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A Chronology of Health Care Marketing Research

Dawn Iacobucci
Owen Graduate School of Management
Vanderbilt University
Nashville, TN 37203, USA
dawn.iacobucci@vanderbilt.edu

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Contents

A Chronology of Health Care Marketing Research

Dawn Iacobucci[1]

[1] *Owen Graduate School of Management, Vanderbilt University, Nashville, TN 37203, USA; dawn.iacobucci@vanderbilt.edu*

ABSTRACT

This monograph describes the marketing research that has been published in the top marketing journals since their inception relating to health care, broadly defined. Over 1,000 articles are summarized across the chapters relating to consumer behavior and food, consumer behavior and other consumption, and business marketing issues. Research from outside of marketing is also briefly reviewed. This monograph celebrates the research that has been accomplished and closes with suggestions for future research.

Keywords: health care marketing; healthcare marketing; marketing research on healthcare.

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Dedication

To Dr. Joel Shalowitz,[1] *founder and first, long-time director of the health-care management programs at Kellogg, Northwestern University, for his tremendous intellect, kindness, and humor. A friend and inspiration.*

[1] Subscribe to his insightful newsletter at: https://www.healthcareinsights.md.

Part I

Introduction and Overview

1

Introduction to the Chronology of Health Care Marketing Research

The health care industry can be challenging to understand. Its economic enormity is the most obvious issue, and perhaps even more overwhelming is the complexity regarding the networks of players: suppliers, providers, business customers and consumers and patients. Health care spending is tremendous, particularly in the U.S., and the level of spending is frequently criticized as not indicative of or correlated with quality of care, at least as measured by life expectancies, such as depicted in Figure 1.1.[1] The extraordinary level of spending is driven in part by innovation reward structures, such as in "Big Pharma" and biotechnology, and in part by minimal economic constraints given that most health care service provision is paid for "by someone else"—both the end-user consumer patient and the intermediary-provider personnel and companies expect someone else to pick up most of the tab. In the U.S., Western Europe, and Japan, the growth of the health care industry is also partly being driven by the large segment of aging baby boomer consumers requiring greater health care attention, and this simple fact of demography increases demand for services, placing pressure on the service provider and paying systems, and changes to accommodate can be confusing and frustrating to consumers and providers alike.

[1] https://www.cia.gov/library/publications/resources/the-world-factbook/.

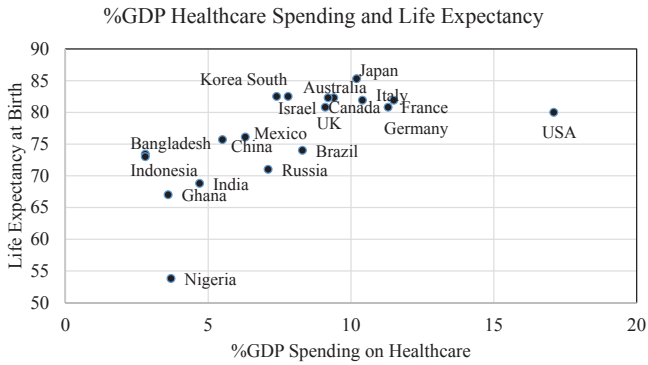

Figure 1.1: %GDP spending versus life expectancy.

This monograph is intended to begin to understand marketing issues in the realm of health care. Much of health care may be partially attributed to, and result in, myriad forms of consumption, thus marketers may be well-positioned to help understand, and perhaps help modify, various forms of health care behavior and consumption. The primary focus of this monograph—its heart—is the collection of summaries of marketing research articles reported in Chapters 2–4, which together represent that which is known in academic research at the nexus of marketing and health care.

It is important to note that Chapters 2–4 do not comprise a traditional literature review that contains statements such as, "Phenomenon X seems to hold under these conditions (cite, cite, cite)," in part because such reviews tend to explain or elaborate upon only a few articles, and simply provide the citations for more. Instead, in this monograph, the marketing research article summaries are richer, with a paragraph for each article.[2] The collection is intended as a "*chronology*" (hence the title of this monograph) to serve as a database of verbal synopses

[2]In these summaries, I stuck to the data and results; the authors often presented some interpretation, the current readers might deduce a different theory, particularly now, viewed across papers. Sticking close to the data seems sensible, à la Sherlock Holmes, to wit: "There is nothing like first-hand evidence" (*A Study in Scarlet*); "Data! Data! Data!," he cried impatiently. "I can't make bricks without clay" (*The Adventure of the Copper Beeches*); and of course, "It is a capital mistake to theorize before one has data. Insensibly one begins to twist facts to suit theories, instead of theories to suit facts" (*A Scandal in Bohemia*).

of the marketing articles that investigate issues regarding healthcare, thus offering a resource for scholars wishing to get acquainted with the research that has been conducted to date on a particular healthcare topic of interest. Accordingly, Chapters 2–4 are not intended to be read through, as if this monograph were a standard text. Rather, a researcher interested in some topic in the *Table of Contents* would turn to that section of the monograph to view the work that had been published in that area to date, as one might flip through a chronology. Within each section, the research on each topic is presented in chronological order so the reader may see clearly how the literature has developed.

In the structure of this monograph, Chapters 2–4 are different from Chapters 5–6 in two ways: First, Chapters 2–4 present the marketing perspective about health care, that is, research that has been conducted *by* marketers, whereas by comparison, Chapters 5–6 contain research and writings about healthcare by scholars in other disciplines provided in this monograph *for* marketers to showcase complementary points of view. Thus, in reporting on scholarship at the nexus of marketing and health care, Chapters 2–4 should interest marketing academics and practitioners, and it may also be informative to those outside of marketing who may be unaware of the research that has been conducted in this field. In contrast, Chapters 5–6 report from other fields and disciplines, with the primary intention of providing interesting and informative coverage to marketers regarding how others approach some overlapping research topics. The second point of difference is that Chapters 2–4 offer depth, aiming to be comprehensive in covering that which is known from marketing research in the healthcare arena, whereas Chapters 5–6 focus on breadth and currency, sampling some representative articles to lend an awareness to marketers of research conducted on healthcare issues by scholars with other areas of expertise.

What's in Chapters 2–4? The Marketing Research Perspective

Chapters 2–4 form the predominant resource of this collection. Upon initiating this quest to better understand health care marketing, I was surprised (this is not a judgmental statement, it is merely descriptive)

that some topics seem relatively under-researched. I began the literature search for this monograph by using key words such as "healthcare," "health care," "medical," "hospital," "physician," etc. and the results yielded relatively few articles.

When health care is defined more broadly, the search yielded more than 1,000 articles published in the top marketing journals (journal details shortly) covering marketing research health care topics as varied as issues of prevention (e.g., healthy diet choices), intervention (e.g., smoking), consumer decisions being affected by emotions or economic incentives, companies testing innovation strategies, marketers crafting effective messaging (e.g., advertising and package labels), and so forth. Reading the journals' tables of contents and the reference section of each downloaded article naturally extended the search terms and blossomed into the enormity of Chapters 2–4.

Specifically, the major marketing academic journals were searched from their inception (volume 1 for each) through issues published in early 2019,[3] including the *Journal of Marketing* (yielding $N = 132$ articles), *Journal of Marketing Research* ($N = 178$), *Journal of Consumer Research* ($N = 216$), *Journal of Consumer Psychology* ($N = 118$), *Marketing Science* ($N = 92$), and given the topic, the *Journal of Public Policy & Marketing* ($N = 282$), and to ensure more global representation, the *International Journal of Research in Marketing* ($N = 47$).[4] The numbers of articles per journal are simply descriptive; that is, they are not normative as if all journals should publish comparable

[3]Issues were searched through the following journal volumes (issue numbers): *JM* 83 (3), *JMR* 56 (2), *JCR* 46 (1), *JCP* 29 (2), *MSci* 38 (2), *JPPM* 38 (2), *IJRM* 36 (1).

[4]Search terms included: healthcare, health care, hospital, medical, doctor, nurse, patients; calorie, diet, exercise, fat, FDA, FTA, grocery, NLEA, nutrition, obesity, packaging, portion size, sugar, variety, self-control; fitbit, fitness, gym, health club, marathon, walk; disease, disorder, emergency, healing, therapy, wellness, wound; addiction, alcohol, beer, drug, wine, cigarette, marijuana, smoking, tobacco; accident, auto accident, car accident, traffic accident, vehicular; abortion, AIDS, contraception, pregnant, sex, STD, hormone; detection, screening, risk, warning; pharmaceutical, physician, prescriptions; mental health, psychiatric; aging, elderly, death; organ, dentist, dental, gun, health insurance, violence. Search term set expanded as relevant articles appeared, in searches and reference sections. Tables of Contents were also manually searched to include articles with noncentral keywords.

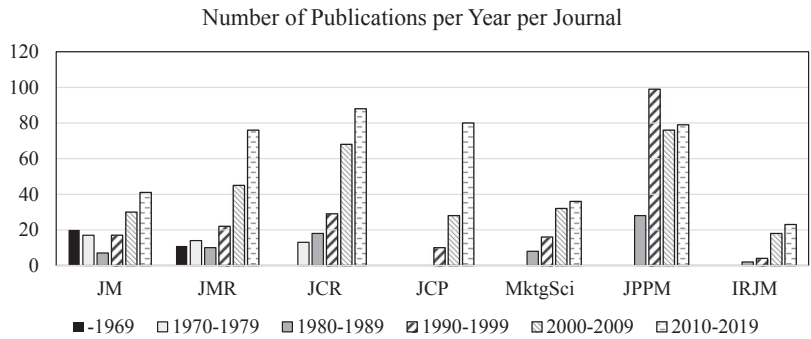

Figure 1.2: Number of marketing health care related publications per year per journal.

numbers of healthcare-related articles. Figure 1.2 indicates an uptick in the appearance of such articles in recent years for most of the journals. The larger recent numbers may be partly attributable to a slight rise in healthcare interest given the environment and media, but the larger recent numbers seem more likely attributable primarily due to the growth of most of the journals, each publishing more pages per issue and more issues per volume, because the proportions of journal pages dedicated to health care have risen only modestly (e.g., 4% in 1990 to 8% in 2010). The resulting 1,065 marketing research articles are summarized in Chapters 2–4.

The majority of articles reviewed in Chapters 2–4 are directly related to healthcare, such as consumer behavior with respect to healthy food choices or smoking, or pharmaceutical firm behavior such as launching new drug products or assessing the effectiveness of sales calls on physicians. In this monograph, health care is broadly defined, so in addition, the articles cover topics that are "supportive" in that they affect consumer healthcare welfare but might not be thought of as central issues, such as happiness and financial well-being (Chapter 3), and topics with perhaps only one degree of separation from health care such as understanding marketing tactics used to attract consumers regarding food purchasing decisions (Chapter 2), or marketing in a B2B capacity to affect drug adoption and diffusion (Chapter 4). Figure 1.3 provides an overview of the topics.

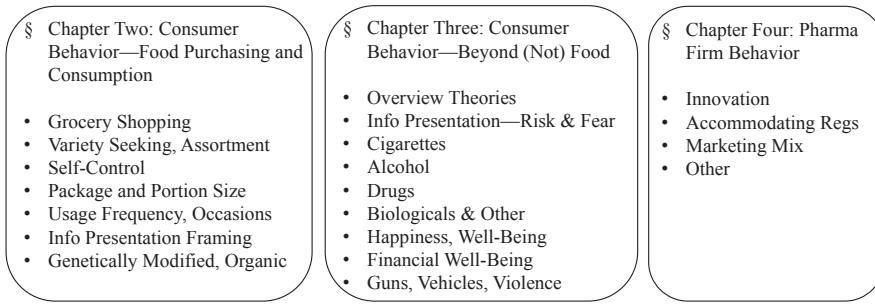

Figure 1.3: Marketing research health care topics.

Note that in the medical-related world, "healthcare," one word, seems to more frequently refer to the industry, whereas "health care," two words, seems to be the phrase used more often to refer to health care provision or health care decisions made by physicians and consumer patients. A distinction in the marketing research literature, as reflected in Figure 1.3, is that quantitative marketers, due to the nature of their research, tend to work with extant real-world datasets, and one large source currently comes from pharmaceutical companies, reflecting their marketing efforts and noting the responses by physicians and patients, hence their focus tends to be on healthcare. Behavioral marketers tend to run small-scale experiments in which elements in marketing communications materials are varied, such as nutrition labels, and responses in attitudes or behaviors measured, hence their focus tends to be on health care. To be sure, those observations are generalizations. There is somewhat more research in health care than healthcare, hence the title of this monograph.[5]

Whereas Figure 1.3 and the Table of Contents list the marketing research health care topics in a linearly organized manner, it may help to view a depiction of the frequency of occurrence of the numerous topics, and a sense of their connections. Figure 1.4 shows that the most frequent marketing research topics relevant to health care include food

[5]Thus in an effort to be precise, the term "health care" appears more frequently (e.g., in Chapter 2) than "healthcare" (in Chapter 4), however the meanings of the two sets of terms are used interchangeably.

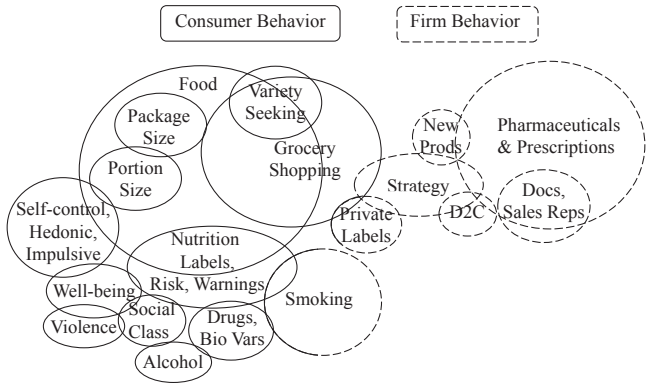

Figure 1.4: Marketing concepts in frequency and interrelationships.

(as relevant to obesity), smoking, and pharmaceutical firms' marketing actions. Most topics may be construed as an interplay between a firm's offerings or positioning and a consumer's response. However, as the figure indicates, most of the food-related topics are studied from the perspective of consumer behavior, and most of the pharma research is studied in assessing firms' marketing activities.

What's in Chapters 5–6? The Perspective Outside of Marketing

While the main focus of this monograph is the marketing research (presented in Chapters 2–4), Chapters 5 and 6 present a broader perspective to be inclusive of other related disciplines. For example, the human elements in the healthcare system can be studied through psychological and economic lenses, by considering motivations and incentives (per Chapter 5). Continuing in Chapter 5, the health care providing organizations and systems themselves can also be studied through different lenses, such as organizational behavior research to understand personnel management or operations analytics to understand effective system processes. In addition, the medical school-based literature was surveyed for research that stretches toward our side of campus, the commercial enterprise. Health care professionals can choose to be employed in any of a number of provider systems, and both the staff and institutions vary in the extent to which they embrace or accommodate business

principles. To step back for an even broader perspective, Chapter 6 summarizes recent books (texts and popular press) across these disciplines to help orient views on healthcare and health care and therein, marketers' roles and potential roles. Whereas the literature coverage in marketing (Chapters 2–4) is intended to be comprehensive, inclusive of all relevant articles in the top marketing journals, the literature coverage in Chapters 5 and 6 is intended for breadth, not comprehensive depth, with the focus more on conveying currency for timeliness and relevance, to give a sense of what other fields are considering that might complement the pursuits of marketers.

Thus briefly, in terms of what to expect, Chapters 2–4 contain summaries of the 1,065 marketing research articles and Chapters 5–6 report from fields outside of marketing. The monograph closes in Chapter 7 with reflections as well as recommendations regarding potentially useful directions for future marketing research in the realm of healthcare.[6] This monograph is intended to be a useful reference; readers are encouraged to glance at the *Table of Contents* and then flip to the relevant sections in Chapters 2–4, much as a *chronology* resource might be used.

[6]Two writing notes: 1) There is no doubt this is an academic tome, yet an effort was made to write in a manner that would be accessible to those outside our field who may be less familiar with our jargon. 2) Abbreviations used frequently throughout this document include: D2C (direct-to-consumer), docs (doctors), kids (children), pharma (pharmaceutical), script (prescription), SKU (stock keeping unit, basically any item on the grocery or retailer shelf).

Part IV

In Close

7

Conclusions and Future Trajectories

Reflecting on the findings presented in this monograph, particularly those in Chapters 2–4 from marketing research, let me first say that for all the variance and Type I and II errors that constitute publishing, I was impressed with how much excellent research has been conducted in this realm, and humbled by my growing awareness that the authors referenced therein have dedicated themselves to solving or improving solutions to problems that truly matter. In this chapter, let us reflect on that which is known, and more, that which is yet to be known.[1]

The order within the Table of Contents in Chapters 2–4 was structured to reflect the volume of articles, with more frequently studied topics appearing earlier (approximately 47% of the marketing research articles were presented in Chapter 2, %41 in Chapter 3, and 12% in Chapter 4, and recall the pie charts in Chapters 2 through 4 depicting the proportions of research articles on different topics therein discussed). In consumer behavior, the literature indicates that we know quite a bit about food consumption (Chapter 2)—from grocery shopping, to consumer information processing such as nutrition labels and how that affects consumer choice and decision making, all the way to contemporary

[1] I'd like to thank the anonymous reviewer once more for really helpful comments!

manifestations in the world of genetically-modified and organic foods, there is a good deal of research in marketing on food-related topics. Chapter 3 continues with additional topics on the behavioral B2C side, including the substantial literatures on how information is presented and framed to the consumer (beyond food packaging) such as with warning labels or risk assessments for diseases and medicines. In addition, we know much about how marketers make cigarette smoking attractive as well as how to assist smoking cessation—that is, we must of course first own up to the role marketing had in increasing smoking in the 1940s-1960s, but marketing has also contributed to solutions, being a complex interplay of package warning labels, product taxes or tariffs, reduction in advertising in some venues, etc. since the 1970s. There was also some research on alcohol consumption, typically regarding package warning labels, though there was less research on alcohol than one might expect given the pervasiveness of drinking compared to smoking. If the volume of articles classified by each topic formed a scree plot, there would be substantial fall-off at this point, with less research on the remaining topics: Drugs, Biological Variables, and Other Issues. Analogously, on the quantitative B2B side (Chapter 4), we know much about Big Pharma's introduction of new drugs, a good deal on certain marketing mix efforts such as sales calls on physicians and the growing impact of D2C advertising to consumers, yet rather a bit less on other B2B issues. All of the less frequently researched B2C and B2B topics comprise great opportunities and potential for contributions.

Conceptually, mostly studied within the B2C realm, we seem to understand information processing and consumers' predictable biases in interpretations, as well as consumers' valuations of short-term and immediate rewards compared with those that might more vaguely unfold in the future. That is, the cumulated research has pursued and seems to have explained the constructs and mechanisms of framing communications positively or negatively, and an almost economic construal of self-control regarding small or big rewards or utilities received now or later. Accordingly, *extending these nomological networks* would be a fine challenge, rather than crafting a paper that merely demonstrates the application of the principles to a new arena. While our colleagues in physics are challenging themselves to find a unifying theory, the

marketing research in the health care arena is creatively generating diversification in thought and approaches. There are a few theoretical constructs or premises that get revisited (e.g., the aforementioned framing or utility construal), but it would be a challenge to conduct a meta-analysis, say, because the numerous constructs, particularly those aimed at understanding processes of mediation or conditions of moderation change so very much from article to article. Continuities are sometimes found, such as within a particular researcher's (or research team's) approach, or occasionally during eras when certain theories were popular and pursued more frequently than others. I suspect that as this part of the field matures, there will be more convergence, but the diversification at the moment is not a shortcoming. In this still relatively young field, or sub-field within, it may be seen as a service in itself to gather data and present effects; the conceptual diversity represents different perspectives in how to optimally study different phenomena, and at the least, the numerous studies have very solidly documented basic effects and results to be explained, within a paper, or, stepping back as in this monograph, across the literature.

The dominant approach on the consumer behavior B2C side, whether studying food or OTC packaging and warning labels, is a cognitive decision making orientation, which makes sense given the discipline. Yet given the topic areas, it should prove beneficial to also consider the *biological* and *emotional* angles more—more frequently, more extensively. For example, do many (any) of us make many (any) deliberative (cognitive) decisions while grocery shopping or do most of us, for most product categories, toss or click familiar items into our carts while we are working out something else in our heads? In studies of planned and unplanned purchases, we saw that consumers are interviewed at the entrance of stores, and then again upon exit, and their receipts viewed and scanned for comparison; we could similarly map whether we shop differently if we are hungry, overweight, happy or sad, PMS-y, poor, unemployed, celebrating. Furthermore, regarding consumption per se, not just purchasing, is it simply known or assumed or should we study more whether we consume differently if we are happy, depressed, hopeful, discouraged, angry or proud of something pertaining to our partners, kids, colleagues, and the world? Similarly, has the mindful

interactive family dinner gone the way of the dinosaurs and how is consumption (eating, smoking, drinking) different when we are distracted, multi-tasking, streaming TV, surfing, or otherwise engaged?

Food consumption can of course contribute to health problems, so the topic can be quite important. Yet it seems plausible that the preponderance of food research is due to the ease with which studies involving food can be executed to examine and test the issues, for a more manageable research program than, say, studies into patients' health compliance behaviors.

Indeed by comparison, sometimes there seem to be structural explanations for the relatively low representation of articles in some areas. For example, there is obviously potential for mutual research with *colleagues* in organizational behavior and operations, as well as finance, accounting, and entrepreneurship, and beyond the business school in areas such as psychology, economics, public health and medicine, engineering, biology or chemistry. Yet who could, in good conscience, encourage more interdisciplinary research given that it is notoriously difficult to publish, in part because the end results are indeed often weak, not being at the cutting edge of either contributing field.

Another kind of structural challenge is access to data (for quantitative research) or the ease of creating studies and data (for behavioral research). For example, consider smoking, drinking, and drugs. We have research dedicated to marketing efforts and consumer responses regarding smoking tobacco and some research on legal drug sales to consumers. There is some research on drinking *alcohol*, though as mentioned, this sometimes uplifting and sometimes problematic product still feels like an under-tapped topic of study. By comparison, we have very little research on *illegal drugs*, which is of course understandable in that the data collection would be difficult with issues in sampling or human subject ethics boards. Yet given the enormity of problems such as the current opioid crisis, perhaps more effort could be put into this inquiry. The massive criminal finding against Purdue Pharma ($600 million) was about fraudulent marketing and was back in 2007; one might have hoped for an improvement, not decline, in the subsequent 12 years, regarding pharma, regulation, and helping consumers. A less threatening drug is *marijuana*, and given the differential status across the United States

regarding legalization, a *natural field experiment* is currently unfolding. An obvious research direction would be to track the commerce and consumption of the drug as it diffuses into the marketplace, noting marketing and local governmental social marketing efforts. There may well be other natural experiments unfolding as well, such as in the United States' differences in implementation of various elements of the purportedly federal but locally implemented Affordable Health Care act, and these state-by-state and longitudinal comparisons could be tested.

Another topic that faces a research process challenge, though perhaps less and less so, is *global and cross-cultural research*. Presumably many research findings will generalize across many countries and cultures. For example, even if what people are consuming differs, they may construe information with some similar cognitive biases, possibly interpreting or misconstruing nutrition information, or behaving and misbehaving in similar patterns worldwide. That is, with regard to many of the topics within this monograph, there may well be more similarities than differences in consumers' and even firms' behaviors. Nevertheless we can predict there would likely be *differences* that would be both interesting and theoretically explainable; for example, perhaps consumers in high uncertainty avoidance *cultures* do in fact read food and medicine labels more carefully, and perhaps consumers in masculine or collectivistic cultures experience greater pressure for social conformity with respect to smoking or drinking, for or against. Some research in each of the journals (not just in the *International Journal of Research in Marketing*) conveyed attempts at some global diversity, yet little of it examined cultural differences. Furthermore, let's face it, while different countries are overlain by cultural differences, the even greater challenge for research comparison purposes are the vast differences in healthcare industry and governmental regulatory contexts.

Nevertheless, regarding global health care marketing, perhaps we could make progress along several lines. For example, there is very little in the journals on homeopathy or *alternative medicines*, and these seem to be embraced more enthusiastically globally than in the U.S. What if it were shown that inexpensive herbal remedies were in fact as effective as very expensive pharma products? Or, when pondering the

complexities of the macro U.S. *service and payer networks*, we might ask, must it be so tremendously complicated, are all health care systems so convoluted? We could all learn a lot from each other in *comparing systems*—what works well where and what can be imported into one's own country? It's been said that Canadians and Brits value excellence, affordability, and equality among citizens for access, thus consumer patients are therefore more willing to wait (or due to the system, simply must wait) for health care services, whereas in the States, we value excellence, expect immediate service, and therefore pay stiffer tariffs to supplement this assortment of service features, with varying degrees of embracing equal versus equitable or opportunistic access. As I tell my students, you cannot have a cheap Ferrari (nor would you want one), and it applies in health care too: no one can have it all. *Thus, what does a culture desire, or what will a culture tolerate?* For all these issues, we all have coauthors all over the world; this challenge of conducting more cross-cultural health care research is approachable. It seems to me that it would be fascinating and eminently helpful if we could benchmark each other to observe and understand best practices. Some global agencies measure countries for comparisons but typically do so, or report at, aggregate levels, such as death incidences and expected longevity. Yet it would be eminently fascinating to drill down to the level of businesses, health care networks, and ultimately the consumer patient to understand more detailed country or cultural comparisons. In doing so, we could see which countries and cultures were excellent at any kind of service—preventative health engagement, compliance, specific protocols such as for heart surgery or pancreatic cancer treatments, consumers understanding payment systems, etc. Those comparisons could potentially inform us as to why one health care system provided more excellent outcomes, or more affordable care, or more timely queue management, so we all might strive for the inexpensive Ferrari, that is, at least to try to optimize it all.

The infrequent studies of some other topics are less explained by structural research challenges. Consider that the World Health Organization lists the *leading causes of worldwide death* (in order) as: heart disease, stroke, respiratory infections, Alzheimer's, lung cancers, diabetes, road traffic injuries, diarrheal, and tuberculosis (HC, 2019a).

Some of those topics are under-studied (i.e., not studied) because they are more prevalent as third-world and bottom-of-the-pyramid problems, which may lessen interest and certainly can imply obstacles making the topics difficult to research for reasons such as lack of data and research-related infrastructures. By comparison, several of the other causes of death are prevalent in developed nations. We might say that we at least indirectly cover some threats to heart disease and diabetes, given the B2C research on food and the B2B research on pharma marketing. Yet even if we check both of those diseases off the list, the other causes of death are mostly simply not studied.

The only non-disease cause of death on the WHO list is that due to *road traffic injuries*. Perhaps we think automobile safety is boring, that we've done all we can with introducing seatbelts, airbags, and speed limits. Yet in the U.S., there were 34,247 fatal vehicle crashes that led to 37,133 deaths in 2017; that's about 10 per 100,000 (which compares to lows of 2.5 in Sweden, 2.6 in the U.K., 3 in Japan, 4.7 in Italy, 4.9 in France, 5 in Australia, and highs of 42 in Venezuela, 47 in Rwanda, 75 in Zimbabwe; HC, 2019b). Furthermore, automobiles are one of the most expensive purchases for most families (houses being number one and childrens' educations vying with cars for numbers two and three). Thus, consumption—purchasing and use of automobiles would seem to be right up the marketer's alley. Furthermore, congruent with an increase in sustainability sensitivities in some consumers, and severe economic constraints among others, an altogether different research path would to be determine the genesis of the consumer decision to not purchase a vehicle at all and rather, to rely upon public transportation of some kind. It would be interesting to understand the extent to which the transportation services (e.g., Uber, buses) might begin to displace the manufactured goods sector, that is, the car, and what the driving factors and consequences might be, or moderators such as constraints among current alternatives—locations and populations supporting infrastructures, a household's needs as a function of its members' ages, distances traveled for work, etc.

Another violent form of death did not make the WHO's global list and that is *gun control* (cf., Bradford *et al.*, 2005), perhaps because some countries have better control over the topic than others. The U.S.

gets the rap for being irrational about gun control, and while the U.S. statistics are not the worst globally, they are certainly the worst among so-called civilized and prosperous nations. In the most recent posted numbers, for 2017, the number of fatalities by gun in the U.S. was almost 40,000 souls, or 12 persons per 100,000 (the 12 compares to lows of 0.2 in Japan, 0.3 in the U.K., 0.9 in Germany, 2.1 in Canada, and highs of 12 in Mexico, 19 in Brazil, 26 in Colombia, 32 in Guatemala, 39 in Venezuela, and 39 in El Salvador; HC, 2019c). These statistics provide an example of the cross-country benchmarking that would be helpful to understand—what is it about the low incidence countries or cultures that enables such excellent records, and what values are embraced by the countries or cultures who do so poorly on such a dramatic index? A heart-breaking point of clarification on that 40,000 statistic is that while there were 14,542 homicides in the U.S. (nonfatal gun-related injuries were about double that), there were 23,854 suicides.

On that cheery note, let's next turn to consider *wide, open spaces of research opportunities*. These have great potential for research contributions, as well as having some fun. Figure 7.1 organizes the topics that follow, including the content areas just mentioned. Any of these topics are worthy of pursuit both as a central consumer behavior and marketing research question due to the consumption and purchasing of goods and services, and of course any of these topics are worthwhile as well as social marketing topics concerned for enhancing societal and consumer good.

7.1 Future Trajectories and Opportunities: Health Care Provision

Aligned with the logic of Chapters 2–4, the following research directions are organized first as those most proximally relevant to the consumer. Then the issues broaden to include the healthcare-providing network and businesses.

7.2 Consumer Behavior, the Micro- Patient-Level

While many studies look at food consumption with the concern toward obesity, only a few look at *exercise* (e.g., intentions to go to the gym,

Consumer Behavior, or the Micro-, Patient-Level
- More regarding emotions and moods, and biological or physiological factors
- More on alcohol, Illegal drugs, marijuana natural field study
- Global alternative medicines
- Exercise, wearable IT and data
- Social media, gamification
- Genetic testing
- Diets, fads and segmentations to optimize body needs and nutrient matching
- Patient experience in medical system, and processing web info on health conditions, treatments, paying and coverage
- Mental health
- Midlife crisis, retirement, more on elderly, end-of-life decisions or purchases
- Demand for cosmetic health care
- Global warming and population displacement
- Sleep, stress, religion, community

Health Care System, Macro-Level of Providers and Networks, Businesses, Societies
- WHO leading causes death mostly diseases: heart disease, stroke, respiratory infections, Alzheimer's, lung cancers, diabetes, road traffic injuries, diarrheal, tuberculosis
- Guns
- Physician decision-making (like in pharma studies, more on choices of medical devices)
- Health care providing teams, empowering nurses and physician assistants
- AI and robotics, efficiencies, personalization, data security
- D2C pharma ads

Health Care Payment
- Paying, transparency, out-of-pocket, shop for quality and value, increased prices, retail health care, health care tourism,

Figure 7.1: More! More! More!

Han *et al.*, 2016; or health club utilization, Spangenberg *et al.*, 2003). Perhaps the difference draws from there being a commercial enterprise with food, that is, consumers buy it, whereas one's exercise activities do not necessarily involve business opportunities (e.g., running). Yet first, consumers certainly do buy goods and services related to exercise (e.g., the aforementioned health club memberships, as well as equipment, clothing, coaches). Second, under the guise of *social marketing*, marketers can study even noncommercial activities as equally relevant. Third, physical activity is becoming increasingly easy to track with *wearable IT* (e.g., FitBit) and phone apps for self-monitoring, and these can certainly comprise mainstream purchases. In fact, a quick Google search for topics in health care indicates that patient engagement is a contemporary priority and buzzword, as providers experiment with

how digital channels might help patients with compliance and health outcomes, thus using electronics beyond tracking exercise. These patient portals take many forms, such as chatbots for answering brief consumer patient questions, with answers coming from providers or social networks (e.g., Carilion Clinic's #YESMAMM as a FAQ forum for breast cancer questions), or using *social media*, like YouTube or the company's own channel site to host and encourage patients to tell their own personal success stories (e.g., New York Presbyterian Hospital), or *gamification*, with contests and quizzes and rewards, to engage, educate, and challenge consumers (e.g., United Healthcare's We Dare You). All of these arenas provide *behavioral data* which could connect and test numerous antecedents and consequences in various marketing theories. Certainly all of these activities and questions seem wholly within the realm of marketing relevance.

Also in the spirit of science and technology, given the increasingly pervasive technology and access, we can surely anticipate growth in numbers of consumers engaging in *genetic testing*, with predictable outcomes regarding health engagement and decision making, involving familial ties, confusion about optimal or normative next steps such as toward prevention or resultant stress management, and of course trait selections for offspring and ethical issues regarding free will, and each of those elements is ripe for additional research.

Diets and *diet fads* are another arm of health care that seem fueled by online information sources and social media sites. For all the conflicting information and claims, a concept central to marketing might actually help resolve the seeming inconsistencies, namely the use of *marketing segmentation*; it might be that the claims of any of the major contending diets are both right and wrong. For example, if AI were used to scrape websites such as social media or support sites related to Weight Watchers and the like, meta-analyses would probably show that different kinds of diets are healthy mostly or only for particular segments of customer patients. Surely the dietary needs and restrictions for people sensitive to sugar (diabetes) or fat (heart) are different, thus yielding better results under one kind of regime than others. Perhaps certain diets can be more optimally mapped to certain body types depending on nutrient needs and provisions, and efficiencies in bodily processing.

Beyond high-tech devices or products, marketing has a rich and extensive tradition in services marketing that could easily be brought to bear. Marketers could *sit with patients* and ask about their *experiences* with their docs and their medical treatment centers. Marketers could also sit with patients who were trying to navigate *health care websites*, those that are official, such as in *provider selection* or viewing their own patient histories, or those that have become de facto *information sources*, which vary in information quality, where some seem reasonably good, such as say, WebMD, and others, less so. If consumers get confused about food labels and portion sizes, as simple as those are, how much more potential is there for confusion regarding *processing online medical information*? Imagine the conjoint-like studies we could create to study consumer (or company) trade-offs among price, quality, waiting time, and other features. Services marketers also work closely with management and HR issues, in this arena suggesting the hospital staff, beginning with telephone operators or web designers for initial contacts, to check-in personnel, and all the numerous providers of services to complement the core, central physician and nursing interactions, and to billing and closure. While these are focused on health care provision, payment is also obviously hugely important, and continuing in the theme of processing available information, even with our Ph.D.'s, who among us can smoothly and decisively discern our own employers' websites and *insurance options*? Marketers excel at information presentation and understanding how consumers process such information, so would be well-suited to help improve how such medical or economic information was provided, how searches could be facilitated, and errors and biases minimized.

That services marketing suggestion of simply sitting with a consumer patient to understand more clearly his/her journey and experiences brings about another line of research directions—a different kind of focus on the consumer patient. In general, I was quite surprised that the literature indicated that marketers rarely consider issues related to *mental health* (though see Yeh *et al.*, 2017, and of course the rising literature in marketing on well-being is presumably the flip side). My surprise arose in part due to the prevalence of psychological training throughout the consumer behavior marketing academic community;

thus, there is strong potential for advancement here. At the least, marketers could probably very effectively help with "positioning," reframing mental health issues so as to reduce the still pervasive stigma for admitting problems and seeking help. Mental health issues can strike at genetically-predisposed or environmentally-vulnerable consumers as a chronic concern, but they can also periodically poke at any consumer. For example, mental health concerns are reaching epidemic levels for adolescents, with stresses related to simply going to school, having fundamental rights like safety no longer being a certainty, or with perennial social issues of fitting in being exacerbated by social media comparisons or particularly bullying, leading to high levels of adolescent suicide. As another example of potentially vulnerable mental health demographics, when scholars speak about health care and aging, they're often envisioning the elderly. However, different phases of one's life are predictably, even stereotypically, more stressful than others. Gurus from Seneca to Montaigne have written thoughtfully about times that seem to require or prompt contemplative renewal so as to emerge newly purposeful; they were often speaking of what we today would call a *midlife crisis*, but given our longevity (since their times), *retirement* fits the bill as a time of renewal and redefinition as well. For the marketer, many predictable consumption patterns accompany these phases, from convertibles, to appearance-enhancing treatments, to new housing, etc.

Taking the midlife crisis and retirement theme further, given the demographics in the U.S. and most of Western and Eastern Europe and Japan, more studies could look at health care provision and choices among the *elderly* or even those approaching that status (cf., Yoon *et al.*, 2009). New health choices arise, and the options can seem bewildering. Furthermore, for most older consumers, the increased health needs often develop simultaneously with constrained budgets, so trying to offer good advice for this segment of many countries' populations would seem to be especially beneficial. Even decisions about when to retire (and therefore draw upon a government's social security monies) seem to baffle the financial experts as they watch waves of people retire "too young," yet marketers could explain the trends easily. Specifically, while financial experts would suggest a person delay retirement as long as possible rather than retiring sooner and redeeming a lesser payment, marketers

and economists know that short-term or immediate valuation of some money may well exceed worth of future payments. In addition, when financial experts criticize people for not saving more for retirement (and likely increased health care costs), a different perspective may view the lack of saving as wholly rational, given that interest rates for savings have been essentially zero for many years (in the U.S.), negligible compared with inflation, for example. Finally, a short-term desire to retire as early as possible is completely understandable psychologically when one reflects on just how awful many people's jobs are and how little satisfaction they derive from their occupations. The non-financial glee of the freedom of retirement coupled with its temporal proximity seems to offset the gloom of continued work "for a few extra bucks in a few more years." Next, also related to aging, *end-of-life decisions*, with and apart from family members are clearly also important, consumption-related, and could be considered more in our discipline. The aging baby-boomers have impacted numerous aspects of our society, and they are likely to impact our research programs in health care marketing as well. Indeed, they should, given their economic value, even if they are more difficult to access than university undergraduates or online panelists, because they continue to represent billions of dollars.

With consumer aging, coupled with some consumers' vanity, we might venture more into the realm of consumer choices in, and firms' marketing efforts for, *cosmetic health care*. Conducting research at the top-of-the-pyramid can be readily accessible, and such products and service treatments can be rather expensive (e.g., face lifts, tummy tucks, implants, laser dental brightening). Yet there is surprisingly little research in this area (though see Giesler, 2012 for a nice study on botox), hence the topic offers another opportunity for a line of marketing research.

That general demographic trend of aging (U.S., Europe, Japan, albeit less a concern in youthful China, India, Africa, and parts of South America) may well collide in the next 10–20 years with impending effects of *global warming*. In the U.S., it is common for older citizens to move from the North (Midwest, e.g., Chicago) or North East (e.g., New York) to more temperate Southern climates (the North West is already moderate). Yet in that same decade or two, those Southern reaches will heat

up (e.g., Arizona) or be under water (e.g., Florida), no longer being inhabitable. The aforementioned collision then will burst the populations in the middle latitude of the U.S., thus local governments need to start building infrastructure in Utah, Colorado, Kansas, Missouri, Kentucky, and the Virginias. And of course, beyond the elderly, population displacement due to global warming will surely increase consumer stress and violence in new homestead areas and probably more suicides. Most projections regarding climate change predict more frequent and more severe floods or complete immersion for Bangkok, Dhaka, Hamburg, Houston, Jakarta, Lagos, (South) London, (Lower) Manhattan, Manila, Miami, New Orleans, Shanghai, St. Petersburg, Venice, even Amsterdam and Rotterdam in spite of their sophisticated systems of gates and levees. These effects are expected within 10-20 years, but presumably not next year, and marketers and economists know that humans and therefore governments tend to ignore future events as too abstract (e.g., as demonstrated in numerous studies in Chapter 2), whereas the utility of a solution rises with imminence. Marketers can help with framing and making the problems seem more personal and urgent.

Speaking of stress, countless biological psychology and self-help books would suggest that a person's health is clearly, immediately, and strongly impacted by *sleep* and *stress*. Neither issue is represented much in the marketing literature. If a marketer wishes to focus on traditional purchasing and consumption (rather than the general issues from a social marketing perspective), then products and services are plentiful: obviously a plethora of prescription drugs and psychotherapy sessions, self-help books and audio streams, as well as gentility in white noise sound machines, lavender essential oils and diffusers, bamboo-derived and satin bed sheets, relaxation retreats, and massages and spa days. *Religion* is sometimes thought to be an antidote to stress, as one takes one's concerns to a higher power. Even without formal religion, there are analogous mechanisms of relevance, from pledges of Alcoholics Anonymous to *community* sharing and social support networks of Weight Watchers.

Consumers' bodies, hearts, and minds reflect a great deal of heterogeneity, some of which is explicable and can be further studied.

The topics just mentioned comprise several suggested directions. In the topics that follow, we broaden the lens to situate the consumer in the health care system and the macro factors acting upon consumers' choices.

7.3 Health Care System, Macro-Level of Providers and Networks, Businesses, Societies

We have seen (in Chapter 4) that marketing scholars are excellent at studying new product introductions of pharmaceutical drugs. In the health care system, thinking about what else consumer patients might need, the literature reflects that in general we don't tend to study *medical devices* much. For some devices, that rarity might be sensible given that there is often little consumer choice in the matter, e.g., stents or prosthetics are presumably purchased only when necessary, and brand choice is frequently not in the consumer's control. But just as the quantitative marketers frequently study pharma sales force detailing efforts, we could study *physicians' decision making* in such matters. Or if the decision is jointly made with the recommendation by a doc to a patient, that interface could be better understood as well.

Additional factors in that doc-patient interface might yield customer satisfaction or dissatisfaction. Marketing scholars have a long tradition and know much about customer satisfaction, and while hospital ratings systems such as those compiled by *Consumer Reports* or *The Leapfrog Group* focus more on indices reflecting quality health outcomes and system processes, patient satisfaction is also typically a component in their consideration HC (2019d). We know *quality and satisfaction* are not the same constructs, and indeed, patients might be more swayed by satisfaction (e.g., a good bedside manner) over quality (was the problem addressed or future problems diminished in likelihood, an evaluation that a consumer may not be capable of assessing) so how might we intervene to enhance both prospects? Can we create a concierge interface, a person skilled with people, to interact between a scared, stressed, overwhelmed patient or caregiver and a likely excellent team of providers all of whom nevertheless vary in their interpersonal abilities or generosity in time provision to patients or ability to communicate the

patients' overall experience and not simply those tied only directly to the provider's narrow realm of expertise. Such issues of "collaborative care" are becoming more prevalent, reflecting an increased reliance upon *health care providing teams* with their inherent needs for communication, coordination, and consistency among the patient, family, and care-givers. Often the role with the most patient interaction time is the R.N.; if we could *empower nurses and physician assistants* perhaps with certain additional certification so as to be official, it might be for the good of the patient, but also the healthcare system, in stemming the tide or reversing the current trend toward a decreasing supply of nurses. The marketing literature is clear in the understanding that quality and satisfaction are also affected by patients' expectations, and those dynamic baselines can be brought into consideration as well.

Artificial intelligence and robotics are certainly in our future, and might they enhance that health care providing team? They might be built to assist communications and health care service provision, standardizing some care, and perhaps lowering some costs. They might also comprise some downsides, such as patients' accompanying concerns regarding lack of personal care or privacy and security issues. That is, there may be both physiological and psychological questions of acceptance or suspicion to slow adoption. Given their expense and novelty, AI and robotics systems are likely to be another experimental playground for field testing—the systems are not likely to be introduced into a health care network in a full-fledged binary manner, rather they will be tried here and there on a small scale, and tweaked before grander roll-outs. These processes would allow fabulous comparative market tests. Even now, such systems are being explored in some countries (e.g., to address Nigeria's 1:4,000 doctor-to-patient ratio, remote communications have patients enter their symptoms, and diagnostic information and medication access are offered in return; in Japan a "Ro-bear," a robot that looks vaguely like a bear, is strong enough to lift patients to and from beds and wheelchairs, intended to help the elderly maintain some daily life independence; in China, dental cleaning is offering by surgical robots, and there, a bot passed medical exams), as well as in particular specialized capacities (e.g., machine learning to scrape numerous records to enhance the accuracy of diagnoses such as image

analysis for detecting tricky melanomas, tele-health communications for remote provision whether for rural patients or cross-country digital consultation, tracking of treatment compliance behaviors, bots for check-in and AI to manage medical records at medical practices, etc.).

Also at the confluence of consumer patients with systems and companies, *direct-to-consumer* (D2C) pharma ads have been studied (see Chapter 4), yet the topic is rich in potential for further investigation. For example, D2C ads seem to emulate in the consumer populace the phenomenon experienced by young medical school students who imagine that they have every disease they read about, in part because commercials communicate a drug's value proposition so abstractly and generically (presumably for legal restrictive reasons). Further, the ads seem to imply that one's physician is good only if s/he recommends that particular drug. As healthcare seems to become more consumer-driven, it will be interesting to see the extent to which certain segments of consumers rely on their own information searches versus expert opinions of medical professionals, and for what classes of health care advice. Empowerment and information-seeking are usually qualities we value, but a typical physician's training, expertise, and experience should be respected on a level higher than a commercial advertisement or a social media posting. D2C marketing communication efforts seem to be inducing, or at the least supporting, societal trends in self-care or collaborative care, yet the direct and indirect actions are asymmetric in this market exchange—the drug companies are reaching out directly to consumer patients who, on their side of the market transaction, must access the drugs through a middle entity, namely the physician, who may well be annoyed by the initiating pharma corporate actions. Given the size of this phenomenon, marketers could test in greater detail what makes D2C claims believable, and for what conditions might the consumer patient be willing to ask for and accept the word of an advertisement versus the physician expert.

Studying the health care network is admittedly daunting—the networks themselves are complex, so the notion of measuring and modeling them as a whole or even in substantial parts seems overwhelming. The focus on pharma firm actions make sense both for the access to data and the importance and sometimes outrageous and newsworthy actions of

the firms. Still, within a company that is but a pod in the system, more research can be done from interviews and ethnographies to surveys, perhaps small scale experiments, and perhaps shaking loose from the firms more of their no-doubt extensive databases. In the next section, we consider findings from Chapters 5 and 6, stepping back from the marketing research to an even broader perspective.

7.4 Broader Health Care Reflections

This chapter, thus far, has reflected upon the marketing research presented in Chapters 2–4. We would be remiss to not also review Chapters 5 and 6, however briefly, to integrate all content.

Chapter 5 drew on academic research beyond marketing—both within and outside of the business school. The *Annual Review of Public Health* is a terrific resource for marketers, in that the articles both include and extend some topics that marketers study. The complementarity of the series lies partly in the fact that the articles typically consider issues from a point of view more macro than we do, but they cover, for example, food and exercise, and smoking, alcohol, and drugs, and they do a better job covering violence and in documenting global health care phenomena and corrective efforts.

Not surprisingly, the medical journals do a better job than we do at understanding the origination and treatment of diseases, but our field's collective training draws on disciplines that could help support their perspective. Articles in the *Annual Review of Biomedical Engineering* are really fun; this series does an outstanding job at covering innovations in information and numerous other technologies. Marketers' interests in new products, innovation, and entrepreneurship could help make headway here as well. The economic journals naturally focus on the paying system, and we could do more here, given that a good portion of our colleagues regularly draw upon economic theorizing.

Chapter 6 also extends beyond marketing, but focuses on presenting timely topics from current texts and popular press business books. The books, especially those offering overviews of the health care industry or its many systems, are particularly helpful for providing the big picture, so we can imagine where in the larger puzzle a journal article with its

necessary focus on a subset of constructs and variables might fit and possibly contribute to a clearer vision of the gestalt of health care.

Across both Chapters 5 and 6 are some reflections on how our b-school colleagues approach health care studies. Perhaps not surprisingly, organization behavior academics are frequently interested in work teams and how their inter-communications help with patient safety. Our operations colleagues often consider how to measure and thereby streamline processes of intake and health care service provision.

Other specific observations from the books considered in Chapter 6 remind us that we could study causes and preventative measures for prevalent medical errors, for example, or we could interview or shadow and observe the craziness of a typical physician's day to understand the context within which he or she makes decisions. We could also easily model the effects of the lack of price competition or any economic incentives to keep prices at bay, indeed, modeling rather the direct and indirect influence of pharma companies and insurance companies in health care provision, to see results in usage (e.g., prescriptions), corporate profitability, and medical outcomes.

A contemporaneous view on the topics that interest the books' authors include retail-like medical care provision, with discussions of questions as to whether medical care quality remains at least steady, and whether such direct distribution systems might impact, that is, hopefully lower, prices. Another current view provided by several of the books is their dedication to global health care comparisons, often citing inequalities due to numerous factors (not solely economic), and generally which provide a bountiful resource to consumer and business marketing. Finally, the theme to which futurist voices point most frequently is data-driven medical decision-making, themes marketers are also well-equipped to contribute in study. Indeed, throughout much of these readings, several trends may be derived and projected forward, including developments in technology (e.g., digitization), to those that will address consumer desires (e.g., consumer choice and voice), and consumer needs (e.g., requirements of aging populations). Marketing research can follow or even pre-empt and redirect lines of scholarly pursuit to better optimize these large classes of questions. In the final section that follows, we turn to that big thorny issue of health care payment.

7.5 Health Care Payment

We can acknowledge with confidence and evidence (per Chapters 2–4) that marketers can help make headway on many of the aforementioned issues surrounding health care provision, but now let's address the big gorilla in the health care space—health care costs and pricing, that is, *how to pay* for that health care provision.[2] Two-thirds of U.S. adults say that the cost of health insurance is a key stressor for themselves or their loved ones, nearly 60% of Americans say they are not financially prepared to handle unexpected costs, and many delay or skip seeking health care because they cannot afford it (HC, 2019e). Marketers study issues related to affordability, thus perhaps marketing research can help address consumers' concerns with their health care budgets.

I suspect solutions for refinancing the complex network of providers and payers will not come from marketers per se, yet we know about related issues so perhaps we could help progress toward *value-based* care and *transparency* in pricing. For example, we know that issues of double marginalization (manufacturers and distributors both seeking profits) may be somewhat redressed, such as by having the manufacturer also play the retailer role (e.g., with B2C advertising in one direction, and C2B purchasing directly from pharma companies in the opposite direction), or by setting a customer price and splitting the profits proportionally between the multitudes of providers. If a culture believes that at least basic health care—whatever "basic" means—is a right rather than a privilege, the government may need to step in to set those customer prices for basic provision at "reasonable" levels, because while corporate competition helps theoretically and could have achieved this coverage, it seems not to have done so or tightened prices recently. If the numerous companies that comprise a health care network find their adjusted profits unseemly, well then at that point, they can opt out.

[2]Perhaps the misnamed Medici family was a foreshadowing of current health-care financing challenges; influential during the 15^{th} – 18^{th} centuries as innovative financiers, accountants, wool merchants, and philanthropists or at least political patrons supporting architecture (Brunelleschi) visual arts (Botticelli, Donatello, Leonardo, Masaccio, Michelangelo, Raphael), piano and opera, science (Galileo) and humanities, yet alas, not a singular medicus or medicō, physician, among them.

As we venture beyond such "basic" health care provision, ethical issues flare up quickly. While fairly universally we recognize and accept as fair that we cannot all afford to own a Ferrari automobile, there seems to be an expectation that because one human life is equally valued to another (at least in cultures that are relatively egalitarian, and not, say, feudal or royal), then any consumer patient would presumably have the right to access any health care procedure or treatment, even those, like a Ferrari, far beyond their financial means.

Speaking of ethics, at the time of this writing, the legal cases and ethical reflections and commentaries have not yet settled on the actions of two *big pharma* companies being caught raising their prices excessively. As CEO of Turing Pharmaceuticals, Martin Shkreli raised the price of an anti-parasitic drug (Daraprim) from $13.50 a pill to $750.00. (I wonder if there would have been a louder outcry if parasites were a common problem in the U.S.) As CEO of Mylan, Heather Bresch raised the price of EpiPens (for life-threatening allergies) from $57 to more than $700 (they cost less than $2 to produce). The involved CEOs wish to argue for free markets, and the argument seems to be persuasive (e.g., the EpiPen price change hit its high mark, so far, in June 2016, and as yet there has been no redress). Yet at the introduction of a new drug, and often with many years to follow, there are typically no competitor products. Specifically, companies enjoy exclusivity rights for 3-7 years, and patent protection for 20 years. Yes, they're trying to recoup their R&D. They're also supposed to be helping patients. What would pricing, profitability, and patient care look like if the protection in the early years were removed, or if a price was limited to some maximum over the course of a treatment?

Chapter 6 had presented a wide array of books and topic coverage, but the stories that stuck with me were the voices of the economists—consistent, urgent, and clear. We (at least in the U.S.) *will not get out from under the financial burden as long as "someone else" pays.* Consumers and companies don't pay much, nor do physicians for malpractice claims, nor do hospitals or medical centers for procedures run; instead, some insurance firm pays, that is to say there is a murky indirect link to businesses and consumers, and all of course with the ultimate safety net being the government (again cycling back to consumers after

all). Perhaps employing firms shouldn't even offer healthcare insurance coverage because that money is taken out before consumers receive their paychecks—in this manner, the paying process doesn't hurt as much, compared to receiving a full paycheck and then having to write personal checks or charge every health care-related transaction, perhaps later getting reimbursed for part of the expenditure. The employer firms would no doubt celebrate if relieved of such a financial burden.

According to the economists, consumers would then start *shopping for quality and cost* (for discretionary health care), ultimately driving quality up and cost down. Consumers shopping for competitive prices and quality can also have the effect of helping insurers who currently have little bases for tough negotiations with demanding providers. Yet I fear the early transition years in a trend toward better value-pricing would take a while, such that costs might remain high for a while before dropping and during transition, the result feel worse to consumers who would now be paying. It doesn't feel risky to predict that health care prices would continue to increase, in some form or other. One large concern is that *increased health care prices* will discourage or prevent the poor and elderly from seeking help. If more consumers opt out of health care altogether, or engage infrequently, the result would be diminished public health status and longevity statistics will decline. Perhaps more positively, increased health care costs, both financial and physical, might encourage decisions that involve affirmative choices for quality of life, and rejecting some treatments, rather than seemingly prevalent reactive choices for expensive and often quite debilitating health care. These issues are all already in place, but given the trends in demography and geography, their numbers and complexities will surely increase.

Economists also desire greater precision regarding terminology in that the word "insurance" is bandied about but in fact, typically applied inappropriately. Insurance is governed by actuary tables, assessments of risk and uncertainty, specifically to determine and manage coverage of likely high impact (e.g., expensive) unfortunate outcomes, but outcomes that occur with low probability. Health care financing instead covers nearly universal probability, that is to say certainty, of customer engagement and redemption. Thus, the financing is more properly referred

to as "pre-paid medical coverage." *If consumers paid larger portions out-of-wallet*, there would likely be less superfluous usage and perhaps more censoring of unnecessary treatments and testing. The movement of employers offering health care plans that require higher deductibles is thought to be a step in this direction—that a consumer will think twice before purchasing what otherwise might have felt like a "freebie."

The movement toward more *retail health care* options would seem to be a step in the direction of consumers paying directly as well. Dental practices split off from medical centers long ago and now seem to host franchise-like cohorts of practitioners. Similarly, eye specialists have long offered assistive eyewear, and for this specialty, online providers seem to be establishing large inroads and loyal followings (e.g., Warby Parker). Chiropractors may be less frequently visited, or psychotherapists, but all of these body parts are treated by off-center providers. Medical collective centers may soon resemble old-fashioned department stores, with "kidney dialysis" occupying the "fourth floor" instead of "women's fashions."

A topic that seems to have flown under the radar for marketing researchers is that of *healthcare tourism*, a huge and still growing industry that seems to combine an answer to access and pricing with the concerns of global and cross-cultural healthcare mentioned previously. Per the economists' claims that consumers would shop for both quality and price, current instantiations might emphasize competitive pricing, but pilgrimages to the likes of Mayo Clinic or other global seats of excellence, speak to the consumer motivation of seeking excellence in quality as well.

While the B2C solutions seem somewhat clear to understand, albeit still not crystal clear in execution (e.g., likely making access inexpensive for preventative care, covering few electives, large deductibles and copays and other out-of-pocket expenses), the B2B costs and prices issues seem more perplexing. Much like a business class flyer who doesn't care how much the ticket cost because his or her company is paying for it, therefore airlines charge many more times for those seats than seats in coach, the question is how to *drastically reduce the B2B* transaction prices. Is it the case that businesses charge whatever they want because if other businesses do not pay, the *government* will? Therefore is it

the case that right-leaning economists are correct to suggest that the government should step out of playing the role of a security net? It doesn't sound compassionate, but then today's system couldn't be called that either. When employers choose coverage networks, the latter have negotiated prices with providers, and in this triad, the providers can wield a great deal of power, in part due to the proximal nature of health care provision. If consumers were *willing to pay other prices*, such as waiting (time), or traveling farther (effort), then the local providers could not be as demanding.

Even if there were clear designs regarding how to restructure alliances, it's not as clear that the powers that be will allow such modification. In the U.S., annual health care expenditure is $3.5 trillion, or 18% of GDP, which is over $10,000 per person (are you getting your money's worth?), therefore clearly there are large, *powerful players with a lot to lose* should the system change. As the following table indicates, health care industries comprise at least 25% of the top 20 U.S. lobbying industries (HC, 2019f).

Industry	**Lobbying spending 1998–2018 (rank)**	**Lobbying spending 2018 (rank)**
Pharmaceuticals and health products	$4 billion (1)	$280 million (1)
Insurance	$2.7 b (2)	$157 m (2)
Hospitals and nursing homes	$1.6 b (9)	$100 m (8)
Health professionals	$1.5 b (13)	$90 m (13)
Health services and HMOs	$1.1 b (16)	$79 m (14)

Note, of course, that this reflection on the power of entrenched players takes numerous forms. Within the healthcare industry, so much more money is spent on treatment (pharma, surgeries and procedures, etc.) than prevention (e.g., essentially no spending on social marketing to increase exercise or watching intake, and selling the likes of Fitbits seems meager by comparison). Outside the healthcare industry, but sending consumers its way, purposefully or somewhat accidentally would be numerous manufacturers. For example, selling potato chips and candy yield much greater margins than selling fruits and vegetables, so where will marketing dollars be directed? Or, how much money is spent to sell

cigarettes (still) and alcohol, and how little is spent as reminders of lung cancer and ill effects of prolonged inebriation (for the latter, "Don't drink and drive" seems to have been surpassed by "Don't text and drive"). The spending differential for vice versus virtue seems insurmountable, with marketers acclaims of "This is how to enhance optimal and healthy consumer behavior!" seeming quite Sisyphean against the insatiable demands of the profit machines that benefit the C-suite, boards, and oh dear, shareholders, perhaps employees (in wages and maybe health care benefits), investors, tax-payers, back to consumers, what a messy circle. Still, marketers tend to be an optimistic lot—we often reframe "problems" into "opportunities"! Well, there are big opportunities in the health care marketing space!

7.6 Final Remarks

To close, when all is said and done, if part of what we marketers are trying to do is enhance the lives and health of consumers and patients and societies, we do need to constantly remind ourselves that *the consumer public is a remarkably, probably overly, trusting lot.* There seems to be a strong consumer trust that something wouldn't be sold if it wasn't good for us and a trust that companies are continuing to rollout useful new products for our benefit (and if they get rich doing so, that's ok). Marketers know about persuasion knowledge, that is, consumer differences in their willingness to believe advertising and package claims versus being skeptical of them. Still, it seems rational to think that if pretzels come in smaller packages, more packages may be consumed; to me, the curiosity is that food manufacturers and marketers are surprised by that consumer behavior. It is rational to think that if a line of cookies or ice cream has 25% less fat, it would be healthier—why suspect that a company had inserted an offsetting increase in sugar, or that low salt/sugar implies high fat/chemicals? Big pharma certainly wouldn't rollout new drugs unless their efficacies exceeded their side-effects, right? Pharma companies complain about extensive FDA procedures, but once the drugs are available, they must have been fully vetted, right? Don't companies care about their customers? Aren't all the government agencies and regulations looking out for us—if not,

what good are they? This trust is an ancient one, older even than the Latin we've inherited, *caveat emptor*, indeed as far back as a fruit vendor in Eden s-s-selling bad apples, and look what that market transaction hath wrought. Buyer beware, indeed.

In close, marketers have made fine research progress in many areas of health care. For scholars interested in health care and healthcare topics, the great news is that there is indeed ever more opportunity!

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