A social marketing approach to value creation in a Well-Women's health service

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ABSTRACT

Understanding consumer value is imperative in health care as the receipt of value drives the demand for health care services. While there is increasing research into health-care that adopts an economic approach to value, this paper investigates a non-financial exchange context and uses an experiential approach to value, guided by a social marketing approach to behaviour change. An experiential approach is deemed more appropriate for government health-care services that are free and for preventative rather than treatment purposes. Thus instead of using an illness-paradigm to view health services outcomes, we adopt a wellness paradigm. Using qualitative data gathered during 25 depth interviews the authors demonstrate how social marketing thinking has guided the identification of six themes that represent four dimensions of value (functional, emotional, social and altruistic) evident during the health care consumption process of a free government service.

Keywords: Value dimensions, Social marketing, Wellness paradigm, Preventative health services, Government services

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INTRODUCTION[1]

In the research that exists on health services, there is a strong emphasis on investigating organisations that provide treatment services to consumers who are experiencing ill-health. This approach can best be termed as an *"illness paradigm."* Following this line of inquiry, health care and some public policy scholars have also studied the management of health by applying this paradigm. Within this paradigm, consumers are viewed as reactive in their behaviour and thoughts in response to the onset of an illness. Yet health care systems are also designed to promote the health status of consumers with increasing interests in preventative rather than treatment oriented strategies and public policy. We argue that there is a lack of investigation into what we describe as a *"wellness paradigm,"* which is focussed on investigating organisations that provide preventative health services where consumers are proactive rather than reactive in their behaviours and thoughts.

In a wellness paradigm, there are positive outcomes for the individual, the organisation, and society, which are also outcomes sought in social marketing. First, the maintenance of good health for the individual is achieved through consistent use of preventative health services. Next, the organisation providing the service achieves its organisational objectives such as the fulfilment of participation rates among target consumers. Finally, an improvement in overall population health is achieved as the burden of the disease in the community is reduced (AHMAC, 2008), which is a societal benefit. Furthermore, the use of preventative health services by members of society reduces the burden on the public health system as illnesses are avoided or are able to be detected at an early stage (DHA, 2008). When detected early, disease may be treated more effectively than later stage illnesses, resulting in lower costs to the public health system. These benefits of preventative health care can be classified as

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economic in nature and while this is important, there are also non-economic outcomes such as emotional and social benefits. Thus any investigation of value using a wellness paradigm needs to also include these non-economic benefits.

Given that many preventative health care services are offered by governments and that these services require the voluntary behaviour change of individuals, a social marketing approach is highly appropriate. Social marketing is *"the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the* ***voluntary behaviour*** *of target audiences in order to* ***improve their personal welfare*** *and that of* ***society*** *of which they are a part"* (Andreasen, 1994). Social marketing operates within the wellness paradigm to avoid negative outcomes (i.e. poor health), which is consistent with the purpose of social marketing's focus on prevention, rather than cure.

A key challenge for social marketers working in preventative health is understanding the value that is created through the consumption of services, particularly government services, which are typically free. Government departments are turning to social marketing as a management strategy to satisfy clients, and also as a tool to assist governments in reducing the burden of chronic disease currently caused by obesity, tobacco and the excessive consumption of alcohol. This problem has been acknowledged in developed countries, such as Australia and the United Kingdom, to the extent that government decision makers are embracing the business approach of social marketing and its related concepts. In Australia, the government has established the Preventive Health Taskforce, 2009 (Department of Health and Ageing, 2009) and in the United Kingdom the government established the National Centre for Social Marketing in 2006 (NCSM, 2006).

While value creation is an area with long-standing importance in the marketing field, there has been virtually no investigation of the value construct as it pertains to the consumption of preventative health services, and none in the area of free services. While the economic approach to value is relevant to commercial transactions (see Zeithaml, 1988), it is limiting to

apply this approach to free transactions. An approach that goes beyond the economic approach to value is the experiential approach (Holbrook, 2006; Sheth, Newman and Gross, 1991). The experiential approach includes both functional value as well psychological and emotional value.

In social marketing, value can be regarded as an incentive for consumers to perform desirable behaviours that lead to both greater social good and individual benefit. As such, providing value to consumers of preventative health services ensures their continued use of such services. This is consistent with a more recent definition of social marketing, which is *"a process that applies marketing principles and techniques to create, communicate, and deliver* ***value*** *in order to influence target audience behaviours that benefit society as well as the target audience"* (Kotler, Lee and Rothschild, 2006 cited in Kotler and Lee, 2008).We argue that an understanding of customer value in the consumption of social products (such as preventative health services) is a necessary first step and an important aspect of designing social marketing interventions that can effectively change social behaviours, which ultimately benefit society. We further suggest that taking an experiential-value approach will provide social marketers with the ability to segment their target audience more meaningfully based on the value-types consumers seek from service interactions. Furthermore, government services will be able to develop responsive service frameworks that deliver value to clients.

The objective of the research is therefore to investigate the value created in a wellness health consumption context. This is achieved through the identification of experiential value-types relevant to a free, social marketing service and how these relate to existing value typologies which are derived from commercial sector marketing. The contribution of this research is new insights into value in a social marketing context, a gap previously identified by Vargo and Lusch (2008). The practical implications of this research relate to marketing processes such as segmentation and marketing mix developments, as well as public policy implications. The intended audience for this paper encompasses a range of scholars and practitioners from fields

of health services, marketing, and public policy interested in the effects of health interventions and prevention strategies.

This paper begins by introducing the wellness paradigm; the context in which marketing value is being investigated. Following this, the authors overview the role of government as a manager of particular health care services – breast cancer screening. The article then moves to an overview of research into the dimensions of value marketing. In particular, studies that add insight in the differences between experiential and economic value are reviewed. After a discussion of the research design and methodology employed, the findings of a series of 25 in-depth interviews are presented. These data suggest that marketing value has a number of potential implications for health institutions, its employees, and customers. The paper concludes with a series of marketing implications for theorists, practitioners, and public policy makers.

THE INFLUENCE OF A WELLNESS PARADIGM

This study focuses on applying a wellness paradigm to investigate the value created in a health consumption context. We propose that a consumer's experience of wellness versus illness will influence the value that is created from their interaction with the health service system. Thus an understanding of the wellness paradigm is an important precursor to understanding how value is created in a wellness context.

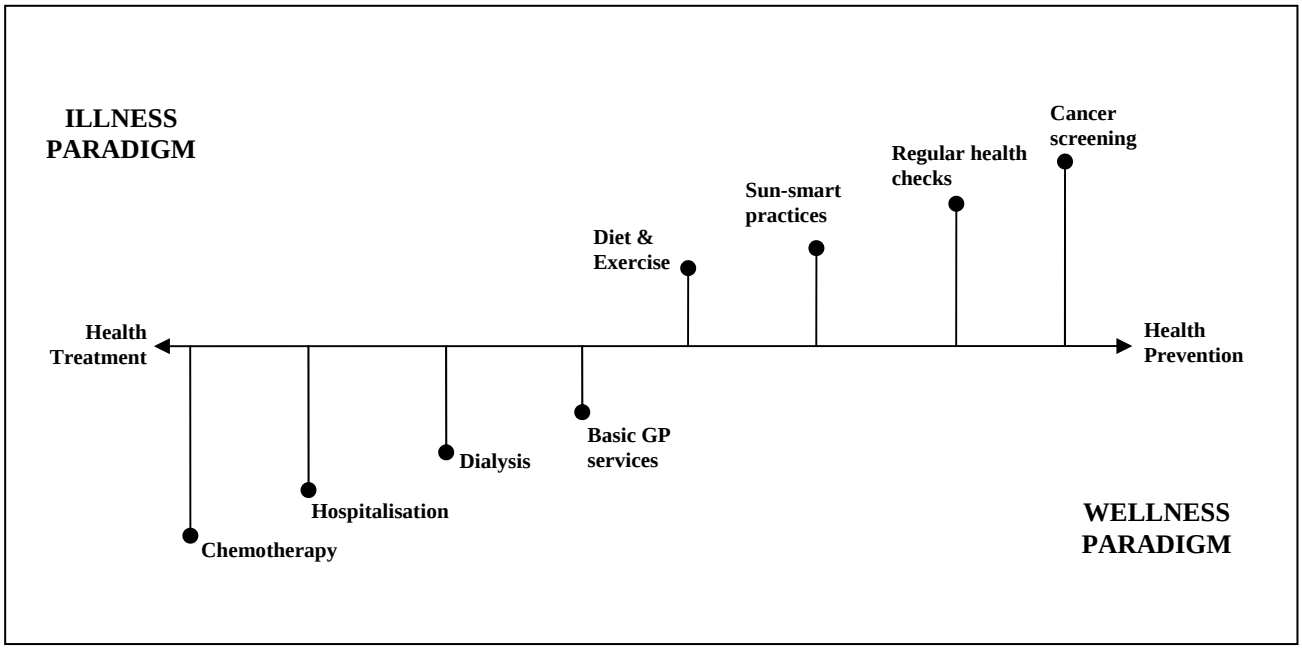
Much of existing research in healthcare marketing is focussed on management issues from either a market perspective or an organisation perspective. As such the scholarship in this area views the health care system as the services, institutions and organisational arrangements needed to deliver treatment and care to people who are ill. In taking this approach, scholars have adopted an *"illness-care system"* (Palmer and Short, 2000) purview of health care. The healthcare sites studied typically offer health services to consumers in the form of treatment services and include emergency services in hospitals, dialysis for kidney-failure,

physiotherapy, or basic general practitioner services for common ailments like the flu. We describe this focus on organisations that offer treatment services as an illness paradigm. However, within the health care system there are also many organisations that offer services that can be described as preventative health services, which healthy consumers use as a means of maintaining good health. Examples of preventative health services include cancer screening services, pap smears for women, prostate checks for men, or immunisations for infants and young children. Within the health academy scholars in positive prevention have also developed a specific focus on positive psychology, which is the *"study of positive emotion, positive character, and positive institutions"* (Seligman and Csikszentmihalyi, 2000). Overall however there is a lack of investigation into organisations that explore preventative health services; this research aims address this gap. Parallel to the work established in positive psychology (Seligman, 2002), which posits positive approaches that amplify clients' strengths rather than their weaknesses; we describe and apply a wellness paradigm guided by social marketing thinking. In this context consumers are encouraged to build their health competency, and the objective of all stakeholders in the system is the prevention of ill health through the provision of health services that maintain good health. We propose this context creates a different value mix when compared to value created by most commercial transactions.

We have summarised the two paradigms in Figure 1 which shows a health continuum and identifies examples of different activities involved in both the illness paradigm and the wellness paradigm. The purpose of consumers' participation in these activities is for the achievement of good health and the point on which consumers find themselves on the continuum depend on their current health status. The examples of activities are placed in order on the continuum according to the extent of their poor health, or good health. For example, the activities at the illness paradigm end reflect reactive behaviours that consumers engage in to improve their health. Whereas, the activities at the wellness paradigm end of the

continuum reflect proactive behaviours that consumers engage in to maintain good health. As such, we anticipate that the proactive nature of good health behaviours will be reflected in types of value created in the wellness context. The following section will now turn to a fuller explanation of value.

Figure 1: Health continuum



MARKETING VALUE IN HEALTHCARE

In the health care industry, in order for health care organisations to engage in value marketing, it is necessary to understand consumers' determination of value received from healthcare services. To understand the consumers' view of healthcare, this paper turns towards a critique of understanding value. Rather than investigating value from the market's perspective or from the organisation's perspective, this paper focuses on investigating value from the consumer's perspective as it is consumers who drive the demand for various products and services from various industries. Demand in the health care context, is for good health, this results in a derived demand for health care services as consumers do not commonly seek health care for its own sake (Evans, 1984).

An experiential approach to value

Understanding value using the experiential perspective is more suitable for preventative health services, particularly those that are free, as there are non-cost factors that drive consumers' demand. Previously, much of the focus on value has been informed by an economic perspective where value is an evaluation of costs incurred from receiving a service against the benefits gained (Zeithaml, 1988). Over time however, the academic discussion of the value concept has gradually broadened from one that is economic-centric and involved price-based studies (e.g. Monroe, 1990), to one that is extended to include the experiential nature of value.

Experiential value is described as an *"interactive relativistic preference experience"* (Holbrook, 2006, p 715). As Mathwick, Malhotra and Rigdon (2001) pointed out in their research about the experiential value-base in retail shopping – the consumption experience itself is rich in value. They further explain perceptions of value as being influenced by interactions which influence the relativistic preferences held by the individuals involved (Holbrook and Corfman, 1985). As such, value offers both extrinsic and intrinsic benefit (Batra and Ahtola, 1991; Mano and Oliver, 1993). This notion of the nature of value is constantly evolving and with the rise of the service-dominant (S-D) logic (Vargo and Lusch, 2004), value has been identified as relevant to social marketing through the notion of co-creation as assisting the achievement of well-being in society. More recently, Vargo and Lusch (2008) pointed out that value is contextually bounded and subjectively experienced. Thus it is not correct to assume that conceptualisations of value can directly transfer across contexts. The characteristics of a prevention oriented social marketing service context differs from a commercial context as the emphasis is on social good, not just individual benefit and the exchange is often non-monetary (Russell-Bennett, Previte and Zainuddin, 2009). We propose that value created in each context will also differ. It is therefore important to explore the nature of value in a social marketing service context.

Dimensions of value

Value has been conceptualised into multiple dimensions, some of which are proposed to be independent of one another (e.g. Sheth, Newman and Gross, 1991), while others have been validated as inter-related dimensions (e.g. Sweeney and Soutar, 2001). While there are differences in the exact terminology of the dimensions by different authors, there appear to be four common dimensions; functional (sometimes termed economic e.g. Holbrook, 1994), emotional (sometimes termed hedonic e.g. Babin, Darden and Griffin, 1994), social and altruistic. Table 1 below shows a typology of customer value developed in commercial marketing by Holbrook (2006), which informed the conceptualisation applied to the social marketing context in this research.

Table 2: Holbrook's Typology of Customer Value

	Extrinsic	**Intrinsic**
Self-oriented	Economic value	Hedonic value
Other-oriented	Social value	Altruistic value

Source: Holbrook (2006)

Functional value (economic value) is extrinsically-motivated (a means to an end), and for the benefit of the self rather than others (Holbrook, 2006). This value shows a focus on performance and functionality (Russell-Bennett, Previte and Zainuddin, 2009; Sheth, Newman and Gross, 1991; Sweeney and Soutar, 2001) which can include economic benefit in a commercial context or the utility provided by the consumption of a product or service (Tellis and Gaeth, 1990). The functional value dimension is likely to be applicable to a government social marketing service that delivers a service as part of the social marketing mix. This relates to the consumption of a social marketing service as a means to a consumer's own objectives (Holbrook, 2006), which in this context is the maintenance of good health.

Social value is also extrinsically-motivated however it is directed at others (Holbrook, 2006). This type of value focuses on influencing other people as a means to achieving a desired goal such as status or influence (Russell-Bennett, Previte and Zainuddin, 2009). Utility in social

value is acquired from a product or service's association with social groups (Sheth, Newman and Gross, 1991) as well as its ability to enhance an individual's self-concept (Sweeney and Soutar, 2001). In social marketing, this value dimension may also be relevant as women choose to perform socially-desirable behaviours in order to fulfil social belonging needs or influence others to perform the same behaviours. Social value is sought when individuals seek to shape the response of others (Holbrook, 2006; Gallarza and Gil, 2006), which is also relevant in the social marketing context as consumers seek congruence with the norms of friends and associates when projecting their health status (Sanchez-Fernandez and Iniesta-Bonillo, 2007).

Emotional value on the other hand, is intrinsically-motivated (an end in itself) and self-oriented whereby products are consumed for the emotional experience and for no other end-goal (Holbrook, 2006). This value is related to various affective states, which can be positive (e.g., confidence and pleasure) or negative (e.g., anger and fear) (Sanchez-Fernandez and Iniesta-Bonillo, 2007, p438). Utility in social value is derived from the feelings or affective states generated or aroused by the consumption of a product or service (Sheth, Newman and Gross, 1991; Sweeney and Soutar, 2001). Similarly, in the context of government social marketing health services, consumers are likely to experience some form of emotion, particularly when thinking about personal health and wellbeing. As such, it is believed that this value dimension is relevant as women may choose to seek tension or anxiety reduction.

Altruistic value is also intrinsically-motivated but directed towards others (Holbrook, 2006) whereby the goal may be self-fulfilment or a sense of well-being. It describes an individual's concern for how their consumption behaviour affects others (Holbrook, 2006) which is particularly relevant in social marketing. Many consumers may be motivated to perform socially-desirable behaviours for the good of others and society than for themselves.

Arguably, this value is central to prevention messages, which aim to identify illness early, so that citizens do not become a cost on society in the future.

A key characteristic that differentiates the social marketing context is the non-monetary costs such as time and effort (Joyce and Morris, 1990; Wang et al., 2004) involved in most exchanges. This feature minimises the economic aspect of value that has been central to commercial exchanges and instead places emphasis on the psychological and emotional dimensions of value. Alongside economic barriers, the social and emotional forms of value are significant barriers to the adoption and maintenance of desired social behaviours, particularly those that are health-related such as quitting-smoking, moderate drinking and breastfeeding. This research proposes that in order for governments to achieve sustainable behavioural change among target consumers, consumers must first see value in changing their behaviours. In order to provide value to consumers, there must first be an understanding of what value is and then how it can be created.

RESEARCH DESIGN AND METHOD

Social marketing remains strongly influenced by positivist methods and objective, evaluation frameworks. In line with other contemporary areas of marketing and consumer research however, some social marketers (e.g. Hastings, 2007; Kotler, Roberto and Lee, 2002) are moving on to "softer" research approaches that yield consumer insights that are more closely aligned with the everyday reality of marketing (Tapp and Hughes, 2008). Learning from these contemporary experiences, the research in this paper is guided by interpretive consumer research (ICR) and draws upon qualitative methods to explore and explicate consumers' experiences. Furthermore, an exploratory research approach was appropriate because there is currently little research that has examined consumers' perceptions of experiential value, particularly in a social marketing service context. We posit that this information is necessary, as health practitioners, government and social marketing decision-makers need to be better

informed about experience-based value which is contextually bounded and subjectively experienced during the process of consumption (Holbrook, 2006; Mathwick, Malhotra and Rigdon, 2001). This research then is, as Kavale (1996) suggests, an attempt to understand the world from the subject's point of view, to unfold the meaning of people's experiences, and to uncover the lived world. Applying this understanding to our research involved talking to women about their consumption experiences before and after they had used a breast cancer screening service.

BreastScreen Queensland (BSQ) is the research site selected for this study because it is a government service organisation that uses social marketing. BSQ is a population-based public health service provided by the Queensland Government (Australia) that offers free breast screening services to women aged 50 to 69 years old. The predominant population profile is Anglo-Australian women, aged over 50 years of age, who are healthy at commencement of screening.

In September 2007, BSQ launched a social marketing campaign, which aimed to achieve a 30% increase in participation of women aged 50 to 69 years by addressing the barriers to regular screening and by dispelling myths about breast cancer (BSQ, 2009a). The services target participation rate is 70% (BreastScreen Australia, 2009), yet the participation rate during the biennial period 2006/2007 among women in the target age group was 56.4% (BSQ, 2009b). The challenge and organisational desire to reach targets indicated a need to investigate the value perceived by women who use the BSQ services, and to identify their motivations for continued use.

Research sample description

The women interviewed for this study were all current users of BSQ's services. A sample size of 25 women was sufficient for the purpose of this study, in that the women interviewed were representative of the BSQ client profile, and their documented experiences provided "adequate data" (*see* Morse, 1995) to give insight to indentify appropriate value themes. As

such, “theoretical saturation” on this group of women was reached after the researchers found similar experiences reported in later interviews, and identified they were not discovering new insights about service interactions and value perceptions. The sample characteristics are summaries below in Table 2. The women interviewed ranged in experience in terms of the length of time they have been health screening consumers. One woman was a first time user of breast screening services, seven women had been using the service for less than 10 years, and 17 were experienced, having used the service for 10 years or more. Additionally, although all the women interviewed were current users of BSQ’s screening services, seven of the women interviewed had used other service providers.

Table 2: Summary of sample description

Sample size (n)	25
Mean Age	57 years
Ethnicity	Anglo-Australian (20) Eastern European (4) Asian (1)
Health status at commencement	Well-women (15) Women with health issues (10) • Breast issues (6) • Other health issues (4)
Screening Experience	First time (1) < 10 years (7) 10 to < 20 years (15) 20 years or more (2)
Service providers used	Used BSQ government services only (18) Used other private and overseas services (7)

Additionally, the sample descriptives at the *commencement* of women’s health screening behaviour who were interviewed are shown in Table 3. BSQ actively targets women 50-69 years old as their research has identified this demographic receives the most benefit from screening services (BSQ, 2009c). Women outside this age group are welcome to use the service; however, the greatest benefit is experienced by women in the 50-69 year age group. In the interview sample, only seven of the women interviewed started breast screening when they were 50 years old or older. The remaining 18 started using breast screening services in their forties or younger. Of the 18 women who started using breast screening services early (i.e. before 50 years old) six started breast screening because they had breast lumps or breast

pain, one woman started menopause, another woman had a heart operation, and another had a hysterectomy. The remaining nine women who started breast screening early were "well-women" that is, they did not have any existing health issues. Five of these women initiated their screening behaviour by approaching BSQ on their own, while four were recommended by their doctors to start screening.

Table 3: Sample descriptive at commencement of health screening behaviour

	Well-women	**Atypical women**		**Total**
		Breast-specific issues	*Other health issues*	
Started breast screening at 50 years or older *(BSQ's target age group)*	6	NIL	1	7
Started breast screening younger than 50 years old	9	6	3	18
Total	**15**	**10**		**25**

Interpretive research process

This study is qualitative in nature, and is focused on uncovering women's views and experiences in using a population screening service. This is an appropriate approach as the current literature on value perceptions in social marketing government services is limited in its understanding of *what* "experienced-based social marketing customer value" is, or *how* social marketing is implemented in a government service. We argue that it is important to explore the experiences and views of clients - women using a cancer screening service - in order to reveal the nature and scope of marketing value as applied by a specific sector.

The data analysed in this study was generated via individual-depth interviews, which were conducted face-to-face with women between October 2008 and February 2009. Given that the aim of this research is to understand the experiences and subjective views of participants, interviewing a discrete sample of experienced consumers was considered a suitable approach that provided three major benefits. Firstly, interviewing enabled the researchers to acquire multiple perspectives on consumers' experiences of the population screening services. King (1994, p33) argues that interviews are "ideally suited to examining topics in which different

levels of meaning need to be explored", such as understanding women's experiences of screening services. Secondly, interviewing a small sample of women was useful because interviewing is a research tool which occurs in a social context. For example, 15 women were interviewed at BSQ services during the data collection period. This was valuable because as Berg (2004, p75) suggests, the researchers were able to conduct the interviews as a "conversation with a purpose", and participants were more likely to be familiar with the research context and more comfortable, and thus be more willing to share their experiences with the researcher.

The third reason why interviewing a small, but experienced sample of women was appropriate was again related to the purpose of the research, which is not quantification. It is, in contrast to gain a holistic and detailed understanding of lived experiences by women accessing population screening. This makes the interview appropriate as Denscombe (1999, p111) recommends interviewing in situations where the researcher is seeking in-depth information which can be gained from a smaller number of informants than a survey would require. The interviews conducted were semi-structured and lasted between 20 minutes and 50 minutes. During the interview a guide was followed (see Appendix 1), however, the list of questions were not followed with rigidity and it was revised based on the ideas that emerged from a breadth of women interviewed.

The research process used builds around Mason's (2005) view that theory is developed from and through data generation and analysis. According to this view, theoretical explanations of the data are developed in a process which is commonly seen as moving from the particular to the more general. The analysis of the data in this study was conducted following verbatim transcription of the interviews, and then thematic coding was employed to reveal the dimensions of value experienced by consumers and of interest to the practice of social marketing. The following sections report the marketing value themes identified from the interview analysis. The discussion commences with the women's views on using a prevention

service, then the analysis moves to the explanation of value using the four common dimensions of value in Holbrook (2006), Sweeney and Soutar (1991) and Sheth, Newman and Gross (1991) interpreted through the a social marketing framework.

CONSUMERS' MARKETING VALUE INTERPRETATIONS

The interview process with women commenced with a discussion of their general experiences with breast screens and then moved into their reasons for having regular breast screens and the outcomes they hoped to gain. The following interpretation reveals six themes that explain value constructions in a government social marketing service.

1. Convenience

Many respondents reported convenience to be an important factor in their decision to perform the behaviour. We define convenience as the facilitation of the desired behaviour through the implementation of relevant processes and structures. This includes widespread availability of service centres throughout the state, convenient location of service centres, useful facilities in and around the service centres (such as parking), and other helpful support services (such as a courtesy phone call reminder), which were all cited by the respondents. These enable them to perform the behaviour easily. Convenience is a form of ability-enhancement (Moorman and Matulich, 1993) in order to continue performing the behaviour. For example, one woman indicated that location and easy parking was a consideration. *"Location would be important for most women. And parking, parking is really important."* Providing convenience to individuals through the necessary processes and structures makes the performance of the desired behaviour more attractive as it reduces barriers in consumers' uptake of the behaviour and encourages easy maintenance of the behaviour. Facilitating an easy performance of behaviour is likely to encourage continuation in the long-term. This is illustrated by one woman's comment: *"I think that BSQ has done everything that they can, short of going to your house and picking you up and delivering you to the service, um, they have made it as*

accessible as they possibly can. And I think that's very important." This view is echoed by another woman, who said: *"It just doesn't make sense to not take advantage of a free service."* Essentially, the more convenient the process, the more likely women were to continue their screening behaviour in the long-term. This is explained by customer loyalty theory where consumers repurchase (rescreen) with suppliers who are conveniently located (Uncles, Dowling and Hammond, 2003).

We situate convenience within the functional dimension of value, specifically functionality and ease of performing the desired behaviour. This relates to practical aspects of the service experience such as receiving a reminder letter in the mail, having a staff member advise the individual on which location is the closest to their home or workplace, or receiving a courtesy call to remind the individual of their upcoming appointment. Many respondents reported that BSQ "made it as easy as possible" for them to have a breast screen and as such, there was no need or reason for them to avoid doing so.

2. Control

A second theme that emerged was that many women saw the act of having breast screens as something that provides them with a sense of control. The achievement of control is a form of motivation-enhancement (Moorman and Matulich, 1993) through cognition in order to continue performing the behaviour. *"Yes, things can crop up in the two years but... knowing you're in the process and... scheduled for appointments … it's a good positive".* We define control as having a sense of management and organisation that allows an individual to feel that they have done all they can to avoid any negative consequences.

The activities and behaviour within a wellness paradigm, such as eating well, maintaining physical activity, or having regular health checks, are all within the control of the individual. The respondents felt that if a woman were to get breast cancer, there was little that she could do to avoid it and they saw this as something that they were unable to control. However, they

were able to distinguish the difference between factors that they could not control and factors that they could. Ensuring that they went for regular breast screens was seen as a behaviour that they could control and a proactive means of managing the occurrence of breast cancer. One woman expresses this clearly: *"It makes me feel that at least I'm doing something to maintain my health (laughs) you know. Let's me off the hook a little bit because I'm actually doing something about it"*. Respondents also had the belief that early detection led to more effective treatment and an improved chance of survival. This is consistent with the findings of the DHA (2008) that treating individuals with early disease detected through screening leads to better outcomes for both the individual and society than detecting and treating disease at a later stage. As one woman put it: *"I guess if I'm going to face this event in my life, at least I will be diagnosed early in my life to save my life. The best thing about it is you get to find out early and get treatment early"*.

Control is situated within both the functional and emotional dimensions of value. Control provides the use of functional means to achieve a desired emotional state (Bandura, 1993). In this context, the women are able to feel better about themselves (desired emotional state) through their behaviour, which is using breast screening services when they can (a functional means) in order to avoid negative consequences.

3. Peace of mind

When asked for the main reason why respondents had regular breast screens, the most common reason cited was a sense of reassurance and peace of mind that they have done something necessary for themselves. We define peace of mind as the reduction of negative emotions and the promotion of positive emotions to achieve relief. The achievement of peace of mind is a form of motivation-enhancement (Moorman and Matulich, 1993) through emotions in order to continue performing the behaviour. One woman describes it as: *"I tend*

to think 'I've had it now, I don't have to think for two years.' I feel very peaceful about that, I've got peace of mind".

Many respondents admitted that the responsibility for safeguarding their health and wellbeing rested solely on their own shoulders. Some explained that they experienced feelings of relief and sometimes pride after having a screen because they had fulfilled their perceived obligation to themselves. One woman noted for example: *"Once it's done, I feel immensely proud of myself that I've just accomplished that thing yet again, that part of my health check (laughs) at least I'm doing one part of my health check properly. And then I get all righteous about it and then it leaves my mind"*.

Appraisal theory posits that emotions such as relief are derived from situations where there is certainty that engaging in the situation will avoid or minimise pain (Roseman, 1991). Relief is the emotion that accompanies peace of mind. Thus this theme is situated within the emotional dimension of value as it provides positive emotional reinforcement and reassurance to consumers of the service. This ensures their performance of the desired behaviour is maintained through the continued use of the service.

4. Behaviour as reinforcement for beliefs

Several respondents expressed an assumption that they were fine and cancer-free. They saw going for breast screens as a means of reinforcing their existing belief that they were perfectly healthy and expected their results to be clear every time they have a screen. *"I don't mind waiting [for an appointment] because there's nothing wrong. I mean, I know there's nothing wrong with me"*. We define this as confirmatory performance of desired behaviours to existing attitudes and beliefs. In this instance, the attitudes of the women precede their behaviour; they hold the belief that they are healthy and then seek to use breast screening services to confirm their expectations of good health. The principle of cognitive consistency explains this behaviour; consumers are motivated to keep their thoughts and behaviours

consistent with each other (Abelson et al., 1968). In this situation, the rescreening is perceived to be the necessary behaviour to accompany beliefs of wellness.

This theme is particularly common among women who during their individual interviews did not openly or strongly express fear or anxiety in thinking about whether they might have breast cancer. These women appeared to function on the assumption that they are healthy which creates a positive mood state. According to the *hedonic contingency model* people are motivated to seek out situations that help them remain in positive emotional states (Wegener and Petty, 1994). Such wellness beliefs build women's confidence in their health status and this belief also triggers positive emotions such as pride. We thus identify this belief as being emotionally-driven and situate in the emotional dimension of value.

5. Identification of self as an influencer

Some respondents also identify themselves as people who influence others to take up the desired behaviour. These women reported trying to encourage as many people as possible to take up this socially-desirable behaviour. We define this as performing desired behaviours for the purpose of being able to exert social influence over others into performing the same behaviours. One woman noted during her interview that: *"I believe that you should be talking to people about it, especially those who haven't done it yet or haven't thought of having these screen tests"*. Although most of the women interviewed reported that they do not discuss breast screening with other people, and that it is not a typical topic of conversation with friends, family members, or peers, many expressed the belief that having a breast screen is of extreme importance for a woman above fifty. Many of the respondents strongly believed that all women above fifty should be engaged in this practice and that women who were non-screeners were doing a disservice to themselves. In these situations, some of the women interviewed indicated that they take it upon themselves to convince non-screeners who they knew to take up regular screening. As the respondents identify themselves as those who

perform the behaviour long-term, they see themselves as a legitimate source of influence over others into performing the same behaviour. This behaviour then forms part of the normative influence that women have on other women. This is an example of subjective norms, which influence the individual's behaviour (Ajzen, 1991). This theme situates well in the social dimension of value as the objective of these women is to influence other women into performing and maintaining the same behaviours. Similarly, the women who are being convinced by their friends, colleagues, or family members may choose to take up this behaviour in order to fulfil social belonging needs.

6. Benefit of behaviour to others

When asked about the benefits of their sustained behaviour, the respondents felt that the primary beneficiary was themselves. In addition, many of them also identified their family members and friends to be secondary beneficiaries of their behaviour and indicated that they performed the behaviour for their family and friends in addition to themselves. A quote from one woman reveals this point, she stated: *"Half of the motivation for wanting to stay well is that you are still around for the rest of your family and your friends"*. We define this as the performance of desired behaviours for the benefit of others. A small number of the women interviewed also identified a tertiary beneficiary of their behaviour as being the community at large. Their belief informs the view that since their behaviour contributes towards early detection and early treatment of breast cancer, it benefited the community via reduced health costs. These women believed that the cost of treatment is greater when treating advanced cancer than treating early-stage cancer. *"There are community costs involved in any kind of illness; so if I don't do the screening and have my breast cancer diagnosed at a later stage, then there are costs, higher costs in terms of hospitalisation costs and medical cost. I believe that if the cancer is caught at an early stage then the impact is much lower … yes, very definite benefits for me and my family and in terms of health cost to the overall community"*.

This denotes a sense of altruism in their behaviour, suggesting this is situated within the altruistic dimension of value.

Value benefits to others, and a sense of altruism appears to be directed at two main groups, the first is the group directly related to the individual. This group of people have a direct relationship with the woman using the service, such as family member and friends. In this situation, the purpose of performing the behaviour is not to convince others to have breast screens, but instead the purpose of having breast screens is to protect the individual's health and wellbeing, of which their family members and friends have a vested interest for them to do so. Whereas the second group of individuals are indirectly related to women using the service. This second group, who have an indirect relationship with the individual, is society at large. Performing desired behaviours for the benefit of others creates additional marketing value, beyond the value received by the individual performing the behaviour. While society also has a vested interest in ensuring that women over fifty are having regular breast screens, the benefit to society is of a different nature. The benefit to family members and friends is that a loved family member is healthy and safe and is able to be around them for a longer period of time. From a societal perspective, the benefit is that the public health system is not over-burdened and that the cost to society to treat individuals with cancer is reduced. In both instances, there are benefits to other stakeholders apart from the individual. This theme is therefore situated in the altruistic dimension of value.

DISCUSSION AND IMPLICATIONS

A central tenant of this exploratory research was that value in a wellness paradigm would be created by proactive behaviours as consumers engage in the management of their own health (see Figure 1). This experiential value includes proactive behaviours, which are consistent with Mathwick, Malhotra and Rigdon's (2001, p41) definition of "active value", which requires the consumer to actively participate with the organisation, rather than simply react.

Similarly, positive psychology views the individual as an active decision-maker capable of making appropriate choices, rather than passively reacting to external forces (Seligman, 2002). These views are consistent with social marketing's view that individuals, when appropriately motivated, with the right opportunities and abilities, are capable of sustaining positive behaviours (Rothschild, 1999).

In this research the analysis revealed six themes that explain dimensions of experiential-value in a free preventative health service. The relationship between these six themes are summarised in Table 4. The presentation of information in Table 4 reveals that an emotion focus is evident in the value sought in preventive health social marketing services. Furthermore, value in this context also appears to be more "self-oriented", and motivated by emotions and functionality. To a lesser extent an "other-orientation" is evident in women's participation through social and altruistic value.

Table 4: Relationship between Experiential Value-Types and Preventative Health Value-Types

		Motivation	
Primary Beneficiary	**Value Type**	**Extrinsic**	**Intrinsic**
Self-oriented	*Experiential Value Types*	Functional/Economic value	Emotional/Hedonic value
	Preventative Health Value Types	Convenience Control	Control Peace of Mind Behaviour as reinforcement of beliefs
Other-oriented	*Experiential Value Types*	Social value	Altruistic value
	Preventative Health Value Types	Identification of self as an influencer	Benefit of behaviour to others

A central focus in this research is the importance of wellness, and prevention services to achieving a healthy society. As such, prevention behaviour must become part of consumer lifestyles. To achieve this end, an experiential-value base provides a useful framework for social marketing practitioners and scholars, so that they better understand the barriers, costs and incentives that inhibit and encourage sustainable, preventative behaviours. If preventive behaviours are to take centre stage for consumers, then this understanding needs to be

translated into social marketing programs that reduce barriers and costs to participation, and increase the incentives (Kotler and Lee, 2008).

This research provides an alternative value perspective about marketing in the health care industry. The above analysis demonstrates how marketers can go beyond the economic perspective, by using an experiential value approach. Furthermore, by using this approach we have identified the health care industry's limited analysis of health care prevention services. Consumers who use preventative healthcare services are likely to use such services for reasons that are not economic or financially based. The six value themes explicate the experiential nature of value and how this value is exchanged and shared between stakeholders in within a wellness care system.

The health care industry is experiencing increasing expenditure, which can be attributed to changes in demographics and disease patterns with western populations living longer but suffering from higher levels of chronic diseases. Furthermore, with changes in government policy and health care provision, health care businesses and social marketers must identify new areas of opportunity and re-orientate their new product and service development activities based on value marketing thinking. We suggest that the experiential view, informed by a wellness paradigm, is an alternative approach which also needs to be used by decision makers in health, so that they provide consumer solutions that are low cost, and offer good value to customers who are prepared to exercise their value choice. Adopting a wellness paradigm will have consequences for consumers using health services, employees and health institutions.

Implications for Health Service Practitioners

In understanding the value dimensions in health services facilitates a greater appreciation of the benefits that consumers seek from using health services by acknowledging that different consumers have a variety of different reasons for choosing to use the same health service. This can lead to an improvement of delivery of health services in terms of providing enhanced

service processes, improved service facilities and support services, improved interpersonal communication and interaction with customers through a show of greater empathy and better understanding of customers' fears, as well as their wants from the service.

This research also provides a guide for health practitioners to carry out refined segmentation of the target audience using psychographic segmentation strategies, moving beyond simple demographic segmentation. As a result, health practitioners can more effectively target first time and existing customers with alternative strategies that reflect the motivation and the beneficiary of the behaviour (see Table 4). This can be achieved through improved communications with the use of more tailored messages developed based on health practitioners' understanding of consumers' experiential-value dimensions. For instance, women motivated by the "control value-type" could be targeted in communication campaigns with a message such as *"There are some things in life which you can't control, like getting diagnosed with cancer. But you can control your odds of surviving it with early detection. Have a breast screen"*. Conversely, for women motivated by the "peace of mind" value type are more likely to respond to a different message such as *"Rest easy, knowing that you done the right thing. Give yourself that peace of mind"*.

The result of more refined segmentation, with accompanying changes to the marketing mix are more likely to achieve repeat usage of the service among existing users and the possibility of increased uptake of the service by non-users. For BSQ, this can improve the likelihood of achieving their target screening rate, which is currently below the desired participation rate of 70%. Other positive outcomes for health services when clients feel that they have received value can include positive opinions about the organisation among the target audience, which can result in positive attitudes or attitudinal loyalty towards the organisation, positive word-of-mouth, and repeat use of the services among existing users (behavioural loyalty) (Russell-Bennett, Previte and Zainuddin, 2009).

Implications for Social Marketing Theory

This research seeks to clarify the concept of value within a government social marketing service context by identifying the value dimensions present in the consumption process of health services. This sets a framework to begin investigations into the sources of value and determining the sources that influence the dimensions of value in health services.

Implications for Public Policy

The government plays a critical role in ensuring that citizens act collectively in order to achieve community goals (Ryan, Parker and Brown, 2003). As such the government intervenes in the market for health care for a number of reasons. For example, citizen-consumers of health care may have imperfect information, or they may be unable to act free of self-interested advice from health care provides, and/or the market may fail by not providing an efficient level of health care (Morris, Devlin and Parkin, 2007). Based on these conditions, governments enact policy to directly finance health care programs (i.e. via taxes and subsidies) to improve social welfare. However, when health policy is informed by an illness paradigm consumer targets for these programs potentially exclude, or at the very least, over look consumers seeking wellness services. As evidenced in this research, such consumers construct value from free government services differently. An understanding of value is increasing in its importance for many commercial organisations (Mele, 2007). This importance naturally extends to non-commercial organisations that undertake social marketing. We argue that policy decision makers need to move beyond applying the economic paradigm, so that they can institute policy that increases consumer value. For government intervention to be desirable it must be able to improve efficiency and equity. Applying the experiential value perspective will assist policy makers in designing social marketing service programs that deliver satisfaction for consumers and other stakeholders (e.g. health care employees, general practitioners) involved in the health care system.

RESEARCH LIMITATIONS AND FUTURE RESEARCH

This study presents some limitations that arise from its theoretical focus and methodological choice. Firstly, the theoretical focus of this paper has been exclusively on an analysis of dimensions of value and does not investigate the impact of the sources of value. Sources of value, such as information (e.g. marketing materials produced by the cancer screening service), service (e.g. providing a sensory experience for consumes such as relief and confirmation of wellness status), interaction (e.g. interaction with employees and the health system) and environment (e.g. the atmospherics and social servicescape), influence consumers' value construction (Smith and Colgate, 2007). Further research is needed to provide a theoretical explanation for these relationships, which in-turn will further refine the research explication of value dimensions in social marketing government services. Additionally, in examining value dimensions in this study, the analysis has focused primarily on benefits received by consumers (economic, social and relational). However, further analysis and research should be undertaken to explicate the sacrifices made (time, effort and risk) by the consumers' using a well women's service. As such the analysis is limited in that it only considers positive value and does not include a consideration of negative value. This study has examined value as a resource that is controlled by women using the service, yet as marketers, we acknowledge that other factors also influence women's value propositions. For example, we need to examine how value is diminished. We believe that the sources of value, as noted above, will impact value in this way. Future research is needed to examine further how the sources of value impact the value dimensions either by increasing or diminishing them. There are different issues for measuring value in a wellness context, compared to a treatment context. Accessing a healthy sample that has not needed any medical services can be difficult. In particular this could lead to high non-response rates due to the lack of relevance of the research inquiry and question items. One of the benefits of our study has been the involvement of BreastScreen Queensland as a partner who provided access to their

customers as a sample. Future studies could follow this example by ensuring that research on health prevention issues involves the health service as a partner. This is likely to overcome some of the difficulties involved in measuring prevention.

Using the current study, the authors have argued and provided interesting exploratory insights into consumers' value construction when using a health care service. Nevertheless, the nature and design of the study limits the generalisability of the findings and implications and in this regard raise a series of potentially attractive avenues for future research. Firstly, to enhance generalisability, the value dimensions identified require evaluation and later testing to gauge the extent to which the ideas are reliable and valid. It is necessary that future research seeks to develop a means of measuring value in order to determine reliability and validity.

Furthermore, from this research social marketers cannot weigh the relative influence of the different value-types on repeat usage behaviour. For example, whilst altruism was a value-type identified in the data, the research does not explicate if this is a primary driver, or a secondary motive that operates in conjunction with other value-types. Further empirical work is needed to examine the relationships and impacts of the value-types on desired behaviours such as preventative screening. In addition, quantitative research is also needed to explicate the typology of users that seek different value-types based on demographic differences, such as income, age and cultural background.

Secondly, the focus of this study has been on breast screening services and women's interpretation of service value. As such, much of the behaviour uncovered is like to be specific to this context. However, men also suffer from breast cancer, and other cancers. Future studies could explore the gender differences and other health sites which provide free-services to the population. Finally, the focus of the current study has been solely on the consumer's behaviour, however, other important stakeholders also influence value constructions, in particular, service employees. Customer-contact employees are a critical asset of service institutions due to the interactive nature of service delivery. This is a worthy

area for future research, which could be used to examine more close the customer-employee relationship in free-service position and the effects of congruence between a customer's self-concept and employee image on important value outcomes in health.

The value dimensions presented in this study contributes to existing knowledge on value in several ways. Firstly, the study demonstrates that the dimensions of value originally developed in commercial marketing are relevant and applicable in social marketing. This suggests that whether the end goal is financial (e.g. profits for the organisation in commercial marketing) or non-financial (e.g. maintenance of positive social behaviour in social marketing), the value sought by individuals can be consistent across both contexts. Secondly, this study presents the dimensions of value as outcomes, rather than factors that influence an overall construct of value. For example, peace of mind (emotional value) and convenience (functional value) are seen as outcomes sought by consumers of health services. This presents implications for empirical measurement of value as existing research on value measures present scale measures that describe value *sources* that influence value outcomes, rather than the value outcomes themselves. Subsequently, further work is required to develop value measures that more accurately measure value outcomes and show a clearer distinction between scale items that measure value outcomes and scale items that measure value sources.

CONCLUSION

The current study was motivated and driven by the lack of research, which documents consumers' views on experiential value when using a free, government service. Whilst it is argued that the present study generates interesting insights, it is also recognised that this research constitutes the first step towards understanding consumers' value interpretations during the consumption of health services. With anticipation, we believe this initial research will stimulate others in social marketing and health care marketing to conduct further research to extend and challenge the ideas and views presented.

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APPENDIX A: ORIGINAL INDIVIDUAL-DEPTH INTERVIEW GUIDE & PROCESS

Individual-depth Interview Guide & Process

Study 1: Identifying types of value and sources of value for consumers of breast screening services

Study 1 Objectives:

1. To determine if consumers follow the consumption process
2. To identify the types of value present in the value creation process model
3. To identify the sources of value present in the value creation process model
4. To identify the stages within the value creation process model where the different types and sources of value are present

PROCESS

A. THANK THE PARTICIPANT FOR THEIR TIME

Interviewer to start with introductions

Thank you for agreeing to participate in this interview today to discuss your experiences with the breast screening services.

There are no right or wrong answers to the questions that we will discuss. I am simply interested in your opinions and experience. This is a completely confidential conversation and information that is recorded and your full name or demographic information will not be kept by the Queensland University of Technology or Queensland Health.

B. EXPLAIN THE PROCESS OF THE INDIVIDUAL-DEPTH INTERVIEW

Today's process involves an individual-depth interview to discuss your opinions and feelings about your service experience. I expect that the complete process will take approximately one hour. I would like to voice record the interview, because this discussion will be transcribed for analysis purposes. When we have completed the analysis, I will write and provide you with a copy of the summary report for feedback and to ensure that your views have been appropriately represented if you wish.

As part of the University's ethical clearance policies, I also require you to complete the two forms in front of you:

1. An ethical clearance form; it is a requirement of the university's research policy to complete this form. The document outlines that the research team will represent your confidentiality and that any information discussed here today will not be used to personally identify you in any publications or conference discussions.

2. Informant details sheet; general demographic information about you. Only members of the research team will be privy to this information.

C. DISCUSSION OF CONSUMPTION PROCESS EXPERIENCED BY RESPONDENTS – PRE-CONSUMPTION STAGE

Objective: to determine if consumers follow the process outlined in the proposed value creation process model and identify types and sources of value at the pre-consumption stage

15 min

To begin, I would like to hear about your thoughts, feelings and opinions about your experiences with having a breast screen. To start, tell me about your experiences in general?

Interviewer to probe for pre-consumption stage of the consumption process

Let's now talk specifically about the things you would expect from a breast screen. What do you hope to gain from consuming this service?

Interviewer to probe for value at pre-consumption stage

How did you come about deciding that these were the things you were hoping to get from this service? What made you decide on these things?

D. DISCUSSION OF CONSUMPTION PROCESS EXPERIENCED BY RESPONDENTS – CONSUMPTION STAGE
Objective: to determine if consumers follow the process outlined in the proposed value creation process model and identify the types of value present at the consumption stage

15 mins

Let's now talk about once you are at the service itself on the day of your appointment.

During your service encounter, while you were at the clinic, were there things that were there that in your opinion impacted on your experience in any way?

Interviewer to probe for sources of value at the consumption stage

E. DISCUSSION OF CONSUMPTION PROCESS EXPERIENCED BY RESPONDENTS – POST-CONSUMPTION STAGE
Objective: to determine if consumers follow the process outlined in the proposed value creation process model and identify the sources of value present at the post-consumption stage

15 mins

After your screen is complete and you are allowed to leave, what happens? Do you reflect or think about your experience at the screening clinic after you leave?

F. DISCUSSION OF REMAINDER OF CONSUMPTION PROCESS – SATISFACTION, BEHAVIOURAL INTENTIONS, AND OUTCOMES
Objective: to determine if consumers follow the process outlined in the proposed value creation process model and identify the sources of value present at the remaining stages of the process model

10 mins

So what are the things that make you decide if you were happy or not happy about your service experience?

Interviewer to probe for how respondents derive satisfaction

As a result of this, what are the things that make you decide that you are going to go back again? Or not go back again?

Interviewer to probe for how respondents derive behavioural intentions

Do you think anyone else, apart from yourself, benefits from you going for a breast screen?

G. DISCUSSION OF CONSUMER PERCEPTIONS OF BSQ
Objective: to understand consumer opinions regarding government services, particularly BSQ

15 mins

I would now like to quickly ask you about your opinions of BreastScreen Queensland.

What do you think of BSQ as a service?

Where do you get your information about breast screening from?

Lastly, what is the most important thing that you hope to get out of having a breast screen?

H. WOULD YOU LIKE TO ADD ANYTHING ELSE, OR RAISE ANY OTHER POINTS?

I. THANK PARTICIPANT FOR THEIR TIME