Missing the mark in marketing healthcare services to emergent populations: Why we go wrong and how we might do better

Gans, R.

Missing the Mark in Marketing Healthcare Services to Emergent Populations: Why We Go Wrong and How We Might Do Better

Roger Gans, PhD
Assistant Professor
Department of Communication, University of Texas at Arlington
Email: roger.gans@uta.edu

Published online, *International Journal of Healthcare Management*, 5/13/2020

LINK TO PUBLISHED ARTICLE

Abstract

Whether because of economic conditions, war, genocide or other reasons, many people are relocating from their under-developed (or under-duress) countries of origin to urban and suburban areas in more peaceful and affluent countries. The close geographic juxtaposition of these newly emerging populations alongside established native populations can lead to significant disparities in the promotion and delivery of healthcare services. An example of this, Hispanic populations are growing rapidly in and around affluent communities across the United States of America. This article explores how under-representation, cultural dissonance, stereotyping, and stereotype threat may be interacting to influence both the content and the effects of health promotion strategies aimed at these newly emerging markets. It concludes with suggestions that may lead to better-targeted marketing strategies that are more equitable as well as more effective for reaching emerging markets in a range of national contexts.

Keywords: Hispanic Americans, healthcare marketing, healthcare disparities, cultural competence, Dunning-Kruger Effect, stereotype threat, health promotion, Hofstede's dimensions of national culture

Wordcount: 2541 (not counting abstract, tables, figures, references)
Figures: 2
References: 22

Missing the Mark in Marketing Healthcare Services to Emergent Populations: Why We Go Wrong and How We Might Do Better

Whether because of economic conditions, war, genocide or other reasons, many people are relocating from under-developed (or under-duress) countries of origin to urban and suburban areas in more peaceful and affluent countries. The rapid growth of Hispanic populations in and around affluent communities across the United States of America (U.S.) is an example of this phenomenon. The close geographic juxtaposition of newly emerging Hispanic markets alongside established "traditional" (e.g., predominantly White) markets has led to increasingly noticeable disparities in the promotion and delivery of healthcare services to these populations.

Although the U.S. Census no longer tracks the countries-of-origin of citizens identifying as White, the majority of U.S. citizens are descended from White European immigrants, and 72.2% identify as non-Hispanic White (U.S. Census, 2018). Those identifying as Hispanic, which includes anyone of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin comprise the largest ethnic minority in the U.S., at 18.1% of the total U.S. population (OMH, 2019).

This article explores how cultural dissonance, unexamined biases and stereotype threat are influencing both the content and the effects of health promotion messages aimed at Hispanic audiences in the U.S. A theory-based assessment of the situation is used as a foundation for suggested approaches to targeted marketing strategies that may be more equitable as well as more effective for reaching emerging markets across a range of national contexts.

Figure 1, below, illustrates the increase of Hispanic populations within 13 of the most affluent (based on median household income/MHI) majority-White counties in the U.S., showing the increase in percentage of Hispanic individuals among the total population of each county.

[INSERT FIGURE 1 NEAR HERE]

In multicultural regions such as the counties described above, health services organizations are finding greater difficulties in connecting with and establishing optimal provider-patient relationships with their newly emerging Hispanic populations than with the longer-established (and predominantly White) populations within their service areas (Markelz, 2016). As a consequence, Hispanic populations are not receiving the same quantity and quality of care as the White populations sharing the same geographic boundaries (Aronson, Burgess, Phelan, & Juarez, 2013; St. Germaine-McDaniel, 2013).

A cursory analysis of this issue underscores the need for greater cultural competence on the part of health services providers (Flores, 2000). Differences of language, tradition, and socio-economic factors cannot be ignored for effective communication of health risks and availability of healthcare services (Fischhoff, Brewer, & Downs, 2011; St. Germaine-McDaniel, 2013). A closer examination of the situation, however, suggests a challenging set of additional underlying influences that may be contributing to the less-than-satisfactory connections between healthcare providers and Hispanic patient populations.

Underserved, Under-Represented, and Under-Targeted

Hispanic adults receive fewer face-to-face or targeted media messages from healthcare professionals than any other major U.S. ethnic group (Pew Research Center Hispanic Trends, 2008). The messages they do receive are likely to be mistargeted (St. Germaine-McDaniel, 2013) and counter-productive (Burgess, Warren, Phelan, Davidio, & van Ryn, 2010).

Before enactment of the Affordable Care Act, also known as ObamaCare, more than 31% of Hispanic adults in the U.S. lacked medical insurance and 25% did not have a regular primary care physician, the highest percentages among U.S. ethnic groups (Pew, 2008). As of 2017,

Hispanics remained the least-insured ethnic group in the U.S., with 17.8% not covered by health insurance compared to just 5.9% of non-Hispanic Whites (OMH, 2019).

In addition to having less opportunity to communicate directly with healthcare professionals, Hispanics in the U.S. have even less opportunity to connect with providers who share their cultural backgrounds. While the overall Hispanic population of the U.S. increased by 243% from 1980 to 2010 (see Figure 1, above), the number of Hispanic physicians per 100,000 of the Hispanic population actually decreased by 22% (Sánchez, Nevarez, Schink, & Hayes-Bautista, 2015). And although Hispanic adults make up 16.9% of U.S. workers, they make up just 10.9% of people employed in hospitals and 9.8% of people employed in nursing care facilities (Bureau of Labor Statistics, 2018).

Hispanic points of view are also not well represented in media communications. Hispanics make up just 8.9% of the people employed in advertising, public relations, media planning and related services in the U.S. (Bureau of Labor Statistics, 2018). Moreover, Hispanic audiences are under-targeted by healthcare marketers. With Hispanics comprising 18.1% of the total U.S. population (U.S. Census Bureau, 2018), pharmaceutical companies spend less than 4% of their marketing budgets on Hispanic-focused ad campaigns (Cultural Marketing Council, 2015). Leaving questions about cultural competence aside, the practical and functional reality of the situation is that the people who make healthcare policies tend to be disproportionately White and Eurocentric—or, what might be termed to contrast with a Hispanic perspective, *Anglo,* a term commonly used by Hispanics to refer to mainstream U.S. culture as well as to non-Hispanic Whites (St. Germaine-McDaniel, 2013). Similarly, the people who craft and disseminate the public communications intended to operationalize and implement healthcare policies—a separate and distinct population—are *also* disproportionately Anglo.

It is important to note the significance of the fact that the healthcare policy makers, marketing managers, message creators, and media buyers are each functionally distinct and separate groups, because any lack of cultural competence in any of their individual outputs is likely to be *multiplied* by the interaction between them. Although cultural competence is a required component of U.S. medical education, there is wide variation in approaches to and outcomes from cultural-competence training in the U.S., with considerable room for improvement (Jernigan, Hearod, Tran, Norris, & Buchwald, 2016). There is no such requirement among the other members of the marketing communications team (Honea, Castro, & Peter, 2017), but each must interact to turn an organization's policy decisions into audience-targeting strategies and messages. If there are multiple levels of cultural incompetence interacting in this process, the product will be a truly broken healthcare marketing campaign.

Anglo-targeted policies, strategies and services may not translate. Long-established healthcare systems tend to target their marketing strategies and messages toward their region's traditional healthcare consumers, i.e., Anglos. Marketing campaigns may be designed to promote a regional medical center's feeder-network of primary care physicians (e.g., *"Your family deserves a family doctor!"*) or utilization of its most profitable service lines (e.g., *"Don't let arthritis get you down. Replace that hip and go out on the town!"*).

To address growing Hispanic markets, it has been common to simply translate the English-language marketing messages into Spanish, with little or no consideration of whether the underlying policies or persuasive message strategies might be effective with Hispanic audiences (Markelz, 2016; St. Germaine-McDaniel, 2013). Differences in dimensions of national culture have been shown to influence the effectiveness of doctor-to-patient communication in healthcare settings (Mazzi, Rimondini, van der Zee, Boerma, Zimmermann, & Bensing, 2018; Meeuwesen,

van den Brink-Muinen, & Hofstede, 2009). Examination of some of these differences may offer some insight into why translated messages often do not connect. Differences in cultural norms between Anglos and Hispanics[1] in the dimensions of Power Distance and Individualism/Collectivism (Hofstede, 2011) are especially stark, as shown in Figure 2, below.

[INSERT FIGURE 2 NEAR HERE]

In the diagram, the values for "Anglos" are taken from Hofstede's (2011) measures of U.S. national culture; the values for "Hispanics" are from his measures of Mexican national culture. The dimensions of Power Distance and Individualism/Collectivism are highlighted because they illustrate the cultural gulf that can exist between people of differing national origins. The extent of the disconnect between common Anglo-sourced message strategies and common Hispanic audience sensibilities is suggested in their positions in the two-dimensional culture model presented in Figure 2.

The relatively low power-distance score for Anglos suggests Anglos routinely operate from a belief that they can exert power over their condition in life; it is acceptable to question authority and challenge fate. The high power-distance score for Hispanics, in contrast, suggests an operating belief that their condition in life is pre-determined and should just be accepted; questioning authority is discouraged. Anglos' high score for Individualism suggests they routinely operate from a belief that everyone should look after their own interests first; it is important to make up your own mind. Hispanics' low Individualism score (which reflects a high degree of Collectivism on the "Individualism-Collectivism" continuum) suggests they routinely operate from the belief that one's decisions and actions should be based on the needs, beliefs,

[1] Hispanic peoples in the United States, although from more than 20 Latin American countries of origin, are heavily represented by Mexican culture, with Mexicans comprising nearly two-thirds of all U.S. Hispanics (Wilcox et al., 2015).

and opinions of the "in-group," which Hofstede (2011) defines as the family, community or affinity group the individual most strongly feels a part of. Collectivists tend to follow the traditions of their in-groups, and so they are less likely than Individualists to challenge the accepted wisdom of their in-group elders or follow the advice of "out-group" experts.

People in individualistic cultures, such as Anglos, are more likely to be influenced by medical professionals in their decision making, not just because they are more likely to actually be in contact with medical professionals, but also because the influential messages they receive are likely to be conceived and communicated from an individualistic perspective. But if those messages urge individuals to exercise personal responsibility for their condition and initiate actions not commonly accepted among their in-groups, the messages may not connect with people from collectivist cultures.

Consequences of stereotyping may not be obvious. Aside from *how* healthcare services are marketed, stereotypical assumptions about Hispanic populations can influence *which* services are marketed toward Hispanics. Hospitals in the U.S. depend on revenue from provision of services, with schedules of reimbursement determined by insurance companies and U.S. government's Centers for Medicare and Medicaid Services. Facing financial pressures regarding reimbursement rates, hospital systems often focus their mainstream marketing efforts on their most profitable service lines—e.g., cardiology, orthopedic joint replacement, high-tech elective surgery (Ellison, 2019)—which may not be accessible or available for patients with less-than-premier-quality insurance coverage. Influenced by the stereotype that Hispanics are largely uninsured, providers may limit their Hispanic-targeted marketing promotions to clearly funded services such as Medicaid-supported maternity and primary care services and grant-supported cancer screenings. This kind of strategy can short-change the healthcare systems as well as the

regions' Hispanic populations because, although Hispanic populations may be more likely than Anglos to be uninsured, members of the Hispanic community are still far more likely to be insured than to be uninsured (OMH, 2019; Pew, 2008).

This consequence of stereotyping may not be the most impactful however. *Stereotype threat* is an increasingly studied phenomenon likely to occur "when cues in the environment make negative stereotypes associated with an individual's group status salient, triggering physiological and psychological processes that have detrimental consequences for behavior" (Burgess et al., 2010, p. S169). The result can be an amygdalic "flight-or-fight" response, increased anxiety, and decreased working memory.

Stereotype threat can be triggered for Hispanic patients by all manner of cues in the clinical environment or health promotion messaging that might escape the notice of Anglo clinicians and message makers. For Hispanics, the cues can conjure "the stereotype of minority patients as unintelligent, 'second class citizens', and unworthy of good care (i.e., wasting the provider's time)" (Burgess et al., 2010, pp. S169-S170).

Not seeing anyone who looks Hispanic in a waiting room can be such a cue. Simply providing one's name to the receptionist or hearing a healthcare provider mispronounce one's name can also activate the sense of being judged pejoratively. Seeing ads obviously intended for Anglos can be such a cue. But even ads that seem purposely targeted towards Hispanics can also trigger stereotype threat if the ads' depiction of Hispanics does not ring true.

Activation of stereotype threat can impair patients' ability to understand their healthcare providers' instructions, remember to provide important diagnostic information, ask important questions, or seek medical treatment at all (Burgess et al., 2010). For Hispanic individuals, inadvertent activation of stereotype threat can lead to avoidance of preventive care such as

routine screenings and annual check-ups, and over-reliance on emergency room services. For healthcare providers, this can result in lost revenues, higher (and often non-reimbursable) emergency department expenditures, and failures of public health policies. And it means bad outcomes for both.

Suggested Solutions and Directions for Research

Finding ways to reduce healthcare disparities and better engage with underserved populations is an important area of concern for healthcare communicators. Following are some suggestions for addressing issues of cultural dissonance and stereotype threat.

Raise the bar on cultural competence. It has been famously documented that incompetent people tend to think of themselves as above average (Kruger & Dunning, 1999). Healthcare providers are not exempt from this issue when it comes to cultural competence and cross-cultural communication (Dunning, 2011; Ehrlinger, Gilovich, & Ross, 2005). Providers should be educated to assume they are probably not, in fact, culturally competent. For instance, when a patient smiles and nods in response to a statement, it may not signify understanding or agreement. Follow-up questions are often advisable.

Build a pipeline to support recruitment and hiring practices. Increased aggressiveness in recruiting practices with greater focus on Hispanic physicians could help increase utilization and effectiveness of care, but a longer-term perspective is required. Healthcare policymakers should work to build the pipeline of future Hispanic healthcare providers by promoting healthcare as a desirable and viable career path for Hispanic young people starting in elementary school. Modest investments in in- and after-school health-science programs and scholarships could pay long-term dividends.

Increase representation on both sides of the camera. Healthcare executives should give greater consideration to hiring Hispanic marketing directors and Hispanic-led marketing firms, and increasing representation of Hispanics as advertising actors, models, writers, and producers.

Don't rely on translated strategies and messages. Strategies designed to resonate with people from individualistic cultures are not likely to connect with people from collectivist cultures.

Use Hispanic-preferred media and messengers. Hispanic media outlets are broadly underutilized by healthcare advertisers, which can make it easy for your organization to stand out. But don't simply run your Anglo-focused messages in Spanish; start with research-driven strategies, then use Hispanic writers, spokespeople, and media vehicles that can connect with authenticity.

Portray Hispanic individuals as smart, healthy, and good decision-makers. One way to combat stereotype threat is to provide positive alternatives to the stereotype. Align depictions of traditional Hispanic healthcare decision-makers with healthy choices and behaviors. And include positive portrayals of Hispanic families in run-of-market advertising, not just Hispanic-targeted advertising.

Don't skimp on your research. Assume your assumptions are probably wrong (see Ehrlinger et al., 2005). Conduct ethnographic studies, surveys, focus groups, and interviews to learn what the actual perceived needs of your particular market are, which messages are working, and how best to connect with your audiences.

Construct messages from a Collectivist perspective. Emphasize extended family responsibility (e.g., "Stay healthy so you can take better care of your family"), depict in-group

approval for healthy decisions (e.g., “You’ll make your *abuela* proud”), and use pluralistic pronouns (“we,” “us,” “our”) rather than individualistic ones (“I,” “me,” “mine”).

Avoid stereotyping triggers. This is easier said than done, but it helps to realize you may be blind to them. For best results, apply the suggestions above, with particular attention to assumptions about your own cultural competence (see Kruger & Dunning, 1999; and Dunning, 2011).

References

Aronson, J., Burgess, D., Phelan, S.M., & Juarez, L. (2013). Unhealthy interactions: The role of stereotype threat in health disparities. *American Journal of Public Health, 103*(1), 50-56.

Bureau of Labor Statistics (2018). Labor force statistics from the current population survey. *Bureau of Labor Statistics, United States Department of Labor.* Retrieved from https://www.bls.gov/cps/cpsaat18.htm

Burgess, D.J., Warren, J., Phelan, S., Davidio, J., & van Ryn, M. (2010). Stereotype threat and health disparities: What medical educators and future physicians need to know. *Journal of General Internal Medicine, 25* (Supplement 2), S169-S177.

Cultural Marketing Council (2015, June 11). Pharmaceutical companies lag behind in Hispanic targeted ad spending: Study shows minor increase in corporate efforts to target Hispanics. Retrieved from http://www.culturemarketingcouncil.org/News/Press-Releases/Hispanic-Ad-Spend-Pharmaceutical

Dunning, D. (2011). The Dunning-Kruger effect: On being ignorant of one's own ignorance. *Advances in Experimental Social Psychology, 44*, 247–296.

Ehrlinger, J., Gilovich, T., & Ross, L. (2005). Peering into the bias blind spot: People's assessments of bias in themselves and others. *Personality and Social Psychology Bulletin, 31*(5), 680-692. DOI: 10.1177/0146167204271570

Fischhoff, B., Brewer, N.T., & Downs, J.S. (Eds.) (2011). *Communicating risks and benefits: An evidence-based user's guide* (pp 1-2). FDA publication available for download at: http://www.fda.gov/AboutFDA/ReportsManualsForms/Reports/ucm268078.htm

Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in healthcare. *The Journal of Pediatrics, 136*(1), 14-23. Retrieved from https://www.jpeds.com/article/S0022-3476(00)90043-X/fulltext.

Hofstede, G. (2011). Dimensionalizing cultures: The Hofstede model in context. *Online Readings in Psychology and Culture*, Article 8. Retrieved from https://scholarworks.gvsu.edu/orpc/vol2/iss1/8/

Honea, H., Castro, I.A., & Peter, P. (2017). Evidence items as signals of marketing competencies and workplace readiness: A practitioner perspective. *Journal of Marketing Education, (39)*3), 145-161.

Jernigan, V.B.B., Hearod, J.B., Tran, K., Norris, K.C., & Buchwald, D. (2016). An examination of cultural competence training in U.S. medical education guided by the tool for assessing cultural competence training. *Journal of Health Disparities Research and Practice, 9*(3), 150-167.

Kruger, J., & Dunning, D. (1999). Unskilled and unaware of it: How difficulties in recognizing one's own incompetence lead to inflated self-assessments. *Journal of Personality and Social Psychology, 77*(6), 1121-1134.

Markelz, M. (2016). Is marketing perpetuating Latino health disparities? *Marketing Health Services*, *36*(1), 24-27.

Mazzi, M.A., Rimondini, M., van der Zee, E., Boerma, W., Zimmermann, C., & Bensing, J. (2018). Which patient and doctor behaviours make a medical consultation more effective from a patient point of view. Results from a European multicentre study in 31 countries. *Patient Education and Counseling, 101*(10), 1795-1803.

Meeuwesen, L., van den Brink-Muinen, A., & Hofstede, G. (2009). Can dimensions of national culture predict cross-national differences in medical communication? *Patient Education and Counseling, 75*(1), 58-66.

OMH (2019, August 22). Profile: Hispanic/Latino Americans. *U.S. Department of Health and Human Services Office of Minority Health (website).* Retrieved from https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64

Pew Research Center Hispanic Trends (2008, August 13). Hispanics and healthcare in the United States. Retrieved from http://www.pewhispanic.org/2008/08/13/hispanics-and-health-care-in-the-united-states-access-information-and-knowledge/

Pew Research Center Hispanic Trends (2016, September 6). Hispanic population growth and dispersion across U.S. counties, 1980-2014. Retrieved from https://www.pewhispanic.org/interactives/hispanic-population-by-county/

St. Germaine-McDaniel, N. (2013). The emerging Hispanic use of online health information in the United States: Cultural convergence or dissociation? In *User-driven healthcare: Concepts, methodologies, tools, and applications, Vol. 1* (pp. 1607-1621), Hershey, PA: Information Resources Management Association.

Sánchez, G., Nevarez, T., Schink, W., & Hayes-Bautista, D.E. (2015). Latino physicians in the United States, 1980-2010: A thirty-year overview from the censuses. *Academic Medicine, 90*(7), 906-912. doi: 10.1097/ACM.0000000000000619

U.S. Census (2018). Annual estimates of population of United States: 2018 American Community Survey. *United States Census Bureau*. Retrieved from https://data.census.gov/cedsci/all?q=Annual%20estimates%20of%20population%20of%20United%20States&g=0100000US&hidePreview=false&tid=ACSDP1Y2018.DP05&t=Counts,%20Estimates,%20and%20Projections&vintage=2018&layer=VT_2018_040_00_PY_D1&cid=DP05_0001E

U. S. Census (2018, July 1). QuickFacts.: United States. Retrieved from https://www.census.gov/quickfacts/fact/table/US/PST045217

Wilcox, D.L., Cameron, G.T., & Reber, B.H. (2015) *Public relations strategies and tactics, eleventh edition.* Upper Saddle River, NJ: Pearson

FIGURES AND TABLES

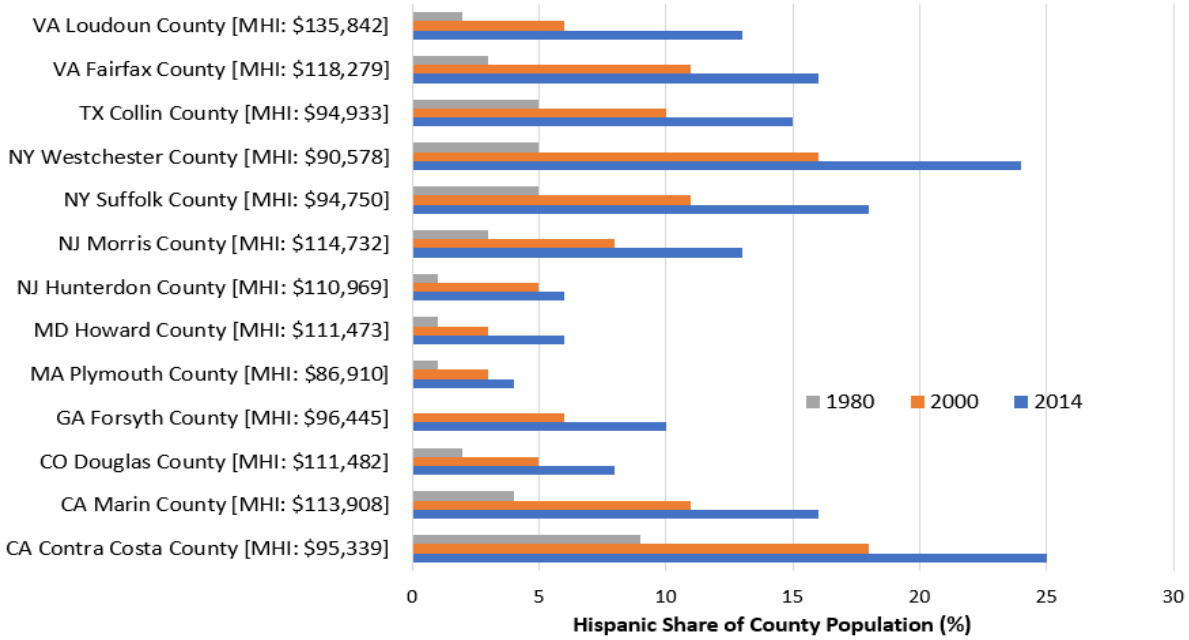

Figure 1. Growth in Hispanic share of population in 13 affluent counties, 1980 – 2014.

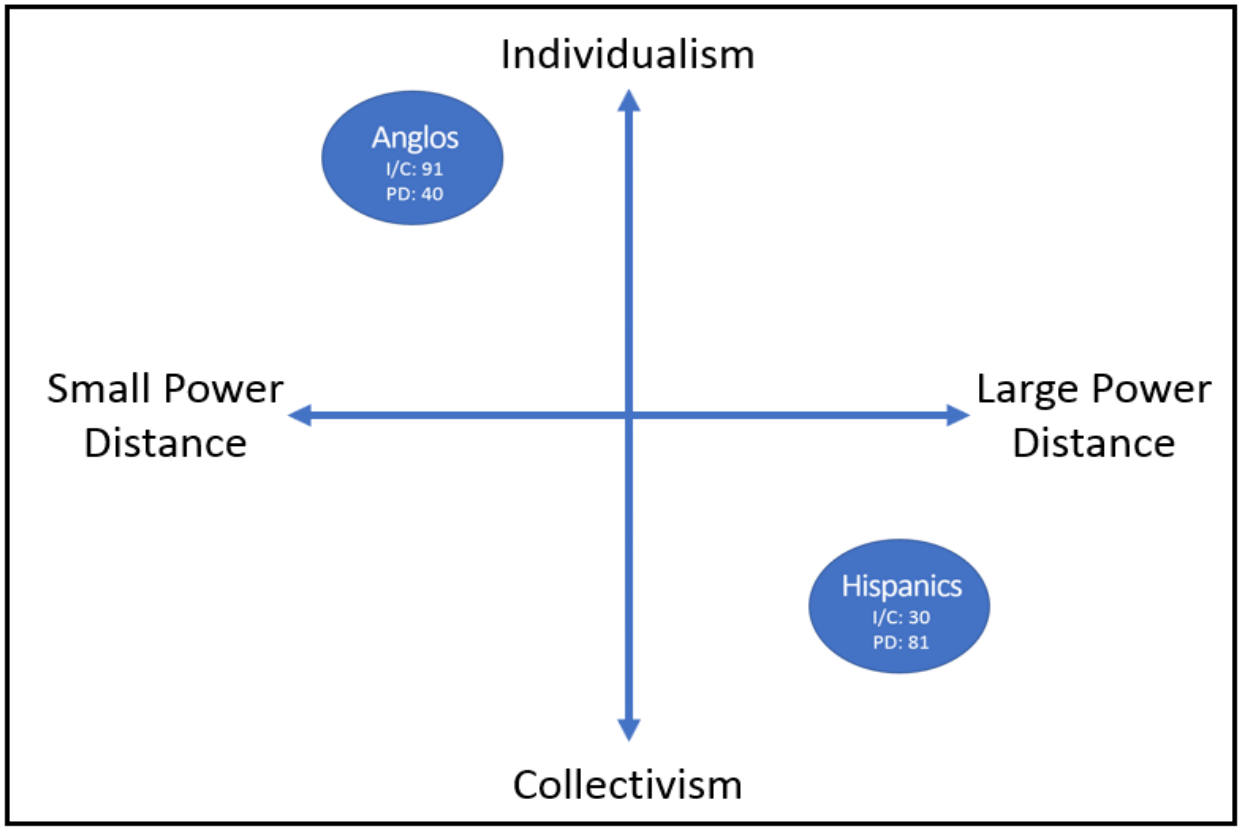

Figure 2. Two-dimensional model of cultural disconnection between Anglos and Hispanics. (Data source: https://geerthofstede.com/research-and-vsm/dimension-data-matrix/)