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From life insurance to safer sex – reflections of a marketing man

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Abstract

Much of the writing on health in developing countries focuses on the public sector rather than the private market, and on providers rather than on consumers. A more consumer-oriented perspective would regard the transactions by which most people in most poor countries buy healthcare as the norm, just one among many purchases of a personal service which all of us, as consumers, have to make - where to get our hair cut, where to go for a meal, from whom to buy insurance, which quack, nurse, clinical officer or qualified doctor to seek advice from. Asymmetric information is not confined to health and medicine, but is a common problem for consumers whatever the GDP of the country they live in, and however rich and poor they may be. Understanding how consumers overcome these problems yields insights into the ways in which providers have to market their services, and into what, if anything, governments and donors can do to extend, improve or regulate the private healthcare market.

Background

In the 1980s, I marketed mortgages and insurance in the UK, and found that my earlier PhD on family planning in Kenya was surprisingly helpful, notably for understanding the (usually slow) uptake of new products and the 'early adopters' who drive it. Marketing life insurance was certainly a good preparation for work on HIV and behaviour change which I found myself doing in the 1990s, since the way people frame and respond to the risks they face are pretty much the same the world over. The similarities between marketing mortgages and condoms were also striking, because both are a 'grudge' purchase -

nobody really wants either of them, they want their own home, or to have sex. Weak regulation and poor quality of private doctors and quacks were likewise not much of a surprise to someone who had lived through the endowment and pension mis-selling scandals of the UK insurance market. After seven years in a retail bank with 450 branches I certainly felt at home in the reproductive health NGO Marie Stopes International, with its commitment to having a strong brand and to delivering it not through advertising but via the *esprit de corps* of its front-line staff.

In this paper I have tried to gather some of this experience together, and to reflect on how far the understanding of consumer and provider behaviours can be stretched to explain the thriving state of the private healthcare market in most developing countries.

The reality of private healthcare markets

Most poor people in most poor countries get most of their healthcare by handing over their own money in exchange for drugs, advice and services such as injections. Most of them, especially the poorest, just buy some pills (Kamat and Nichter, 1998). 'Estimates of the amount of household health expenditure (largely out of pocket) going to the 'private sector' range from 40 to 50 per cent in parts of sub-Saharan Africa to up to 80 per cent in India' (Standing, 2004, p9).

And it is not just the rich who use private providers. World Bank economists note that 'Despite the financial burden, numerous recent surveys recognize that the poor in many countries receive much of their health services from the private sector' (Harding & Preker, 2004, p41). In Sri Lanka, a country often praised for the quality of the government health service, 'if a condition was deemed serious enough to need a

doctor all case study household respondents, whether male, female, poor, or better off, stated that they preferred to use a private doctor of pharmacy, rather than visit the municipal dispensary or a public hospital...wage-earners from the poorest households used private doctors and pharmacies more frequently in order to obtain treatment quickly and avoid wage losses' (Russell, 2005, p1402).

Until recently, you would not have known from most developing country health sector plans or donor health strategies that this was the case. For various reasons, there has been a strong bias towards thinking of the 'health system' as basically what the government does, or more often does not, do. The academic literature reflects reality rather better, though it tends to focus less on consumers and more on the supply side, on drug-selling (Greenhalgh, 1987; Nichter and Vuckovic, 1994) and on providers (Bhat, 1993; Bennett and Mills, 1997).

At the end of the 1990s Hanson and Berman noted that 'the importance of the private sector in providing health services in developing countries is now widely acknowledged' (Hanson and Berman, 1998, p197). By 2006 this news had reached Geneva, when an editorial in the WHO Bulletin acknowledged that 'In many low-income countries, private providers have long been a significant source of health care'. It went on to note that after decades of focusing only on the public sector, 'There is growing recognition of their importance, however, and signs of a shift in attitude' (Travis & Cassells, 2006, p427).

The attention to the supply side is reflected in the use of terms such as 'private sector' and 'private providers', rather than 'market'. But this is a market, and in a market you

cannot have suppliers without consumers, and it is their behaviour which determines the way in which providers behave and market their services – not the other way round.

Buying products, experiences and service

Broadly speaking, when we consider buying a tangible product such as a pair of trousers or a bunch of bananas, even the poorest among us can usually compare different items in different outlets before they purchase. We can look at the trousers and maybe try them on to see if they fit. We can visually inspect the bananas, and can buy just one to see if they are good. Because we can evaluate beforehand and the price is clear, buying such tangible products is a fairly low risk decision, in which the main activity is a search for our preferred product and preferred seller.

When it comes to deciding which food-stall or restaurant to visit for a meal, or who to go to for a haircut, we cannot evaluate before we buy. We have to commit ourselves and actually experience what we are buying before being able to judge whether it was good or bad. We may be able to demand our money back if the barber makes a complete mess of our hair, but we cannot return the product itself.

The experience of eating a meal or having a haircut does at least give us some evidence on which we can evaluate the transaction. We are pretty clear about what it is we are buying, so we can later rely on our own previous experience, or on the recommendation of a friend, or even a review in a newspaper, to protect ourselves from the risk of making a major mistake. If we buy these things fairly frequently, we can further minimise the risk by going back to the same place, to the same familiar restaurant or hair-dresser. Here we are not only familiar with what is on offer but, by becoming repeat customers, we stand a good chance of getting better or more reliable service.

At the other end of the continuum, if we are buying a service such as life insurance, legal advice or medical care, we are vulnerable to the problem of 'asymmetric information' familiar to readers of this journal. We are unclear what our problem is, we are ill-equipped to assess the diagnosis and prognosis, and afterwards we may still not be sure whether problem has really been solved. (We may even be unclear on the price – marketing mortages and associated life insurance in the UK in the 1980s I was always surprised how people in focus groups, most of them satisfied customers, often had no idea how much they had paid in commissions or other charges, or in some cases whether they had paid anything at all.)

What is so special about services?

Gronroos (1978) suggests there are five characteristics of services. Unlike tangible products, services are intangible; whereas products can be produced today and consumed tomorrow, production and consumption of a service are simultaneous; while products can be standardised, by their nature services are heterogeneous – the people delivering them introduce their own traits and preferences into the encounter, however hard their professional body or employer tries to standardise it. Fourthly, services are perishable, so they cannot be stock-piled to accommodate peaks and troughs of demand. Lastly, while the purchaser of a product clearly now owns it, when you pay for a service you have bought the benefit of it, not the service itself. Berry (1980) had a suggestion which will be familiar to any medical service provider, that the essence of what is purchased is a 'performance', in which the customer/patient plays a supporting, and sometimes critical role. Others have observed that it is not just the provider and the customer on the stage, but there is a supporting cast as well, as there are often other consumers around whose presence can influence the outcome (Kelley *et al,* 1990).

In a classic article, Zeithaml (1981) suggested that because of the nature of services and the difficulties in obtaining effective information, consumers tend to be more loyal once they have found an acceptable alternative. Gabbott and Hogg (1994, p320) agreed that 'The process of repeat purchasing is likely to result in an incremental strengthening of service relationships….it is evident that this continued relationship also produces a sense of ownership over the service with consumers referring to 'my accountant', 'my hairdresser', or 'my mechanic'. They also suggest that this sense of loyalty 'may have an impact upon attribution in the case of failure.' The investment they have made in the relationship may lead consumers to rationalise poor service as the provider 'just having a bad day', and even blaming themselves for not correctly communicating their needs.

It was Levitt who first noted how consumers of intangible services such as medical care tend to use more tangible aspects of the service experience as 'cues' by which to judge the quality of the service itself. 'In the absence of any tangible indications of what the service will be like consumers must use other means of comparing services in the pre-purchase phase….[leading to a] subsequent reliance upon peripheral tangible cues to predict quality. The more intangible the service, the fewer clues are likely to be available.' (Levitt, 1981, cited in Gabott and Hogg, 1994, p316) This is certainly true of healthcare consumers, who often mention the cleanliness of the premises or the presence of machines such as ultra-sound when they are asked about the quality or skills of a particular medical provider.

These cues are often delivered by the ancillary staff of a service provider, such as the check-in staff of an airline or the receptionist of a clinic. 'Hence the importance of the environment in which the consumption of the service takes place in providing these

metaphors or cues…corporate wear, décor, appearance of service providers, standard equipment or furnishing, all may be used to approximate the missing tangible product information' (Gabbott & Hogg, 1994, p316).

Consumers often use the price of a service as a proxy for its likely quality. This is evident in the hotel business, where the great majority of offerings are pretty much the same when you come down to it (roof, clean bed, sanitation), but where prices can range five or fifty-fold from one hotel to another. The most obvious example of price-as-proxy in the healthcare market, at least in the UK, is the continuing attraction of Harley Street, where specialists pay huge rents for consulting rooms because they know that prospective patients (and not just rich ones) value the reassurance of that address – and will pay more for it.

How consumers behave when buying services

These characteristics of service transactions have important consequences for consumers and providers alike, and for the ways in which these markets and the businesses in them can develop.

First, consumers buying services do not assess many alternatives – in fact, they often resist even considering a reasonable alternative if they already have a regular provider. They rely on limited indicators of professional quality, such as the fact that the private provider is also employed by or associated with a larger organisation such as a Government clinic. Patients in Sri Lanka placed more trust in private-sector doctors' technical competence 'if they were government doctors who had retained their prodigious prestigious position at a public hospital' (Russell, 2005, p1404).

Consumers of services rely heavily on personal recommendation, preferably form someone they know or an acknowledged 'expert'. They also look for additional reassurance that they made the right decision after they have used the service (television advertising by insurance companies is actually aimed as much at reassuring existing policyholders that they made the right decision as at attracting new customers).

Because buying services is a risky business we rely heavily on reputation. In some places we can use professional or government regulation for this, but mostly we rely on a word-of-mouth recommendation from someone we ourselves trust, or who seems to have some expertise. Above all, we rely on our own personal experience. We also tend to stick to the service providers we know, even when their service to us is poor, or their wider reputation goes down.

Two healthcare consumers

In Orissa, India, Ager and Pepper (2005, p180) found that 'The factor most often cited by villagers as influencing their choice of healthcare provider, frequently overriding both cost and access, was reputation. Villagers commonly relied on the opinions and experiences of others when choosing where to get treatment. On numerous occasions. respondents reported knowing of doctors, healers and pharmacists (compounders) who had a reputation for successfully treating various conditions. Users sometimes even delayed getting treatment until they heard of someone with a good reputation in curing their condition*: I have a sore on my foot; it just won't get better. I don't know of anyone who is good at treating it, so I will put up with it until I hear of someone. There is no point in just going to a doctor. How do you know if he will fix it?'*

Three years ago I myself strained my back lifting a suitcase, and had to abandon a meeting in London and head for home on the train. Figuring that the free, fully-trained and highly-regulated family doctor who had known me for twenty years probably had little expertise in backs, I telephoned a friend who I knew had had a similar problem. The recommended osteopath was away, but his secretary referred me to another one, where I made an appointment. Arriving at the railway station, I gave the taxi driver the address where I was planning to spend my money entrusting my body to someone I knew absolutely nothing about.

As he lifted my suitcase into his car, the taxi driver said ‘Bad back, sir? You should go to the Brighton Physiotherapy Clinic.’ ‘Really, is it good?’ I asked. ‘I take all the Roedean girls there’, he said. (Roedean is a very expensive boarding school near Brighton). ‘Where is it?’ ‘On the sea-front near the pier’ (I live 10 minutes walk from the pier). I promptly changed my plans, phoned to cancel my appointment and asked to be taken to the clinic recommended by my taxi-driver.

Reflecting on this experience I am struck by the powerful combination of word-of-mouth recommendation, from someone whose job could be said to make him a sort of expert in a range of things; the reassurance that rich girls used this physiotherapy centre, so it would be quite expensive, which I think I used as one proxy indicator of quality; and the convenience of going somewhere near my home. None of these, of course, told me anything about the actual quality of the provider. The one factor which did make sense was that the girls’ school as an institution must have approved, maybe even selected, the clinic.

How service providers have to market their services

Because every service transaction is different, providers can never deliver exactly the same service every time to every customer. Leading service companies such as airlines, hotels and fast food chains devote enormous effort to designing their systems and processes to minimise the inevitable variation between different employees. They then recruit the right sort of staff, train them thoroughly to deliver a standardised service to their customers, and keep them motivated day after day. (This does not have to mean turning them into robots. Ritz-Carlton Hotels comes top of most rankings for service quality, and they authorise even their lowliest employees to do whatever they can to solve the customer's problem themselves).

The reason it is so difficult to standardise a service is not just that the service provider may not follow the script, but that the consumer is an essential part of the performance. Thus the receptionist at a hotel has to be ready to adapt to the tired pensioner who just wants to get to bed; then handle the executive demanding an internet connection in her room; and then a dozen drunken tourists who do not speak a word of the local language.

But buying the service is also difficult. Consumers faced with the uncertainty of buying a service such as freshly-cooked food or a hotel bed are nervous, because of the risk. They will pay a premium price, or go out of their way to locate, a 'trusted provider', which in the fast-food and hospitality business means a branded outlet. The greater the uncertainty faced by the service consumer, the stronger their brand loyalty – not because they have been duped by slick advertising, but because of the nature of the transaction they want to make.

Montagu (2002, p129) notes that 'standardisation is at the root of the quality assurance systems that been developed by McDonald's and other large food franchises, but their

successes do not easily transfer to medical services. The typical McDonald's restaurant menu in the United States has approximately 50 items…the range of services provided in medical practices, makes them difficult to standardise, and expensive to monitor…' It is for this reason that 'there are few developed country examples [of medical franchising]: the limited number of medical franchises that exist tend to be pharmacies or provide non-clinical services.'

The writer used to a director at one of the UK's most successful health NGOs, Marie Stopes International, which runs reproductive health clinics in over 30 countries (including the UK). Ten years ago when I worked there the founder, Tim Black, liked to say he wants this social enterprise to be 'McStopes', because standardisation was at the heart of his approach. This is an idea whose time has come - recently The Economist ran a story about the rise of 'convenient care clinics', under the headline 'McClinics' (The Economist, April 12th, 2007). There is even more of a marketing logic to the success of Farmacias Similares drugstores, founded by Mexico's leading manufacturer of generic drugs, and one of Latin America's fastest-growing retail chains. According to the Wall Street Journal, these 'stock only generic drugs, including many that González manufactures. Next door to most of the stores are clinics that he subsidizes, staffed by doctors who charge US $2 a visit and write prescriptions for generic drugs (Wall Street Journal, Feb 14, 2005).

Conclusions

Looking at health systems in developing countries from this perspective has a number of advantages. It puts the reality of consumers' behaviour with shop-keepers and private providers at the heart of the discussion. It treats the commercial exchange of money for services as being as or more important in determining the nature of the transaction, than

the fact that it is health which is the subject of the exchange. We can learn as much about private healthcare decisions by looking at how people go about buying other services, as we can by looking at how private healthcare differs from public healthcare.

By highlighting the differences between the way consumers buy products (such as medicines from a shop when self-medicating) and services (such as advice and an injection from a private provider), we can also better understand the opportunities and pitfalls of intervening in these two very different markets. This approach may also suggest parallels with other markets (regulated and unregulated), from which we may be able to glean insights about how, if at all, consumers can be protected or protect themselves from poor quality healthcare, not to speak of quacks and fake drugs.

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