

HOSPITAL ADVERTISING IN THE BEGINNING: MARKETPLACE DYNAMICS AND THE LIFTING OF THE BAN

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ABSTRACT

The beginning of the hospital advertising industry followed the successful Federal Trade Commission's application of the antitrust laws to healthcare, fully opening the competitive floodgates. The 1982 Supreme Court decision, upholding the FTC petition, triggered the start of a new era of advertising—hospital advertising. This paper will examine the unique qualities of this service industry that challenged marketers; the turbulent industry environment of the 1980's with the introduction of new Medicare reimbursement policies; the influence of the rise of HMO's; and how each of these changes affected the behavior of hospitals as they began to explore the possible benefits of advertising in their industry.

Introduction

Change has always been an integral part of the hospital industry, but the period from the 1960s through the 1980s represented unusually turbulent times. Changes in regulations, financing and market structure altered the managerial parameters so completely that hospitals were forced to begin experimenting with new and competitive approaches for survival. At the same time there were important social and cultural trends influencing the public's perception of health care. The wellness, environmental, consumer, and women's movements all emphasized consumer/patient concerns in the health care field.¹ And in 1975, when the Federal Trade Commission decided to apply antitrust laws to health care, the competitive floodgates were pushed wide open. Concepts of marketing and advertising began to be viewed as necessities in an industry of overcapacity and declining governmental reimbursements.

The belated merger of medicine and advertising provides a fascinating case study of the role of advertising, as practitioners searched, through experimentation and application, toward a productive role of informing and educating the public, rather than merely trying to sway through persuasive imagery.

This paper will examine the historical context of the hospital industry during the 1970s and 1980s, which foreshadowed the emergence of industry competition. And then it will examine the affects and function of advertising in competitive environments, the challenges of advertising for service industries in general, and health care specifically, and finally, what actual advertising behaviors were observed as the industry began embracing the concept of marketing.

Industry Changes

The health care industry has always been an industry in change. An historical perspective helps in understanding the shifts in this field and how the forces of competition began to emerge. In the first three-fourths of the century, 1900-1969, the solo practitioner exemplified the practice of medicine.² It was a simple environment, slow to change, with few varieties of health care organizations. Institutions, in general, had no particular priorities or objectives, and planning—except in the area of public health—was nonexistent.

The era from 1960-1975 was a time of abundance with money available for new technologies, services and buildings. More and larger institutions grew as the environment became more complex. Management skills became critical as growth proliferated. In 1966, the Medicare and Medicaid programs opened the door for expansion of both hospital costs and inpatient demand. These programs, in which the federal and state governments paid hospitals according to their costs (plus two percent for Medicare), substantially increased the use of health care by the aged and medically indigent.³ And the demand for employee health insurance went up with the inflationary economy. Employees often preferred to receive the inflationary income increases in health insurance and other benefits to avoid paying increased income tax.⁴

As more and more of the health care costs began being covered by the government and by insurance companies, consumers' concerns with direct health care costs began to decrease. In 1965, before the introduction of the new government programs, the government was paying for only 23.5 percent of the total personal health care expenditures, but by 1985 the government's share had risen to 41.1 percent. And in 1985 patients were only paying for 9.4 percent of the total hospital bill, with the government paying 53.9 percent and private insurance paying 35.6 percent.⁵

The final era (considered by this paper), post-1975, was the time dominated by network medicine, characterized by a dramatically changing environment suddenly scarce in resources. Hospitals, so long buffered from the realities of the marketplace, were now facing competition—competition from other hospitals, and from new kinds of health providers. Costs, technology, and regulations were all on the rise. In 1983 the biggest cost shock-wave came from the federal government, the hospital's biggest customer, in how it paid for Medicare patients. Previously, hospitals were simply reimbursed for whatever costs Medicare patients incurred in their treatment. But the new government approach set prices in advance, based on the diagnosis. The use of DRGs—diagnostic related groups—had the effect of discouraging expensive tests and extended hospital stays. The days of automatic cost-plus reimbursement that allowed hospitals to ignore rising costs and cross-subsidize unprofitable services were gone. Physicians affiliated with HMOs were already being rewarded for reducing their patients' overall medical bills, and now hospitals joined them in a concerted effort to slow rapidly increasing health care costs. One of the reasons for the government's drastic change in policy was the concern over the continuing rise in national health expenditures. In 1973, total

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spending in billions of dollars was \$103.2, representing 7.8 percent of the GNP. By 1983, that figure, \$355.0 billion, had risen to 10.8 percent of the GNP.⁶ Per capita medical expenditures rose from \$180.73 in 1965 to \$2,278 in 1990.⁷ Health care had grown to become the second largest economic industry in the United States.

In addition, the recession of 1981 hit those industries with the most comprehensive health insurance benefits—automobile and steel—the hardest. Health insurers began to feel the pressure to hold their costs down. A survey of 1,185 companies in 1984 found that the percentage of companies requiring deductible payments for their employees' inpatient care grew from 30 percent in 1982 to 63 percent in 1984.⁸ Two additional results came out of this increased concern of insurers. First, the insurers became more concerned with utilization, concurrent review, second opinions for surgery and preauthorization for admission, all of which contributed to the second effect, the development of excess hospital capacity.⁹ In 1983, over 18 percent of hospitals had occupancy rates of less than 50 percent, while only 22 percent had rates greater than 80 percent.¹⁰ Occupancy rates for short-term general hospitals decreased from 78 percent in 1980 to 64.8 percent in 1985.¹¹ In 1980, less than 10 percent of all surgery was performed outside hospitals, while outpatient surgery approached 30 percent by 1985.¹²

External pressures, one regulatory and the other economic, foreshadowed the arrival of industry competition. These pressures included federal legislation that created excess hospital and physician capacity, and the strong interest of businesses in reducing their employees' health costs. But it was the Federal Trade Commission's application of the antitrust laws to health care that fully opened the door to the competitive pressures of the marketplace.¹³ Until the FTC's actions in 1975, the health profession was considered one of the "Learned Professions" and was therefore free from antitrust regulations. This philosophy had effectively kept physicians and hospitals from advertising and had severely limited the acquisition of comparative information by patients.

In 1847, the code of ethics adopted by the AMA specifically noted that, "...it is derogatory to the dignity of the profession to resort to public advertisements or private cards or handbills inviting the attention of individuals affected with particular diseases...(advertising is) highly reprehensible in a regular physician".¹⁴ In 1957, the AMA's *Principles of Medical Ethics* amplified the association's position:¹⁵

Solicitation of patients, directly or indirectly, by a physician, by groups of physicians, or by institutions or organizations is unethical. This principle protects the public from the advertiser and salesman of medical care by establishing an easily discernible and generally recognized distinction between him and the ethical physician. Among unethical practices are included the not always obvious devices of furnishing or inspiring newspaper or magazine comments concerning cases in which the physician or group or institution has been, or is concerned. Self-laudations defy the traditions and lower the moral standard of the medical profession; they are an infraction of good taste and are disapproved.

Medical societies and state practice acts were free to inhibit competition through fee splitting, limiting advertising, delegation of tasks, corporate practices and restraints on innovative forms of health care delivery.¹⁶

In 1975, the FTC charged the American Medical Association, the Connecticut State Medical Association and the New Haven County Medical Association with attempting to prevent their members from advertising, engaging in price competition and other competitive practices. By the time the dust had settled, the FTC had filed 27 health care antitrust cases.

The American Medical Association did not accept the change in its members' status lightly. The FTC actions were appealed to the Supreme Court, but the decision, rendered in 1982, was a clear signal that health care providers were not exempt from the antitrust laws.¹⁷ Despite the stated position and protests of the AMA that "...the standards of quality established by the American Medical Association and other medical societies... are being undermined by a federal agency that possesses no medical qualifications,"¹⁸ the courts went ahead and applied the antitrust laws to the health care field. The health care industry was recognized as a commercial marketplace in which goods and services were bought and sold.

During the appeal process, perhaps recognizing the inevitable, the American Hospital Association adopted guidelines on advertising. These guidelines were intended to "...provide benchmarks to ensure that hospitals maintain their ethical sense of public accountability and that they conduct their communication activities with fairness, honesty, accuracy and impartiality."¹⁹ While the 1977 guidelines on advertising were less restrictive than those of the more traditional American Medical Association, they still incorporated many conservative practices, such as only permitting educating the public regarding services available, avoiding claims of prominence and comparisons to other providers and warning against the promotion of individual professional's practices except when undertaken with the greatest of care. In 1984 the AHA published its revised guidelines that reflected the changing attitudes toward health care advertising. The new guidelines stated that advertising is an acceptable part of a marketing plan that is designed to increase market share. Comparative ads also became permissible as long as the claims made were appropriate and verifiable.²⁰

The net effect of the industry changes and deregulation was the introduction of new forms of market structure—including increasing competition and growth in for-profit ownership and multi-hospital systems. Issues such as economies of scale and competitive positioning gained importance. Wide variations in per unit costs among similar hospitals, large annual increases in hospital costs and the underutilization of facilities had often been cited as indicators of extensive industry inefficiencies.²¹ And development of various innovative alternative care systems increased competitive pressures from nontraditional sources. For example, in 1980 there were only 180 urgent care centers; that number grew to 3,000 by 1985.²² By 1983, 33 percent of all hospitals in the U.S. belonged to a hospital chain.²³ While community nonprofit hospitals (both religious and nonreligious) were still the most common form of hospital, the advent of for-profit

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hospital care had injected a new twist in the already complicated arena of health care competition.

The Potential Role of Advertising

Information was a critical prerequisite for medical services competition, and with the approval of advertising for hospitals it had the potential to become an important source of that information. Before the advent of health care advertising, information about competitor hospitals was nearly nonexistent. A patient was typically unaware of differences in accessibility, pricing and quality, effectively reducing the perceived substitutability of hospitals. Thus each medical provider had a less elastic demand curve. Advertising became a source of information that could lower both the consumer's cost of acquiring that information and the hospital's cost of disseminating it.

Feldstein, in his classic text *Health Care Economics* (3rd edition), claimed that for the hospital industry at least, advertising did result in lower rather than higher prices.²⁴ Empirical evidence to support this claim is limited, but there was one classic area of study that was frequently cited. Advertising by optometrists had a long history of regulation in various states. In a study based on 1970 data, Benham and Benham²⁵ measured the degree of information control in each state and compared it to the prices that consumers were charged for eyeglasses. The evidence clearly showed that the greater the limitation on information the greater the price paid for optometric services. This study further determined that the effect of information control was greater on the less educated, that they were more likely to pay higher prices than the more educated consumer in similar situations. These results were confirmed by a later study (1984) by the FTC that found "the presence of advertising causes substantial and significant declines in the prices of eye examinations offered by all types of optometrists."²⁶

An important prerequisite to competition in health services is information which advertising can provide. Advertising provides this assistance in two ways: first, it gives the consumer information on the similarity and differences between competitors, thus allowing the consumer to evaluate the degree of substitutability, and second, it reduces the search costs for the consumer since the various media are so accessible. The search costs of obtaining health care information other ways can be very high.²⁷ Advertising encourages the flow of information about health care, builds an awareness of health concerns in general, and acts as a spur for hospitals to initiate and innovate as they seek ways to differentiate themselves. One hospital marketer identified six potential benefits hospitals hoped to gain from advertising:²⁸

1. It can inform the consumer about services they may not be aware of.
2. It can enlighten consumers, helping them make intelligent choices between alternatives in the health care marketplace.
3. It can blow away some of the mystique which hospitals and physicians have created.
4. It can encourage correct use of hospital services.

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5. It can help the undoctored and the under-doctored get assistance they might not otherwise receive.
6. It can let consumers know which hospitals and services best meet their needs.

Having considered the benefits that advertising potentially had to offer, there were some basic questions that needed to be answered in determining how the consumer would gather and process the information he was exposed to.²⁹

1. What cues did consumers in fact use to evaluate service offerings?
2. Do these cues vary significantly across service categories?
3. Can consumers be segmented on the basis of the types of cues they prefer to use?
4. Do consumer preferences for cues vary with their personality traits, past experience with the service, general confidence as consumers, education or social class?

There are three categories of qualities that consumers consider when evaluating goods and services—search qualities, experience qualities and credence qualities.³⁰ Search qualities are those attributes a consumer can determine prior to purchase. Goods are high in such search attributes as price, fit, smell and style. Experience qualities are those attributes which can only be evaluated after purchase or during consumption. Many of the less abstract services would fall into this category, such as restaurants or haircuts.

It is the third category, credence qualities, where the highest degree of consumer risk is found. Credence qualities include characteristics which the consumer may find impossible to evaluate even after purchase and consumption. Examples would include medical diagnoses, auto repair and legal services. Few consumers possess the appropriate skills to determine the quality of the services performed, or even if they were truly required in the first place.

The challenge for the newly appointed hospital marketer was to identify the search, experience and credence qualities and cues that the consumer considered when selecting a hospital—and then develop an advertising message that focused on and featured those qualities.

Unique Challenges for the Health Care Industry

It was one thing for hospitals to embrace the idea of using advertising for a competitive advantage, it was a challenge of a different kind to decide on the most effective approach. Marketing and advertising for services in general was more challenging than advertising products, and the health care industry was a complicated industry in many unique ways. It was a non-standardized product in terms of the staff, procedures followed, rules and regulations. It was intangible. It was a perishable commodity and production/consumption must be simultaneous. And related to that was the concept of

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the variable length of the purchase cycle, how could you predict a consumer's use of the emergency room? The high level of perceived risk further complicated the process. And felt risk was compounded by the decision-making process in times of emergency hospitalization. If you wanted to make an informed choice, the alternatives and their strengths had to be known before the time of usage/purchase.

Consumers had always engaged in information searches to reduce their risk in an attempt to decrease their anxiety.³¹ Information came from either personal sources (friends and experts) or nonpersonal sources (selective or mass media). One study identified various pieces of information in advertisements and categorized them in the following ways: price or value, quality, performance, components or contents, availability, special offers, taste, packaging or shape, guarantees or warranties, safety, nutrition, independent research, company-sponsored research and new ideas.³² Knowing this information, hospital marketers were challenged to determine the factors that the consumer used in decision making and focus on those salient features.

Ultimately, consumers made their choice from the alternatives based on the perceived differences between them. However, the most important attributes may not be the ones that were used to effectively distinguish the alternatives. For example, all medical doctors are licensed and thus seem to be qualified, and selecting a qualified doctor may be the most important attribute in determining where to seek medical care. But if all doctors are qualified, what then determines the choice? These factors are called the determining attributes.³³ The determining attributes might include years of medical experience, atmosphere in the doctor's office or ease of getting an appointment. Once the marketer identified what those attributes were, they could be used effectively as the basis for differentiation and developing a unique selling proposition. An additional challenge that hospitals faced was that a typical hospital offers at least 50 different services.³⁴

A survey conducted for *Hospitals* magazine revealed the following responses when the consumer sample was asked, "When selecting a hospital, what do you consider 'very important?'"³⁵

Courtesy of hospital staff	87.1%
Latest technology and equipment	84.7
Variety of specialists	78.7
Physician's recommendation	71.6
Cost of service	55.6
Close to home	51.7
Recommended by friend or relative	29.9
Religious affiliation	12.8

Hospitals magazine, which conducted similar surveys over time, concluded that physician influence had been declining over a three-year period, which was consistent with the profile of health care consumers becoming more involved in their own health care decisions as more information had begun to be available to them.³⁶

In the beginning (mid-1970s), hospital advertising campaigns were not very focused. One of the most popular copy appeals was of the soft-sell, "We Care" variety.

Over the next ten years the appeals, the research, and the strategies became increasingly sophisticated, particularly in larger hospitals. "Hospital administrators are beginning to realize that using image advertising to tell consumers 'we care' isn't enough,"³⁷ was the opinion of one marketing expert. An early example of a more competitive, hard-hitting advertising was the ad run by Eisenhower Medical Center in California (in the *Wall Street Journal* and local Palm Springs newspapers), publicizing the fact that the medical center had the lowest mortality rate in the country for heart bypass operations among hospitals performing 150 or more surgeries on Medicare patients during 1984.³⁸ There was some fear at the time that the turning away from the more "statesman" approach might negatively affect the perception by the consumer who had only recently embraced health care advertising.

By 1987, one decade after it had first been introduced to the marketplace, health care advertising had gained a high level of acceptance. One study by *Hospitals* magazine, found that 73.6 percent of the respondents believed that hospitals should advertise to inform the public of their services.³⁹ Consumers were now looking for and favoring advertising as a source of information about health care services. Two additional studies by *Modern Healthcare* and *Hospitals* magazines showed that 78 percent and 86 percent, respectively, of consumers who had read, seen or heard a hospital advertisement in the month before were able to recall the name of the hospital.⁴⁰

Market changes on all fronts were forcing hospitals to become more responsive to consumer demand and to embrace the principles of marketing. Slowly, they became more market-driven, becoming more responsive to consumer needs and wants. As one marketer put it, "The aim of marketing is to know and understand the consumer so well that the product or service fits him and sells itself."⁴¹ For too long, hospital services had been organized to suit the hospital and the physician rather than what was best suited to or wanted by the community and the patient. (Allowing fathers in the delivery room was an example of that. For years doctors fought against what finally became standard procedure.) A marketing approach by hospitals had the potential to help the hospitals and to make consumers happier with the services available.

Hospitals discovered the benefits of marketing and began using it to attract patients, to attract physicians, and to advertise their more profitable health care services. The projected spending on marketing for hospitals in 1988 topped \$1.34 billion, a significant increase from just \$700 million in 1985.⁴² Ninety-one percent of the responding hospitals in a 1987 study had an advertising budget, up from only 64 percent in 1985.⁴³ In 1983 medical and dental services ranked nineteenth in the top 25 local television advertising categories, spending \$41,047,500, an increase of 48 percent over 1982 expenditures.⁴⁴

However, despite all the seemingly positive effects of advertising health care, the practice was not without its critics. If it was true that U.S. hospitals had at least 25 to 30 percent too many beds, as some industry experts had estimated,⁴⁵ then why not let some unneeded hospitals close instead of propping up demand with last ditch attempts at marketing? Could the money being spent on advertising go to a more worthwhile cause?

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And why should hospitals need to market if the majority of them were nonprofit anyway? The investment of funds in advertising, instead of on real hospital services, raised some questions on the ethicality of hospital advertising as a whole, regardless of the message. Dr. Fred Whitehouse, head of the Ford Hospital's Metabolism division in Detroit, was sharply critical of the use of limited funds on advertising, as quoted in a 1988 article in *The Detroit News*.⁴⁶

In this day of cost constraints, shrinking budgets, and cries of out-of-control cost for medical care, a line item in hospital budgets on advertising seems incongruous if not obscene.... Hundreds of thousands of hard-to-come-by dollars are spent annually on advertising when these same institutions are hard pressed to care for the medically indigent or cannot find dollars to establish needed new services for their patients...

During this same time, Detroit area hospitals spent \$1.8 million on advertising.⁴⁷ These criticisms cut to the core of the entire issue of health care advertising. The marketing activities of a single firm do not just affect that firm and its target market alone. Marketing activities interact and react to the environment, the cognitions and the behaviors of the entire community and the entire industry.

Conclusion

It is an unusual opportunity to be able to examine the introduction of an important market force, such as advertising, into a major industry, such as health care, in today's economy. Few other industry interactions offer the opportunity to examine the birth, growth and application of marketing principles. And while many of the hallmarks of health care are unique, there has been a rapid learning curve as the sophisticated concepts developed in other industries are applied. The lifting of the ban on advertising has had a significant effect on the marketplace dynamics of the health care field since the very beginning and those repercussions continue today.

The rapid acceptance by the public and the quick movement along the adoption curve by hospitals achieved an impact that had only been theorized before the lifting of the advertising ban. And while the emergence of advertising was not the cause of the dramatic industry shifts, there is little question that it played an important role. Few of the negative results direly predicted by the American Medical Association have been observed. Indeed the availability of information about services, and in some cases pricing, has helped the consumer and has lowered the barriers to entry for new competitors and new forms of health care delivery. From the vantage point of the 21st century it is hard to imagine the market forces that prevented the free flow of information that seems so consumer-friendly in an age driven by responsiveness to consumer concerns.

Twenty years later advertising by hospitals is so commonplace it rarely elicits comments and current literature searches reveal little information—an amazing commentary on the acceptance of advertising in the health care industry. And where the market lead-

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ers in advertising once had an initial competitive advantage, when nearly everyone is using the same tools, the playing field is leveled, altered in a different way, but leveled. As the FTC had desired, and as the Supreme Court had dictated in their landmark ruling, the health care industry has evolved to become a marketplace driven by commercial interests as well as those of service to the patient.

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