



Health marketing: Toward an integrative perspective[☆]

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ABSTRACT

This paper pinpoints what health marketing exactly covers and to places this nascent field in an integrated perspective. The ongoing evolution of medicine, technologies, health systems and role of various actors leads to a new grid of lecture of the domain. Marketing has been discarded of health since a long time but now becomes one of its best supports. Five original contributions about this field are then introduced.

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1. Introduction

In its broad definition, the field of health marketing seeks simultaneously to reach individuals who are healthy and wish to remain so, as well as individuals who are sick and seek to recover their health. Health marketing operates within a context that is, in many ways, pivotal: global and competitive, legislative and regulatory, social and societal... from the communication of knowledge about illness to the communication of health information. Today, the new information and communication technologies revolution obliges this traditionally reserved sector to open itself toward the exterior in general and toward patients/clients in particular. In a broader sense, the sector must increasingly engage all stakeholders.

2. Definition of health marketing?

The term, health marketing, here signifies the systematized application of the marketing principles within the very broad, heterogeneous, and complex field of health. Although many authors have praised the emergence of health marketing as a distinct field of research (Berry & Bendapudi, 2007; Lega, 2006; Stremersch, 2008), few ultimately have

provided clear and integrative definitions. Indeed, health marketing refers to a number of realities, e.g. marketing of the life sciences (Manchanda et al., 2005; Stremersch & Van Dyck, 2009), social marketing (Hastings & Saren, 2003; Kotler & Zaltman, 1971), and marketing of health services (Berry & Bendapudi, 2007; Latham, 2004; Smith, 2011; Zaltman & Vertinsky, 1971).

We analyzed the relevant academic journals for occurrences of the term health marketing. A thorough search of the EBSCO online database (<http://search.ebscohost.com>; accessed: 3 Feb. 2012) shows that health marketing was used 2038 times between 1971 and 2012. Of 778 deduplicated results, we classified 489 articles according to their subject of study, as assessed through an examination of the abstracts (after subtracting editorials and sample title pages). Health marketing referred to social marketing 115 times, to marketing of services 105 times, to consumer behavior 77 times, to pharmaceutical marketing 60 times, and to public health 40 times. In another 25 cases, the term was used in more comprehensive approaches involving the three types of actors. These results complement those reported by Honeycutt and Paul (2004), who surveyed the most frequently cited subjects in Health Care Marketing Quarterly.

3. Sector specificities

Important differences exist between the medical contexts and other contexts of consumption (Kahn et al., 1997). For Stremersch (2008), health marketing constitutes a new field, characterized by specific features and closely associated with its applications, but does not constitute a new paradigm. However, because the patient is not a regular consumer, and the rationalities of the actors and the functioning of the markets differ in numerous points, several questions arise.

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Health is not a good. Health is a state or a process, sometimes determined, sometimes random, in which psychology occupies a place of importance and in which ethics, compassion, empathy, and solidarity are the reference values.

3.1. Tied to context

The object of studying health marketing research aims at specific objects: the consumption (or lack consumption of) of a product or service may have gravely deleterious, even lethal consequences. A wide range of essential services is not particularly desired (Berry & Bendapudi, 2007). Desires and needs frequently and paradoxically come into conflict, resulting in the consumers' reluctance to play the role of co-producer (Smith, 2011). The demand for customization is high, the strictly personal nature of the service and trust are major elements of health service quality. Patients must paradoxically both safeguard their privacy and surrender part of their intimacy to health personnel.

Sick individuals are vulnerable, experience suffering, are frightened, and lack control over the health service process. They can be highly emotional, demanding and sensitive, while facing reduced choice capacities. Consumers, notwithstanding the importance and the specificity of the regulatory environment, remain confronted by high levels of uncertainty and a lack of adequate information on which to base rational choices. Flawed decisions may acutely impact the well-being of consumers who thus partly delegate consumption to an expert within an agency relationship.

Kahn et al. (1997) shows that traditional constructs, such as involvement, affect, stress, uncertainty, and satisfaction take on different, non-transposable meanings within decision processes in which compromises are impossible or are altered. Excessive involvement can raise patients' stress levels. Complex decision situations often lead patients to rely on their feelings or emotions as grounding criteria (Kahn et al., 1997). The family, frequently involved, can also intensify emotions connected with the challenges of sickness and its social consequences (Agrawal, Menon, & Aaker, 2007).

Affective reactions play a crucial role in health (Agrawal et al., 2007) and displace the value of consumption onto a third object: the healing process. Clients are exposed to the triple risk connected with illness, its diagnosis and its treatment, while service recovery often proves impossible. Health care is a credence service (Berry & Bendapudi, 2007) in which a stochastic relationship links results in quality (Kahn et al., 1997), bringing a degree of difficulty to assessments of the notions of satisfaction and service quality. Parasitic effects exist in medical practice, such as the placebo and nocebo effects. Ultimately, individual differences must also be considered (health capital, heredity, risk perception, personality...).

3.2. Tied to market contingencies

Marketing mix variables do not fit easily with the health context (Kahn et al., 1997). Place refers to the way in which care and products are distributed, including also treatment choices. Legal restrictions set limits on consumers' freedom of choice (as in the case of prescription drugs). Promotion is frequently considered discreditable among the medical profession. There is, in fact, a strong social norm against advertising in the health field, which is actively present in the collective unconscious; thus demand can only rarely (esthetic medicine) be created through advertising (Latham, 2004). Patients are rarely conscious of the true price/cost of the services they purchase, since they bear that cost only in part. Insurance systems offering "first dollar coverage" limit the direct burden on consumers, whose attention is consequently focused, to a greater extent, on the benefits of care and the associated physical and psychosocial potential costs, than they are on the financial costs (Evans & McCormack, 2008).

4. Toward an integrative perspective

Expanding the value chain proposed by Burns (2005), we position actors in accordance with the logic of marketing practice influence. Social marketing is identified as an integrative meta-dimension whose influence encompasses all actors and which regulates other marketing strategies either through reinforcement or by countering the excesses of commercial marketing that is possibly deleterious to health (Fig. 1).

4.1. Evolutions, revolution, and perspectives

Patient emancipation is substantial (Camacho, Landsman, & Stremersch, 2010), whether prior to sickness (prevention) or upon its emergence (diagnosis, treatment), during its evolution (compliance) or afterward (secondary prevention), and fundamentally modifies not only doctor-patient relationships but also those of individual-society-patient, as well. The traditional notion of a passive and 'subjected' patient is supplanted by the reality of a consumer who is involved and proactive in designing the process of care.

Greater authority and involvement in care on the part of regulatory and funding bodies increases the injunctions for actors to change their behavior, through financial, structural, and organizational mechanisms, as reinforced by patient expectations. Public and private insurers will need to improve patient support through personalized communication of preventive advice and orientation within the health care system based on consumption analyses.

Approaches in medicine are evolving from the curative toward prevention-prediction. Personalized medicine formalizes the transition from a medicine of ablation/substitution toward a medicine of repair, just as we are witnessing a shift from the chemical to the genetic. Time dedicated by health practitioners to health practice is increasingly scarcer in a society where role conflicts are more common. Health management is becoming a management of flows: patient flow, treatment flow, disease flow, and flow of information among all stakeholders.

There are specificities – linked to the patient, to the context, and to the marketplace – as well as an emerging tendency toward consumerism, but also an activism that reflects a new social demand (Evans & McCormack, 2008).

Health marketing calls for an integrative perspective because the health care system is an integrated whole, uniting all actors within a number of convergences:

- a common, dual objective: patient health and consumer well-being through a 'patient-centered' approach;

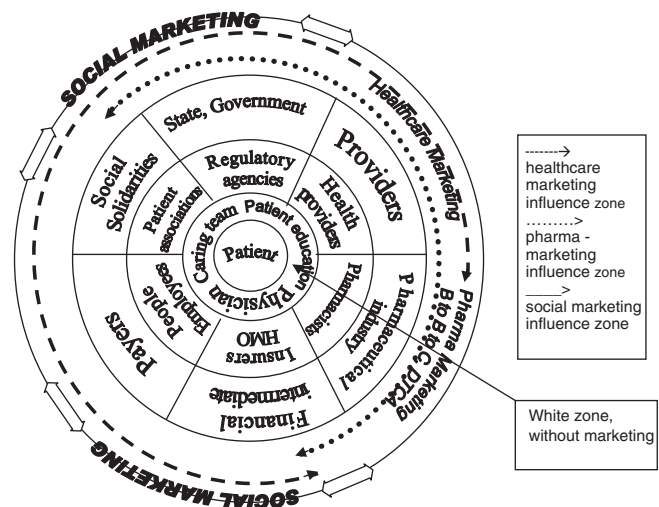


Fig. 1. Health marketing wheel.

- the diversity and proximity of simultaneous aims (patients, payers, prescribers...) define a multisided market that necessitates message congruence and convergence; each actor must simultaneously satisfy a number of internal and external stakeholders;
- the sector's inherent ethics, in which values are paramount;
- the professionalism interposed because of, notably, information asymmetry and the complexity of medicine;
- the similarity of the constraints weighing on marketing mixes in accordance with national regulations;
- the central and actor roles of payers;
- the technological and paradigmatic developments inexorably erasing frontiers between actors (e.g. medication vs. surgery), making cooperation necessary;
- the changes in pathology chronicization and population aging;
- the fewer resources and major revolutions in approaches to treatment (biotherapeutics, nanotechnologies, tissue engineering);
- the treatment education, justified primarily by disease chronicization, unites all actors and includes programs addressing compliance, patient support, and patient education on health and understanding of pathologies.

Integrative research into the entirety of Burns (2005) value chain is largely non-existent, despite its manifest relevance (Stremersch, 2008). Health care systems posit themselves as ecosystems perpetually evolving and transforming under the triple constraint of: first, their network interrelations; second, the economic and ethical injunctions of state, citizenry, and regulatory bodies; and lastly, the development of medical, biological, and technological knowledge. The field of health is characterized by organizational reconfigurations/integrations that tend to erase its boundaries, melding them in a common objective encapsulating prevention, health promotion, treatment, and patient support. This malleability, as much institutional as organizational, affects: (1) national health care systems in their entirety through the definition of new market rules; (2) the missions of health organizations and their modes of operation; and (3) professional practices redefining approaches to the coordination of individuals and groups that are actors within given territories. These processes evolve under the nascent control of a complex information system operating not only for accounting and statistical purposes, but directed also at the evaluation of the efficiency of therapeutic activities and the provision of frameworks for medical practices.

The concerns addressed by the articles included in this Special Issue provide examples of critical questions for the health sector and for public policy. Two of them tackle social marketing and the struggle against brand marketing and addiction, two examine patient/consumer behavior, and one considers the spatial organization of health care systems.

The first research questions to be addressed concern the contribution of packaging promoting public health to the fight against tobacco use and the promotion of responsible gaming behavior among youth. In this perspective, Gallopel-Morvan et al. examine the attractiveness of tobacco packaging as a marketing tool and support WHO recommendations on dedifferentiation and the imposition of plain packaging accompanied by graphic health warnings. Lemarié and Chebat draw attention to the effects of gaming advertising on youth and suggest that the original approach of inoculation theory (McGuire, 1964) may induce persuasion resistance to gaming industry messages.

The two subsequent contributions address our understanding of the behavior of health care and health product consumers. Maille and Hoffmann evaluate compliance factors for therapeutic prescriptions vis-à-vis third parties. Social risk, the degree of patient attachment and the level of patient trust in the physician, as well as the 'physical' component of perceived risk, all emerge as determinants of compliance in dependency situations. Lastly, Bonnal and Monnier examine elements of official services that contribute to patient and consumer satisfaction based on Llosa's (1996) tetraclass model, which classifies factors as either key, plus, basic, or secondary. Clients in France appear to be rather 'patients' than 'consumers', the key

elements being essentially linked to pharmacist competence in issuing ethical products, while no basic elements are denoted.

In the closing article, Barry and Cliquet shed an instructive light on the policy of redeployment of health facilities (maternity wards) to be implemented in physical planning in France. The trend toward a rationalization of health care services that aims to concentrate delivery in central locations raises questions for populations concerned about the growing physical distances between health care facilities and residential areas. Health care delivery has a distinctly spatial character that, in contrast to commercial offers, has thus far been severely understudied. A maximum coverage model allows for the optimization of maternity ward installations in France, thus maximizing accessibility and demonstrating that 80% of total demand can be met by 100 central locations. Promising avenues of research are proposed to further improve the model's efficiency.

Most issues raised in these papers are essentially cross-cutting and concern the behavior of health consumers – who play an increasingly central role because of their involvement, their compliance and their purchasing behavior – with a particular focus on the pressure levers that have the potential to curb harmful behavior through social marketing, giving rise to questions about the effectiveness of health policies. This special Issue focuses on elements of value inherently created by the individual within the preservation, improvement and coproduction of health factors (e.g. Scammon et al., 2011). Health marketing is essentially a marketing of services whose client is always a cocreator of value.

This fruitful approach calls for continued development. We strongly encourage further research into the specific characteristics of health consumers and into health marketing as an integrated field.

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