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Godfrey M. Hochbaum
University of North Carolina

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SELLING HEALTH TO THE PUBLIC

GODFREY M. HOCHBAUM, Ph.D., F.A.P.H.A.
School of Public Health
University of North Carolina

Let me confess at the outset that I feel uncomfortable with the title given to my presentation, "Selling Health to the Public," and that I feel equally uncomfortable with such terms as, "marketing health," "the health marketplace," or any others that equate the health area with the marketplace.

These terms have become quite popular in recent years because the presumed success of Madison Avenue and the methods and gimmicks of commercial sales promotion easily tempt health professionals to adopt these same methods and gimmicks in the cause of health education.

I feel uncomfortable with these terms and with what they seem to suggest for health education because I believe that they threaten to lead the health professions into ineffective and even self-defeating approaches.

There are many critical differences between selling commercial goods and services to consumers on the one hand and selling people on using health services and healthful living habits on the other. I would like to point out just a few of the most glaring differences.

The single and possibly most important difference lies in the purposes pursued in the two areas. In the commercial area, the focus is generally on selling goods and services, but in the health area, the focus is (or should be) on persuading people to make changes, some of them rather profound ones, in their living habits and practices of which the utilization of health services is only *one* aspect and the purchase of specific goods plays only a very small role.

Thus, health professionals are concerned with inducing the public to maintain balanced diets, to abstain from cigarettes, to be physically active, to take proper personal hygiene and environmental sanitation measures, to volunteer for periodic medical checkups and disease screening, to adhere to medical regimens when they are ill, and so forth. Many of these actions require people to change, often

radically, long-established living habits, to sacrifice practices they enjoy, to adopt practices they dislike, and to do all this not just once but over a long time, even for the rest of their lives. This is certainly rarely true in the commercial area.

A second difference is that the kinds and amount of goods and services produced and offered in the commercial market are usually adapted to consumer demand. No competent entrepreneur will produce or try to sell goods unless he has reason to believe that there is already a substantial demand for them. Moreover, he will package, offer and distribute them in ways that he believes will attract the attention of people who are already interested in his product and will make the product appear as one that best fits existing demands for such goods.

In contrast, the *health* actions on which we try to “sell” the public are given. They are defined relatively exactly and inflexibly by the health professions. The prescribed (or proscribed) consumer health practices, whether preventive or therapeutic, can be and are only to a very limited extent tailored to consumers’ desires, motives or preferences. In fact, many and perhaps most of the actions we would like consumers to take are inherently unpleasant, inconvenient, humiliating, painful, or disruptive of cherished living habits. There is precious little we can do to fit the product to the consumer’s taste, to package it attractively, or to make it otherwise more palatable.

Therefore, the problem in the health area is not how to give people what they want, but how to change people so that they will want what we have to offer. To be more precise: *physicians* decide what is good for people to do, and people are expected to do it.

Now, it may be said that we are trying to sell people something they really want: health, a long life, and all the pleasures that are presumed to be associated with health. But do we need to sell health? Surely, people do want to live a long, productive life, free from disease and disability. There can be no doubt that all but a small minority of people do. People are *already* sold on health. The problem is something else.

Being motivated to remain healthy the rest of one’s life does not necessarily mean being also motivated to do all the many things one should do to assure attainment of this goal. We all know that the vast majority of current smokers do not want to die of cancer, but this does not mean that they are motivated at the moment when they crave a smoke not to light a particular cigarette. The 40-year old man who knows that he could reduce his risk of heart disease (and wants to reduce it) by more physical activities and a more prudent diet, does not thereby necessarily want to jog or exercise daily or give up his favorite food.

If the wish for lasting health really were an effective incentive to

do the things that supposedly assure it, we would not have to worry about how to persuade people to do them . . . they would come knocking on our doors to learn and use what we have to offer.

But we in the health area have been brainwashed in our training and have brainwashed ourselves in years of professional life to make "health" into a worshipped idol. We have come to expect that other people worship the same idol, and therefore we appeal to it in our health educational programs despite evidence of its very limited success.

Of course, many people do engage in actions, even unpleasant ones, for the sake of assuring their present and future health, but very few do it systematically and conscientiously, and most people do it rarely if at all. The task is, therefore, to motivate people to adopt *specific health-related behaviors*, and, since waving the flag of that vague, illusive thing called, "health" does not seem to work too well, we have to find ways of making these behaviors themselves palatable, desirable and rewarding.

This is exactly what is done in commercial sales promotion. When, say, General Motors tries to sell cars, its campaign is based on things that people are known to value. The campaign may stress beauty of lines, power, prestige, comfort, absence of annoying defects, or more recently, gas economy. Note that each of these is a concrete, observable, directly experienced benefit, and that they promise to accrue to the buyer immediately and in tangible form. To put it differently: the buyer is promised (and he can expect) *immediate, concrete, and assured* rewards for buying the car.

Medical treatment for unpleasant or painful conditions also brings such immediate, concrete and perhaps even assured rewards in many cases and when true, we have more often than not, little trouble with people's cooperation. But in many cases these immediate rewards do not happen, certainly not in preventive health behavior where rewards, if they come at all, come only after many years, are uncertain, and are not experienced in a conscious, unmistakable and dramatic way. Therefore, holding out such rewards as an incentive for actions which themselves are likely to be unrewarding at the time, unsavory and conflicting with other desires is all too often an exercise in futility.

Fortunately, many of these same actions may become desirable when they can be linked to needs and motives which, although unrelated to health, do play an important role in individuals' lives. Personal hygiene practices, exercise, and control of body weight through proper diet have not only health effects but also make the individual (or at least feel) attractive and strong. Giving up cigarettes makes a person proud of his willpower, makes him feel better, endows him with more enjoyment of meals, and renders his teeth and breath more attractive to members of the other sex, besides giving

him the peace of mind of being somewhat protected against dreaded disease. These are only a few examples of the fact that there are strong motives in people likely to move them to do things which they may never do merely for the sake of what is indeed a vague, uncertain, elusive health goal. We should use this well-documented fact more systematically.

Let me give you a few examples: We know that educational television programs which concern certain health and medical topics have a sizable but very limited audience, an audience that consists almost totally of only those who are already interested in and therefore knowledgeable about the topic. Those people who are not so educated and therefore need the education most, turn to *All in the Family*, *Orlando and Dawn*, *Ironside* or whatever. We could surely reach a much wider audience if such programs were designed (and announced) to deal with, say, "retirement," "how to find and identify cheap and reliable health insurance," "problems in parent-adolescent communication" or other topics of interest to many people who would never turn the knob to a program on health and disease. Each of these topics could provide excellent opportunities to get important health information across to people who are not reached by explicitly announced health topics.

Similarly, people select their foods far more often according to taste, cost, and accessibility rather than nutritional value. Instead of fighting this, we could use it. To convince people that certain foods which happen to have nutritional value taste as good as or better than less desirable foods, cost the same or less, and are available in markets and restaurants would surely lead more people into sounder eating habits than merely telling them to change their present habits for health reasons.

Even in such efforts as accident prevention, say, farm equipment accidents, we must realize that a man who sees himself as capable, experienced, and skillful will not readily listen when told that he could cause himself to have an accident because of negligence or clumsy handling of equipment. He may listen, however, if we could persuade him that certain steps taken by him would lead to greater productivity, would prolong the life of the equipment, or would save him repair costs. Health is so intimately and inseparably interwoven with people's total lives that only we in the health professions single out health actions, beliefs, attitudes and needs and act as though these represent an autonomous area of concern. If we could relinquish this paradoxical view, we would discover many new approaches, appeals and strategies to accomplish what we strive for.

Let me repeat that while the commercial entrepreneur tries to appeal to consumers who are already interested in his product, we, in the health area, try to appeal to consumers many of whom are indifferent to or even reject what we have to offer. This means that

we are often in a position where we have to find other means for cajoling them to "buy" our message or even to pay attention to us. Even the most devastatingly seductive sex symbol in a TV commercial (who may send men rushing to buy Grecian Formula or after-shave lotions) will hardly send them out to a cancer screening program.

Besides, what can we in the health area promise our consumers?

The commercial seller promises, perhaps not always truthfully but at least persuasively, full satisfaction with his products or services. Buy my pills and your headache will disappear; buy my toilet paper and it will be the softest ever.

But in the health area, such a promise can be made only relatively rarely because there is always a strong element of uncertainty in the outcome. We cannot, for example, promise the smoker that, if he quits, he will never contract cancer of the lungs or emphysema or heart disease, and, conversely, we cannot with any degree of certainty predict that, if he continues to smoke, he will fall victim to any of these diseases. Only rarely can a physician promise for sure that a particular treatment, medication, or surgery will cure the patient.

Thus, people are often urged to give up long-standing, comfortable, pleasurable, and deeply ingrained living habits, to sacrifice things and activities they cherish, and to submit themselves voluntarily to all sorts of distasteful, unpleasant, even painful deprivations and experiences and for what? For an uncertain and unpredictable outcome which in many cases, even if it is as hoped for, may not be realized for many years.

Who in the commercial realm faces the task of selling people on a product like this? Obviously the methods of Madison Avenue which are so predominantly based on promised consumer satisfaction cannot be applied as universally or as simply in the health area. A third difference is that the objective of the commercial sales promoter is to increase sales volume. Once consumers have bought a given product, they are of no further interest to the promoter except that consumer satisfaction may promote future sales. But the seller does not really care very much when and how the consumer uses the product and, indeed, whether he uses it at all.

I happen to be a sucker for all sorts of gadgets. My wife keeps complaining about all the gadgets cluttering up our closets, gadgets I had bought because I was hooked by an advertisement or fascinated with their inventiveness, not because I have much use for them. Thus, from the point of view of the producers of these gadgets, I represent a beautiful success case even though these gadgets lie around unused and even forgotten.

But in the health area, the concern with use *after* "purchase" is as critical as and even more critical than the concern with the purchase itself. The person who is sold on and goes through disease screening

procedures but does not follow through with medical treatment for a diagnosed condition is as much of a failure as a person who did not avail himself of the screening program to begin with. The obese individual who goes on a medically prescribed diet for one week, and then is lured back to chocolates and apple pie, is as much a failure as if he never had been sold on the need to lose and control his weight.

Indeed, particularly in public health, the most challenging, most difficult, most perplexing problem is *not* how to sell the public on health-supportive practices, not even to get them to initiate such practices. It is to persuade and help them to stick with new practices, to keep these up conscientiously and consistently for the rest of their lives. But which automobile salesman cares whether his customers drive their cars at all or how long they drive them . . . as long as they bought them from him?

Let me once more illustrate by an example. We know that the single most prevalent and most powerful motive for giving up cigarettes is fear of disease, especially cancer. This has tempted health professionals to use the appeal to fear of disease . . . and, I must say, very effectively. Millions of smokers gave up smoking in response to this appeal. But what happens afterward to most ex-smokers? For days, weeks, months, perhaps years after throwing away the last pack of cigarettes, the ex-smoker experiences innumerable incidents when he suddenly craves a cigarette . . . a single cigarette . . . just a puff off a cigarette.

Now, what prompted him to quit was the fear of cancer, a disease caused by the accumulated consumption of thousands of cigarettes over many years. This one cigarette which he craves right now certainly would not contribute at all to this danger. So the fear-motive that caused him to give up the habit is rather powerless at such a moment against the conflicting motive to satisfy his intense and painful craving for this one cigarette.—He yields, and tomorrow this episode is repeated . . . and again . . . and before he knows it, he is back in his old ways.

Similar processes can be observed in patients on prolonged regimes, such as long-term medication schedules, diets, etc.

As illustrated in this example, motives, appeals and methods that may be effective in getting people to make sound health decisions and to initiate the first step towards implementing these, are often relatively impotent in helping the same people to persist with their new behaviors—and this is the critical issue.

It is, to return once more to our automobile salesman, as if he had to worry not only about selling cars to his customers, but also about how often, where, and when they drive them in subsequent years. And the appeals, methods and techniques he would have to use to influence his customers' driving habits would obviously have to be

very different from the sales techniques that led to the purchases to begin with.

Since this whole question of how to help people keep up the good work after they have started is itself too complex a subject to be covered here, I will proceed to still another critical difference.

I agree fully that many of the methods and techniques that have proved successful in commercial sales promotion *should* indeed be utilized in the health area, but we must not let ourselves be blindly seduced in expecting very impressive results.

For one, advertising campaigns are intended less to create (and are less effective when they try) new desires for a given type of product in heretofore disinterested consumers than they are designed to lure already interested consumers away from similar competitive products and to one's own product. Advertisements for a given brand of, say, toothpaste or cigarettes or lawnmowers, only occasionally try deliberately to sell products to people who do not yet use them. Most such advertisements are designed to stress the advantages of one's own brand over other producers' brands. In the health area, this would be tantamount to physicians or hospitals publically claiming that their medical services are less painful or more effective than those offered by other physicians or hospitals.

Except for relatively few cases, there is little evidence that the mass media do generate new demands, and that they change public attitudes, values and behavior in a purposefully intended direction, even in respect to political views. Their effectiveness lies more in triggering latent audience desires, reinforcing existing habits, and accelerating already initiated spreads of new fads and practices.

But even if we accept claims of effectiveness, the criteria by which such successes are evaluated are not quite the same which we in the health area would apply.

Consider a hypothetical manufacturing company whose product is bought by, say, 20 percent of its potential consumer population. If a sales campaign succeeded in increasing this volume by another five percent in one year, the company would probably be highly pleased. But if a health program that tried to get all women at risk of cervical cancer to have a yearly Pap smear attracted only 20 or even 30 or 40 percent to begin with and succeeded only to add another five or ten percent to this number, the program would be regarded as a failure. Indeed, what would be proudly proclaimed as victory in the commercial arena will often be bemoaned as defeat in the health arena. Thus, mass media sales campaigns are not quite as effective as is often claimed and believed if we measured them by standards used in the health area. And yet, such relatively moderate gains by commercial sales campaigns are accomplished by enormous investments for an only slightly greater return. A large company may spend millions of dollars on sales promotion and would call the

investment worthwhile if it leads to an increase in sales volume by a few percent.

In contrast, financial and other resources available in the promotion of desirable health behavior are infinitesimal compared to those available in the commercial area. A case in point are the producers of Alka Seltzer who spent about seven times as much in 1975 to promote its use as the entire annual budget of the Federal Bureau of Health Education.¹

Finally let me point out a situation that bedevils us in the health area but which rarely worries our colleagues in the commercial realm. Consider the consequences for the most effective automobile or home sales campaign if banks refused to provide loans to eager buyers.

Yet, here we are urging people to have periodic health examinations, to see their dentist every six months, and to engage in other preventive and health maintenance practices—but very few health insurance policies cover their considerable costs.

We urge people to develop healthful dietary habits, but our entire food production, distribution and marketing system is designed to prevent or at least inhibit such habits.

We urge people to become physically more active but our transportation technology, city planning, architectural designs which require elevators, and other factors militate effectively against physical exercise.

I could give many more examples of cases where, even where we have effectively educated the public to engage in healthful practices, the social, economic and physical man-made environments make such practices difficult or impossible.

In fact, our society and its technology, even our health care system itself, seem at times to be a giant conspiracy to prevent people from carrying out the very actions we try to sell them on.

What can we learn from Madison Avenue that will help us with *this* problem, a problem rarely, if ever, faced by our colleagues on the commercial side of the road?

By now, you will surely understand—and I hope agree—why I regard as naive, hazardous, and self-defeating the notion that health education and planned health-behavior change are a simple matter of selling and marketing.

It is as naive, hazardous and self-defeating as the notion that our most important task is simply to transmit more health knowledge to the public.

All the evidence points to the fact that the American public is better informed about health and disease and is more health-conscious and health-motivated than at any other time in history. The equally evident fact that the American public still fails to use its

knowledge in its daily life fully and conscientiously points to the complexity of the problem faced by health education.

What it all means in my view is that the problems of health education and planned behavioral change are far more complex and difficult than those problems encountered in selling on the marketplace. While many of the methods used in the latter can be and are very useful to us, we must use them with circumspection, and we must apply methods, approaches and techniques that are peculiarly appropriate to our tasks.

REFERENCES

¹Report of the National Conference on Preventive Medicine, Fogarty International Center, NIH, (November 1975): 53.