

Step 5

On the basis of the information gathered through the initial research and the internal and external audits, the team settled on an educational strategy that would push information out to all relevant parties. Marketing efforts would focus on increasing awareness of and support for the aqua therapy program. At the same time, the strategy would emphasize the fact that SouthCoast was the only organization offering this therapy in the service area.

(continued)

STEP 6

With background data indicating significant potential for a successful and profitable service, the team set a goal of establishing SouthCoast's aqua therapy service as the premier aqua therapy program in the region.

STEPS 7 AND 8

In support of this goal, the team established and prioritized the following objectives:

- Create and implement a comprehensive internal marketing effort for the aqua therapy program within six months.
- Directly contact all of SouthCoast's affiliates and potential external referrers within six months.
- Recruit and train a full-time marketing liaison for the aqua therapy campaign within six months.
- Identify and contact all community groups that could benefit from the aqua therapy pool within six months.
- Integrate aqua therapy into SouthCoast's sports medicine and occupational medicine programs within one year.

STEP 9

The team specified the following actions needed to accomplish these objectives:

- Create promotional material to distribute to potential referral agents.
- Set up meetings with relevant internal parties (including medical staff) to explain the program.
- Identify an appropriate person to train as a marketing liaison with the community.
- Identify appropriate external targets for promotional and educational activities.

STEP 10

The implementation matrix identified the required resources, the required financial commitment, the parties responsible for the tasks, and timelines

(continued)

for all activities. In keeping with the educational and relationship-building approach, the marketing mix consisted of low-key promotional activities, not high-profile media advertising. For internal audiences, the marketing plan included a newsletter, articles in other internal publications, flyers in employees' pay envelopes, posters, information sessions for staff and referring physicians, and a DVD explaining to health professionals and insurance plans the purpose of the program. For external audiences, the marketing plan included a newsletter, press releases (and other media coverage as appropriate), limited print advertising, a DVD, exhibits (e.g., at schools and health fairs), and public presentations (e.g., for support groups, medical societies, voluntary health associations). A dedicated page on SouthCoast's website was created to introduce the program and its attributes. The page featured videos illustrating the therapy process and offering testimonials from successfully rehabilitated patients.

Step 11

The team delineated an evaluation procedure to assess the progress made. Because it was a start-up operation, service utilization was easy to track. The plan also arranged for a pre-test and post-test to be administered to referral agents to determine the extent to which they were made aware of the program (i.e., whether they knew enough about the program to feel confident about referring their patients to it). Satisfaction surveys were developed for patients and referrers. The extent to which the program generated secondary benefits in the community (e.g., with community groups, schools, swim clubs) was also tracked and periodically reported.

Case Study Discussion Questions

1. How did broad trends in healthcare marketing influence SouthCoast's new service development?
2. Why did SouthCoast need to assess the public's openness to the idea of an aqua therapy program during the initial information gathering?
3. What factors influenced the team's choice of strategic approach? Were there other strategies the team might have considered?
4. How did SouthCoast's promotional techniques reflect its overall strategy?
5. In what ways could the success of this marketing initiative be measured?

Summary

A marketing plan should be in place before undertaking any marketing effort, large or small, and it should support the organization's overall marketing plan and strategic goals. Although marketing plans geared toward changing an organization's image are understandably broad, most marketing initiatives focus on a particular good or service.

While most healthcare organizations have some level of marketing expertise, that does not necessarily mean they are skilled in marketing planning. Systematic implementation of a marketing initiative is not possible without a marketing plan. A marketing plan should be in place before undertaking any marketing effort, large or small. Although marketing plans geared toward changing the image of an organization are understandably broad, most marketing initiatives focus on a particular good or service.

Marketing planning can take place at a variety of organizational levels—from the highest facility- or systemwide level (strategic) to the lower operational level (tactical). The typical marketing plan focuses on a service, a program, or an event. A plan to roll out a new service, an office site, a piece of equipment, or patient education seminars is fairly narrow in scope and short in duration (i.e., tactical).

The marketing planning process involves steps that carry the planner from the initial marketing concept to plan implementation to evaluation. The organization must establish goals, objectives, and action steps for accomplishing these ends. Objectives must be prioritized, and the intended and unintended consequences of meeting an objective must be considered. Objectives are broken down into actions, and these actions are laid out in sequence in an implementation matrix. Plan evaluation should be a consideration from the outset of the planning process, and mechanisms for evaluating the marketing effort should be built into the marketing plan.

Key Points

- Marketing planning is the development of a systematic process for promoting an organization, good, service, or program.
- Marketing plans geared toward changing the image of an organization are often broad in scope, while marketing plans that focus on a particular product (a good or service) are typically narrow in scope. The type of marketing initiative envisioned influences the scope of the marketing plan.
- Planning can occur at different organizational levels, from the C-suite to a subunit of a department.

- The marketing planning process involves a prescribed set of activities, which begins with the plan for planning and ends with evaluating the plan.
- The diffuse goals of healthcare organizations are a challenge in marketing planning.

Discussion Questions

1. In what ways does marketing planning differ from other types of planning in healthcare?
2. What determines the organizational level at which planning should occur?
3. Why do planners need to state assumptions not just on the front end but throughout the campaign?
4. What types of data are generated through an internal audit? An external audit?
5. Within the planning context, what are the differences between goals, objectives, and actions?
6. Given that it may not be possible to pursue all possible marketing objectives, how may planners prioritize them?

Additional Resources

Quick MBA. 2013. "Marketing Plan Outline." Accessed September 5, 2019. www .quickmba.com/marketing/plan.

Savage A. 2019. "How to Create a Healthcare Marketing Plan: All You Need to Know." Digital Authority Partners. Published August 17. www.digital authority.me/resources/healthcare-marketing-plan-guide/.

Westbrook, K. 2018. "The Ultimate Guide to Developing Your Email Marketing Plan. Campaign Monitor. Published October 30. www.campaignmonitor .com/blog/email-marketing/2018/10/the-ultimate-guide-to-developing -your-email-marketing-plan/.

17

MARKETING DATA

Healthcare marketers require data of different types to support marketing activities. They need data to calculate market share, profile potential markets, and initiate direct-to-consumer marketing campaigns, all of which require extensive experience with and knowledge of data sources. This chapter examines the types of data available to healthcare marketers and describes methods of accessing, interpreting, and applying them. The importance of the internet as a source of marketing information is also explored.

The Data Challenge

Healthcare marketers seeking data are presented with a paradox: The healthcare industry generates a wealth of data, but large portions of this bounty are inaccessible to marketers. Unlike other industries, healthcare has not yet developed a national clearinghouse or central repository for industry data. When data are available, they often are deficient in one way or another. Because data are often generated internally by private healthcare organizations, most are unpublished, proprietary, or difficult to access. The enactment of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 further limited marketers' access to health data (see exhibit 17.1).

HIPAA protects the privacy of personal health data and guides the behavior of any entity that has access to individuals' medical information. When the legislation was passed in 1996 and its provisions finalized in 2001, healthcare entities expressed confusion over the types of healthcare communications that HIPAA exempted (and did not exempt) from the marketing definition. Questions were raised concerning customer communication activities, such as disease management information, prescription refill reminders, general health education, and wellness promotion.

Under HIPAA, every healthcare provider that communicates with its customers must address two issues. First, the definition of marketing and the kinds of communications allowed without customer (patient) authorization

(continued)

EXHIBIT 17.1
HIPAA and Healthcare Marketing

have to be examined. The definition of marketing worried hospitals and other providers that they could no longer use their patient records to promote services or programs that could be beneficial to those patients' health conditions. Fortunately, most kinds of communication between providers and their patients are allowable under HIPAA's marketing exclusions.

Second, the key tenets of the relationship between caregiver and patient—maintaining and improving health—have to be considered. This relationship is based on trust, and providers should be able to send information to their patients about recommended screenings and immunizations, new procedures, treatments, and healthcare seminars without fear of violating HIPAA regulations.

The US Department of Health & Human Services conceded that when hospitals, physicians, and other providers offer such information to their patients, they advance the goal of improving their patients' health. Patients, in turn, expect their clinicians to share with them any medical knowledge and alerts that are essential to their care or healing. This concession by the Department of Health & Human Services permitted doctors, hospitals, pharmacists, and health plans to communicate freely with patients about treatment options, disease management, case management, care coordination, and myriad other healthcare issues. Thus, most of the communications programs that healthcare entities develop and implement today are not prohibited by HIPAA and do not require prior authorization.

Healthcare's increasingly consumer-driven approach has led to a growing demand for market data, yet the healthcare industry still lags other industries in collecting and disseminating market-related data. The local orientation and autonomous nature of many healthcare organizations have impeded data sharing. Increasingly, the healthcare marketer's ability (or inability) to access, manipulate, and interpret these data determines whether marketing initiatives succeed or fail. The passage of the Affordable Care Act (ACA) of 2010, the implementation of its provisions, and the reimbursements and rewards related to those provisions are changing the way data are shared between and among disparate providers.

The primary purpose of this chapter is to outline the categories of data required for marketing activities, describe the ways in which data are generated, and indicate sites where relevant information might be accessed. This chapter, however, is not an exhaustive discussion of this topic; given the growing number of types and sources of health data, a comprehensive study would be unwieldy. Rather, the intent here is to elaborate on many of the data sources introduced earlier in the book and highlight these sources'

important characteristics, such as frequency of release, geographic specificity, and methodological limitations.

Initially, a number of the data sets described in this chapter may not seem to be pertinent to healthcare. However, much of what affects the healthcare industry relates to other aspects of society, such as employment, housing, and crime.

Data Dimensions

The data that are useful to healthcare marketers can be categorized along a number of dimensions. This section addresses some of these dimensions.

Community Versus Organizational Data

Health data can be compiled at two levels: community and organizational. The community-level approach involves analyzing community-wide data—whether the "community" is a nation, state, county, or market area. Community data typically emphasize overall patterns of health service delivery and dominant practice patterns, such as information on patient flow into and out of the service area, levels of overcapacity or undercapacity affecting the area's health facilities, and the availability of different types of biomedical equipment in the service area.

The organizational-level approach focuses on the characteristics and concerns of corporate entities, such as hospitals, physician groups, and health plans. Organizational data typically detail an entity's operations in relation to competitors' activities. The focus is on the particular organization and its internal attributes, and the overall pattern of health system operation (i.e., community-level data) is important only to the extent that it affects the organization in question. A specialty physician practice, for example, may be primarily interested in the details of competing specialty practices (e.g., patient volume, market share, procedures performed) rather than general data on the health service area.

The ACA mandated that not-for-profit hospitals conduct a community health needs assessment every three years. At the same time, the growing importance of social determinants of health, especially in the context of the population health movement, has shifted attention from individual patients to the community at large. Both of these developments require unprecedented attention to the attributes of consumers outside the walls of healthcare facilities. The ACA requires that tax-exempt hospitals acquire knowledge of the needs of the entire service area population and not just of their patients—and develop a plan for addressing those needs. Incorporating the social determinants of health into an environmental scan involves collecting

and analyzing data from a number of sectors not historically considered by healthcare marketers—housing, education, criminal justice, transportation, and food access, among others.

Internal Versus External Data

Marketers require data on the internal and external environments. Although organizations usually turn first to internal information sources, data on the external environment have become increasingly important. External data are sometimes difficult to locate and access, but they are more available to the public than are internal data. (See exhibit 9.2 in chapter 9 for examples of internal and external data used in audits.)

Internally generated data are a ready source of information for healthcare marketers. Organizations routinely produce a large volume of data as a by-product of their normal operations, including information on patient characteristics, utilization patterns, referral streams, financial trends, staffing levels, and other data that have implications for marketing. Internal data are usually compiled through an *internal audit*, which typically analyzes the organization's structure, processes, customers, and resources. The internal audit may compile data from standard reports generated by the organization's data management systems (e.g., patient activity reports), but additional reports often are run to obtain the necessary data.

Even today, few data management systems in healthcare are in place to generate data for marketing purposes, although contemporary systems have a greater ability to generate custom reports that may be used by marketers. Often, marketers have to be creative in manipulating internal databases to obtain the data they require. Financial data are an increasingly important component of the internal data with which marketers must be familiar. Marketers must be aware of the profitability of services provided by the organization, the pricing process, and the cost–benefit breakdown associated with different marketing approaches. Benchmarking internal data against those of competitors, the community average, or some recognized indicators (e.g., Medicare performance indicators) has generated additional information marketers may use.

Today, most data collection efforts are directed toward external data. As healthcare providers have become more consumer driven and emphasis has shifted to externally oriented marketing activities, interest in external data of all types has grown. Marketing activities must address the external environment in which they operate. Marketers need to take into consideration national, state, and local trends in healthcare delivery, financing, and regulation. They also need to be aware of developments in the local market that will affect their initiatives. In particular, marketers must have an understanding of the characteristics of other organizations—especially competitors—in

	Primary data	Secondary data
Source	Collected by marketer	Collected by someone else
Reason	Collected specifically for this project	Collected for some other unrelated purpose
Usefulness	Directly applicable to the specific project	Must be interpreted to address the project
Ownership	Marketer owns	Someone else owns
Expense involved	Expensive	Free or inexpensive
Skills required	Data collection and analytic skills	Analytic skills
Time required	Significant data collection time required	Immediately available once accessed
Quality	Controlled by marketer	Potentially unknown

the market area. In fact, organizations that ignored external data in the past will need to be sensitive to community-wide data, especially in light of ACA provisions affecting not-for-profit hospitals.

Primary Versus Secondary Data

Primary research involves the use of surveys, focus groups, observational methods, and other techniques to collect original data. Secondary research, meanwhile, involves the use of data collected for some other purpose; indeed, most of the data in marketing research come from secondary sources. However, because of the lack of health data transparency, primary data collection is a concern more for marketers in healthcare than marketers in most other industries. Exhibit 17.2 provides a comparison of primary and secondary data collection.

The Geographic Dimension

Data are available for a number of different geographic units—political or administrative, statistical, and functional. A detailed discussion of these units can be found in chapter 4, particularly exhibit 4.1.

- **Political or administrative units are official entities set up for administrative purposes.** States, counties, municipalities, and school

districts are examples of administrative units. Much of the data available to marketers are collected for political or administrative units.

- **Statistical units are established primarily for data collection purposes.** Primary examples are the units established by the federal government for purposes of data collection during the decennial census, including census regions, metropolitan statistical areas, census tracts, and census blocks. Most demographic data are compiled from these units.

- **Functional units are established to carry out some practical function and may be unrelated to political or administrative and statistical units.** The best-known examples are the zip codes designated by the US Postal Service. The zip codes' primary function is to support mail delivery; however, because zip codes have become such a common unit for analyzing the spatial distribution of phenomena, they are frequently used as the geographic basis for marketing research.

Another example of a functional unit of particular significance to marketers is area of dominant influence (ADI). ADI was established by media monitoring organizations to indicate the sphere of influence of radio, television, and other forms of media. This measure is relevant to broadcast and print media that have limited geographic reach (e.g., local radio and television, local newspapers).

Healthcare marketers are likely to operate at different levels of geography, depending on the product being marketed and the type of organization involved. The Centers for Disease Control and Prevention (CDC), for example, focuses on national-level data and examines morbidity trends for the entire US population. Pharmaceutical companies with a national market also tend to examine data at that level. A large specialty group is likely to draw patients from a wide geographic area covering several counties; in this case, the county is probably the best unit for data collection. A family practitioner in a solo practice typically serves a fairly defined service area in a county. In this case, the zip code may be the level at which data are best collected and analyzed.

The choice of geographic unit for the analysis is important not only because of its implications for the service area under study but also because of the different types of data available for geographic areas. For many types of information, the county may offer the most extensive range of data; less data are accessible for lower levels of geography—that is, the smaller the geographic unit, the less the available data. Although use of the zip code or census tract may allow for more precise delineation of the service area, access to certain types of data becomes more limited. Thus, a trade-off is likely between the specificity of the service area and the types of data available.

The Temporal Dimension

Health professionals typically think in terms of "current" data—that is, data related to the present time frame or, at least, to the immediate past (e.g., the most recent set of lab tests). However, current data many not be all that current. In healthcare, limited "real-time" data are available, and the data that are readily available may not be useful for marketing purposes. Healthcare marketers, of course, follow the lead of administrators in emphasizing current data.

On the other hand, current data may be less important than future data and even historical data for most purposes. Current data are most valuable as a baseline against which past data can be compared and from which future figures can be projected. Marketing is future oriented, and effective marketing depends on insight into likely future conditions affecting the healthcare environment.

Because actual future data do not exist, conditions relevant to the community or the healthcare organization five or ten years into the future must be projected. For planning purposes, projections of the size and characteristics of populations and of trends in health service demand and utilization are emphasized. Marketers are increasingly being asked to project the future conditions of the healthcare market and the demand for health services down the road. They must either develop this capability or identify a reliable source of such data.

Data Generation Methods

The data generation methods discussed in this section are divided into four categories: (1) censuses, (2) registration systems, (3) surveys, and (4) synthetic data. The first three are traditional sources of data that support healthcare marketing activities, and the fourth—synthetic data—has become a standard marketing analysis tool.

Censuses

A census is the complete count of the people residing in a specific place at a specific time. The US Census Bureau conducts a census every ten years (the decennial census); the 2020 enumeration will be the twenty-third decennial census. A census of the population is required under the US Constitution for the purpose of assigning congressional seats to the states. The results also are used to determine the distribution of hundreds of billions of dollars of federal funds to states. The census form distributed to every household elicits a limited amount of data on each household member. The US Census Bureau collects data using the household unit (e.g., house, duplex, apartment,

dormitory) as the basis for identifying respondents, with each recognized household being queried.

Although a census theoretically is a complete count of the population, the usefulness of the decennial census conducted in the United States is limited in three respects:

1. **Every decade, a segment of the population is missed in the census, resulting in some level of undercount.** The undercount is typically less than 3 percent, but the fact that different segments of the population reflect different rates of undercount is problematic. The presence of significant numbers of noncitizens who may be hesitant to respond to the survey increases the likelihood of an undercount. The mere existence of an undercount creates myriad problems.

2. **The census's administration is infrequent.** In a society where rapid change is common, collecting data at ten-year intervals has its shortcomings. As time elapses after the census year, the usefulness of the data decreases. Marketers typically need the most current data possible, and even at the time of their release two to three years after administration, census data have essentially exceeded their "shelf life."

3. **Beginning in 2010, the census no longer included the "long form"** (which contained hundreds of population and housing items and historically was administered to one in six households). The "short form" was distributed to each household in 2010, thereby limiting the data collected to age, sex, race and ethnicity, and household composition. The remainder of the data (which were historically captured by the decennial census) are collected on an ongoing basis through the American Community Survey (described later).

Census data may be accessed through a variety of sources. Many libraries, for example, are designated as depositories of US government publications and maintain copies of most Census Bureau reports before 2000. Census data sets in electronic format are distributed by the bureau and by other data repackagers, which offer online data for free or at a low cost. Almost no print publications are produced today. The Census Bureau gives free and relatively user-friendly online access to its data sets through its website (www.census.gov).

A lesser-known enumeration of business units—the *economic census*—is conducted every five years (currently in years ending in 2 and 7). The economic census covers businesses engaged in retail trade, wholesale trade, service activities, mineral industries, transportation, construction, manufacturing, agriculture, and government services. The information collected through the economic census includes data on sales, employment, and payroll, along with more specialized data. These data are available for a variety

of geographic units, including states, metropolitan areas, counties, and places with 2,500 or more residents.

The economic census compiles extensive data on healthcare businesses as well. All businesses are assigned a code based on the North American Industry Classification System (NAICS). Aggregated data on businesses in NAICS categories that involve healthcare activities (e.g., physician practices, pharmacies, medical laboratories) are available from the bureau. No other all-inclusive source exists that indicates, for example, the number of hospitals, pharmacists, and chiropractors located in a particular area. As with population and housing data, the bulk of the data generated through the economic census is available only in electronic format.

Registration Systems

Registration systems compile, record, and report on a broad range of events, institutions, and individuals in a regular, systematic, and timely fashion. Most registration systems relevant to this discussion are sponsored by some branch of government, although other types of registration systems are covered here as well.

The best-known health-related registries in the United States are the *vital events* (i.e., births and deaths) registries established by the CDC's **National Center for Health Statistics (NCHS)**. These registries are the definitive source of data on fertility and mortality, and a number of disease registries are maintained by the CDC. Registries maintained by other federal agencies may be valuable, especially when examining changes in the level and types of health services required by a population. Examples include registration systems supported by the Social Security Administration and the Centers for Medicare & Medicaid Services (CMS). Statistics from these agencies are increasingly being made available, and many provide raw data from their files.

Many state government agencies also maintain registration systems of health conditions, reflecting the fact that many healthcare activities are regulated at the state level. State health departments typically maintain registries of selected diseases (e.g., cancer cases), noteworthy public health problems (e.g., hazardous waste sites), and program participation (e.g., family planning counseling). In addition, state health departments or other designated agencies are responsible for maintaining registries of physicians and other healthcare personnel, hospitals and other health facilities, and other types of health information.

Commercial data vendors also maintain different types of registries, including registries of health personnel (often extending beyond clinical personnel to purchasing agents, chief information officers, and so on) and registries of health facilities (from urgent care centers to ambulatory care centers to hospitals). In some cases, vendors supplement registries maintained by

registration system
A mechanism for systematically compiling, recording, and reporting a range of events, institutions, or individuals.

National Center for Health Statistics (NCHS)
The federal agency charged with collecting health data in the United States.

government agencies or professional associations. In others, vendors develop proprietary registries to fill voids in the market.

Health departments at the county (or county equivalent) level are charged with filing certificates of births and deaths and thus are the initial repositories of vital statistics data. These certificates are forwarded to the vital statistics agencies of state governments, which are responsible for compiling these data for their respective states and then transmitting the information to the NCHS. Exhibit 17.3 describes the work of the NCHS.

EXHIBIT 17.3
The National
Center for
Health Statistics

Many consider the NCHS, a division of the CDC, to be the Census Bureau of healthcare. For more than 50 years, this agency has been charged with the collection, analysis, and dissemination of data about and related to health and healthcare in the United States and relevant subareas.

The massive amounts of data that the NCHS compiles, analyzes, and makes available are the building blocks for calculating fertility, mortality, and morbidity rates, as well as for producing population estimates and projections. The agency generates much of the available epidemiologic data on chronic diseases in the nation. In addition, it is the foremost administrator of health surveys in the United States. Its sample surveys are generally large scale and take two forms: community based and facility based.

The agency's most important community-based survey is the National Health Interview Survey (NHIS), which collects data annually from approximately 50,000 households. These data provide insight into the incidence and prevalence of health conditions, health status, injuries and disabilities, health services utilization, and other health indicators in the population. Other NCHS surveys that use samples of participants from the community include the Medical Expenditure Panel Survey, the National Health and Nutrition Examination Survey, and the National Survey of Family Growth. The National Maternal and Infant Health Survey involves a sampling of birth, fetal death, and infant death certificates.

Important facility-based surveys include the National Hospital Discharge Survey, the National Nursing Home Survey, and the National Ambulatory Medical Care Survey (NAMCS). The NAMCS samples the patient records of 2,500 office-based physicians to obtain data on diagnoses, treatments, medications prescribed, and characteristics of physicians and patients.

The agency's publications include annual books such as *Health, United States* (the official government compendium of statistics on the nation's health) and periodicals such as *Vital and Health Statistics*. It

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sponsors conferences and workshops and offers not only the findings from its research but also training in its research methodologies.

By contacting the appropriate NCHS division, health data users (including marketers) can obtain detailed statistics (many of which are unpublished) on any of the extensive number of topics the agency monitors. Staff members also are available to help with any data issues. In short, the NCHS performs an invaluable service for those who require data on health and healthcare.

The CDC has been involved in disease surveillance activities since it was established as the Communicable Disease Center in 1946. Its surveillance activities now include programs in human reproduction, environmental health, chronic disease, risk reduction, occupational safety and health, and infectious diseases. It compiles data generated by these programs into registries, which then serve as a basis for much of the epidemiologic information in the United States.

Data registries are the main source of data for many categories of health personnel. Most health professionals must be registered in the state in which they practice. In addition, most belong to professional associations whose rosters become de facto registries. Like the registration of other types of data, the registration of healthcare personnel involves regular, timely recording of people entering a given profession. Updating registries of health personnel is difficult, making them more prone to error than most other registries.

The federal government is a major source of nationwide data on health facilities. The National Master Facility Inventory (NMFI) is a comprehensive file of inpatient operations, including hospitals, nursing homes and related facilities, and other custodial or remedial care centers. The federal government keeps the NMFI current by periodically adding the names and addresses of new establishments licensed by state boards and other agencies and by conducting annual surveys.

Commercial data vendors maintain databases of physicians and other personnel. Some of these databases are comparable to the traditional databases maintained by professional organizations and government agencies. Data vendors may identify emerging professions or marginal practitioners that do not have an association base or are not tracked by the government.

Local organizations—such as marketing firms, regulatory agencies, and business coalitions—maintain databases on healthcare facilities as well. Some private data vendors collect, disseminate, and even sell data on non-hospital businesses, such as health maintenance organizations, urgent care centers, freestanding surgery centers, and other provider groups.

Arguably, the most complete hospital registry is maintained by the American Hospital Association (AHA). The AHA annually compiles data on

the availability of services, utilization patterns, financial activity, management, and personnel in US hospitals. It updates this database through an ongoing survey. Certain commercial data vendors also have established hospital databases.

administrative record
A registration system for the transactions involving members or enrollees of a registry.

Administrative records are a variation of the registries used in healthcare research. They are not intended to be registries of all enrollees or members of an organization or a group; rather, they are records of transactions involving these individuals. Thus, a list of all Medicare enrollees is a registry, but the recorded healthcare encounters of Medicare enrollees constitute an administrative system.

Administrative records can serve a useful function because they provide access to data sources not otherwise available. However, unlike other forms of data generation, such as censuses and surveys, the raw data are not strictly under the control of those who establish the data file. Administrative records may be submitted by a variety of parties, creating inherent problems in data quality and standardization. A great deal of effort is currently being expended to improve the accessibility of data maintained by federal agencies. For example, Medicare data on the number of current enrollees are now available for all US counties, as are year-to-year migration data from the Internal Revenue Service.

With the growing interest in population health, both registries and administrative records are garnering more attention. The need to better understand community populations and the transactions in which they are involved has increased the focus on these sources of data. Indeed, the Census Bureau and other government agencies are increasingly accessing these types of databases to supplement their standard data collection activities.

Surveys

A sample survey involves the administration of a survey form or questionnaire to a systematically selected segment of a target population. The sample is composed of respondents who are representative of the population being examined. Conclusions about the total population are then formed on the basis of the data collected from the sample.

The federal government—primarily through the NCHS—is a major sponsor of health surveys. It administers myriad surveys focusing on different topics, such as medical care expenditures and utilization of hospital, ambulatory care, nursing home, and home health facilities and services. In addition, the National Institutes of Health (NIH) and the CDC episodically conduct surveys that generate data of interest to healthcare marketers.

Each year, the Census Bureau randomly contacts a sample of 3.5 million households in the United States to complete the American Community Survey (ACS). Designed to replace the long form that was administered through the decennial census, the ACS poses questions about households' income, expenses, health insurance coverage, disabilities, education levels, work commute, veteran status, and so on. Answers to these questions allow

the bureau to generate statistics and reports that help determine how billions of dollars in federal and state funds are distributed each year.

The ACS is different from the traditional census in that it is continuous, not periodic. The demand for current data led federal policymakers to collect social, economic, and housing data on an ongoing basis. The benefits of having current data—along with the anticipated decennial census benefits of cost savings, better planning, improved census coverage, and more efficient operations—led the Census Bureau to develop and implement the ACS.

Data generated by the ACS are presented for several levels of census geography. The lowest level is the census block group. The results of the ACS are published in three temporal versions: one-year data, combined three-year data, and combined five-year data. The more years that are combined, the greater the sample size and the more reliable the estimates.

While the ACS does not have the statistical power of the long form sent to one in six households in the decennial census in the past, and demographic purists raise some issues with the methodology, the benefit of having continuous data collection outweighs any drawbacks. ACS data can be accessed directly through the Census Bureau's website.

Some professional associations—such as the American College of Healthcare Executives, the American Medical Association (AMA), and the AHA—regularly survey their members. Voluntary health associations—such as the American Cancer Society and the American Heart Association—may commission surveys of consumers, patients, or physicians. Foundations may fund research projects that collect health-related data. Some commercial data vendors sponsor nationwide surveys every year or two that involve as many as 100,000 households and that yield information on health status, health behavior, and healthcare preferences. Certain market research firms collect health data as part of their consumer surveys, and public opinion pollsters may compile data on health and healthcare. Some of the data collected in this manner are considered proprietary and are available only to clients of these firms. Other vendors sell data to the general public.

Synthetic Data

Synthetic data are figures—estimates, projections, and forecasts—generated in the absence of actual data through the use of statistical models. These data are created by merging existing demographic or health data with assumptions about a population. When census and survey activities are limited because of budgeting and time issues (e.g., the long time between official censuses), synthetic data are particularly valuable, filling the gap as needed. In the case of future data, synthetically produced projections are the only source available. The production of synthetic data has become a major business. Case study 17.1 presents an example of synthetic data production.

synthetic data Estimates, projections, and forecasts generated in the absence of actual data.

Case Study 17.1
Generating Population Data for Marketing Planning

In 2014, SunCoast Hospital began exploring the possibility of locating a satellite hospital in a fast-growing suburb next to its service area. SunCoast's marketing department was given the task of determining the size of the market in the targeted area. The decision to proceed with planning for a new facility was dependent on whether the market was large enough to support a 50-bed hospital.

Although the question was straightforward, the answer was difficult to determine. Data from the decennial census (last taken in 2010) were considered the most accurate, but census data were now four years old. Data that old might be accurate enough to use (with appropriate disclaimers) in a relatively stable community, but in SunCoast's target market, the population had grown so rapidly in a short time that the four-year-old data were likely to be far from accurate. (The 2012 population estimates for the target population were available from the ACS, but these figures were not considered current enough.)

The marketing analysts considered techniques to estimate the current (2014) population in the target area. They could extrapolate trends from known data, assuming that present trends were a continuation of past trends. In this case, the analysts acquired data for the target area from the 2000 and 2010 censuses, assuming that figures from these two periods would be most realistic. (They could have gone back farther to the 1990 census, but given the rapid growth in the community, they thought much older data would not be appropriate.)

To estimate the population at the time of the study (2014), the analysts used a straight-line method to determine the average annual population increase for the area between 2000 and 2010 and then applied that rate of change to the 2010–2014 period. Thus, the calculation was as follows:

(2010 population – 2000 population) ÷ 10 years
= (Average annual population increase × 4) + 2010 population
= 2014 population estimate.

The equation yielded the following result:

(20,000 – 10,000 = 10,000) ÷ 10 = 1,000 × 4
= 4,000 + 20,000
= 24,000.

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Thus, the technique generated a 2014 population estimate of 24,000 residents for the service area. This approach assumed a steady population increase of 1,000 each year.

For comparison purposes, the analysts examined the year-to-year percentage increase rather than the increase in absolute numbers. The formula for that calculation was as follows:

[(2010 population − 2000 population) ÷ 2000 population] ÷ 10 years =
[(Average annual percentage increase × 4) × 2010 population] +
2000 population = 2014 population estimate.

The equation yielded the following result:

(20,000 − 10,000 = 10,000) ÷ 10,000 = 100% ÷ 10 = 10% per year
× 4 = 40% × 20,000 = 8,000 + 20,000 = 28,000.

This approach yielded an estimate of 28,000 residents rather than 24,000, indicating that the proportionate increase was relatively greater than the absolute increase.

Both approaches were equally valid, and both indicated a rapidly growing population. From SunCoast's perspective, a population of 28,000 was considered more favorable than a population of 24,000. The experience of the analysts was brought to bear to determine which estimate appeared to be the most viable.

Case Study Discussion Questions

1. Why was a current population estimate unavailable to the SunCoast administrators?
2. What data did the analysts choose as a basis for calculating population estimates and why?
3. To use a straight-line estimation method, what assumptions have to be made?
4. Why did the two techniques yield different estimates when the same baseline data were used?
5. Given the goal of the hospital, should it have used the more conservative figure or the larger estimate?

Both government agencies and commercial data vendors generate synthetic data. In the federal government, population estimates for states, metropolitan statistical areas, and counties are prepared each year as a joint effort of the Census Bureau and the state agency designated under the Federal–State Cooperative for Population Estimates. The purpose of the program is to standardize data and procedures so that generated estimates are of the highest possible quality.

Data generated by commercial vendors are available for geographic units (e.g., zip codes, census tracts), and they often provide greater detail (e.g., sex and age breakdowns) than government-produced figures. Vendors may also generate estimates and projections for custom geographic areas (e.g., a market area). Calculations for smaller geographic areas and population components, however, are less precise than calculations for their larger counterparts, but because these vendor-generated figures are easily accessible and timely, they have become a mainstay of healthcare marketers.

A major category of synthetic data comprises estimates and projections of health services demand. There are few sources of actual data on health services utilization, and projections of future demand are often required; thus, a number of approaches have been developed to synthetically generate data to fill this void. The general approach is to apply known utilization rates to current or projected population figures. To the extent possible, these figures are adjusted for, at a minimum, the age and sex composition of the target population. Most of these calculations are based on utilization rates generated by the NCHS.

Commercial data vendors have led the way in developing demand estimates and projections. Some vendors have developed calculations for the full range of inpatient and outpatient services, although often these data are available only to the vendors' established customers. Other vendors provide select data on the demand for a particular service line, for example. Case study 17.2 presents an example of estimating demand using synthetic data.

Case Study 17.2
Methodology for Estimating Health Services Demand

For strategic planning purposes, Mountain View Hospital needed to determine the morbidity level of its service area population and estimate the health services demand that these conditions would yield. Unfortunately, these types

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of data were not readily available, and the market analyst had to develop estimates and projections of demand on the basis of modeled data.

To develop an estimate of the demand from the target population, the analyst needed two types of information: utilization rates that could be applied to the defined population and population estimates and/ or projections. The utilization rates available reflected the population's age and sex, adjusted for region of the country. The population figures broke down the population into relevant age–sex categories. For each DRG (diagnosis-related group), for example, the utilization rate was calculated for each of 18 age–sex groups. These rates were then applied to the respective age–sex groups in the population in question, and the sum of the estimates or projections was calculated.

Utilization rates based on data collected through nationwide surveys were obtained from the NCHS. When the rates of each age–sex group for each medical diagnosis for hospital patients were applied to the population estimate (broken into age–sex groups), a detailed estimation of health services utilization could be generated. The following table on cardiac catheterization services illustrates this process.

CALCULATION OF DEMAND FOR CARDIAC CATHETERIZATION

Population					Ages				
	<5	5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44
Males	1,000	1,050	970	270	2,580	3,530	3,170	3,270	3,230
Females	1,200	1,100	1,030	20	420	1,220	1,550	2,350	3,170
	45–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	>85
Males	3,110	2,020	1,070	690	280	130	1,050	970	270
Females	2,570	2,560	2,450	1,850	1,530	1,430	1,100	1,030	20

Utilization Rate					Ages				
	<5	5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44
Males	0.1	0.0	0.0	0.0	0.0	0.1	0.3	1.1	2.5
Females	0.0	0.0	0.0	0.1	0.0	0.0	0.2	0.3	0.7
	45–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	>85
Males	3.6	9.8	10.4	14.8	18.0	19.8	28.0	24.6	9.4
Females	1.7	2.6	5.2	3.9	9.3	11.7	12.8	8.2	8.9

(continued)

Demand	Ages								
	<5	5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44
Males	0	0	0	0	0	0	1	4	8
Females	0	0	0	0	0	0	0	1	2

	45–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	>85	Total
Males	11	20	11	10	5	3	29	24	3	129
Females	4	7	13	7	14	17	14	8	0	88

Each age–sex category had its own utilization rate for cardiac catheterization. Because this procedure is primarily performed on older adults and senior citizens, relatively few children were affected. As this table demonstrates, the number of cases was calculated separately for each age–sex category, and the results were totaled to determine the overall demand for the population. For example, women in the 40- to 44-year-old age group reported a utilization rate of 0.7 per 1,000, compared with a rate of 2.5 per 1,000 for men in the same age group. Thus, although the populations of men and women in this age group were similar, four times as many cardiac catheterizations were predicted for men than for women in that age group. Each age–sex category was compared in a similar manner.

For this particular population, it appeared that there would be demand for 216 cardiac catheterizations annually—129 for men and 87 for women. In the absence of actual data, this model returned a reasonable approximation of the level of demand for this procedure.

Case Study Discussion Questions

1. Under what circumstances is it necessary to generate synthetic data (estimates and projections) for health services demand?
2. What assumptions were made about the utilization rates and population projections used?
3. How might the figures look different for a similar table for childbirth or breast cancer?
4. What are the dangers involved in making any type of projection with regard to health services utilization?
5. How many years out (e.g., 5, 10, 20) should one feel comfortable making a projection?

Sources of Data for Healthcare Marketing

Many sources of data are available to healthcare marketers today, and the range of options continues to grow. These sources fall into four main categories: government agencies, professional associations, private organizations, and commercial data vendors. The products available from these sources fall into two categories: reports that summarize the data and the actual data sets. Although the sources presented in this section consist of the agencies and publications responsible for disseminating these data sets, numerous compendia also exist that marketers may find useful. Exhibit 17.4 describes useful data available from the federal government.

Because no national clearinghouse for health data currently exists in the United States, identifying and acquiring data is a challenge for healthcare marketers. However, certain compendia of health data are available that are useful for marketing purposes. No single publication provides all of the information a marketer needs, but the ones listed here offer a starting point and direct analysts to other relevant resources. These and similar reports are now accessible on—and increasingly only on—the internet.

The NCHS issues *Health, United States*, the best-known annual compendium of health data. This report includes data on health status, health behavior, health services utilization, healthcare resources, healthcare expenditures, and insurance coverage. These data are mostly at the national level, but some state and regional data are presented as well. A companion publication to *Health, United States* is *Behavioral Health, United States*. Although this is released less frequently, it is the primary source of data on behavioral healthcare. The statistics are based on data collected by the Center for Mental Health Services, a division of the Substance Abuse and Mental Health Services Administration.

CMS publishes the *Data Compendium*, a collection of Medicaid and Medicare figures drawn primarily from CMS files and supplemented with records from other agencies. These data are at the national level, but some state-level data are also included. No substate levels of data are presented.

Until 2011, the Census Bureau produced three statistical compendia. The first was called *Statistical Abstract of the United States*, which drew data from the decennial census, the Bureau of Labor Statistics, and other public and private sources. The abstract covered subject categories (e.g.,

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vital statistics, nutrition) as well as data for states and metropolitan areas. The second compendium was a supplement to the abstract titled *County and City Data Book*. This publication contained data on all states, counties, and cities with 25,000 or more residents, as well as all other places with a population of 100,000 or more. The third compendium was also a supplement called *State and Metropolitan Area Data Book*. It contained data for each state, variables for each metropolitan statistical area (MSA), and variables for each MSA's central city. In 2011, the bureau shuttered its compendia program, ending the publication of these three data references. Most of the data, however, are still accessible but are no longer in compendium form.

County Business Patterns, another annual publication of the bureau, presents data on the economic activities of counties and other small areas. It includes a comprehensive account of the healthcare business in a county. This work will continue to be produced by the bureau.

Government Agencies

Governments at all levels generate, compile, manipulate, and disseminate health data. The NCHS, the CDC, the NIH, and other organizations are prominent sources of a large share of the nation's health data. The Bureau of Health Professions (which operates under the Department of Health & Human Services' Health Resources and Services Administration) maintains the Area Health Resources File, a master record of health data compiled by the federal government. In addition, other non-healthcare federal agencies create healthcare databases, such as the Bureau of Labor Statistics (e.g., data on health occupations) and the US Department of Agriculture (e.g., nutritional data). The number and diversity of databases maintained by federal agencies are impressive, and the information covered, content, format, cost, data collection frequency, and accessibility of these disparate databases vary from agency to agency.

State and local governments also are major sources of health data. State governments generate demographic data, and each state has a data center responsible for demographic projections. At the state level, vital statistics may be obtained in the most timely fashion and state university data centers can be involved in processing health data. Local governments may generate demographic data for use in marketing functions. City or county governments may produce population projections, and county health departments are responsible for collecting and disseminating vital statistics data.

The growing recognition of the role of social determinants in the health status of the population and increased interest in community health

needs assessments has generated demand for types of data not historically considered within the purview of healthcare marketers. Government agencies are typically the sources of the types of data being increasingly sought—related to housing, food security, job availability, pollution, crime, and so forth. Federal-level departments are a major source of such data, although many of the relevant monitoring activities are relegated to state governments.

Professional Associations

As mentioned earlier, associations in the healthcare industry (e.g., AMA, AHA) compile an assortment of data about their members and those members' activities. This information is typically for internal use only, but some associations do make their databases available to external entities.

Reliable, accurate, credible, timely, and well-managed data are invaluable not only to the business of healthcare but also to the practice of medicine. This fact is the foundation of the many information-focused healthcare associations that exist today, such as the Healthcare Information and Management Systems Society, the National Association of County and City Health Officials, and the National Association of Health Data Organizations.

Private Organizations

Many private organizations (mostly not-for-profit) generate health data. Voluntary healthcare associations often compile, repackage, or disseminate data relevant to their organizations. The American Cancer Society, for example, distributes morbidity and mortality data related to cancer. The American Heart Association performs a similar function related to heart disease. Private organizations may commission and publish special studies on fertility or related issues.

Many organizations repackage data collected elsewhere (e.g., from the Census Bureau or NCHS) and present them in a specialized context. For example, the Population Reference Bureau—a private not-for-profit organization—distributes population statistics in many forms. Other organizations, such as AARP, not only assemble and disseminate secondary data but also conduct primary research and sponsor numerous studies.

Commercial Data Vendors

As discussed earlier in the chapter, commercial data vendors have emerged to fill perceived gaps in the availability of health data. Commercial data vendors may establish and maintain their own proprietary databases or reprocess or repackage existing data. This group also includes the major data vendors (e.g., ESRI, Claritas, Experian) that incorporate healthcare databases into their business database systems.

Summary

Healthcare marketers need a wide variety of data to research, plan, implement, and evaluate marketing activities. Marketers use demographic, psychographic, economic, and other data—even data that are seemingly unrelated to healthcare, such as information on housing, employment, and crime in a service area. Health data can be categorized as community or organizational, internal or external, and primary or secondary as well as in terms of geographic level and time period (i.e., past, present, or future). Health data are generated through censuses, registries, and surveys. Synthetic data in the form of estimates and projections are generated in the absence of actual data.

Healthcare marketers can access health data in a number of ways. Government agencies at all levels are important sources, and the federal government is a major collector and distributor of myriad types of data. The Centers for Disease Control and Prevention, the National Center for Health Statistics, and the Centers for Medicare & Medicaid Services are useful sources of health data.

Professional associations, such as the American Medical Association and American Hospital Association, compile statistics and data sets and make them available to the public, their constituents, and interested parties. Not-for-profit associations, such as the American Cancer Society and the American Heart Association, do the same. Educational institutions and research organizations provide a significant amount of data to health professionals. Increasingly, commercial data vendors have entered the field to supplement—or, in some cases, supplant—the data provided by other organizations.

The internet enables massive amounts of health data to be distributed. The federal government has led the way in posting health data online, and a variety of public and private entities have followed suit.

Key Points

- Data on healthcare and other related topics are essential in researching, planning, implementing, and evaluating marketing activities.
- Because health information is often internally generated by private healthcare organizations, useful health data sets may be unpublished, proprietary, or difficult to access.
- HIPAA rules place restrictions on the use of health data.
- Most market research is based on secondary data, although primary research must be conducted in some situations.
- Marketers must be familiar with the geographic levels at which data are aggregated to effectively use this information.

- Health data are generated via censuses, registration systems, and sample surveys, and marketers need to be familiar with the characteristics of each method.
- In the absence of actual data, synthetic methods are used to generate demand estimates and projections.
- The NCHS is the primary source of health data in the United States, but other federal agencies are major sources of health data as well.
- Other sources of health data include governments at all levels, professional associations, private organizations, and commercial data vendors.
- The internet makes it easy to distribute health data to a wider audience.
- The ACA mandate and the growing interest in community health needs assessments have broadened the range of data of interest to marketers.

Discussion Questions

1. Why has the healthcare industry not developed data clearinghouses and nationwide sources of market data, as other industries have?
2. Under what circumstances might primary rather than secondary data need to be collected?
3. What are the disadvantages of using the decennial census as a data collection method?
4. Why are registration systems and administrative records important sources of data for healthcare marketers?
5. What function does the NCHS serve, and why is it an important resource for healthcare marketers?
6. Under what circumstances do marketers need to access synthetic data generated by government agencies or commercial data vendors?
7. Why do healthcare marketers frequently use health data generated by state agencies?
8. What are the advantages of accessing health data online?

Additional Resources

AHA Guide, published annually by the American Hospital Association Bureau of Health Professions: bhpr.hrsa.gov.

Centers for Disease Control and Prevention: www.cdc.gov.

County Business Patterns, published annually by the US Census Bureau Health Resources and Services Administration: www.hrsa.gov.

Health, *United States*, published annually by the Centers for Disease Control and Prevention: www.cdc.gov/nchs/hus/index.htm.

Healthcare Information and Management Systems Society: www.himss.org.

Morbidity and Mortality Weekly Review, published by the Centers for Disease Control and Prevention: www.cdc.gov/mmwr/about.html.

National Association of County and City Health Officials: www.naccho.org.

National Association of Health Data Organizations: www.nahdo.org.

National Center for Health Statistics: www.cdc.gov/nchs.

Physician Characteristics and Distribution in the US, published annually by the American Medical Association.

Socioeconomic Characteristics of Medical Practice, published annually by the American Medical Association.

US Census Bureau: www.census.gov.

V

THE FUTURE OF HEALTHCARE MARKETING

Part V summarizes the current and future status of healthcare marketing. Its sole chapter proposes factors that are likely to influence this future and identifies areas of growth on which healthcare marketers may wish to capitalize.

18

A LOOK AHEAD

As healthcare marketing continues to mature, it will undoubtedly undergo substantial changes. The fluid and unpredictable environment in which healthcare marketers operate, however, makes it difficult to predict what those changes will be. This chapter reviews the current status of healthcare marketing and considers the factors that will influence its future.

Where Healthcare Marketing Is Today

Healthcare marketers have learned much from past successes and failures. They now have better data, tools, and techniques at their disposal, and their expertise has increased dramatically. They are highly skilled at monitoring and assessing initiatives, collecting reliable and relevant data, incorporating those data into activities, harnessing the internet and other contemporary technologies to reach target audiences, and seeking out and responding to consumer needs and wants.

Because more and more healthcare organizations have integrated their marketing activities into their business development function, marketing is now considered an integral part of corporate operations. The question is no longer "To market or not to market?" but "To what extent will marketing contribute to the success of the organization?" To that end, new hires are likely to receive a marketing orientation regardless of their position, and incentive programs that reward superior customer service are turning employees into marketers. In addition, the marketing department works closely with the fund development department and initiates co-marketing activities with the community relations department. Marketers foster customer-friendly facilities and develop affinity programs for target populations. While not all healthcare entities share the same enthusiasm for marketing, every single one of them benefits from marketing activities—especially in today's cash-poor but regulatory-rich environment.

The passage and implementation of the Affordable Care Act (ACA) of 2010 opened up new opportunities but also introduced new threats. This reality has required marketers to develop new strategies. Before the ACA, for example, health plans marketed mostly to employers or businesses that provided insurance benefits to their workforce. Today, health plans are marketing

directly to individuals and households, who receive incentives under the ACA to have medical insurance coverage. Some of the strategies that health plans employ include search engine optimization (e.g., attaching a popular descriptive tag to posted content), educational content production, and data collection and analysis (Tribune Media Group 2014). At the time of this writing, the future of the ACA remained uncertain. The elimination of any provisions of the ACA would have significant implications for the healthcare system and for healthcare consumers.

new media
A catchall term for technological channels for creating, storing, distributing, transmitting, and accessing content; also known as *digital media.*

New media (also known as *digital media*) and social media play a significant role in disseminating promotions and other marketing initiatives in healthcare. The opposite of analog or traditional media (e.g., print, television, radio), new or digital media (e.g., internet, e-mail, smartphones, data cloud, streaming media) are no longer an emerging technology in healthcare. Their continued evolution keeps marketers chasing new ways to apply or incorporate them to healthcare campaigns—big or small. As discussed in chapter 13, social media tools (part of new media) are invaluable to healthcare marketers striving to influence their target markets and strengthen their organization's brand and products.

Healthcare executives, administrators, and clinicians have become increasingly comfortable with social media, and many hospital and system CEOs are blogging and tweeting. Many health professionals (managers, researchers, nurses, physicians, allied health practitioners, policymakers, professors, consultants, pharmacists, vendors, and so on) are active users of Twitter and LinkedIn; they log on not only to share and follow healthcare-related news and debates but also to promote their own organizations and professional achievements.

Financial pressures continue to plague many healthcare organizations—and, by extension, their marketing functions. Although pharmaceutical and biotech companies, among others, have robust marketing budgets (reaching up to tens of millions of dollars), in other sectors of the healthcare industry, marketing fortunes ebb and flow depending on local circumstances. Some hospitals and other providers have eliminated their in-house marketing departments, opting instead to outsource the function to an agency or hire external consultants as needed.

co-marketing
An agreement between two or more organizations to combine their efforts to achieve their respective objectives.

Co-marketing, co-branding, co-sponsorship, and other forms of partnerships are not new to healthcare marketing, but the present environment is ripe for more of these endeavors. The cost of marketing is always an issue, and this trend is driven in part by the spate of mergers and acquisitions that require the standardization and coordination of marketing initiatives for disparate healthcare entities. Pharmaceutical, diagnostics, and biotechnology companies as well as hospitals and health systems have entered into co-marketing deals for a number of reasons:

- To share resources and expertise
- To cross specific areas or expand market reach
- To increase visibility
- To gain credibility in another market
- To boost sales and revenue

The two keys to a successful marketing partnership are the compatibility or business alignment between the parties and the complementarity of their products. Organizations, with guidance from marketing, must identify conflicting interests, possible complications, and other opposing factors before pursuing such deals with each other.

Being optimistic about where healthcare marketing will be in the future is not hard. Judging from its continued evolution and accepted use in the industry (especially in the care delivery sector), it seems to be steadily moving forward.

Current Trends That Could Affect Future Practices

The trends described in this section represent possible future realities for healthcare marketers. However, as stated throughout this book, rapid changes occur in healthcare. Thus, the priorities that demand attention today may not be as urgent tomorrow. Healthcare marketers, nonetheless, must be vigilant of these trends and similar shifts in the industry.

Expected Rise in Healthcare Demand
During the first ACA open enrollment period (October 1, 2013, to March 31, 2014), tens of millions of Americans enrolled in health plans through state and federal health insurance exchanges (Henry J. Kaiser Family Foundation 2014). Many of these enrollees were deemed eligible for state Medicaid programs. These newly insured individuals, as well as those who have bought coverage on their own, are expected to increase demand—not just for primary care but also for preventive and mental and behavioral health services. The number of Americans with health insurance increased by 17 million during the first three years under the ACA. (It should be noted, however, that more than a million citizens have lost their insurance coverage since 2017 as a result of changes to ACA provisions.) More attrition is likely as the ACA remains the focus of political opposition and pressure to allow substandard insurance plans continues.

Other present realities that are expected to drive up future demand include the following:

- Healthcare practitioner shortages (including primary care physicians and specialists, nurses, and allied health professionals)
- An increase in older, high-risk populations
- Longer lifespans involving chronic illness and disability
- The emergence of "diseases of despair," such as depression, substance abuse, and addiction
- The reality that Americans as a population are getting sicker

Experienced healthcare marketers anticipate and study demand to develop and implement initiatives that will reach the right audience at the most opportune time.

Continued Consumer Involvement

Health plans are now trying to capture individual (not just business) purchasers of health insurance, appealing to consumers with customizable options. Meanwhile, employers (including healthcare organizations) are offering incentives to workers who improve their health or adopt a healthy lifestyle. Hospitals, systems, and other providers are creating infrastructures and tools to encourage patient and family participation in treatments, disease prevention, health maintenance, and decision-making. In addition, many patients and other healthcare customers have become involved in self-advocacy. They conduct their own informal research, talk to peers and access other resources, bring information to discuss with their physicians, monitor their conditions, and so on.

Consumer engagement is a buzzword in healthcare, and its pursuit requires that marketers understand existing and prospective customers better. In particular, marketers must better understand complex patterns of consumer motivation—motivation that is increasingly driven by social group identification. Target marketing, mass customization, direct-to-consumer marketing, customer relationship marketing, and social media marketing are just some of the essential techniques that marketers use to generate consumer engagement.

Mergers and Acquisitions

Since 2009, the number of hospital consolidations has skyrocketed. In 2017, the number of mergers and acquisitions was more than twice the total in 2009 (115 versus 50), and many of those deals involved multiple hospitals (RevCycle Intelligence 2018). Although for-profit chains have led the charge, since 2007, not-for-profit hospitals have been aggressively involved in such transactions. Many small community hospitals are attractive to large and financially stable healthcare organizations seeking to expand. These developments leave the future viability of independent hospitals uncertain.

Initially driven by a desire for economies of scale, market share expansion, and standard business development assumptions, the growing emphasis on value-based reimbursement has created an additional incentive for consolidation. Such activities, previously thought of as incremental in advancing the fortunes of a healthcare system, are now considered transformative within the healthcare environment as hospitals and health systems attempt to introduce population health, reduce the cost of care, and introduce innovative treatments (RevCycle Intelligence 2018).

These consolidations have not been limited to hospital acquisitions, as the purchase of physician practices by hospitals has continued apace. Indeed, some 5,000 physician practices were acquired by hospitals between 2015 and 2016 alone (RevCycle Intelligence 2018). Recent acquisitions have doubled the number of physician practices owned by hospitals.

Every merger or acquisition represents both a challenge and an opportunity for marketers. Disparate entities must be brought under a single marketing umbrella, widely varying marketing approaches must be standardized and coordinated, and new acquisitions must be rebranded under the aegis of their new owners. A national chain acquiring a local hospital is not likely to have an in-depth understanding of the local market and thus requires effective marketing input to develop a smooth ownership transition process.

Technological Advancements

The electronic health record, mobile or *mhealth*, proprietary decision support software and other clinical solutions, personal health and fitness apps, telemedicine, wearable sensors, physicians-only social networks, online medical consultations, language translation application for doctors, remote and wireless patient monitoring, and voice search capability (e.g., Siri—Apple's personal assistant) are just some of the healthcare technologies that have been introduced in the recent past or are being tested today (Jayanthi 2014; Lee 2013). More health-specific tools, devices, and programs emerge and are adopted daily.

One disappointing realization is the unfulfilled promise of electronic medical records (EHRs) (National Public Radio 2019). Despite investing $36 billion to incorporate EHRs in hospitals and physician practices, not only have the promised benefits not been realized, but the massive acceptance of EHRs by healthcare organizations has had negative side effects. These include unanticipated risks to patient safety, opportunities for fraud, unrealized interoperability, physician burnout, and cover-ups of the flaws in EHR systems. Given the now-ubiquitous nature of electronic medical records and healthcare organizations' inability to effectively leverage this expensive resource, healthcare marketers who depend heavily on their organization's information technology function for support face significant challenges.

These developments indicate that many healthcare organizations are investing in technology and view it not only as a partner in improvement but also as a competitive advantage. (In addition, the HITECH [Health Information Technology for Economic and Clinical Health] Act of 2009 mandated that healthcare organizations establish information systems and ensure their meaningful use.) For healthcare marketers, this means knowing the names, types, functions, and pros and cons of the technology used within the organization by its clinical providers, patients, staff, leaders, and other stakeholders. Marketers do not have to be experts, but they do need proficiency in these technologies to convince others of the benefits and to capitalize on them for marketing purposes.

Emphasis on Outcomes

In response to concerns about the effectiveness of the healthcare delivery system and persistent disclosures of the high level of medical errors in the system, unprecedented emphasis is being placed on clinical outcomes. Healthcare providers must not only defend the adverse outcomes they report but capitalize on favorable outcomes. As more payers turn to a **pay-for-performance** model, the importance of positive outcomes will further increase. Indeed, Medicare is no longer reimbursing hospitals for the costs of patients readmitted within 28 days of discharge. Patient safety issues will continue to be paramount, and a considerable groundswell of support for more controls over patient care has emerged.

pay for performance
A payment method used by third-party payers to reimburse health facilities for the services they provide based on the outcomes of their efforts rather than the volume of services provided.

Marketers will have to be front and center on the outcomes issue. They must ensure that outcomes research addresses salient issues above and beyond clinical factors (e.g., patient demographics, lifestyles, social context). They need to develop promotional campaigns based on high surgical success rates or low mortality rates. They may have to rationalize low success rates or high mortality rates. Marketers are likely to be the go-between for providers and the public, the regulators, and the policymakers.

Further, healthcare marketers must become knowledgeable about population health management if they are to support their institution in achieving its goals. This approach applies the principles of population health (discussed in chapter 8) to the management of a defined group of patients, employees, insurance plan members, or consumers in an effort to manage utilization of services and control costs.

Population health management takes a proactive approach to increasing the efficiency of provider organizations to address the demands of the new healthcare environment. This approach emphasizes quality over quantity, prevention over treatment, group outcomes over individual patient outcomes, and, most important, keeping people well rather than treating them after they become ill.

Health Professional Shortages

The addition of many newly insured health consumers into the system, the aging of the population, the retirement of aging practitioners and aging faculty, the length of professional training and education, changes in medical specialty distribution, and other factors have all contributed to shortages of physicians, nurses, and other health professionals. Simply, demand exceeds the supply, and the supply is likely to fall short for the foreseeable future.

Given the competition for medical personnel, healthcare marketers are in a position to contribute to recruitment efforts. They can tell a story of the hospital, physician group, or other provider that will resonate with potential employees and make job openings attractive. Marketers should be more knowledgeable about the organization than almost anyone else and recognize the factors that appeal to physicians, nurses, and other personnel. The organization's marketers should be intimately involved in any recruitment effort.

Staff shortages in hospitals open up opportunities in other healthcare settings that are ready and able to meet increased customer demands. Retail clinics, concierge medicine practices, urgent care facilities, private practitioners, independent labs, and even health systems in other countries may see more business if doctor's offices or hospital units are experiencing backlogs of patients. The marketer's job includes finding such opportunities and capitalizing on them.

Diversified Healthcare Environment

The globalization that is widespread in other industries has affected US healthcare delivery as well. Although the provision of healthcare remains primarily local, for many healthcare products, the market has become global. Immigration—not births—is expected to be driving factor in US population growth in coming decades. Since the late twentieth century, the patient and employee populations of many hospitals and other healthcare facilities have become less homogeneous, no longer composed of just US-born citizens. In addition, foreign-trained medical personnel have become common not only in large medical institutions but in inner-city and small-town physician practices. Foreign-trained practitioners will continue to be recruited to fill positions in the US healthcare system given ongoing personnel shortages.

Medical tourism (or global medicine) has also added to healthcare's ethnic and racial diversity. Some US healthcare systems actively court patients from other countries, adapting their marketing techniques to the sensibilities of foreign target markets. Other providers are opening facilities overseas, exporting the well-respected American brand of medicine and health management. Conversely, American healthcare consumers are lured abroad to take advantage of lower-cost but highly sophisticated medical services offered in Brazil, India, Singapore, Thailand, Turkey, and other countries. American

health insurance companies, recognizing the cost savings of medical tourism, are slowly supporting this movement.

These developments represent opportunities for marketers to differentiate their organization from competitors. A facility's diverse patient and staff makeup, as well as its culturally appropriate and sensitive programs, may be leveraged to attract both local and international customers. Marketers will need to be innovative, resourceful, and technologically skilled if they are to contend with global competitors.

In chapter 2, the enterprisewide, operational, educational, and promotional functions of healthcare marketing are described. These functions will be especially salient in the future as healthcare continues to be consumer driven, technology enabled, and globally oriented.

Seizing Market Opportunities

Now that healthcare marketing is considered a contributor to the success of the healthcare enterprise, marketers have the obligation and the authority to seek and pursue opportunities to promote the organization and influence its internal and external customers.

To do the best job, marketers must do the following:

- Go beyond applying successful marketing approaches and shift their perspective to that of a healthcare customer or decision maker
- Get involved early in the strategic planning process to understand and influence organizational decisions
- Know enough about financial analysis to calculate and demonstrate the return on the marketing investment
- Develop an acute understanding of both the customers and the available services to match the right type of need with the right type of supply
- Ensure that all organizational initiatives have a marketing component and provide evidence that those components are achieving the stated objectives
- Acquire knowledge of the social determinants of health and develop skills in population health analysis
- Develop expertise in population health management and the intricacies of value-based healthcare

In addition, marketers must identify clinical areas of growth on which the organization may want to capitalize. Some growth trends will be national

in scope, but, since the provision of healthcare is always local, local circumstances must be taken into consideration. Under the ACA, not-for-profit hospitals and other providers must conduct community health needs assessments for the purpose of population health management. Through this process, marketers can identify not only the unmet needs of the service population but also potential business opportunities.

Anticipated Growth Areas

The following are just some of the many areas that are likely to thrive in the foreseeable future. Given the unpredictability of healthcare, however, these areas of growth are very likely to change. Thus, marketers should monitor the marketplace for similar emerging opportunities. Involvement in these (or similar) areas may help the organization fulfill the population health management provision of the ACA.

Elder Care

People are living longer, thanks to myriad factors, including better lifestyle choices and better medicine. In the United States, the Census Bureau reports that the elderly population is projected to increase yearly, doubling to about 80 million by 2050. These numbers mean that a commensurate growth in demand for services for seniors (those aged 65 to 84), the very elderly (those aged 85 or older), and older adults (those aged 55 to 64) can be expected. (Note that these age group terms and age ranges may vary, as no standard definitions exist yet.)

Referred to as *senior care*, *elder care*, or *aging services*, this sector of the healthcare industry will continue to grow for the foreseeable future. In the United States, increased life expectancy means that more people are living longer—but coping with an increasing number of chronic conditions. Despite the persistent need to adapt to an aging population of chronically ill and disabled patients, the development of services for these populations continues to lag.

Older adults typically do not require the same intensity of services as seniors and the very elderly do, but they are at an age when chronic conditions arise and symptoms of physical and mental deterioration appear. All three groups may demand both essential and elective services, traditional and alternative therapies, physical and mental healthcare, and more. Their medical condition and risk, health insurance, employment status, quality of life, family situation, financial assets, physical and mental acuity, technological prowess, decision-making ability, and other factors vary widely. Thus, marketers should be careful about lumping the elderly together.

Rehabilitation and Disability Management

One of the paradoxes of the US healthcare system is that more people are struggling with a physical or mental disability as more people are living longer. An estimated 13 percent of the US population (40 million citizens) have a disability (Kraus et al. 2018). The majority of the afflicted are the very elderly, followed by younger seniors, although a significant number of working-age Americans report disabilities. This number increases dramatically as those disabled by chronic disease are considered. The 25 percent of Americans reporting multiple chronic conditions could be included in this category.

Part of the reason for this high disability rate is that debilitating conditions come with aging. Much, however, can be attributed to the ability of modern medicine and therapy to keep individuals (e.g., trauma and burn survivors, severely injured people, and premature babies) alive and functioning at some level.

The need for rehabilitation services and disability management clearly exists, and insurance companies today are more willing to reimburse for these services. In fact, some government programs mandate these services in the aftermath of various medical events.

The rehabilitation field overlaps with a variety of medical specialties (e.g., cardiology, orthopedics, neurology) and with other settings (e.g., long-term care, end-of-life care). In the future, rehabilitation is likely to be included in most medical treatment plans.

Fitness and Wellness

Today's fitness "space" is filled with specialized diets, senior-specific and children-specific exercises, certified trainers, and antigravity movement, among other things. These trends demonstrate Americans' professed devotion to fitness and wellness (an irony given that the United States has among the highest rates of obesity in the world). Nutritionists, dietitians, sports medicine doctors, physical therapists, behavioral health practitioners, trainers or exercise instructors, bariatric surgeons, orthopedic surgeons, rehabilitation and recreational counselors, and other health professionals in the field—as well as the facilities in which they provide services—can expect to be in demand.

The advent of mobile health gave rise to mobile fitness and wellness. Wearable devices that take and record vital statistics, count steps taken and calories burned, and monitor other body inputs and outputs are the next frontier of fitness technology. On-demand personal trainers, massage therapists, nutritionists, yogis, and other wellness service providers can be arranged and paid for through a mobile app; these practitioners come to the home or business designated by the person who ordered the service.

Some fitness and wellness activities fall under the vanity services category, such as body sculpting exercises, massage, and salon and spa treatment. Vanity services are elective, paid out of pocket, and deal with the natural deterioration of the body typically caused by aging, exposure to harsh elements, or weight loss or gain. They include face and neck lifts, dental implants, tummy tucks, weight-loss surgery, hair transplant and hair removal, breast and butt augmentations, Botox and collagen injections, laser eye surgery, and arthroscopic procedures, among others. Despite the slow economic recovery, the natural beauty movement, and the high cost and high risk of these procedures, the demand for vanity services is expected to surge in the coming years.

Alternative Therapy

Complementary and alternative medicine—encompassing non-Western treatments such as acupuncture, chiropractic adjustments, hydrotherapy, reiki, and yoga—has been around for many years, and now it is considered mainstream. In fact, it has become so popular that many alternative therapies are offered in medical spas and by people with some training but no expertise. The same can be said for homeopathic vitamins, food supplements, or drug substitutes. With 33 states and the District of Columbia (as of mid-2019) approving the use of medical marijuana to relieve pain and other symptoms, more forms of nontraditional remedies for all types of ailments are poised to emerge in the near future.

Alternative therapies do not appeal to a cross-section of the population but to selected subgroups. Marketers of alternative therapies should be knowledgeable about the demographic and psychographic groups that find these treatments appealing.

Pain Management

Long left out of the medical school curriculum and clinical research, pain management is finally gaining well-deserved attention. The US healthcare system is notoriously ineffective at managing pain (Advisory Board 2019). Doctors are not trained in pain management and often fall back on a one-size-fits-all approach to ameliorating pain and discomfort. The catastrophic effect of the overprescribing of opioids underscores the shortcomings of the current approach to pain management.

The traditional conservative approach to managing the pain of terminally ill patients, for example, is slowly being overcome, and recent research is providing guidance to doctors who administer pain medication. In addition, a number of pain management clinics have been established to address pain (e.g., back pain) not associated with terminal disease. The growth of end-of-life care and the emergence of the hospice movement have heightened interest in pain management.

End-of-Life Care

end-of-life care
The group of support services, methods, providers, and settings for managing the pain and comfort of terminally ill patients; also known as *hospice care*.

Conventional wisdom holds that Medicare spends approximately 25 percent of its annual outlays on **end-of-life care**. This figure is eye-opening, raising the question of whether providing so much care to terminally ill people is cost-effective or whether the money could be spent on lifesaving interventions instead. Healthcare providers are faced with many questions regarding the provision of care toward the end of life: For example, how appropriate is it to expend resources on patients who are going to die soon? Are the right resources being allocated to the right people? Is quality of life being neglected in the attempt to extend life? These and many other issues must be considered given the large and growing investment being made in end-of-life care.

Despite its financial, ethical, and other implications, hospice care can be a profitable business and is expected to experience significant growth in the years ahead. Given the cost of end-of-life care, this expense is likely to be an ongoing issue in a society with a growing elderly population and during a period of financial constraints.

Summary

Although healthcare marketing has encountered some fits and starts during its nearly 40 years of history, it appears to be stronger today than ever. The industry has come to recognize that marketing is not an optional activity. As more and more organizations have coupled their marketing function with their business development function, marketing has become an integral part of corporate operations. The data, analytical techniques, and technology available today offer capabilities that past healthcare marketers could not have imagined.

Currently, the US healthcare environment is marked by the ACA, consumer-driven (instead of business-driven) commerce, new media, financial pressures, and partnerships. In addition, it is experiencing trends that will likely influence how marketers do their job in the near future—trends such as increased demand, consumer involvement, technological advances, health professional shortages, and population diversity. Further, the emergence of the population health movement and its application within healthcare organizations (population health management) is redefining healthcare marketing.

A number of developments are expected to shape the healthcare marketing environment of the future, including increased healthcare demand, consumer involvement and engagement, continued merger and acquisition efforts, and health personnel shortages. The increasingly diverse patient

population and the emphasis on outcomes will call for different types of expertise on the part of healthcare marketers.

Anticipated growth areas for the future include elder care, rehabilitation and disability management, fitness and wellness, alternative therapy, pain management, and end-of-life care.

Today, healthcare marketers tend to be highly skilled, knowledgeable, and experienced. They are well positioned to help their organization improve the outcomes—clinical or otherwise—delivered to customers in their service areas.

Key Points

- Marketing has moved from the fringes of healthcare to a central position in the C-suite.
- Healthcare marketing will continue to evolve in response to developments in the healthcare industry.
- One of the strategies that health plans—which now market directly to individuals because of the ACA—employ is search engine optimization.
- New media and social media play a big role in disseminating promotions and other marketing initiatives.
- Health professional shortages, the aging but growing population, longer lifespans, and chronic illness are some of the factors that will drive healthcare demand in the near future.
- Investment in technology indicates that healthcare organizations view technology not only as a partner in improvement but as a competitive advantage.
- Marketers have the obligation and the authority to seek and pursue opportunities to promote the organization and influence its internal and external customers.

Discussion Questions

1. In what ways is healthcare marketing now considered part of corporate operations?
2. Where is healthcare marketing today, and what are some of the changes that have occurred in the past five years?
3. What are some of the current trends in the industry, and what are their implications for the future of healthcare marketing?

4. How is marketing uniquely positioned to address some of the challenging aspects of contemporary healthcare?
5. What developments indicate that marketing is becoming more of a core function in healthcare organizations?
6. What responsibilities do marketers have in promoting the field of marketing to internal customers in their organizations?
7. How can marketers respond to areas of growth or opportunities?

Additional Resources

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GLOSSARY

accountable care organization: A structure involving a group of voluntary providers collectively held responsible for the overall cost and quality of care for a defined patient population.

account management department: The marketing function that interacts and builds a relationship with a marketing client throughout a campaign.

administrative record: A registration system for the transactions involving members or enrollees of a registry.

admission rate: For a healthcare market area, the number of patients admitted to a hospital in a specified year per 1,000 population.

advertising: Any paid form of presentation or promotion of ideas, goods, or services.

advertorial: An advertisement that is designed to look like an editorial or news report.

affinity marketing: A marketing approach that involves a partnership between an organization and people sharing the same interests that is intended to expand the organization's consumer base.

agency: An independent organization that supports one or more marketing functions on behalf of a client.

alternative therapy: Therapeutic modalities used as alternatives or as complements to conventional allopathic medicine.

American Marketing Association: The primary professional organization devoted to the marketing field.

area of dominant influence (ADI): The geographic territory covered by a particular form of media.

attitude: A position that a person adopts in response to a theory, a belief, an object, an event, or another person.

audience: People or organizations that read, view, hear, or are otherwise exposed to a promotional message.

average length of stay: The average number of days patients spent hospitalized in a facility during a specified year (i.e., the total number of patient days for the year divided by the number of patients).

awareness: Recognition of or familiarity with an organization or its product; the ultimate goal of a public relations effort.

banner ad: A small, rectangular promotional graphic that appears in printed material or on a website.

benefit segmentation: A method of dividing the target audience according to the benefits it seeks from a good or service.

brand: A name, term, symbol, or design (or combination thereof) that signifies the goods or services of one seller or group of sellers.

branding: The creation of a brand for a company, service, or product.

business-to-business marketing: The process of building profitable, value-oriented relationships among businesses.

call center: A centralized communication hub established to capture incoming customer inquiries and generate outgoing marketing messages.

call to action: A statement, usually at the end of a marketing piece, that encourages the audience to take initiative regarding the good or service being promoted.

campaign spokesperson: An individual—typically well known—who represents the organization's marketing campaign.

causal research: Research that identifies the specific functional relationship between two or more variables.

census: A complete count of the people residing in a specific place at a specific time.

Centers for Disease Control and Prevention (CDC): The federal agency charged with monitoring morbidity and mortality in the United States.

channel: The mechanism used to distribute a promotional message, good, or service.

channel management: A formal program for reaching and servicing customers through a particular marketing channel.

client: In healthcare, a customer that consumes services rather than goods; in advertising, the entity being served by the advertising agency.

coding system: A structure for classifying and recording medical diagnoses, procedures, and other events.

collateral material: Material in any form used to reinforce an organization's image or support a media advertising campaign.

co-marketing: An agreement between two or more organizations to combine their efforts to achieve their respective objectives.

commercial data vendor: A private organization that collects, compiles, analyzes, and/or disseminates data.

communication: The process of conveying information to internal and external audiences.

community benefits: Under the Affordable Care Act, the benefits presumed to accrue to a community through the actions of not-for-profit hospitals.

community health needs assessment (CHNA): An in-depth assessment of a community's population, health status, health-related issues, and unmet needs.

community outreach: A presentation of an organization's programs and services to the community to establish a relationship.

competition: The effort of two or more organizations acting independently to secure the business of the same customers.

composition: Characteristics exhibited by a population, such as demographics, lifestyle patterns, or payer categories.

concierge services: Customized health services offered to customers who pay a premium for the personalized attention.

consumer: In healthcare, any individual or organization that is a potential purchaser of goods and services.

consumer behavior: The consumer's pattern of consumption of goods and services.

consumer engagement: The process of identifying and profiling consumers and subsequently involving them in desired behaviors.

consumer health products: Healthcare goods distributed through retail outlets and purchased directly by the customer.

consumerism: A movement in which consumers participate in defining their healthcare needs and how those needs are met.

convenience good: A product that consumers purchase frequently without forethought.

corporate culture: The values, beliefs, and attitudes that characterize an organization and guide its practices.

cosmeceuticals: Health or beauty products that combine the attributes of a cosmetic and a drug.

cost–benefit analysis: An evaluation technique that compares the cost of a project with its anticipated benefits.

creative department: The marketing function that generates ideas for a campaign and translates them into words, images, and other artistic content.

cross-selling: A sales approach that encourages the purchase of additional products and services related to the initial purchase.

culture: A society's tangible and intangible aspects reflecting its beliefs, values, and norms.

Current Procedural Terminology (CPT): The coding system used to classify medical procedures for recordkeeping purposes.

customer: In healthcare, the actual purchaser (but not necessarily the end user) of goods or services.

customer relationship management (CRM): A business strategy designed to optimize profitability, revenue, and customer satisfaction by focusing on customer relationships rather than transactions.

customer satisfaction: The degree to which customers' wants and needs are fulfilled.

database marketing: The use of a data set of past, current, and prospective customers to promote an organization's products.

decision-making: In healthcare, the process of determining the need for a good or service, evaluating the available options, and making a choice.

decline stage: The fourth phase of a product's life cycle, in which the product or industry decreases in importance and is supplanted by another.

defined contributions: The set of covered services whose combination and value are chosen by individual plan members and not the insurer.

demand: The extent to which a target population needs or wants a product or service.

demographics: The range of biosocial and sociocultural attributes of a population.

descriptive research: Research that describes (but does not explain) the characteristics of a community or population.

diagnosis-related group (DRG): The coding system used to classify inpatient diagnoses and procedures.

***Diagnostic and Statistical Manual of Mental Disorders* (*DSM*):** The primary reference used to classify mental health problems.

direct marketing: The process of targeting groups or individuals with specific characteristics and transmitting promotions directly to them.

direct-to-consumer marketing: A marketing approach that targets the end user rather than referral agents or intermediaries.

discharge rate: The number of patients discharged from a hospital in a specified year per 1,000 residents.

discretionary purchase: A purchase of a good or service that is elective rather than required.

disease of civilization: A health condition that is thought to be a product of the conditions of modern society.

display advertising: A promotional approach using posters, billboards, and other eye-catching signs.

diversification strategy: A marketing approach that emphasizes the introduction of a new product into a new market.

durable good: A product used repeatedly over an extended period.

early adopter: An individual or a group willing to try new products and services before they are accepted by the general public.

earned media: The free exposures, publicity, or word of mouth that a brand, product, initiative, or content receives.

effective market: The portion of the potential business within a market area believed to be suitable for cultivation.

elasticity: The tendency of demand to rise and fall in response to factors inside and outside an industry.

elective procedure: A clinical service not considered medically necessary and obtained at the discretion of the customer.

electronic media: Media that transmit content electronically, such as radio, television, and the internet.

emergency care: Emergency treatment or services provided in response to an urgent medical need.

end-of-life care: The group of support services, methods, providers, and settings for managing the pain and comfort of terminally ill patients; also known as *hospice care*.

end user: The person or organization that ultimately consumes a good or service, regardless of who makes the purchase decision or pays for the product.

enrollee: An individual who is enrolled in a health plan; also known as a *member*, *insured*, or *covered life*.

epidemiologic transition: A change in a population's epidemiologic profile—from acute to chronic health problems—as a result of aging and changing demographic characteristics.

estimate: The calculation of a figure in a current or past period using a statistical method.

ethics: A code of behavior that specifies a moral stance, particularly in professional dealings.

ethnicity: A common racial, national, tribal, religious, linguistic, or cultural trait or background of members of a population.

etiology: In epidemiology, the cause or causes of an identified disease.

exploratory research: Research that discerns the general nature of a problem or an opportunity to identify factors of importance.

external audit: The examination of the outside environment in which an organization operates; also known as an *environmental assessment*.

flanking strategy: A marketing approach that seeks to avoid confrontation with better-positioned competitors by bypassing their captive audiences and cultivating neglected target audiences.

focus group: A data collection technique that involves eliciting opinions and perspectives from a panel of individuals who interact under the direction of a leader.

forecast: A form of projection that incorporates likely future developments into the calculations.

functional unit: A bounded geographic area that is formally defined for the execution of some practical function, such as mail delivery.

gatekeeper: An individual or organization that makes decisions on behalf of an end user or otherwise controls the purchase of goods and services.

geographic information system (GIS): A computer application that collects, analyzes, and organizes data geographically for the purpose of spatial analysis and map generation.

geographic segmentation: A method of dividing a target audience on the basis of geographic location.

geographic unit: A physical area that is demarcated by defined boundaries and used as a basis for market analysis.

goal: The ideal state or position the organization strives to achieve.

goods: Tangible products typically purchased in an impersonal setting on a one-at-a-time basis.

government relations: Organizational liaisons with government agencies that enact regulations, determine reimbursement levels, provide funding, and monitor activities.

growth stage: The second phase of a product's life cycle, in which the product or industry gains dominance in the market.

health: Traditionally, a state reflecting the absence of biological pathology; today, a state of overall physical, social, and psychological well-being.

health behavior: Any action aimed at restoring, maintaining, or enhancing an individual's health status.

health belief model: A model of health behavior that emphasizes the influence of consumers' perceptions on their health behavior.

healthcare: Any formal or informal activity intended to restore, maintain, or enhance the health status of individuals or populations.

healthcare model: A holistic view of health and illness that includes biological, social, and psychological dimensions.

healthcare system: A multifacility healthcare organization; also may refer to the overall healthcare delivery system in the United States.

health disparity: Observed difference in health status or behavior between various groups in society.

Health Insurance Portability and Accountability Act (HIPAA): Legislation enacted in 1996 that limits access to and protects individuals' protected health information.

health literacy: The level of understanding exhibited by a healthcare consumer with regard to health and healthcare.

health plan: Public or private medical insurance.

health promotion: Promotional activity geared toward influencing the knowledge, attitudes, and behaviors of healthcare consumers.

health status: The degree to which an individual or a population is characterized by health problems; the level of ill health in a population.

hierarchy of needs: The prioritization of personal needs, which range from basic survival to self-actualization.

image: The perception an organization wants to project about itself, its products, and its services.

impact evaluation: An assessment of the changes brought about by a marketing effort.

implementation matrix: The list of specific actions, tasks, or activities needed to accomplish goals and objectives.

incentive: An enticement offered by a healthcare organization to current or potential customers to achieve a desired result.

incidence: The number of new cases of a disease, disability, or other health-related phenomenon in a population during a specified period; used to generate an *incidence rate*.

in-depth interview: A data collection technique in which the interviewer asks probing questions to elicit detailed information from the interviewee.

infomercial: An in-depth advertisement that mimics the look and feel of a daytime talk show, news report, documentary, demonstration, or other presentation format.

inpatient care: Medical care provided by a hospital to patients who are admitted for at least one night.

institutional advertising: Promotion of an organization rather than its products.

integrated marketing: A marketing approach that emphasizes consistency in the promotional strategy to achieve synergy among its components.

internal audit: The examination of internal data to assess organizational efficiency and effectiveness.

internal marketing: The process of training and motivating customer service employees and support personnel to work as a team to generate customer satisfaction.

International Classification of Diseases (ICD): The standard coding system that medical practitioners use to classify diseases.

internet marketing: A marketing approach that uses the internet to promote an idea, an organization, a good, or a service.

introductory stage: The first phase of a product's life cycle, in which the product or industry is launched.

life circumstances: Adverse conditions that individuals and households face on a daily basis that influence their health status and health behavior.

life cycle: The maturation of a population, a product, or an industry from birth to death.

lifestyle: The entirety of attitudes, preferences, and behaviors of an individual, group, or culture.

long-term care: Nonacute care provided for an extended period or, sometimes, until death.

mail survey: A data collection technique that uses a self-administered paper questionnaire mailed to a sample of respondents.

market: A setting in which buyers and sellers (actual and potential) come together to exchange goods and services.

market area: The actual or desired area from which organizations draw or intend to draw customers; also known as *service area*.

market development strategy: A marketing approach that emphasizes introducing an existing product to a new or poorly cultivated market.

marketing: A multifaceted process that involves research, planning, strategy formulation, promotion, and other activities in support of an organization, product, or idea.

marketing brief: A short document that presents the specifics of a marketing campaign.

marketing budget: The itemized allocation of financial resources to the department or a campaign.

marketing campaign: A formal, organized effort to promote a product to a target audience.

marketing consulting firm: An external agency that provides various services to support an organization's marketing function.

marketing management: The analysis, planning, implementation, and control of marketing programs.

marketing mix: The combination of product, price, place, and promotion used to influence the target market.

marketing planning: The development of a systematic process for promoting an organization, a good, or a service.

marketing research: The collection of information for myriad marketing purposes, such as identifying opportunities and problems, evaluating actions, monitoring performance, and clarifying the process.

market penetration strategy: A marketing approach that emphasizes extracting more product sales or greater service utilization from an existing customer base.

market segmentation: A process for grouping individuals or households who share similar characteristics for the purpose of target marketing.

market share: The percentage of the total market captured by a company.

market specialization: A marketing approach that emphasizes the introduction of a range of products into a particular market.

mass marketing: An approach that targets the total population—typically through network television or newspapers—as if it were one undifferentiated conglomeration of consumers.

mass media: Promotional techniques intended to reach a large audience (the mass of consumers), such as commercial television, radio, and newspapers.

maturity stage: The third phase of a product's life cycle, in which the product or industry reaches its apex and ceases to grow.

media plan: A document that outlines the objectives of a marketing campaign, its target audience, and the media to be used.

media planning and buying department: The marketing function that researches, selects, and negotiates with media channels to increase a campaign's media exposure.

media supplier: An entity that provides communication channels for marketing campaigns.

Medicaid: The joint federal–state health insurance program for low-income individuals.

medical model: The traditional paradigm of Western medicine, which is based on germ theory and emphasizes a biomedical approach.

medical tourism: The practice of traveling to another country to obtain medical care; also known as *global medicine.*

Medicare: The federal health insurance program for Americans aged 65 or older.

message: The information a marketer is trying to convey; the content of a promotional piece.

micromarketing: An approach that breaks the market down to the household or even the individual level to target those most likely to consume a product.

mission: The overarching purpose of an organization; the reason an organization exists.

monopoly: Control of the total market for a good or service by one organization.

morbidity: The amount of sickness and disability characterizing a specified population.

mystery shopper: An individual hired by an organization to pose as a customer to covertly collect information on its own or a competitor's operations, goods, or services.

National Center for Health Statistics (NCHS): The federal agency charged with collecting health data in the United States.

need: A condition objectively determined as requiring a health service.

networking: The process of establishing and nurturing relationships that may result in a mutual benefit.

new media: A catchall term for technological channels for creating, storing, distributing, transmitting, and accessing content; also known as *digital media*.

new product strategy: A marketing approach that introduces different levels of quality or entirely new products into an existing market.

niche: A segment of a market that can be carved out because of the unique qualities of the target population, the geographic area, or the product being promoted.

nondurable good: A product used once or a few times and then disposed of.

nonelective procedure: A clinical service considered medically necessary.

not-for-profit: An organization granted tax-exempt status by the Internal Revenue Service.

nutraceuticals: Food or dietary supplements that contain nutritional value and provide health benefits.

objective: A specific, concise, time-bound, formally designated target in support of a goal.

observation: A data collection technique in which the actions or attributes of those being studied are recorded by either an individual or a recording device.

oligopoly: Domination of a market or an industry by a few organizations.

online survey: A data collection technique that uses a self-administered questionnaire that can be completed and submitted on the internet.

outcome: In healthcare, the consequences of a clinical episode; in marketing, the results of a promotional campaign.

outcome evaluation: An assessment of how effectively a marketing initiative reached its objectives.

outpatient care: Medical care provided outside a hospital or an inpatient facility; also known as *ambulatory care*.

owned media: Online channels that an organization develops, maintains, and cultivates for marketing and other purposes.

packaging: The presentation of the physical attributes or the positioning of a good or service.

paid media: Ads or sponsorships purchased to promote a brand, product, initiative, or content.

patient: An individual who has been officially diagnosed with a health condition and is receiving formal medical care.

patient career: The stages through which an individual passes in transitioning from wellness to sickness and (ideally) back to wellness.

patient days: The total number of days recorded by an organization or population that patients spent hospitalized during a specified year.

Patient Protection and Affordable Care Act (ACA): Legislation enacted in 2010 that aimed to expand health insurance coverage and improve healthcare delivery and quality.

payer: In healthcare, the individual or organization responsible for medical expenses.

payer mix: The combination of payment sources characterizing a population; the basis for payer segmentation.

pay for performance: A payment method used by third-party payers to reimburse health facilities for the services they provide based on the outcomes of their efforts rather than the volume of services provided.

personal interview: A data collection technique that involves face-to-face interaction and the administration of a survey by the interviewer to the respondent.

personal sales: An oral or conversational presentation of promotional material to a prospective purchaser for the purpose of sales.

place: The point of distribution for a healthcare product.

political or administrative unit: A bounded geographic area that is formally defined for administrative purposes, such as a state, county, municipality, or school district.

population health: An approach to community health improvement that focuses on the health status and health behavior of groups rather than individuals.

population health management: A process for proactive clinical and financial management of a defined population using population health principles.

predictive model: A statistical method for identifying and quantifying the likely future need for health services for a defined population on the basis of known utilization patterns.

predictive research: Research that forecasts future characteristics or actions on the basis of known present characteristics.

prevalence: The total number of cases of a disease, disability, or other health-related condition at a particular point in time; used to calculate a *prevalence rate*.

price: The amount of money charged for a product.

primary care: Basic, routine health services, including preventive care.

primary data: Data generated directly through surveys, focus groups, observational methods, and other techniques.

primary research: The direct collection of data for a specific use.

print media: Any ink-on-paper medium used for promotional purposes.

process evaluation: An assessment of how efficiently a marketing initiative is carried out.

product advertising: Promotion of an organization's goods and services rather than the organization itself.

production: A focus on generating (rather than distributing) goods that deemphasizes the role of marketing.

production department: The marketing function that converts ideas into tangible outputs, such as posters, catalogs, videos, and websites.

production good: A product or raw material used to produce other goods.

products: Ideas, goods, and services.

projection: The use of a statistical technique to calculate a future estimate.

promotion: Any means of informing the marketplace that the organization has developed a response to meet its needs.

promotional mix: The combination of marketing techniques used to execute a marketing campaign.

prospect: A consumer who might be swayed to buy or use a good or service.

protected health information: A patient's identifiable healthcare data, including physical and mental health status, treatment record, and insurance and payment information.

provider: A health professional or an organization that provides direct patient care or related support services.

psychographics: The lifestyle characteristics of a population.

psychographic (or lifestyle) segmentation: The process of subdividing a population into groups of like individuals on the basis of their psychographic designation.

publicity: Any promotion that draws general attention to an organization but does not target a particular audience.

public relations (PR): The management of communication that uses publicity and other persuasive techniques to influence feelings, opinions, or beliefs.

public service announcement (PSA): A no-cost advertisement that supports a community program or public initiative.

purchase decision: A consumer's commitment to buy a good or to use a service.

qualitative research: A data collection technique that uses subjective methods, such as observations, interviews, and focus groups.

quantitative research: A data collection technique that uses objective methods, such as experiments and sample surveys.

quaternary care: Specialized services provided in large medical centers for complex conditions.

receiver: In communication theory, the target audience of a message.

registration system: A mechanism for systematically compiling, recording, and reporting a range of events, institutions, or individuals.

reimbursement: In healthcare, compensation paid by a third-party payer to a provider or customer for the cost of services rendered or received.

relationship management: An approach to cultivating long-term relationships rather than short-term or one-time transactions.

report card: A mechanism for comparing the performance and outcomes of providers and health plans.

return on investment (ROI): The value and benefit received in exchange for the resources given.

safety net: In healthcare, a safeguard against potential adversity—for example, a publicly funded hospital.

sales: An approach to business that emphasizes transactions rather than promotions.

sales promotion: The process of highlighting the value of a product to induce a purchase.

sample survey: The administration of a questionnaire to a segment of a target population that has been systematically selected.

secondary care: Services provided for conditions that are moderately complex and need a moderate level of resources and skills.

secondary data: Data gathered through primary data collection and used for some other purpose, such as marketing research.

secondary research: The analysis of data originally collected during primary research and for some other purpose.

second-fiddle strategy: A marketing approach that concedes the lead position in the market in favor of being an effective runner-up.

segment: A component of a population or market defined on the basis of some characteristic that is relevant to marketers.

segmentation: The process of dividing a population into meaningful segments for the purposes of market analysis and strategic planning.

selective specialization: A marketing approach that emphasizes the customization of a line of products (e.g., pharmaceuticals) to meet the needs of different target populations.

sender: In communication theory, the party that generates and disseminates a message to the target audience.

service line: A bundle of unique, related services.

services: Activities or processes (or sets thereof) that meet the needs of a consumer.

shopping good: A product consumers compare to competing brands (on price, style, and features) before purchasing.

social cognitive theory: A theory of social behavior that emphasizes the role of interpersonal and environmental factors in determining behavior.

social determinants of health: Characteristics of society that contribute to conditions of health or illness in a population, thereby mitigating the effects of disease pathology and genetics.

social marketing: An approach to effecting behavior change in the general population through public relations, advertising, and other techniques.

social media: A variety of communication modes that use internet technology to support innovative forms of interaction between people.

social media marketing: The promotion of an idea, a good, a service, or a brand using social media.

specialty good: A product—often expensive—that carries a brand name.

spokesperson: An individual—usually a celebrity—paid to deliver the organization's message or to speak publicly on its behalf.

sponsorship: Organizational support—typically financial—of a community project or event.

stages of change: A construct that delineates five stages that healthcare consumers may exhibit vis-à-vis their health—precontemplation, contemplation, decision/determination, action, and maintenance.

statistical unit: A bounded geographic area that is formally defined for data collection purposes, such as the geographic units developed by the US Census Bureau.

strategic plan: A comprehensive guide to action developed by an organization for carrying out a specific strategy.

strategy: A general approach taken by a healthcare organization to meet market challenges.

support good: A product used to supply or support the provision of goods and services.

support services: Nonclinical, operational activities that support the provision of medical care.

survey: A data collection technique that involves the use of a questionnaire administered in any number of ways.

SWOT analysis: An assessment of an organization's strengths, weaknesses, opportunities, and threats.

synthetic data: Estimates, projections, and forecasts generated in the absence of actual data.

target marketing: An approach that focuses on a market segment to which an organization desires to offer goods or services.

telemarketing: Sales conducted by telephone, through either outbound or inbound calls.

telephone interview: A data collection technique in which a survey instrument is administered by an interviewer to a respondent over the telephone.

tertiary care: Services provided for conditions that are highly complex (or serious) and need specialized clinicians, equipment, and facilities.

test market: A group or population on which a marketing theme or concept is tested.

third-party payer: An entity—other than the provider and the patient—that pays the cost of goods or services.

trade show: A convention at which vendors present their products to attendees.

traffic department: The marketing function that delivers promotional content to the appropriate media channels on time.

underinsured: An individual who is insured under a health plan—either public or private—that provides inadequate coverage of healthcare expenses.

upselling: A sales approach that encourages the purchase of an upgraded (and more expensive) product over a lesser and cheaper option.

urgent care: Medical care for a condition that requires immediate attention but is not serious enough to warrant emergency care.

usage segmentation: A method of dividing a target audience on the basis of historical utilization of a product or an organization.

US Census Bureau: The federal agency responsible for the decennial census and other data collection activities.

user-generated content: A website model that relies on user submissions and comments; the discussion thread is part of the content.

utilization: A measure of the extent or level of health services use.

value: Anything—usually intangible—that a society considers important, such as freedom or economic prosperity.

vanity services: Health services, usually elective, intended to improve physical appearance or functioning.

video advertising: Display advertising that incorporates video.

viral: The rapid, epidemic-like dissemination of content on the internet.

visibility: A marketing campaign goal that raises the public's awareness of the organization, program, or product to increase consumers' top-of-mind recall.

want: A consumer's desire (rather than a need) for a health service.

word of mouth: Positive or negative communication among consumers about an organization, a good, or a service.

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