Faculty Working Papers

CONSUMERISM AND THE BROADENED MARKETING CONCEPT

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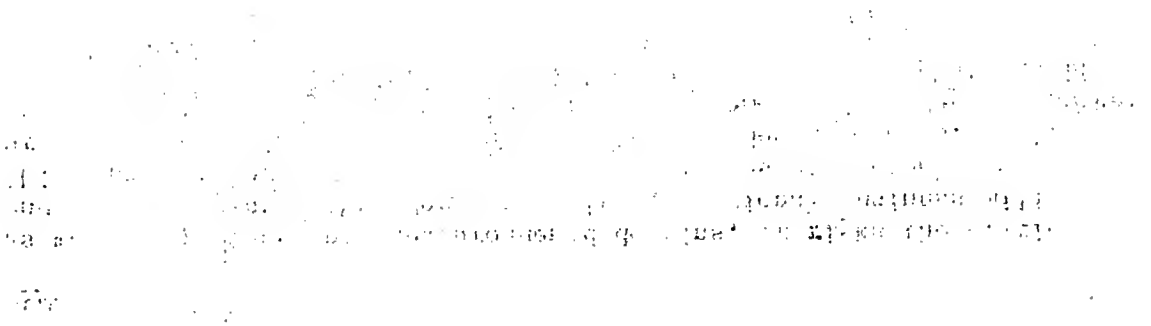
Summary:

As marketing moves into new broadened domains, it risks the criticism and public disfavor that dogs it in its traditional business milieu. This paper explores several alternative measures of consumer and practitioner satisfaction in one of these broadened domains, health care. It argues that evaluations of the outcomes and process of marketing are essential if marketing's past life cycle is not to repeat itself in this new area.



Introduction

Marketing is a major force in our society. By subtly matching heterogeneous supplies and demands for products and services, it serves, as one marketing sage has put it, to deliver our "standard of living."[1] During the 1930's and 1940's, there were many who questioned whether the marketing process cost too much.[2] With the second World War and the postwar boom, marketing flourished with only rare suggestions that it was less than a wholesome force in society.[3]

But all that changed in the early 1960's. With the rise of Naderism, marketing again came into question, but this time on two different grounds. First, it was argued that marketing was not really delivering products and services of good quality; that consumers were much more dissatisfied than market data traditionally showed. The support given to Nader and his imitators was offered as evidence that this level of profound dissatisfaction did, indeed, exist.[4]

The second charge against marketing was that not only were its outcomes less than desirable for the society, but so too was its process. Many rose to argue that the advertisements that were selling toilet paper to adults or Farrah dolls to kids were turning society into manipulated mush.[5] Others pointed out that the same system that provided credit and low cost, honestly promoted products to the white middle class also provided deceptively promoted products sold at exhorbitant costs and usurious interest rates to those who have the misfortune to be poor and/or members of racial minorities.[6]

My colleague, Peter Webb, has argued persuasively that this criticism of marketing was (a) inevitable and (b) desirable. The criticism was inevitable as marketing became more and more visible as business' interface

with a skeptical world. The growth in per capita spending power meant that more consumers spent more time on the material dimensions of their lives. This forced them to actively seek out more contact with advertising, salesmen, packages and the like to make purchase decisions. At the same time, the growing ubiquity of television and other media in our leisure lives meant that consumers were "forced" to have more passive contact with this same voice. These contacts, I would argue, became not only more frequent but progressively more distasteful as increasingly well-educated consumers felt vague guilt about the growing inroads that both materialism and television made in their lives. Marketing's increased visibility and its direct link with both forces made it a natural target for consumer anger.

But the criticism that arose can be considered a very healthy sign, particularly when it is directed back at business. It can be the irritant, the flashing red light, that causes the business system to correct itself and the consumer's frustration to be released. However, as I have noted in another forum, business' present use of this self-corrective and frustration-relieving feedback mechanism is surprisingly low.[7] Fifty-eight percent of all problems with products and services are never voiced to business. And, further, of those that are voiced, fully 44 percent are never resolved to the consumer's complete satisfaction. This leaves both a substantial vocal group of unsatisfied complainers who will lead the chorus of anti-business criticisms and a second non-vocal army which other researchers have described as a "frustrated and even possibly an alienated group of consumers . . . [i]n frustration, . . . direct[ing] their anger toward the system, viewing both business and government in very negative terms."[8]

Andreasen and Best have proposed that one solution to this feedback problem is:

> . . .to market the complaint-handling system to customers. Business should encourage customers to speak out when things go wrong—and make it more convenient for them to do so. Through advertising, point-of-sale promotion, and product inserts, business can tell customers that it wants to know when things go wrong.[9]

This feedback can not only reduce consumer frustration but improve the information management has to correct its product and service offerings.

Broadening Marketing

It is a curious historical phenomenon that just at the point in time when criticism of the traditional marketing system by one part of society is most virulent, another part is just discovering that marketing has a set of tools that are capable of having profound effects on such crucial domains of our quality of life as health care, the arts, education and social services. In a sense, business' whipping boy now has a chance at redemption.

But history can repeat itself. As marketing becomes more and more visible as a tool of non-profit administrators, it may again become the lightening rod for the frustrations of those whom these administrators are trying to serve. The problem, obviously, is to avoid this seemingly inevitable outcome. The solution, equally obviously, is to develop feedback systems that will allow non-profit administrators to improve (a) the outcomes of their marketing systems and (b) the process whereby marketing helps deliver those outcomes. If marketing is to continue to have a positively valued impact on these key life quality dimensions, an effective measurement system must be devised.

The remainder of this paper explores several of the key measurement issues raised by the "broadened marketing concept" with particular attention to health care. The problems of evaluating outcomes and process are discussed independently.

Evaluating Health Care Outcomes

To make the discussion concrete, let us suppose that the administrator of a federal program that makes grants to medical clinics for diagnostic equipment wishes to make those grants at least in part on the basis of how good patient care outcomes are at various clinics. He/she wish to see developed what Hunt calls "consumer satisfaction/dissatisfaction" (CS/D) measures[10] to insure both that clinics are rewarded for providing good outcomes and that the clinics themselves get adequate feedback to correct their own operations and to reduce customer frustration.

Elsewhere,[11] I have suggested that the administrator's first choice is to specify whether he/she wishes the clinics:

1. to minimize dissatisfactions or maximize satisfactions; in health care, the analogous question is whether one merely wishes to minimize the frequency, duration and seriousness of illness or to optimize health;
2. accept a subjective judgment of satisfaction or dissatisfaction; that is, should the patient or practitioner be allowed merely to tell you how healthy or free from illness the patient is; or
3. measure satisfaction/dissatisfaction before or after the marketer has had a chance to correct any dissatisfactions, which, of course, presumes some system for handling patient complaints.

The alternative measures that this taxonomy offers in business are outlined in Figure 1. In the main, there are six principal kinds of measures:

1. Sales;
2. Repeat purchasing (versus "brand" switching);
3. Salesmen's or middlemen's opinions;
4. Consumer's satisfactions;
5. Voiced complaints; and
6. Reported problems.

We will consider each in turn.

(1) Sales. Sales at first evaluation is not a very useful measure to test the effectiveness of health care systems, although it has the advantage of being non-subjective and relatively easily and frequently measured. In the first instance, if the number of customer visits or customer revenues are used as criteria one can raise the question as to whether more is necessarily better at either the individual or societal level. If individuals visit the clinic more often, this does not necessarily mean that the clinic is doing well or that consumers are paying more attention to their health. It may simply mean that problems are not being resolved satisfactorily as often on first visits.[12] On the other hand, if consumers are found to be spending more, particularly per visit, this may reflect one of two socially undesirable outcomes:

1. It may indicate a greater willingness of clinics to take advantage of price inelasticities in a market where most payments are by third-party insurers.
2. It may indicate a growing use of laboratory procedures to hedge against malpractice suits.

In either case it means that the nation's health bill may be rising unnecessarily. In neither case does it mean that consumers are healthier.

One useful alternative may be to measure the number of customer visits of a particular type. One could, for example, catalogue the frequency with which existing patients appear for full or partial physical examinations or for first visits for various ailments. These would appear to be more valid indicia of improved health care behavior.

But even if such measures were developed, they only seek to evaluate one function of health care systems, what may be called the curative function. Visits to clinics are to diagnose or cure problems. Yet a clinic could be performing marvellously if it had a superior preventive function, and, therefore, seldom had to cure. Many of the marketing activities that pursue the preventive function may be secondary to, or independent of, clinic visits. Brochures, posters, mailers, patient education, television talk show discussions, and other public information activities may all serve to encourage people to take up jogging, stop smoking, practice breast self-examination or to take their medicine (e.g., for high blood pressure). Yet these are exchanges that, unlike curative encounters, do not involve money changing hands. The role of the health marketer is to get the customer to perceive that the benefits of what Kasl and Cobb describe as "health behavior"[13] exceed the costs. Indeed, the product or service is typically one that customers administer to themselves!

It would again appear highly useful if health care systems could develop measures of "sales" in preventive health care, e.g., patients taking up jogging and other health giving acts. Among other benefits,

such a measurement device could in the long run redirect health professionals toward more preventive marketing.

(2) Repeat purchasing. Hunt has argued that:

> . . .intention to repurchase is an excellent composite measure of CS/D. The value of this measure is that it is a composite measure getting at all the influences affecting the decision without having to identify those influences. It in essence says, given the real world and your psychological world, what ever they may be, what choice will you make next time.[14]

Repeat visit behavior by clinic patients, however, is not a very good measure of performance of the curative function primarily because of the inertia that is built into doctor-patient relationships. Choosing among alternative doctors is typically not an activity a patient undertakes at each visit as he or she might with a toaster or a car repair shop at each repurchase. In part this is because many patients believe that the effectiveness of a medical doctor in both a psychological and medical sense is in part a function of his/her accumulated knowledge of the patient. Patients are reluctant to give this up even if they have misgivings about a doctor. Further, they fear (incorrectly) that all the written minutae of their history (x-rays, test results, etc.) cannot be transferred, thus incurring further costs for repeat "work-ups" along with the aforementioned risk that without these records a misdiagnosis is more likely.

Then, there is the uncertainty involved in any switch in practitioner occasioned by the basic difficulty of acquiring the necessary information to make an informed choice among doctors. In most communities (although there are exceptions), the marketing system does not make it easy for patients to shop around. Information on a doctor's (or clinic's) training, experience or even prices is simply hard to come by and, thus, a known mediocre

medical doctor may be preferred to an unknown alternative. In sum, until the health care marketing system is redirected to encourage easy choice and uncomplicated doctor-switching, the absence of "brand-switching" should not be considered a very good measure of the curative outcomes of health care systems. On the other hand, repeat "purchasing" measures may be very useful indicators of good preventive care outcomes. In preventive health care, one is asking people to engage in behaviors that Hochbaum has described as "inherently unpleasant, inconvenient, humiliating and painful; they disrupt old, accustomed living habits; and they necessitate depriving oneself of things one wants and enjoys."[15] Given this characteristic, Hochbaum continues:

> In the health area, the concern with use after "purchase" is as critical as and even more critical than the concern with the purchase itself. . . . The most challenging, most difficult, most perplexing problem is not how to sell people on health-supporting practices, not even how to get them to initiate such practices. We have been fairly successful with these. It is to persuade and help them to stick with new practices, to keep these up conscientiously for the rest of their lives.[16]

Again, focus on this measure of repeat purchasing appears necessary to assume that marketing direct its efforts toward the essential preventive health goal. If marketing focuses on the first purchase, this may lead to greater dissatisfaction and frustration rather than less as consumers complain that, as marketers urged, they tried to quit smoking (exercise, brush after meals) but they couldn't stick to it (i.e., marketing did not follow up). They may feel badly about themselves and, as in marketing's business domain, take it out on the marketing community, e.g., "Why do they keep pushing me to stop smoking; I feel guilty enough as it is?"

(3) Salesmen's or middlemen's opinions. Can one ask clinicians about how satisfied their patients are? The answer is no for two very good reasons. First, the nature of the medical practitioner's job is one that requires that they be very confident. People who must make daily what are often life-and-death decisions about other human beings would sink into catatonia if they regularly questioned their skills in the field.[17] Second, there is the growing problem of malpractice. It is unrealistic to expect doctors to indicate that their patients are less than fully satisfied if this evaluation is to be written down somewhere (as it presumably should). Such data could well be grounds for a successful future malpractice claim.

(4) Consumers' satisfaction. A number of scales have been developed in recent years which allow consumers to report how well they are satisfied with the products and services they have received. Pfaff and Blivice in particular have sought to develop consumer satisfaction scales applicable to public services.[18] Such scales could be administered annually to patients of various clinics. However, as Ölander has pointed out,[19] a problem with such measures is whether health consumers really have enough knowledge to make the appropriate judgments. Partly, this is because the medical system has historically been less than candid with patients about the patients' condition and/or the medical doctor's frequent uncertainties. There are sometimes good medical reasons for this. But often lack of candor is designed to maintain "face," to prevent time-consuming debates about appropriate care, or to prevent malpractice claims. Thus a patient may well feel fully satisfied with a clinic's curative function when this merely reflects the practitioner's ability to maintain silence!

A second problem relates to standards. Patients may not really know whether a better alternative exists somewhere. The difficulty of directly comparing medical doctors has already been mentioned. A second type of ignorance is at the systems level. Most patients have little familiarity with alternative health care systems. In North America, the medical profession is oriented toward cure and not prevention. In other countries, such as England or Scandinavia, the orientation is much more toward prevention. Someone who is socialized to a curative system may be very pleased with the frequent cures without questioning whether more attention to prevention might have made the cures unnecessary.

Then there is the matter of one's expectations. As Oliver[20] and others have shown, perception of system performance is a function of expectations. It may well be that a given clinic, because it sets and vigorously advertises its high standards, may have low consumer satisfaction ratings while having superior performance in some objective sense. On the other hand, it may be that the medical system in general stresses too high standards. If patients are led to expect the latest, best equipment in every facility, the cost to society in duplication may be excessive. As Hunt suggests, reducing expectations may be good public policy:

> [G]overnment could increase satisfaction just as well by getting consumers to lower their expectations. At first it sounds silly, but with the conserver society coming fast upon us it may be critical in the near future to find ways to reduce consumer expectations because increasing product quality will be socially unacceptable.[21]

A third problem is, of course, that patients are sometimes unable to judge whether curative treatments or preventative recommendations are successful. A case in point is the problem of educating high blood pres-

sure patients. With this disease it is very difficult to tell whether a treatment is working since the disease has no symptoms. Thus a patient told to diet, exercise and take specified pills may not feel any different from one who did not follow this regime. As a consequence he or she may well feel (mistakenly) dissatisfied with the medical care received.

Finally, there is a basic methodological problem with satisfaction scales that may be especially serious in health care. Satisfaction scales tend to overreport dissatisfaction because they often reflect inflationary factors. Research by Andreasen and Best reported that when people were asked how satisfied they were with a product or service, fourteen percent of those who were dissatisfied said that high price was their only problem. That figure rises to almost nineteen percent for those dissatisfied with medical and dental care.[22] The latter is not surprising given the very rapid increase in health care costs in the last decade.

(5) Voiced complaints. A technique used by many businesses to monitor performance is to rely on the complaints that naturally come to it from disgruntled customers who choose to speak up either by letter or in person. And, indeed, many clinics and hospitals have sought to generate such complaints data by establishing "patient advisory boards."[23] A problem noted in our own research on consumer complaints, however, is that voiced complaints underreport the true level of dissatisfaction since, as noted earlier, the majority of all non-price problems are never voiced. Not only do they underreport problems, they present a distorted picture of the types of problems that actually exist since some types of complaints are more likely to be voiced than others.[24]

Our study suggests that on both counts, complaints data may be especially unsatisfactory in the medical field. First, we found that 77 percent of all medical and dental problems were unvoiced. For such an important issue to most consumers, this rate of voicing is exceedingly low. Second, our research in general showed that the kinds of problems that did get voiced were those where the problems were important and/or had a high likelihood of resolution. While medical problems are important, they were not very likely to be resolved satisfactorily. Our data showed that consumers who did voice their medical and dental complaints felt that the complaints were satisfactorily resolved only 34.5 percent of the time. (This was the second lowest figure in the entire study.) This result may well accurately reflect the considerable inapproachability the medical profession has assiduously cultivated over the years.

A third feature of the types of problems that were not voiced was that they were what were called "judgment" problems. These were the cases where ". . .deficiencies [were] complicated or ambiguous, and therefore relatively difficult to perceive clearly and state with assurances."[25] It is, of course, just those types of problems with which medical encounters abound. Consumers who are unsure of their grounds in a highly sophisticated and arcane subject as medicine are understandably reluctant to challenge, even indirectly, the medical high priests.

(6) Reports of problems. My own experience strongly argues for the use of data generated from consumers in surveys on the problems they have encountered with goods or services as the best measure of curative outcome.[26] Such measures overcome the overreporting bias of simple satisfaction scales and the underreporting bias and distortions of consumer complaints data

(discussed above). In our research, the rate at which medical or dental care problems involving non-price issues were mentioned was fifteen percent. Given consumer ignorance in this area, this figure is undoubtedly low and I would argue vigorously for consumer education in evaluating medical care. Still, survey reports of problems are at present probably our best measure of curative outcomes.

Measures About Process

We have already seen that a major defect of the health care marketing process is that consumers seldom have adequate information to evaluate the care they are receiving. While in the short run consumer expectations can be suppressed by practitioners to keep them satisfied, in the long run, however, adequate information is essential if customer suspicion and frustration is to be reduced and if the self-correcting potential of an open marketplace is to be actualized.

A second requirement for the process to work well is that it become more consumer oriented. There is considerable evidence that in curative settings practitioners are frequently not very much concerned with consumer interests.[27] And several authors have pointed out that even in preventive contexts, health care specialists take the view that they know what is best for consumers;[28] it then becomes marketing's task to convince consumers to adopt the system's view. As Flexner puts it:

> One of the major reasons that preventive health care has a relatively low priority among consumers is that all concerned entities . . . have placed too little emphasis on the intended recipients of the product--the consumers, their motivations, and the benefits that attract them to certain behaviors.[29]

It is just the kind of production orientation that characterized commercial marketing of 40 years ago. A measure then of progress in the health marketing process is the extent to which medical practitioners begin to adopt the perspectives, particularly in preventive health care, that change programs will only be maximally successful when they begin with consumer needs and wants.

The product-as-given approach of most health care professionals naturally leads to heavy emphasis on advertising and promotion to achieve behavior change. Needless to say, this approach may be entirely appropriate to many preventive health care marketing programs. But even here there is a danger. As Moriarty notes: "Preventive health care behavior in some cases has only long run and uncertain outcomes for the individual. Advertising claims of a more healthy life associated with specific changes in behavior will have to be documented. . . ."[30] Monitoring of the truthfulness of health care promotion therefore would also seem important if the marketing process is not to receive a black eye in this new broadened context.

And just as we should be concerned about the product and promotion elements of the health care marketing mix, so should we be concerned about price and distribution. As noted earlier, there is very little price competition in health care. In part, this is because often the products are not comparable. But this is not always the case, and if marketing is to be effective this element too must become more open and flexible.

Finally, one should note the difficulties business marketers have had by not paying heed to the concerns of what I have called "disadvan-

taged consumers."[31] Adequate health care is seen by many as a right of all individuals in an affluent society. Health marketers are in most cases already sensitized to the problems of the disadvantaged and are attacking them. It is, however, not impossible that the white middle class medical establishment (like the white middle class consumer establishment) may not be well attuned to the needs of the disadvantaged. Thus, if the process is to be relatively free from criticism we must be sure not only to keep the overall level of satisfaction high but ensure that this satisfaction is equitably distributed across all population groups at risk.

The final problem marketers should be sensitive to is not to overpromise its contributions to its other major public, the health care practitioners themselves. Chamberlain puts it well:

> Our concern should be that marketing will not be equipped to fulfill the expectations of the health professionals. Such expectations may be exaggerated beyond the capabilities of marketing practitioners. The marketer who achieves a 15 percent change in consumer behavior will very likely be viewed as a failure by health professionals expecting 99 percent compliance.[32]

If we do not monitor the health professional's expectations and our accomplishments, we run the distinct risk that they too will see marketing as a source of deception. As one health marketer told the author: "Marketing to many health professionals means putting bells and whistles on some very basic messages." For them, marketing's (inevitable) failure to make large gains may indelibly label it as just another health management fad--or worse, a con job by some ivory tower academics.

Some Research Implications

We are clearly a long way from being able to measure these marketing outcome and process variables. At the consumer level, we need to know a good deal more about how individuals evaluate medical care. We need to know their knowledge of the system and its alternatives; what their expectations are of each health encounter and what they know of the health system as a whole. We need to know who perceives problems and who acts on them and why. We need to know what practitioners think of marketing and what their expectations are of its performance. And finally we need to know what will change these variables in a favorable direction.

The development of instruments and related methodologies to assess consumer and practitioner satisfactions with health care outcomes and the marketing process that brings them should occupy our attention for several years. Certainly these are critical issues if marketing is to serve its full potential in improving the quality of life in this and similar broadened domains.

ENDNOTES

1. Paul Mazur, "Does Distribution Cost Enough?" Fortune, November, 1947, p. 138.

2. Paul W. Stewart, J. Frederic Dewhurst, with the assistance of Louis Field, Does Distribution Cost Too Much? (New York: Twentieth Century Fund, 1939).

3. See, for example, Richard K. Farmer, "Would You Want Your Daughter to Marry a Marketing Man?" Journal of Marketing, Vol. 31 (January, 1967), Number 1, pp. 1-5.

4. Mark V. Nadel, The Politics of Consumer Protection. (Indianapolis: The Bobbs-Merrill Co., Inc., 1971).

5. Evelyn Kaye, The Family Guide to Children's Television (New York: Pantheon books, 1974).

6. Alan R. Andreasen, The Disadvantaged Consumer (New York: The Free Press, 1975).

7. Alan R. Andreasen and Arthur Best, "Consumers Complain--Does Business Respond?" Harvard Business Review, Volume 55, Number 4, (July-August, 1977), pp. 93-101.

8. Rex H. Warland, Robert O. Herrmann and Jane Willits, "Dissatisfied Consumers: Who Gets Upset and Who Takes Action?" Journal of Consumer Affairs, (Winter, 1975), p. 161.

9. Andreasen and Best, same as reference 7 above.

10. H. Keith Hunt, "CS/D: The Program Planning and Evaluation Perspective," in Beverlee B. Anderson (ed.) Advances in Consumer Research, Vol. III. (Cincinnati: Association for Consumer Research, 1976), pp. 259-60.

11. Alan R. Andreasen, "A Taxonomy of Consumer Satisfaction/Dissatisfaction Measures," Journal of Consumer Affairs, Volume 12, Number 2, (Winter, 1977), pp. 11-24.

12. The analogy of car repairs is appropriate. One would certainly not describe an increase in visits to the repair shop as a sign that cars were being built better or, necessarily, that people were taking better care of them.

13. Stanislov Kasl and Sidney Cobb, "Health Behavior, Illness Behavior and Sick-role Behavior," Archives of Environmental Health, Volume 12 (February, 1966), pp. 246-266 and Volume 12 (April, 1966), pp. 531-541.

14. H. Keith Hunt, "CS/D: Bits and Pieces" in Ralph L. Day (ed.), Consumer Satisfaction, Dissatisfaction and Complaining Behavior (Bloomington, Indiana: Department of Marketing, School of Business, Indiana University, 1977), p. 39.

15. Godfrey M. Hochbaum, "A Critical Assessment of Marketing's Place in Preventive Health Care," in Philip D. Cooper, William J. Kehoe and Patrick E. Murphy (eds.), Marketing and Preventive Health Care: Interdisciplinary and Interorganizational Perspectives (Chicago: American Marketing Association, 1978), p. 5.

16. William J. Nolen, The Making of a Surgeon (New York: Random House, Inc., 1970).

17. Hochbaum, same reference as 15 above, p. 6.

18. Martin Pfaff and Sheldon Blivice, "Socioeconomic Correlates of Consumer and Citizen Dissatisfaction and Activism," in Day, same reference as in 14, pp. 115-123.

19. Folke Ölander, "Consumer Satisfaction—A Skeptic's View," in H. Keith Hunt (ed.) Conceptualization and Measurement of Consumer Satisfaction and Dissatisfaction (Cambridge, Mass: Marketing Science Institute, 1977), pp.

20. Richard L. Oliver, "A Theoretical Reinterpretation of Expectation and Disconfirmation Effects on Posterior Product Evaluation: Experiences in the Field," in Day, same as in reference 14, pp. 2-9.

21. Hunt, same as reference 14, p. 41.

22. Andreasen and Best, same as reference 7.

23. Edmund Ricci, Bardin Nelson and Robert Pecarchik, "The Consumer Movement in Health Care," paper presented at the American Sociological Association annual meetings, Montreal, Canada, August 5, 1974.

24. Andreasen and Best, same as reference 7.

25. Arthur Best and Alan R. Andreasen, "Consumer Response to Unsatisfactory Purchases: A Survey of Perceiving Defects, Voicing Complaints and Obtaining Redress," Law and Society Review, Volume 11, Number 3, (Spring, 1977), p. 709.

26. Andreasen, same as reference 11.

27. It is recognized that increased competition is not favorably regarded in the medical community. However, the trend is in this direction with the advent of generic drug prescribing and advertising of basic medical services.

28. See, for example, Hochbaum, same as reference 15 and M. Venkatesan, "Preventive Health Care and Marketing: Positive Aspects," in Cooper, Kehoe and Murphy, same reference as in 15, pp. 12-25.

29. William A. Flexner, "By Choice A Limited Government Role," in Cooper, Kehoe and Murphy, same reference as in 15, p. 64.

30. Mark Moriarty, "Advertising Preventive Health Care: Informational, Persuasive, Ethical?" in Cooper, Kehoe, and Murphy, same as in reference 15, p. 57.

31. Andreasen, same as reference 6.

32. Robert M. Chamberlain, "Is Marketing Too Stigmatized to be Effectively Accepted in Preventive Health Care," in Cooper, Kehoe, and Murphy, same as in reference 15, p. 58.

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