Social Risk Efficacy in Preventing Youth Obesity

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Obesity prevention campaigns highlighting health risks and using a promotion orientation are pervasive. Yet, adolescents are especially susceptible to obesity social risks. An experiment conducted in French schools shows that social arguments change adolescents’ immediate behavior (real snack choice) and intentions to watch eating behavior. Health arguments have no effect on behaviors and limited influence on intentions.

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Extended Abstract
Obesity prevention campaigns highlighting health risks are omnipresent in France nowadays. A content analysis of official prevention messages in use since 2001 revealed the pervasive use of arguments based on health risks or benefits linked to prevention behaviors (eat healthy, exercise, etc.). However, these campaigns neglect social risks and adolescents are especially sensitive to social norms and the positive or negative consideration of their peers (Steinberg and Scott 2003).

Previous research on anti-smoking advertisements shows that the use of social arguments can be more efficient in the short term because they address concerns that are important to adolescents (Ho 1998; Pechmann and Knight 2002; Pechmann and Ratneshwar 1994). In an exploratory study, we found that adolescents are especially susceptible to social risks associated with obesity, such as disapproval or rejection from the group. We therefore suggest that arguments focusing on social issues are likely to be more efficient in the short term because they address concerns of importance to adolescents. Therefore, the first objective of this study is to verify the efficacy of using social risks in obesity prevention campaigns targeting youths.

A second objective is to verify if the message regulatory orientation (Higgins 1997; Zhao and Pechmann 2007) can moderate the impact of the type of obesity prevention argument being used (social vs. health). Other prevention campaigns unrelated to obesity, such as anti-smoking or anti-alcohol campaigns, frequently use prevention-oriented messages. They highlight the negative consequences of an undesired behavior, while obesity prevention campaigns in France use the opposite approach. They put forth the benefits of healthy eating and rarely bring up the negative consequences of obesity. We propose that obesity prevention messages using a prevention orientation will be more efficient in changing behaviors and intentions than messages using a promotion approach.

We conducted an experiment with 797 adolescents (mean age=14 years old) from low-income middle schools and high schools in Grenoble, France. The low income population is, in fact, the most affected by obesity. Parental and student consent were obtained prior to the study. Of the subjects, 57% are male and 88% have a normal body-mass-index.

The design was a between-subjects factorial with two factors: obesity prevention argument (health vs. social) and message orientation (prevention vs. promotion), and control. A professional advertisement agency created five advertisements; four obesity prevention advertisements and a control advertisement about ecology. All advertisements had the same design (colors and typo) and they used characters to avoid stigmatization of obese kids. The health prevention oriented message slogan was “Too many forms, not in shape!” and the image showed characters representing fast-foods (hamburger, fries) in the top of a scale that was breaking down. The social promotion oriented message slogan message was “Balanced meals, lots of friends!” and the image showed characters representing fruits and vegetables (carrots, orange, tomato) playing together.

Target advertisements were placed into a brochure with four filler advertisements about unrelated topics (local public transportation system, a videogame, clothes, and recycling), to reproduce a realistic exposition context. The target ad was shown twice to ensure a strong exposure. Participants received the brochure and were asked to look at each advertisement for a given time (15 seconds, controlled by a research assistant) and then turn the page. After seeing all the pages of the brochure, research assistants collected the brochures and distributed questionnaires. In the first part of the questionnaire, participants were asked to indicate their choice for a thank-you snack to be received at the end of the study; there were two options: a cereal bar (healthy) or a chocolate bar (less healthy). Then participants indicated their intentions to watch what they eat in the future on 5-point Likert scale, but also responded to filler questions about their eating habits, family model (parenting feeding styles and family food environment), and personal questions (age, gender, height, and weight).

Our behavioral results show that 65% of the participants exposed to the messages using a social argument chose the healthy snack option (cereal bar), while only 55% of those exposed to the health argument made the same choice (Chi-square=6.16; p=.01). There was no effect of the regulatory orientation of the message on the snack choice. These results indicate that the social message leads participants’ to healthier food choices than the health argument.

Concerning their intentions to watch what they eat, we found an interaction between the message argument (social vs. health) and the regulatory orientation (promotion vs. prevention) of the message (p=.060). The prevention orientation works better for messages using the health argument, while the promotion orientation generates higher intentions in conjunction with the social argument. Pairwise comparisons show that intentions of participants exposed to the message using a health argument and a promotion orientation is not different than intentions of the control group. The other three messages elicited intentions higher than control. Thus, a health message using a prevention orientation and both social messages (prevention and promotion oriented) are efficient to prevent obesity among adolescents.

Our results confirm that an argument based on social consequences of obesity is more efficient because it is closer to the current concerns of young people. Public policymakers should consider including social risks and prevention oriented messages when designing obesity prevention campaigns.

References
Partnership in Healthcare: The Impact of Co-Production on Healthcare Outcomes
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Healthcare in the United States is facing a crisis. The United States spends $6,401 per capita on healthcare which is far greater than other developed economies (in comparison, Switzerland comes in second and spends $4,177 per person). This crisis stems from the fact that although healthcare spending is high, the United States ranks last among 19 industrialized nations in preventing death from treatable conditions (Ginsburg, Doherty, Ralston, and Senketo, 2008). The majority of deaths related to treatable conditions are the result of modifiable behavior choices (e.g., diet, smoking, physical activity). Consumer lifestyle choices contribute to 40% of the deaths in America (McGinnis, Williams-Russo, and Knickman, 2002). Consumers hold responsibility for their lifestyle choices; however, making behavioral changes requires not only self-discipline but access to information and resources through healthcare and social systems.

How can consumers and healthcare providers work together to improve the quality of life in the United States? The purpose of this research is to explore how consumers and healthcare practitioners, through co-production, impact healthcare outcomes. The importance of this research lies in the fact that due to the rising cost of care, our current healthcare system is not sustainable (Berry 2008). Berry and Bendapudi (2007) call for more research in healthcare as its problems are “perennial (mortality and suffering) but also mutable (technology, advances in science, and social mores continually affect the delivery of health care).”

The commitment-trust theory of relationship marketing provides a framework from which to investigate this issue (Morgan and Hunt 1994). Past research suggests shared values positively impact the level of relationship commitment and trust leading to outcomes of improved compliance and cooperation while reducing uncertainty. Social exchange theory suggests shared values with the firm make customers more likely to voluntarily participate in the firm’s initiatives (Bettencourt 1997). Healthcare practitioners represent the firm to consumers, thus, it is reasonable to conclude that shared values (i.e., treatment or therapy goals) between practitioner and patient would yield similar outcomes. Successful health outcomes often require patient participation both during (i.e., answering questions) and after (i.e., taking medication) the service encounter (Berry and Bendapudi 2007). Co-production is a growing trend and past research suggests examining the role customers play in the service production process (Lengnick-Hall 1996). However, the impact of co-production on the relationship between shared values and relationship commitment and trust has yet to be illuminated.

Customer participation is defined as, “the degree to which the customer is involved in producing and delivering the service” (Dahalikar 1990). Co-production represents a shift towards active creation of service encounters (Wind and Rangaswamy 2000). Past research suggests consumer cooperation during the service encounter contributes to their own and others’ satisfaction and service quality perceptions (Bendapudi and Leone 2003; Bettencourt 1997). Patients are often suffering from an illness and feel a great amount of stress during health encounters (Berry and Bendapudi 2007). By involving consumers in the creation of their health encounter, the moderating effect of co-production on the relationships between shared values (i.e., health goals) and relationship commitment and trust should be positively affected.

Shared values are defined as, “the extent to which partners have beliefs in common about what behaviors, goals, and policies are important or unimportant, appropriate or inappropriate, and right or wrong” (Morgan and Hunt 1994). Past research suggests shared values lead to the development of relationship commitment and trust (Dwyer, Schurr, and Oh 1987). Patients and practitioners share a common goal of positive health outcomes. However, many patients suffer from anxiety and engage in avoidance coping strategies due to the fear associated with making behavioral changes or undergoing a medical procedure (Berry and Bendapudi 2007). The introduction of co-production opportunities for consumers creates an opportunity for control which has been found to increase satisfaction (Bendapudi and Leone 2003).

Berry and Parasuraman (1991, p. 139) suggest, “relationships are built on the foundation of mutual commitment.” Relationship commitment is defined as, “the exchange partner believing the ongoing relationship with another is worth maintaining” (Morgan and Hunt 1994). Trust exists when one party has confidence in the exchange partner’s reliability and integrity (Morgan and Hunt 1994). Healthcare is a service that is unique from many other services in that consumers need it but often do not want it. Health encounters (between practitioners and patients) are of an interpersonal nature owing to the fact that healthcare is one of the most personal and important services consumers purchase. The relationships between healthcare providers and consumers are inherently personal and, aside from acute care, usually persist over an extended period of time and require trust in technical abilities (Berry and Bendapudi 2007). Social exchange theory supports the idea that customers exhibiting cooperative attitudes toward the firm feel the firm values their contributions and cares about their well-being (Eisenberger, Huntington, Hutchison, and Sowa 1986). If patients feel health providers care about their well-being then it is reasonable to conclude that relationship commitment and trust will have an impact on outcomes related to care compliance, cooperation in care, and uncertainty reduction.

An empirical study using scenario-based surveys is planned to investigate the impact of co-creation on healthcare outcomes. Survey respondents will be adults from a large southeastern city with experience in healthcare encounters. The relationships between the constructs will be analyzed using structural equation modeling. Coproduced healthcare experiences are hypothesized to positively impact...