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# The Effectiveness of Product vs. Image Strategies in Health Care Marketing

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# THE EFFECTIVENESS OF PRODUCT VERSUS IMAGE STRATEGIES IN HEALTH CARE MARKETING

BY

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TABLE OF CONTENTS

LIST OF TABLES

# INTRODUCTION

Marketing has long been recognized as a vital element for success in the corporate world (Copeland, 1923). One notable exception to this has been the health care industry.

It was not until the late 1970s that marketing finally entered the health care realm (Cooper, 1979). The majority of initial advertising and promotional efforts focused on "image" as opposed to "product" (Super, 1986).

While the goals of both image and product marketing are to increase sales of goods and services, their methods are different. Image or "institutional" advertising is used to create a favorable image of the corporation in the public's mind and is especially useful if this public has any pre-existing negative perceptions. Product advertising, on the other hand, promotes the actual goods and/or services of the corporation (Sachs, 1983).

There are two main reasons the health care industry first chose to employ image over product promotion. First, the medical industry was highly skeptical about any form of marketing, particularly advertising, and wanted to approach it in a low key style. They shied away from the hard sell tactics of product advertising and chose instead to promote a new image (Super, 1986).

Secondly, there was a very real need for a new image. Since the 1960s, the health care industry had been experiencing an increasingly severe crisis of confidence on the part of the general public (Cooper, 1979). Therefore, the majority of hospitals decided that what they needed to promote was a more positive, humane representation of their institutions (Brown, 1973). In addition, they did not view their services as "products," and therefore felt no need to sell them as such (Starr, 1982).

Based on these assumptions, the first several years of health care marketing were predominantly image oriented. Gradually a few "products" were eased into the marketing strategy. Leading the way were the health care services involving women, most notably childbirth facilities. Again the industry was responding to a crisis, in which women increasingly were turning to alternative methods of childbirth, such as mid-wifery, to escape the so-called "coldness" or "impersonal" image of the maternity wards (Starr, 1982).

Hospitals were slow to employ marketing research as well (Mages, 1985). Eventually they did begin hiring outside research companies in order to test the effectiveness of their advertisements. The results were surprising: the ads were not working (Powills, 1986d).

According to one recent study conducted by an Omaha, Nebraska-based firm, Professional Research Consultants, Inc.

and Hospitals, an industry magazine, more than half of health care consumers did not recall seeing the hospitals' advertisements. Hospitals' marketing writer, Suzanne Powills (1986d, p. 66), attributes this in part to "the fact that many hospitals continue to advertise image rather than specific services."

The president of Professional Research Consultants, Inc. had this comment: "Consumers want to know why they should utilize one hospital's services over another, and an advertisement saying 'We care' does not give consumers reason enough to choose a particular hospital." (Powills, 1986d, p. 66).

The researchers involved in this survey reached this conclusion when they realized that the ads that were remembered most frequently by nearly 44% of surveyed consumers contained information about specific services, such as emergency department care and obstetrics and birthing centers. Further it also showed that 86.1% of this group could recall the name of the hospital sponsoring the ad (Powills, 1986d).

The view that image marketing, although highly utilized by the health care industry, may be the most ineffective strategy for them, is new. The few articles expressing similar views appeared in health care trade journals and were all published within the last year. These articles appear to be based almost solely on individuals' intuitive

judgments. And in some cases their arguments are derived from privately commissioned surveys which appear self-serving and are therefore academically suspect.

It will be the intent of this study to test with empirical measurement the validity of the hypothesis that hospital product marketing is more effective than image marketing in terms of consumer recall and usage.

## LITERATURE REVIEW

A review of the United States' health care industry over the past few decades aids in the clarification of the development of conflicting marketing strategies. Not only does this reveal how the health care industry differs from other industries in terms of structure, but also in terms of public perception and, therefore, marketing techniques.

The health care consumers of the 1940s and 1950s were largely seen as being patient, unquestioning receivers of relatively scarce products and services. In the 1960s, economic prosperity swept the country and as a consequence yielded radical changes in all areas of consumerism. Consumers moved from passive to active, and began scrutinizing all industries, including the previously exempted health care industry (Cooper, 1979).

One criticism was that hospitals, while often called "community hospitals," had long ago stopped being responsive to the community (Constantine & Cassidy, 1969).

According to Brown (1973, p. 11), "...there is evidence to support the criticism that the hospital and the medical care system have not looked and listened outside its own walls."

Brown further asserts that the health care industry's perspective was introverted, having been so focused on

technological advances that it overlooked the community's health concerns.

During the 1960s, hospitals were focused on the development of both human and technological resources, to keep up with rapid scientific advances in the field. Vast research programs were implemented and tremendous emphasis was placed on improved education and training for medical personnel (Fuchs, 1968).

According to Brown (1973, p. 12), "The hospital had developed into a highly sophisticated system, but had lost sight of the individuals it was supposed to serve. From the eyes of the community the technological achievements were overshadowed by the view that the hospital system was only accountable to itself."

Another major contributing factor to this alienation of hospital and community was the increasing intervention of third party health care financing agencies--both voluntary and governmental (Berry and Daugherty, 1968). This, in effect, was a relinquishing of the patients' economic proxy, and thus the consumers' voice, in many matters. On an even larger scale, the local community had fallen victim to the same situation, since state and national level governments usually were footing the bills. Therefore, the medical care system responded to financing agencies and developed those services and programs that corresponded with third party reimbursement policies (Inglehart, 1976).

These reimbursement practices led to the most significant rift between the health care industry and its public--the issue of costs (Feldstein, 1971). Third party institutions insulated patients and providers from the true cost of treatment decisions, reducing the incentive to analyze costs versus benefits. From 1960 to 1975, the share of health care expenditures paid by third parties increased from 45% to 67%. Most private plans, as well as Medicare and Medicaid, paid on a fee-for-service basis. In order for the hospital and doctor to increase their income, they had to increase their volume of services provided. Thus, third-party fee-for-service payment became the central mechanism behind medical inflation (Macstravic, 1977).

Since hospitals were reimbursed based on their costs for services or products, it meant that any institution reducing its costs would also reduce its income. This system encouraged hospitals to solve financial problems by maximizing costs. Therefore, according to Starr (1982, p. 385), what became a solution for the industry became a problem for the society it was serving.

For doctors, these reimbursement plans meant an increased incentive not only to raise their fees, but to hospitalize patients instead of treating them in their offices.

Medicare and most private insurance companies paid doctors according to "customary" fees, assuming them to be

the prevailing fees in the area, and, therefore, reasonable. Fees began to soar, particularly as more new doctors entered practice. With no established schedule of fees, they discovered that if they billed at unprecendented levels, they were paid. Older colleagues soon recognized this and raised their fees as well. What was "customary" spiraled higher than ever before (Starr, 1982).

Another important policy that affected both physicians and their patients was that third party reimbursement provided even higher compensations for services performed in a hospital instead of in an office, even if the procedures were identical. This system encouraged the overuse of hospitalization, tests and surgery, according to Starr (1982, p. 386).

In the mid 1970s physicians earned 50% to 60% more per hour for hospital labor time than for office labor time. Therefore, even as technology made some procedures easier to perform, the prices for these services continued upward. This also led to a serious deficiency in several areas of medical services, especially ambulatory, preventative and basic family health care. Specializing became more popular because it was so financially beneficial. Patients could no longer expect one physician to treat them for everything from diagnostic to post-operative care. Surgeons were relieved of many duties by technicians and assistants (Starr, 1982).

As the medical bills escalated, so did the crisis of confidence by consumers. In 1965, with the passing of Medicare and Medicaid legislation, the goverment was spending $42 billion for health care. This number jumped to $133 billion by 1975, and by 1982 the figure had soared to $322 billion. (Rosenstein, 1984/1985).

Until the 1970s, insurance companies had been able to offset rising costs by raising premiums. However, with the growth of government spending, insurance companies became concerned that, in order to offset some of these costs, the government might shift some charges to the consumer, and thus, in turn, to the insurance company. Employers, meanwhile, struggled to meet continuing increases in group insurance costs. By the 1970s, rampant costs caused these three agencies--employers, the insurance companies and the government--to unite against the health care providers in a move for state regulation of hospital charges (Starr, 1982).

At the same time the issue of human rights was at the forefront of public interest. In the 1960s, this was primarily focused on the civil rights of Black Americans. In the 1970s attention moved to other groups, such as women, children, other ethnic groups, homosexuals and students. Included in this concern were patients and their rights, especially for the mentally ill, retarded and handicapped. A trend of deinstitutionalization phased out many long-term health care facilities. There developed a strong desire to

"demedicalize" certain critical life events, such as birth and death. A public rejection of hospital care was expressed in the rise of hospices and home births (Starr, 1982).

"Health care moved into an issue of rights and no longer privilege," according to Starr (1982). "No other idea so captures the spirit of the time."

Further health care rights issues were pressed: (a) the right to informed consent, (b) the right to refuse treatment, (c) the right to see one's own medical records, and (d), the right to participate in therapeutic decisions (Winston, 1984). This recognition of rights obligated doctors and hospitals to share more information and authority with their patients. The laws began to recognize a right to health care. Courts ruled that doctors had a duty to present all material facts to their patients, including risks of treatment and medical procedures. Any patient who had been denied such information and suffered an injury could sue for malpractice. In 1972, the trustees of the American Hospital Association, following the lead of some local hospitals and health care centers, adopted a Patients' Bill of Rights, which included rights to informed consent and "considerate and respectful care" (Starr, 1982).

These radical changes led to patients becoming more interested in being educated about the nature of their health problems, their treatment and preventative measures.

They became more concerned about health care costs, convenience and accessibility, creating a demand for a return to ambulatory care (Rosenstein, 1984/1985).

They also began to practice many simplier medical precautionary services in their own homes, such as taking their own blood pressure (Jarrett, Swanson & Swanson, 1985).

But, according to Starr (1982, p. 389), the greatest distrust of physician domination came on the part of women. The women's movement significantly affected the health care industry in a variety of ways. First, there was a significant increase in the number of women entering medical schools, going from 9% in 1970 to over 25% by 1980 (Golin, 1985).

Women began to assert themselves in health care in other ways. In 1973, the Supreme Court legalized abortions, and an underground industry "surfaced" with the support of women's groups. This led to a major change in gynecological care and services, encouraging more "self-care" and a return to midwifery (Starr, 1982).

Feminists argued that medical care needed to be demystified and women's lives demedicalized, as childbirth was not a disease and that normal deliveries did not require hospitalization and the supervision of an obstetrician (Ruzek, 1978).

This notion generated one of the biggest conflicts between women's health care consumers and the medical

profession (Starr, 1982). And it was this battle that eventually lead toward the first marketing of a health care product--maternity care. By the late 1970s, hospitals had begun promoting alternative methods of childbirth, such as the Lamaze method. Conditions, while still antiseptic and supervised, became more personalized, with husbands being allowed to participate in births. Rooms were designed to look "like home," lights were lowered, drugs avoided. Visiting hours were extended and babies were allowed to stay with the mothers longer. Hospitals even began to promote packages--citing prices for the entire stay, and even throwing in gourmet meals and celebratory bottles of champagne. The first promotional items also appeared here, with newborns receiving personalized bibs, rattles and certificates bearing the hospital's name (Starr, 1982).

Obstetrics became one of the first areas of medicinal service to be marketed as a product by the hospitals. They put together package rates and used billboards, radio, television, and direct mail promotion (Starr, 1982).

The women's movement also had a dramatic impact in advocating holistic medicine. This broad cultural and political movement sought a humane alternative to the impersonal, symptom-treating medicine of the contemporary hospital. It challenged the necessity of many surgical procedures, and the values of elitist medical practice,

dominated by sophisticated technology and techniques (Starr, 1982).

The growing acceptance of a right to medical care and the mobilization of various advocacy groups led to the realization that equal access to medical care required that cost control be built into the health care delivery system. According to Starr (1982, p. 390), "If health care was a right, then structural reform was a necessity."

American medicine in the 1970s was caught in a political vice between the concern of government and business about high costs and the demand of protest movements for equality and participation in medical care. The health care industry was in a crisis and the finger was pointed at the medical profession (Starr, 1982).

On February 5, 1970, HEW officals met with Paul M. Ellwood, Jr., a Minneapolis physician who directed the American Rehabilitation Foundation. Ellwood addressed the issue of "structural incentives." In rehabilitation, as in other fields, fee-for-service payment penalized medical institutions that returned patients to health. The financing system, Ellwood argued, ought to reward health maintenance. Prepayment for comprehensive care could achieve that end. Ellwood introduced an idea that would change the structure of American medicine permanently--the Health Maintenance Organization (HMO) (Starr, 1982, p.395).

The economic rationale behind this and other prepaid health plans was to provide the organization and its physicians with a financial incentive to minimize the cost of medical care to enrollees. This incentive was the "margin," the difference between the capitation payment and the actual costs of providing medical services. The margin represented profit for the HMO (Feldstein, 1979).

This new scheme brought competition to the health care industry. There was a whole new emphasis on supporting "wellness" by the insurers, employers, providers, citizens and especially the government (Boyd, 1984/1985). This idea brought financial incentive for ambulatory and outpatient care. When HMOs did need to refer to a hospital, they were making their selection based on obtaining the necessary quality care at the lowest available cost (Starr, 1982). Since the least costly avenue was the best, outpatient surgery increased, and hospital stays for convalescence after major surgery decreased. There was also a whole new incentive for preventative health care and education (Venkatesan, 1978). HMOs benefited most by keeping their patients healthy, and thus their costs at a minimum. This also meant reducing the costs of prescriptions, as the HMOs would be the patients' main source of drug information, along with a preference for generic drugs at reduced prices (Falkson, 1980).

The White House gave its approval for HMOs in March 1970. By the late 1970s President Nixon viewed HMOs as the answer to what he termed "a massive crisis in health care." The administration's goal was to help create enough HMOs by the end of the decade to have them available to 90% of the population (Starr, 1982, p. 396).

Further, Nixon called for a limit on doctors' fees to annual increases of 2.5% and on hospital charges to increase six% (Starr, 1982).

About this time, divergent attitudes appeared among medical professionals. The American Medical Association membership fell to 50% of all physicians in 1972, as young doctors refused to join. A new competing organization, the Medical Committee for Human Rights was formed and soon claimed 7,000 members. The AMA was forced to shift to a more liberal posture and publicly called for concern for the poor and a shift to family practice. In 1973, the AMA supported neighborhood health centers where doctors could be paid by fee-for-service, salary or capitation as they chose. This new advocacy was an effort to forestall the administration from totally restructuring the health care system. The desperate hope was that if physicians took it upon themselves to provide 24-hour, seven-day-a-week health care in the population centers, then the government would back off (Starr, 1982).

But the government continued passing regulatory legislation, the biggest impact coming with the National Health Planning and Resource Development Act. This was the foundation of a new planning system, with 200 health systems agencies (HSAs) to be run by boards with consumer majorities representative of their areas. They were to draw up three-year plans, review proposals for projects and send recommendations to the states on certificates of need and to Washington on proposed uses of certain federal funds. All states were required to pass "certificate of need" legislation and to establish state health planning and development agencies and health coordinating councils. According to Starr (1982, p. 399), this law seemed to be a decisive rejection of the view that the market could correct itself and that the doctors and hospitals had the last word on how medical care ought to be organized. Certificate of need legislation was a vast departure from the past. Once the focus was on expansion of hospitals; now it was on containment (Rosenfeld & Rosenfeld, 1975). President Nixon was also very strongly in favor of national health insurance, and it is believed that if Watergate had not taken Nixon out of office, he would have succeeded in his plan to have it implemented by 1974 (Starr, 1982).

In 1974-1975, a severe economic recession, accompanied by soaring inflation, stopped many medical and social reform programs. In August 1974, the controls on price increases

for medical services were lifted. So while the medical profession had maintained only a 4.9% inrease in prices from 1971-1974, the removal of the controls let the inflation rate hit an annual figure of 12.1%. This stopped the movement for national health insurance since many believed it would bankrupt the country. And indeed, by 1977, Medicare and Medicaid outlays had doubled (Starr, 1982).

Meanwhile, HMOs were developing more slowly than had been anticipated, due to lack of capital and of trained professional management. They finally began picking up momentum in 1976, and by 1979, there were 217 HMOs, far fewer than the 1700 the Nixon administration originally foresaw. HMO enrollment in 1979 was 7.9 million, twice as many as in 1970. By June 30, 1985, enrollment had increased to 18.9 million (Higgins, 1986c).

Although they were slow to start, the HMOs had a strong impact on hospitals' income. Between 1986 and 1983, research by the American Medical Association revealed that consumers had saved an estimated $12 billion through the use of HMOs as opposed to traditional methods of health and hospital care ("New 'realities' challenge," 1986). According to another survey, by 1985 hospital occupancy hit the lowest point in two decades, 66% (Spragins, 1985).

Competition in the medical profession then appeared in yet another way--the doctor surplus. In the early 1960s there had been a physician shortage, so the government took

several steps to help increase the numbers. Between 1965 and 1980, federal aid succeeded in increasing the number of medical schools from 88 to 126 and raising the number of graduates from 7,409 to 15,135. The federal government even relaxed immigration policies to encourage foreign medical graduates into this country. But by 1976, these policies had to be reversed to reduce this influx. The numbers of doctors in the United States had grown from 377,000 in 1975 to 450,000 in 1980. Projections estimate that figure will rise to 600,000 by the end of this decade (Rosenstein, 1984/1985).

This rapid increase in physicians is coinciding with a decrease in population growth. For every 100,000 citizens in 1960, there were 148 doctors; 177 in 1975, and 202 in 1980. In 1990 it is expected to jump to 245 (Ellwood & Ellwein, 1981).

While competition was forcing doctors to seek alternatives such as group instead of single practice and a return to outpatient services, the same thing was happening to the hospital (Fuchs, 1981).

Between the rising costs and decreasing client base, consolidation became a way to survive. The industry was becoming dominated by huge health care conglomerates (Brown, 1985). This unification also helped offset some of the expenses of marketing, particularly advertising ("Multi marketers supported," 1985). In 1983 it was estimated that

health care marketers spent $200 million. By the end of 1986, that figure has been projected to top $1 billion (Gray, 1986).

While consolidation of this type is normal in other industries, this was unheard of in hospitals (diPaolo, 1981). In 1961 there were only five consolidations of hospitals in the United States, in the early 1970s the number had grown to about 50 a year (Johnson, 1981). In 1980 a survey of multi-hospital systems found that 176 owned or managed 301,894 beds. In 1983, 40% of the hospitals belonged to some type of multi-hospital system (Rosenstein, 1984/1985). This system is expected to encompass 60% by 1990 and 80% by 1995 (Johnson, 1981).

All this led to the formation of several major types of health care providers: (1) the academic medical "empire," with its extended network of affiliation agreements; (2) the regional, non-profit multi-hospital system; (3) the national, for-profit hospital chains; (4) HMOs, both independent and chains; and (5) the diversified health care conglomerate with different lines of businesses in health care, but not offering comprehensive services to a defined population as in HMOs (Starr, 1982).

Another organization which has recently developed and is expected to exceed HMOs in number, is the Preferred Provider Organization (PPO). This program offers discounts of about 15% to 25% to consumers for using certain

contracted providers. This is beneficial to hospitals and physicians in that it increases volume, and beneficial to the employer and consumer in terms of savings. It is also less restrictive than the HMO in terms of choice of physician (Rosenstein, 1984/1985).

In addition, alternative ambulatory care systems, such as urgent care centers and freestanding emergency centers began appearing (Eisenberg, 1980). Their fees typically falling 33% less than the hospital emergency room (Burns & Ferber, 1981). This also led to the establishment of outpatient surgery centers, causing many hospital emergency rooms to reduce their fees up to 60% in an effort to compete (Siegel, 1981). In 1978 there were only 80 emergency care centers in operation. By 1984, the number jumped to 2,300, 69% of which are owned by chains. Commerce International Inc., a Washington, D.C. research firm, projects 5,500 centers by 1990 (Rosenstein, 1985/1986). These ambulatory care centers were also employing strong advertising campaigns (Powills, 1986a). This new competition forced hospitals into this type of decentralized services. They began to establish their own centers in conjunction with their physicians (Goldstone, 1986).

All of these corporate health care forms are now engaged in both economic and political competition, forcing them to turn to marketing as their primary weapon in this arena (Goldsmith, 1981).

The Reagan administration encouraged competition hoping that free market forces would accomplish what regulation had not, namely, to reduce the runaway escalation of health care costs (Magers, 1985/1986).

In the early 1980s a reimbursement plan based on diagnostic related groups (DRG) was established. This meant hospitals were paid based on costs established as "typical" for treating people with similar illnesses. If the hospital exceeded this amount, they had to pay for it themselves. This, too, provided incentive for cost reduction ("Coming: Competition," 1984).

Competition, according to Feldstein (1979, p. 288), along with the elimination of cost-based reimbursement, put the consumer in a stronger position.

Hospitals can no longer rely on the shrinking number of acute care inpatient clients, and they therefore are having to diversify and market their services. Expansion into the ambulatory care market is one of the most important steps to increasing revenues and patient volume (Winston, 1984/1985).

In 1977, the United States Supreme Court acknowledged this need for marketing, by allowing the health care industry to advertise. It was a decision that met with mixed reaction (Pinto, 1984).

A 1985 study by Pradeep Korgaonkar showed that despite a negative attitude toward the marketing profession, physicians nonetheless expected marketing to play an

important role in the practice of medicine. Ninety percent of those physicians surveyed, however, defined marketing as advertising. Physicians were most opposed to advertising because they felt that consumers would be misled and induced to purchase unnecessary services. They also felt the prices of these services would have to be increased because of the costs of advertising (Marshall, 1977).

Mindful of the concern of misleading consumers, hospitals and physicians both chose to use advertising strategies focused exclusively on image, not product. (Persinos, 1986).

Unlike physicians, consumers have been reported as being receptive to hospital advertising. One survey reported that 66% of consumers felt hospitals should advertise. Magers (1985/1986) duplicated this study and found similar results.

According to another study in 1986 by Modern Healthcare, half of all consumers were aware of recent health care advertisements (Jensen, 1986).

Hospital advertising does seem to improve community awareness of the hospital, but it had not been proven to increase usage. In 1986, at the AMA's symposium on health services marketing, Francoise Simon-Miller, a researcher with a private firm, reported that advertisements were not a significant factor in the supplier-selection process, although they did enhance awareness. Further, she

recommended that hospitals focus on product, since "less than half of the consumers want image advertising" ("New 'realities' challenge," 1986, p. 8).

Hospital marketing has been additionally complicated by the diversity of its consumer base (Hicks, 1986). Marketing must not only target patients, but staff, visitors, medical professionals and the community as well (Ruga, 1984).

For years, hospitals only promoted themselves to physicians, in order to have them affiliated with their hospital, and thereby bringing patients with them. A 1986 study in Denver showed, however, that 34.3% of consumers were now deciding either solely or in conjunction with their spouses, which hospital they would utilize. In addition, 15.1% said they would take into consideration a physician's recommendation, therefore making a total of 49.4% of consumers deciding for themselves which hospital to use (Stier, 1984). Other studies across the nation have reinforced these findings, including one in Chicago in which 43% of consumers decided independently or participated in the decision. A study in Omaha showed 61% selecting their own hospital (Mistarz, Powills, Riffer & Shannon, 1984).

"While it is still necessary to advertise and market to physicians, overall they are carrying less clout," according to Paul H. Keckley, president, Keckley Group for market research (Higgins, 1986b, p. 1) "Signs of the physicians' eroding influence are everywhere."

Hospitals, therefore, are realizing the need to market not just to doctors, but to the consumer public as well (Bauer, 1986). According to Stier (1986, p. 19), such considerations should include the development of a "product line," for example, cardiac care. "They need to look at other things, too, such as improved accessibility, location convenience, signage, and convenient hours," Stier added. "They should also compile product packages with prices that offer such luxuries previously only associated with hotel stays."

In 1980, this need led the American Medical Association to form a committee to organize annual symposiums on health services marketing ("Health care marketing: ethics," 1985). In 1985 this committee became the Academy for Health Services Marketing, a wholly owned and independently funded subsidiary (Reiling, 1985).

"Almost overnight, marketing has become recognized as a vital management function in the health care field," said the American Medical Association president, Stephen W. Brown (1973, p. 23). The academy now serves about 2,000 of an estimated 10,000 health care marketing professionals. Last year, the AMA's health services membership increased 72% ("Book contains papers," 1985).

Even though health care advertising is one of the fastest growing areas in advertising, hospitals are still approaching it somewhat haphazardly, according to Les J.

Hauser, vice president, corporate planning and marketing, at the DePaul Health Center, St. Louis. Hauser further states that given the American Hospital Association's prediction that 20% of the United States' hospitals could be closed by 1990, it is imperative for hospital administrators to educate themselves about the true nature of health care marketing (Hauser, 1985, p. 6). Hospitals were at first just appointing their community relations representative as their marketing department, and taking a "glorified public relations" approach to marketing. Often this marketing person did not have the expertise to handle this new position (Higgins, 1986b, p 1). In 1979 only 4% of the hospitals had a staff member with a title associated with marketing. By 1982 this increased to 36%, according to Mackesy (1985).

Studies show that one way in which hospitals have tried to get away from this "haphazard approach" to advertising has been through the use of marketing research, most typically in the form of community and patient surveys (Jenson, 1985b; Rowland, 1985).

The American Hospital Association also had released a guide in 1977 for advertising by hospitals, outlining the purposes of hospital advertising as follows:

1. Public education about available services
2. Public education about health care (focusing on preventative care)
3. Public accountability (accounting to the communities for the ways community resources are being used)

4. Maintenance or increase of market share
5. Public support (both for funds and political assistance)
6. Employee recruitment
7. Medical staff support

To date, health care marketing has been predominantly image oriented, focusing on "we care" advertisements and strong public relations and community visiblity. But in the last few years, more and more hospitals are formulating product-line management strategies. According to one survey, products that marketers have targeted as most important to the consumer include (in order): general surgery, cardiac care, obstetrics and geriatric services (Powills, 1985e, p. 61).

Still other hospitals are just restructuring their image campaign techniques. For example, in 1986, hospitals in Tennessee, Illinois and California began using celebrities to promote their hospital, a typical strategy for other industries promoting image ("Health care marketing," 1986).

It is the purpose of this study to contribute to the larger question of whether product is superior to image marketing for hospitals.

## HYPOTHESES

H1. AMI Brookwood Community Hospital, after the implementation of a marketing program, will show considerable improvement in the areas of community (a) awareness, (b) usage and (c) image of the hospital.

H2. There will be more improvement or respondent recall in attributes related to the products that were marketed by Brookwood than in the image marketed during that period.

H3. Consequent to the specific development and marketing of products relevant to women's interests, there will be an improvement in women's (a) awareness, (b) usage and (c) image of Brookwood.

## RESEARCH QUESTIONS

1. Is there a difference in the opinions expressed by long-term residents (10 years or longer) as opposed to short-term residents (less than 10 years)?
2. Is there a difference in the opinions expressed by older respondents (35 and older) as opposed to younger respondents (less than 35 years old)?

## METHODOLOGY

To achieve the goals of this study, a Central Florida hospital, AMI Brookwood Community Hospital (hereafter referred to as Brookwood), has been selected for analysis. This hospital was chosen because it has closely followed the most typical hospital patterns outlined by a consensus of previously mentioned writings, and should therefore have widespread application. Brookwood had to deal with a negative public image and very little marketing organization in the early stages (Copeland, 1982). This led to the use of image marketing. Later, Brookwood strategically employed product marketing as well.

To review, Brookwood was first opened under the name of Mercy Hospital in 1965 by the Catholic Diocese of Orlando. Like most community hospitals, it had the same problem that Brown summarizes as being a "community" hospital that is not aware of or responsive to the community (Brown, 1973).

Mercy Hospital never had a formal marketing department or marketing plan. As was the industry pattern, however, it had one full-time community relations person. The only "marketing" that occurred from 1965 to 1983 was concerned with image recognition in the community. This was loosely structured and was achieved more through civic service than anything else. There were few advertisements and no

structured public relations campaigns. Most importantly, there was no "product" promotion whatsoever, according to Brenda DeTreville, marketing director.

In 1978, Brookwood Health Services, Inc., purchased the hospital and changed the name to Brookwood Community Hospital. No changes occurred in the area of marketing, with the exception of limited efforts to promote the hospital name change. Then, in 1981, American Medical International (AMI), one of the largest health care services companies in the country, purchased Brookwood. AMI immediately invested $4 million in updating the hospital's medical equipment (DeTreville, 1985). While there was some effort to continue with "image" strategies, particularly the promotion of the new affiliation, there was no promotion of the improved "product," according to DeTreville.

In 1983 AMI took the first two steps toward a marketing plan. First, they conducted a Community Awareness and Image Tracking Study (CAITS) for the primary and secondary service areas surrounding the facility. According to DeTreville, the alarming results of the CAITS led them to their second major move--hiring a director of marketing, whose expertise was marketing, not medicine.

CAITS revealed that less than one out of five people would consider using Brookwood for general hospitalization, although it was the most conveniently located facility.

Further, 22% volunteered that they would not want to go to Brookwood at all.

Brookwood's position with respect to serious illness or injury treatment was even worse. Most expressed a preference to travel the extra distance to either Florida Hospital or Orlando Regional Medical Center. The most active rejection came from women who had lived in the area for more than five years (CAITS, 1983).

The hospital's most salient characteristic relates to the dimension which was least important to consumers--convenience of location. However, one out of four respondents did not even know where the hospital was located (CAITS, 1983).

The CAITS results concluded that Brookwood had an extremely poor image that fell well below the AMI norm in terms of favorable ratings and well above average with respect to unfavorable ratings. Moreover, it was viewed by respondents as being substantially worse than its competitors.

Finally, when questioned as to the ownership of the hospital, only one person out of 300 responded correctly. Most believed it to still be privately owned (CAITS, 1983)

This negative image can be linked to a variety of causes. Certainly it evinces the lack of marketing strategy and the ineffectiveness of the image promotions that were done.

The new marketing director decided to structure the marketing plan in two directions. First there was a continued effort at "image" marketing, most importantly a focus to identify this hospital with the larger corporate chain. Secondly, there was a product marketing strategy to include such services as childbirth facilities, the emergency room and outpatient services (DeTreville, 1986a).

These and other similar promotions have been in place for three years. It is the intent of this study to conduct a post-test, replicating the original CAITS questions, in an effort to keep the comparative measurements valid. In addition, the survey will add some specific questions concerning products, such as childbirth facilities, outpatient surgery and emergency room usage.

The following more clearly defines the categories of Brookwood's image and product marketing activities over the three year period between the pre-test and post-test.

First, in the area of image marketing is the strong promotional effort to link Brookwood with their national ownership, American Medical International, Inc. (AMI). This was done to expunge the negative image that had developed over their early years as Mercy Hospital. Brookwood and AMI administrators believed that identification with their national affiliate would improve their credibility and overall image.

Further, there was a continued problem of being confused with Brookwood Recovery Center (or Brookwood Lodges, as they had been originally named), a substance abuse center that at one time was affiliated with Brookwood. A large number of respondents seemed to confuse the two organizations (CAITS, 1983).

To eliminate this confusion, "AMI" was added to Brookwood's formal name. All printed materials, such as hospital stationery and brochures, as well as all advertising, displayed this new name. A new logo was also devised. One tactic used to announce this change was billboards with the image slogan "AMI Brookwood--Changing for the Better."

In addition, a direct mail campaign was implemented. Direct mail had become very popular in the hospital marketing industry and was believed to be one of the most effective methods of hospital advertising, although there has been no empirical data to support this (Powills, April 20, 1986c).

Five different collateral pieces were mailed out into the primary and secondary service areas over a period of about six months. Three of these brochures had image messages, two related more to product.

The first mailing introduced another image slogan, "Quality Care, Personal Touch." This phrase was also used

on other pieces of collateral advertising and billboards (DeTreville, 1986b).

A second mailing also focused on "quality care." It was a brochure with photographs and brief biographies of staff members, primarily nurses. Nurses were featured because the 1983 CAITS had shown poorest attitudes towards the nursing staff.

"This mailing was designed to show the community that Brookwood's staff offered quality care (expressed through cited credentials) and yet gave a personal touch by letting the community meet the staff, many of whom they could recognize as their own neighbors," said DeTreville.

A third image mailing revealed the future plans of Brookwood and stressed its commitment to the community. This was done to again stress the "we care" approach of image advertising. It also was designed to strengthen their ratings in terms of community involvement, since Brookwood had previously not rated very high (CAITS, 1983).

To further enhance community image, Brookwood became involved in several community education programs. Like many health care marketers, Brookwood believed that educating the community would lead to increased usage of the hospital facilities (Gavin, 1975). While studies have shown similar hospital education programs to be well-received, it has not yet been proven to increase hospital usage (Cunningham, 1985/1986).

Brookwood's most successful program, in terms of earning marketing and community service awards, was the "Snakes Alive" program, which identified different venomous snakes and first aid measures for snake bites. It was promoted through a printed brochure, lectures, radio and television appearances and advertisements.

Another safety program, called "Little No-Nos," was a poison prevention program specifically directed toward children. This also incorporated lectures, a brochure and media coverage.

Other safety programs included first-aid instruction, infant car seat promotion and cardio-pulminary resuscitation certification classes. Brookwood also printed and distributed an emergency medical guide and other educational newsletters. Producing educational newsletters has become almost a standard marketing procedure in the hospital industry, including the Central Florida area (Burns, 1986).

Brookwood established a speakers' bureau, making available staff as experts for community organizations and the media. The hospital established regular "round table" conferences with invited community leaders, media and physicians.

Other community image promotions included hosting a Florida Symphony concert on the property, and supporting local Boy Scout chapters and charities.

Brookwood improved the facility's appearance and convenience for patients. They increased the parking area and moved it closer to the hospital. They also improved their signage on the street and made a double boulevard entrance/exit, which created a better traffic flow. They also improved both the interior and exterior of the building and the landscaping.

Internally, they used established public relations techniques for improvement in staff attitude towards the patients by improving overall communication (Beyer, 1986).

Areas of product marketing that occurred during this period include a very strong promotion of their emergency room facilities. The 1983 CAITS showed that in an emergency, most respondents would prefer to travel the extra distance to either Florida Hospital or Orlando Regional Medical Center, instead of using the more conveniently located Brookwood. Brookwood, meanwhile, had earned a level three trauma rating, the highest an emergency room can have. The promotion of their emergency room included a direct mail campaign, newspaper, magazine, radio and billboard advertising. Billboard marketing has been proven very effective in emergency room promotion for other markets ("Emergency care promoted," 1986).

There was an extensive public relations promotion and a direct mailing concerning the purchase of upgraded equipment, particularly a $5.5 million investment in

equipment for clinical services, obstetrics, surgery and radiology.

There was an expansion and promotion of ambulatory care services, especially in outpatient surgery. Management implemented a physical therapy program, a sexual dysfunction center and the Opti-fast center. Opti-fast is a medically supervised weight loss program, especially well-received by women patients.

This study also examined Brookwood's marketing of products or services targeted specifically to women. Products of specific interest to women that were developed and/or promoted during this period include an improved birthing center service. This encompassed the addition of Lamaze classes, new obstetric equipment, upgraded facilities and personal touches such as birth announcements. These were marketed as "packages" with package prices. Promotion was primarily through public relations efforts and print materials distributed mainly in doctors' offices.

Brookwood also had a women's services program which focused on linking awareness about preventative or self care with the hospital's gynecological services. For example, a brochure on how to administer a breast self-examination, which also covered related medical tests and services offered by Brookwood. This strategy has been suggested as being an effective way to generate hospital usage (Fink, 1972).

These were all part of Brookwood's image and product marketing strategies over the three years and comprised the independent variables for this study.

## Subjects

Subjects were randomly selected residents within the primary and secondary zip code service areas of AMI Brookwood Community Hospital, as determined by admissions records and previous demographic studies.

A zip code format was determined to be most appropriate for targeting subjects in this type of study (Greene, 1981).

In order to test Hypothesis #3, and not to prejudice overall results, subjects were evenly divided between males and females.

Interviews were terminated if the subjects were employed in the health care industry or had their health care provided by the military.

Subjects were asked their age and length of residency, to see if there was any correlation between these factors and the attitudes expressed. In the first CAITS study, the longer a person had lived in the area, the more negative the attitudes were concerning Brookwood.

Subjects' age were later divided into two categories based on reported age: 35 and over, and under 35. Fifty-nine percent of the respondents fell in the first category and 40% in the second (1% gave no answer). As with the previous study, length of residency was divided between 10

years or less, and over 10 years. Forty percent of the respondents were Central Florida residents for 10 years or less, 57% for 11 or more years (3% gave no answer).

Health Maintenance Organization (HMO) participants and other prepaid insurance plan holders were not eliminated. This was due to other studies in the field revealing that HMO subscribers have just as much awareness as non-HMO subscribers about health care services in their communities (Stier, 1986).

A total of 702 phone calls were completed, 368 of which were determined to be qualified as respondents. The other 334 were eliminated because of the above mentioned factors or not wishing to participate in the study. Those phone numbers with no answer were tried twice and then discarded if still no answer (they were not included in the 702 figure). Eighteen of the 368 respondents were eliminated once interviewing was underway because they asked to discontinue the study.

## Design

### Independent Variables

The independent variable for Hypothesis #1 was the change of strategy in the marketing program at Brookwood, specifically, a structured program that included emphasis on product marketing.

There are two independent variables for Hypothesis #2,image marketing and product marketing by Brookwood. Image and product marketing are operationally distinguished as follows: "Image" marketing refers to any advertisement, public relations or promotional effort concerning the institution of Brookwood or AMI, as opposed to its specific services or products (Schudson, 1984). The detailed accounting of which has already been outlined.

The independent variable for Hypothesis #3 was those products or services targeted specifically to women.

## Dependent Variables

The dependent variable for both hypotheses #1 and #2 is attitudinal change. The dependent variable for Hypothesis #3 is attitude change among women only.

To aid in the measurement of attitudinal change, questions were designed to incorporate three different areas in which change may have occurred--awareness, usage and image (Grass, Bartges & Piech, 1972).

Hospital awareness questions included asking respondents to name hospitals in their area to see how many knew about Brookwood. They were also asked the location of the hospital and its ownership. Ownership was particularly important in determining if that image campaign was a success. A question was added to this study to determine if Brookwood AMI was still confused with the recovery center.

Advertising and news awareness questions were also asked. Respondents were asked if they could recall seeing any advertisements or news stories about Brookwood. Futhermore, respondents were asked if the news stories had been favorable, neutral or unfavorable in content.

Usage questions included the respondent or immediate family member's usage of Brookwood in the last two years, as well as projected usage of Brookwood in the future. These areas are further broken divided into categories for overnight stay, serious illness, emergency room treatment and outpatient services. This has been done to determine whether specific product promotions, namely emergency room and outpatient facilities, produced significant improvement.

Some future usage questions that were not in the original CAITS were also added. These included some products that Brookwood specifically promoted, and some that were not, in order to see if those that were marketed were better received.

Image questions focused on the respondent's opinions of both specific images and products of Brookwood. Image items included the hospital's: (a) putting the patients' well being first; (b) excellent medical staff; (c) excellent hospital overall; and (d) involvement in the community. Product items were the hospital's: (a) up-to-date equipment, (b) excellent emergency room, and (c) convenient location.

## Apparatus

A post-test survey, with some minor additions from the original conducted in 1983, was administered.

## Procedure

The survey was administered via the telephone at various times during the day. The callers did not identify themselves as being interested in or affiliated with one particular hospital, so as to not prejudice answers received (Burns, 1985/1986).

Some questions were unaided (open-ended, with no specific hospitals mentioned), particularly the introductory ones, so as to not affect recall. Later questions were aided, with the questions being specifically directed at Brookwood and its six major competitors.

## RESULTS

### Hypothesis #1

Hypothesis #1 was not supported. Post-test results show no overall improvement in the public's attitude towards Brookwood.

### Awareness

Awareness of the hospital was changed slightly. The prior number of respondents who recalled Brookwood as a hospital in their area was already 79%. It dropped by 1% in the post-test.

Respondents' awareness of Brookwood's location decreased from 65% to 58%. However, an increase of 5% over the first study realized it was the nearest hospital to their home, for a total of 36% of the respondents.

One-third of the respondents could recall seeing advertising for Brookwood, up 3% from 1983. News item recall, however, only increased by 1%, for a total of 14%. An interesting finding, however, is that the majority of these respondents remembered the news as being favorable in nature, when in fact the most recent news story had stated that Brookwood had the highest room and service rates in the area. This gave evidence of the Sleeper Effect, where, over time, the content of articles read shifted to being recalled

as being positive, whether they were actually positive or not (Wimmer & Dominick, 1983).

The area of awareness that showed the most improvement was the recognition of the proper hospital name and its affiliation with AMI. Those who knew the ownership was a corporation was up 17%, for a total of 36%. Those who correctly named AMI specifically jumped from only 1% to 11%.

## Usage

In terms of hospital usage, Brookwood showed a decrease. Those who said they or their family had used Brookwood during the past two years for general service had dropped from 17 to 15%. Those who reported using Brookwood for an overnight stay dropped from 15 to 10%. Emergency room usage dropped from 17 to 10%. Only outpatient services showed any improvement, but this was only 1%.

When responding about future usage, the hospital again showed decreased results. Projected general service use dropped from 12 to 10%. Serious illness use dropped from 11 to 7%. Emergency room use dropped from 19 to 10%.

It is interesting to note, however, that the number of people actively rejecting Brookwood decreased. Those that would reject it for general hospitalization dropped from 15 to 14%. Those rejecting it for serious illness usage

dropped 6% to a total of 14%. And those rejecting the emergency room service dropped from 13 to 11%.

### Image

For those questions in which respondents were asked to rank a hospital on a variety of image attributes, Brookwood showed some minor improvement. Those who rated Brookwood high on "putting the patients' well-being first" increased 7% to a total of 27%. Those who felt Brookwood had an "excellent medical staff" rose 3% to 19%. The number saying Brookwood was an "excellent hospital overall" rose 8% to 21%. The "excellent nurse" ranking was up 8% to 24%. The rankings for "up-to-date equipment" and "community involvement" remained unchanged. Those feeling that Brookwood had "nice rooms" went up 6% to 18%. Brookwood's ranking of "convenient location" was still the highest of all rankings, even though it dropped 1% to 36%.

## Hypothesis #2

Hypothesis #2 was not supported.

### Product

The largest product promotion was for the emergency room facility. The past two years' usage of this facility was down 7%, to only 10% usage by survey respondents. Projected usage also dropped from 19 to 10%. Those actively

rejecting the emergency room, however, had decreased from 13 to 11%.

Contradicting this, however, is the rise in the high-image ranking of the emergency room from 16 to 26%.

Outpatient services was the only area of hospital usage that increased, but it was only by 1%.

Respondents in the 1986 study were also asked which hospital they would recommend for five different services: outpatient surgery, childbirth, women's health services, cardiac and orthopedic. The first three of these were promoted by Brookwood, the other two were not. While all ratings were low, the first three were ranked slightly higher than the two not promoted. Outpatient surgery was at 6%, childbirth was at 3%, women's services at 4%, the other two were 2%.

## Image

The effort to link recognition of Brookwood with its national affiliate appears to be an area that is improving for the hospital. Those people who perceived ownership of the hospital jumped 17% to 36%. Eleven percent of these knew specifically the link with AMI, with only 1% naming AMI in 1983. No one identified it as Mercy Hospital, unlike the 1983 study.

One question was added in this study that was not in the 1983 study. Brookwood, until late 1985, had been

affiliated with Brookwood Lodges (or Brookwood Recovery Center as it was later called). Brookwood Lodges, a substance abuse recovery center, was managed as a totally separate facility and was not even located near the hospital property. Brookwood Lodges was heavily advertised and because of this, people were confusing the two. Brookwood received many daily inquiries that had to be redirected to the recovery center. When asked if they thought Brookwood was affiliated with a drug rehabilitation center 22% responded yes.

All other areas of image also showed slight improvement. The image of Brookwood "putting the patients' well being first" increased from 20 to 27%. "Having an excellent medical staff" was up only 3%; however, "having excellent nurses" was up 8%. The quality of nurses was specifically promoted in one of the direct mailings. Rating it as an "excellent hospital overall" increased from 13 to 21%. Having "nice rooms" was also up 6% to 18%. Being considered "very active in the community" was the only rating that remained unchanged.

The difference in the pre-test, post-test findings for product and image shows image ratings increasing more than product ratings.

## Hypothesis #3

Hypothesis #3 was not supported.

### Awareness

General hospital awareness was down for women from 88% in 1983 to 81% in 1986. Location awareness was also down, dropping by 17% to 58%.

An area where awareness increased was in advertising and news recall. One-third of the women surveyed recalled seeing an advertisement for Brookwood, this is up 4% from 1983. News recall jumped 9% to 21%.

Ownership awareness also increased for women respondents. One-third of the women knew Brookwood's ownership, with 13% specifically identifying AMI. This is up from 18% awareness and zero identification with AMI.

### Usage

Hospital usage was up slightly for overnight stay, from 11 to 14%. Outpatient services also showed a minor increase from 8% to 10%. General service and emergency room usage were down 1% and 5% respectively.

Projected usage, however, was down in all areas. General hospitalization use dropped 1% to 10%, serious illness was down 2% to only 8%. Emergency room went from 16 to 9%.

The number of women rejecting Brookwood decreased. Those rejecting Brookwood for general hospitalization went from 18 to 15%, serious illness from 24 to 17% and emergency room from 14 to 13%.

The five projected usage categories concerning specific hospital programs did not overall rank very high. Using outpatient surgery and women's health services received the highest rankings at 5%. Only 4% would go to Brookwood to have a child, 3% for cardiac care and 2% for orthopedics.

Image

There was some improvement in general image, as women did rank the hospital's image higher. Belief that Brookwood "puts the patients' well being first" was up 5% to 29%. "Excellent hospital" only increased 1%. "Excellent emergency room" ranking doubled going from 15 to 30%. "Excellent medical staff" ranking dropped 5% to 16%, while "excellent nurses" increased to 27% from a former 18%. "Community involvement" increased 3% to 23%. "Nice rooms" went up 10% to 23%.

Research Question #1

Residents of 10 years or more had greater awareness of Brookwood in all areas than did those residents of less than 10 years. Residents of 10 years also ranked Brookwood higher in image characteristics. But, surprisingly, it was the residents of under 10 years who claimed more usage, and projected more future usage than did longer-term residents.

## Awareness

Long-term residents were consistently higher in their awareness of Brookwood than were short-term residents. Overall awareness of Brookwood was improved for short-term residents, going from 62 to 74%. Long-term residents showed a slight decrease, going from 85 to 81%. Location awareness went from 42 to 48% for short-term residents, but dropped from 74 to 66% for long-term residents. Both groups improved in advertising and news recall. Short-term residents more than doubled ad recall, going from 13 to 29%. Long-term residents showed only slight change, going from 35 to 36%. News item awareness jumped from eight to 16% for short-term residents, and from 13 to 22% for long-term residents. Awareness of ownership nearly tripled for short-term residents, going from 11 to 31%, with half of them specifically identifying AMI. Long-term residents also showed improvement on this item, going from 21 to 40%, with 15% identifying AMI.

## Usage

Twice the number (14%) of short-term residents reported having used Brookwood for an overnight stay. Eighteen percent of the short-term residents reported using Brookwood for general services--this was 5% higher than long-term residents. Four percent more used the emergency room (total of 12%), and 3% more used the outpatient services (total of

15%). Short-term residents' use of outpatient services went from 5% in 1983 to 15% in 1986, whereas long-term residents showed no change in the 12% response from 1983 to 1986.

In terms of future usage, all three areas of care--general hospitalization, serious illness and emergency room--found short-term residents more likely to use the service than long-term residents. The rejection rate by long-term residents was higher in two of the three categories than for the short-term residents. Fifteen percent of the long-term residents rejected Brookwood for general hospitalization, compared to 12% of short- term residents. Sixteen percent of the long-term residents rejected it for serious illness, compared to 12% of short-term residents. The short-term residents showed a 2% decrease in rejection rate (12% to 10%) for the emergency room.

It is interesting to note, however, that long-term residents' rejection levels for all three areas have improved over the last three years, while short-term residents rated two of the three (general hospitalization and emergency room) services worse than in 1983.

Short-term residents rated all five specific services higher than did long-term residents. Seven percent of short-term residents would recommend Brookwood for outpatient care, compared to 6% of long-term residents.

Childbirth facilities would be recommended by 5% of short-term residents and 2% of long-term residents. Attitudes towards women's services revealed the largest divergence between the short- and long-term residents: 6% compared to 2%. For cardiac care, 3% to 2%; and for orthopedics, 3% compared to 1%.

## Image

In terms of image characteristics, both short- and long-term residents seemed generally to improve from the 1983 rankings, although long-term residents' rankings were higher in all but one category. Brookwood's "putting the patients' well-being first" rated 28% with short-term and 26% with long-term residents. Brookwood's "excellent medical staff" rated 15% by short-term and 21% by long-term residents. Having an "excellent hospital overall" ranked 17% with short-term and 24% with long-term residents. In the area of "up-to-date equipment," short-term residents went from zero in 1983 to 8% percent in 1986, while long-term residents dropped from 15 to 14%. "Excellent emergency room" more than doubled in rating for both short- and long-term residents--short-term residents went from 7% to 16%, while long term residents went from 15 to 32%. "Community involvement" remained almost unchanged for both groups, although long-term residents still scored it higher at 21% compared to 17%. "Having nice rooms" dropped

considerably by short-term residents, from 21 to 12%, while more than doubling for long-term residents from 11 to 23%.

## Research Question #2

In the areas of awareness, usage and image, respondents aged 35 and over gave higher ratings than did respondents under 35.

### Awareness

People 35 and over were slightly more familiar with Brookwood, rating 81% compared to 74% in general awareness. Older respondents were also more familiar with Brookwood's location, 62% compared to 52%. Younger respondents were slightly more aware of advertising (35 compared to 32), although recall fewer news items (15 compared to 23). Older respondents were considerably more aware of Brookwood's ownership. Forty-one percent of older respondents knew ownership, with 18% having named AMI specifically. This compared to 28% of younger respondents, with 11% indentifying AMI. Both groups had nearly doubled in their ownership awareness.

### Usage

In general, usage was down for both groups from 1983, except for a 1% increase in use of outpatient services. For hospital usage over the past two years, there was no

meaningful difference reported between the groups except for overnight stays, in which the older group doubled in usage (from 6% to 12%).

Projected use for general hospitalization declined for younger respondents, dropping from 15% in 1983 to 8% in 1986. The older respondents, meanwhile, rose from 10 to 12%. When asked whether Brookwood would be considered for serious illness, the younger group reported decreased interest, dropping by one-half to an 8% projected usage. The older group dropped only 1%, from 8% to 7%. Emergency room projected use dropped more than half for the group under 35, going from 24 to 11%. The older group dropped from 15 to 10%.

Rejection levels showed slight improvement for both groups. Rejection for general services was still 15% for the younger group, while the older group dropped from 16 to 14%. Rejection for serious illness dropped considerably for the younger group--from 24 to 15%, while the older group also dropped from 17 to 14%. Emergency room rejection improved by 5% for the younger group, going from 17 to 12, and remained at 10% for the older group.

In the ratings for the five specific services, the older group scored them higher than the younger group. Six percent of the younger group would consider using Brookwood's outpatient services, as would 7% of the older group. The group under 35 gave a zero rating for the

childbirth facilities at Brookwood, while the 35-and-over group rating totaled 6%. Women's services rated 3% with the younger group and 5% with the older. Cardiac care and orthopedic care each rated only 1% from the younger group, and 3% and 2% respectively for the older group. The older group did rate the three promoted services higher than the two not promoted.

## Image

Older respondents consistently ranked the image categories higher than did the younger group. The older group's responses also showed more improvement in these areas from the 1983 study than did the younger. Five of the eight attributes decreased for the younger group.

Brookwood's "putting the patients' well-being first" dropped 3% to 17% for the younger group, while the older group jumped 10% to 31%. Having an "excellent medical staff" dropped from 19 to 12% for the younger group and increased from 13 to 23% for the older group. "Excellent emergency room service" did increase for both groups, going from 10 to 18% for the younger group, and from 21 to 32% for the older group. "Up-to-date equipment" dropped more than half for the younger group to 7%, while it increased 3% to 13% for the older group. "Excellent nurses" increased by 1% for the younger group to 14%, and jumped from 19 to 30% for the older group. Brookwood's rating as an "excellent

hospital overall" dropped by 2% with the younger group to 12%, and increased from 12 to 27% for the older group. Having "nice rooms" increased for both groups, going from 9% to 14% for the younger group and from 15% to 22% for the older group. Brookwood's being viewed as "community active" dropped for the younger group from 23% to 18%, and increased from 16% to 20% with the older group.

## Summary of Findings

### Hypothesis #1

Hypothesis #1 was not supported. There was no improvement in the areas of awareness, usage or image. There was, in fact, a decrease in usage.

### Hypothesis #2

Hypothesis #2 was not supported. There was no greater awareness or recall of products over image. In fact, image ratings were higher than product ratings.

### Hypothesis #3

Hypothesis #3 was not supported. There was no increase in the areas of awareness and usage. There was some increase in image ratings.

### Research Question #1

Long-term residents were found to have a higher awareness and more favorable image of Brookwood than

shorter-term residents. Surprisingly, it was the shorter-term residents who claimed more past usage and projected more future usage of the hospital. Short-term residents were also less likely to reject Brookwood.

The short-term group showed more improvement over the three-year period in awareness in all categories. Both groups improved in news item recall and ownership identification.

Usage and projected usage generally decreased for the long-term residents, and only improved in a few areas, such as outpatient services, for the short-term residents.

Image ratings had improved for both groups, although long-term residents' ratings were higher in all but one category.

## Research Question #2

Those respondents aged 35 and over were found to be more aware of, and to have a better image of, Brookwood Hospital than did the group under 35. They also reported past usage and plans for future usage more frequently.

In terms of improvement over the three-year period, both groups showed more awareness of Brookwood's ownership. The older group also improved in news item recall, while the younger group showed less improvement. The older group also showed improved in all areas of image ratings, while the younger group only showed improvement in three areas, two

of which (emergency room and nursing staff) had been heavily promoted.

## DISCUSSION

### Hypothesis #1

This study found that the implementation of a structured marketing program at Brookwood has not yielded improvement in overall community awareness, usage or image of the hospital.

Because the area of hospital marketing is so new, and therefore the study of it even newer, it is difficult to ascertain the best ways to test new theories. Comparing surveyed attitudes and reported usage in a pre-marketing and post-marketing condition would seem an effective method. The problems that arise in such conditions, however, must be considered. The main problem is the effect of time on certain variables, which may diminish the effectiveness of the design.

One such unpredictable variable could be the impact of hospital competitors' marketing campaigns on the same group being studied. This is particularly true in this case, as Brookwood is in an increasingly competitive environment. And since Brookwood is substantially smaller than its two main competitors, Orlando Regional Medical Center and Florida Hospital, its marketing budget, as well as its staff, is only a fraction of its competitors'. With advertising costs' being so high, it is reported that one-

half of most hospitals' marketing budgets are absorbed by their advertising (Steiber & Jackson, 1985). Therefore, the effectiveness of Brookwood's marketing program may have been overshadowed by the effectiveness of its competitors' campaigns, simply because those hospitals had more dollars to spend and more manpower available to execute them.

Another factor that gives Brookwood's competitors a possible edge is that Brookwood has gone through an identity crisis over the past 10 years, changing ownership and name twice. The former Mercy Hospital had developed such a negative reputation that in this case a less negative rating might carry just as much significance as another hospital's more positive one.

In addition, because half the population of the community studied have been Central Florida residents for over 10 years, there isn't the advantage of a constantly changing market that would be unbiased and more receptive to a marketing campaign.

Another reason a study of this type could be ineffective is that physicians or particular insurance plans may be determining for the patient which hospital they should use. In this study, when asked why they selected a hospital for their most recent stay, 59% said the decision had to do with their physicians' recommendation, but only 7% said it had to do with their health coverage.

Thirty percent of the respondents said they selected their hospital based on prior experience with that hospital.

Another potential problem for a study of this type would occur if the hospital was not offering the quality of service it was promoting. This possiblity was examined in this study by comparing the answers of those respondents who have used Brookwood in the last two years to those who have not. The results show that in all questions relating to future hospital usage, people who have used Brookwood before gave it much higher ratings than those with no recent Brookwood experience. A single positive usage experience has proven to be a significant factor in future hospital selection, according to Costello (1985). This would lead to the conclusion that Brookwood does have the product, but is having difficulty marketing it.

A final possiblity may be that the questionnaire itself was ineffective in measuring what it was designed to measure. The image questions, however, were based on a previous study by AMI in 1981, asking patients to rank those attributes of a hospital that they considered most important when selecting one for service. In addition, there were considerable changes in certain areas of the tests for other hospitals, particularly Orlando Regional Medical Center.

Hypothesis #2

The effectiveness of product over image marketing was not established. This is due, in part, to the fact that Hypothesis #1 was not supported.

If anything, image traits on the whole had improved for the hospital. Attitudes towards both the nursing staff and the emergency room showed improvement. Both these programs were heavily promoted, the former as an image and the latter as a product. But this improvement in attitude did not correspond with an increase in usage or projected usage of the hospital's facilities.

Further results would indicate that image promotion was effective in terms of hospital name awareness and ownership identification, as well as location and community involvement, but again this did not affect usage.

When those respondents that had used Brookwood over the last two years were asked why they selected it, the number one reason was location, followed closely by physician's recommendation. Also listed were the recommendation of a friend or the respondent's prior usage of Brookwood. Not one respondent cited any of the image-related characteristics, such as quality of care, or equipment, as a reason. This finding was similar for respondents who had used any hospital in the last few years. Fifty-nine percent consulted with their physician in the decision, followed by 30% who had used the hospital before. The next most

frequently cited factor was location, and then came quality of staff, friend's recommendation and quality of equipment.

It may be that both Brookwood and other Central Florida hospitals have been using more image than product advertising and, therefore, their marketing plans have not had a major impact in changing consumers' decision making process.

## Hypothesis #3

Hypothesis #3 was not supported, and also relates to the first two hypotheses not being supported either. Women in the previous study were found to be very negative toward Brookwood. The active rejection rate of Brookwood by women has improved; however, the usage rate has decreased.

Females in this study followed the same trends overall as the general population, and therefore previous explanations for hypothesis rejection would also apply here. There be a further correlationship between women having a negative attitude toward using Brookwood and the overall population having a negative attitude toward using the hospital. Other studies' findings have led some researchers to believe that women have a stronger influence on hospital selection than do men in the household (Bluestone, 1978).

One additional possiblity as to why there was no improvement in women's ratings is that much of the promotional literature concerning the childbirth facilities

and women's health services was distributed through physicians' offices. When questioned as to why they chose a particular hospital, however, 60% of the women had consulted with a physician, so it is hard to determine, what if any impact this had.

## Research Question #1

This research question, relating to long-term versus short-term residents' ratings, lends more credence to the theory that improved hospital awareness and image may not necessarily correlate with increased usage. A similar finding was reported (as previously mentioned in this study) by a private research firm hired by the American Medical Association. That study led the researcher to infer that although hospital advertising improved awareness, it did not increase usage, especially in the case of image advertising ("New 'realities' challenge," 1986).

Not surprisingly, the longer-term residents had a higher awareness of Brookwood than did the short-term residents. The longer-term residents, who in the past had been more negative about Brookwood in terms of image, were now more positive than the shorter-term residents. Conversely, the short-term residents claimed more hospital usage and projected more future usage than long-term residents.

Brookwood administrators had determined that it would be more difficult to change the opinions of the long-term residents. Apparently it is easier to change or improve opinions, but more difficult to improve usage.

Research Question #2

Respondents 35 and over were found to have higher awareness, higher usage and more positive image of the hospital than respondents 34 and under.

One explanation may be that older respondents would tend to use hospitals more over all (Ostroff, 1985). However, in looking at those who had used a hospital during the last two years, there was only a 9% higher usage rate by the older group.

This study would also tend to disagree with a previous study showing that 75% of consumers aged 35 and older, left hospital decision-making exclusively to their physicians (Jensen, 1985a).

It would appear then that Brookwood's campaign has been more effective for those 35 and over.

# CONCLUSION

When examining the scope of this study, it should be noted that no known research has been conducted previously in the specific area of product marketing versus image marketing in the health care industry.

While the hypotheses were not supported, this study has added a foundation for research in health care marketing. This study indicated that marketing for hospitals, unlike almost all other industries or products, did not have an effect on end usage. Was this due to a flaw of a particular hospital's campaign strategy or in the study's design? Or could this actually be what is being experienced in the early days of health care marketing? According to the one report, stating that hospital marketing, particularly image marketing, did not increase hospital usage, this might be a very real possibility ("New 'realities' challenge", 1986).

Or, if this is true, could it just be that once again the health care professionals are out-of-touch with the general public? While the doctors and hospitals decided that they preferred image marketing and would therefore implement that strategy, no one determined what the consumer wanted (Cebrzynski, 1985). The consumers of today have shown that they are no longer easily manipulated into

domination by the medical industry in other areas, would it not be logical to assume that this would carry over into marketing as well? The hospitals have never really understood what the consumer wanted in the past, and perhaps it is going to take time to realize that these strategies are not what they appear to want now (Bean, 1985).

Knowing which direction to take will not be easy for health care marketers, as they are trying to communicate for an industry that has undergone major structural changes in a relatively short period of time. The economic climate and consumer profile would lead to the conclusion that these changes will become even more dramatic in the years ahead. Health care, therefore, is a very difficult product to know how to package or promote (King, 1985).

Consumers, on the other hand, are not used to "shopping" for medical services, and it may be that it is going to take time for them to grasp this concept (Andrus & Kohout, 1984/1985). Consumers have shown a strong interest in being educated about health care, particularly preventative medicine (Flexner, McLaughlin & Littlefield, 1977). As the public's level of knowledge increases in this area, their buying habits would probably become more sophisticated, as indicated by gradually declining role of physicians in patients' hospital selection. One study actually suggests that when consumers were not well informed, or became confused by too much information, they

were more likely to allow their physician to make the choice for them (Powills, 1986b).

Brookwood's attempt to establish itself as the one most frequented by its community might have been achieved if they had given more focus to promoting specific programs and products that the consumer might purchase, instead of trying to establish itself as a "good neighbor" (Bonnen & Falberg, 1977). For example, activities like hosting a Florida Symphony Orchestra concert may make the community more aware of Brookwood or rate it higher on civic involvement, but it is probably having and promoting quality medical services that will bring patients to the door (Clarke, 1978).

It may also be that this study, or certain aspects of it should be replicated in a controlled, instead of actual, environment. Using the real population, instead of a controlled study group, seemed to be the right direction when trying to determine not only hospital awareness and image, but actual usage. This was further reinforced by previous findings showing that the most effective method of assessing hospital consumers was through telephone surveys in specified zip code areas (Keckley, 1985). However, testing the marketing effort in the field and not the laboratory created some influences that could not be predicted or controlled, and that, too, may have affected the resulting data.

A similar study repeated in a laboratory environment would allow screening for such outside variables as competitors' campaigns or hospitals' size differences. The researcher could use fictitious hospitals, whose only differences would be in marketing strategy whether product- or image-oriented. All other factors would be neutralized.

One problem with controlled environment studies, however, is that many of them must rely on the usage of college students as subjects, due to limited funds or the the time demands of the subjects. But this study showed that only 1% of the 18-24 year old bracket had used any hospital service in the last two years, and would therefore, not be representative subjects.

Perhaps the best option would be to replicate this study with other hospitals in other marketing areas, this would also tend to neutralize some outside variables and peculiarities of specific hospitals.

Health care marketing is a new area which needs additional research and replication in order to offer a basis for comparison with these results.

TABLE 1

PERCENTAGE PRE-TEST/POST-TEST RESULTS
FOR ALL 350 RESPONDENTS

| AWARENESS | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Total Awareness | 79 | 78 | -1 |
| Location Awareness | 65 | 58 | -7 |
| Advertising Recall | 30 | 33 | +3 |
| News Recall | 13 | 14 | +1 |
| (Favor./Nuet./Unfav.) | (10/2/1) | (12/5/3) | |
| Ownership | 19 | 36 | +17 |
| AMI | 1 | 11 | +10 |
| Drug rehabilitation | - | 22 | |

| BROOKWOOD USAGE | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Last two years: | | | |
| Overnight | 15 | 10 | -5 |
| Any Service | 17 | 15 | -2 |
| Emergency Room | 17 | 10 | -7 |
| Outpatient | 13 | 14 | +1 |
| Projected usage: | | | |
| General | 12 | 10 | -2 |
| Serious Illness | 11 | 7 | -4 |
| Emergency Room | 19 | 10 | -9 |

TABLE 1 -- CONTINUED

| BROOKWOOD USAGE | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Projected for Specific Service: | | | |
| Outpatient Surgery | - | 6 | |
| Deliver baby | - | 3 | |
| Women's services | - | 4 | |
| Cardiac | - | 2 | |
| Orthopedic | - | 2 | |
| Reject usage: | | | |
| General | 15 | 14 | -1 |
| Serious Illness | 20 | 14 | -6 |
| Emergency Room | 13 | 11 | -2 |

| IMAGE | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Patients' Well Being First | 20 | 27 | +7 |
| Excellent Medical Staff | 16 | 19 | +3 |
| Excellent Hospital | 13 | 21 | +8 |
| Up-to-date Equipment | 12 | 12 | 0 |
| Excellent Emergency Room | 16 | 26 | +10 |
| Excellent Nurses | 16 | 24 | +8 |
| Community Active | 19 | 19 | 0 |
| Attractive/Comfortable Rooms | 12 | 18 | +6 |

TABLE 2

PERCENTAGE PRE-TEST/POST-TEST RESULTS
FOR 175 FEMALE RESPONDENTS

| AWARENESS | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Total Awareness | 88 | 81 | -7 |
| Location Awareness | 75 | 58 | -17 |
| Advertising Recall | 29 | 33 | +4 |
| News Recall | 12 | 21 | +9 |
| (Favor./Nuet./Unfav.) | (10/0/1) | (12/6/4) | |
| Ownership | 18 | 33 | +15 |
| AMI | 0 | 13 | +13 |
| Drug rehabilitation | - | 21 | |

| BROOKWOOD USAGE | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Last two years: | | | |
| Overnight | 11 | 14 | +3 |
| Any Service | 16 | 15 | -1 |
| Emergency Room | 16 | 11 | -5 |
| Outpatient | 8 | 10 | +2 |
| Projected usage: | | | |
| General | 11 | 10 | -1 |
| Serious Illness | 10 | 8 | -2 |
| Emergency Room | 16 | 9 | -7 |

TABLE 2 -- CONTINUED

| BROOKWOOD USAGE | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Projected for Specific Service: | | | |
| Outpatient Surgery | - | 5 | |
| Deliver baby | - | 4 | |
| Women's services | - | 5 | |
| Cardiac | - | 3 | |
| Orthopedic | - | 2 | |
| Reject usage: | | | |
| General | 18 | 15 | -3 |
| Serious Illness | 24 | 17 | -7 |
| Emergency Room | 14 | 13 | -1 |

| IMAGE | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Patients' Well Being First | 24 | 29 | +5 |
| Excellent Medical Staff | 21 | 16 | -5 |
| Excellent Hospital | 18 | 19 | +1 |
| Up-to-date Equipment | 17 | 16 | -1 |
| Excellent Emergency Room | 15 | 30 | +15 |
| Excellent Nurses | 18 | 27 | +9 |
| Community Active | 20 | 23 | +3 |
| Attractive/Comfortable Rooms | 13 | 23 | +10 |

TABLE 3

PERCENTAGE PRE-TEST/POST-TEST RESULTS
DIVIDED BY LENGTH OF RESIDENCY

| | YEARS | | | |
|---|---|---|---|---|
| | LESS THAN 10 | | 10 AND GREATER | |
| AWARENESS | 1983 | 1986 | 1983 | 1986 |
| Total Awareness | 62 | 74 | 85 | 81 |
| Location Awareness | 42 | 48 | 74 | 66 |
| Advertising Recall | 13 | 29 | 35 | 36 |
| News Recall | 8 | 16 | 13 | 22 |
| Ownership | 11 | 31 | 21 | 40 |
| AMI | 0 | 15 | 1 | 15 |
| Drug rehabilitation | - | 51 | - | 47 |
| BROOKWOOD USAGE | 1983 | 1986 | 1983 | 1986 |
| Last two years: | | | | |
| Overnight | 19 | 14 | 11 | 7 |
| Any Service | 14 | 18 | 17 | 13 |
| Emergency Room | 13 | 12 | 17 | 8 |
| Outpatient | 5 | 15 | 12 | 12 |
| Projected usage: | | | | |
| General | 11 | 12 | 11 | 9 |
| Serious Illness | 10 | 10 | 10 | 5 |
| Emergency Room | 15 | 13 | 18 | 9 |

TABLE 3 -- CONTINUED

| BROOKWOOD USAGE | 1983 | 1986 | 1983 | 1986 |
|---|---|---|---|---|
| Projected for Specific Service: | | | | |
| Outpatient Surgery | - | 7 | - | 6 |
| Deliver baby | - | 5 | - | 2 |
| Women's services | - | 6 | - | 2 |
| Cardiac | - | 3 | - | 2 |
| Orthopedic | - | 3 | - | 1 |
| Reject usage: | | | | |
| General | 7 | 12 | 19 | 15 |
| Serious Illness | 15 | 12 | 22 | 16 |
| Emergency Room | 9 | 12 | 14 | 10 |
| **IMAGE** | **1983** | **1986** | **1983** | **1986** |
| Patients' Well Being | 21 | 28 | 21 | 26 |
| Excellent Med. Staff | 9 | 15 | 18 | 21 |
| Excellent Hospital | 11 | 17 | 14 | 24 |
| Up-to-date Equipment | 0 | 8 | 15 | 14 |
| Excellent Emer. Room | 7 | 16 | 15 | 32 |
| Excellent Nurses | 28 | 22 | 12 | 26 |
| Community Active | 18 | 17 | 20 | 21 |
| Attractive/Comf. Rooms | 21 | 12 | 11 | 23 |

TABLE 4

PERCENTAGE PRE-TEST/POST-TEST RESULTS
DIVIDED BY RESPONDENT AGE

| | AGE | | | |
|---|---|---|---|---|
| | LESS THAN 35 | | 35 AND GREATER | |
| AWARENESS | 1983 | 1986 | 1983 | 1986 |
| Total Awareness | 78 | 74 | 79 | 81 |
| Location Awareness | 66 | 52 | 65 | 62 |
| Advertising Recall | 26 | 35 | 32 | 32 |
| News Recall | 13 | 15 | 12 | 23 |
| Ownership | 15 | 28 | 22 | 41 |
| AMI | 1 | 11 | 0 | 18 |
| Drug rehabilitation | - | 49 | - | 49 |
| BROOKWOOD USAGE | 1983 | 1986 | 1983 | 1986 |
| Last two years: | | | | |
| Overnight | 14 | 6 | 16 | 12 |
| Any Service | 16 | 14 | 18 | 15 |
| Emergency Room | 14 | 10 | 20 | 9 |
| Outpatient | 13 | 14 | 13 | 14 |
| Projected usage: | | | | |
| General | 15 | 8 | 10 | 12 |
| Serious Illness | 16 | 8 | 8 | 7 |
| Emergency Room | 24 | 11 | 15 | 10 |

TABLE 4 -- CONTINUED

| BROOKWOOD USAGE | 1983 | 1986 | 1983 | 1986 |
|---|---|---|---|---|
| Projected for Specific Service: | | | | |
| Outpatient Surgery | - | 6 | - | 7 |
| Deliver baby | - | 0 | - | 6 |
| Women's services | - | 3 | - | 5 |
| Cardiac | - | 1 | - | 3 |
| Orthopedic | - | 1 | - | 2 |
| Reject usage: | | | | |
| General | 15 | 15 | 16 | 14 |
| Serious Illness | 24 | 15 | 17 | 14 |
| Emergency Room | 17 | 12 | 10 | 10 |
| **IMAGE** | **1983** | **1986** | **1983** | **1986** |
| Patients' Well Being | 20 | 17 | 21 | 31 |
| Excellent Med. Staff | 19 | 12 | 13 | 23 |
| Excellent Hospital | 14 | 12 | 12 | 27 |
| Up-to-date Equipment | 15 | 7 | 10 | 13 |
| Excellent Emer. Room | 10 | 18 | 21 | 32 |
| Excellent Nurses | 13 | 14 | 19 | 30 |
| Community Active | 23 | 18 | 16 | 20 |
| Attractive/Comf. Rooms | 9 | 14 | 15 | 22 |

TABLE 5

MEAN DIFFERENCES FOR PRE-TEST/POST-TEST RESULTS

| AWARENESS | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Total Awareness | .7866 | .7771 | .0095 |
| Location Awareness | .6533 | .5771 | .0762 |
| Advertising Recall | .2966 | .3314 | .0348 |
| News Item Recall | .1266 | .2000 | .0734 |
| **USAGE** | **1983** | **1986** | **DIFFERENCE** |
| Last two years: | | | |
| Overnight | .1456 | .1027 | .0429 |
| Any service | .1233 | .1057 | .0176 |
| Emergency room | .0833 | .0457 | .0376 |
| Outpatient | .0466 | .0600 | .0134 |
| Projected usage: | | | |
| General | .1200 | .1000 | .0200 |
| Serious Illness | .1733 | .0742 | .0991 |
| Emergency Room | .1733 | .1028 | .0705 |
| Reject usage: | | | |
| General | .1533 | .1400 | .0133 |
| Serious Illness | .2066 | .0742 | .1324 |
| Emergency Room | .1266 | .1057 | .0209 |

TABLE 5 -- CONTINUED

| IMAGE | 1983 | 1986 | DIFFERENCE |
|---|---|---|---|
| Patients' Well Being | .1271 | .1761 | .0490 |
| Excellent Med. Staff | .1059 | .1193 | .0134 |
| Excellent Hospital | .0847 | .1363 | .0516 |
| Up-to-date Equipment | .0720 | .0681 | .0039 |
| Excellent Emer. Room | .1016 | .1590 | .0574 |
| Excellent Nurses | .1016 | .1534 | .0518 |
| Community Active | .1228 | .1079 | .0149 |
| Nice Rooms | .0762 | .1136 | .0374 |

APPENDIX A

1a. Hello, I'm _____from Interviewing Service of America. We're conducting a survey on health care. Today, we are calling people in your area and I would like to include your opinions.

1b. Is your or your family's health and hospital care provided by the military? (If yes, terminate interview)

1c. Are you or anyone in your family employed by a hospital? (If yes, terminate interview)

1d. Confirm interviewee's zip code. (If incorrect, terminate interview)

2. I'd like to ask you some questions about hospitals. When you think of hospitals in your general area, which ones come to mind?

3a. If you required hospitalization, which hospitals in your general area would you consider going to?

3b. Which hospitals, if any, would you not want to go to?

4a. If you needed to be hospitalized for a very serious or complicated illness, which hospitals in your general area would you consider going to?

4b. Which hospitals, if any, would you not want to go to for a very serious or complicated illness?

5a. If you required emergency treatment which hospital emergency rooms or other health care facilities would you consider going to?

5b. Which hospital emergency rooms or other health care facilities, if any, would you not want to go to for emergency treatment?

6a. Have you or a close family member been a patient for at least one night in a hospital in your general area in the past two years?

6b. At which hospitals?

7a. Have you or a close family member used a hospital emergency room in your general area in the past two years?

7b. At which hospitals?

7c. Why did you or your family member select this hospital?

8a. Have you or a close family member used any outpatient services offered at a hospital or other health care facility in the past two years? This would include surgery, x-rays, lab tests, physical therapy or other services not connected with an emergency room visit or overnight stay.

8b. At which hospitals or other health care facilities?

(Questions 9 - 15e required the use of a chart that listed seven hospitals: AMI Brookwood Community Hospital, Florida Hospital, Humana Hospital Lucerne, Orlando Regional Medical Center, Sand Lake Hospital, West Orange Memorial Hospital, and Winter Park Memorial Hospital.)

9. Have you ever heard of ('x' hospital)?

10. Have you seen or heard any advertising for ('x' hospital) in the past few months?

11a. Have you seen or heard anything in the news media about ('x' hospital) in the past few months?

11b. Overall, would you say that what you heard about ('x' hospital) in the news media was it generally favorable, unfavorable, or neutral?

12. Do you know where ('x' hospital) is located?

13. I'd like to get your opinions of some hospitals in your general area. Even though you may never have been to some of the hospitals, please give me your opinions based on anything you may have heard about each hospital. I'll mention some characteristics that can describe a hospital and for each one I'd like you to tell me how much you agree or disagree that it describes each of the hospitals. Let's use the numbers from one to 10. The more you agree that the characteristic describes the hospital, the higher the number you should give it, and the more you disagree, the lower the number you should give it.

    Has an excellent emergency room.....
    Has the most up-to-date equipment.....
    Has attractive and comfortable rooms....
    Puts the patients' well-being first.....
    Has an excellent nursing staff.....
    Is an excellent hospital overall.....
    Is involved in community activities.....
    Has an excellent medical staff.....

14. I'd like to know who you believe owns some of the hospitals in your general area. Let's start with _____. As far as you know, who owns this hospital? (This question is to be unaided with answers recorded in the appropriate categories)

15a. Which one hospital in your area would you be most likely to go to or recommend going to for treatment of broken bones/orthopedics?

15b. For the delivery of a baby?

15c. For outpatient surgery?

15d. For women's health care services?

15e. For cardiac care?

16a. How many years have you lived in this general area?

16b. What is your age?

## REFERENCES


AMI Brookwood Community Hospital. (1985). AMI Brookwood Community Hospital renovation and expansion fact sheet. Orlando, FL: Author.

AMI Brookwood Community Hospital. (1986). AMI's Brookwood Community Hospital equipped to meet health care needs. Orlando, FL: Author.

AMI Brookwood Community Hospital. (1986). Brookwood Community Hospital: Quality care with a personal touch. Orlando, FL: Author.

Andrus, D. & Kohout, F. J. (1984). The effect of rural consumer satisfaction on outshopping for medical services. Health Marketing Quarterly, 2(2,3), 171-184.

Bauer, B. (1986, February 26). Health-care ads come of age. USA Today, p. 14.

Bean, E. (1985, March 15). Doctors find a dose of marketing can cure pain of sluggish practice. The Wall Street Journal, p. 23.

Berry, W., & Daugherty, J. (1968). A closer look at rising medical costs. Monthly Labor Review, 91, 6.

Beyer, C. (1986). Health-care public relations in practice. Public Relations Journal, 42(3), 32.

Bluestone, N. (1978). The future impact of women on American medicine. American Journal of Public Health, 68, 760-763.

Bonnem, S., & Falberg, W. C. (1977, June 1). Good marketing helps a hospital grow. Hospitals, p. 22.

Staff. (1985). Book contains papers from health services symposium. Marketing News, 19(12), 21.

Boyd, S. H. (1984). Fitness and health promotion: Big business and good business in Dallas. Health Marketing Quarterly, 2(2,3), 75-89.

Brown, R. E. (1973). The hospital and the community. In P. D. Cooper (Ed.), Health care marketing: Issues and trends (pp. 11-15). Baltimore, Maryland: Aspen Systems.

Brown, S. W. (1985, November). Future directions in health marketing. Health Care Strategic Management, pp. 23-26.

Burns, D. H. (1986, July 24) Health is the topic of the day: Newsletters unlock wealth of good advice. The Orlando Sentinel, pp. E1, 3.

Burns, J. A. (1985) Knowledge is power: How to develop effective market surveys. Health Marketing Quarterly, 3(2,3), 99-112.

Burns, L. A., & Ferber, M. S. (1981, May 16). Freestanding emergency care centers create public policy issues. Hospitals. pp. 73-76.

Cebrzynski, G. (1985). Marketing, tradition clash in health care. Marketing News, 19(23), 1, 30.

Clarke, R. N. (1978). Marketing health care: Problems in implementation. Health Care Management Review, 3(1), 37-42.

Staff. (1984, January). Coming: Competition in the medical supermarket. Changing Times, pp. 76-81.

Constantine, A., & Cassidy, J. E. (1969, August). This hospital holds itself accountable to community. Modern Hospital, p. 17.

Cooper, P. D. (1979). Health care marketing: Issues and trends. Baltimore, Maryland: Aspen Systems.

Copeland, M. T. (1923, April). Relation of consumers' buying habits to marketing methods. Harvard Business Review, pp. 282-289.

Copeland, V. (1982, March 5). Brookwood works on cure for ailing image. The Little Sentinel, p. 5.

Costello, M. M. (1985, October 25). Patient satisfaction is often ignored by health marketers. Marketing News, p. 8.

Cunningham, D. (1985). Community education as a marketing tool for your hospital. Health Marketing Quarterly, 3(2,3), 197-206.

diPaolo, V. (1981). Gloomy economic prospects will spur hospital acquisition market. Modern Healthcare, 11, 70.

Eisenberg, H. (1980, November 24). Convenience clinics: Your newest rival for patients? Medical Economics, pp. 71-84.

Ellwood, P. M., & Ellwein, L. K. (1981, January 16). Physician glut will force hospitals to look outward. Hospitals, pp. 81-85.

Staff. (1986, January 17). Emergency care promoted with billboard series. Marketing News, p. 13.

Falkson, J. (1980). HMOs and the politics of health system reform. Paper presented at the meeting of the American Hospital Association, Chicago, IL.

Feldstein, M. (1971). The rising cost of hospital care. Washington: Information Resources Press, pp. 53-57.

Feldstein, M. (1979). Health care economics. New York: John Wiley & Sons.

Fink, R. (1972). Impact of efforts to increase participation in repetitive screenings for early breast cancer detection. American Journal of Public Health, 32(3), 328.

Flexner, W. A., McLaughlin, C. P., & Littlefield, J. E. (1977). Discovering what the health consumer really wants. Health Care Management Review, 2(4), 55-58.

Fuchs, V. R. (1981). The coming challenge to American physicians. New England Journal of Medicine, 304, 1487-1490.

Fuchs, V. R. (1968). The growing demand for medical care. The New England Journal of Medicine, 68, 192.

Gavin, M. P. (1975, July 16). Consumer services: In hospital reachout. Hospitals, pp. 65-67.

Goldsmith, J. C. (1981). Can hospitals survive? The new competitive health care market. Homewood, Illinois: Dow Jones-Irwin, pp. 35-36.

Goldstone, A. R. (1986, January 17). Hospitals join walk-in ranks to maintain market share. Marketing News, pp. 10, 14.

Golin, C. B. (1985, July 19). Marketing's importance continues to grow. American Medical News, pp. 1, 9-11.

Grass, R. C., Bartges, D. W. & Piech, J. L. (1972). Measuring corporate image advertising effects. Journal of Advertising Research, 12(5), 61.

Gray, J. (1986, January 20). The selling of medicine, 1986. Medical Economics, pp. 180-194.

Greene, R. H. (1981, January 1). Community survey profiles hospital's image, helps set goals. Hospitals, pp. 60-63.

Hauser, L. J. (1985, July 5). Health-care field needs true marketing commitment. Marketing News, pp. 6-7.

Staff. (1986, April 10). Health Care Marketing. The Wall Street Journal, p. 1.

Staff. (1985, June 7). Health-care marketing: Ethics for emerging field a key topic before 1,000 attending Health Services Marketing symposium. Marketing News, pp. 20-21.

Hicks, N. J. (1986). Patients and other publics. Public Relations Journal, 42(3), 28-32.

Higgins, K. T. (1986, April 11). Health industry must emulate retail, financial. Marketing News, p. 9.

Higgins, K. T. (1986, April 11). Hospital marketers lack technical, analytical skills. Marketing News, pp. 1, 20.

Higgins, K. T. (1986, January 17). Supermeds apply brand identity to health-care alphabet soup. Marketing News, pp. 11, 19.

Iglehart, J. K. (1976). The rising costs of health care--something must be done, but what? National Journal. 8, 8.

Jarrett, S. L., Swanson, J. A., & Swanson, K. J. (1985, March 1). Physicians and patients benefit when product, price, distribution, and promotion variables are manipulated. Marketing News, p. 10.

Jensen, J. (1985, March 15). Advertising helps more consumers select hospitals. Modern Healthcare, pp. 58, 60.

Jensen, J., Jackson, B., & Miklovic, N. (1985, September 27). Two-thirds of hospitals relying on marketing research studies. Modern Healthcare, pp. 84-85.

Jensen, J. (1986, March 28). Half of all consumers have noticed recent healthcare advertisements. Modern Healthcare, pp. 75-76.

Johnson, D. E. (1981, May). Nonprofits will merge, add services in the 1980s. Modern Healthcare, p. 66.

Johnson, R. L. (1981, April). Health care 2000 A.D.: The impact of conglomerates. Hospital Progress, pp. 48-53.

Keckley, P. H., (1985, December). Using and misusing marketing research in the healthcare industry. Healthcare Financial Management, pp. 31-35.

King, S. (1985, July 8). Rx for medical ad shops. Advertising Age, p. 24.

Korgaonkar, P. K. (1985, February 15). Physicians are not crazy about marketing, but they do accept it. Marketing News, p. 12.

Lieberman Research. (1983, May). [Community awareness and image tracking study for Brookwood Community Hospital]. Unpublished raw data.

Mackesy, R. (1985, November). Marketing acceptance in small and medium sized hospitals. Health Care Strategic Management, pp. 19-22.

MacStravic, R. E. (1977). Marketing health care. Denver, Colorado: Aspen Systems.

Magers, B. (1985/1986). Hospital advertising: Pitfalls to avoid, opportunities to seize. Health Marketing Quarterly, 3(2/3), 113-116.

Mages, P. M. (1985). Marketing is the art and science of listening. Health Marketing, 4(2), 2-5.

Marshall, C. (1977, April). Ethics aspect of advertising debated. Modern Healthcare, p 1.

Mistarz, E., Powills, S., Riffer, J., & Shannon, K. (1984, June 16). Marketing wrap-up. Hospitals, pp. 33,34,38,46, 56-68.

Staff. (1985, December 1). Multi marketers supported by corporate office: study. Multis, p. 12.

Staff. (1986, April 11). New 'realities' challenge health-service marketers. Marketing News, p. 8.

Ostroff, J. M. (1985, October 25). Dual-market targeting could be the key in penetrating elderly health-care market. Marketing News, p. 9.

Persinos, J. F. (1986, March 17). Doctor advertising: Economics vs. dignity, competition forcing physicians into media age. The Orlando Sentinel, p. 29.

Pinto, J. (1984). The bottom line on advertising. Health Marketing Quarterly, 2(1), 73-81.

Powills, S. (1986, March 5). Ambulatory center advertising jumps. Hospitals, p. 72.

Powills, S. (1986, March 5). Consumers ask MDs to select hospitals. Hospitals, pp. 68, 70.

Powills, S. (1986, April 20). Direct marketing prompts response, results. Hospitals, pp. 60, 62.

Powills, S. (1986, January 5). Hospital advertising invisible to consumers. Hospitals, p. 66.

Powills, S. (1985, December 16). Hospital marketing, ad budgets triple. Hospitals, p. 61.

Reiling, L. G. (1985, March 29). Academy for health services marketing established. Marketing News, p. 1.

Rosenfeld, L. S., & Rosenfeld, I. (1975). National health planning in the United States: Prospects and portents. International Journal of Health Services, 5, 441-453.

Rosenstein, A. H. (1984/1985). The changing trends of medical care and its impact on traditional providers: Adaptation and survival via a marketing approach. Health Marketing Quarterly, 2(2/3), 11-34.

Rowland, S. (1985, March/April). Providing vital information. Health Marketing, 4(2), 1.

Ruga, W. (1984). Environmental design can strengthen a hospital's marketing campaign. Health Marketing Quarterly, 2(1), 43-61.

Ruzek, S. B. (1978). The women's health movement: Feminist alternatives to medical control. New York: Praeger.

Sachs, W. (1983). Advertising management - Its role in in marketing. Oklahoma City, Oklahoma: PennWell.

Schudson, M. (1984). Advertising, the uneasy persuasion. New York: Basic Books.

Siegel, E. (1981, June 8). Emergence of Emergicenters. Boston Globe, p. 21.

Spragins, E. E. (1985, September 2). A high-powered pitch to cure hospitals' ills. Business Week, pp. 60-61.

Starr, P. (1982). The social transformation of American medicine. New York: Basic Books.

Steiber, S. R., & Jackson, E. D. (1985, November). Hospital marketing budgets in 1985: What will bigger budgets bring? Health Care Strategic Management, pp. 4-7.

Stier, R. D. (1986, January/February). Marketing strategies to consider in planning your campaign. Hospital Topics, pp. 6-9.

Stier, R. D. (1984). Strategic planning in hospitals: Winning the war for survival. Health Marketing Quarterly, 2(1), 19-42.

Super, K. (1986, January 3). Hospitals will favor 'hard-sell' in advertising, experts predict. Modern Healthcare, p. 74.

Venkatesan, M. (1978). Preventative health care and marketing: Positive aspects. In American Marketing Association (Ed.), Marketing and preventative health care (pp. 12-25).

Wimmer, R. D., & Dominick, J. R. (1973). Mass media research. Los Angeles, California: Wadsworth.

Winston, W. J. (1984/1985). Entrepreneurial support for developing marketing strategies: Example of urgent care, same-day surgery and emergicenters. Health Marketing Quarterly, 2(2/3), 1-10.

Winston, W. J. (1984). Public policy and hospital marketing. Health Marketing Quarterly, 2(1), 3-17.