MDVIP – A case of integrating Services-Marketing principles to transform health-care delivery

based on the original hand-written assignment or the course

'Services Marketing' (MKT-5005)

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1. ABSTRACT:

This abstract **(Section-1)** provides an outline of the assignment and its sections. The assignment involves an analysis of Dr. Ray's adoption of the MDVIP healthcare model in the light of services-marketing principles. It shows how the MDVIP model, in response to traditional healthcare's inefficiencies, offering a personalised and preventive care, improving both physician satisfaction and patient experience and quality compromises.

Section-2 summarises the assignment case which shows how Dr. Charles Ray, dissatisfied with the traditional system's overwhelming patient loads, poor reimbursements, and ethical compromises, discovered the MDVIP model. It not only aligned with his philosophy of preventive treatment and patient wellness, but also offered financial stability, professional fulfilment, and improved his overall work–life balance. For patients, the MDVIP provided personalised healthcare, easy access to doctors, and uninterrupted care through nationwide networks. However, Dr. Ray's reduction of his practice (from 3000 to 600 patients) raised concerns of exclusion and equity.

Section 3 forms the main body of this assignment where the case questions are introduced along with the key marketing concepts they explore. Each question is subsequently answered in sub-sections 3.1-3.4, following a brief review of the related literature. **Section 3.1 answers case question-1** after reviewing the literature on Buyer's Perception of Value. The answer shows how the MDVIP model delivers clear value, shifting from high-volume reactive practice to a premium, patient-centred approach. **Section 3.2 answers case question-2,** after a brief literature review of price-sensitivity, elasticity of demand, and assessing Monroe's framework (1990) in the light of recent empirical studies in healthcare. The answer illustrates reduced sensitivity overall but variations contingent to service types and owing to fairness perceptions. **Section 3.3 answers case-question-3**, following a review of the related literature on *Niche marketing, Relationship marketing, Customer Equity Management, Demarketing strategies* and *Graceful exit from market segments*. While the literature establishes a clear marketing rationale for Dr. Ray to reduce his service volume, the answer to the case-question discusses three distinct strategies (*Selective demarketing*, *General demarketing* and *Graceful-exits*) to manage his discontinuation with 2400 patients. **Section 3.4**, **answers case question-4** after reviewing the literature on *the ethicality of excluding or under-serving certain segments in healthcare* and *strategic ethics and responsibility in relationship marketing*. The answer highlights the complex ethical dilemma in Dr. Charles Ray's transition to the MDVIP.

The assignment concludes that while the MDVIP model enhances physician satisfaction and service quality, it also confronts ethical issues of equity, access, and continuity of care. Overall, the MDVIP is clearly a viable, yet ethically complex, innovation that requires balancing profitability, excellence, and social responsibility.

- End of Section 1 -

2. SUMMARY OF THE CASE:

2.1 Dr. Ray's situation prior to discovering the MDVIP Model:

Dr. Charles Ray, a preventive medicine specialist, experienced deep dissatisfaction with the traditional healthcare system due to overwhelming patient loads, inadequate insurance reimbursements, and the strain these placed on his personal life. His expertise in preventive care was underutilised as most patients had to face long delays in getting an appointment, and visited him only when they were already very sick. These conditions left him ethically compromised, unable to deliver the quality of care he believed patients deserved

2.2 Dr. Ray's Discovery of MDVIP :

Dr. Ray learned about MDVIP while attending a medical conference. MDVIP, a network of approximately 300 physicians across 26 states, promoted a subscription based model of personalised and preventive healthcare. This model intrigued him as it aligned with his training and professional philosophy.

2.3 How the MDVIP service delivery model addressed the concerns of Dr. Ray:

The MDVIP service delivery model provided Dr.Ray with a comprehensive solution to the personal, financial, professional, and ethical challenges he faced in traditional healthcare practice. By reducing patient load, the model offered an improved work–life balance, without the strain of constantly attending long queues of sick patients. The yearly subscription model ensured a stable and predictable revenue stream, sparing the trouble of collecting insurance reimbursements.

In addition to the above, MDVIP's emphasis on preventive and personalised healthcare completely aligned with Dr. Ray's expertise and philosophy, allowing him proactively, oversee the wellness of his patients well ahead of a sickness. Ethically, the model enabled longer consultations with fewer patients, restoring his ability to deliver quality, patient-centred care.

2.4 What the MDVIP meant for the patients:

It is apparent from the case that MDVIP model provided its subscribers the following benefits:

*(A more thorough assessment of its value offering has been presented in Section-3)

- **Smaller physician to patient ratio,** allowing patients more time and attention from their doctors.
- **Rigorous physician selection** to filter and include only doctors who are committed to preventive care and strong patient-centric philosophy.
- **Uninterrupted care** via MDVIP's network of physicians and partner hospitals and research facilities such as those in Cleveland, UCLA and Sloan-Kettering. This offers the patients continuity in care even during travel or in the absence of their preferred doctor.

- **Enhanced patient access** through same or next-day appointments, access to doctor's cell phone and email, and coverage for adult children under 25 or visiting guests at no extra charge.
- **State-of-the-art technology** such as personal wallet-sized health record CDs and a web-based personal portal facilitating communicating with doctors and partner hospitals.
- **Year-long personalised wellness plan** included within the $2000 annual subscription fee. This meant that the subscribers would be in constant supervision of preventive-care experts to stay healthy, hence saving their overall health expenditure in the long run.
- **Monthly payment facilities** arranged through banks for account holders of certain savings accounts.

- End of Section 2 -

3. ANSWERING THE CASE QUESTIONS IN THE LIGHT OF SERVICES MARKETING PRINCIPLES:

The case questions are:

- **Question 1.** *Using the Buyer's Perception of Value, discuss the value provided by the **MD**VIP business model. Do you believe that **MD**VIP offers a good value to patients?*
- **Question 2.** *Based on the 10 factors that influence price sensitivity, select five of these factors and discuss whether patient demand for health care is elastic (patients are typically price sensitive) or inelastic (patients are typically less price sensitive).*
- **Question 3.** *If Dr. Ray reduces his practice to 600 patients, discuss the pros and cons of three possible strategies for making arrangements for his 2,400 patients that will no longer be his responsibility.*
- **Question 4.** *Discuss the ethical or social responsibility issues that Dr. Ray faces as he considers signing on with **MDVIP**.*

In answering the above questions, the topics of the literature reviewed were as follows:

Topics of the literature reviewed for Question 1:

- Buyer's Perception of Value

Topics of the literature reviewed for Question 2:

- Price Sensitivity Factors and Elasticity of Demand
- Price Elasticity of Demand in Healthcare
- Monroe's framework in the light of recent empirical studies

Topics of the literature reviewed for Question 3:

- Niche marketing
- Relationship marketing
- Customer Equity Management
- Demarketing strategies
- Graceful exit from market segments

Topics of the literature reviewed for Question 4:

- The ethicality of excluding or under-serving certain segments in healthcare
- Strategic ethics and responsibility in relationship marketing

3.1 Perceived Value Framework, and the answer to Question-1

3.1.1 A brief review of relevant literature on Buyer's Perception of Value:

Parasuraman, Zeithaml and Berry's SERVQUAL model is one of the most influential frameworks for assessing service quality, widely applied across industries including healthcare. Its adaptability allows integration of functional and emotional aspects of care, making it a dependable tool for evaluating patient-centred service delivery and sustaining trust in health systems

The SERVQUAL model conceptualizes service quality as the gap between customer expectations and perceptions, measured across five dimensions: tangibility, reliability, responsiveness, assurance, and empathy. Research consistently demonstrates that Parasuraman, Zeithaml and Berry's SERVQUAL model is a reliable framework for assessing healthcare service quality. Evidence from Pena, Silva, Tronchin and Melleiro (2013), Chahal and Kumari (2012), and Liu and Xiaohang (2023) affirmed SERVQUAL's reliability and adaptability in healthcare contexts, reinforcing its role as a cornerstone for patient-centred quality assessment (Pena et al., 2013; Chahal & Kumari, 2012; Liu & Xiaohang, 2023).

Perceived value in healthcare is multidimensional (i.e. functional, relational, and experiential) and must be managed responsibly to enhance patient outcomes and organisational success. Research highlights its central role in shaping patient satisfaction, loyalty, and advocacy. Pevec and Pisnik (2018) demonstrate that service quality, reputation, and price perceptions strongly influence perceived value, while Soare et al. (2026) extend this by showing how value perceptions drive electronic word-of-mouth, reinforcing trust and organisational reputation. Complementing these perspectives, the *Journal of the Academy of Marketing Science* (2024) emphasises the importance of integrating emerging technologies and patient-centric analytics to personalise value delivery and sustain competitive advantage.

3.1.2 Answer to Case Question-1

The Buyer's perceived value regarding the MDVIP model can be assessed using the SERVQUAL framework's 5 key dimensions - empathy, responsiveness, reliability, assurance, and tangibles.

In terms of **empathy**, MDVIP demonstrates a strong patient-centred philosophy though emphasising preventive and personalised healthcare, and by limiting the physical to patient ratio. This allows physician to build deeper relationships and better understand individual patient needs.**The dimension of responsiveness** also scores high through features such as same-day or next-day appointments, 24/7 physician availability via phone and email, and the availability of doctors and health centres even during travel. **Reliability** in the MDVIP model is reflected through its preventive care approach, offering dependable and timely physician advice to all its subscribers, all year long. The **assurance** dimension is reinforced though partnerships with reputable medical institutions and the careful selection of physicians based on expertise and commitment to preventive care. Finally, **tangibles** such as the patient files in wallet sized CDs, the online portal, the network of partner hospitals together reinforce the perceived value of the MDVIP.

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Overall, The MDVIP model offers good value to the patients in all the five dimensions discussed above.

3.2 Price Sensitivity Factors and Elasticity of Demand, and the answer to Question-2

3.2.1 A brief review of relevant literature on Price Sensitivity Factors and Elasticity of Demand:

Monroe's framework on price sensitivity provides a comprehensive model for understanding how demand for a product or service responds to price changes. He identifies several key factors that influence sensitivity, including (i) **perceived value**, where higher value reduces responsiveness to price; (ii) **reference prices**, which anchor consumer expectations and heighten sensitivity when deviations occur; (iii) **fairness perceptions**, where perceived inequity increases resistance to price changes. (iv) **availability of substitutes**, which increases price sensitivity and elasticity of demand when alternatives exist, and (v) **the unique value effect**, where differentiation of the product or service lowers sensitivity to price. Monroe aso notes the **price–quality effect**, whereby higher prices often signal superior quality, reducing consumer sensitivity to price (Monroe, 1990).

Recent empirical studies demonstrate that healthcare demand elasticity is contingent upon the nature of the service. Elective and preventive services are more price-sensitive than more necessary treatment such as chronic and emergency care (Manning et al., 1987; Ellis, Martins & Zhu, 2017). Fairness perceptions are particularly critical in healthcare, as patients react strongly to co-payments deemed as unfair, underscoring the importance of transparent pricing strategies (Nagle, Hogan & Zale, 2016).

Overall, Monroe's factors are applicable in healthcare, but their expected effects are contingent to the urgency of the treatment and other factors such as insurance coverage and ethical considerations (Moorman et al., 2024).

3.2.2 Answer to Case Question-2

To assess elasticity in the MDVIP case, Monroe's (1990) factors must be interpreted alongside the contextual insights from section 2.4. As seen earlier, elasticity in healthcare is dependent on the type of service sought, with discretionary services being more elastic and chronic or emergency care being largely inelastic (Manning et al., 1987; Ellis, Martins & Zhu, 2017).

The MDVIP's subscription design reduces the sensitivity overall, due to its *perceived value* (Monroe, 1990, especially in features such as its country-wide network of medical facilities and its team of experts on preventive healthcare. These features contribute to a ***unique value effect*** with a **lack of availability of substitutes** as they cannot be easily replicated by individual hospitals or practitioners. The coverage of family members of patients within the wellness programme of MDVIP also helps in establishing **perceptions of fairness** regarding its services. Together, these lower the price sensitivity.

On the other hand, as the service is preventive care based, and hence, not seen as an emergency, the demand could be moderately elastic and price sensitive (Ellis, Martins & Zhu, 2017)

3.3 Demarketing, leaving segments and graceful exits - answer to Question-3

3.3.1 A brief review of relevant literature on demarketing, leaving segments and graceful exits

Reducing the customer base and narrowing target markets is a well-established theme in services marketing, supported by several strategic approaches. Concentrated and niche marketing direct resources toward fewer segments, often enabling premium pricing (Kotler & Keller, 2016). In service contexts, Lovelock (2001) introduced the notion of "firing customers," while Rust, Zeithaml and Lemon (2000) framed customer equity management as retaining profitable clients and letting go of those who destroy value. Relationship marketing perspectives (Berry, 1995; Grönroos, 1994, 2007) similarly emphasize prioritising fewer, high-value customers to build sustainable bonds. Collectively, these strategies converge on the principle that narrowing the customer base is not a loss but a deliberate move to enhance efficiency, profitability, and service quality.

Kotler and Levy's (1971) framework of demarketing highlights that firms may deliberately reduce or redirect demand through general, selective, or ostensible strategies, aligning consumption with capacity, reputation, and societal objectives. In healthcare, this approach acquires ethical significance: Moorman et al. (2024) describe "disrupted exchanges" where discouraging demand protects service quality and equitable access, requiring transparent communication to preserve trust. Similarly, Zhu, Chakravarti and Ni (2019) show that responsible demarketing can curb harmful or unnecessary service use, guiding patients toward healthier choices and long-term wellbeing. Collectively, these perspectives position demarketing as an ethical tool for balancing sustainability, equity, and patient welfare.

When service providers withdraw from segments, scholars stress a graceful exit rather than abrupt abandonment. Tax & Brown (1998) show recovery preserves trust through fairness, communication, and even referral to alternatives, while Hart, Heskett & Sasser (1990) argue recovery can act as a profit center, with effective handling of failure often generating more goodwill than if no failure occurred. Together, these perspectives frame customer reduction not as abandonment but as a strategic transition requiring transparency and ethical management to safeguard reputation and long-term success.

3.3.2 Answer to Case Question-3

Dr. Charles Ray's transition to the MDVIP model reduces his patient base from 3,000 to 600, leaving 2,400 patients to be discotinued. Sections 2.1–2.4 highlight that this move can resolve his personal and financial concerns, and improve the quality of his healthcare. This may therefore seem to be a more professionally pragmatic step.

However, the reduction raises operational and ethical challenges and dilemnas.

Literature in section 3.3.1 provides three strategic lenses—selective demarketing, general demarketing, and graceful exit—which can be applied but must be critically examined in the context of Dr. Ray's case.

Selective demarketing (Kotler & Levy, 1971; Rust, Zeithaml & Lemon, 2000) would involve retaining patients who value preventive care and can afford the $2000 MDVIP fee. In practice, this allows Dr. Ray to devote more time to patients aligned with his wellness philosophy, strengthening long-term relationships (Berry, 1995; Grönroos, 1994, 2007). However, the disadvantage is that patients excluded due to cost may perceive this as discrimination, potentially damaging their trust in Dr.Ray's ethical commitment.

General demarketing (Kotler & Levy, 1971) would involve reducing the demand uniformly through mechanisms such as Dr. Ray's annual membership fee and the capacity limit of 600 patients. As all patients face the same enrolment criteria and fee, this will portray fairness despite the ethical concern of reducing the patient size. The disadvantages of this approach is the same as that discussed under selective demarketing.

Graceful exit strategies (Tax & Brown, 1998; Hart, Heskett & Sasser, 1990) emphasize fairness, communication, and referrals. Applied to Dr. Ray, this would involve clear advance communication of the transition, referral networks to other physicians, and smooth transfer of medical records. For example, he could partner with local practices to ensure continuity of care for departing patients, or provide resource lists for affordable clinics. The advantage is preservation of trust and reputation, consistent with relationship marketing principles (Berry, 1995; Grönroos, 2007). However, disadvantages include administrative burden, time costs, and the inevitability that some patients will still feel abandoned—particularly those who struggle to secure alternative care despite referrals.

3.4 Ethical and Social Responsibility Issues in Service Delivery, and the answer to Question-4

3.4.1 A brief review of relevant literature on Ethical and Social Responsibility Issues:

The ethicality of excluding or under-serving certain segments in healthcare services is a contested issue in marketing scholarship. While classical theory views segmentation as a strategic tool for efficiency, its application in healthcare raises distinctive ethical challenges given the sector's societal role and collective welfare orientation (Purcarea, 2019). From a consequentialist perspective, selective provision may be defensible when it enhances overall health outcomes or allocative efficiency, with evidence showing that targeted interventions can improve consumer decision-making and mitigate disparities (Moorman et al., 2023; Newton, Newton & Ewing, 2013). However, justice-based frameworks emphasize fairness and equal access, warning that exclusionary practices risk reinforcing

structural inequalities and undermining social responsibility (Newton, Newton & Ewing, 2013; Brenkert, 1998).

Equitable access to healthcare is increasingly framed in marketing scholarship as a core ethical and social responsibility rather than a peripheral policy concern. Recent contributions stress that equity must be embedded into the design, evaluation, and delivery of healthcare marketing strategies, moving beyond symbolic or episodic campaigns (Parkinson & Davey, 2026). Parkinson and Naidu (2024) highlight the need for robust evaluation frameworks to ensure that marketing interventions reduce disparities and generate measurable social impact, particularly for marginalized groups. The literature therefore clearly positions strategic ethics in healthcare marketing as inseparable from equity, inclusivity, and accountability.

One of the pioneers of the relationship marketing paradigm, Christian Grönroos, showed that relationship marketing is both a strategic and moral practice, inseparable from the ethical responsibilities of trust, fairness, accountability, and care. His focus on trust and fairness positions ethics as central to service quality, while his definition of marketing as the "mutual exchange and fulfillment of promises" elevates promise-keeping to a structural principle of relational strategy (Grönroos, 1994). By linking risk reduction to value creation, he frames social responsibility as a strategic imperative that strengthens loyalty and reduces customer vulnerability (Ravald & Grönroos, 1996). His later work reinforced that long-term success depends on organizations acting in ways perceived as fair and trustworthy, embedding ethics into managerial logic (Grönroos, 2007).

3.4.2 Answer to Case Question-4

Dr. Charles Ray's decision to join the MDVIP model raises significant ethical and social responsibility issues as he reduces his patient base from 3,000 to 600, leaving 2400 patients who potentially face a disruption of their healthcare.

While the decision allows Dr. Ray to utilise his expertise better, maintain higher service quality, and hence may be justified (Moorman et al., 2023; Newton, Newton & Ewing, 2013), marketing scholarship stresses that equity must be embedded into healthcare (Parkinson & Davey, 2026; Parkinson & Naidu, 2024) to avoid being perceived as privileging only the wealthy (Brenkert, 1998).

The literature reviewed in section 3.4.1 also clearly highlights that exiting or underserving a segment in healthcare requires a careful consideration of ethical issues and social responsibilities.

Hence Dr. Ray's narrowing his patient base must be accompanied by the steps outlined in section 3.3.2, i.e. transparent communication, advance notice, and support in transferring medical records. Such actions can reduce patient vulnerability (Ravald & Grönroos, 1996) and will help in preserving goodwill, or at least minimising the reputational damage. While this may ensure continuity for the patients, they may still perceive this as a downgrade.

- End of Section 3 -

4. CONCLUSION

In conclusion, Dr. Ray's adoption of the MDVIP model demonstrates a compelling shift towards personalised, preventive healthcare that combines physician satisfaction and patient experience, while also raising significant ethical concerns. Although the MDVIP model represents an innovative and viable healthcare approach, its long-term legitimacy depends on how effectively such models balance commercial success with ethical responsibility and broader social welfare.

- End of section-4 -

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- End of the section-5 -