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Understanding the Impact of Choice Claims in Health Policy Among Veteran Patients

Stacie Marie Rivera
Walden University

Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

Stacie M. Rivera

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Review Committee
Dr. Christopher Jones, Committee Chairperson,
Public Policy and Administration Faculty

Dr. Lee Bewley, Committee Member,
Public Policy and Administration Faculty

Dr. Frances Goldman, University Reviewer,
Public Policy and Administration Faculty

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Abstract

Understanding the Impact of *Choice* Claims in Health Policy Among Veteran Patients

by

Stacie M. Rivera

MPH, Tulane University, New Orleans, LA, 1999

BA, Loyola University, New Orleans, 1992

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

The patient-as-consumer has emerged as a narrative in the government health care system that cares for beneficiary veteran patients, elevating the phenomenon of choice in health care legislation and administration. The problem of the submerged state of a health policy was the issue examined within the context of access to health care and what patients experience when choice is present. The purpose of this study was to explore the motivations of beneficiary veteran patients to choose a preventive care option, a seasonal flu shot, at a private sector retail pharmacy rather than at their government health care provider, with the goal of understanding what social marketing strategies supported their decisions, how they defined choice, and what they expected from their choice option. Research questions focused on reasons for patients' decisions to choose outside preventive care within the context of a social marketing campaign and their interpretation of choice in health care policy. Drawing on the policy feedback theory, an interpretative phenomenological approach was employed. Purposive semistructured interviews of 7 patients were conducted. Data were analyzed using a 3 step process that included descriptive theme-centered coding, emergent sub-coding, and a clustered coding analysis. Two key themes emerged: first, choice in health care policy is relative to a patient's individual circumstance, and in order to have choice, one must have options; and second, veterans value their earned health care benefits and trust their government provider. Implications for social change include policy maker awareness of the importance of social marketing as a tool for communicating a health policy and legislation so they can make more informed decisions and veterans can feel empowered as patients.

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Dedication

"It does not matter how slowly you go as long as you do not stop." — Confucius

This dissertation is dedicated to my life partner, biggest cheerleader, and ever-present inspiration – my husband, Fernando O. Rivera – who urged me to take this journey, step-by-step, and overcome my fear with the richest love, support, and understanding. And to my children, Fernando, Jr., Mateo, and Dulcé, who have grown into independent young adults while I was on this journey, always understanding that Mami was working on her schoolwork. Life moved forward; we each kept marching, hand in hand, as a team.

Finally, to those "who have borne the battle," may you have real choice in health care that meets your needs, expectations, and earned benefits.

Acknowledgments

"Gratitude is the sign of noble souls." – Aesop

I would like to express my sincere gratitude to the following noble souls who have helped me along my dissertation journey, which began on March 3, 2014.

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My sincerest appreciation to all who have walked with me, encouraged me to keep stepping, and believed in me.

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Chapter 1: Introduction to the Study

Introduction

Government-sponsored health care for America's eligible veterans has been a fundamental and universal right for that population administered by the United States (U.S.) Department of Veterans Affairs (VA). Notwithstanding conflicts and public misperceptions since its inception as the nation's largest, integrated, and publicly funded health care system in the United States, the Veterans Health Administration (VHA), one of three branches of the VA, consistently outperforms its private sector partners in key quality measures, including risk-adjusted mortality rates, patient-safety factors, and other process performance measures, including influenza immunization rates for enrolled patients (Anhang Price, Sloss, Matthew, Farmer, & Hussey, 2018; Botts, Pan, Olinger, Donahue, & Hsing, 2017; Springer, 2016; Weeks & West, 2018). While the VHA meets or exceeds private-sector and publicly-insured patients under Medicaid or Medicare in terms of mortality and patient safety practices, it lacks the capacity (e.g., aging infrastructure and clinical staff shortages) and customer service expectations to meet the health care demands of its growing and diverse patient population (Farmer, Hosek, & Adamson, 2018; Longman & Gordon, 2017; United States Department of Veterans Affairs, 2018; Westat, 2010). The role of patients driving or slowing the idea of choice and competition in health care policy and programs is unclear.

As a result, there remains a decades-long public mismatch between perception and reality concerning health care administered by the United States government-run health care system available for enrolled and eligible veterans. It is difficult to reveal the

material strengths and weaknesses in the health care industry, particularly when there is a comparison between private sector and government-run health care systems (Khamis, 2017; McGregor, Eduardo Siqueira, Zaslavsky, & Blendon, 2017). The trend today is to move from a public to a private philosophy, something called neoliberalism (McGregor et al., 2017). Further, the visibility of government social programs also has helped to advance this concept of a submerged policy that attributes government programs to earned benefits, thus hiding the source of the benefit (Mettler, 2011). As a result, there is an overgeneralized dominant negative narrative concerning this government health care option that adversely impacts health policy issues and implementation of more direct and visible policies and programming of the government-run health care system.

Even with the moral understanding that this health care system is about serving a beneficiary population who earned the rights to health care via their service in uniform to the United States of America, there remains the predominant assertion that this government-run health care system is not up to the task of providing efficient and effective health care to America's veteran patients. However, as both a provider and payer of health care with a public service mission to care for service members who shall have borne the battle, the system has no ability to engage in high-cost marketing or branding campaigns as its private and not-for-profit counterparts (Gordon, 2017; U.S. Department of Veterans Affairs, 2018; U.S. Department of Veterans Affairs, About Us, 2018). By conducting government business in submerged policy reference, citizens are not provided with clear, accurate, and timely information from which they can trust the government, understand its services, or engage in policy debates (Mettler, 2011). Thus,

misleading publicity and political assertions that lack evidence about the government-run health care system has adversely impacted the health care policies, political debates, and public narratives surrounding the future of the system in the 21st Century, particularly beginning in 2014 when media and legislative coverage focused on the dominant negative narrative that the government-run health care system for beneficiary veteran patients is poor, inaccessible, and inadequate (Gordon, 2017; Longman & Gordon, 2017).

However, the government-run health care system is not immune to today's market-driven landscape where health is defined as more of a commodity and less as a social good or right, even for beneficiaries of the vast health care system, men and women who have sacrificed so that they can access earned benefits. While supporters have argued that the health care system for veteran patients is a system worth saving, critics have cited the need for patient choice to amplify efforts to privatize all or parts of the government health care system (Gordon, 2017). However, the system itself is not in a position, either politically or professionally, to enter market-based competition in an environment where today's patient is considered a consumer or customer.

Although the commitment to care for America's eligible veterans is strong both within the veteran community and among external policy-makers, advocates, and the public, the government-run health care system is suffering the same fate as its for-profit and nonprofit partners – adjusting to the effects of a consumer-driven health care market where patients have perceived choice and options. Health care providers have made deliberate attempts to enhance this market-based narrative, transitioning from *patients* to *consumers* or *customers* (Health Care Transformation Task Force, 2018; Longman &

Gordon, 2017; West, 2014). Unlike health care patients, or consumers, of community or nongovernment health care providers, beneficiaries of the government-run health care system are beholden to the democratic process, the electorate, and the citizenry. Private-sector intrusion into government services calls into question accountability and the impact of the voice of the veteran citizen (Gingrich & Watson, 2016). In discussing veterans' health care and access to care, one of the most commonly used words is *choice*.

Since 2014, and more recently in 2018 and 2019, new access standards in the government health care sector have made the concept of choice and the power to choose core value statements. Freeman (2012) asserted that "sometimes the starkest realities are hidden by the language that we choose to speak about them" (par. 1). Freeman further argued that providing health care is a core social service that is opposed ideologically to today's market-driven medicine culture whereby lawmakers believe that "private is good" and "public is bad," pitting earned health care benefits of America's veterans against consumer choice and the free market concept of making money off of patients. West (2014) agreed with this concept, arguing that choice in health care is not equivalent to consumer choice as understood in the free market of the American economy. For the health care industry, the patient-as-consumer does not negotiate or have full knowledge of the goods, in this case, health care services (West, 2014). Therefore, patients cannot shop and choose as they might in other markets. With this imbalance and the ongoing debate about whether the government-run health care system is up to the task of serving today's veteran patient in context of a free market landscape, the object of studying patients' lived experiences was critical to understanding if the concept of choice in a

market-based system versus a government-provided service should impact policy planning, diffusion, and implementation.

Patient choice is at the core of today's health policy discussions both in and outside of the government health care setting. Although there is a body of literature concerning the patient-as-consumer phenomenon in relation to health policy promotion and adoption, there is little known about the interpretive effects of a social marketing based preventive health choice program and the role of policy diffusion and policy implementation (Crawshaw, 2013; Maltby, 2017). In fact, the Office of Disease Prevention and Health Promotion has called for an increase in the use of social marketing as part of HealthyPeople 2020 to promote health activities and prevent disease starting at the state and local levels (Office of Disease Prevention and Health Promotion Website, 2019). There was a need to understand the context of choice policy and the motivations of the patients who chose to use other-than government-sponsored health care when given unfettered choice based on their experience to advance the practice and implementation of health choice policy (Crawshaw, 2013; Lightfoot, Gal, & Weiss-Gal, 2018). Stated simply, health care policy makers continue to use the moniker of choice to advance a transactional approach to what is innately an interactional experience whereby patients may or may not have full choice.

Several studies that involved social marketing and preventive health care included a variety of focuses such as source credibility, the impact of narratives, emotional appeals, shaming, and the myth/fact frame in reaching consumers through health communication (Royne & Levy, 2015). Some researchers separately analyzed how health

communication enabled people to achieve optimal health (Mettler & Sorelle, 2018; Neville, Adams, & Holdershaw, 2014). Government health policy consultants even used consumer data to advance the idea that the consumer priorities of people, processes, and place account for what shapes a positive or negative experience about a health care visit (Wolfe, 2018). However, there remains a long-standing gap in academic research concerning the use of social marketing that stretches beyond program evaluation (Truong, Garry, & Hall, 2014). Therefore, this research was conducted to take an initial step in understanding how policy feedback affects a targeted group within the framework of a social marketing campaign for an unfettered choice program in health care aimed at America's veteran patients when the choices are equal.

The topic for this research project was to understand the influence of a private-sector retail immunization program on veterans' perceived impact of choice as a recipient of government health care benefits. The period covered by the research was significant because the program predates the enactment of the Veterans Access, Choice, and Accountability Act of 2014, known as the Veterans Choice Program (Public Law 113 – 146; U.S. Department of Veterans Affairs, 2015) or the VA MISSION Act of 2018 (H.R. 5674), which was implemented in the summer of 2019. However, it should be noted that these choice programs may have impacted the views of patients who participated in this choice study.

For purposes of discussion, I focused on recipients of the Retail Immunization Coordination Project, or the no-cost flu shot program. The timeframe of this study was covered by Phase 2, which took place from September 2014 to January 2015, Phase 3,

which dated September 2015 to January 2016, and the sustainment and final phases from 2016 to 2019. The research topic was formulated based on a review of the literature that suggested a missed opportunity in the United States, and specifically the government-run health care system, to evaluate the impact of various social marketing, media, and political forces that lead to patient understanding, program durability, and policy mobilization (Hafer, 2018; Karch & Cravens, 2014; Luck, et al., 2009; Mettler, 2011). Using a qualitative framework to understand the research about choice views helped to elucidate a better understanding of patient motivations and experiences as users of health choice policy.

Using the foundation of an innovative health policy choice project that gives unfettered choice to beneficiary veterans, the positive social change implications of the research include a better understanding of the needs and motivations of patients who have earned government health care benefits. This study helps shed light on whether veteran patients see their health are as a right – a social good provided by the government – that they have earned or as a commodity that can become marketized for profit by private industry. The results indicated that understanding the voice of the veteran can contribute to the primary objective of communicating a health policy of program with the effective use of social marketing principles. Data also revealed that the idea of choice in government-provided health care is complex and dependent upon the patient having similar, no-cost options. Therefore, I provide recommended solutions for public administrators to consider when designing, implementing, or promoting health policy

throughout a government-run health care system, advancing the idea that health care is an earned right and not a commodity, as is the case of most other industrialized nations.

In Chapter 1, background about the Retail Immunization Coordination Project is presented. I also provide a more in-depth review of the purpose of the study, which is to understand the influence of a private sector retail immunization program on veterans' perceived impact of choice in the government health care policy, focusing on the period from September 2014 to August 2019. Using a social marketing framework, the research is grounded by the policy feedback theory and guided by the theory of planned behavior (see Ajzen & Fishbein, 1969; Mettler & Sorelle, 2018). The research questions helped evoke a better understanding of choice claims made in the greater patient-as-consumer phenomenon and ongoing political debate on privatizing government run health care services and their perceived importance to eligible and enrolled veteran patients.

The scope of the study was limited to the Retail Immunization Coordination Project; given its qualitative nature, the study lacks generalization but provides a starting point to better understanding the choice phenomenon within this unique patient population. However, the results served as evidence and a complement to the assertion that when given unfettered choice to a nongovernment entity for preventive health care services, access to care improves, unserved veterans get needed care, and cost savings are achieved (see Botts et al., 2017). This study served to set the stage for understanding what motivates beneficiary veterans to seek privately administered health care outside of their government provided health care system and may set in motion a robust research

agenda to better understand the voice of the veteran in an age of consumerism when designing social marketing programs that support health care policy.

Background

Flu is a potentially fatal but vaccine-preventable illness, yet there remains a low rate of immunization in adults despite the broad flu shot availability and access. Flu vaccination is a recognized health measure to prevent death and hospitalizations (Centers for Disease Control and Prevention, 2016; Ko et al., 2014). Laws and national health objectives call for health providers to promote health prevention activities, including vaccination, and optimize health care delivery. However, policy enactment seldom provides funding for health prevention and promotion activities in government settings, particularly in a government health care system that relies on appropriations by Congress to advance its priorities.

In the health care system for veterans, for instance, there is a legislative prohibition on the use of appropriated funds to market or advertise government services unless otherwise directed by legislation (Gordon, 2017; Short, 1991). Meanwhile, in the age of consumerism, health providers have recognized that today's patient values choice, options, and access. Ko et al. (2014) argued that barriers to obtaining adult immunizations include lack of public knowledge, weak administrative systems, and infrastructure challenges including access. Royne and Levy (2015) further asserted that it is critical for public administrators to understand what motivates patients to act in today's market-based medical environment. Therefore, there was an opportunity to better understand the chasm that exists between public perception and clinical reality when

today's patient is given unfettered choice in preventive health care, such as flu immunization.

Beginning in 2013, the government-run health care system partnered with a contracted retail private sector pharmacy that has been around since 1901 to provide flu vaccinations to veteran patients at no cost to veteran patients who were eligible for and enrolled in the beneficiary health care system for United States veterans. The cost of the flu shot was paid by the government entity on behalf of the eligible patient as part of contracted sole-source services agreement with the pharmacy retail provider (VA-Walgreens flyer, 2016; Walgreens Website, 2019). In 2014, the government program expanded access to flu vaccines with over 20,000 veterans participating, signifying by the numbers that eligible veteran patients are willing to choose to go to a nongovernment, retail pharmacy to obtain their seasonal flu shots even though their government health care providers administer the same immunization during the same timeframe and at no cost to the patient at facilities throughout the United States and its territories.

Program administrators asserted that the Retail Immunization Coordination Project's participation increased access to government-funded and improved care coordination, in part because the immunization data were delivered directly into the veteran's electronic medical record. According to the program clinical director, "This [partnership program] has been heralded nationally, in the press and at national interoperability meetings, as an advance towards seamless care. This is where [we] should be headed" (M. Donahue, personal communication, March 6, 2019). Further, government administrators concluded that publicly funded but privately provided

preventive care helped to improve access to care, a key priority of the health care system (Botts et al., 2017; U.S. Department of Veterans Affairs, 2018). Recent claims in advance of the enactment of the VA MISSION Act of 2018 (H.R. 5674), but after the start of this project, amplified this notion that the government is giving patients the power to choose, offering them convenience and affirming their ability to select health care providers just like most other Americans (Heath, 2019; Wilkie, 2019). However, there is little scholarly research to confirm that access to preventive health care services such as a flu shot by public-private partnerships opens the door to preferred unfettered choice among eligible and enrolled veterans or that having this type of choice meets the needs of the patient population.

Understanding that the health care system's vaccination rates were above the national average, but remained below its target objective of 90%, public administrators sought to expand the program and use U.S. Code 38, Section 1703 to broaden the reach and care coordination efforts of the program. During this same timeframe, commercial health plans also were exploring retail pharmacy partnerships (see Ko et al., 2014) to meet the demands of adult immunization rates under the expanding health benefits afforded by the enactment of the Affordable Care Act (Pub. L. No. 113 – 146, 2014). For the government-run health care system for veterans, the no-cost flu shot program met contemporary choice values of patients, removed access barriers to travel, and provided clinical value propositions that supported care coordination efforts through the electronic data transfer of the immunization (Donahue, 2018; Ko et al., 2014). It advanced the growing narrative within government that "private is good" and "public is bad"

buttressed by the ideas that a private-driven, marketized system strengthens an economy and promotes competition. Something that health experts argued is both unfounded and injustice (Freeman, 2012). The policy ideas that patient care improves with competition is not new.

Government health care policy makers have advanced the idea that government subsidized care from private providers is best for its veteran patient population. When previewing the tenets of the VA MISSION Act of 2018 (H.R. 5674), the current administrator suggested that patients want more convenient care that is closer to home, despite the facts that both patient quality and safety measures are higher in the government-run health care system than its private-sector counterparts (Farmer et al., 2018; Wilkie, 2019). Gingrich and Watson (2016) offered evidence that choice and privatization may be a slippery slope in the rise of what they called neo-liberal or marketized public service. While a vibrant democracy calls upon its citizens to take an active role in the public discourse, the submerged state minimizes the effects of these social benefits, supporting the idea that the market may better provide the service.

Except for a growing body of literature on choice and privatization in other industries, including nonprofits, homelessness, energy, education, and criminal justice, there is little evidence-based research on the concept of choice in health care when public and private options are equally available (Hafer, 2018; Karch & Cravens, 2014; Russell, 2018). With the government-run health care system's care cited as good as or better than private-sector care, choice in government health care policy must include an examination of the attitudes and motivations of the consumer-patient to understand the context in

which a decision is made to seek private-sector health care as an option once a policy is designed or when a government-sponsored program is administered in partnership with private-sector vendors. The idea of choice is one that is commonplace in today's discussions about health care. Within the literature, there appeared to be little evidence to understand this choice phenomenon in the growing landscape of submerged health policies.

Applying the notions of choice, privatization, and citizen feedback, in the present research, I attempted to provide a better understanding of the experiences and insights of enrolled and eligible veterans of the government-run health care system when its patients were given unfettered choice in health care prevention activities, such as a flu shot. The literature, although sparse, revealed claims that privatization efforts in traditionally public administered programs likely shape patterns of political preference of the citizen or in this case, patient-as-consumer (Gingrich & Watson, 2016). This topic of research helped to advance the need for evidence-based research that uses the policy feedback theory to explore the relationships between politics, policy, and administration (Hafer, 2018). In this research, therefore, I focused on the perceived impact of choice claims made in the Retail Immunization Coordination Project, a program that supported unfettered choice in a preventive health setting with a private sector entity.

The findings of my research may be used to inform current and future government health policy makers, those who must communicate these policies, and lawmakers who must enact policies that are determinant and predictable to satisfy the health needs of patients who have earned lifelong health care benefits. Its results may underscore health

care as a right within a commodity-based environment taking into consideration the evidential experiences of patients who were faced with real choice. The use of the policy feedback theory provided a better understanding of the consequences of choice, health policy implementation, and citizen mobilization within the veteran community. It helped form the framework for this study, in which I explored the paradox of features of a submerged health choice policy.

Problem Statement

The government-run health care system offers a social contract between the United States and enrolled and eligible veterans who are given health care benefits, including preventive health care services such as flu shots, based on their service in uniform to America; it is an earned benefit. However, there is a long-standing policy that prohibits government entities from marketing such benefits as freely as its private sector counterparts may advertise their services or programs; the government health care system is not free to advertise but is controlled by regulation and appropriations administered by the United States Congress.

This chasm presents a perceived lack of communication that contributes to the simmering debate over government-provided health care services versus commercially-administered health care benefits. Communication is integral to public health and government institutions, enabling people to achieve optimal health and mediating various stakeholder interests, including the interpretive effects of public policy (Lindridge, MacGaskill, Ginch, Eadie, & Holme, 2013; Mettler & Sorelle, 2018; Neville et al., 2014). Growing evidence has suggested that communication campaigns can increase the

likelihood that a targeted population will participate in potentially life-saving health behaviors (Elder, Karras, & Bossarte, 2016). A still-emerging, but an increasingly prevalent component of health communications, is social marketing (Crié & Chebat, 2013; Luca & Suggs, 2013; Whitelaw, Smart, Kopela, Gibson, & King, 2011). There is a long-standing gap that exists within academic research concerning social marketing that stretches beyond program evaluation (Truong et al., 2014). Systematic research in social marketing as a construct in the public policy arena lacks maturation, and it is not existent in today's government health choice policy debate that relies on the growing negative narrative.

In an unregulated marketplace of medicine within what Mettler and Sorelle (2018) referred to as the *submerged state*, social marketing techniques promote voluntary healthy behaviors or provide options for people to achieve optimal health outcomes. However, research on the use of social marketing in government-sponsored programs is sparse (Giordano et al., 2013; Luca & Suggs, 2013; Neville et al., 2014; Royne & Levy, 2015; Suarez-Almazor, 2011). Elder et al. (2016) agreed that few researchers have examined the influence of the social marketing phenomenon in preventive health care services targeting patients. Aranguren, Magro, and Wilson (2017) further contended that there must be a bridge between academic literature and the implementation of public policy underpinned by theory. This gap in the literature is wide, especially for patients or potential patients of the government health care system, particularly post enactment of the Veterans, Access, Choice, and Accountability Act of 2014 (Pub. L. No. 113 – 146, 2014) and now under the most recently signed VA MISSION Act of 2018 (H.R. 5674),

which underwent the regulatory process during the timeframe of this study and is now in the policy implementation phase.

Current, market-driven health policy debate messaging promises to expand private care options to eligible veterans if they feel unhappy or if they are dissatisfied with their earned benefits by the government. However, evidence from the Westat (2010) research report showed that 42.3% of veterans surveyed never applied for their earned health care services because they were not aware of the benefits. Those providers familiar with the government health care system for veterans have argued that the public does not get a complete picture of this health care system and its high quality of care measures. This narrative may be due to politically-charged narratives that pit the publicly-funded health care system against the more acceptable narrative that private health care is better health care (Black, 2017; Gordon, 2017; West, 2014). Consumer-driven health care is expected to grow due to demographics, legislation, and technology (Whitler, 2015). However, there remains a lack of systematic research in this nascent field of health care.

The patient-as-consumer is expected to evolve. Whitler (2015) argued that the United States health care system faces increased usage thanks to Baby Boomers, an entitlement mentality versus outpaced spending on health care services, and expensive technology. Today's health care consumer is engaged; therefore, public administrators must understand their patients as consumers (Crié & Chebat, 2013; Whitler, 2015; West, 2014). West (2014) suggested that the patient-as-consumer is a paradox, particularly in government-run health care grounded by public policy. Few government-sponsored health communications programs involve the public in understanding their motivations,

values, or intentions to act (Langford, Litts, & Pearson, 2013; Pullen & Flynn, 2014; Turvey et al., 2014). However, with the enactment of the Affordable Care Act (Pub. L. No. 113 – 146, 2014), consumers were engaged at an individual level (Whitler, 2015). In the health care system for veterans, public outcry by policy makers made care in this system an issue debated in the public arena; the issue was based on anecdote and fueled by proprivatization political activists (Day, 2018; Gordon, 2017). What remained void is the collective feedback from veteran patients to understand how they viewed choice in health policy and what motivated them to choose the no-cost flu shot private option.

The policy feedback theory posits that policy success is a path-depended process (Mettler & Sorelle, 2018). Therefore, knowledge is needed to understand how social marketing concepts can promote behaviors that a person can change easily so that government programs can better anticipate the interpretive and resource effects of policy (Mettler & Sorelle, 2018; Suarez-Almazor, 2011). Crawshaw (2013) went even further, stating that there is "paucity of evidence" to support the efficacy of social marketing in the context of health policy (p. 621). There is a general need to understand the consumer, in this case, the veteran patient, in designing, implementing, and promoting health policies that meet their needs rather than simply meeting a policy agenda that satisfies corporate profits above quality health care for veteran patients of the government-run health care system.

This problem of meeting the health care needs of the veteran-as-consumer in the public policy arena is salient to many government agencies. Government agencies are the foundation to serving citizens. Public administrators, therefore, must communicate

messages about new or changed policies to citizens in a crowded media landscape that may be tainted by legislative grand-standing (Giordano et al., 2013; Gordon, 2017). In the present research project, I targeted veteran patients who participated in the Retail Immunization Coordination Project in Phase 2, Phase 3, and sustainment of the program.

In the present research project, I used the theory of planned behavior to support evidence-based data to better understand if contemporary choice policy-making aligns with patient users of the system. My aim was to investigate the behavioral insights into the design of a submerged public policy to better determine patient needs and wants (see SBST Website, 2017). I considered the impact of feedback, both negative and positive, of the veteran patients who chose the private sector option and sought to understand their motivations to engage in the policy advocacy (see Goss, 2010). I helped provide some insight in understanding how social marketing concepts can improve communications to military and veteran populations in an era of health care choice and policy discussion concerning privatization options (see Langford et al., 2013; Turvey et al., 2014). In sum, the present research study can help to show why veteran patients chose outside, free market care when given unfettered choice; I provided a glimpse into the feedback related to emerging private-public health care policy enactment in the United States government but was indeterminant in linking this option with engagement.

Purpose of the Study

The purpose of this qualitative research project was to discover what strategies of a social marketing campaign motivated enrolled and eligible veteran patients of a government-run health care entity to decide to seek a preventive health option outside of

their government health care provider and the impact of choice claims made in the government's health policy claims from 2013 to 2019. The results may help to set an agenda for research using the policy feedback theory to identify how behavioral insights can lead to evidence-based public policy designs that inform policy-makers to develop health programs that are more effective, efficient, and serve veteran citizens better (see Maltby, 2017; SBST Website, 2017). Rather than empty assertions, my aim was to understand the experiences of this unique and understudied population of veteran patients and discern what they want or need to make informed choices when offered options.

There is a substantial gap in research in public health communications aimed at military and veteran patients. Langford et al. (2013) cited several government reports that highlighted the need for additional research on the use of social marketing to inform stakeholders whose job it is to design health communications. This research was designed to broaden the understanding of the enrolled and eligible veteran patients by investigating their views of choice and feedback related to the Retail Immunization Coordination Project.

By examining what elements of a social marketing-preventive health choice program impacted participants' intentions to seek preventive health care services outside of the government-run health care system, the research may add to the limited body of knowledge in this area. Results may make practical contributions to inform policy makers and better understand how health policy design affects political attitudes or support for government-sponsored programs of this citizenry (see Langford et al., 2013; Mettler & Sorelle, 2018). Data did not substantiate any relationship between politics, policy, and

administration/implementation, but they did reveal the need for clear, concise, and timely information when providing patients with choice options (see Hafer, 2018).

With patient choice at the heart of contemporary policy discussions, there was a need to explore if choice in government-provided health care is a force multiplier to health care access. The method of investigation was exploratory in nature with the use of phenomenology as a foundation (see Diaz-Maurin & Kovacic, 2015; Isserman & Markusen, 2013). I examined choice claims within a government-private partnership and sought to understand from the eligible veteran patients' perspective what is expected from their lifelong health care benefits as a person who served in uniform.

Research Questions

In this interpretative phenomenological study, the idea of choice was at the center of the research. Using a social marketing-based, private-public program, I sought to understand the influence of a choice policy program on patient users. My aim was to understand the interpretative effects of a health care choice policy, assessing the influence of a retail immunization program on veterans' perceived impact of choice in health care policy diffusion and veteran citizen mobilization.

The central research question guiding this study was as follows: How can government sponsored social marketing campaigns support evidence-based policy making by identifying what factors influence veteran feedback and the adequacy of the choice claim in patient decision making for seeking preventive health services? Research Question (RQ)1: Why is the no-cost flu shot option an appealing choice for veteran patients in this era of the patient-as-consumer?

RQ2: How do veteran patients of the government-run health care system decide to use the option to access the free-market no-cost flu shot option at a contracted private-sector retail pharmacy?

RQ3: How do participating veteran patients describe their decision making related to the principles of social marketing and their perceived feedback related to choice legislation?

Theoretical Framework

The theoretical framework guiding this qualitative research project was policy feedback theory. I specifically aimed to understand whether participation in a privatized preventive health program shaped future behaviors and understanding of current choice claims in health policy debates (see Mettler & Sorelle, 2018). This theory served as a foundation to the present research project as today's government health care environment anecdotally functions within a framework of patient engagement, public policy, and free market. It provided a lens to better understand the submerged state of public policy and go beyond program evaluation by employing additional insights from the theory of planned behavior (see Neville et al., 2014).

By using the policy feedback theory as a backbone to my research project, it buttressed a qualitative focus on how or why veteran patients choose outside, free market care when given unfettered choice (see Rudestam & Newton, 2015). I focused on the idea that while most veteran patients experience the social benefits of a government program, their lived experience with how they receive the benefit may coalesce to support or reject the concept of a health choice policy (see Sorelle & Shanks-Booth, 2016). This

framework was accompanied by Ajzen's theory of planned behavior (see Ajzen, 2013; Ajzen & Fishbein, 1969).

Ajzen's theory of planned behavior was used to shape questions that formed the basis of data gathering (see Ajzen, 2013; Ajzen & Fishbein, 1969). The theory of planned behavior posits that information alone is not enough to move a person to action, supporting the idea that norms, values, and attitudes of a citizenry shape policy design and implementation (Mettler & Sorelle, 2018; SBST Website, 2017). Using an interpretative phenomenological approach, the results of this study support the need to keep to the voice of the veteran patient in the health policy design, implementation, and promotion efforts. Data supported the ideas posited in the theory of planned behavior and the policy feedback theory that patients want and expect direct, clear, and easy-to-understand communication along with some type of endorsement by trusted others (see Ajzen, 2013; Ajzen & Fishbein, 1969; Pierson, 1993; SBST Website, 2017).

The theory of planned behavior has long been used as a best practice for developing and evaluating social marketing campaigns that focus on behavioral intentions. Less studied is how policy influences a cohort of veteran patients who must choose to accept or reject a predominantly public narrative. Research concerning the interpretive and resource effects of the policy feedback theory is in its infancy (Luca & Suggs, 2013; Mettler & Sorelle, 2018). Because I evaluated the attitudes and motivations within the construct of the concept of choice resulting from a government program in this study, the theory of planned behavior combined with the policy feedback theory provided for relevant lenses to explore the choice phenomenon. Both theories have an interest in

the effects of norms, values, and attitudes of the end user. Both theories set the stage for conceptualizing what attitudes, subjective norms, and perceived behaviors exist for the patients-as-consumers bound by new and ever-changing public health policy. The theory of planned behavior underpins components of a social marketing framework within the context of health communications evaluation and research (Luca & Suggs, 2013; SBST Website, 2017). Such a foundation provided a formidable position of credibility, trustworthiness, and reliability in this study. It was the use of the policy feedback theory that served as the overall framework for the study.

The policy feedback theory seeks to understand how policies shape politics. The theory relies on a path-dependent process of its target population, which may or may not affect the future of a policy design, diffusion, and implementation (Mettler & Sorelle, 2018). Chapter 2 provides more background and context on the use of these theories and show how they intersect with the present research on what motivated an eligible and enrolled veteran patients to choose to seek preventive health care services from a private-sector provider rather than their government health care provider.

Nature of the Study

The research was qualitative in nature. A qualitative approach helped to elicit the views of participants to provide a holistic understanding of the influence of a retail immunization program and generate a descriptive understanding of the veterans' feedback concerning choice in their health care policy options. Creswell (2013) contended that phenomenology allows a researcher to capture a variety of narratives to determine a universal understanding of a phenomenon based on experience of

individuals. A phenomenological design proved valuable for this study because it supported the use of individual and personal feedback to discern a collective experience.

Phenomenology was suitable for this research because personal narratives based on lived experiences helped illuminate the essence of a participant's experience, which is hard to quantify. Phenomenology was a formidable option for a study that aimed to understand policy adoption or diffusion. Developing personal, experienced-based narratives were essential to counter shallow evidence-deficient claims of choice in current government health policy debates (see Creswell, 2013; Isserman & Markusen, 2013). Finally, this approach helped provide a pathway to understanding the impact of unfettered choice to participants, perhaps serving as a guide administrators on how to make policies more relevant. It illuminated the understanding on how a government policy shapes the norms, values, and attitudes of a constituency within the umbrella of the policy feedback theory (see Isserman & Markusen, 2013; Mettler & Sorelle, 2018). To better understand the phenomenon of choice in a government health care policy design, diffusion, and implementation, data came from a small cohort of veteran patients who participated in the no-cost flu shot from 2014 to 2019. A screening tool and subsequent semistructured interviews helped me better understand how or why government-eligible and enrolled veteran patients chose to seek their flu shot at a private sector retail pharmacy rather than their government health care provider when they were given unfettered choice.

Definitions

There is a need to establish a common understanding of the word *choice* as it pertains to my research project. In discussions surrounding private versus publicly funded health care, the concept of choice is ill-defined. Choice is relative in health policy development and implementation. Choice in contemporary discussion offers the idea that the consumer gets to choose his or her care options; scholars contended that real choice in health care is limited when it comes to government-supported measures because there is an imbalance between rights and market-driven choice (Crawshaw, 2013). Some scholars have argued that the only choice policy makers and lawmakers are providing is the choice to go outside the government-run health care system as they restrict funding and infrastructure assets, along with the continued negative narrative about the government system of health care (Gordon, 2017). Choice in the present research included broadening the understanding of the choice phenomenon by eligible and enrolled patients who may be subjected to the ongoing negative narrative that to choose a private-sector provider equals a solid decision.

Choice was not defined, in this case, as opting for outsourcing the government-run health care services full scope. In this research, the definition of choice matched that of the other study related to this program and other health care indicators that are critical to quality health care–lower cost of care combined with care coordination, ease of access, and patient safety (see Botts et al., 2017). Choice in this case entailed presenting all patient care options despite rhetorical claims that choosing outside care is the best value for the government and the patient, that the patient is trapped by a health care system that

lacks competition (Pipes, 2017). It was not simply deciding on one course of action or another but choosing the best option when given all factors of a given situation. Choice in this case was not a right to health care or how one selects it, but choice was measured by evidence-based outcomes and how a patient evaluates them.

Other definitions relevant this the present study include the following:

Policy evaluation: Policy evaluation is a critical element in the evolution of the policy-making process that provides intelligence from past experiences and future expectations (Aranguren et al., 2017).

Privatization: Privatization is moving traditionally public-rendered services to the private-sector partners, setting a new trend of making public services administered by private-sector entities but paid for by taxpayers; the privatization trend is increasing in both the U.K. and the U.S. It opens the door for a submerged state, blurring the lines of public accountability (Gingrich & Watson, 2016; Sorelle & Shanks-Booth, 2016).

Social marketing: Social marketing takes the traditions of marketing by employing the four Ps of product (service), place (convenience), price (personal costs), and promotion (targeted communications). Both social and behavioral sciences form the foundation of social marketing programs and may advance health policy that yield changes in behavior (Singaiah & Laskar, 2015; Suarez-Almazor, 2011).

Veteran Health Information Exchange (VHIE): VHIE is a health informatics program within the Department of Veterans Affairs (VA); it promotes the seamless, electronic exchange of health information from private-sector health partners and the Veterans Health Administration (VHA) to improving quality, coordination, and

continuity of care for eligible and enrolled veterans of the VA health care system. It hosts several projects including the Retail Immunization program to offer health clinicians a more complete summary and picture of a veteran's health and medication information, reducing duplication of tests and processes, and empowering Veterans to improve their health (Donahue, 2018).

VHIE Retail Immunization Coordination Project: The program established a private-public partnership between VA and Walgreens to provide no-cost flu shots to enrolled and eligible veterans of VHA; it is informally known as the VA-Walgreens project or the no-cost flu shot program (Botts et al., 2017).

Assumptions

Given the qualitative nature of the present research, results may not generalize to other government-run or government-sponsored social service agencies due to the unique nature of enrolled and eligible veterans of the government-run health care system in a distinct, small region of the United States. Thus, the findings from the study may be limited to the participants' personal experiences and motivations of patients who are eligible and enrolled in the local health care system of the targeted 5-region area in the south. The use of the policy feedback theory buttressed by the theory of planned behavior framing this study assumed that these theories are adequate lenses in which to design the study, understand the data, and explore the choice phenomenon.

By focusing on the concept of choice based on personal experience, there was an inherent assumption within the study that participants would be honest with their feedback and willing to share their perceptions about choosing the private sector retail

pharmacy as opposed to their government-run health care provider. In addition, the parameters of the study presumed that the participants had similar experiences with the program and had been exposed to similar messaging about the Retail Immunization Coordination Project. Also, as designed, I focused on participants unique to the partner site, a government-run health care system in south. With this participant pool, administrative support helped to provide access to the participants as supported by the data parameters in the system's electronic record system. The resulting assessment and summary results may contribute to social change to better engage veteran citizens in health care policy-making but more importantly helped to identify that the target audience requires clear, concise, and informed messaging to contribute to the acceptance of health policies stemming from the government-run health care system.

The focus of this research was on choice claims and reflected the effects of the on-going debate concerning privatizing government health care services for veterans, including preventive care measures such as flu shots. Given this broad topic, data related to participants of a private-public partnership program resulted in a general but not absolute understanding of what choice claims represent to the target cohort of veterans who are actively enrolled in the government for health care services. A postpositivist framework was used, seeking outside validity for the research but understanding that new knowledge will come from interpreting themes that derive from participants (see Creswell, 2013).

In sum, I relied on the beliefs and ideas that flowed organically from the participants, using the policy feedback theory and the theory of planned behavior. Their

voices helped determine the effectiveness of choice claims and supported the focus of this research in understanding what motivates the patient-as-consumer to participate in policy discussions, diffusion, and implementation efforts. Results may work to widen the lens on what they need as patients of the government run health care system and understand why they may have chosen private-sector care over the traditionally administered government option. It may add to the body of knowledge of the patient-as-consumer in the United States and amplify the social justice concern of health care as a right versus a commodity, particularly for this unique patient population.

Scope and Delimitations

The research problem is critical to understanding the impact of lived experiences from enrolled and eligible veterans of the government-run health care system and determining the role of participant feedback and their effects on policy diffusion and implementation. The study helped to shed new light on the relationship between politics, policy, and administration, clarifying participants' interpretation of the concept of choice and the meaning of privatization of earned benefits to offer a counter narrative to the over-hyped negative storylines in the media and legislative grandstanding.

In the present research, I focused on the participants of the Retail Immunization Coordination Project with a timeframe of 2014 to 2019; this project served as a relevant supplement to the only other study related to this topic within this setting (see Botts et al., 2017). I obtained rich, descriptive data to confirm other utilization data about this project. Therefore, with a qualitative approach, participant feedback added interpretation to the choice claims made by the Retail Immunization Coordination Project based on the

study's findings as presented by Botts et al. (2017). Research biases were bracketed as strict adherence to the study's site, and participant guidelines were used as guardrails. The use of epoche was employed. I used the theoretical frames to undergird the focus of this study to better understand the behaviors and motivations surrounding the choice claims made by the Retail Immunization Coordination Project. This framework helped to focus the participants' feedback on objective findings as opposed to personal interpretation along.

In the present study, I used a qualitative methodology based on a phenomenological approach to help establish a research agenda for policy making and administration focused on choice and benefits for enrolled and eligible veteran patients. As demonstrated by the literature, privatization and choice are prevalent concepts in a variety of industries, including education, criminal justice, energy, and homelessness (see Ainley, 2015; Aubrey & Dorsi, 2016; Burkhardt, 2014; Dorfman & Harel, 2015; Hafer, 2018; Karch & Cravens, 2014; Russell, 2018). However, there is scant evidence of the impact of choice claims in health care, particularly government-provided health care services. In this research project, the focus was to better understand and establish the meaning of choice in health care from the participants' experience and further examine the impact of choice from an existing choice program. As described in the guidelines of the partner site, an executive summary will serve to inform key constituents and stakeholders of the program. To enhance transferability, the findings will be shared with the local site partner, the central office program owner of the Retail Immunization

Coordination Program, and public affairs officers for use in current and emerging health care choice policies.

Limitations

To understand the influence of a retail immunization program on veteran patients' perceived impact of health care choice in the government-run health care system using a policy feedback perspective, there were some limitations using a qualitative approach. Participants were recruited based on health data located in their electronic health record that signified that they had received a seasonal flu shot from the contracted, private-sector retail provider using a limited timeframe of 2014 to 2019 and within a selected geographical area in the southern part of the United States.

This specific program, the participants' feedback, and the time interval, therefore, may not be generalizable to the entire patient population of this health care system. The selected participants also may have had other influences that are not accounted for in this study, for example, poor or good experiences at their local government sponsored health care place of care or with another choice-like program offered by the government. Secondly, this study was designed to be a first step in setting a research agenda for feedback policy effects. However, its results may serve to complement the only other study that analyzed Retail Immunization Coordination Project claims data and applied the Geographic Information System technology (see Botts et al., 2017). Finally, the choice phenomenon is complex, lending to a variety of interpretations that may generate more questions that are beyond the scope of this study.

By employing a qualitative methodology, there may have been potential bias and reliability from participants of the program. However, the study did generate a new way to understand the impact of feedback and set the stage for a larger, more quantifiable study. Not since Mettler's 2005 work on the GI Bill's impact and provisioning on veterans has there been a study with a focus on veterans underpinned by the policy feedback theory. Study respondents had differing backgrounds and enjoyed varying experiences with the government-run health care system that may have impacted their responses; there remains national variation in the quality and type of health care services rendered throughout the government-run health care system (Anhang Price et al., 2018).

Significance

There is a critical need to marry evidence-based research and the policy-making agenda of the government run health care system for veterans of the United States. In an era of marketized medicine, the health care system for veteran patients lacks a systematic research agenda to study, understand, and use feedback from its patients when designing, diffusing, and implementing regulations. This lack of coordinated communication leads to an uninformed, and arguably, a weakened cohort of veteran-citizen-consumer. There is a need to understand how to market to the veteran-patient-consumer when legislation prevents it. Indeed, social marketing has been studied and analyzed as part of health care promotion and communications for over 40 years (Neville et al., 2014). However, inconsistent findings in social marketing research within the health care sector suggest that there is a substantial gap in understanding how social marketing may improve health prevention behavioral outcomes and policy-making initiatives (Croker, Lucas, & Wardle,

2012; Luca & Suggs, 2013; SBST Website, 2017). Truong et al. (2014) argued that research is a critical indicator of academic maturity of a field of study. Truong et al. cited several studies that failed to move beyond program evaluation and called for social scientists to enrich the understanding of social marketing by moving from a practice-based approach to a theory-grounded framework. Therefore, the aim of this study was to begin to move health policy within this sector in a direction that includes the voice of the veteran and that ensures its design, development, and diffusion are based on systematic study.

There is a gap in understanding the motivations and behaviors that lead a beneficiary veteran patient to seek outside services and why they do so. More systematic research is needed to understand how health communications, underpinned by social marketing concepts, leads to evidence-based policy making (Elder et al., 2016; Langford et al., 2013; SBST Website, 2017). This study provided a first-glance view of how to advance an alternative to the ongoing negative narrative that private care is better than government care despite earned benefits and studies that show the government-run health care system is most often as good or better than private care as evidenced by other studies (see Anhang Price et al., 2018; Farmer et al., 2018; Weeks & West, 2018). It can give a voice to veterans who do not hold power positions in their Veterans Service Organization (VSO) communities or legislative authority.

With the ongoing private-public debate surrounding the value concept of choice in health care, the government-run health care system for veterans regularly implements health communications campaigns to inform veterans. However, it has yet to amass

consistent empirical evidence that suggests which strategies increase the knowledge of and access to health care options and optimize policy diffusion and implementation for veteran and military patients (Elder et al., 2016; Langford et al., 2013). The results of this present study may serve to elucidate the motivations and attitudes among veteran patients who now have greater choice options when seeking preventive health care services such as flu shots or urgent care needs.

The results may bridge the gap in understanding veteran behavioral insights to better inform policy makers of the need to consider norms, values, and attitudes of consumers when designing, implementing, promoting, or evaluating public policy (see Advisory Board Website, 2016; Mettler & Sorelle, 2018; SBST Website, 2017). The implications for positive social change include policy changes once policy makers are informed of the importance of evidence-based social marketing concepts grounded in theory to increase the knowledge of and access to options for preventive health services offered by government-sponsored programs. By understanding veteran patients' motivations, characteristics, and intentions to act, results may generate evidence-based, participant knowledge and insight on the use of choice claims; these findings could serve to improve health care access or information about health care policies and programs for veteran patients because they confirmed that practical research and data align public policy with government communications resources.

Summary

In this chapter, the concept of choice was introduced as part of the contemporary government-run health care system policy vernacular, and I discussed key components of

my research based on the challenge of the complex relationship between politics, policy, and planning. The Retail Immunization Coordination Project was used to understand the feedback of targeted participants to present the purpose of the study, an initial step in understanding how choice claims in health care motivate patients to seek private care options, developing the roadmap to present competing narratives of choice policy for eligible and enrolled veterans of the government run health care system for veterans. The policy feedback theory was discussed as the theoretical framework to understand the implications of a social marketing campaign on policy design, diffusion, and implementation. A qualitative methodology involving phenomenology was adopted for this study. Also provided and discussed was a working definition of choice within a defined timeframe to focus the research. A summary of limitations and the study's significance as they relate to the concept of the choice claims were presented. The data analysis was designed to provide a general understanding of feedback effects from the targeted cohort, thereby filling the gaps in literature on how policy impacts veterans' beliefs in government-administered health benefits and the impact of ongoing choice legislation.

A more detailed discussion of the literature that was used to develop this study is provided in Chapter 2. In this chapter, a presentation of the research using the literature searched, the search strategy, and conceptual framework selected are provided. There is a more developed discussion on the intersection of policy, politics, and administration. Chapter 3 follows with a description of the study design, participants, and procedures used to better understand how policy feedback plays a role in a large integrated

government run health care system for veterans. Finally, in Chapter 4, I present the results, and Chapter 5 includes a discussion.

Chapter 2: Literature Review

Introduction

In today's landscape of marketized medicine where the patient is now the consumer, public administrators must manage politics with public trust while fulfilling their agency's mission and obligation to what is known as essential state functions based on societal benefits. The largest, integrated, publicly funded agency that provides health care services and benefits to eligible and enrolled veterans has faced immense scrutiny with a running negative narrative throughout its history. However, since 2014, despite evidence-based studies that show its quality of care is as good as or superior to private-sector health care entities, this government-run health care system has had to operate within a backdrop of neoliberal policies (Anhang Price et al., 2018; Burkhardt, 2014; Farmer et al., 2018; West & Weeks, 2018). The present research was designed to examine the choice phenomenon and perceived impact of a public-private partnership during the period from 2014 to 2019; this timeframe overlaps with today's mainstream argument and legislative activity to move government-granted health care for eligible veteran patients outside of the traditionally-provided in-house health care system.

The neo-liberal trend has been to provide beneficiaries with government subsidized services via private health care entities in the name of consumer choice. The policy feedback theory guided this research, in which I aimed to understand the submerged state of public policy in a public-private partnership, the Retail Immunization Coordination Program, as it relates to the choice phenomenon evident throughout the

health care industry today. It is under the umbrella of the submerged state of a health policy that I formulated this research.

There is no federal agency more criticized for offering no choice to its customers than the health care administration that serves as the largest government-run integrated health care system in the United States. In political speeches and during campaign rallies, political leaders and policy makers alike have recognized this agency as a national treasure or public trust that the United States has with the men and women who have served in uniform to sacrifice for American values in times of war and peace (Shulkin, 2018). For decades, the government-run health care system and its beneficiaries have been a rare apolitical entity on the national political stage.

However, in today's environment where market-driven medicine clashes with perceived patient choice and the idea that patients are now consumers, there continues to be a struggle between providing a service that is inherently a governmental responsibility and contracting out that care for the benefit of for-profit endeavors. Gordon (2017) asserted that today's health care system that serves beneficiary veterans is more politicized than ever, serving only to highlight an ongoing negative narrative that urges lawmakers to outsource care to private health care providers for veterans who deserve choice (see Day, 2018). Mettler (2011) argued that this trend is not new, suggesting that the lack of relevance of a policy to the individual directly impacts the social impact of that program on its constituencies. Choice in this health care is now a matter of public policy, hence the focus of the present research.

The road toward privatization of the government-run health care system for veterans began in earnest in 2014 despite the system's steady indicators of leading quality and coordinated health care, being an innovator in whole-person or patient-centered care, and exceeding patient safety standards for decades. Despite the outreach of a 2014 wait and access scandal that was fueled by a neoliberal trend, studies revealed that the government-run health care system consistently outperforms its for-profit and not-for-profit counterparts in patient safety, quality of care, care coordination, and wait times for some sectors (Gordon, 2017; Penn et al., 2019; Price et al., 2018; Weeks & West, 2018). Many studies dating from the 1990s to today support a high performing, integrated, and innovative government health care system that meets or exceeds the quality of care and patient safety standards of other United States health care systems, for-profit and not-for-profit alike (Anhang Price et al., 2018; Gordon, 2017; Hollingsworth & Bondy, 1990; Longman & Gordon, 2017; Penn et al., 2019). Mainstream media began touting the need for privatization of this often-cited high-quality health care system due to poor performance regardless of peer-reviewed, systematic data. Their call to expose government-provided health care as less-than and provide vouchers for veteran patients to obtain privatized care amplified a negative narrative that pitted anecdote against data (Pipes, 2017). It emphasized the us versus them mentality that often surrounds submerged features of invisible government programs and policies.

Longtime policy advocates claim that the government-run health care system is worth saving. While their cries were dwarfed among the loud critics, often lobbyists, who cited the need for a market-based system, advocates tried to articulate facts about quality,

coordination, and costs even amidst the public calls to fully or partially privatize the VHA (Gordon, 2017; Longman & Gordon, 2017; Mettler, 2011). Critics of maintaining a national health care system devoted to the integrated health care of enrolled and eligible veterans moved the lexicon from privatization to community care during the time of this research to make their arguments more palatable to the citizenry that consists of only 7% veterans compared to 18% in the 1980s (Gordon & Craven, 2018). However, it remains unclear what the majority of the beneficiary audience believes about the choice phenomenon, and even less is known about how members of the government-run health care system define choice in services that are intrinsically linked to their oath to defend the United States as service men and women. The balance of right or commodity is the social justice concern that was under investigation and how beneficiary patients understood the impact of choice in health care policy.

As the nation's only publicly funded, fully integrated health care system in the United States, the health care system for veteran patient beneficiaries provides critical research and clinical education investment not only for eligible and enrolled veterans but to the United States citizenry as a whole. However, unlike its for-profit or even not-for-profit counterparts, it is subject to the fiscal constraints, political pressures, and immense governmental oversight from legislators who see patient choice as paramount in modern-day medicine. Its policies are often a result of lobbyists who have the ear of these same lawmakers. Mettler (2011) projected that lobbyist and campaign contributions rose almost 186% from 1990 to 2008, significantly increasing their power interests while views of the constituent public became submerged (pages 32 – 36).

Since the 1990s, despite the sacred mission of this government-administered health care system for those who have borne the battle, there has been a growing narrative of the patient-as-consumer both within and external to the government. The once-touted innovative government-run health care system has begun to lose its countervailing force (Advisory Board Website, 2016; Gordon, 2017; West, 2014). West (2014) suggested that consumers care about choice, but they may not equate choice in health care with true market competition. Competition in health care is different than in other industries, making the argument of consumer choice even more elusive (Khamis, 2017). This narrative is particularly poignant to the government-run health care system, which is both a payer and provider of health care to more than 9 million consumers. Therefore, the patient-as-consumer phenomenon formed the foundation of the present research.

Based on the conceptual framework of social marketing and buttressed by the policy feedback theory, I sought to understand the impact of lived experiences from enrolled and eligible veteran patients of the government-run health care system who participated as patient consumers in a private-sector retail immunization choice prevention program from 2014 to 2019. My focus was intentionally narrow as the private-sector retail immunization program offers unfettered choice to enrolled and eligible veterans to get a no-cost flu shot at either their government-run health care facility or their local retail pharmacy, which is the contracted partner, without an appointment; it also ensures that health data are shared between the two entities due to an enhanced health data sharing agreement, maintaining coordination of care standards (U.S.

Department of Veterans Affairs, Community Care Webpage, 2018). Using a qualitative approach, my aim was to understand the interpretative effects of the private-sector retail immunization program that offers unfettered choice to eligible and enrolled veteran patients.

The idea of farming out government programs to private-sector entities is not new. In fact, Mettler (2011) argued that the design of contracting out these types of services made social service programs funded by taxpayers more palatable for conservatives beginning in earnest in the day of Reagan but growing exponentially over the next 3 decades. Mettler and Sorelle (2018) wrote that policy design, implementation, and diffusion may play a role in future policies. In other work, Mettler and Welch (2004) and later Mettler (2011) pointed out examples of how the visibility of one program, the G.I. Bill, had lasting cognitive effects on recipients who knew that their benefits emanated from the government; they were more likely to embrace other social programs and express gratitude. Contrast that reaction with today's recipients of student loans; they often doubt they have ever even used a government social program when, in fact, this program is a government-subsidized program, albeit invisible.

It was Pierson (1993) who first introduced and hypothesized that policies have side effects that may be categorized as resource or interpretive. In this seminal work, Pierson argued that it was necessary to move beyond the effects of a policy. Pierson's work premiered the idea of the policy feedback theory as necessary to understand causal implications to a variety of actors including mass public and key constituencies. Pierson

set a research agenda to understand if or how beneficiary groups mobilize to protect "their" benefits.

Similarly, this research project may set a pragmatic research agenda for the government-run health agency communicators and its public administrators to better understand the concept of choice from the veteran patients' point of view. It may help to develop more effective and actionable health policies that are durable, meet the social justice needs of the beneficiary patient group, and mobilize the targeted group of veterans who are enrolled and eligible for beneficiary health care services, but are caught in the debate over public and private roles of health care (see Isserman & Markusen, 2013; Lockwood, Kuzemko, Mitchell, & Hoggett, 2017). In this study, I aimed to understand if use or experience of a submerged policy program advanced the patients' understanding of the government's role or if the invisible nature of the program reinforced the submerged effects of social service program.

This approach aligns with the government agency's roadmap to advance health care practices that are research-based. The policy feedback theory offers a lens to discover the interpretive effects of a policy while analyzing feedback from a specific civic community. I aimed to explore the behavioral predispositions of this veteran patient community and examine an outsourced government policy with critical analysis (see Kilbourne, Elwy, Sales, & Atkins, 2017; Mettler & Welch, 2004). It is important to understand what motivates these beneficiary veteran patients to accept nongovernment administered care under the banner of choice, which is now a matter of public policy (see Affordable Care Act, 2014; Botts et al., 2017; VA MISSION Act, 2018; West, 2014;

Smith, 2017). Few researchers have used the policy feedback theory linking veteran patient experiences of a private-public program with the choice phenomenon in a social marketing context.

A review of relevant literature on the nature and use of the policy feedback theory and social marketing, particularly in the health care and social sectors, kicked off this research. In designing this study, the patient-as-consumer phenomenon, including the idea of choice and privatization, remained core concepts to discover the after-effects of a health care policy that moved a program from the traditional in-house service to one that was outsourced to a sole-sourced private-sector entity in the name of efficiency and cost-effectiveness. Finally, a working roadmap to the research method developed to identify the policy feedback effects of the private-sector retail immunization program. By forming this focused research study through the lens of the policy feedback theory within a social marketing context, the examination of choice claims in the government-run health care system policy of consumer choice as amplified via the private-sector retail immunization program became centerpiece.

The hope was to formulate an argument for policy administrators and communicators to design and implement regulations and guidelines that support a social provision for beneficiary veterans that not only meet the legislative markers but provide meaningful and balanced information through policy delivery. The goal is often overlooked as the highly publicized legislative process fades after the enactment of the law; it is the government entity that must inform its citizens of the features of the

legislation, an area that called for more research, particularly with this agency (Mettler, 2011).

Therefore, the aim of this research project was to introduce a new area of inquiry to support government responsiveness and civic participation (Ortiz, 2006). Central to the present research was understanding the influence of veteran choice with the government health agency's policy transition to move health care services from the government-supported providers to contracted out private sector partners. This approach is similar to Khamis (2017) who argued that there is both ambiguity and confusion over the term "privatization" and a lack of empirical evidence concerning private-sector influence on public policy and access to care issues within a regulated public health care system. Following this introduction is a literature review that focuses on the policy feedback theory, social marketing, the choice phenomenon, and the need for evidentiary policy-development opposed to passion-only politics.

Literature Search Strategy

A systematic review of publicly available documents related to the private-sector retail immunization program, agency strategic planning tools, government-supported online data sources, and other official documents related to the private-sector retail immunization program and partnership was conducted to jumpstart this research project. The search was limited from 2014 to 2017 to coincide with the timing of Phase 2 and Phase 3 of the private-sector retail immunization program, an innovation project that outsourced flu shots to a well-known retail pharmacy for eligible veteran patients at no cost to the patient. The search was expanded to 2018 and 2019 because of the ongoing

and increase in choice policy debates surrounding the large, integrated health care agency that serves 9 million enrolled veterans of the United States. The initial, formal library search yielded one peer-reviewed article, a strategic plan, and background documentation found on the government agency's website, signifying scant research around choice and veteran preferences using the backdrop of the private-sector retail immunization program.

As a result, there was a need to expand the search parameters to identify peer-reviewed literature concerning the use of social marketing as a framework to promote healthy behaviors and attitudes. This search was conducted using Sage Publications online research database as the primary means of gathering information about the use of social marketing to target enrolled and eligible veterans, particularly those veterans who were patients of the government-run health care system. A Lexis search for additional literature on outreach campaigns related to adult influenza immunizations helped to supplement the other search efforts that lacked significant literature related to this research topic and focus. With support from national librarians of the government-run health care system, the following search terms served as a starting point for an expanded literature review: *social marketing*, *VA health care*, *veterans*, *flu shot*, *influenza*, *immunization*, *consumer health*, and *patient-as-consumer*. The search revealed inconsistent results in the use of social marketing aimed at the target participant group.

Less than a handful of studies fully appeared to focus on the use of social marketing and a veteran program or have a veteran patient focus. The search for peer-reviewed literature on flu shot programs yielded 21 articles; many of these articles discussed the clinical efficacy of flu shots and a patient's behavioral intentions to get the

seasonal flu shot. A sample set of over 30 articles revealed a lack of academic maturity in this field of study due to scant empirical and theory-based research that employs social marketing, particularly in the United States where there is little research done around health policy using a social marketing backdrop (Giordano, et al., 2013; SBST Website Background Document, 2014). Therefore, the preliminary literature review focused on about a dozen articles that fit the focus and timeframe of the present research study.

The core of this content dealt primarily with clinical outreach to move a targeted patient audience to action. There was little intersection between social marketing and the policy feedback theory, which served as a foundation to the present research. Therefore, with this background in place, and after having met twice with the Walden University public policy and administration subject matter expert in the library, the electronic search for applicable literature was expanded to include the following key word combinations in a variety of databases and Google Scholar searches: *social change, policy feedback theory, policy, private-public partnership, Veterans Affairs, health, Retail Immunization Coordination Project, Walgreens, flu, flu vaccine, preventive care, military, choice, veterans choice, options, privatization, outsourcing*.

Because the focus of the present research was purposefully narrow and project-specific the search timeframe was limited from 2013 to 2017; it was later expanded to include the years, 2018 – 2019 as the topic of *choice* in health care became more commonplace. This strategy was developed by establishing several search queries that continued to offer articles on *choice* and *privatization* through 2019. It should be noted also that before focusing on the policy feedback theory as the lens by which the research

is based, much time was spent reviewing literature on the theory of planned behavior to examine how a patient might be motivated to act. The research suggested that the theory of planned behavior may be appropriate to understand a person's intention to act along with the evaluation of how this action leads to negative or positive feedback. In total, the following databases were utilized: ProQuest Central, ProQuest Health and Medical Collection, Military and Government Collections, Communication and Mass Media Collection, Thoreau, Google Scholar, and Science Direct. Additionally, to ascertain more discreet articles related to the topic of the present study, the following relevant databases were used also:

- Sage Journals: Policy Studies Journal; Communications and Media Database; Sage Journals Premier
- SageKnowledge
- Political Science Complete
- Academic Search Complete
- Social Science Citation Index
- SocINDEX with Full Text
- Sage Research Methods
- Nexis
- PubMed

In addition, contemporary, non-peer reviewed writings about the private-sector retail immunization program were reviewed regularly as news and legislation increased about choice throughout 2018 and 2019. This routine review of newsworthy reading

helped with current policy implementation knowledge and kept the researcher informed about the veteran patient choice claims. By reviewing daily news briefs provided by the government run health care agency, the topic became more relevant and timelier. This contemporary review helped bring meaning to this present research.

In a sample search of non-peer-reviewed news stories about the private-sector retail immunization program and other flu shot campaigns, the Lexis search yielded 30 articles ranging from 2012-2016. Reliance on contemporary writings about the government run health care agency for beneficiary veterans and the privatization claims from health policy writers, Suzanne Gordon and Phillip Longman, also helped illuminate the need to better understand the effects of a submerged health policy that affects a beneficiary patient population that has earned these health care opportunities. Throughout the course of the literature review over 90 sources were used to structure the initial argument that few government-sponsored health communications or policy programs involve the beneficiary public in understanding their motivations, values, or intentions to act prior to or when designing health care policy and then implementing and diffusing the intentions of the legislators (Langford et al., 2013; Pullen & Flynn, 2014; Turvey, et al., 2014). An expanded to focus on *privatization*, *choice in health care*, and *outsourcing of public services* helped to ensure that the present study was well-grounded. Additional articles, numbering more than 25, using Nexis, PubMed, Sage Journals, and Google Scholar, helped round the review.

Other than literature reviews in non-industrialized countries or countries that subscribe to mostly government-supported health care, there was scant research. It was

not an easy task to identify peer-reviewed studies that addressed the choice phenomenon in a way that influences privatization policy practices in the government run health agency for beneficiary veterans. While some studies showed promise around the choice argument in the government-run health agency for beneficiary veterans, many overlooked the beneficiary perspective and focused rather on the role of the manager or key informants (Finley et al., 2017; Korlen, Essen, Lindgren, Amer-Wahlin, & von Theile Schwarz, 2017). Other studies used quantitative analysis only, reviewing and analyzing utilization of services to compare use in the era of choice (Humensky et al., 2012; Vannenman et al., 2017). Others focused on nongovernmental health care entities with a specific focus on cancer care and hospitalization (Aggarwal, Bernays, Payne, van der Meulen, & Davis, 2018). Therefore, it became clear that there was a gap in this topic area. Knowledge was needed to understand how social marketing concepts can promote a health policy that is both salient and socially responsive, taking into consideration the motivations and feedback of the beneficiary public (Mettler & Sorelle, 2018; Ortiz, 2006; Suarez-Almazor, 2011). Understanding how a policy is enacted and what are the benefits or provisions should be part of the information flow from the government to its citizenry. Yet, in the case of choice in health care policy for this beneficiary veteran patient population it was unclear if there was an understanding of the policy-specific information for this program, and less about the balanced facts of the program.

Therefore, the basis for the present research was the policy feedback theory because there is scant evidence to understand the impact of how a once-publicly administered health program that is marketized may impact the beneficiary audience of

an inherently earned benefit under the responsibility of the United States government, specifically the health agency that has the mission to serve veteran patients who earned the health benefits due to their time in service. Mettler (2011) argued that salient information to a beneficiary audience may influence their engagement and may have a direct impact on their understanding and thus evaluation of the program. Thus, this research was highly practical and timely as legislation to open choice and private-sector expansion for veteran patients was expanding and on-going throughout the course of the period under investigation.

The use of the policy feedback theory and its focus on implementation and diffusion naturally align with social marketing concepts given the prohibition on the government's ability to advertise versus the private sector health care entities that have advertising budgets more than $10 billion (Gordon, 2017; Gordon & Craven, 2018; Short, 1991; Taylor & Kent, 2015). A more complete discussion of how the policy feedback theory was used to examine the choice claim in the private-sector retail immunization program and analyze the impact of choice in the present research follows in the discussion titled, theoretical framework. During this discussion, there also is a discussion of the theory of planned behavior as a foundation to designing the research methodology along the evaluative nature of the policy feedback theory, taking into consideration both the negative or positive feedback within a backdrop of neoliberal policies and designs with the focus on understanding the patient experience within a choice program.

Theoretical Framework

The emergence of the patient-as-consumer phenomenon in the government agency that serves veterans from 2013 to 2019 is the phenomenon that forms the basis for this research. The intersection of politics, policy implementation and diffusion serve as the cornerstone of this inquiry that focused on the adoption of the choice claim in a private-sector retail immunization health policy program. The health care system that serves veterans at the national level is publicly bound to provide health care services, such as preventive care, e.g. flu shots, to eligible and enrolled veteran patients at no cost and as part of their continuum of care. It is considered a sacred mission to care for "him who shall have borne the battle" (VA Website, par. 1, 2018). However, in recent years, the lines have blurred between a universal right governed by earned benefits and a marketized commodity of preventive health care for these veteran patient beneficiaries.

In the review of literature concerning privatizing inherently government-administered programs, there was an identified a gap in the use of the policy feedback theory in research on this aspect of the health sector, particularly in the government run health care agency for veterans and surprisingly in the United States. While there are many studies that have focused on privatization efforts in the education arena, the energy sector, and the United States prison system, less is known about the relatively new concept of choice in health care, specifically eligible veteran patient choice options stemming from legislation. Therefore, the use of the lens of the policy feedback theory served as a frame to examine what motivates patients of the government-run health care agency to seek care outside, or private sector care, for preventive health care services. It

was a relevant theory to analyze if the patients' lived experiences of the patient-as-consumer phenomenon shaped subsequent participation in expanding government-endorses choice programs or policy debates since the theory posits that there are iterative or interpretative effects of any policy enactment that spans beyond the narrow use of the legislation.

Whether it is technology, the rise of consumerism, or laws that test the limits of health care as a right, privilege, or commodity, the emergence of the choice claim in health care for veterans' policy during the period covered by this study is the phenomenon that formed the basis for this research project. The contemporary, yet indeterminate use of the term, choice, amplified the need to align VA's social contract with its beneficiary veteran patients and a policy research agenda that is evidence-based, comprehensive, and grounded in theory and practical experience (Aranguren et al., 2017; Sullivan & Lazier, 2014). Choice in policy development is not unique to health care. However, there was scant empirical evidence that evaluated the choice claim in United States public health policy, specific to the government run health agency for beneficiary veteran patients (Crié & Chebat, 2013; Reynolds, 2012; West, 2014). Alexander Hamilton (as cited in Harris & Tichenor, 2010, p. 374) claimed "the true test of a good government is its aptitude and tendency to produce good administration". Therefore, the theoretical foundation of the policy feedback theory was utilized to examine the relationship between choice claims, citizen feedback, and policy diffusion and mobilization among beneficiaries of the health care system for veterans.

Policy Feedback Theory

Since the start of the private-sector retail immunization program in 2013, there has been a growing public narrative that veteran patients who use their beneficiary health care system need, deserve, and want choice. This narrative has prevailed in public discourse despite the government run system's long-standing role as a safety net health care system for veterans and years of evidence that the system meets or exceeds patient quality and safety standards, and it is well-liked by its consumers (Anhang Price et al., 2018; Chan, Burgess, Clark, & Mayo-Smith, 2014; Gordon, 2017; Ohl et al., 2018; Penn et al., 2019, Weeks & West, 2018). Three structural narratives emerged, yet they lacked evidence. These narratives involved health care access, quality, and cost (Gordon, 2017; Gordon & Craven, 2018). The policy feedback theory was used to help examine these narratives and understand the choice phenomenon from the patient perspective.

In the present research, a variety of uses of the policy feedback theory was examined. The application of Pierson's (1993) approach was examined to confirm if self-interest of the beneficiary plays a factor in positive feedback of a policy. Using Mettler and Welch's (2004) application, beneficiary feedback was analyzed as inter-related with the potential political effects of a policy. In particular, the focus of this project sought to understand whether there are shifts in the legitimacy of the government-run health care system, and more specifically if veteran patients are motivated by a moral frame or an instrumental frame as was tested in understanding public discourse in prison privatization (Burkhardt, 2014; Fernández & Jaime-Castillo, 2013). Using the policy feedback theory to sketch out a health policy research agenda for the government health care system that

is evidence-based and explores the attitudinal responses of beneficiary veterans who experienced unfettered choice using the private-sector retail immunization program aligns with other researchers whose work centered around the shift from public to private entities using a market-based argument (Dorfman & Harel, 2015; Isserman & Markusen, 2013; Mettler & Sorelle, 2018; Mettler & Welch, 2004). More than how the personal experience motivates the individual, the policy feedback theory underscores the actions that one may or may not take because of the experience.

Therefore, building upon the seminal policy analysis work of Skocpol (1992) and Pierson (1993) and later Campbell (see Fernandez & Castillo, 2013), the policy feedback theory illustrated how a beneficiary public mobilizes to protect its self-interest. Researchers have illustrated that the policy feedback theory can be used to examine three distinct areas of policy – design, resources, and implementation – and it appears to provide a lens with which to better understand how policy shapes the attitudes and subsequent behaviors of publics (Mettler & Sorelle, 2018; Mettler & Welch, 2004; Pierson, 1993). Although the more traditional approach to understanding the cause-effect of a policy and its beneficiary public is to investigate the relationship between one's self interest and political action, it seems appropriate to examine the underlying motivations and attitudes that drive or slow a beneficiary public to a phenomenon such as choice in health care, and the adoption or rejection of subsequent emerging choice health policies. Recently, there has been increasing interest in the scholarly examination of the hidden effects of policy, known as the submerged state, and more critically how a policy reinforces or constrains inherently government programs once a program is privatized.

The private-sector retail immunization program was used to better understand how an unfettered choice program may or may not shape the political orientations and participation of eligible veteran patients in current and future beneficiary health policy deliberations, decisions, and diffusion or adoption. This approach was like Maltby's (2017) use of the policy feedback theory in her work with criminal justice policies. Since health care and consumerism are intrinsically connected in today's political landscape, it was critical to understand how the private-sector retail immunization program influenced the creation of new a choice policy or impacts existing choice policy. Like the ideas expressed by Abramovitz and Zelnic (2015) and in reporting from Gordon and Craven (2018), the social justice mission of the government run health agency for beneficiary veterans as a provider of care is at risk in an era of neoliberal, market-driven policies. Choice legislation or privatization of human services delegitimized the government's role to beneficiary citizens and commoditizes government's obligations to its constituents (Abramovitz & Zelnick, 2015; Sullivan & Lazier, 2014; U.S. DVA, 2018; Mettler & Sorelle, 2018). Examining the lived experience and analyzing the feedback from participants in the private-sector retail immunization program align with understanding the interpretative effects of a policy and the sense of policy efficacy when administered by a private sector partner.

Using the lens of the policy feedback theory helped to explore the experiences of the participants of the private-sector retail immunization program and understand the motivations that surround the choice claims about an unfettered choice policy enacted by a government-run health agency for beneficiary veterans. Whereas contemporary news

clips focus anecdotally on the negative narrative of a dysfunctional government health care system, quality indicators and veterans service organization (VSO) polling suggested that veteran patients enjoy *their* health care system once they are actively enrolled and using the VHA (Longman & Gordon, 2017; Pipes, 2017; Westat, 2010). The use of the policy feedback theory leveled the playing field by providing research-based evidence that listens to the voice of the veterans, those beneficiary patients turned consumers who had real choice in their care with this private-sector retail immunization program.

The program, as analyzed using phenomenology and the policy feedback theory, may lead to the promotion good governance that meets the social justice needs of the beneficiary veteran patients. The results may support a better understanding what might mobilize this beneficiary public of veterans and reveal ways to encourage active civic engagement within a social marketing framework and free market environment (Abromovitz & Zelnick, 2015; Mettler & Sorelle, 2018). To my knowledge, there is no other comparable research that evaluates this type of choice phenomenon within a preventive care, private-sector retail immunization choice program for veteran patients.

Central to the present research is the legitimacy of the choice argument in contemporary health care policy within the government-run health care system. Ainley (2015) presented a provocative essay on the controversy of privatizing an education system and increasing choice in a society that enjoyed education as a fundamental right and benefit. His depiction of privatizing a traditionally public program presented itself as an unattainable utopia due to the inevitable rise in costs and decrease in equity. Similarly, Gordon and Craven (2018) argued that private, fee-for-service care is likely to increase

costs and decrease quality. While cost is a factor in the argument for commoditizing health care services, so is access.

With the concept of choice comes the arguments of access, care coordination, patient safety, and quality. Use of the policy feedback theory was used by Aubrey and Dorsi (2016) to test the impact of the outsourcing of schools on education equity as a right or benefit. Therefore, it is formidable to expand on these ideas for health care policy, citing a need for empirical research. This present research examined the feedback from the citizens who were beneficiaries of the unfettered choice program associated with the private-sector retail immunization program to not only test the impact of outsourcing this care, but also to answer Mettler and Welch's (2004) call to examine the role of government on individual beneficiaries when a government service is administered by a private entity.

There is a growing abyss in the examination between micro individual behaviors and macro level events such as privatization that warranted research in this space. Anecdotally, the mass public notices largescale events, but ignores slow-moving take-overs of government services. Once the drama of the legislation enactment is done the so-called curtain is drawn, according to Mettler's work (2011). A focus on the role of government on individual beneficiaries, such as veteran patients who are eligible for primary care in the era of choice, is an area rarely explored. The present study was untraveled research for the government-run health care system for veteran beneficiaries (see Maltby, 2017; Commission on Care Interim Report, 2015; Mettler & Welch, 2004). To use the policy feedback theory as a framework is appropriate to understand the

interpretive effects of choice policies for veteran patients. This approach aligns with the recommended new research needs of the policy feedback theory, where policies are complex, involving non-government actors, and increasingly based on individual experience (Mettler & Sorelle, 2018). This research and its finding may help fill a gap in understanding if individual experiences influence personal acceptance of or rejection of broader policy-making decisions that impact a person's choice in his health care administration.

The use of the policy feedback theory provided an applicable lens for understanding the attitudes, social influences, and motivations that could lead to the development of or discontinuation of a policy. Researchers who have used the policy feedback theory have reinforced the notion that beneficiaries of perceived favorable policies translate into support for more of these types of policies, e.g., the GI Bill, pension reforms in Europe (Fernández & Jaime-Castillo, 2013; Mettler & Welch, 2004; Pierson, 1993). Goss (2010) argued that there is a need to understand by using evidence-based research if personal experiences predetermine if one believes in private, voluntary, or public welfare state solutions when it comes to policy-making. Her argument was that policy feedback can impact individual-level engagement by examining how policy works in one of five stages: stimulation; constraint; capacity; framing of an issue; forging a political community. She highlighted Mettler's study that showed how beneficiaries of the American G.I. Bill were a "remarkable participatory" cohort in the policy arena.

In the search for this research study, there appeared to be no other studies with a policy feedback-based approach attempting to understand the influence of a government-

run health system administered program on veterans' participation in policy-making and subsequent impact on policy diffusion despite the growing choice argument in the health choice policy and political discourse. However, recent empirical data confirmed that patients who are members of an Affordable Care Act (Pub. L. No. 113 – 146, 2014) exchange in their state are more favorable to health care access laws (Liebertz, Bunch, Shaw, 2019). The use of the policy feedback theory to understand the effects of a pro-choice policy program like the Retail Immunization Coordination Program, therefore, was a good fit. Goss (2010) suggested that use of policy feedback theory is essential to understand the interpretive effects of policy on the individual. Given that the health of a democracy depends on active engagement of its citizens, the use of the policy feedback theory in the choice phenomenon served as a natural backdrop to understanding if unfettered choice in a traditionally government sponsored health program leads to preferred privatization of inherently governmental services or if choice is simply in the eye of the beholder.

Scholarly researchers agree that there is little known about how citizens' views change when a traditionally public-rendered service is turned over to a private sector partner to administer. While Pierson (1993), Campbell (see Fernandez and Castillo, 2013), and Mettler and Welch (2004) laid the groundwork for researchers to understand how policy impacts citizenship, governance, influence, and sets the political agenda, it was Schattschneider in 1935 that determined that policies can create new politics. This work revealed that feedback from the implementation of a policy may influence the attitudes of a person.

With both the complexity and density of politics and policy, the personal impact of a policy can either reinforce or diminish the outcomes of a policy and the policy-maker (Lockwood et al., 2017). Gingrich and Watson (2016) argued in a limited case study based in the United Kingdom (U.K.) that privatization of welfare-like provisions created a *submerged state* and blurred the lines of accountability of public service. The work done by Sorelle with Shanks-Booth (2016) confirmed this idea that American's experiences with a government social program and how it is administered frames their support for other social policies and programs. Using a framework of the policy feedback theory, they further concluded that such privatization patterns diminish citizens' voices and weaken democratic accountability. Mettler's (2011) work confirmed this idea with an extensive review of various programs and the rise of the submerged state beginning in the 1990s. These works offered a rare window into the privatization consequences of a public service program that clouds governance, decreases quality for all, and leaves voters stymied. The Sorelle and Shanks-Booth (2016) study served as a counter argument to Mettler's seminal GI Bill research, which showed that government beneficiaries who enjoyed governmental benefits increased civic participation over time because of their appreciation for the benefits provided (Gingrich & Watson, 2016; Mettler & Sorelle, 2018; Mettler & Welch, 2004). Little is known, however, about how a veteran patient's views about their government-administered and provided health benefits change based on the choice claims and personal experiences. The health care system for beneficiary veteran patients has a public duty to provide health care services to eligible and enrolled

veteran patients. Yet, as programs are privatized, there is little know about the effects of these policies and how invisible policies may or may not impact a public benefit or right.

Publicness is valuable to citizen engagement and public responsibility. Outsourcing of traditionally government services weakens political engagement and erodes democracy (Abramovitz & Zelnick, 2015; Dorfman & Harel, 2015). Health care choice in the veterans' health system administered by the government causes a tension between a right or benefit earned, and the liberty to choose within a market-based framework for veteran beneficiaries. Unlike the argument for choice in education, the right to health care for veterans is clear. What is not as clear is who provides that care to ensure the benefit of access, quality, availability, equity, and safety (Aubry & Dorsi, 2016). Research was needed to understand the interpretive effects of a choice policy in the government run health care system. There was a gap in empirical evidence in analyzing how privatization of veterans' health care services, using the private-sector retail immunization program as an example, impacted commoditizing a government service and its causal effects on constituents in pending and future free-market, choice-type health policies.

Feedback, positive and negative, helped illuminate the largely unexplored terrain of health care choice among veteran patient beneficiaries. Abramovitz and Zelnic (2015) argued that social welfare and privatization have normalized human services agencies. They concluded that the neoliberal focus in the name of market-based austerity did not help the citizens who were meant to be served. Rather, the market-based approach of choice weakened publicly funded providers, delegitimized the agency's role, devalued

the quality of services provided, and traded public safeguards for profit-making margins (Abramovitz & Zelnic, 2015). While these arguments exist, there is a lack of peer-reviewed research about choice or privatization in health care, specifically for beneficiary health care for veterans provided by the government agency.

There was a need to understand the personal effects of a health policy like the privatization, or choice, which is hard to quantify, but which exists in other industries such as education and the criminal justice system (Aubry & Dorsi, 2016; Dorfman & Harel, 2015). While all feedback is not equal, Matlby (2017) concluded that the policy must be salient to the targeted cohort to either support or reject the current or future policy. More research is needed to understand why a beneficiary public is mobilized based on a policy claim like choice (Matlby, 2017). Soss and Moyniham (2014) agreed citing the wide applicability of the policy feedback theory to examine how administrative programs can shape politics. There is a need to understand the relationship between the choice health policy and the public administration of the private-sector retail immunization program once it has been adopted or rejected by its citizenry.

The use of the policy feedback theory has matured over the last two decades. However, exploring the effects of complex policy arrangements and citizens' responses to these non-governmental actors within a policy feedback framework is still in its infancy; there is limited meaningful discourse on the matter of preserving the obligation of the government health care agency to care for beneficiary veteran consumers in an era of marketing health care (Aubrey & Dorsi, 2016; Hafer, 2018; Mettler & Sorelle, 2018). Using the policy feedback theory to understand if the private-sector retail immunization

program sets the tone for future or current private-public partnerships in the government run health care agency, and the choice debate was appropriate for this study. There remains scant research to give policy-makers the answer to understand if the submerged state of health policy has either a negative or positive effect on current or future health policies for veteran consumers. Therefore, this project may help set a policy research agenda to interpret the feedback of beneficiary veterans and examine their motivations to seek health care outside of the government-issued system to analyze the privatization impacts on commoditizing a government service on a constituency that has earned the benefit as a right.

In sum, the present research contributed to the very nascent field of understanding the impact of choice in health care policy. Its results add to the scant knowledge of practice to illustrate how public-private partnerships can be used as an administrative tool, formalizing a process of analyzing feedback related to benefits and services to meet the social compact of serving America's eligible and enrolled veterans while preserving the public, mission driven role of the government-run health agency for beneficiary veterans (Abramovitz & Zelnick, 2015; Hafer, 2018; Sullivan & Lazier, 2014). The information gathered, based on the lived experience of participants, provided a foundation to better understand the feedback related to beneficiary patients of an outsourced health care policy. Its results may help to balance the public battle and rhetoric between public perception and policy evaluation from the beneficiary perspective. Policy and public administration are dynamic phenomena and should include both a supportive theory-based foundation, but also an examination of the salience of a

policy as related to their beneficiary public. When the novelty of a policy wears off, the effect may prove more sustainable (Mettler, 2011). Understanding what types of motivations activate a beneficiary public in policy debates that move once-public services to private entities, may facilitate more sustainable health care administration within an environment of market-based medicine.

Ajzen's Theory of Planned Behavior

Understanding the motivations of veteran patients to choose non-government administered care may elucidate other policy rejections or acceptances. It was essential to include aspects of Ajzen's theory of planned behavior along with the policy feedback theory in the design of this study. The particular emphasis was the idea that a person's perception of control over a behavior, may be critical in understanding the lived experience of patients who choose to obtain their flu shot at a contracted private sector retail provider. Whereas limited research exists to show how the policy feedback theory explains the concept of that a person's self-interest may be linked to the endorsement or rejection of a policy, or whether personal benefits cause a predisposition to political engagement of health policy enactment, individual motivation to lean toward positive or negative feedback is seldom considered by public administrators working to diffuse policy (Fernández & Jaime-Castillo, 2013; Hennink-Kaminski, Willoughby, & McMahan, 2014). In contrast to a classical approach to the policy feedback theory, the concepts of the theory of planned behavior in designing the study methodology helped to focus on elements of the policy feedback related to why and how the patient decided to choose the outsourced option.

This focus is now new. Singaiah and Laskar (2015) concluded that both social and behavioral sciences form the foundation of social marketing efforts to move a person to act, specifically to adopt a new health care behavior. The future of social marketing campaigns, such as the private sector retail immunization project for veteran patients, may be at the health policy level that works strategically to solve issues that demand an understanding of behaviors, e.g. motivations (Crawshaw, 2013; Singaiah & Laskar, 2015). Therefore, the theory of planned behavior offered another dimension to the policy feedback theory as examined throughout this study.

By coupling these two theories in analyzing the micro-level feedback, the central task of understanding what drives a veteran patient consumer to choose non-VA care came into focus. This dual use proved particularly important to understand choice when the patient was given similar options from which to choose, a key factor (Crawshaw, 2013). Using the theory of planned behavior did illuminate the internal and external sources of motivation that provided both negative or positive feedback concerning the choice phenomenon. By incorporating this theory in the methods design, it helped articulate the findings that align with the behavioral characteristics of the individual that moved them one way or another when given choice. Comparable to the work done by Diaz-Maurin and Kovacic's (2015), the use of a combination of theories helped to understand the experiences and perceptions of individuals in changes to policy enactment.

Using the theory of planned behavior along with the policy feedback theory moved the discussion of the choice phenomenon from the macro to the micro level (El

Refaie, 2015; Neville et al., 2014; Royne & Levy, 2015). Feedback are not uniform among the citizenry in one social construction group. An individual's values and emotional appeals are critical to policy implementation, agenda-setting, and acceptance according to Mettler and Sorelle (2018). Evidence from Matlby (2017) maintained that although policymakers gain electoral benefits from one beneficiary group, the effects may be either positive or negative, but they are not uniform at the individual level. One's position in the group and experience with the policy impact the feedback. Therefore, there was a need to understand the personal motivations of eligible and enrolled veteran patients who participated in the private sector retail immunization project for veteran patients to better determine if personal experiences predetermine one's belief is private or public solutions when it comes to health policy benefits for veterans.

As a result, the use of Ajzen's theory of planned behavior to develop theory-driven data themes and inform the interview questions for the research participants proved complementary to exploring the concept of choice within the framework of the policy feedback theory. The theory itself helps explain how information alone is not enough to move a person to action, and that the primary determinant of intentions is motivations based one's perception of ease or difficulty (Ajzen & Fishbein, 1969; Green, Cross, Woodall, & Tones, 2019; Values Based Management Website, 2016). The use of the theory of planned behavior served as a best practice for developing and evaluating the impact of this social marketing campaign that focused on behavioral intentions like other studies (Luca & Suggs, 2013). Because understanding attitudes, experiences, and

intentions within the construct of the choice claim was critical to this study, the theory of planned behavior was relevant.

The theory applies to social marketing health interventions; it set the stage for conceptualizing what attitudes, subjective norms, and perceived behaviors exist for the cohort. The theory of planned behavior underpins components of social marketing within the context of health communications evaluation and research and lends itself to producing feedback of the choice policy claims (Luca & Suggs, 2013; Values Based Management Website, 2016). There is scant evidence in using the social marketing as part of the health policy discussion for programs aimed at veteran patient beneficiaries of the government health care system. While there is a gap in understanding how social marketing concepts impact public health, there is evidence that social marketing is effective when policy aligns with the expressed needs or experiences of a target audience (Lindridge et al., 2013). Therefore, to better understand the patient-as-consumer phenomenon, social marketing projects may provide a researcher with the understanding of what motivates a key audience, what types of messages resonate with members of this audience, and how relevant behavior or change is perceived by the target audience.

Literature Review Related to Key Variables or Concepts

Patient-as-consumer phenomenon. Private sector health care entities are beholden to shareholders and must make a profit. Public sector health care institutions, such as the government run health care agency for beneficiary veterans, are accountable to the democratic process, the electorate, and the citizenry. Today's government-run health care system for veteran patient beneficiaries, for instance, is both a provider and insurer of

care. It is a nationally integrated health care system that more than often meets or exceeds quality care, wait, and patient safety standards that does not align with the market-based trend of health care in the United States, which is a mixed economy (Anhang Price et al., 2018; Dorfman & Harel, 2015; Gordon, 2017; Penn et al., 2019; Weeks & West, 2018). As a publicly-funded health care system, it offers primary and specialty care as well as support services to eligible and enrolled veterans who have earned the benefit because of their service in the military (Department of Veterans Affairs Website, 2018).

Even when other avenues open for its beneficiaries, veterans who receive care from a one of the country's government-run health care facility's often cite a culture of respect, ready access, and high, quality care along with no or low co-pays as incentives to obtaining health care at one of the facilities (Chan et al., 2014; Ohl et al., 2018; U.S. DVA Survey, 2012; Veterans of Foreign Wars, 2017). However, there was little understanding as to why veterans choose private-sector care and if privatization is preferred in this era of patient-as-consumer when there is an overwhelming appreciation to the government for these health benefits and a growing trust for its provider network. There was a gap in understanding the concept of choice in health care policy from the veteran patient's point of view.

Health care in the United States remains captured between a right and a consumer products issue. Single-payer health care versus market-driven, competitive health care services for veteran patients is a growing hot-button political issue and market-driven argument (Freeman, 2012). West (2014) argued that today's health care policy uses a consumer information framework that promotes personal responsibility versus a health

care mandate. Based on interviews, West also suggested that the patient-as-consumer concept may not be valid, but it must be examined given the landscape of the choice phenomenon. The patient, like consumers of other goods and services, values choice. Results from work done by Berwick via his Advisory Board (2016) expressed that today's patient, like it or not, bases his consumer value on consumer experience, whether he is shopping at a retail store or getting an annual checkup at his community clinic. However, health care and health information are hard to understand, and the consumer is not the primary decision maker, despite the government claim that "most Americans can already choose their health care providers" (Luthi, 2019). Just as education is a public good, so is health care for veterans who have earned the benefit by their service to this nation.

The United States is a mixed economy fueled by public services and private goods. It is critical to understand what matters most to beneficiaries in a democracy. Consumers, or in this case, constituents, should play a shared, but significant role in policy production (Dorfman & Harel, 2015). However, the government-run health care system for veteran beneficiaries is limited in how it can communicate policies and amplify information (Gordon, 2017; Short, 1991; Taylor & Kent, 2015). Social marketing helps move beyond the information-only maneuvering but it cannot match the private-sector's well-funded communications and advertising to move patients to action, when choice, like privatization may be illusive (Gordon, 2017).

Public health information or health policy campaigns often compete against an unregulated consumer-marketing backdrop. Health care communications is unregulated

and there is a lack of maturation to advance social marketing as a legitimate framework to for this field of study (Royne & Levy, 2015; Truong et al., 2014). Government-sponsored health communications campaigns might fall short in a consumer-driven society (Royne & Levy, 2015; West, 2014). Elder et al. (2016) and Langford et al. (2013) offered similar conclusions concerning the need for systematic research on health policy and social marketing to evaluate campaigns targeted at military and veteran patients. Empirical evidence may provide a foundation for government health policy makers to use when developing communications campaigns that aim to move a person to positive action or better engage a cohort whose views depend on active engagement and robust debate (Luca & Suggs, 2013; Mettler & Sorelle, 2018). There is a need to better understand the patient-as-consumer phenomenon in an era when policy determines politics and policy salience depends on beneficiary adoption or rejection.

Social marketing and the patient-as-consumer

Although social marketing is an effective approach to promote health care policy, few research studies have systematically evaluated how social marketing can lead to behavior change or action in the beneficiary group of eligible and enrolled veteran patients. Other than the occasional Veterans Service Organization-sponsored survey, utilization studies, or disease-specific research queries, there is a general lack of empirical understanding whether choice programs, like the private sector retail immunization project for veteran patients, lead to amplification of unwanted or adequate privatization of health care resources per the policy feedback theory (Finley et al., 2017; Humensky et al., 2012; Ohl et al., 2018; Vanneman et al., 2017; Veterans of Foreign

Wars, 2017). Lindridge et al. (2013) revealed that a scant 6% of published articles use the frame of policy-theory and social marketing. They contended that social marketing is most effective when all systems function cooperatively to achieve behavior change for a targeted audience. External forces such as politics and policy may influence the evolving nature of a program. What is missing is the understanding of consumer or customer motivations and how messages or messaging may or may not impact behaviors of a targeted audience.

Both positive and negative feedback streams of a consumer group are needed to advance a policy or discontinue it. While the present research was not designed to establish a pro/against privatization position of health care policy for veteran beneficiaries using the policy feedback theory, it was intended to understand if the lived experiences of a veteran patient gains or loses motivations to utilize earned benefits from the government because of participating in the private sector retail immunization project for veteran patients that offered unfettered health care choice.

Mettler and Welch (2004) focused on the civic generation of veteran recipients of the G.I. Bill to analyze if their utilization of the government-administered educational benefit from the government translated into political activism or involvement. Their study followed that of Pierson (1993) who examined the policy feedback effects of citizens more broadly. However, largely unexplored is the micro level relationship between government and citizen, known in the government-sponsored health care system today as veteran patients turned customers who are given choice.

Social marketing targets communications such as the private sector retail immunization project for veteran patients was designed to focus on the intrinsic needs of veteran patients – convenience, access, no-cost, coordinated care. In its communication, the social marketing for the no-cost flu shot implied choice (Botts et al., 2017; U.S. Department of Veterans Affairs, Community Care Webpage, 2018; Walgreens Website, n.d.). Since public health policy is lacking empirical attention and there exists tension between individual motivations and choice, it follows that a social marketing-based program, such as the private sector retail immunization project for veteran patients, was ideal to use to understand the patient-as-consumer to discern how a policy impact a citizen's belief in government, their civic participation, or their adoption or rejection of whole-sale health policy changes.

Following their analysis of the European pension policy reform, Fernández and Jaime-Castillo (2013) argued that pre-existing policies and their impact on citizens correlate with the approval or disapproval of new or revised policies. Results showed that a person's self-interest is inextricably linked to the endorsement or rejection of a policy. They concluded that policymakers must frame the project or policy within well-defined outcomes and messaging, which may lead to public perceptions in this era of consumerism. Evidence-based campaigns are needed to compete in today's media-heavy landscape (Hennink-Kaminksi et al., 2014). Public policy alone fails to nudge a consumer to action. To support the patient-as-consumer phenomenon there was and remains a need to bridge social marketing and public health policy, particularly in the government run health agency for beneficiary veterans.

Social policy interventions should be guided by behavioral principles when consumer choice is an issue. Based on a series of in-depth and semistructured interviews of key informants of a public health policy in the United Kingdom, Crawshaw (2013) concluded that there is a need to have active engagement in health policy by what people choose. Both society and regulations play a part in behavior change. Yet, Crawshaw (2013) argued as did West (2014) that choice in health care may be a false claim. Crawshaw (2013) went further with this argument and stated that *consumer choice* in health care is a *scheme*. His work called into question whether the patient-as-consumer concept really exists and summarized that choice is relative. This claim was assessed throughout this study.

The Crawshaw (2013) study is relevant because, like the government-run health care system for beneficiary veteran patients, the United Kingdom's health care system is a universal benefit offered as a public health good. Crawshaw (2013) offered the need to better understand the balance between health care consumer rights and responsibilities within the context of health care policy and the attitudes of the patient-as-consumer. The private sector retail immunization project for veteran patients, therefore, was ideal to understand whether veterans-as-consumers when given unfettered choice within a social marketing program seek real policy change or may drive change based on their lived experience.

The patient-as-consumer phenomenon calls health care policymakers to examine the connection between policy, governance, and personal experience. While much work in this area of choice has been done in the energy sector, education, and United States

prison system, little is known about the relationship between policy adoption and diffusion and the experiences of the health care consumer. Even still, policy may lack personal feedback and alternative narratives that sustain policy revisions or new policy adoption (Diaz-Maurin & Kovacic, 2015; Isserman & Markusen, 2013; Matlby, 2017). Some critics of *choice* and *privatization* argue that the scales are not balanced in terms of theory versus practice. In an analogy to prison privatization, Craig (2018) determined that private-sector prisons may be nimbler and more competitive. In practice, however, they are less transparent, more expensive, and focused on profit-making rather than reform and rehabilitation. Policy scholars must do more to understand how policy feedback affect the targeted groups because of policy salience, particularly when choice and privatization are the reasons for government policy changes.

The choice claim

Policymakers, media pundits, and legislators alike have promoted the idea that choice in health is better for the economy, boosts competition, and is what patients demand. However, choice in health care may not be real choice at all (West, 2014). Choice may, in fact, raise costs and limit services or access to care (Saloner, 2017). Even the leadership of the government-run health care agency for beneficiary veterans has presented the choice claim as consumer-driven, amplifying the themes that today's health care environment demands easy access, greater choice, more convenient, and cost-effective care that is in the hands of the consumer. They also argued that veteran consumers need clear information to make informed decisions (Commission on Care, Interim Report, 2015; Longman & Gordon, 2017; Luthi, 2019).

Guided by emerging choice legislation and the neoliberal view that has expanded since the 1990s but amplified since the VA Choice Act (2014) and the VA MISSION Act of 2018 (H.R. 5674), choice claims are now part of the fabric of government health care in the United States despite evidence that there is no real choice in health care and that private care is more affordable and better than publicly-administered care (Farmer et al., 2018; Freeman, 2012; Weeks & West, 2018; West, 2014; Ohl et al., 2018). Similarly, in their study concerning educational choice in the Global South, Aubry and Dorsi (2016) concluded that choice in matters of traditionally provided government services is limited. Their analysis viewed education as right, which became privatized, but undermined the concept of choice and weakened the social interest of the service.

There is a similarity with the choice phenomenon to education choice and that of choice in the government-run health care agency where eligible veteran patients have a right to health care, but the present, neoliberal environment signifies choice as a value proposition in today's market-driven medicine. Abramovitz and Zelnick (2015) contended that neoliberal forces in the name of market-based measures do not help the citizens it is meant to serve. Analyzing the marketization of human social welfare programs, they suggested that a market-based approach commoditizes a government's obligation to its constituents but fails to offer real choice. Choice in the matter of transitioning government services from a traditionally run government agency to a private enterprise may weaken or delegitimize the agency, shifting taxpayer resources to the private sector, which gains an unfair dominance in the market, with little or no oversight.

Advocates of health care choice in the government-run agency for beneficiary veterans suggest that choice equates to better quality of care, increased access to health care, and better value for health care services (Kupfer, Witmer, & Do, 2018). These choice claims in contemporary policy and politics, while popular, lack empirical evidence and form a misleading, negative narrative that government-run health care is bad and private health care is good (Freeman, 2012; Gordon, 2017). Using a financialization or consumer framework, the opposite may result.

Shifting appropriations from an appropriated agency product to a fee-for-service private-sector model may starve the agency while it bolsters a private entity. The results of this shift in resources and administration may result in unregulated, higher costs, and poorer, fragmented quality services (Abramovitz & Zelnick, 2015). A critical analysis in Saudi Arabia confirmed this notion citing a rise in cost to the individual, decreases in access to care, and a loss of services that were not profit-makers, but necessary for low income, sicker patients (Khamis, 2017). Critics of privatization or the choice claim dispute the popular consumer view, claiming that outsourcing government run health care restricts choice because it erodes the idea of earned benefits thereby presenting an imbalance of goods or services offered to veteran patients (Day, 2018). Moreover, the United States health care marketplace ranks as the least cost-effective of industrialized countries, providing little evidence that market-driven medicine supports the idea that greater choice leads to better, more affordable, and accessible health care for the United States citizenry (Freeman, 2012; Kupfer, Witmer, & Do, 2018).

People in the aggregate tend to make choices based on their financial interests or ability to determine the cost-effectiveness of a product of service based on data. The prominence of the choice phenomenon in the government-run health care agency for beneficiary veterans organizes health care services as a commodity within a free market rather than a social benefit earned through military service. For this long-standing government health care entity, access to care, ease of access, and coordination of care are key determinants of choice. Current United States leaders have suggested that greater choice for veteran patients means that care is consumer-driven (Commission on Care, Interim Report, 2015; Longman & Gordon, 2017; Matthew & Milligan, 2018; Luthi, 2019). As West (2014) noted this consumer frame in health care is flawed. In health care, beneficiaries must rely on third-party actors or depend on trade-offs to make health care decisions.

The idea of a free market in health care, particularly for beneficiaries of a government-run health care agency for beneficiary veterans, may not exist because there are no contemporary cost-comparison studies. There is an imbalance of what is or can be communicated about the health care products and services (Gordon, 2017; Kupfer, Witmer, & Do, 2018). For example, legislation such as the Affordable Care Act (Pub. L. No. 113 – 146, 2014) and the Veterans Access, Choice and Accountability Act of 2014 gave patients the false idea of a free market. But there is no free market at play. One law functions as a tax with reinsurance provisions and the other is comprised of limited funding tied to eligibility criteria (Alonso-Zaldivar, 2016; Mettler, 2011; West, 2014). West (2014) argued that health care as a commodity accentuates the "us-versus-them"

mentality. Without a global perspective about health care and health care coverage for citizens of the United States, defensive politics, ideology, and division will remain. In the current state, personal responsibility in health and health care teeters on the see-saw of mandate versus consumer choice, and there is little evidence of what the veteran patient-as-consumer wants, or needs based on experience or their voices.

Critics who argue that health care is a right view health care as a need and not a consumer choice purchase. The endless debate over the choice claim is a push-pull over health care costs, quality, choice, convenience, and access to health care (Fitzgerald, 2014). Health for health's sake is not the end state because health care in the United States remains a business, and a lucrative one.

In the United States, no matter how health care is disbursed, someone pays: private insurance, Medicare, Medicaid, or out-of-pocket, or federal government-appropriated Congressional funds via the agency that treats military personnel or veterans, i.e., funded by taxpayers. There are no overarching policies to control health care costs and no universal process to monitor private sector health care compared to the oversight by Congress over government-run health care for veteran patients (Berenson, 2005; Executive Producer, 2008; Kupfer, Witmer, & Do, 2018). Therefore, the scope of this research serves as a first step in determining if beneficiaries of the government-run health care agency for veterans experience positive or negative feedback of a choice program, e.g., the private sector retail immunization project for veteran patients, as result of a public-private partnership where the veteran patient is given unfettered choice for a seasonal flu shot. The research provided evidence to the nascent field of social marketing

campaigns used to promote a health policy; it helped contribute to the knowledge of practice to illustrate how public-private partnerships can be used as an administrative tool to address the ubiquitous and complex public health issue of choice while addressing the needs of its constituent public. Rigorous evidence continues to be needed to make objective, policy decisions that are based on beneficiary needs and lived experiences as the government moves from providing a sacred service to the promises of patient choice.

Summary and Conclusions

While polling data from the Veterans of Foreign Wars (see Veterans of Foreign Wars, 2017) reflects the overwhelming perception by its members that the quality of care is what matters, there is a growing negative narrative that private health care is good and publicly, government- based health care is bad. The literature search revealed a gap in understanding if an existing government health agency program, such as the private-sector retail immunization project for veteran patients, foreshadows the policy acceptance or rejection of future policies related to the choice phenomenon and privatizing health care services for United States veterans.

Despite data that show support for the government-run health care system as one that is of excellent quality and safety practice, there is a growing negative narrative in the public discourse that cites it as a flawed government health care system unable to meet the needs of its veteran customers. However, most of its users want the health care agency to be strengthened and saved; only 5% of veterans surveyed believe that veterans should be given a universal health care card or unfettered choice to seek other-than-government provided care. Yet, there remains scant empirical evidence that supports or

negates the choice claims in the health agency for beneficiary veterans or provides for a basic understanding of the feedback of the patient-as-consumer phenomenon.

From various studies in the United Kingdom and Canada, there is some evidence that feedback conform to personal experience especially when communicated from a social marketing perspective. Both the policy feedback theory and the analysis of social marketing have relatively short histories in public health and social service studies. The literature search of the present study revealed a demand for more evidence-based understanding on the future of social marketing at the health policy level that works strategically to solve issues based on the motivations of veteran beneficiaries. Overall, there is scant attention paid to the role of policy and policy diffusion or implementation in the government run health care agency for beneficiary veterans, particularly when it comes to the choice phenomenon in an era of the patient-as-consumer.

In Chapter 3, the content will demonstrate how the research for this topic of inquiry was planned and developed into the design of the present study. It will elaborate on how the participants were identified, expound on data collection methods, coding, and analysis plans, and discuss the questions asked of participants. It concludes with how the information was organized and provides insight into ethical considerations and trustworthiness of the study.

Chapter 3: Research Method

Introduction

The purpose of this qualitative research project was to explore the influence and perceived impact of a public-private choice health care program available to eligible and enrolled veterans of a government-run health care agency for beneficiary veterans, focusing on the period from 2013 to 2019. While today's mainstream legislative and media arguments point to the phenomenon of choice as a critical concept in health care, particularly in the government-run health care system, the literature lacks both empirical evidence and personal experience feedback to understand the complexities and needs of veteran patients who face the backdrop of conflicting messages and health policy implementation that include choice options for preventive health care services; therefore, a qualitative methodology was deemed appropriate for this study.

To understand what motivated veterans who are patients of the government-run health care system to seek preventive health care services, such as flu shots, outside of their designated government health care provider, it was important to understand their lived experience. Critical to this undertaking was to discern the meaning of the choice phenomenon as it related their motivations to seek this outside option, specifically as they face broad and emerging health policy changes that loosen administrative rules and become more permissive, in today's marketized medicine environment. This qualitative discovery provided a start to understand some best practices in policy development, implementation, and most critically diffusion in the community of veteran patients who inherently must make the choice of where to seek preventive health care. The policy

feedback theory supported the use of a qualitative method and design. This theory helped lay a foundation for use in understanding both the positive and negative feedback of health care policy for this unique patient population. It served as the framework for the present study while the theory of planned behavior served to support the analysis of the data.

In this chapter, I provide an outline for a phenomenology-based qualitative research design and study methodology for the evaluation and impact of the Retail Immunization Care Coordination Program. The summary of why this approach was selected shows an alignment with gaps in literature previously discussed in Chapter 2. In this chapter, I discuss my role as researcher and provide details on the approach, including participant selection, process for recruitment and participation in the research, study design, as well as data collection and analysis. I conclude the chapter with a discussion about ethical considerations and how I dealt with issues of trustworthiness, including credibility, transferability, and coding. Its content also elaborates on the plan used to secure compliance with partner site and the university's requirements for institutional review board (IRB) documentation and procedures with the privacy and confidentiality.

Research Design and Rationale

As discussed in Chapter 2, there is a public refrain that health care provided by the government-run health care system for beneficiary veterans is the lesser choice than private sector administered health care despite decades-long evidence to the contrary. The literature search revealed an apparent narrative fueled by neoliberal policies that have

been insufficiently explored and suggested a research design that examined the human factors of how veteran patients experienced the phenomenon of choice that potentially could counter or support the neoliberal narrative. As examined in the literature review, the meaning of choice in health care is complex. The idea of choice in the era of neo-liberal policy-making is a nascent field of study, particularly within this unique patient population of veterans who are eligible for health care services as administered by the government run health care agency designed to serve eligible and enrolled veterans of the United States Armed Forces.

The choice phenomenon within the context of the Retail Immunization Coordination Program is exclusive because, at the time of this study, it was the only government-sponsored program that offered unfettered choice to eligible and enrolled veterans to my knowledge; it should be noted that expanded choice options for limited urgent care needs were implemented in the final 2 months of this study as a result of the VA MISSION Act of 2018 (H.R. 5674). Capturing patient feedback via their lived experiences within the context of a program that provided unfettered choice of a preventive health care option was best analyzed using qualitative techniques. It was too early to seek a quantitative approach until more in-depth analysis can explore common themes and the meaning of choice in policy, implementation, and diffusion from the patient perspective. Findings from this project served to shed light on the choice preferences of health policy of the government-run health care agency and can substantively support future quantitative survey methodology to further assess views on choice and the feedback loops of suggested policy directions and diffusion tactics.

While there is scant evidence presented by the government or associated advocacy groups such as the Veterans of Foreign Wars (see Veterans of Foreign Wars,2017) that shows a prevalence for preferred government provided health care once veterans experience such care, to my knowledge, there is no documented research that has addressed the essence of choosing private sector administered preventive care when unfettered choice is presented to the veteran patient as in the case of the Retail Immunization Care Coordination Program (see Creswell, 2009; Longman & Gordon, 2017; Westat, 2010). Choice claims appear frequently in veterans' health policy and publicity today (Arnsdorf & Greenberg, 2018; Fichero, 2018; Sisk, 2018; Smith, 2017) despite a vacuum of public input from the personal or collective experiences of those veterans for whom the policies are created. Therefore, I examined the choice phenomenon and perceived impact of the Retail Immunization Care Coordination Program public-private partnership during the period from 2013 to 2019 to understand the motivations of the veteran patients who chose to use outside care in this era of choice. It was for this main reason that a qualitative methodology, and more specifically, a phenomenological approach was selected.

Creswell (2009) asserted that phenomenological research can reveal the essence of a phenomenon beyond the numbers. Due to lack of investigation of this patient population in relation to the choice claims in current and emerging health policy, the selection of phenomenology afforded the necessary depth to understand what motivated some veteran patients to choose nongovernment administered care, even if current statistical data suggested that only 5% of veterans surveyed believed that unfettered

choice to privatized health care is a preferred solution (Veterans of Foreign Wars, 2017). The literature search revealed a gap in understanding if an existing private-sector choice program, such as the Retail Immunization Care Coordination Program, resulted in overall health care choice policy acceptance or rejection, and what personal or collective experiences may have motivated veteran patients to select a privatized health care service rather than one provided by their government provided health care agency of record.

Phenomenology offered a lens in which the participants were able to provide unfiltered perceptions about their experience with the concept of choice, forming a foundation for future qualitative research in organizational or program-specific health policy in the government health agency to explore and then transfer their responses to other programs or policies. At the core of phenomenology is the concept that personal experiences may give meaning to the phenomenon so that one may "judge it, remember it, make sense of it, and talk about it with others" (Patton, 2015, p. 115). The use of phenomenology was appropriate for this research topic because my aim was to understand how veteran patients experienced a public policy centered around a phenomenon called choice, which is further amplified by traditions of the policy feedback theory.

I sought to understand what motivated veteran patients of the government-run health care system for beneficiary veterans to choose outside, privatized preventive health care (e.g., a no-cost flu shot at private-sector, retail provider) and understand the perceived impact of feedback related to the choice phenomenon. Although there were limitations to the use of this approach, including generalizability, its value was found in

transferability and the participants' humanistic reaction to the phenomenon of choice (see Dawidowicz, 2016). The data resulted in information that confirmed some assumptions in the only other study about this topic that featured a geo-study. The analysis helped to amplify some additional insights about the assumptions concluded by the previous study concerning veterans who chose to use a private entity (e.g., the private, retail pharmacy provider) versus the traditional government health care system to get their seasonal flu shot, namely access and ease. Cost did not factor in as it was an assumed benefit in this first and only other study (Botts et al., 2017).

Phenomenology proved to be a solid methods selection for this research because I investigated a personal decision presented by a health policy program by the health agency based on choice—a concept that contemporary policymakers tout as the reason to develop new access to care standards that loosen administrative regulations and open to the doors to pay-for-fee private services (see Luthi, 2019). The selected methodology also aligned with the VLER Health Performance Management Plan (2014), the strategy that outlined a need to evaluate customer feedback via qualitative methodology.

In researching other types of methodology, the idea of shared meaning and personal experience continued to move the research methods of this study toward phenomenology. Because my aim was to understand the personal motivations behind the numbers, this type of interpretative phenomenology assessment (IPA) seemed to be an appropriate method for understanding the concept of choice from the lived experience of participating veteran patients. Thousands of participants have used this no-cost flu shot choice program throughout the United States since 2013; therefore, case study did not

seem ideal or practical. Both Dawidowicz (2016) and Patton (2015) contended that case study can be arbitrary, voluminous, bounded by time and activity, and may be difficult to define. At the onset of designing this project, case study was considered, but the policy feedback theory and the sampling strategy did not lend themselves to a bound case that would be readily defined. Additionally, to triangulate the necessary types of data required more time and resources to conduct; it did not seem feasible given the ongoing choice debate in the government-run health care system.

The selection of ethnography did not seem appropriate because there was no natural setting. Creswell (2009) suggested that both ethnography and narrative research require a single or multiple views within a natural setting (ethnography) or from a personal biographical experience (narrative research); neither of these would have been applicable to the present research focus, which primarily aimed to understand the meaning of a lived experience and what motivated veteran patients to use a nongovernment health care provider for a preventive health care service. This research did not require immersion in a culture or provide an opportunity or need for extensive observation or self-administered histories or journaling.

Previous research among veteran populations has used phenomenology, according to the literature review. In seeking to understand the concept of hope among traumatized Israeli reserve soldiers, investigators recruited soldiers to obtain descriptive data to investigate a topic that was not well understood (Levi, Liechtentritt, & Savaya, 2012). Similarly, a phenomenological study was guided Beks (2016), who analyzed personal accounts of female partners of men who were veterans and who suffered from

posttraumatic stress disorder. The selection of phenomenology methodology for this present study, rather than another qualitative method, centered on the need for thick, rich data that captured the intersection of concepts of the theory of planned behavior and the policy feedback theory.

The central goal was to understand what motivated veteran patients to obtain a flu shot at a private-sector, retail pharmacy rather than their government health care agency when both are offered at no cost within the context of a social marketing program. At the time of the study, it was the only program in this health agency that offered unfettered choice to my knowledge. However, in the last few months of the study, emerging *choice* programs began to be implemented as a result of the VA MISSION Act of 2018 (H.R. 5674). According to Creswell (2013), phenomenology helps to explore the common or shared experiences of a phenomenon to reveal the layers of decision-making. This approach helped provide data to capture the collective experiences of a population with a unique, but similar backgrounds so that health care policies may be better suited to their needs and that the agency can better meet their expectations of communication, while fulfilling the legislation obligation to these patients.

The idea of understanding and revealing what experiences led a veteran patient to make the decision to seek a flu shot outside of his/her traditional government provided health care entity was best understood using a phenomenological approach where multiple, but a limited, number of participants provided patterned responses. Their collective responses, once combined, provided a more conscience reality of the concept of choice. This data then may better inform health care policy decision-makers and

improve both the implementation and diffusion of choice programs within the government health care system for beneficiary veterans. The findings lay the foundation to generate new, expanded knowledge on understanding the concept of choice in health care from a veteran patient's point of view, an area where scant research has been identified yet could be ideal for exploring as claims are made without the necessary evidence in veteran health policy and diffusion.

Research Questions

The research questions that guided this investigation were developed through an examination of the literature. They were designed to address the gap in literature that addressed the need to understand the choice claim from the veteran patient perspective amidst the larger patient-as-consumer phenomenon within an ongoing neoliberal environment that is moving government health care services for beneficiary veterans from the public domain to private-sector entities. These research questions focused on the perceived importance to eligible and enrolled veterans of the government health care system to which they earned benefits.

RQ1: Why is the no-cost flu shot option an appealing choice for veteran patients in this era of the patient-as-consumer?

RQ2: How do veteran patients of the government-run health care system decide to use the option to access the free-market no-cost flu shot option at a contracted private-sector retail pharmacy?

RQ3: How do participating veteran patients describe their decision making related to the principles of social marketing and their perceived feedback related to choice legislation?

Role of the Researcher

I am not a veteran patient of the government health care agency for beneficiary veterans, nor am I a military veteran. Therefore, my role as the researcher was to collect data from interviews, organize the data, and then analyze the content in a deliberative and unbiased manner (Dawidowicz, 2016). Since I do have experience in working for the government-run health care agency, I put strategies in place to practice bracketing throughout the research process. I employed the practice of reflective journaling throughout the research process. I used an audio recording in participant interviews. bracketed my experience in data collection and analysis and worked with a Principal Investigator (PI) who helped to verify and member-check both the process and the data collection and analysis process. I used the peer support from an executive from the agency to verify certain data and kept in weekly contact with the assigned PI from the local participant partner site. I followed the guidelines and the regulations as approved by the site Institutional Review Board (IRB) throughout the study. Finally, I plan to share my data and findings with the site partner as agreed upon via the IRB approval and with the program office that oversees the Retail Immunization Care Coordination Project.

My interest in understanding what motivates veteran patients of the government run health care agency for beneficiary veterans to accept or reject health care policy or programs was a culmination of decades-long work in designing communications campaigns and more recently my work in communications support for establishing the Retail Immunization Care Coordination Program when I served as a public affairs specialist from 2013-2016. However, when carrying out this project, I functioned as a

named co-investigator, an external researcher with no direct link to the program or local site partner. The administration of the Retail Immunization Care Coordination Program was transferred to another agency staff office in 2016 and was set to sunset in 2019 with the implementation of the VA MISSION Act of 2018 (H.R. 5674) as it was designed. Also, I am not employed by the local site partner. Therefore, my interest was both academic and professional. Also, the VLER Health Performance Management Plan (2014), which guides the Retail Immunization Care Coordination Program, called for multiple assessments of customers to understand the impact of the program. Phenomenology offers a humanistic lens in which to understand the impact of a health-related, policy-based programs such as the no-cost flu shot for veteran patients.

As a researcher, I was mindful of epoche and phenomenological reduction. To accomplish the perspective of epoche, I adjusted my way of thinking and set aside natural "prejudices, viewpoints, and assumptions" regarding the concept of "choice" (Patton, 2015, p. 575). To assist me with this perspective, I used a reflective journal to understand and report relevant preconceptions prior to data collection (Janesick, 2016). Since I am not a veteran, a patient of the government-run health care agency for beneficiary veterans, or caregiver in the health care system, I do not foresee, nor did I encounter, any conflicts of interest. Also, since I am no longer associated with the Retail Immunization Care Coordination Program, I did not experience any ethical dilemmas. Also, I have no ongoing personal or professional relationship with principals who oversee the program and I plan to work with a local site partner to make the recruitment arrangements.

Following the strict research guidelines of the partner site helped to maintain objectivity and study rigor. I did not have direct access to any personally identifiable patient data without the participants' consent. Since the data of the retail pharmacy-provided flu shot are part of the patients' electronic health records, it was feasible for a designated site management analyst to parse these records to obtain a list of potential participants that met the study criteria. Once the data was obtained, IRB-approved invitation letters, a consents for to participate in the study, a consent form to audio-record the interview, a screening tool, and return envelope were mailed to the potential participant pool to request voluntary participation in this study on my behalf. The site required two official forms in which the participant had to complete to signify consent and interest. This process aligned with the site's research protocol and provides a way for participants to opt into my project.

Given this established process and methodology, the study met the appropriate privacy and confidentiality standards throughout the research process, ensuring that both university and partner site requirements and approvals were met before proceeding. Finally, I did not maintain any management authority in my current role so there was no concern in the area of coercion. All approvals were in place before proceeding. Two required research and privacy trainings were completed prior to the commencement of the study. No patient was interviewed without the appropriate consents prior to any research inquiry to maintain rigor, ensure objectivity, and avoid power imbalances.

Methodology

In this qualitative research project, the choice claim in government health policy was the phenomenon at issue. More specifically, interpretative phenomenology analysis (IPA) was employed to develop an understanding of what social marketing campaign strategies and elements motivated enrolled and eligible veteran patients of a government-run health care system to decide to seek a preventive health option (e.g., the no-cost flu shot at the private-sector, retail partner pharmacy provider) outside of their government health care provider. The overall intent was to explore and therefore, better understand the impact of choice claims made in VHA health policy from 2013 – 2019.

IPA aims to uncover descriptive data that may offer a deeper understanding of a participant's experience. In this study, the use of IPA helped to uncover how veteran patients experience choice and its relative meaning to current and future health policy in the government health agency. To support this research, it was essential to work in partnership with the local participant site to obtain a purposive sample of participants. To obtain informed consent and seek interested participants for this study, an extensive IRB process had to be undertaken. The plan included detailed study information and process planning that ensured participant voluntary consent to participate. As part of the research package, the initial study information included the VA Research Consent Form (Form 10 – 1086), a Consent Form to Record the interviews (Form 10 – 3202), and a Choice Screening Tool for the local site partner to send to a potential study pool that met the criteria of the study.

The Choice Screening Tool helped to establish baseline demographic and thematic data. It was used primarily to answer Research Question 1: Why is the no-cost flu shot option an appealing choice for veteran patients in this era of the patient-as-consumer? Contained in the package was a letter with instructions to opt-into this project, e.g., a return mail-in envelope with instructions on how to respond. Follow-up with respondents who opted-in to the project was made via telephone calls to conduct semistructured, audio-recorded one-on-one interviews. This approach helped secure participants who are willing to provide their information, maintain privacy, and achieve the inclusion criteria below. It also added credibility to the study due to guidelines of the IRB and the security maintained by adhering to the site's regulations.

Participant Selection Logic

The research was limited to eight to 12 veteran patients who participated in the Retail Immunization Care Coordination Program and who met the inclusion criteria. The research inquiry was open to male and female veteran patients who chose to get their no-cost flu shot at the private retail provider partner rather than their government health care provider. The inclusion criteria for the research project was: (a) the veteran must be eligible for and enrolled in the government-run health care system as of 2013, (b) have obtained a flu shot from the private retail provider partner vice their government health care provider at least one time from 2013 - 2019, and (c) the veteran must have been a registered and enrolled patient of the partner site and reside in one of the five selected market areas, e.g. counties that make up a portion of the site partner's market. There were no exclusion criteria. However, the data in the patient's electronic health record must

have indicated that the participant obtained the no-cost flu shot at the private retail pharmacy provider as indicated by the electronic health record data. This data is integrated directly into the Veteran's VA electronic medical record. Eligible participants included veterans of all ages, demographics, branch of service, or era served.

The approach was to use purposive sampling within a specific geographical area as defined by five market-area (e.g., counties) within the market that the site serves. This five-market segment was a mix of urban, suburban, and rural populations to provide a wide variety of feedback. In addition, convenience sampling also was factored into the participant selection logic. This type of participant selection approach aligns with other qualitative research studies (Miles, Huberman, & Saldana, 2014; Patton, 2015).

Given this program-supported and systematic data set, the expected research sample was between eight and 12 due the participant pool anticipated. However, ten participants' data were utilized, and seven participants met the entire methodology strategy. Saturation was reached and no additional volunteers. The process met the intent of IPA (Dawidowicz, 2016; Patton, 2015). Given the data pool, maximum variation and distribution was met and was void of selection bias due the nature of the outreach for volunteers. The process ensured study rigor. Following full consent received by the co-investigator, each participant was contacted in order to hold a semistructured, audio-recorded interview. Seven of the ten potential interview participants were contacted and interviewed, while data from the screening tool of ten participants were included in the study. Saturation was reached.

The recruitment arrangements were made by working with local administrative data analysts and PI staff. Since the data of the retail pharmacy-provided flu shots are part of the patients' electronic health records, it was feasible to parse these records and send letters on behalf of this research project following IRB approval. Details of the study and chronology of the effort were placed in a VA Research Consent Form (Form 10 – 1086). Personally, identifiable information (PII) was kept confidential per IRB guidelines. There were no known risks to participating in this research project. The participants names were not used in the data analysis. Pseudonyms, or code names, were used in the data collection and analysis. This process ensured that all personally identifiable information such as social security number, date of birth, etc. was de-identified.

The research sample was expected to be between 8 and 12, but saturation was reached at seven participants and no additional volunteers for interviews were obtained. Preliminary, themed data analyses from obtained from ten participants' screening tools (Dawidowicz, 2016; Patton, 2015). This approach was consistent with other phenomenological studies of this unique patient population. Ruiz and Stadtlander (2015) recruited veteran spouses via social media, emailed them a consent form, and a qualitative questionnaire to acquire the data from 10 participants when they reached saturation. Similarly, investigators collected data via in-depth interviews from 10 Israeli reserve soldiers to derive rich descriptive content for their study (Levi et al., 2012). It was understood that participants must engage in both screening tool and the semistructured interviews to comply with this phenomenological research plan (Dawidowicz, 2016). However, it was essential that both the screening tool data from ten participants and the

subsequent seven interviews were used for the data analysis of this project. Upon reflection, both saturation and redundancy were considered when conducting phase two of the data collection.

Working with both the university and the local partner site, all guidelines were followed. As instructed by the preliminary ethical review by the university, an IRB with the local partner site was filed since the institution would be overseeing the data collection and storage. This present research project was classified as a non-exempt human subject's research requiring a limited IRB review by the local government agency site of record. As a co-principle investigator, there was not a requirement for a formal letter of cooperation from the site administrator or designee and work under the supervision of a designated principle investigator (PI). As such, there was no need to provide a letter of participation per the university ethics review. All contact including the screening tool and the semistructured interviews took place via the phone as agreed upon and arranged in advance between the participants and the researcher and as approved by the site IRB.

To build trust and maintain confidentiality between the researcher and the participant, a follow-up, introductory phone call was held to confirm consent once the opt-in screening tool and consent forms indicated a veteran patient's willingness to participate. See Appendix A for script. Each participant was given a confidential identifier (e.g., a pseudonym) that was used during data collection, analysis, and the dissemination process of the dissertation. The consent forms are maintained in the

patients' electronic health records and they were provided the opportunity to withdraw at any time. The PI's contact information was provided for questions or follow up.

Instrumentation

Since phenomenology seeks to study the individual and his/her insights or experiences, a combination of the screening tool and personal semistructured interviews were utilized. Observations were not applicable in the present research; therefore, I employed the interview process to obtain unfiltered information from the participants. The combination of the screening tool and the semistructured interview added to the study's rigor and worked to reduce researcher bias (Creswell, 2009). IPA was the focus of this study; IPA is a useful qualitative approach for health and social science research. IPA uses small sample sizes to elucidate rich, descriptive data (Boniface, Ghosh, & Robinson, 2016). In this tradition, the data were transcribed and stored using Dedoose™. Each interview was audio recorded, and not personal identifiable data details was part of the transcription or analysis to protect anonymity.

Screening tool. To form a baseline of active and willing participants who are representative of the population, a screening tool along with the official consent form to opt-in to the research project was utilized. The screening tool was used as the foundation to obtain motivational type themes from the participants. Since the theory of planned behavior was critical to the central research of this study, the results from the screening tool helped form initial, parent-coded themes. The screening tool consisted of statements that include confirmatory factors of the patient's participation in the no-cost flu shot program and some general experiences of the idea of choice and why one may obtain a

flu shot within or outside the government. These statements were derived from the literature and the concepts used in the no-cost flu shot marketing campaign to promote the private retail program, including the ideas of *ease*, *access*, *convenience*, and the opportunity to maintain seamless electronic records – all messages entailed in the Retail Immunization Care Coordination Program choice program (Ajzen, 2013; VA Retail Immunization Care Coordination Program Fact Sheet, 2017; Walgreens Website, 2018). See screening tool in Appendix B.

Interview. Using methods characteristic of phenomenology, seven semistructured, one-on-one interviews were conducted. These audio-recorded interviews focused on the participant's lived experience, perceptions, and personal motivations to obtain a no-cost flu shot outside of the government run health care system for veterans. Each interview, while not identical, followed a pre-scripted guide that derived from the theory of planned behavior concepts. Understanding that the qualitative research process tended to be iterative, both the interview schedule and interview questions served as prompts for each semistructured interview. Interviews were scheduled for approximately 60 minutes each via the telephone and using the site's telephone interview protocol. This phase was designed to stimulate patients to reveal their personal motivations for choosing to opt-out of government-provided preventive health care and explore in-depth their experiences about the choice phenomenon in health policy. It was meant to explore any connection between this program with emerging choice health policy programs. A copy of the sample semistructured interview guide can be found in Appendix C.

Each participant was agreeable to use of their direct quotes with the blanket agreement of the signed and audio-recorded consent forms. Member checking helped strengthen this process. As indicated on the IRB paperwork and to the participants, I plan to provide them with an Executive Summary once the project is completed and approved by all parties. All participants have the PI's contact information for questions or follow-up. All participants were assured that their information would be kept in a secure location and kept confidential as per agency privacy standards. If the information is used beyond the dissertation, participants will be notified, and their personally identifiable information will remain protected.

Data Analysis Plan

The purpose of this qualitative research project was to uncover what motivated enrolled and eligible veteran patients of the government-run health care system to choose a preventive private-sector health care option and to understand what experiences led them to accepting or rejecting choice claims in health policy in general. Phenomenological research is iterative and evolutionary. Therefore, the data were dissected from the screening tool and compared them with clusters of theory-driven data themes derived from the theory of planned behavior to form a first-stage of coding, which form a preliminary codebook. These codes served as parent codes to which further analysis led to interpret themes that emerged from the interviews following multiple readings of each transcript. Upon this phase, sub-codes were developed to help amplify the meaning of each parent code with descriptive theme-centered analyses to examine patterns or showcase discrepancies.

The theory of planned behavior states that past behavior is a good indicator of future behavior (Ajzen & Fishbein, 1969; Values Based Management Website, 2016). The use of a screening tool help set the stage to understand some baseline behavioral norms, attitudes, and beliefs about participating in the Retail Immunization Care Coordination Program. The thematic response data were charted in an Excel spreadsheet to capture demographic data along with the analysis of responses; the responses were clustered for careful examination, analysis, and interpretation to form a general understanding of the participants' perceptions and baseline experiences in choosing the no-cost flu shot at the private retail provider partner. This first stage of data analysis will helped form theory-based codes, which will form a preliminary codebook of parent codes.

For the one-on-one semistructured interviews that followed, horizontalization of the data was made possible due to the verification of this data. Also, this process provided a *fresh-view* look at all the statements as an equal, distinct idea. Note-taking in the margins and reflective comments were made after each interview was transcribed (Moustakas, 1994 as cited in Ruiz & Stadtlander, 2015). The data was hand-coded and then uploaded to Dedoose™ for data analysis. This process allowed for emergent themes to amplify the baseline parent coded data. It also provided similarities and distinctions, using the screening tool data analysis as an organizational framework. The use of a highlighter was employed to emphasize significant statements that illustrated a poignant experience on how a participant experienced the choice phenomenon.

Using Dedoose™, a security-controlled, qualitative analysis web-based software program, the original transcripts were uploaded and stored in the site's password-protected electronic environment. All hard copies were locked securely onsite at the site partner until data analysis is completed. Once the study is done, this hard copy data will be shredded per IRB protocol. While there were no discrepant case(s) identified, there was a plan in place to provide that information to the parent site and reflect that information in the data analysis. Data analysis did confirm some outliers to themes on some claims as part of the complexity of unraveling the choice phenomenon.

Issues of Trustworthiness

This qualitative research project followed all ethical and required guidelines to ensure the project maintained internal and external validity. While the issue of trustworthiness is arguably fluid in phenomenology, Creswell (2013) cited several validation strategies in which a researcher may employ to strengthen her study. The initial challenge is to bracket personal bias, using tools such as a reflective research journal and peer reviewer of the data to establish an audit trail and credibility. I used both; I kept a detailed research journal and maintained the support of a peer-mentor, the PI, to provide an external check on the research process, analysis, and interpretations (Creswell, 2013).

The planned strategy of this study to obtain information from a screening tool from willing participants who opt-in to participate added to the credibility of the present research project as a first layer of data that forms theory-driven parent codes. The semistructured interviews provided for rich, descriptive data generation, adding a layer of

sub-codes for each parent code. According to Miles, Huberman, and Saldana (2014), a diverse sample that yields thick, rich descriptions of a participant's experience may establish transferability to similar programs and projects. In both the analysis and the summary output, the use of abundant details was employed so that the readers may "make decisions regarding transferability" (Creswell, 2013; p. 252). Finally, all tools and strategies used were shared with and approve by the designated PI to examine and assess. These items included the recruitment package, the study instruments, and the final data outcomes to strengthen the dependability of this research (Creswell, 2013). The goal of this study was to produce a balance of information that is rich in description but provides a thematic roadmap to understanding what motivates veteran patients to choose external preventive health care in an era of neoliberal policies and marketized medicine.

Ethical Procedures

Since the researcher serves as the primary instrument in the qualitative research process and qualitative research may be considered subjective by some, transparency remained paramount. The telephone script to introduce the project fully introduced the project, its background, goal of this project, and intention to publish results as part of a dissertation process. I maintained the commitment to "do no harm" (Miles, Huberman, & Saldana, 2014, p. 56). I followed all university and partner site IRB protocols. The IRB approval number for this study is 07-03-19-04411200. The site protocol number is 392.

Participants were reminded that they could withdraw from the project at any time and that all information would be kept confidential; close attention was paid to maintain patient privacy in all matters and ensure compliance with local partner site privacy and

confidentiality compliance measures. No monetary compensation was exchanged for participation in the research. Systematic records to increase reliability were kept; these records include raw data, researcher journal notes, consent forms, and instrument development background. These steps helped showcase the rigor, integrity, and accountability of this research project (Miles, Huberman, & Saldana, 2014).

The focus on obtaining rich, thick descriptive data derived from the qualitative nature of this study but rested on the narrative nature of it. The use of transcripts was essential as was the balanced data obtained from the Choice Screening Tool. Review from the PI helped to negate any potential bias (Creswell, 2013; Maxwell, 2014). Only participants who agreed to participate and who submitted signed informed consents and disclosures for this research project were interviewed. Privacy, confidentiality, and anonymity were maintained. Per the site partner IRB, the data has been locked in the PI's locked office files for five years. All consent forms were scanned into the patients' electronic health record for safekeeping and per agency standards and protocol to safeguard the data.

Summary

This chapter began with a review of the purpose of the present research – to understand the submerged state of public policy in the government health care agency for beneficiary veterans as it relates to the choice phenomenon evident throughout health care today, and particularly in the population of veteran patients who have unfettered choice when obtaining a seasonal flu shot. The rationale for selecting an interpretive phenomenological approach to explore the lived experiences of this unique population of

patients was described. A discussion on my role as a researcher followed. I described in detail the selected two-step approach to the research and provided an outline of participant selection, instrumentation, interview protocol, and a data analysis plan. I concluded with a discussion about the issues of trustworthiness and highlighted ways I intend to ensure research confidence including internal and external validity strategies. Finally, a summary of ethical procedures that will guide the research efforts including treatment of participants and their data, IRB requirements, handling of their personal information, and the use of a qualitative analysis software program for the coding and analysis process concluded this section.

Chapter 4: Results

Introduction

The effective application and resulting implications of an emerging health policy within a government-run health care system that loosened administrative rules amidst a backdrop of marketized medicine were at the core of this qualitative study. Research exploring the concept of choice in health care is beset with challenges due to the complexity of today's submerged state of a health policy within a framework of increasing access to private-sector entities at government expense, a growing social justice debate. Today, patients who are beneficiaries of the largest government-provided integrated health care system are recipients of health policy decisions that impact the way they receive their earned health care benefits within the larger patient-as-consumer phenomenon. However, there remains little to no formative or descriptive research to understand their perceived needs or values when choosing how or where to receive their earned health benefits.

Through an analysis of the lived experience of patients of the government-run health care system for veteran patients, I aimed to capture patient feedback within the context of a submerged policy program that provided an unfettered choice option to seek private sector, preventive health care, that is, a seasonal flu shot, at a contracted retail pharmacy provider. The parameters of the study included patients living in a five-market (e.g., county) geographical area surrounding a major metropolitan, government-run health care system for veterans in the South. I sought to understand the perceived importance of the concept of choice in health care policy and services when given

unfettered freedom to choose how to access a seasonal flu shot; the time period was 2013 to 2019.

The qualitative assessment was based upon a social marketing preventive health care program that promoted patient choice when offering unfettered access to a seasonal flu shot either within the traditional government-provided entity or at the contracted private-sector retail pharmacy to eligible and enrolled veteran patients who met the criteria. The program was known as the Retail Immunization Coordination Program. Both a screening tool, which provided baseline, parent codes, and in-depth semistructured interviews, and which amplified descriptive themes of choice, served to establish the adequacy and perceived impact of choice claims in health policy to determine the impact on current and future choice policy implementation and dissemination among constituent audiences. The data obtained from these two sources were used to provide a more comprehensive understanding of the central research question that guided this study: How can government sponsored social marketing campaigns support evidence-based policy making by identifying what factors influence veteran feedback and the adequacy of the choice claim in patient decision making for seeking preventive health services?

Additionally, the data helped reveal information to elicit participants' feedback about the perceived impact of having choice options in preventive health care available to them as a beneficiary of a government-run health care entity, including elements related to access to care, a commonly used phrase to describe patient choice as a health care priority and one that presented itself before in the only other study related to this program (see Botts et al., 2017). Finally, the respondents provided insight on whether the use of a

program that offered unfettered choice at no additional cost to the patient opened the door for more neoliberal policies using government-funded programs to strengthen the submerged state of policy in this sector, a growing phenomenon, yet one that is understudied in the United States.

While not evaluative in nature, I did operate with a partner site to obtain volunteer participants who revealed their feedback based on experiences of a choice program, the Retail Immunization Coordination Program. The scope of the study was local in nature, but I examined a national issue regarded as important to emerging health policy within the government-run health care system and its stakeholders. Under the direction of a site principal investigator (PI) and with the cooperation and approval of the site IRB, I followed a strict process of participant selection, data collection, and review of the results. Also, the study may have been subject to external factors of the federal government's activities that appeared to be expanding choice options amidst the backdrop of consumer choice during the time of data gathering and analysis. This notation is critical to both the frame of the study and the reporting of its findings.

The results, presented in this chapter, address the impact of the lived experience of patients who benefitted from a choice option within a submerged policy program. I also shed light on the likelihood that future choice health care policies would either be accepted, tolerated, or rejected, underscoring tenets of the policy feedback theory through the lens of Ajzen's theory of planned behavior. The research questions addressed were as follows:

RQ1: Why is the no-cost flu shot option an appealing choice for veteran patients in this era of the patient-as-consumer?

RQ2: How do veteran patients of the government-run health care system decide to use the option to access the free-market no-cost flu shot option at a contracted private-sector retail pharmacy?

RQ3: How do participating veteran patients describe their decision making related to the principles of social marketing and their perceived feedback related to choice legislation?

The subsequent sections of this chapter include a description of the study setting, participant demographics, and data collection methodology and analysis. Following this presentation, a discussion of trustworthiness and the results of the data are provided. Finally, I summarize the chapter in the conclusion.

The Setting

The study was conducted in the privacy and security of the PI's office at the partner site, a major metropolitan government health care facility in the South. The main center, as referred to by patients during the interviews, is newly constructed and offers primary, specialty, mental, and inpatient health care services. According to non-peer reviewed, informal information about the main center, it was designed to satisfy three national core missions of education, research, and emergency assistance. Activities related to participant recruitment, review of consent forms, and a choice screening tool analysis took place from June to July 2019. The partner site was essential for soliciting participants for this study. Because the data for those eligible patients are maintained in the system's integrated electronic health record (EHR), and privacy and confidentiality

were to be maintained, administrative support was required to query the data from the EHR using parameters of this qualitative study. Volunteer participants opted into the study by completing two consent forms, the choice screening tool, and they mailed back the information to the PI's office.

Semistructured interview telephone calls took place in August 2019 to those patients who consented to participate in the study. The calls were made from the health care facility's location using government-issued equipment as per the IRB approvals. Conditions related to the setting were optimal: The office was free of distractions and was private; the use of the facility's phone system was a necessary assurance to the study participants who were accustomed to receiving calls from the main number; and the study materials were kept onsite, maintaining participant confidentiality.

Demographics

The target population for this study was veteran patients who were eligible and enrolled for beneficiary health care services of the government-run health care system as of 2013 and who obtained a seasonal flu shot from a private retail pharmacy provider, a national chain that was designated by the system via contract. The potential patient participant must have received his or her seasonal flu shot from the retail provider vice their government provider at least one time from 2013 to 2019; multiple shots from multiple years was acceptable but not required. The veteran patient's medical record (e.g., EHR) would indicate where the patient received the flu shot, making the data request acceptable to the partner site and amenable to this study's recruitment process, which was approved by the local site's IRB.

Additionally, the veteran must have been a registered patient at the main hospital for veterans in the targeted major metropolitan area in the South and reside in one of five surrounding markets. The selected areas represented urban, suburban, and rural areas of the main health care entity serving patients throughout 23 surrounding markets (e.g., counties) in a Gulf South state. The site partner's administrative support acquired 119 matches to the data request parameters.

The response rate from the request for participation resulted in a sample size of an initial 10 patients who returned the choice screening tool, seven of whom participated in a follow up telephone interview. Two letters were returned due to undeliverable addresses and two were returned because the patients were deceased. The final participant pool ranged in ages from 37 to 79 years old, representing three of the five targeted markets. The final patient participant pool provided a balanced distribution of patients' time in service and era of service, which was reflective of the veteran population data trends (U.S. Department of Veterans Affairs, 2016). See Table 1 for details.

Table 1

Participant Demographics

ID	Age	Gender	Time in service	Branch of service	Era of service
ID-1	62 years old	Male	0 – 5 years	Air Force	Vietnam
ID-2	37 years old	Female	0 – 5 years	Marines	Iraq/Afghanistan
ID-3	69 years old	Male	6 – 10 years	Army & Coast Guard	Vietnam
ID-4	40 years old	Male	6 – 10 years	Army	Iraq/Afghanistan
ID-5	73 years old	Male	0 – 5 years	Army	Vietnam
ID-6	79 years old	Male	0 – 5 years	Navy	Peacetime
ID-7	47 years old	Male	20 + years	Air Force	Iraq/Afghanistan
ID-8*	70 years old	Male	0 – 5 years	Army	Vietnam
ID-9*	62 years old	Male	20 + years	Army	Gulf War/Desert Storm
ID-10*	66 years old	Male	20 + years	Navy	Gulf War/Desert Storm & Iraq/Afghanistan

The purposively sampling strategy employed in this study aimed to reflect the national demographics of the health care system that provides health care to beneficiary veteran patients. Accordingly, the participant pool age bands appeared to mirror the distribution of veterans (U.S. Department of Veterans Affairs, 2016). Also, approximately 10 percent of the current projected population of veterans in the United States is women, which aligns with the participant pool of this study. Additionally, the sample size yielded an even distribution of years in service for veteran patient participants and was reflective of the era of service in which the health care entity serves presently (Table 1). Thus, the sample goal to achieve a broad variation of age, time in service, era of service, branch of service, market distribution, and reflective characteristics of the patient population under study (gender and location) was achieved. Individuals were not compensated for their participation in the study and telephone interviews were conducted during the month of August 2019.

Data Collection

The data for this study were collected from two different data sources. The sources of data included information from the Choice Screening Tool and semistructured interviews. The Choice Screening Tool was designed to address Research Question 1 – Why is the no-cost flu shot option an appealing choice for veteran patients in this era of the patient-as-consumer? This tool provided parent-coded data, laying the groundwork for subsequent interviews and emerging themes. The semistructured interviews helped to amplify preliminary choice claims, which were revealed from the screening tool, using

interpretative phenomenology analysis to expound upon themes and answer the final two research questions:

RQ2: How do veteran patients of the government-run health care system decide to use the option to access the free-market no-cost flu shot option at a contracted private-sector retail pharmacy?

RQ3: How do participating veteran patients describe their decision making related to the principles of social marketing and their perceived feedback related to choice legislation?

The Process

Following the study approval by the IRB at the partner site, recruitment took place via a traditional mailing to a potential pool of 119 participants, thus making use of purposive sampling within the five-market geographical region of the main health care facility. The study recruitment package consisted of the Choice Screening Tool to obtain parent coding and provide baseline demographic and participant data to conduct audio-recorded semistructured interviews. Obtaining the returned consent forms (2) and the screening tool were essential to ensuring that IRB/partner site requirements of patient consent, confidentiality, and privacy were maintained. Without the signed forms and verbal verification of the participant, the telephone interviews could not take place. Only after the patient had mailed in the signed forms and confirmed over the phone his/her understanding of the study could the interview take place. This process occurred in July 2019.

During August 2019, telephone interviews using a guided interview script took place with seven of the 10 patients who returned the sets of forms. It was during the

telephone interviews in which emergent coding was applied. Since phenomenology seeks to understand the individual experience in order to discern rich, descriptive data, the Choice Screening Tool was designed and sent to capture initial insights and develop thematic parent codes for data analysis. The use of the screening tool data combined with semistructured interviews added to the rigor of the study and help reduce researcher bias.

The Choice Screening Tool

Following the mailing to potential participants, the Choice Screening Tool data were collected from 10 participants. Each participant was assigned a de-identified pseudonym, which was used throughout the data collection and analysis process (e.g., ID-1, ID-2, etc.). The analysis of each participant's "experience of choice" statement(s) was documented via an Excel spreadsheet throughout the month of August 2019. The data from the screening tool helped establish descriptive root, or parent, codes that would serve as inductive themes during the subsequent interview process. In addition, it helped underscore the idea that, according to Ajzen's theory of planned behavior, information alone is not enough to move a person to action (see Values Based Management Website, 2016). In the screening tool, participants reported their primary reasons for choosing to obtain their seasonal flu shot from a private sector retail pharmacy rather than their government-administered provider.

In addition to providing parent, thematic coding related to the participants' experiences of choice in a health care program, the data from the analysis of these screening tools were used to answer the first research question: Why is the no-cost flu shot option an appealing choice for veteran patients in this era of the patient-as-

consumer? Within each of these claims of choice reasonings, the data were examined to discern a first-glance reality of the phenomenon of choice in health care administered by a government-run health care system that is primarily a provider of care based on the lived experience of the patient participants. The claims of why participants chose to obtain their seasonal flu shot was then used as a coded descriptor aligned with each participant and uploaded into Dedoose™, a qualitative, secure, and password-protected software program where a two-stage coding process was undertaken following a series of seven in-depth semistructured interviews.

The Semistructured Interviews

Following parent-coding based on the Choice Screening Tool, seven semistructured interviews were conducted using a guided interview script. The interviews took place over the phone at the site participant location as planned. Using methods characteristic of phenomenology and following insight from the theory of planned behavior within a social marketing framework, one-on-one interviews were conducted from August 6 - 20, 2019. Each interview was audio-recorded and transcribed. Immediate researcher reflections were noted as well. Each transcription was then uploaded to Dedoose™ where child codes were developed based on the following theory-driven themes: Control Factors; Behavioral Outcomes; and Normative Referents.

The second stage of the process was a data-driven approach from reviewing the text of each interview to developing sub-codes that emerged after a review of the subset of the seven transcripts. These sub-codes, or child codes, were then applied to the contents of the transcripts and linked to the participants to determine code occurrence,

code presence, and code frequency. The output from Dedoose™ was then examined to elucidate potential relationships between choice preferences and demographic variables.

This second source of data, the in-depth interviews from veteran patients of the government-run health care system, lasted between 20 and 50 minutes each. The variation arose because some patients spoke more plainly and did not appear comfortable with elaborations. While others spoke freely and willfully about their experiences using a choice program. An inductive-thematic analysis of the data from these interviews relied on the following: The process included extracting key data from the written notes, transcribing the interview, and reading the document thoroughly while notating interesting features and themes, generating initial codes, searching for themes, reviewing themes based on coding, and defining themes. The data gathered from the semistructured interviews helped to provide thematic responses to answer the final two research questions:

RQ2: How do veteran patients of the government-run health care system decide to use the option to access the free-market no-cost flu shot option at a contracted private-sector retail pharmacy?

RQ3: How do participating veteran patients describe their decision making related to the principles of social marketing and their perceived feedback related to choice legislation?

The interview process itself was not meant to be prescriptive, allowing me as the researcher to explore more about a topic should that reveal itself by the participant's responses and anecdotes. Participants were invited to speak freely and reflectively. Since three participants failed to provide their signed consent forms along with their screening

materials, seven viable candidates were interviewed. Although the original plan was to interview a minimum of eight participants, there appeared to be data saturation as a result of the screening tool and semistructured interviews, which produced a total of ten participants. Therefore, data collection ceased when no new information emerged from the interviews and no new respondents volunteered to participate. There were no unusual circumstances encountered in the data collection.

Data Analysis

The purpose of this study was to uncover what motivates enrolled and eligible veteran patients of a government-run health care system to choose a preventive, private-sector solution to obtain their seasonal flu shot. The goal was to understand what experiences of having unfettered choice in seeking preventing health care services at government expense reveal about the beneficiary veteran patients. Secondarily, the study aimed to evaluate how this kind of submerged health policy may or may not impact their views on current and future health policies within a social marketing framework guided by the policy feedback theory.

Since phenomenological research is iterative and evolutionary, the data from the screening tool provided six main reasons for answering the first and formative research question: Why is the no-cost flu shot option an appealing choice for veteran patients in this era of the patient-as-consumer? From the analysis of the data from the screening tool and the contents of the interviews, superordinate theme that emerged describing their reason to obtain a seasonal flu shot by a private retail provider was that it was *closer to home*. All the respondents expressed this theme in either their written documentation,

their interview, or both. They cited the number one reason for obtaining their flu shot at the retail pharmacy was proximity to where they lived or worked.

The second reason that participants identified as seeking a flu shot outside of their traditional government health care provider was that they *didn't have to wait*. This theme was expressed by half the respondents who suggested that not having to wait to get a flu shot was a key driver to choosing this private-sector option. This theme was also amplified by sub-thematic ideas of having a round-the-clock pharmacist on duty to administer the shot, having the shot available when they just felt the urge to get the shot, and being able to decide while shopping for other things.

Three of the ten participants suggested that they decided to take advantage of the outside flu shot option because they felt like their doctor told them to do so. This theme reflected the idea that since the *government mailed me something and told me to go to the retail provider*, then that was what affirmation that it was okay. This third theme, while not relevant for all participants, was a significant endorsement for three of the respondents who felt better about trying out this option.

The final three themes were not perceived by the participants and critical drivers, but nonetheless could be viewed as urgent in their decision-making since motivation to act requires both behavior, knowledge, and a catalyst. For a small number of respondents, the following themes expressed their experience of choice and were added to the thematic coding process. They are:

- I don't like going to my government provider to get my flu shot.
- Members of my VSO told me about this option.

- I saw a sign at the private retail provider.

These six main reasons for seeking the outside options were captured as major themes and placed in Dedoose™ to further analyze content from the in-depth interviews. These thematic expressions provided the basis for structural themes and boundaries to effectively manage potential bias in the subsequent interviews. They also aligned with the concepts in both the theory of planned behavior and the policy feedback theory, in which I framed this study.

While the study was not designed the evaluate the efficacy of the social marketing program that framed the Retail Immunization Coordination Program, it did provide some insight into what veteran patients value when their government health care provider communicates with them. For instance, of the six main themes as described above, participants stated that they obtained the flu shot at the retail provider because as ID-3 shared, "the [government health care provider] mailed something to me that told me to go to [the local retail pharmacy] for my flu shot." As indicated by this participant who said that since the [government provider] told him to go to the local pharmacy to get this flu shot, he went. Had the communication emphasized the same action at his government-sponsored clinic, he would have gone there instead. This experience amplified the need of the government-run health care entity to present information, whether it is health care options, innovations, or policies, in a clear and concise communication that does not get lost in bureau-speak.

The Epoche

The outlay of these "experiences of choice" sentiments helped me employ the primary step of phenomenological reduction, epoche (see Patton, 2015). By having a specific parent codebook derived from the screening tool, the researcher's experiences and potential biases were better managed because the subsequent interviews would stem from these key concepts for each individual participant. This approach purposefully bounded any personal experiences, beliefs, or opinions of the researcher and helped to better manage individual participant interviews that followed.

Horizontalization

To achieve maximum variation with equal value of the data, I bracketed the interview data, the second step in phenomenological reduction. Each statement was viewed equally and non-weighted. Every statement emerged as a fresh, independent idea. I then analyzed the data using Dedoose™ to more objectively aggregate similarities in concepts and derive code frequency and the meaning choice from the participants' perspectives. A *fresh-look* review of each transcript revealed emerging ideas under the pre-determined theory-based parent codes of Behavioral Outcomes; Control Factors; and Normative Referents. The data derived from the interviews were reviewed independently. Themes and sentiments were identified as distinct ideas coded under child codes as meanings emerged within the review of the interview data to better amplify the values of choice in health care and their lived experiences within the context of a social marketing outreach program as expressed by the participants. The following Table of Codes further describes this activity (Table 2).

Table 2

Table of Codes

Parent code (pre-determined based on theory)	Description	Child codes (that emerged)
Behavioral outcomes	The advantages and disadvantages of seeking a flu shot outside of your government health care provider.	Convenience of location Convenience of time Overall experience Situational convenience Seamless records No need for an appointment Smoothness of transaction
Control factors	Based on one's personal experience what makes it easy or enables "outside choice" care or alternatively prevents choice care options like a flu shot.	Authority influence Family influence VSO influence
Normative referents	Motivational factors related to seeking a flu shot at a private retail pharmacy/provider.	Administrative burdens Cost Easy access I am in control of my own health Lack of awareness/information Loyalty to my government health care provider No loyalty to my government health care provider Prefer choice because I have options Quality of care Seamless electronic health record Wait time

Discrepant Case Analysis

Discrepant, extreme, or deviant cases are those that do not reflect the sum of the whole of the participants. These outliers help add clarity to findings and serve to increase confidence in the study (Miles, Huberman, & Saldana, 2014). For example, while the majority of those interviewed (N = 7) held some trust and loyalty to their government health care provider even amidst the choice debate, only one participant, ID-4, expressed having "no loyalty to the [government-run health care entity]" whatsoever because he just did not "feel comfortable in [those] facilities." This participant iterated that he considered the concept of choice to be an opportunity to avoid government bureaucracy despite having a great deal of respect for his individual health care providers who worked there. In fact, he would rather pay out of pocket than seek certain services at the government-run health care facility, a sentiment that was not shared by the other participants. While ID-4 was the outlier in this view, both ID-3 and ID-2 were concerned about out of pockets costs. It was ID-6 who suggested that free care is good care and did not express any interest in paying out of pocket for earned health care benefits.

The Choice Screening Tool Data

The screening tool data served as a baseline for answering the first research question – Why is the no-cost flu shot option an appealing choice for veteran patients in this era of the patient-as-consumer? The data, identified via the six major themes, provided a framework to bracket any potential bias throughout the research process. Responses of this tool revealed that few patients considered any loyalty or trust as paramount to their decision to seek the outsourced, no-cost seasonal flu shot. In fact, as

ID-1 participant stated, “I don’t do a whole lot with [the retail provider] except the occasional flu shot; so not much trust required for that.”

Overall, participants measured convenience differently. Their responses indicated that being *closer to home* was fundamental to their decision making, suggesting that behavioral components were likely more critical than other factors. Another key parent-coded indicator included the ideas that circumstances made the choice easier. For instance, since they were already out and at the location, they might as well take advantage of the benefit of getting the no-cost seasonal flu shot. What is unclear is if they realized that the benefit was one provided by and subsidized by their government-run health care system or somehow part of another plan or private-sector give-away. They simply knew that it was their benefit to take advantage of and that they did not have to incur any additional out-of-pocket costs or provide any additional paperwork from their routine government health care provider. Nor did they have to make an appointment beforehand.

The Semistructured Interviews

Following analysis and charting of the parent-coded themes derived from the Choice Screening Tool, seven semistructured interviews of varying lengths were conducted. Each interview was audio-recorded and then transcribed. In addition, to the recorded audio files of the semistructured interviews, written notes on the print-outs served as additional analysis data to determine impressions that would later develop into the emergent child codes that appear in Table 2. Since IPA requires an ideographic approach, each participant’s experience was analyzed line-by-line and within the existing

construct of "why choose" this option at all based on the screening tool feedback. The interviews were designed to answer the following research questions:

RQ2: How do veteran patients of the government-run health care system decide to use the option to access the free-market no-cost flu shot option at a contracted private-sector retail pharmacy?

RQ3: How do participating veteran patients describe their decision making related to the principles of social marketing and their perceived feedback related to choice legislation?

Each interview transcript was read independently to gain a holistic understanding of the participants' lived experience and views about choice while utilizing a health care program option outside of the traditional government health care provider. The interviews were then transcribed and hand-coded. The transcriptions and screening tools were then uploaded into the Dedoose™ program while the researcher applied the pre-determined parent codes. The child codes emerged as each transcript was analyzed further within the Dedoose™ program. I organized the emergent themes under the pre-coded parent themes that were derived from the theory-based approach and amplified from the initial screening tool.

This process resulted in both a paper and electronic-based process, which could be member checked, or verified, by the site participant PI. Because the interview questions reflected the sentiments of the screening tool, the data were able to confirm both the understanding and the accuracy of the participants' reflections and experiences. Weekly updates to the PI helped keep the processing of the research project on track as well as member checking with a senior member of the facility.

During the analysis, negative cases were identified and reported, e.g. deceased patients or patients with wrong addresses. There were no out-of-the-ordinary occurrences or findings to report to the local partner site regarding patient health, safety, or security of the patient participants. In fact, all of the patients expressed an appreciation to the government-run health care provider for their care or loyalty for their earned health care benefits despite the increasing public choice narrative and their past participation in the season flu shot program that gave them the option to seek outside care at government expense. Examples included the following:

- ID-3 shared, "I feel a pretty good degree of loyalty to [the government-run health care system] because I see it as always getting a bad rap…[it] always seems to be the underdog…it tends to make me support it."
- ID-1 stated, "The [government-run health care system] is what I have. I like their care. I mean if their care was horrible, I wouldn't stay with them."
- ID-7 shared, "I fully trust the [government-run health care system]."
- ID-5 stated, "I am comfortable with the facility and my provider."
- ID-5 said, "I feel a certain margin of loyalty to the [government-run health care system]. It's a comfort factor – I always have [it]."

Evidence of Trustworthiness

This qualitative research project was reviewed and approved by the site partner; it followed all ethical and required research guidelines to ensure a project that maintained internal and external validity, including purposive sampling, inductive theme analysis,

bracketing, and reflective journaling (see Creswell, 2013). The credibility of the research process was ensured by strictly adhering to the agency partner's thorough and comprehensive IRB process and working under the guidance of a designated PI. The approval process following the completion of the following certifications of the investigator: Collaborative Institutional Training Initiative (CITI) and the Department's Privacy and Health Insurance Portability and Accountability Act (HIPAA) Focused Training. The study was approved after a review by the site's IRB, which determined that the study met the requirements for implementation, including safeguarding all patient data and de-identifying participants.

Per the IRB, the PI was kept informed throughout the study process; there were no modifications made to the design of the study protocol. There were no adverse events encountered. Since participants had to sign consent forms, the investigators were required to place the signed forms in the patient medical records (e.g., EHR), flag the chart, and enter a progress note stating that the patient entered in this study; this was achieved with site administrative support in August and September 2019. The information included the name of the study and the PI. In addition, a regulatory binder was developed and must be maintained for review upon request by the site's Research Compliance Officer.

In addition, research records were kept as confidential as possible, adhering to all privacy and confidentiality standards of the agency. The pseudonyms, or de-identified code names, were not based on any information that could be used to identify the participant. They were randomly assigned. The master list linking first names to code names was kept stored securely in the PI's locked cabinet and in the agency's password-

protected and firewall-secure electronic environment. Only I as the researcher and the PI had access to the data during the study. All other data was electronically stored in the patient record and the password-protected research shared drive designated for this study. All other data not required for the study, e.g. returned mail, excel database of names, was shredded using agency shredders. Following publication of this study, all hard copy records will be destroyed via the agency's shredders.

Full interview transcripts, which are de-identified, will be held in password-protected environment online and all printed copies will be kept in a locked and private setting onsite in the PI's office until publication. The only reports that will be disclosed will include common themes that emerge. Quotes or attributions were de-identified and used only the ID-# pseudonym. Participants signed official consent forms and validated their consent verbally to participate in the study and to provide permission to audio record the interviews. The PI will store all the materials five years then destroy and delete all records per agency records protocol (U.S. Department of Veterans Affairs., 2019).

To maintain credibility and trustworthiness for this study, the two-phases of data collection – the Choice Screening Tool and the semistructured interviews – worked together to confirm and validate findings; this horizontalization of data enhanced the study's reliability. The use of a reflective research journal and the PI's role as peer reviewer of the data helped to establish an audit trail and increased credibility. Finally, regular external checks on the research process, analysis, and interpretations were verified with the site's PI and a member of the senior executive staff (see Creswell, 2013). The similar questions in the screening tool and the in-depth interviews also helped

to confirm the accuracy of the investigators' understanding of the participant's lived experience related to the choice phenomenon in health care. The use of Dedoose™ helped achieve an objective analysis of the text data, adding to the credibility and rigor of the study.

Also adding to the rigor of the study was the balanced representation of the participants. As shown in Table 1, the sample pool of participants mirrored the veteran population nationally and locally. Since the participants originated from a diverse and varied representative pool of veteran patients who reside in urban, suburban, and rural areas in relation to a main government-run health care center, their experiences may be reflective of the larger beneficiary patient population. Therefore, the findings of the present study potentially are transferrable to other areas of the country or choice programs administered by this government-run health care system for veteran patients.

The results of this choice study may support recommendations to better communicate to the constituent public about health policy programs for more effective diffusion and engagement of the polity in alignment with the policy feedback theory and within a social marketing framework. The findings support most of the claims, namely access (e.g., convenience) and ease (e.g., close to home; no appointments needed) in the only other study concerning the Retail Immunization Coordination Program, which concluded that veterans who chose to use a private entity to get their flu shot versus the traditional government health care system did so because of access, ease, and cost (see Botts et al., 2017). These confirmations affirm the planned strategy as a dependable one as previously outlined in Chapter 3. The study, therefore, may provide a roadmap for

future researchers who seek to understand the concepts of choice in other health care policies or programs within a government-run system.

The planned strategy to obtain baseline information from a screening tool from willing participants who opted-in to participate also added to the credibility of this research project as a first layer of data that forms theory-driven parent codes. The semistructured interviews provided for rich, descriptive data generation, adding a layer of sub-codes for each parent code. According to Miles, Huberman, and Saldana (2014), the diverse sample of participants and their thick, rich descriptions of their experience using a choice program may help establish transferability to similar programs and projects. The details in the subsequent results section add clarity to the data and choice expressions of the participants. Finally, the screening tool and interview guide were part of the IRB approval package and therefore, were reviewed in detail with the designated PI to examine and assess the study instruments and the final data outcomes to strengthen the dependability of this research (see Creswell, 2013). The results section provides a discussion of the information that is rich in description but provides a thematic path to understanding what motivates veteran patients to choose external preventive health care in an era of neoliberal policies and marketized medicine and what they view as needed and wanted in health care policy presently and into the future.

The Results

In total, 10 individual sets of collective responses from veteran patient participants contributed to the primary objective of this study: to better understand the "voice of the veteran" as the government-run health care agency moves traditionally

internal services to private-sector, community providers in the name of *choice*. While only seven eligible participants participated in both the Choice Screening Tool and the semistructured telephone interviews, the data from the aggregate provided evidence to the growing narrative to either "build it" or "buy it" to better serve and care for veteran patients who have earned their health care benefits. Participants ranged in ages from 37 and 79 years, met the criteria as outlined in the recruitment letter and the IRB submission, and reflected a representation of the patient population served by the government-run health care system (Table 1).

With a focus on understanding behavioral insights and experiences of patients who chose a private-sector alternative to their seasonal flu shot, the present research project identified specific choice indicators that are summarized through the following themes, which are illustrated in the code frequency display of data below:

1. Convenience: *Location, location, location; Closer to my home*

2. Easy Access: *Situational convenience; No appointment necessary; No hassle*

3. I am in control of my own care: *I have options; Cost neutral; I like free*

In the frequency of coded data from both the screening tool and the discussions via the semistructured interviews substantiated the *choice* concept that convenience of location, and specifically having a place "close to my home" to get the seasonal flu shot, were significant indicators of the choice phenomenon when a patient is given health care options for preventive health care. In the analysis of the participant feedback, more than 20 mentions of *convenience of location* appeared in the meta-data, followed closely by 17 mentions of the location being *closer to my home.* Rounding the top three areas of how

patients described the choice phenomenon when given unfettered choice in a health care program was the idea that the patient "was told" to go to the private-sector retail provider to get this flu shot; this concept was identified as *authority influence* and present throughout the analysis both verbally and as part of the screening tool data. This coding emerged 15 times throughout the course of the study.

Research Question 1

The first research question was as follows: What do veteran patients believe is appealing about the no-cost flu shot option choice at a private sector retail pharmacy, specifically in this era of the patient-as-consumer? For this research question, the Choice Screening Tool provided baseline, parent coded data that confirmed the following: The option of having a preventive health care solution "closer to home" was a key driver and the most appealing choice to veteran patient participants who opted in to participate in this no-cost flu shot program. To most participants, like ID-5, Army veteran, 73-year-old male respondent, "Location is a top priority" when choosing health care options. Location was closely tied with the concept of convenience. Convenience was described by ID-6,79-year-old Peacetime era veteran, who lives in the outskirts or rural areas of one of the distant federal clinics as "not having to drive to [the city]."

Other participants described convenience in terms of time. For instance, ID-3, 69-year-old Vietnam era veteran, is retired just in the last two years, but he is "conscience of time." He explained that in making health care decisions he often weighs both time and convenience. For example, he stated that since he has an upcoming appointment this year (2019) at the government-run health care system during flu shot season, he'll be there

anyway so he plans to get his seasonal flu shot there despite receiving it two previous years at the local retain provider.

Finally, another sentiment that continued to emerge was the idea of "not having to wait so long" for the flu shot as indicated by ID-4, 40-year-old Iraq-Afghanistan veteran. This same indicator of choice in health care was shared with others outside of his demographic. For instance, ID-5, 73-year-old Army veteran who served in Vietnam shared that convenience means saving time and getting the flu shot on his time, "when I decide, I just walk in; I don't have to have an appointment." Similarly, other patient participants agreed that it was a matter of convenience; in all cases, convenience was defined in a variety of ways.

Convenience of location held greater influence in those patients ranging in age from 37 to 50 and from 72 to 79. The younger demographic also placed greater significance on convenience of time and situation. For instance, both the 37-year-old female veteran and the 47-year-old male veteran stated that having this option helped when they were "out and about" with their children. For the female veteran, ID-2, "having the pharmacist already on deck" and getting her children vaccinated as well was a big time-saver. This situation was similar for ID-7, 47-year-old Air Force male veteran, who was out doing a little shopping with his son and decided that they would both get their seasonal flu shots together; he iterated that this activity could not happened at the [government provided agency] due to the eligibility rules.

In sum, convenience for these patients was a significant choice factor in deciding to take advantage of the no-cost flu shot option at the outsourced private retail provider.

What arose in the interview discussions that followed the baseline findings from the screening tool was the fact that the decision was easy because in all cases the cost was neutral, and the risk was minimal with no real need for trust. One observation that emerged during the interviews for some of the patients was that the idea of choice comes into play when one has options and there are no additional administrative burdens, quality of care issues, or patient safety risks. As ID-3 participant put it, "Choice may be a problem when you think about quality. Quality of care is always a concern. Convenience sometimes overrides quality. Quality is critical."

In examining this idea further, while these veteran patients valued the choice to seek outside care, the majority agreed that with choice one must have options. Many participants acknowledged having alternative means of health insurance (e.g., private health care insurance provided by the spouse, TriCare from the Department of Defense, or Medicare/Medicaid) should they have a need or desire to seek health care outside of their earned benefits from the federal health care entity for veteran patient beneficiaries. Most of them valued their earned health care benefits and the majority of them trusted their government health care providers. In fact, out of the seven fully compliant participants of the study, only one patient, ID-4, iterated that he did not like going to his government-provider for his flu shot. In all, wait times were not viewed as a burden although the participants enjoyed the benefit of not having to make an appointment to get a routine flu shot. Easy access and the feeling of control also added to their choice value system when making the decision to seek the no-cost flu shot at the national private-

sector retail provider. Having clear, concise, and easy-to-understand instructions were instrumental in the decision-making as well.

Research Question 2

To examine this second research question, responses to the theory-based coding, *Control Factors*, were evaluated. About a third of the participants indicated that the primary motivator to access the free-market, private-care option was a direct result of "authority influence." Participants described receiving either a traditional mailer or email from their government health care provider directing them to go their neighborhood [local retail pharmacy provider] to get the no-cost seasonal flu shot. The influence of this directive aligns with a common thread from their experiences as a military member or current beneficiary of the government-run health care system, meaning that if directed, they do as they are directed to do. For instance, one participant, ID-3, a 69-year-old male who spent 6 to 10 years in the service in both the United States Army and Coast Guard said, "…if it [the mailer] had said to go to the [government clinic] and walk in [to get my flu shot] maybe I would've done that."

Other respondents who indicated that receiving information from the government-run health care entity iterated that while they did not initially remember receiving the mailer, during the interview they recalled that the mailer did serve as a prompt to getting the flu shot at the local retail provider. One participant recalled factors that helped him decide how to use the options available including the presentation of the information. For instance, ID-4, the 40-year-old, male, Iraq/Afghanistan veteran said, "factors for me in something I read are that it has to look easy, especially from [the government health care

entity]…like the flu shot – it looked easy enough, so I did it. If it did not appear easy, I would not have considered it an option." Appendix D is example of the voucher for patients during the 2018 – 2019 flu shot season.

Other participants suggested that they often seek the professional advice from either their trusted [government health care providers] or other credible associations to seek or validate their decision-making. In two instances, ID-7, a 47-year-old, male, Air Force veteran who served in Iraq/Afghanistan stated that he was told about the private-sector retail option by his government provider. Also, ID-5, a 73-year-old male who served in the Army in Vietnam also was told by his provider about the option; so, he decided to try it out. Both patients are years apart in age and from different geographic regions but held the trust of their government providers as central to their decision-making in making the choice to opt into this outside, no-cost flu shot option.

Only two veteran participants, both Iraq/Afghanistan era veterans and the two youngest to be interviewed, stated that they were influenced by their Veterans Service Organizations (VSO), namely the Veterans of Foreign Wars (VFW). The VFW provided them with resources about the program and talked about it during meetings. This reinforcement of a VSO or group influence reminded ID-2 and ID-4 about this choice option and provided them with an incentive to "try it" according to their feedback. One outlier to this motivator to choose was from ID-3, a 69-year-old Vietnam-era veteran who did not agree with the VFW even though he was a member of the organization. He was the only participant to suggest that he was "all for privatization" of the [government-run

health care system] for veterans, suggesting that it would okay with him that it transitions from a provider of care to an insurer of care.

Armed with what the participants viewed as information of authority, they felt in control of their decision-making to take advantage of the convenient choice option, especially when cost was not at issue and risk was relatively low. Their decision reinforced other choice values that they described as critical to their decision making, namely *convenience*, *location*, *time*, and *easy access*. Behavioral objectives that led to their decision-making relied heavily on the idea that the option was "closer to home."

Seven of the 10 screening tool respondents indicated that getting their flu shot at a place that was "closer to home" was a key driver to why they selected this program. Simply put, ID-1, Air Force veteran, 62-year-old male patient said, "that's it… it's closer." At the other end of the spectrum, ID-2, 37-year-old female veteran who served in the Marines during the Iraq/Afghanistan era agreed, saying "locale, meaning it's closer to home, half a mile away." Convenience of location was the main reason resonating with nearly each respondent. As ID-4, 40-year-old Army veteran said "there's a [retail pharmacy provider] on every corner. Location!" Even those patients who expressed satisfaction with their care from their government provider liked the idea of choice and stated that location was critical in their decision-making. The oldest participant, ID-6, at 79-years-old summed it up this way, "I'd rather take a whippin' in the rain than go across that [bridge] to the [city/main center]" to get my flu shot. Normative referents to this question reinforced participants' choice decisions by the easy access to the shot, the

feeling of being in control of when and where they get the flu shot, and not having to wait or set up an appointment to obtain the flu shot.

Research Question 3

Emerging data themes combined with the aggregate summary data gather from code frequency and narrative descriptions of the patients' experiences of this no-cost choice program were used to understand Research Question 3: How do participating veterans describe their decision making related to the principles of social marketing and their perceived feedback related to choice legislation? Despite the growing public narrative about expanding community care options for beneficiary veteran patients of the government-run health care systems, there was little to no association between this no-cost flu shot choice program and current or future choice legislation. Crawshaw (2013) argued that the use of social marketing in health and social policy adoption broadens awareness and increases adoption. While social marketing aims to improve public health outcomes as in the case of increasing flu shots among veteran patients, social marketing methods have been criticized for ignoring the structural and neoliberal nature of health care administration.

As noted by Crawshaw (2013) and confirmed by the respondents of this present study, choice relies first on knowing one's options and next on understanding if the option can be exercised given a number of factors, e.g., cost, administrative burden, quality of care, or seamless and coordinated care. As ID-3 participant stated, "It's important to have all my records available. I'm not sure if [the retail pharmacy provider] or a local hospital has my records. That's another reason I like going to [my government-

run health care provider].” Another respondent, ID-2, agreed, stating, “I like having my health care in the same place. I like my health record to be thorough.”

In response to this idea, respondents suggested that while convenience and easy access are key drivers to the idea of choice in preventive health care options, the concept of “feeling in control” is relative. Pure choice in health care has limitations. In the case of the no-cost flu shot program, most participants suggested that they like being able to choose this option, but they understood that it was because it was cost-neutral with no additional administrative burden or additional shuffling of paperwork. For instance, ID-7, 47-year-old male Air Force veteran, claimed that he “could pick and choose” because he had secondary insurance which helped.

Choice as a key driver or universal “good” in health care delivery is limited. More importantly, the respondents preferred that they were given more complete, accurate, timely, and concrete information to make well-informed and educated choices. One participant stated that experience also played a role. He had two past instances at the private retail pharmacy provider that did not live up to his choice expectations even though he saw the option as an easy and convenient one. In one scenario, he was in New York for a funeral and had some extra time. So, he went to the local private retail provider to get his seasonal flu shot. He showed his identification and the pharmacist knew nothing about the program, so he left. On another occasion, closer to home, he tried again to get the “senior dose,” or higher dose version of the flu shot, at the private retail pharmacy provider. However, the pharmacists said that he could not get this version so rather than leaving or going to his government-run health care provider, he “settled” for

the lesser dose version. In each of these cases, he said that he thought about the current VA MISSION Act of 2018 (H.R. 5674), new legislation that recently expanding some choice options for outside care for beneficiary patients. He referred the new benefit as using those "doc-in-boxes" located near his home. He wondered if he should take his government health care identification card and see if it would be honored before he may need it in an urgent situation. He said that he received a mailer about this new program from the government-run health care system, but it was unclear to him. It stated that the patient "may" be responsible for the co-pay. Upon telling this account,ID-3 stated, "I would rather it say what the co-pay is and know what to expect."

Therefore, it is unclear if the present study's participants viewed this no-cost program as a slippery slope into privatization or expanding neoliberal policies that may siphon federal dollars away from an integrated health care system that by all accounts has the same or better quality of care, maintains a high level of patient trust, and outperforms private-sector entities in wait times for a number of care specialties. What became evident was that social, economic, and environmental factors were key determinants of an individual's ability to choose a preventive health care option when unfettered choice exists.

Also, facilitating better choice requires the government-run health care system to provide clear, concise, and actionable communication to its constituency. Since the concept of choice has so profoundly permeated the public health policy discourse government-run health care systems should systematically review what choice indicators are important to their customers when designing health policies and programs. As was

indicated in the interviews, patients have expectations for health care delivery and values for choosing that include being in control of their health care, access to convenient care, and easy access when costs are neutral, and risks are nominal (Table 3):

Table 3

Subjective Choice Indicators

ID-7	I like the choice to pick a provider that a person has recommended, not for routine care, but for important things like surgery.	*I am in control of my own health.*
ID-4	I like the option of more choice – control.	*I am in control of my own health.*
ID-5	We should have the freedom to choose – don't accept what is given.	*I am in control of my own health.*
ID-6	Choice is great; it's free. I don't like to wait because of my time in the service. You had to wait for everything!	*Convenience and Easy Access*
ID-3	I'm all for privatization – anything if it makes it easier.	*Convenience and Easy Access*

Summary

In considering this no-cost flu shot option external to their government-run health care entity, only one patient entertained the idea of privatizing the public benefit. One other participant did express the concern of this type of program being a slippery slope into defunding the current status of the veteran beneficiary health care system. Responders expressed interest in being involved in current and future choice discussions about their health care and the majority suggested that they valued the benefit of having free health care as a result of their service. However, the findings did reveal a general

lack of engagement in policy development, diffusion, or mobilization as posited by the policy feedback theory.

Despite the public refrain that consumers and certainly veteran patients must have, and deserve, choice in health care, remains a complex and even context area of discussion. The findings of this study reveal that a significant driver of choice is convenience, yet convenience is relative given the individual patient and his or her demographic and situation. While most of the respondents define convenience as "closer to home," others describe convenience relative to time and circumstance. A small minority considered quality of care or seamless care as issues to play a role in their decision about this preventive health care measure. Most respondents value their earned health benefits and even trust their government-run health care provider. Only one respondent sought to stay away from this care while one other suggested privatization as the next best answer to choice in health care. Most respondents enjoy the peace of mind that comes with free health care and having seamless electronic health records and coordinated care that they can count on for all their health care needs. Overall, there appeared to be a general lack of awareness of what is offered to these beneficiary veterans in relation to their ideas of choice or "having control of their own health care."

In Chapter 5, the discussion will focus on additional insights and interpretations of these findings to provide more context to the choice phenomenon in health care, particularly health care aimed at beneficiary veterans of a government-run health care system. The discussion will help reveal ideas about offering more choice under the restriction of the government entity while using lessons learned from the social marketing

program known as the Retail Immunization Coordination Program. Finally, the chapter will amplify how best to utilize the "voice of the veteran" in current and future health policy discussions. The chapter will conclude with a discussion of the limitations of the study, recommendations for future studies, and implications of the study on positive social change.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of this qualitative study was to examine the motivations of beneficiary veteran patients who chose a preventive health care option, a seasonal flu shot, from a contracted private-sector retail pharmacy rather than the government-run health care system to which they were entitled health care services. My aim was to discern what conditions were inherent for these patients to select the option of a no-cost flu shot, which represented, at the time of this study, the only available unfettered choice program where all things were equal to these beneficiary veteran patient participants. The nature of the study was qualitative in order to develop customer-driven themes that corresponded to emerging public narratives about the phenomenon of choice in health care. Specifically, I focused on government-provided health care benefits that over the past decade have been challenged by what some researchers have called the submerged state amidst a background of marketized medicine.

The study was conducted to evaluate the effects of a private-sector partner program with a government-run health care system using the framework of the policy feedback theory and the constructs of the theory of planned behavior. Further, I sought to understand more broadly whether private-partnership programs improved access to care, enhanced earned health care benefits, and provided a cost-savings as concluded by the only other study that focused on this immunization retail access program for beneficiary veterans (Botts et al., 2017). The other focus was to evaluate if the submerged state of this government-outsourced program had any bearing on the participants' attitudes on current or emerging government-administered health choice program legislation or

implementation efforts (see Mettler, 2011). While the funding for this outsourced immunization program was provided by the government via direct payment to the contractor, the flu shot was given by the national retail pharmacy provider, a private-sector entity.

From July to August 2019, 10 participants provided baseline assessments on what factors mattered to them when given unfettered choice to a government benefit that was contracted out to a private entity, namely a no-cost flu shot at a national private-sector retail pharmacy in what was termed the Retail Immunization Coordination Project. Common themes from the screening tool revealed that having a choice option close to home was the number one reason for the patients opting into this outsourced, government-sponsored program. Not having to wait for an appointment just to get a flu shot was a motivator, and the convenience of having the service available where they were already shopping with family followed close behind. Many of the respondents said that because they were told to use this option by their government-run health care provider, they did so. These themes of convenience and easy access were amplified and further defined in the semistructured interviews that followed the evaluation of the screening tool data.

This second source of data came from the analysis of seven semistructured interviews that took place over the phone using a guided script. This activity helped to further define subjective perceptions about the patients' ideas of choice in health care to better explore how patients of the government-run health system decided to use the

private-sector option. It also elucidated how their decision-making was related to specific principles of the social marketing aspects of this program.

I followed a purposive sampling approach and had to adhere to the guidelines of the site-supported local IRB. This support offered an endorsement necessary to obtain a participant pool reflective of the veteran patient population, representative of those patients who had experienced the choice program, and observance of the privacy and confidentiality rules and regulations of the health care system. The results of the interviews provided data to further define the phenomenon of choice in a preventive health option, such as a flu shot. Namely, convenience was relative; it was linked with several factors, including situation, time, and location (e.g., close to home). Findings also revealed that easy access meant not needing to have an appointment for the relatively routine procedure as well as not having to deal with any administrative hassle (e.g., no need for a consult, prior approval from the parent, government-run health care entity, and no paperwork). Finally, the feeling of being in control rounded out the themes; this feeling was identified with concepts of having options that are cost-neutral, being able to pick and choose providers, and having no-hassle health care that is seamless and becomes integrated in the patient's electronic health care record that is a mainstay of the government-run health care system.

Interpretation of the Findings

The findings of the present study offer support for the growing consumer framework that has dominated the public discourse and more specifically health care policy development in the government-run health care system for veteran beneficiaries in

the last decade. Through analysis of the common threads of the choice themes uncovered in this study, the idea of the consumer frame was evident throughout the participants' responses. For instance, the ways that these participants talked about their choice to opt into this program demonstrated the increasingly prevalent mindset of the patient-as-consumer frame discussed by West (2014). As West concluded, the politics of health care consumerism has challenged the social trust and public responsibilities of the government. While the consumer, or in this case the recipient of a government-earned health benefit, values market-like conditions, health care as an industry may be unable to accommodate this expectation. Many of these participants expressed highly individualized approach to health care in general.

Arguably, as was confirmed by this study, choice in health care is highly individualistic. This program, like many government programs in the United States over the last decade, promoted the anthem of choice as part of an individual market moniker. As West (2014) posited, not only is choice in health care individualistic but it is also divisive and does not lead to better quality of care at lower costs universally as one might expect in a market-driven environment. The present study confirmed these ideas. ID-5 stated outright that "loyalty to self is what matters. Quality means respect and individualism." Others expressed the ideas that they like to make their own health care decisions and that they like to pick and choose where they go.

Not many of the respondents discussed cost or quality outright as part of their decision-making strategies when deciding to opt into this program. However, ID-3 stated that "choice may be a problem when you think about quality. Quality of care is always a

concern. Convenience sometimes overrides quality. Quality is critical." There were very few of the respondents who linked their views of choice to seek preventive health care using outside entities to diminishing quality of care or repositioning an inherently government responsibility to the private sector at the expense of weakening their health care benefits provided by the government-run health care system; there was also no apparent concern about rising costs due to this type of a program. Only one participant feared that such a program, and its success, may lead to a slippery slope of siphoning needed resources from the government health care entity. ID-7 stated,

> Choice is a good thing because some people don't trust the [federal government health care provider] whatsoever. I fully trust the [federal government health care provider]; but choice is the best of both worlds, especially due to distance. Choice is good when necessary like if I need someone in a week. I get the best of both worlds. If I can't schedule to go to the main center, then having choice is good.

Most of the participants viewed choice within the scope of having options; without options, the majority agreed that there was no choice available. Most of the participants had other health care resource options, including their spouses' private insurance, TriCare, Medicare, or Medicaid. In fact, most participants did not see that this type of government outsourcing of a public service program as a slippery slope to privatizing an inherently public responsibility to beneficiary patients. They simply viewed it as another available option promoted by their health care providers. What is evident is the idea that these patients already have access to what is sometimes referred to

by proponents as universal health care coverage. This concept of universal health care coverage is a sustainable development goal, comprised by the Inter-Agency and Expert Group in 2016 (United Nations, 2016). It was evident from the respondents that they value their universal health coverage, including "financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines" as are the outlined goals in the United Nation's report (see United Nations, 2016, p. 5). What was less evident was their understanding of the diminishing value of these key elements should their universal access be sold off to privatized partners.

While critics and proponents have agreed that private-public partnerships, like the Retail Immunization Coordination Program, are opportunities to improve some aspects of performance of the health care system, there is little to no evidence that suggests privatizing the government-run health care entity would improve care on the whole for its patient base or even expand such care as argued by neo-liberal politicians and other think tanks (Longman & Gordon, 2017; West, 2014). Since the early 1990s and throughout the time period covered by this study, renowned scientific studies have shown that the care provided by the government-run health care system is as good or better than any private sector for most forms of care, including primary care, mental health care, oncology, and women's health care. On the average, the health care system shows wait times that are as good as or better than the private sector, improving substantially in a variety of care settings since 2014 (Penn et al., 2019). Finally, these same studies have revealed that the government health care system's patients have a high level of trust and that they enjoy a

system that treats the whole patient, regardless of medical complexity or ability to pay (Farmer et al., 2018; Longman & Gordon, 2017; Penn et al., 2019; Weeks & West, 2018). While I did not identify appreciable concern about the future erosion or weakening of the government health care system due to this type of programming, many participants remained loyal to their earned health care benefits, its system and providers, and the overall care delivered by the system at large.

Most of the participants valued their care delivered within the government-run health care system of care, citing their general trust in the providers and overall dependence on the system itself. ID-1 said, "[It's] what I have. I like their care. I mean if the care was horrible, I wouldn't stay with them." Other patients affirmed the idea of being satisfied even amidst the backdrop of choice and the growing public debate of public versus private care and access issues. ID-3 shared, "I'm happy with all contacts with the [government health care entity];" and ID-2 added, "I'm well satisfied with the [government health care system] …I like having my health care in the same place. I like my health record to be thorough."

As a result of this study, it appears that these value sentiments expressed are areas that the government-run health care system should emphasize when promoting programs – a balanced and concise view of the features of a program. The results revealed that all parties discussing these types of choice issues should use facts and disclose all the information to patients upfront when sharing data about these programs. Just as the concepts of convenience, easy access, and a feeling of being in control dominated the analysis of why this choice option was selected, one claim that was absent from the

analysis is wait times. Wait times is often mentioned when suggesting that government services expand to private-sector entities.

Most of these patients did not have an issue with wait times; wait time data was used by neoliberal policy-makers as a negative driver to move patients from the government entity to the private sector, particularly during the time of this program. Proponents of outsourcing programs asserted that the government could not meet the demands of the patient population thereby providing subpar care (Anhang et al., 2018; Gordon, 2017; Weeks & West, 2018; West, 2014). As ID-2 stated plainly, "Wait times are not that important to me." Another participant, ID-1, echoed this sentiment saying, "Wait time doesn't bother me." While some participants expected to wait, most did not see this as a motivator to seek other, outside care. What surfaced most throughout these interviews and was reaffirmed by the baseline data intake was the relative meaning of convenience when weighing choice in health care services.

Convenience, while touted as a value metric for newly implemented choice legislation, the VA MISSION Act of 2018 (H.R. 5674), is relative according to the summary findings of the present study. Recent claims of the government giving its beneficiary patients the power to choose because it offers convenience and gives them what most other Americans have – the ability to choose their health care providers – only sharpens the us versus them argument that arises when today's administrators attempt to marketize medicine (Heath, 2019; West, 2014; Wilkie, 2019). However, what emerged from this study was that the concept of convenience is relative, making choice in health care only as good as the options one has. This findings of this study confirmed the

deliberate attempts by today's policy-makers to transition the narrative from patients to customers or consumers; most patients did act as consumer of medicine when presented with this choice option (Health Care Transformation Task Force, 2018; Longman & Gordon, 2017; West, 2014). Each patient interviewed did express the sentiment that he or she had real choice in the matter of the no-cost flu shot. Upon deeper discussion, however, the participants' suggested that choice in this case was due to its relatively low risk and its no-cost, no-hassle administration. Many respondents acknowledged that if cost was an issue, they would opt for the government-provided service to control costs and coordinated care with seamless health care records. Also, the idea that this service was "routine" and did not require much trust played a role in their decision-making. The following statements emphasize these points:

- ID-2 stated, "I like free."
- ID-3 shared, "Cost is a concern but it's relative to convenience."
- ID-1 said, "Yes, I'm on disability so I don't have a lot of money. It doesn't cost me anything."
- ID-4 iterated, "If the treatment is covered by [the government health care entity] then I may choose it."
- ID-6 said, "Choice is great; it's free."
- ID-1 also expressed, "I don't do a whole lot with [the private retail provider] except the occasional flu shot. So not must trust is required for that."

What became evident throughout these interviews was the idea that choice depends upon having options. For most of the patients who participated in both the

screening tool and the interview process, choice was a factor in these health care decisions because they had other options from which to choose, e.g. spouse's health insurance, TriCare, Medicare, or Medicaid, and they were given the easy-to-follow directions by their trusted government health care provider. However, many of the participants acknowledged that these other options come at a cost. Costs included direct costs such as co-payments as with TriCare. Costs also included intangibles such as not having a complete electronic health record, which was a high value point for many of these patients. Also, not receiving any travel benefits could be an emerging issue as expressed by one respondent. Finally, choice comes with unintended consequences, which most participants were aware of but not seemingly motivated by to take an active role in health policy work or engagement.

These realities presented by the analysis of the participant data in this study affirm the consumer metaphor posed by West (2014) who cited that the health care consumer is individualized, not understanding the impact of universal access, individual responsibility, or the responsibility to share the risk. In this generalizing, these participant patients were not different in their feelings. All participants expressed that they should have the freedom to choose and they were limited in their knowledge of the impacts of outsourcing care to the community might have on their earned health benefits and government providers' resources. What was not as evident was the tie between the interpretative effects of this program to current or emerging health care policy choice programs being implemented throughout the government-run health care system.

Policy Feedback Theory

To understand the context of choice policy and the motivations of the patients who used a no-cost, outsourced option, the framework of the policy feedback theory was used. These patient participants demonstrated that they had the knowledge of the no-cost flu shot as a convenient, government-approved option. However, what was less apparent was the participants' understanding that they earned the benefits that provided this convenient option, meaning it was a government benefit, administered by a private-sector entity. As demonstrated by the policy feedback theory, there are interpretative effects of a public policy or program such as the Retail Immunization Coordination Program (see Mettler & Sorelle, 2018). However, analysis of the data in this study was not clear in this area; more research is needed to better understand how much influence using a choice program has on acceptance or rejection of other health policy choice programs for this constituency of beneficiary veteran patients.

In this era of outsourcing government services to private-sector entities, the individual participants did not seem to find quality measures and higher costs as potential outcomes of this program. Each patient assumed that their data was safe and seamlessly adopted into their medical records, which was a key value point for most of them. The fear of rising costs, siphoning off resources of the government provider at-large, and fragmented health care did not come up as possible effects of this type of program as is the case in other privatized programs (Abramovitz & Zelnick, 2015; Gordon, 2017; Khamis, 2017). Therefore, what was less clear in this investigation is the assessment of the path-dependent process of how actions of a cohort lead to the adoption or rejection of

health care choice policies. The results of this study could not discern whether understanding the interpretive effects of a health care choice program/policy would lead to all-out rejection or acceptance of emerging choice policies. Less evident was the participants' willingness to engage in the choice policy debate unless they were part of an authoritative entity, such as the VFW that provided credible information and education about the policy under consideration or at risk.

Answering the Central Research Question: How can government sponsored social marketing campaigns support evidence-based policy making by identifying what factors influence veteran feedback and the adequacy of the choice claim in patient decision making for seeking preventive health services?

What was confirmed by this study is that the use of motivational messaging via a social marketing approach did play a role in patients seeking this no-cost, outside flu shot. While few studies examine the effectiveness of a social marketing program targeting veteran patients, my study presented positive findings that may provide a roadmap for other government-sponsored health care policy dissemination efforts. For instance, nearly half of the respondents were motivated to try the no-cost flu shot because they received communication in one form or another from their health care entity or a credible figure in their social circle – direct mailer from the health care entity, email from the health care entity, message from their VSO leadership, or message from their provider. This direct link provides evidence that direct, concise, and easy-to-understand and execute messaging should be used to communicate health policies and programs to patients. As ID-3 noted, "I received a postcard in the mail, and it said to go the [retail

pharmacy provider]. If it had said to go to the [government] clinic and walk in, maybe I would've done that."

Government agencies form a foundation to serve its citizenry. This study confirmed the need to communicate directly to these patients using a variety of media and tactics. While there was little negative feedback received about the government-administered health care entity itself, the participants did express the need to get information that is direct and to the point. In reaction to another mailer concerning an emerging choice program, ID-3 put it this way, "I got the mailer that says we 'may' be responsible for a co-pay. I would rather it say that the co-pay is 'X' and know what to expect." Another patient, ID-4, at the opposite end of the age spectrum, had this to say about the matter, "I read the information and the mailings from the [government-run health care entity] – but I choose what's best for me. Factors for me in something I read are that it has to look easy…like the flu shot – it looked easy enough, so I did it. If it did not appear easy, I would not have considered it."

These findings confirm that in order to enact and diffuse health policy to the veteran patient population, behavioral insights of the targeted patient population must be considered along with engaging communication strategies that integrate patient motivations (see SBST Website, 2017; Goss, 2010; Suarez-Almazor, 2011; Mettler & Sorelle, 2018). This study signifies systematic findings suggestive of the positive use of the social marketing framework to achieve policy implementation efforts. It closes a gap in understanding whether social marketing principles lead to acceptance of policy implementation efforts (see Elder et al., 2016; Langford et al., 2013; SBST Website,

2017). The results help confirm the effective use of social marketing techniques beyond promoting healthy behaviors; they highlight that social marketing-based approaches can be adopted and integrated into policy implementation efforts in a large health care system (see Luck, et al., 2009). This analysis of this study's data point to a need for the government health care provider to use communications that optimize patient participation, improves shared decision-making, and integrates its efforts to both educate and inform its beneficiary constituency using the principles of social marketing that have been lacking in the health care sector.

Limitations of the Study

This study was subject to several limitations. First, due to the qualitative approach using a phenomenological design, this study does not allow for generalization of the findings; it used a purposive sample of ten participants of which only seven consented to the semistructured interviews. With this knowledge, it is unclear if the general consent of the population echoed these same sentiments of convenience when offered choice in health care policy. Also, participants were recruited from a select geographical area in the southern part of the United States. Therefore, findings may not reflect the overall sentiment of the entire beneficiary veteran patient population.

Second, it is unclear if contemporary or emerging health choice policies or personal experiences using these other programs conflated or had any influence on their views of the choice phenomenon in health care. For instance, during the time of this study (June – August 2019), the government-run health care entity began implementation efforts to expand eligibility for veteran patients of the government-run health care system

to seek outside, private-sector care at government expense, often using the word *choice* as the key reason for the health policy decision (see Wilkie, 2019). During this same timeframe legislators spoke openly in session, on camera, and via their social media accounts about the agency's efforts to expand eligibility, arguing that this policy change offered patients more choices and was more convenient. Critics of the legislation, on the other hand, claimed that it was just another neoliberal policy designed to siphon off federal dollars to private entities that serve shareholders rather than the public interest, eventually selling off the government's responsibility to care for veterans for profit despite the high quality of care and innovations that have come from the government-run health care system. Therefore, this increasing health care choice narrative in the news cycle and in normative circles among the target participant group for this study could have had some influence on the volunteer participants and their responses during the intake screening tool and subsequent telephone interviews.

Finally, analysis efforts to collate data sets from the federal partner site were complicated by a reliance on site administrators with access to the private data and the use of the traditional mail-in method of seeking and obtaining volunteers. While 119 letters of request were issued to potential volunteers, only 14 were returned; four of these were discarded due to administrative errors (wrong address or deceased patient). Of the remaining ten, only seven participants volunteered to share their views on choice in health care. Also, lack of complete data from the volunteers (e.g. phone numbers) added some delay to the study. As a result, the participants may have presented inherent biases

due to their experiences with the agency, geographic residency in relation to the agency, or use of other choice programs not evaluated in this study.

Recommendations

Future research using the three broad choice themes derived from this study should more exhaustively identify the antecedents of opting into non-government health care services using a larger, more generalizable approach. A quantitative follow-on to this choice phenomenon study could help articulate how the health care entity should message to its patients, include its patients in health policy discussions, and identify opportunities to align customer research with policy development and implementation. Another recommendation is to crossmatch the findings of this study with that of other audiences. For example, examining upstream factors (e.g., improved infrastructure, changes in policy within the walls of the health care system, research findings, and the media) combined with midstream influencers (VSO leaders, facility directs and other leadership, or direct health care providers) may show intersections and disconnections in the choice phenomenon and patient-as-consumer landscape. Finally, a mixed methods approach may be helpful to identify both beneficiary veteran patients and staff perceptions about the ideal practices for designing, adopting, and implementing choice policies within the health care system. The methods suggested are focus groups involving both patients and key informants, one-on-one interviews with health care system staff members from a variety of disciplines, and a Q-methodology survey that would provide an opportunity for the participants to rate and rank the relevance of each value point and policy implementation strategy (see Pullen & Flynn, 2014). Each of these research opportunities

would advance the research practices on understanding how or whether choice claims in health care motivate veterans to seek outside care; they would also help design a roadmap to presenting choice narratives that balance the narrative among choice options and within segments of the population.

Implications

The findings from this study suggest that the use of the social marketing framework in diffusing policy changes or introducing new policies in a government-run health care system would impact the acceptance of health care policy and position the beneficiary veteran patient as a more informed, educated, and "in control" recipient of health care services. At the heart of social marketing is the customer; this concept aligns with the neo-liberal view that patients are consumers in today's era of marketized medicine. As such, understanding the customer/patient motivations, characteristics, and intentions to act must become part of the planning and execution strategy of any choice program. There is a need to align the government-run health care system's messaging with that of the new health care narrative that suggests a person's need to be at the core of the health care policy, be heard as a consumer of the health policy, and regain power within the limitations of his or her eligibility (Reynolds, 2012).

In the absence of evidence-based social marketing concepts grounded in theory, such as the policy feedback theory, administrators make decisions in a vacuum or at the behest of upstream influencers, such as Congress and lobbyists. Promoting choice policy within the constructs of a neo-liberal focus requires combining customer-focused needs and social marketing strategies (Novelli, 2008). This alignment was especially

highlighted as the qualitative data summarized the importance of three key values when the patient was presented with choice options – convenience, easy access, and the idea of being in control.

What was confirmed is that beneficiary veteran patients trust their current government-provided health care overall but enjoy the freedom to choose when all things are equal, meaning no-cost, seamless electronic health records, and equally informed administrators of the preventive health care service. This finding supports the need for government offices to conduct and use research to understand the needs of their priority publics, despite the politics at play. There is a desire and need for social marketing -based information campaigns to make the beneficiary veteran patients understand their benefits, healthier due to generally high-quality indicators of the health care system, and safer when given health care choice options (Luck et al., 2009; Suarez-Almazor, 2011; Taylor & Kent, 2015). The government-run health care agency, therefore, must recognize that choice if an important value point for its patients, but present clearly the other values that were highlighted in this study – trust in the providers, having seamless health care records available, no-cost coverage within the administration of the health care entities run by the government, and unintended consequences of choice policy options.

Conclusion

Consideration of how the beneficiary veteran patient understands the concept of choice in health care policy or the unintended circumstances of choice-base policies comes at no better time given the rise of neo-liberal policies advancing the public narrative that health care provided by the government is somehow less than. Although

there remains a universal debate about health care being a right or a commodity, the patient-as-consumer model may not work for the government-run health care system. From this study, participants seem to value their earned health care benefits and enjoy the no-cost nature of health care. However, when lawmakers and the media advance the narrative that "public is bad" and "private is good," this frame pits the provider against the consumer (see Freeman, 2012; West; 2014). Private-public partnerships make sense for the government-run health care system to undertake. However, health care policy moving toward more outsourced options must avoid the pitfalls of fragmentation and overtreatment often found in private-sector health care (Longman & Gordon, 2017). The choice value themes revealed in this study should be integrated with clear and concise messaging that reveals all aspects of a health care policy, emerging or changing. Administrators of the health care system must integrate the needs of its patients while balancing the mandates of legislation. Afterall, veterans are considered both civic and economic assets to the United States (Rieley, 2019). Ultimately, use of the policy feedback theory within a social marketing framework may allow a more robust alignment of research and policy while allowing its citizenry to engage in an open and transparent way.

References

Abramovitz, M., & Zelnick, J. (2015). Privatization in the human services: Implications for direct practice. Clinical Social Work, (43)3, 283 – 293. doi: 10.1007/s10615-015-0546-1

Advisory Board. (2016, April 12). Berwick: The 9 changes needed to make health care more 'moral'. Retrieved from https://www.advisory.com/daily-briefing/2016/04/12/berwick

Affordable Care Act (Pub. L. No. 113 – 146, 2014).

Aggarwal, A., Bernays, S., Payne, H., van der Meulen, J., & Davis, C. (2018). Hospital choice in cancer care: A qualitative study. Clinical Oncology, *(30).* 10.1016/j.clon.2018.03.009

Ainley, P. (2015). Reversal Reversed? The New Consensus on Education and Training. *London Review of Education, 13(2),* 179 – 185. Retrieved from https://eric.ed.gov/?id=EJ1160145

Ajzen, I. (2013). *Theory of Planned Behaviour Questionnaire Measurement Instrument Database for the Social Science*. Retrieved from http://www.midss.org

Ajzen, I., & Fishbein, M. (1969). The prediction of behavioral intentions in a choice situation. *Journal of Experimental Social Psychology, 5*(4), 400-416. doi:10.1016/0022-1031(69)90033-X

Anhang Price, R., Sloss, E. M. Matthew, C., Farmer, C. M., & Hussey, P. S. (2018). Comparing quality of care in Veterans Affairs and non-Veterans Affairs settings. *Journal of General Internal Medicine, 33*(10), 1631 - 1638. doi:10.1007/s11606-

018-4433-7

Aranguren, M. J., Magro, E., & Wilson, J. R. (2017). Regional competitiveness policy evaluation as a transformative process: From theory to practice. *Environment and Planning C: Politics and Space*, *35*(4), 703–720. https://doi.org/10.1177/0263774X16662469

Arnsdorf, I., & Greenberg, J. (2018, December 18). Veterans back out of VA program after delays in payments, services. *Charlotte Observer.* Retrieved from https://www.newsobserver.com/news/politics-government/article223257805.html

Aubry, S., & Dorsi, D. (2016). Towards a human rights framework to advance the debate on the role of private actors in education. *Oxford Review of Education, 42*. 1-17. doi: 10.1080/03054985.2016.1224301.

Baxter, P., & Jack, P. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report*, *13*(4), 544 – 559. Retrieved from https://nsuworks.nova.edu/

Beckwith, H., Kingsbury, M., & Horsburgh, J. (2018). Why do people choose nephrology? Identifying positive motivators to aid recruitment and retention. *Clinical Kidney Journal*,*11*(5), 599–604. doi:10.1093/ckj/sfy076

Beks, T. A. (2016). Walking on eggshells: The lived experience of partners of veterans with PTSD. *The Qualitative Report*, *21*(4), 645-660. Retrieved from https://nsuworks.nova.edu/tqr/vol21/iss4/4

Berenson, A. (2005, July 12). Cancer drugs offer hope, but at a huge expense. *New York Times*. Retrieved from http://www.nytimes.com

Black, R. (2017, May 17). The chasm between public perception and clinical reality at the VA. *Healthcare Analytics News*. Retrieved from https://www.idigitalhealth.com/news/the-chasm-between-public-perception-and-clinical-reality-at-the-va

Boniface, G., Ghosh, S., & Robinson, L. (2016). District nurses' experiences of musculoskeletal wellbeing: a qualitative study. *British Journal of Community Nursing*, *21*(7), 350-355. doi:10.12968/bjcn.2016.21.7.350

Botts, N., Pan, E., Olinger, L., Donahue, M., & Hsing, N. (2017). Improved veteran access to care through the Veteran Health Information Exchange (VHIE) Retail Immunization Coordination Project. *AMIA ... Annual Symposium proceedings. AMIA Symposium*, *2016*, 326–331. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5333250/

Burkhardt, B.C., (2014). Private prisons in public discourse: Measuring moral legitimacy. *Sociological Focus, (47)*, 279 – 298. doi: 10.1080/00380237.2014.940264

Burkholder, G. J., Cox, K. A. & Crawford, L. M. (Eds.). (2016). *The scholar-practitioner's guide to research design*. Baltimore, MD: Laureate Publishing.

Centers for Disease Control and Prevention. (2016). Immunizations and infectious diseases. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/immunization-and-infectious-diseases

Chan, S., Burgess, J. F., Clark, J. A., & Mayo-Smith, M. F. (2014). Experience of the Veterans Health Administration in Massachusetts after state health care reform, *Military Medicine*, (179)11. 1288–1292. doi: 10.7205/MILMED-D-14-00093

Commission on Care, Interim Report. (2015). *Interim Report of the Commission on Care*. Retrieved from https://commissiononcare.sites.usa.gov

Craig, J. (2018, June 27). Privatized VA healthcare will look like the private prison industry. *Task & Purpose*. Retrieved from https://taskandpurpose.com/va-privatization-health-care-prison

Crawshaw, P. (2013). Public health policy and the behavioural turn: The case of social marketing. *Critical Social Policy, 33*(4), 616 –637. doi: 10.1177/0261018313483489

Creswell, J. W. (2009). *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Creswell, J. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Crié, D., & Chebat, Jean-Charles. (2013). Health marketing: Toward an integrative perspective. *Journal of Business Research*, *66*, 123- 126. doi:10.1016/j.jbusres.2012.09.002

Croker, H., Lucas, R., & Wardle, J. (2012). Cluster-randomized trial to evaluate the 'Change for Life' mass media/social marketing campaign in the UK. *BMC Public Health*, *12*(404), 1471- 2448. doi:10.1186/1471-2458-12-404

Dawidowicz, P. (2016). Phenomenology. In G. J. Burkholder, K. A. Cox, & L. M. Crawford (Eds.), *The scholar-practitioner's guide to research design* (pp. 203-214). Baltimore, MD: Laureate Publishing.

Day, M. (2018, June 11). The assault on veterans' health care. *Jacobin*. Retrieved from https://www.jacobinmag.com/2018/06/veterans-administration-health-care-privatization

Diaz-Maurin, F., & Kovacic, Z. (2015). The unresolved controversy over nuclear power: A new approach from complexity theory. *Global Environmental Change, 31,* 207 – 216. doi.10.1016/j.gloenvcha.2015.01.014

Donahue, M. (2018, March). *Veterans Health Information Exchange (VHIE): Past, present, and future*. Paper presented at the meeting of Healthcare Information and Management Systems Society, Las Vegas, Nevada.

Dorfman, A., & Harel, A. (2015). Against privatisation as such. *Oxford Journal of Legal Studies, 36*. gqv029. doi: 10.1093/ojls/gqv029

El Refaie, E. (2015). Scoring a goal or an own-goal against disease? A multilevel framework for describing metaphor coherence in health campaigns. *Metaphor and the Social World, 5*(1), 102- 123. doi:10.1075/msw.5.1.06.ref

Elder, H., Karras, E., & Bossarte, R. M. (2016). Promoting help seeking among veteran households: Associations between exposure to multiple types of health messages and intentions to utilize related public health hotlines. *Military Medicine, 181*(7), 649- 654. doi:10.7205/MILMED-D-15-00244

Farmer, C. M., Hosek, S. D., & Adamson, D. M. (2018). *Balancing demand and supply for veterans' health care: A summary of three RAND assessments conducted under the Veterans Choice Act,* Santa Monica, Calif.: RAND Corporation, RR-

1165/4-RC, 2016. Retrieved from https://www.rand.org/pubs/research_reports/RR1165z4.html

Fernández, J. J., & Jaime-Castillo, A. M. (2013). Positive or negative feedbacks? Explaining popular attitudes towards pragmatic pension policy reforms. *European Sociological Review*, *29*(4) 803- 815. doi: 10.1093/esr/jcs059

Fichero, A. (2018). Trump and the Veterans Choice Program. *FactCheck.org*. Retrieved from https://www.factcheck.org/2018/03/trump-veterans-choice-program/

Finley, E., Noël, P., Mader, M., Haro, E., Bernardy, N., Rosen, C., . . . Pugh, M. J. (2017). Community clinicians and the Veterans Choice Program for PTSD care: Understanding provider interest during early implementation. *Medical Care, (55)* Suppl 7 Suppl 1, S61 – S70. doi: 10.1097/MLR.0000000000000668

Fitzgerald, S. (2014, April 6). Democrats joining Republicans in protest over Medicare Advantage cuts. *Newsmax.* Retrieved from http://www.newsmax.com/PrintTemplate.aspx/?nodeid=563935

Gingrich, J., & Watson, S. (2016). Privatizing participation? The impact of private welfare provision on democratic accountability. *Politics & Society*, *44*(4) 573–613. doi:10.1177/0032329216674005

Giordano, T. P., Rodriguez, S., Zhang, H., Kallen, M. A., Jibaja-Weiss, M., Buscher, A. L., …Ross, M. (2013). Effect of a clinic-wide social marketing campaign to improve adherence to antiretroviral therapy for HIV infection. *AIDS Behavior*, *17*(1), 104- 112. doi:10.1007/s10461-012-0295-x

Gordon, S. (2017). *The battle for veterans' healthcare: Dispatches from the frontlines of policy making and patient care*. Ithaca, NY: Cornell Publishing.

Gordon, S., & Craven, J. (2018, June). Unhealthy skepticism. *Washington Monthly*. Retrieved from https://washingtonmonthly.com/people/suzanne-gordon-and-jasper-craven/

Goss, K. (2010). Civil society and civic engagement: Towards a multi-level theory of policy feedbacks. *Journal of Civil Society*, *6*(2), 119- 143. doi:10.1080/17448689.2010.506370

Green, J., Cross, R., Woodall, J., & Tones, E. (2019). Health promotion: Planning and strategies. (4th ed.). Thousand Oaks, CA: Sage Publications.

Hafer, J. A. (2018). Understanding the Emergence and Persistence of Mandated Collaboration: A Policy Feedback Perspective of the United States's Model to Address Homelessness. *The American Review of Public Administration*, *48*(7), 777–788. doi.10.1177/0275074017729877

Harris, R. A. & Tichenor, D. J. (Ed.) (2010). *A history of the U.S. political system: Ideas, interested, and institutions*. Santa Barbara, CA. (page 374). Retrieved from https://books.google.com

Health Care Transformation Task Force, Nonprofit Consortium Report. (2018). *Consumer engagement structures and mechanisms: Current patient involvement in organizational governance among providers pursuing value*. Retrieved from https://hcttf.org/

Heath, S. (2019, June 17). VA estimates cost hikes for community care access programs. *Patient Engagement HIT*. Retrieved from https://patientengagementhit.com/news/va-estimates-cost-hikes-for-community-care-access-programs

Hennink-Kaminski, H. J., Willoughby, J. F., & McMahan, D. (2014). Join the Conquest: Developing a Campaign to Increase Participation in Clinical Research in North Carolina. *Science Communication, 36*(1), 30–55. doi.org/10.1177/1075547013492434

Hollingsworth, J. W., & Bondy, P. K. (1990). The Role of Veterans Affairs Hospitals in the Health Care System. *New England Journal of Medicine, 322*, 1851-1857

Humensky, J., Carretta, H., Groot, K., Brown, M., Tarlov, E., & Hynes, D. (2012). Service utilization of veterans dually eligible for VA and Medicare fee-for-service: 1999–2004. *Medicare & Medicaid Research Review, (2)*3. doi: 10.1056/NEJM199006283222605

Isserman, N., & Markusen, A. (2013). Shaping the Future through Narrative: The Third Sector, Arts and Culture. *International Regional Science Review*, *36*(1), 115–136. doi: 10.1177/0160017612447195

J. Freeman. (2012, November 2). Health is not a commodity: Let us get the language right. *Physicians for a National Health Program*. [Medicine and Social Justice blog post]. Retrieved from http://www.pnhp.org/print/news/2012/november/health-is-not-a-commodity-let-us-get-the-language-right

Janesick, V. J. (2016). *Stretching exercises for qualitative researchers*. (4th ed.). Thousand Oaks, CA: Sage Publications.

Karch, A. & Cravens, M. (2014). Rapid diffusion and policy reform: The adoption and modification of Three Strikes Laws. *State Politics & Policy Quarterly, 14*(4) 461–491. doi: 10.1177/1532440014561867

Khamis, A. (2017). Critical analysis and review of the literature on healthcare privatization and its association with access to medical care in Saudi Arabia. *Journal of Infection and Public Health*. doi: 10.10.1016/j.jiph.2017.02.014

Kilbourne, A., Elwy, A. R., Sales, A. E., & Atkins, D. (2017). Accelerating research impact in a learning health care system: VA's Quality Enhancement Research Initiative in the Choice Act era. *Medical Care, (*55) S4–S12. doi: 10.1097/MLR.0000000000000683

Ko, K. J., Wade, R. L., Yu, H. T., Miller, R. M., Sherman, B., & Goad, J. (2014). Implementation of a pharmacy-based adult vaccine benefit: Recommendations for a commercial health plan benefit. *Journal of Managed Care Pharmacy*, *20*(3), 273-82. Retrieved from https://digitalcommons.chapman.edu/cgi/viewcontent.cgi?referer=https://search.yahoo.com/&httpsredir=1&article=1001&context=pharmacy_articles

Korlén, S., Essén, A., Lindgren, P., Amer-Wåhlin, I., & Von Thiele Schwarz, U. (2018). Managerial strategies to make incentives meaningful and motivating. *Journal of Health Organization and Management, (31)*2, 126-141, doi: 10.1108/JHOM-06-2016-0122

Kupfer, J., Witmer, R. S., & Do, V. (2018). Caring for those who serve: Potential implications of the Veterans Affairs Maintaining Internal Systems and Strengthening Integrated Outside Network Act of 2018. *Annals of Internal Medicine*. doi: 10.7326/M18-1539

Langford, L., Litts, D., & Pearson, J. L. (2013). Using science to improve communications about suicide among military and veteran populations: Looking for a few good messages. *American Journal of Public Health, 103*(1), 31 – 38. doi: 10.2105/AJPH.2012.300905

Laureate Education, Inc. (Executive Producer). (2008). *Health policy and management: Healthcare funding policies*. Baltimore: Author.

Levi, O., Liechtentritt, R., & Savaya, R. (2012). Binary phenomenon of hope: Perceptions of traumatized veterans. *Journal of Health Psychology, 18*(9), 1153 – 1165. doi: 10.1177/1359105312461661

Liebertz, S., Bunch, J., & Shaw, S. (2019). Federalism and public opinion on healthcare: The design of the Affordable Care Act's insurance exchanges and user experience with the exchanges. *Publius: The Journal of Federalism*, 1 – 7. doi: 10.1093/publius/pjz002

Lightfoot, E., Gal, J., & Weiss-Gal, I. (2018). Social Policy in Social Work PhD Programs in the United States. *Research on Social Work Practice*, *28*(3), 234–242. doi: 10.1177/1049731517710328

Lindridge, A., MacGaskill, S., Ginch, W., Eadie, D., & Holme, I. (2013). Applying an ecological model to social marketing communications. *European Journal of Marketing, 47*(9), 1399 – 1420. doi: 10.1108/EJM-10-2011-0561

Lockwood, M., Kuzemko, C., Mitchell, C., & Hoggett, R. (2017). Historical institutionalism and the politics of sustainable energy transitions: A research agenda. *Politics & Space, 35*(2) 312–333. doi: 10.1177/0263774X16660561

Longman, P., & Gordon, S. (2017). *VA Health Care: A system worth saving*. (Report prepared for the American Legion). Retrieved from https://www.legion.org/publications/238801/longman-gordon-report-va-healthcare-system-worth-saving

Luca, N. R. & Suggs, L. S. (2013). Theory and model use in social marketing health interventions. *Journal of Health Communication*, *18*, 20 – 40. doi: 10.1080/10810730.2012.688243

Luck, J., Hagigi, F., Parker, L. E., Yano, E. M., Rubenstein, L. V., & Kirchner, J. E. (2009). A social marketing approach to implementing evidence-based practice in VHA QUERI: the TIDES depression collaborative care model. *Implementation science: IS*, *4*, 64. doi:10.1186/1748-5908-4-64

Luthi, S. (2019, January 30). VA releases proposed access standards for community care. Government Section. *Modern Healthcare.* Retrieved from https://www.modernhealthcare.com/article/20190130/NEWS/190139996/va-releases-proposed-access-standards-for-community-care

Maltby, E. (2017). The political origins of racial inequality. *Political Research Quarterly, 70*(3), 535 – 548. doi: 10.1177/1065912917704518

McGregor, A., Eduardo Siqueira, C., Zaslavsky. A. M., & Blendon. R.J. (2017). Do elections matter for private sector healthcare management in Brazil. *BMC Health Services Research, 17*(483). doi: 10.1186/s12913-017-2427-5

Measurement Instrument Database for the Social Sciences (MIDSS) Website. (n.d.) *Theory of planned behavior questionnaire*. Retrieved from http://www.midss.org/content/theory-planned-behaviour-questionnaire

Mettler, S. (2011). *The submerged state: How invisible government policies undermine American democracy*. Chicago: The University of Chicago Press.

Mettler, S., & Sorelle, M. (2018). Policy feedback theory. In C. M. Weible, & P. A. Sabatier (Eds.). *Theories of the policy process.* (4th ed., pp. 103 - 134). New York: Westview Press.

Mettler, S., & Welch, E. (2004). Civic generation: Policy feedback effects of the GI Bill on political involvement over the life course. *British Journal of Political Science, 34*(3), 497-518. doi:10.1017/S0007123404000158

Miles, M. B., Huberman, A. M., & Saldana, J. (2014). *Qualitative data analysis: A methods sourcebook* (3rd ed.). Thousand Oaks, CA: Sage Publications.

Moynihan, D. P., & Soss, J. (2014), Policy Feedback and the politics of administration. *Public Administration Review, (74).* 320-332. doi:10.1111/puar.12200

Nevedal, A.L., Wagner, T.H., Ellerbe, L.S. et al. (2019). A qualitative study of primary care providers' experiences with the Veterans Choice Program. *Journal of General Internal Medicine, (34)*4, 598 - 603. doi: 10.1007/s11606-018-4810-2

Neville, S., Adams, J., & Holdershaw, J. (2014). Social marketing campaigns that promote condom use among MSM: A literature review. *Nursing Praxis in New Zealand*, *30*(1), 5 – 16. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/24839743

Novelli, W. D. (2008). Transforming the healthcare system: A focus on prevention. *Healthcare Financial Management, (62*)4. 94 – 99. Retrieved from https://www.hfma.org/hfm/

Ohl, M. E., Carrell, M., Thurman, A., Vander Weg, M., Hudson Pharm, T., Mengeling, M., & Vaughan-Sarrazin, M. (2018). Availability of healthcare providers for rural veterans eligible for purchased care under the Veterans Choice Act. *British Medical Journal, (18)*1, 315 – 321. doi: 10.1186/s12913-018-3108-8

Ortiz, S. R. (2006). Review of Mettler, Suzanne, *Soldiers to Citizens: The G.I. Bill and the Making of the Greatest Generation*. Retrieved from http://www.h-net.org/reviews/showrev.php?id=11935

Patton, M. Q. (2015). *Qualitative research & evaluation methods* (4th ed.). Thousand Oaks, CA: Sage Publications.

Penn M., Bhatnagar S., Kuy S., et al. (2019). Comparison of wait times for new patients between the private sector and United States Department of Veterans Affairs

Medical Centers. *JAMA Network Open.* Published online January 18, 20192(1):e187096. doi:10.1001/jamanetworkopen.2018.7096

Pierson, P. (1993). When effect becomes cause: Policy feedback and political change. *World Politics, 45*(4), 595-628. doi:10.2307/2950710

Pipes, S., (2017, January 17). The VA doesn't need protection -- It needs competition. *Forbes*. Health Policy. Retrieved from https://www.forbes.com/sites/sallypipes/2017/01/09/the-va-doesnt-need-protection-it-needs-competition/#4a1c47d91391

Pullen, H. & Flynn, T. (2014). Co-orienting community engagement in hospital system planning: Understanding internal and external perspectives. *Public Relations Journal, 8*(2). Retrieved from http://www.prsa.org/intelligence/PRJournal/Vol8/No2/

Reynolds, L. (2012). 'No Decision About Me, Without Me': A place for social marketing within the new Public Health architecture? *Perspectives in Public Health, 132*(1), 26–30. doi: 10.1177/1757913911431030

Rieley, S. (4 Sept. 2019). Opinion: Open up the 'iron triangle' that stultifies veterans policy. *The Hill*. Retrieved from https://thehill.com/opinion/national-security/459842-open-up-the-iron-triangle-that-stultifies-vets-policy

Royne, M.B., & Levy, M. (2015). Reaching consumers through effective health messages: A public health imperative. *Journal of Advertising, 44*(2), 85 - 87. doi: 10.1080/00913367.2015.1019249

Rudestam, K. E., & Newton, R. R. (2015). *Surviving your dissertation: A comprehensive guide to content and process.* (4th ed.). London: Sage Publications.

Russell, K. (2018). The politics of hidden policy: Feedback effects and the charitable contributions deduction. *Politics & Society, 46*(1) 53–80. doi: 10.1177/0032329218754504

Ruiz, S. L., & Stadtlander, L. (2015). Social media as support for partners of veterans with posttraumatic stress disorder. *Journal of Social, Behavioral, and Health Sciences, 9*(1), 1 – 18. doi: 10.5590/JSBHS.2015.09.1.01

Saloner, B. (2017, August 3). What does choice mean when it comes to health care? *The Conversation*. Retrieved from http://theconversation.com/what-does-choice-mean-when-it-comes-to-health-care-81800

SBST Website. (2017). Retrieved from https://sbst.gov/

Short, W. D. (1991). *Effect of the Gillett Amendment of 1913 on the public information activities of federal government communicators*.

Shulkin, D. J., (2018, March 28). David J. Shulkin: Privatizing the V.A. Will Hurt Veterans. *The New York Times*, Opinion, Retrieved from https://www.nytimes.com/2018/03/28/opinion/shulkin-veterans-affairs-privatization.html

Singaiah, G., Laskar, S. R. (2015). Understanding social marketing: A conceptual perspective. *Global Business Review, 16*(2), 213 – 235. doi: 10.1177/0972150914564282

Sisk, R. (2018). Trump Signs $55 Billion Bill to Replace VA Choice Program. *Military.com*. (6 June). Retrieved from: https://www.military.com/daily-news/2018/06/06/trump-signs-55-billion-bill-replace-va-choice-program.html

Skocpol, T. (1992). Protecting Soldiers and Mothers. Cambridge, MA: Harvard University.

Smith, J. A., & Osborn, M. (2015). Interpretative phenomenological analysis as a useful methodology for research on the lived experience of pain. *British journal of pain, 9*(1), 41–42. doi:10.1177/2049463714541642

Smith, R. R. (2017). President Signs Veterans Choice Act. *Fedsmith.com*. Retrieved from: https://www.fedsmith.com/2017/04/19/president-signs-veterans-choice-act/

Sorelle, M., & Shanks-Booth, D. (2016). The acknowledgement gap: Partisanship, policy feedback, and social programs. *ASPA Best Poster in Public Policy Award*.

Springer. (2016, July 18). Quality of care in VA health care system compares well to other settings: Systematic review sheds light on medical and surgical services provided to veterans. *ScienceDaily*. Retrieved from www.sciencedaily.com/releases/2016/07/160718110919.htm

Suarez-Almazor, M. E. (2011). Changing behaviors with social marketing. *Osteoporosis International*. Supplement 3, 461 – 463. doi: 10.1007/s00198-0011699-6

Sullivan, S., & Lazier, R. (2014, June). *Aligning research & policy: The Department of Veterans Affairs, a case study*. Presentation for Walden University, Online.

Taylor, M., & Kent, M. L. (2015). Towards legitimacy and professionalism: A call to repeal the Gillett Amendment. *Public Relations Review, (42)*1, 1 – 8. doi: 10.1016/j.pubrev.2015.09.012

Tellis, W. (1997). Application of a case study methodology by Winston Tellis. *The Qualitative Report, 3*(3). Retrieved from www.nova.edu.ssss/QR/QR-3-3/tellis2.html

The VA MISSION Act: Enhancing healthcare for veterans. (2018, June 12). *National Law Review*.

Truong, V. D., Garry, T., & Hall, C. M. (2014). Social marketing as the subject of doctoral dissertations. *Social Marketing Quarterly, 20*(4), 199 – 218. doi: 10.1177/1524500414546230

Turvey, C., Klein, D., Fix, G., Hogan, T. P., Woods, S., Simon, S. R., …Nazi, K. (2014). Blue button use by patients to access and share health record information using the Department of Veterans Affairs' online patient portal. *Journal of the American Medical Informatics Association, 21*, 657 – 663. doi: 10.1136/amiajnl-2014-002723

United Nations, United Nations Global Geospace Information Management. (2016). *Report of the Inter-Agency and Expert Group on Sustainable Development Goal Indicators*. (E/CN.3/2016/2/Rev.1) Retrieved from http://ggim.un.org/knowledgebase/KnowledgebaseArticle51479.aspx

West, E. (2014). Consumer subjectivity and U.S. health care reform. *Health Communication*, 29, 299 - 308. doi: 10.1080/10410236.2012.753140

Whitler, K. A., (2015, September). The new world of healthcare marketing: A framework for adaptation. *Forbes*. Retrieved from https://www.forbes.com/sites/kimberlywhitler/2015/09/06/the-new-world-of-healthcare-marketing-a-framework-for-adaptation/#60ebb8531c10

Wilkie, R. (2019, January 28). *Statement: Revolutionizing VA health care*. Retrieved from https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5186

Wolfe, J. A. (2018). Consumer perspectives on patient experience. *The Beryl Institute*. Retrieved from https://www.theberylinstitute.org/page/WhitePapers

U.S. Department of Health and Human Services Website (2012). Retrieved from http://www.hhs.gov/healthcare/facts/factsheets/2010/09/The-Affordable-Care-Act-and-Immunization.html

U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion Website (2019). Retrieved from https://www.healthypeople.gov/2020/topics-objectives/health-communication-and-health-information-technology/objectives

U.S. Department of Veterans Affairs, *About Us*. (2018). Retrieved https://www.va.gov/ABOUT_VA/index.asp

U.S. Department of Veterans Affairs, *Community Care*. (2018). *VA Retail Immunization Care Coordination Program*. Retrieved from https://www.va.gov/communitycare/programs/veterans/immunization.asp

U.S. Department of Veterans Affairs. (2018). *Department of Veterans Affairs FY 2018 – 2024 strategic plan*. Retrieved from https://www.va.gov/oei/docs/VA2018-

2024strategicPlan.pdf

U.S. Department of Veterans Affairs (2015). *Progress Report: Veterans Access, Choice, and Accountability Act 2014*. [2015 March 24]. http://www.va.gov/opa/choiceact/documents/FactSheets/Progress-Report-March-2015-Fact-Sheet.pdf

U.S. Department of Veterans Affairs, Interagency Program Office, Virtual Lifetime Electronic Record Health. (2014). *VLER health performance management plan*.

U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. (2011). *Department of Veterans Affairs: Veteran Surveys and Studies*. Retrieved from http://www.va.gov/vetdata/docs/QuickFacts/Surveys-slideshow.pdf

U.S. Department of Veterans Affairs. (2019). *Records Control Schedule 10-1*. Retrieved from https://www.va.gov/vhapublications/RCS10/rcs10-1.pdf

U.S. Department of Veterans Affairs. (2016). *Veteran Population Projections*. Retrieved from https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/Vetpop_Infographic_Final31.pdf

VA MISSION Act of 2018, H.R. 5674 (2018).

VA-Walgreens Flyer. (2016). Retrieved from https://www.walgreens.com/images/adaptive/pdf/84924_VA_Flu_Voucher_2016.pdf

Values Based Management Website. (2016). *Theory of Planned Behavior*. Retrieved from http://www.valuebasedmanagement.net/methods_ajzen_theory_planned_behavior.html

Vanneman, M.E., Harris, A. H. S., Asch, S. M., Scott, W. J., Murrell, S. S., & Wagner, T. H. (2017). Iraq and Afghanistan veterans' use of Veterans Health Administration and Purchased Care before and after Veterans Choice Program implementation. *Medical Care*, (55) S7 S1, S37 – S44. doi: 10.1097/MLR.0000000000000678

Veterans of Foreign Wars. (2017). *Our Care 2017: A report evaluating veterans health care* (March 2017). Retrieved from Advocacy on Veterans of Foreign Wars website: https://www.vfw.org/-/media/VFWSite/Files/Advocacy/VFW-Our-Care-2017--Executive-Summary.pdf?la=en

Veterans Access, Choice, and Accountability Act of 2014 (Pub. L. No. 113 – 146, 2014)

Walgreens Website. (2019). Retrieved from https://www.walgreens.com/pharmacy/immunization/seasonal_flu.jsp?ext=msnFY20_Flu_Brand_BMM_Flu_Brand_General_BMM_Broad_+walgreens_+flu&sst=72e5dac9-eddb-4c66-b3ed-86dadf3e50a9&msclkid=775ac55dd64c1c6efff798fd2a747601

Walgreens Website. (n.d.) Newsroom. Retrieved from https://news.walgreens.com/404.cfm?404;http://news.walgreens.com:80/fact-sheets/about-walgreens/?404;http://news.walgreens.com:80/fact-sheets/about-walgreens/

Weeks, W. B., & West, A. N. (2018). Veterans Health Administration hospitals outperform non-Veterans Health Administration hospitals in most health care markets. *Annals of Internal Medicine*. [Epub ahead of print] doi: 10.7326/M18-1540

West, E. (2014). Consumer subjectivity and U.S. health care reform. *Health Communication*, 29, 299 - 308. doi: 10.1080/10410236.2012.753140

Westat (2010). National survey of veterans, active duty service members, demobilized national guard and reserve members, family members, and surviving spouses (Contract GS-23F-8144H Task Order 101-G87089). Retrieved from https://www.va.gov/vetdata/docs/SurveysAndStudies/NVSSurveyFinalWeightedReport.pdf

Whitelaw, S., Smart, E., Kopela, J., Gibson, T., & King, V. (2011). Developing social marketing capacity to address health issues. *Health Education, 111*(4), 319 – 331. doi: 10.1108/09654281111144274

Zoellner, J., Krzeski, E., Harden, S., Cook, E., Allen, K., & Estabrooks, P. A. (2012). Qualitative Application of the Theory of Planned Behavior to Understand Beverage Behaviors among Adults. *Journal of the Academy of Nutrition and Dietetics*, *112*(11), 1774–1784. doi.org/10.1016/j.jand.2012.06.368

Appendix A: Telephone Script

Hello, Mr./Mrs./Ms. _____,

My name is Stacie Rivera. I am calling to thank you for your interest in my research project. You may recall signing a VA consent form that indicated you were interested in providing your feedback concerning the idea of "choice" in health care because of your participation in the private-sector no-cost flu shot program at a local retail pharmacy in the area.

Does that ring a bell?

Let me take a few minutes to explain. The purpose of my research project is to understand what motivated you and other veterans to choose to get your seasonal flu shot at a local retail pharmacy instead of your VA health care provider. I would like to hear from you to get a better idea of your attitudes about this choice, understand your motivations to seek outside care, and get some background about current health care policies that expand choice to you as a veteran patient.

For these reasons, I would like to invite you to a 60-minute interview in the next month. If you are willing to participate, I will set up either a telephone or face-to-face interview that will ask you about your motivations, attitudes, associated behaviors, and other feedback related to the concept of choice in health care provided by the government agency. There are no foreseeable risks associated with this project, nor are there any direct benefits to you.

As a participant, your participation is voluntary, and you may withdraw at any time. Your information will be kept confidential. Your responses will not be identifiable,

and the results will be kept safe and secure in a password-protected e-file; all other notes will be locked securely as well.

This study is being conducted by me as an educational requirement for a doctoral program with Walden University. I can be reached at XXX or XXX@waldenu.edu for questions or concerns.

Appendix B: Screening Tool

Name:				
Age:			Gender:	
Branch of Service:	Army	Navy	Air Force	Marines
	Coast Guard	National Guard	Merchant Marines	Other
Time in Service:	0 – 5 years	6 – 10 years	11 – 19 years	20+ years
Era of Service:	Korea	Vietnam	Gulf War/Desert Storm	Iraq/Afghanistan
	Peacetime	Other		
Are you a member of a Veterans Service Organization?	Yes	No	If yes, which one(s)?	
Which market do you live in?	XXX	XXX	XXX	
	XXX	XXX	Other: (list)	
For the statements below, check the best answers that describe your experience(s),				
I choose to get my flu shot at Walgreens because (circle all that matter to you): It was closer to my home. I don't like going to the VA for my flu shot. I didn't have to wait. I was picking up a prescription at Walgreens and saw the sign. The VA mailed something to me that told me to go to Walgreens for my flu shot. I trust Walgreens more that the VA. Members of my VSO get theirs from Walgreens, so I thought I'd try it. I believe that Walgreens offers better flu shots than the VA does. I feel in more control when I get my flu shot at Walgreens.				
Next year, I intend to get my flu shot at (circle one):				
VA Walgreens				
Other I do not plan to get a flu shot.				
I am interested in sharing my feedback about choice in VA health care: Yes No				

Thank you for taking the time to complete this screening tool. Please mail this completed tool to ADDRESS and send it to the provided stamped envelope or email a scanned copy of the document to XXX@walden.edu. If you are unable to email or mail this screening tool Ms. Rivera but are interested in participating in the project, please call her at XXX to arrange to get the information to her and arrange a 60-minute interview to share your ideas about choice in government health care.

Sincerely,
Stacie Rivera
Student, Walden University

Appendix C: Interview Guide

I am interested in understanding your ideas about the concept of choice in VA health care.

Behavioral outcomes

(1) What do you see as the advantages of your choosing to get your seasonal flu shot at your neighborhood private retail pharmacy for the last few years rather than getting it as your VA doctor or health care clinic?

(2) What do you see as the disadvantages of going to local private retail pharmacy to get your seasonal flu shot instead of going to your local VA to get it?

(3) What else comes to mind when you think about getting preventive health care services like a flu shot outside of the VA?

Normative referents

When it comes to seeking preventive care, like a flu shot, outside of your VA health care provider, there might be individuals or groups who would think you should or should not perform this behavior. Meaning, that you should be loyal to VA.

(1) What do you think about this idea of loyalty to VA health care?

(2) Who in your life helps you make health care decisions about seeking health care outside of VA? And what factors into that decision? What motivated you to seek a flu shot at a local private retail pharmacy?

(3) Please list the individuals or groups who would approve or think you should get your flu shot at your local private retail pharmacy and not the VA.

(4) Please list the individuals or groups who would disapprove or think you should not get your flu shot at your local private retail pharmacy, but prefer for you to always use the VA.

(5) Sometimes, when we are not sure what to do, we look to see what others are doing. Please list the individuals or groups who offer you motivation to seek care outside of VA. And let me know what types of ideas move you to act based on that feedback.

Control factors

(1) Please list any factors or circumstances that would make it easy or enable you to get your flu shot at your local private retail pharmacy.

(2) Please list any factors or circumstances that would make it difficult or prevent you from getting your flu shot at your local private retail pharmacy.

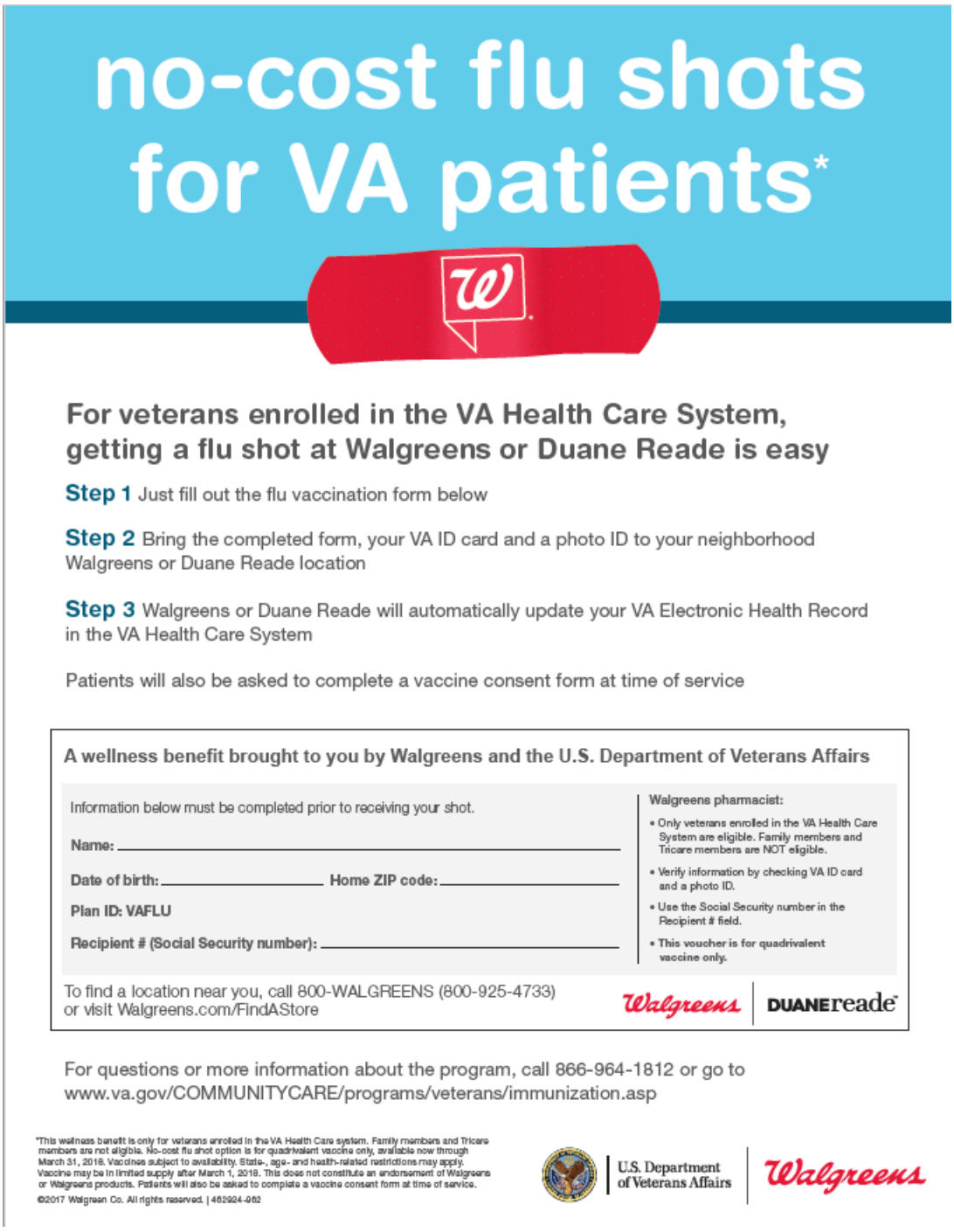
Based on your experienced of getting your seasonal flu shot at your local private retail pharmacy, have you considered using other non-VA provided health care?

(1) If yes, please explain.

Would you use any other community or non-VA care if it were available to you?

(1) Tell me about the criteria that might be important to you. [easy access; wait times; cost; seamless health records?]

Appendix D: Sample No-cost Flyer/Information Sheet (2019)



no-cost flu shots for VA patients*

For veterans enrolled in the VA Health Care System, getting a flu shot at Walgreens or Duane Reade is easy

Step 1 Just fill out the flu vaccination form below

Step 2 Bring the completed form, your VA ID card and a photo ID to your neighborhood Walgreens or Duane Reade location

Step 3 Walgreens or Duane Reade will automatically update your VA Electronic Health Record in the VA Health Care System

Patients will also be asked to complete a vaccine consent form at time of service

A wellness benefit brought to you by Walgreens and the U.S. Department of Veterans Affairs

Information below must be completed prior to receiving your shot.

Name: _____

Date of birth: _____ **Home ZIP code:** _____

Plan ID: VAFLU

Recipient # (Social Security number): _____

Walgreens pharmacist:

- Only veterans enrolled in the VA Health Care System are eligible. Family members and Tricare members are NOT eligible.
- Verify information by checking VA ID card and a photo ID.
- Use the Social Security number in the Recipient # field.
- This voucher is for quadrivalent vaccine only.

To find a location near you, call 800-WALGREENS (800-925-4733) or visit Walgreens.com/FindAStore

Walgreens | DUANEreade

For questions or more information about the program, call 866-964-1812 or go to www.va.gov/COMMUNITYCARE/programs/veterans/immunization.asp

*This wellness benefit is only for veterans enrolled in the VA Health Care system. Family members and Tricare members are not eligible. No-cost flu shot option is for quadrivalent vaccine only, available now through March 31, 2018. Vaccines subject to availability. State-, age- and health-related restrictions may apply. Vaccine may be in limited supply after March 1, 2018. This does not constitute an endorsement of Walgreens or Walgreens products. Patients will also be asked to complete a vaccine consent form at time of service.

U.S. Department of Veterans Affairs | Walgreens