THE PHARMACEUTICAL MARKET'S COMPLAINING PROCESS: AN APPLICATION OF HIRSCHMAN'S THEORY TO A PUBLIC POLICY PROBLEM

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ABSTRACT

The pharmaceutical industry provides products to society that improve the health status of its population. It currently performs in a free market system, although the products and promotional material are subject to regulations imposed by the Food and Drug Administration (FDA). Given the unique characteristics of the prescription drug market, its responsiveness to consumer needs is questioned by policy makers. Hirschman's theory for explaining consumer-industry relationships provides a mechanism of market evaluation unique from traditional static economic analysis. This paper begins by asking patients, who will be referred to as consumers, if they are bothered with three aspects of the prescription drug product-safety, effectiveness, and price. The second part describes the complaining process in the prescription drug market. The contribution provided by this paper is the application of Hirschman's theory to a public policy question.

THE COMPLAINING PROCESS FROM THE CONSUMER BEHAVIOR PERSPECTIVE

Westbrook (1987) defines complaining as "consumer-initiated communications to marketers, their channel members, or public agencies to obtain remedy or restitution for purchase- or usage-related problems in particular market transactions." The first component in the complaining process is a consumer identified purchase-or usage-related problem. Traditionally researchers use dissatisfaction as a precursor to the act of complaining (Blodgett and Granbois 1992). A recent study of the high blood pressure drug market found a higher percent of the persons (70.2%) were bothered with at least one specific attribute of the prescription drug therapy than those who stated they were dissatisfied (2.0 to 4.4%) with three more global aspects of the prescription drug therapy-the physician, the pharmacist, and the prescription drug product. The term "bothered" was selected from focus group interview. The authors explained, "It appears that using operationalizations with which respondents were familiar led to greater reports of negative post-exchange feelings (Pathak, et al 1993)."

After consumers experience a negative post-exchange event, actions that may follow include (1) complaining to a channel member, (2) complaining to non-channel members, (3) exiting the market, or (4) doing nothing at all. Hirschman (1970) theorized the role of the consumer is to behave in response to any deviations from an expected "norm" in product or service performance. This post-exchange behavior is dependent on the availability of substitute products, the consumer cost to shift from one firm to another and other consumer demographics. These consumer characteristics are the ability to articulate, the degree of discontent, and the loyalty towards the firm or product.

Day and Landon (1979) later described complaining behavior as a function of (1) propensity to complain, (2) opportunity to become dissatisfied, (3) opportunity to complain, (4) and individual knowledge. The propensity to complain was defined by the circumstances of the purchase and product use, expectations, tastes and personality factors. Opportunity to become dissatisfied was measured by the number of transactions and the value of the purchase. Opportunity to obtain redress or complain was defined as the consumer's access to product distribution channel. The final component, consumer knowledge, would convey the ability to identify the cause of their dissatisfaction.

Andreasen (1991) matched the complaining behavior framework with the needs of policy makers. He proposed the objectives of social policy research should assess if exchanges in the market are fair, equitable, safe, and contribute to improved economic and social welfare. Andreasen applied Hirschman's theory of consumer voice/exit

behavior as a mechanism to patrol market failure in the physician market. The physician market involved consumers who may not have information about alternative physician choices, who feel a considerable sense of loyalty to their physicians, who perceive a high level of costs associated with changing physicians, and who may perceive societal norms against shopping around for physicians. Therefore, one can expect a greater number of vulnerable consumers in such a market than other consumer markets. Andreasen found 22.9% of his sample expressed dissatisfaction with physician services. These respondents possessed characteristics that fell into one of three groups (1) frequent encounters with the physician, (2) ability to detect problems, and (3) assertive. Just as Hirschman and Day and Landon theorized, Andreasen found those consumers who had opportunity to experience dissatisfaction were more likely to be actually dissatisfied. Consumer knowledge and concern about health care described those persons who were able to identify problems with their physicians. Finally, consumers with higher income level, higher education level, and who were younger were more likely to find problems. Of those who were dissatisfied, 11.2% voiced their complaints or took some other action and 63.2% switched physicians. Andreasen (1985) concluded that it appeared the health care market, specifically the physician market, was not policed by its consumers.

The outcome of the complaining process is evaluated by consumer satisfaction with the firm's response. The firm's failure to respond to consumer complaints may be explained by two events. First, the complaining process may prohibit consumers to complain to the appropriate channel member. Second, the firm may choose to ignore the consumer complaints. Intentional avoidance of market signals may warrant intervention from regulators.

Andreasen and Best (1977) studied consumer perception of complaint resolution. They found only 25% of the consumers perceived their problems were resolved whether they complained or not. Consumers felt that 56.5% of their complaints for all products and services received a satisfactory response from business. There was a greater percent of satisfactory responses (62.4%) to complaints filed for frequently purchased products, and a lower frequency rate for services (43.9%). When examining services in more detail, medical and dental services offered a satisfactory resolution to only 34.5% of complaints. Andreasen and Best warned the failure of business to respond to complaints could lead to other means of problem resolution. The outcome of the complaining process is therefore consumer satisfaction with complaint resolution. It is expected that failure to satisfy the complainer can perpetuate the complaining process or an alternative process may be called upon, namely external regulations.

THE U.S. PRESCRIPTION DRUG MARKET

Policy makers argue the U.S. prescription drug market requires regulations that would restore equity and improve the distribution of resources from the societal perspective. The pricing practices of pharmaceutical firms have been the target of criticism during the past three decades. Recently, the issue of drug prices has gained visibility of the general public. The first argument against the drug industry is that prescription drug prices increase faster than the general inflation rate. Also, Americans pay more for the same products as citizens of other industrialized nations. Industry critics state that the inequity in the pharmaceutical market is explained by the inelastic demand curve for pharmaceuticals and the freedom given to the manufacturers under the U.S. economic system (Price Increases...1985; Price Increases...1987; A Status Report, 1992; Prescription Drugs...1989).

Differential pricing strategies used by drug firms is one example of inequity in the prescription drug market. In 1991, prescription drug prices increased at an average of 9.6% for the retail private pay (uninsured) consumer. The inflation rate for prescription products for the hospital market was 5.0% and it was 6.0 to 7.0% for the managed care market (Schondelmeyer 1992). The industry explains that health care organizations that represent a large share of the market reduce the cost of distributing their products in that market. This savings is passed on in the form of discounted prices. Thus consumers who do not have prescription drug insurance therefore pay a higher price for prescription drug.

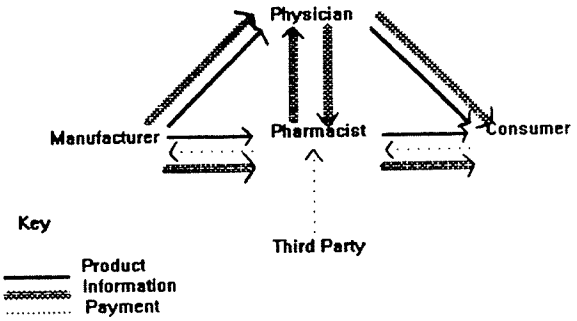
The industry responds to critical arguments with evidence of new products and their clinical contribution. First, pharmaceutical firms invest 16. 1% of sales in research and development (R&D), compared to 3.6% for the average industry. The cost of conducting R&D averages $231 million and takes 12 years for one product to reach the market after it is discovered. Pharmaceuticals have contributed to the reduction in mortality rates, particularly for infectious diseases and cardiovascular diseases. The average life expectancy for a person born in 1920 was 54.1 years, compared to 75.3 years today (Facts...1992).

Industry critics respond by stating that over half of the drugs discovered during 1985 through 1990 were "me-toos" or not innovative and therefore do not provide any clinical advantages. However, these non-innovative products enter at the same or higher price as the market leader. The increased number of products in a therapeutic market does not lead to price competition (Office of Technology...1993).

The exchange process for prescriptions is unique from most consumer products. The prescription drug demand curve is derived by the physicians rather than the actual users of the products. The product is selected based on the disease condition of the patient. The prescriber considers the effectiveness and safety profile of the product. Because prescribers have no financial stake in the purchase, their decision is often not sensitive to price. The prescription is then purchased at the pharmacy when it is either paid in cash by the consumer or paid by a third party agent. The complexity of the pharmaceutical market is depicted in Figure 1 which describes the flow of information, product and money between the manufacturer, physician, pharmacist, third party payer and the consumer (patient).

Policy makers express the need to protect the consumer because they feel the consumer is a vulnerable participant in the prescription drug exchange process. Critics state the inelasticity of demand for pharmaceuticals and the monopolistic power possessed by the firms allow them to price their products at unreasonable levels. According to Hirschman's theory, if the price of a product is too high the consumer may complaint, signaling the firm of its deviation from the norm. Inopportunity to do so because of forces beyond the control of the consumer would indicate that they are indeed vulnerable and further regulations are needed to protect them. If the exchange between the consumer and the firm is equitable, then the response from the firm should satisfy the needs of the consumer. Consumer needs can be met if firms provide them with a satisfactory response to their complaints.

Figure 1
Movement of Economic Resources in the Pharmaceutical Market



In summary, Day and Landon proposed and Andreason and Best demonstrated that consumers must have opportunity to experience the transaction, to access the complaining channel, and to be motivated to enter the complaining process. After the complaint has been registered with the channel member, its resolution must be satisfactory to the consumer, or else the complaining process is perpetuated. Failure to resolve complaints may be perceived as businesses intentional avoidance and thus warrant further action from outside forces. Thus the complaining process and its outcome is proposed as an mechanism to evaluate the responsiveness of the pharmaceutical market.

The complaining process in the prescription drug market must first be explored. This study evaluated the complaining process with respect to three product characteristics- safety, effectiveness, and price. The first two characteristics must be proven before the Food and Drug Administration

approves the drug to be sold in the general patient population. The third characteristic is currently under debate as to whether it should be regulated. The study of the complaining process for each product characteristic was done to capture the possible variability due to the complexity of the pharmaceutical market.

The following objectives were included in the study:

1. Identify market channels used by consumers to voice their complaints with pharmaceuticals.

2. Assess consumer satisfaction with the complaining process for pharmaceuticals.

3. Identify post-purchase behavior of non-complaining, but bothered consumers.

4. Identify reasons why bothered consumers do not voice their complaints.

5. Identify the demographics of non-complaining and bothered consumers.

METHODOLOGY

Survey research was used to study the complaining behavior of prescription drug consumers. The population was limited to residents of a midwestern state. The sampling frame was developed with the assistance of pharmacies in 21 metropolitan statistical areas of 50,000 or greater. Pharmacies were selected randomly from a mailing list acquired from a local college of pharmacy. A total of 100 community-based pharmacies were contacted. The pharmacist was asked to distribute fliers, describing the study, to patients. The following were the population criteria:

1. resident of the midwestern state

2. purchased prescription drug for themselves or a dependent

3. prescribed drug must be used for the first time by the patient

4. purchase experience must have occurred within one week to six months ago

From the sampling frame, a sample of 400 was randomly selected.

The survey instrument consisted of four parts. Part I consisted of questions about the purchase experience. The participants were asked to describe their product and their service encounter. Parts II-IV asked the participants to indicate the level of being bothered with a particular aspect of the product. Then they were asked to identify actions they took after they purchased the prescription, including complaining. If the respondent complained, they were asked to identify to whom they complained and the level of satisfaction they felt with the resolution of their complaints. If the consumers did not complain, they were asked to express their reasons for their decision. The participants were allowed to choose multiple answers. These questions were duplicated for three aspects of the product- safety, effectiveness and price. Part V of the questionnaire acquired basic demographic information and prescription drug payment information. Appendix A contains the questionnaire.

RESULTS

A total of 400 surveys were mailed to persons who had initially agreed to complete the survey. There were 310 returned surveys of which 277 were usable. The response rate for the study was 69.3%. Cronbach's Coefficient Alpha for the survey instrument ranged from 0.68 to 0.87.

The mean value of the level of being bothered with the three aspects of the prescription drug product ranged from 3.04 (safety) to 3.25 (price). The higher values indicated a higher degree of being bothered. There were 22.7%, 19.9% and 21.4% of the respondents who indicated a higher level of bothered feelings with effectiveness, safety, and price, respectively. Table 1 summarizes the results of the bothered scale.

Table 1
Consumer Level of Being Bothered with Effectiveness, Safety and Price of Pharmaceuticals

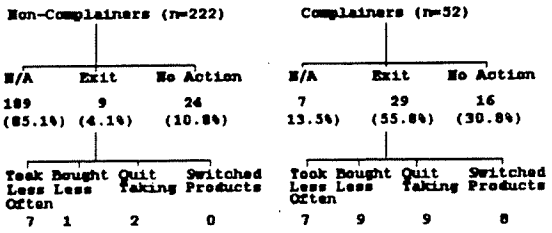
Product Characteristic	Mean (s.d.)	Number of Ratings > 4
Effectiveness (n = 277)	3.16 (2.04)	63 (22.7 %)
Safety (n = 277)	3.04 (1.96)	55 (19.9 %)
Price (n = 271)	3.25 (2.08)	58 (21.4 %)

* Multiple answers were allowed for this question.

POST-PURCHASE ACTIONS OF COMPLAINERS AND NON-COMPLAINERS

The post-purchase actions of the respondents were divided into two categories: complainers and non-complainers. The results indicate complainers also choose other actions to remedy their negative situation. Therefore, voicing and exit behaviors are not mutually exclusive. Another important finding is the majority of consumers who complained about prices chose no other action. This was not the case for those who complained about product safety or effectiveness.

Figure 2
Post-Purchase Behavior in Prescription Drug Market (Effectiveness) (N=274)



Certain consumers will exit the market without voicing a complaint. This represented 3.5% to 4.1% of the noncomplainers when the safety or the effectiveness of the product bothered them, respectively. Only one consumer chose to exit because of price. Figures 2 through 4 illustrate the post-purchase actions with respect to the three aspects of the prescription product for complainers and non-complainers.

Figure 3
Post-Purchase Behavior in Prescription Drug Market (Safety) (N=272)

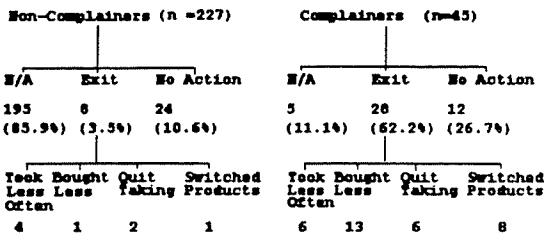
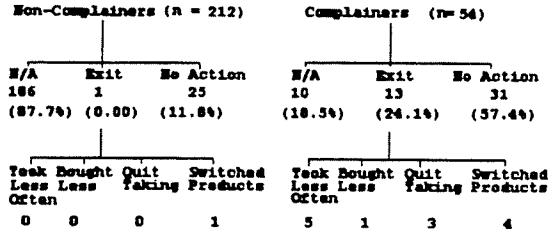


Figure 4
Post-Purchase Behavior in Prescription Drug Market (Price) (N=266)



THE COMPLAINING PROCESS

The majority of the complainers contacted the physician for issues of safety and effectiveness. The pharmacist was contacted for concerns about price. Another important group to whom consumers voice complaints is family and friends, even though this group may not offer a solution to

their problems. Also, some respondents complained to more than one channel member. There were 14 multiple answers for effectiveness, 17 for safety and 21 for prices. Thus, consumers do not make a mutually exclusive decision when selecting the person to voice complaints. Finally, consumers do not complain to manufacturers, thus they appear to be insulated from consumer voice. Table 2 summarizes the persons contacted by the respondents.

Table 2
Complaining Channel Members

	Effectiveness	Safety	Price
Prescriber	39 (75.0%)	35 (77.8%)	13 (24.1%)
Pharmacist	9 (17.3%)	15 (33.3%)	31 (57.4%)
Manufacturer	1 (0.02%)	0	1 (0.02%)
Family/Friends	17 (32.7%)	16 (35.6%)	29 (53.7%)
Total Complaints*	52	45	54

* Multiple answers were allowed for this question.

SATISFACTION WITH THE COMPLAINT RESOLUTION

Consumers were satisfied with how complaints about effectiveness and safety were handled by physicians, however, complaints about prices were not resolved as satisfactorily.

Table 3
Consumer Satisfaction with Complaint Resolutions (mean satisfaction score, number of respondents rating > 4)

	Effectiveness	Safety	Price
Prescriber	5.38	5.51	3.38
	27 (69.2%)	27 (77.1)	2 (15.4%)
	n = 39*	n = 35	n = 13*
Pharmacist	4.71	5.17	4.31
	6 (66.7%)	9 (75.0%)	13 (44.8%)
	n = 9*	n = 15	n = 31
Manufacturer	-	-	7.00
	-	-	1 (100%)
	n = 1**	n = 0	n = 1

* 2 respondents marked not applicable.
** 1 respondent marked not applicable.

Table 3 summarizes the satisfaction scores. Satisfaction was rated on a seven-point Likert Scale with one indicating a low level of satisfaction, seven indicating a high level of satisfaction and four was marked as neutral.

EXPLANATION OF NON-COMPLAINING BEHAVIOR

The explanations of non-complaining behavior were categorized into three groups: (1) perceived value of complaining, (2) the complaining process, (3) consumer personality. Of the three groups, the perceived value of complaining was the most common reason for not complaining. Table 4 lists the explanations for not complaining.

Table 4
Reasons for Not Complaining About Effectiveness, Safety and Price

Reasons	Effectiveness	Safety	Price
Value of Complaining:	n = 225	n = 232	n = 223
It was not worth the effort.	37 (16.4)	36 (15.5)	43 (19.3)
It was not important to me.	36 (16.0)	34 (14.7)	33 (14.8)
Complaining Process:			
I did not know to whom to complain.	19 (8.4)	26 (11.2)	24 (10.8)
It is difficult to approach the appropriate person.	22 (9.8)	24 (10.3)	29 (13.0)
..because not much was done the last time I complained.	15 (6.7)	17 (7.3)	22 (9.9)
Personality:			
I wanted to avoid the confrontation.	14 (6.2)	19 (8.2)	22 (9.9)
Complaining is not nice.	15 (6.7)	19 (8.2)	25 (11.2)
I am not assertive.	24 (10.7)	23 (9.9)	26 (11.6)
			n = 18

CONSUMER DEMOGRAPHICS

A statistically significant relationship between consumer demographics and being bothered with a particular aspect of the prescription drug was found. As expected persons with a higher education level, with a higher income, and those

without prescription drug insurance were bothered with the price of the prescription product. There was also a significant relationship between income level and being bothered with the effectiveness of the product. Those with lower income were more likely to be concerned with this latter issue.

Table 5
Level of Being Bothered (Score > 4 on Likert Scale) and Consumer Demographics

Demographics	Effect	Safety	Price
Age			
<= 55	46 (73.0)	43 (78.2)	45 (77.6)
> 55	17 (27.0)	12 (21.8)	13 (22.4)
	n = 63	n = 55	n = 58
Sex			
Male	14 (22.2)	12 (21.8)	45 (77.6)
Female	49 (77.8)	43 (78.2)	13 (22.4)
	n = 63	n = 55	n = 58
Education Level			
<= High School	11 (17.5)	5 (9.1)	3 (5.2)*
H.S. Diploma	20 (31.7)	19 (34.5)	12 (20.7)
Some College of	21 (33.3)	20 (36.4)	20 (34.5)
College Degree	11 (17.5)	11 (20.0)	23 (39.7)
	n = 63	n = 55	n = 58
Income Level			
<= $13,400	30 (49.2)*	20 (39.2)	13 (22.8)*
13,401 - 30,000	16 (26.2)	13 (25.5)	20 (35.1)
> 30,000	15 (24.6)	18 (35.3)	27 (47.4)
	n = 61	n = 51	n = 57
Insurance			
Prescription	46 (73.0)*	45 (81.8)	36 (62.1)**
Hospital	55 (87.3)	49 (89.1)	50 (86.2)
Physician	46 (73.0)	43 (78.2)	45 (77.6)
	n = 63	n = 55	n = 58

* Statistically significant difference between demographic variables and bothered rating with aspects of prescription drug product at $p < 0.05$.
** Statistically significant difference between demographic variables and bothered rating with aspects of prescription drug product at $p < 0.10$.

The demographics of those consumers who were bothered with specific product attributes did not share the same relationship with complaining behavior. First, although there was difference between the level of being bothered for men and women, women were more likely to complain about the product effectiveness and price. Second, even though the more educated consumer were more likely to be bothered about the price of the prescription, they were not more likely to complain. There was no relationship between education level and complaining. There was also an inverse relationship between the level of income and complaining about safety and effectiveness.

Table 6
Demographics of Complainers about Effectiveness, Safety and Price, frequency (%)

Demographics	Effect	Safety	Price
Age			
<= 55	43 (79.6)	37 (78.7)	37 (68.5)
> 55	11 (20.4)	10 (21.3)	17 (31.5)
	n = 54	n = 47	n = 54*
Sex			
Male	10 (18.5)	11 (23.4)	23 (42.6)
Female	44 (81.5)	36 (76.6)	31 (57.4)
	n = 54*	n = 47	n = 54*
Education Level			
< High School	8 (14.8)	9 (19.1)	5 (9.3)
High School Diploma	20 (37.0)	13 (27.7)	12 (22.2)
Some College of	16 (29.6)	15 (31.9)	19 (35.2)
College Degree	10 (18.5)	10 (21.3)	18 (33.3)
	n = 54	n = 47	n = 54
Income Level			
<= $13,400	22 (42.3)	24 (55.8)	16 (29.6)
13,401 - 30,000	15 (28.8)	11 (25.8)	17 (31.5)
> 30,000	15 (28.8)	8 (18.6)	21 (38.9)
	n = 52*	n = 43*	n = 54
Insurance			
Prescription	38 (70.4)	31 (66.0)	31 (57.4)
Hospital	40 (74.1)	35 (74.5)	44 (81.5)
Physician	39 (72.2)	34 (72.3)	42 (77.8)
	n = 54	n = 47	n = 54

* Statistically significant difference between demographic variable and complaining at $p < 0.05$.

Those with lower income were more likely to complain about effectiveness and safety of the product. However, there was no direct relationship between income level and complaining about price. This corroborates the cost/benefit model for explaining non-complaining behavior.

It appears that although consumers at a higher income level are bothered with prescription prices, they will not complain. The costs associated with complaining may not outweigh any benefits.

CONCLUSIONS

Evaluating the complaining behavior of prescription drug consumers in a midwestern state demonstrated the complexity of the market. The results revealed attribute specific actions. Although the level of being bothered among the three aspects of the product were not significantly different, the complaining process did differ. More consumers complained to the physician about safety and effectiveness and complained to the pharmacist about prices. Consumers were more satisfied with how their complaints about product safety and effectiveness were handled rather than price. This may be explained by two reasons. First, physicians may switch products until the patient has recovered or satisfied. Second, patients may not be able to evaluate the safety and effectiveness problems as easily as price. This latter explanation may not be valid because the results showed no significant difference in feeling bothered with the three product attributes (Table 1).

Those who complained about safety and effectiveness also did chose no other action, 30.8% and 26.7%, respectively. This finding is particularly serious from a clinical perspective. This study did not collect specific information to address reasons for no action by complainers. One needs to identify if those complaints were legitimate. If they are legitimate, the source of the problem may be the product or the clinical decision making process. First, the drug firms study the drugs in a limited controlled environment before they are released into the general population. If there are adverse drug reactions and evidence of ineffectiveness, then these should be reported to the company and the FDA. Second, the appropriate selection of the drug product may be improved with pharmaceutical services. The failure to change drugs after a patient complains may be the inability of the physician to detect any therapeutic problems.

The complainers' satisfaction with the way their complaints were handled was lower for prices. Exit behavior was more prevalent as a response to problems with safety and effectiveness, but not for price. This finding supports the argument that the demand curve for pharmaceuticals is inelastic. Although consumers may be bothered by the price, they choose not to exit the market. It appears that the cost of discontinuing the product due to economic reasons is higher than the price. And, the complaining channel members who receive the "voice" are unresponsive to the needs of the consumer. Many pharmaceutical firms provide free products or products at a reduced price to indigent patients. However, a recent Senate report found such programs accessible through physicians. Policy makers criticized these programs for not being accessible to patients who need them. This study found that consumers more frequently complain to pharmacists about prices. Thus, if such programs are to be effective in helping the medically indigent, then they must be directed through the pharmacist.

Complaining behavior research offers new opportunities for health care practitioners to understand their patients (consumers), specifically to address problems that arise after therapy is initiated at the home. Concerns about prices go unaddressed by complainers and non-complainers. This latter result supports critical arguments that the demand for pharmaceuticals is inelastic, allowing member firms to possess monopolistic power. The solution to improve the responsiveness of the firms is not necessarily regulations, but directing complaining behavior to an amplifier, such as consumer advocacy agencies and professional associations (health care professionals). These organizations possess the political power to force policy makers to pressure industry to complying with consumer needs. The current complaining process is not sufficient to address the concerns of consumers in the prescription drug market.

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