

The Concept of Social Marketing

From Local Development Initiatives to Global Integration



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The Example of Health Care in Rural India



1 - Introduction

“Concern for man himself and his safety must always form the chief interest of all technological endeavour; never forget this in the midst of your diagrams and equations” - Albert Einstein

A) The Concept of Social Marketing

- At a time when the adjective “commercial” is often discredited and replaced by the adjective “social”, it is not surprising that this is happening to marketing.
- Social marketing is not about commercial marketing tempered by a sense of social responsibility (such as the use of profits for charitable purposes) nor is it the fair pricing and equitable distribution of a given product.
- The term “social marketing” denotes the marketing of commodities enjoying social priority (Neelanegham, 1994, p.836)
- How does one define a social priority?
 - It may arise from:
 - The consumers themselves
 - The nature of the products
 - The philosophy of economic development adopted by the country

• **B) Social Marketing Applied to Health Care in Rural India**

➤ Nature of the consumers:

- What is the population under scrutiny in our study?
- The poor living in rural areas (mostly villages) of Tamil-Nadu (South India)

➤ Nature of the product:

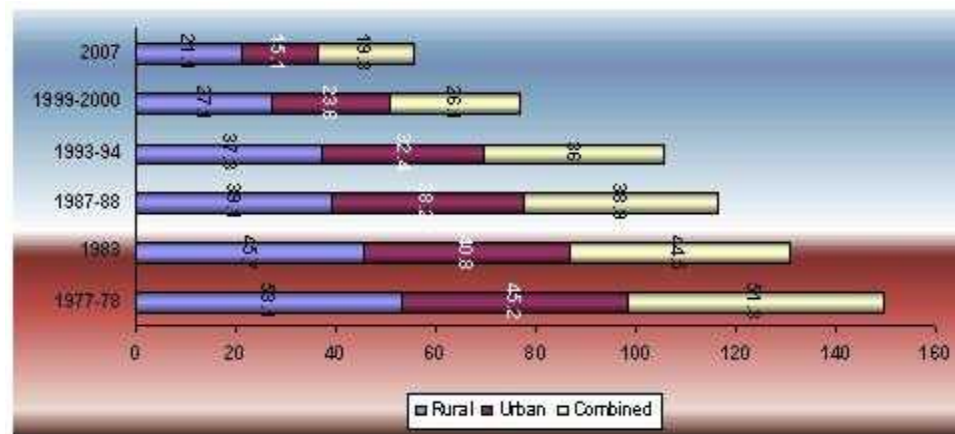
Health care. The emphasis is here on human capital (Becker, 1964), which is similar to "physical capital / means of production " (e.g. factories and machines). One can invest in human capital (via education and health care)

➤ The philosophy of economic development adopted by the country:

- A major shift in thinking is happening in the global economy. Given the wide implications of health (on society's well-being and on the economy's performance), we subscribe to the following axiom: "Health is wealth, and health is everybody's business".
- *"Our greatest concern must always rest with disadvantaged and vulnerable groups. These groups are often hidden, live in remote rural areas or shantytowns and have little political voice."* - ***Dr Margaret Chan World Health Organisation Director-General***

• C) Globalization and Poverty in India

- In July 1991, India started a liberalisation process, holding the promises that the new economic reforms would lead to increased flows of Greenhouse FDI and considerable improvements in the living standards.
- Poverty incidence in rural India : 220.1 million people living below the poverty line i.e nearly 21.1% of the entire rural population (World Bank, 2007)



- About 370 million workers constituting 92% of the total workforce in a country are employed in the unorganized sector. They account for 64% of Indian GDP.

• C) Globalization and Poverty in India

- Market-oriented Economy vs Caste-based society
- Hindu = 82% of the population
- 4 orders:
 - Brahmins (priests)
 - Warriors (kshatriya)
 - Traders (vaishya)
 - Servants (shudra)+ Untouchables (pariah)
- The cast-system is based upon religious distinctions between social activities and functions with the importance of the concept of purity. It is worthwhile investigating the implications of this social order on the activities undergone in the marketplace.
- Two weapons against poverty:
 - Empowerment: *“to gain power to make sure that the voice of the poor is heard”*
 - Opportunity: *“possibility to take part in the growth process”*.

Table 1.1 India Data Profile 1/3

Source: *World Development Indicators database*, April 2007

	2000	2005
Population, total	1.0 billion	1.1 billion
Population growth (annual %)	1.7	1.4
Poverty headcount ratio at national poverty line (% of population)	28.6	..
Life expectancy at birth, total (years)	62.9	63.5
Fertility rate, total (births per woman)	3.1	2.8
Mortality rate, infant (per 1,000 live births)	68.0	56.0
Mortality rate, under-5 (per 1,000)	94.0	74.0
Births attended by skilled health staff (% of total)	42.5	..
Malnutrition prevalence, weight for age (% of children under 5)
Immunization, measles (% of children ages 12-23 months)	56.0	58.0
Prevalence of HIV, total (% of population ages 15-49)	..	0.9
Primary completion rate, total (% of relevant age group)	75.4	..
School enrollment, primary (% gross)	98.8	..
School enrollment, secondary (% gross)	47.9	..
School enrollment, tertiary (% gross)	10.2	..
Ratio of girls to boys in primary and secondary education (%)	76.9	..

Table 1.1 India Data Profile 2/3

Source: *World Development Indicators database*, April 2007

	2000	2005
GDP (current US\$)	460.2 billion	805.7 billion
GDP growth (annual %)	4.0	9.2
Inflation, GDP deflator (annual %)	3.5	4.4
Agriculture, value added (% of GDP)	23.4	18.3
Industry, value added (% of GDP)	26.2	27.3
Services, etc., value added (% of GDP)	50.5	54.4
Exports of goods and services (% of GDP)	13.8	20.5
Imports of goods and services (% of GDP)	14.6	24.2
Gross capital formation (% of GDP)	24.8	33.4
Revenue, excluding grants (% of GDP)	11.9	..
Cash surplus/deficit (% of GDP)	-3.9	..
Time required to start a business (days)	..	71.0

Table 1.1 India Data Profile 3/3

Source: *World Development Indicators database*, April 2007

	2000	2005
Market capitalization of listed companies (% of GDP)	32.2	68.6
Military expenditure (% of GDP)	3.1	2.9
Fixed line and mobile phone subscribers (per 1,000 people)	35.4	127.7
Internet users (per 1,000 people)	5.4	54.8
Roads, paved (% of total roads)	47.5	..
High-technology exports (% of manufactured exports)	5.0	..
Merchandise trade (% of GDP)	20.4	28.5
Net barter terms of trade (2000 = 100)	100.0	..
Foreign direct investment, net inflows (BoP, current US\$)	3.6 billion	6.6 billion
Long-term debt (DOD, current US\$)	95.6 billion	114.3 billion
Present value of debt (% of GNI)	..	15.9
Total debt service (% of exports of goods, services and income)	14.5	..
Official development assistance and official aid (current US\$)	1.5 billion	1.7 billion
Workers' remittances and compensation of employees, received (US\$)	12.9 billion	23.7 billion

II - Research and methodology

A) Background

- Need to emphasize the qualitative aspects of the growth process → better distribution of opportunities (access to health care, nutrition, clean and sustainable environment...). Those aspects go hand in hand with a shift towards a global competitive environment.

B) Formulation of the Research problem

- How to increase purchasing power, promote entrepreneurship, generate income among rural masses of India by investing in human capital and using social marketing applied to health care?

II - Research and methodology

C) Usefulness of the study

- This study aims at a better understanding of the social determinants of economic growth at the micro and the macro level in rural India in the high-pressure context of globalisation.

D) Survey of existing literature

- Concept of social marketing in India (Neelamegham, 1994)
- Concept of underdevelopment in India: “Indian Economy” (Sankaran, 1999), “Development as Freedom” (Sen, 1998)
- Health Care in India: no single comprehensive study encompassing all aspects; World Bank and World Health Organisation publications.
- NGOs in India (Kandasami, 1997)

II - Research and methodology

E) Working hypothesis

- Our working hypothesis is that the critical mass of consumers of health care in rural India may be reached through the design of an adequate institutional framework as well as renewed partnerships between private and public institutions, small-scale enterprises and multinational corporations, business and non-governmental organisations, between the formal and the informal sectors.

F) Objectives, design and sources of the study

- Objective 1: to provide a comprehensive and multidisciplinary analysis of the political, economic, environmental, social and technological factors influencing health care in rural India. This will require a PEEST analysis.
- Objective 2: to provide an illustration of the empowerment concept through the identification of new business and social opportunities for selected target groups in rural India.
- Objective 3: to summarize findings, to underline the limitations of the pure microeconomic approach, to emphasize the need for new public and private synergies and more coordinated macroeconomic policies to face the challenge of globalisation.

III - Analytical Framework: PEEST analysis

- Introduction: We provide a few useful definitions hereafter:
- Health: general state of physical, social and mental well-being, which does not merely consist of the absence of infirmity (World Health Organisation)
- Health Care System: people and actions whose primary purpose is to improve health.
- Disease: “the distinction between health and disease is essentially arbitrary and rests mainly on a consensus of what is acceptable (Smith, 1968)”

III - Analytical Framework: PEEST analysis

- **3.1) Political factors**

- **3.1.1 Strategic Objectives of Planning:**

- The example of the Integrated Rural Development Programme (IRPD)
 - Designed in March 1976, its objective (similar to the concept of social marketing) can be seen as “*improving living standards of the masses of low-income population, residing in rural areas, making the process of rural development self-sustaining*” (World Bank, 2005)

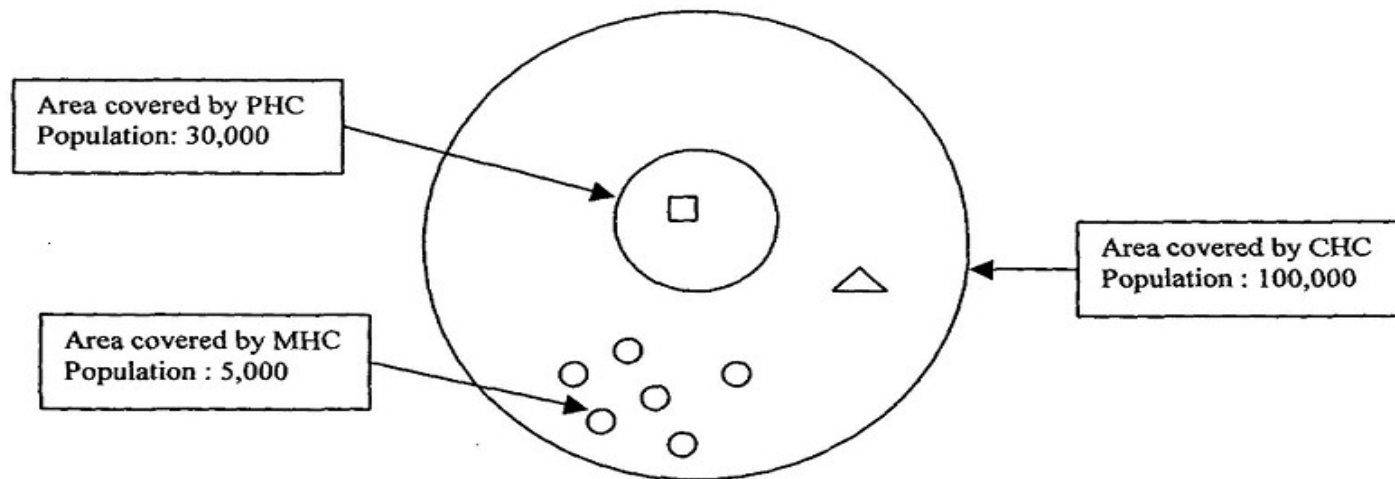
- **3.1.2 Political and Administrative Health System in India**

- Administrative Set-up of the Public Health System

III - Analytical Framework: PEEST analysis

➤ 3.1.3 Aspects of Public Health Care in Rural India

➤ Example of Geographical Coverage of Public Health in Rural India



Primary Health Centre (PHC) covering a population of 30,000



Mini-Health Centre (MHC) covering a population of 5,000



Community Health Center covering a district block: population of 100,000



Source: The Institute of Community Health, Madras (2000, personal communication)

III - Analytical Framework: PEEST analysis

➤ 3.2.1 Definition of Health Economics

- Economic relationships between the actors of the health system

➤ 3.2.2 Application of Health Economics:

- the Global Pharmaceutical Industry and the Pricing of Drugs in rural India
- The price of drugs is not the sole obstacle to enhanced access to health care; other factors exist such as infrastructures (hospitals and dispensaries), the number and the quality of training of the various actors in the health care system, the level of education of the population, which helps them understand the importance of hygiene and medical treatments. The pharmaceutical industry has already taken many initiatives:
 - Free delivery of 50 million anti-polio vaccine doses (Aventis Pasteur)
 - Considerable investments in R&D programmes
 - A special endeavour towards Aids patients: a concerted action by five major multinational pharmaceutical groups (Boehringer Ingelheim, Bristol Myers Squibb, Glaxo-Wellcome, Merck & Co and F. Hoffman – La Roche).
 - The rise of generic products

III - Analytical Framework: PEEST analysis

- **3.2.3 The Rise of the Private Sector in India:**
 - Distribution of Health Facilities and Beds in India between the Rural/Urban Areas and the Public/Private Sector
 - Distribution of Private Indian Doctors Trained Abroad and Returned
 - Availability of Doctors by type in India

- **3.2.4 Segments of the Health Care Market in India**

- **3.2.4.1 *The Indian Pharmaceutical Market***

- **3.2.4.2 *The Medical Electronic and Consumables Market***
- **3.2.4.3 *The Biotechnology Market***
- **3.2.4.4 *The Vaccine Market***
- **3.2.4.5 *The Natural Health Care Market***
 - A successful example: Indfrag Biosciences Ltd.
 - Strategic Matrix for the Indian Health Care Industry

III - Analytical Framework: PEEST analysis

- **3.3 Environmental Factors**

- 3.3.1 Definition (physical, biological and socio-cultural)
- 3.3.2 Application of Social Marketing: Water Supply in India.

- **3.4 Social and Demographic Factors**

- 3.4.1 Statistical Indicators of Human Development in India
- 3.4.2 Importance of Maternity and Child Welfare

III - Analytical Framework: PEEST analysis

➤ 3.4.3 Empirical Study: Statistical Analysis of the Correlation between Family Planning Practices and Birth Rates in Rural India

➤ Introduction

➤ A) Definitions:

Family planning: “a way of thinking and living that is adopted voluntarily, upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote health and welfare of the family group and thus contribute to the social development of the country (World Health Organisation)”.

Birth rate (BR): number of births per year / number of married¹ couples (‰)

Death rate (DR): number of deaths per year / total population (‰)

Growth rate (GR): Birth rate (‰) – Death Rate (‰)

Couple Protection Rate (CPR): the percentage of eligible couples effectively protected against child birth by one of the approved methods of family planning

Eligible couples (Ecs): married couples wherein the wife is in the reproductive age.

¹ It is worth mentioning that a child is not «legal » in India unless the parents are married

III - Analytical Framework: PEEST analysis

➤ B) Statement of the problem

To study the correlation between the practice of family planning methods by eligible couples and effective birth rates in the area covered by a community health centre.

➤ C) Methodology and selection of the field

The data referred to originates from the Institute of Community Health of Madras in Tamil-Nadu, which is in charge of the provision of health care for a population of about 100,000 inhabitants. The population covered is divided into 14 Mini Health Centres (MHCs) located in small village areas. Each MHC does its own data collection on the local population: average family size (AFS), growth rate (GR), birth rate (BR), death rate (DR), infant mortality rate (IMR), couple protection rate (CPR)...

III - Analytical Framework: PEEST analysis

Table 4.2: Characteristics of the Population Sample Data for the 14 MHCs

MHC	Pop.	Families	AFS	BR	DR	IMR	CPR	GR	Ecs
1	9486	2519	3.8	18.1	2.8	17	52.5	1.5	1873
2	11373	2781	4.1	16.8	3.1	14.4	45	1.4	2089
3	8227	2145	3.8	16.7	4.1	13.1	48.1	1.3	1603
4	7199	1677	4.3	15.6	4	22.1	35.5	1.2	1446
5	7075	1559	4.5	19.6	2.3	8.1	63.2	1.7	1126
6	9380	2049	4.6	18	2.3	8.1	63.2	1.7	1126
7	7994	1545	5.2	15.2	4.6	19	66.8	1.1	1172
8	7489	1442	5.2	15.2	4.6	19	66.8	1.1	1172
9	5396	1058	5.1	11.2	8.6	40	57.6	0.3	852
10	5401	1050	5.1	14.7	5.6	56.8	46.2	0.9	886
11	5170	1093	4.7	16.1	3.7	24.1	48.9	1.2	767
12	5546	1201	4.6	18.7	3.4	28.9	40.3	1.5	1106
13	5102	901	5.7	13.8	2.8	36.1	59.9	1.1	889
14	4475	964	4.6	14.4	3.6	31.3	55.6	1.1	703

III - Analytical Framework: PEEST analysis

➤ D) Purpose of the Empirical Study:

To investigate the impact of family planning practices on the measured birth rates; ultimately, the question is “could a model be developed to predict the effects of CPR variations on the birth rate and therefore support family planning practices?”

➤ E) The linear regression model

We assume a linear relationship between couple protection rate and the birth rate.

$BR = a \text{ CPR} + b + \varepsilon$ where (a,b) are two linear coefficients and ε is a stochastic variable taken as a residual.

Result of the least square method:

$R^2 = 0,0256$

$BR = 18.09 - 0.04CPR$

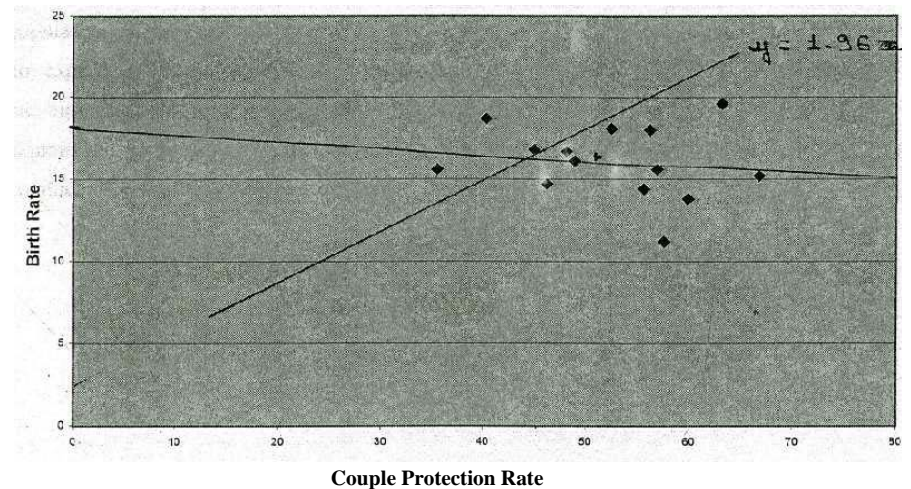


Figure 1: Graph of the estimated regression equation for $BR = 1.96 + CPR*0.3$

III - Analytical Framework: PEEST analysis

➤ F) Hypothesis testing for the correlation coefficient

The selected samples are the CPR and BR data ($n = 14$). With a level of significance of 95%, we use a (two-tailed) Student-test:

$t_c | = 3,21 < t^* = 4,303 \rightarrow$ the null hypothesis $\{H_0: r = 0; \text{no significant correlation between CPR and BR}\}$ is accepted.

Conclusion: Our very simple model aiming at the prediction of birth rates in rural India is not robust enough. We need to take into consideration the impact of other factors influencing the birth rates; need for future research in order to assess the need for family planning in relation to the level of development of a country. Areas to be thoroughly investigated:

- The change of social attitudes towards child birth (especially female birth)
- Economic uplift and generalised access to public health and education services.
- Social and economic empowerment of women in rural communities

III - Analytical Framework: PEEST analysis

• 3.5 Technological Factors

➤ 3.5.1 The impact of Globalisation on Health Care Services in India

➤ 3.5.2 International Trade and FDI in Health Services

➤ 3.5.2.1 *Cross-border trade in health services*

➤ 3.5.2.2 *Consumption abroad*

- outward flow of Indian patients into developing countries
- outward flow of Indian patients into developed countries
- inward flow of patients from developing countries into India
- inward flow of patients from developed countries into India

➤ 3.5.2.3 *Commercial presence*

- outward flow of Indian capital into developing countries
- outward flow of Indian capital into developed countries
- inward flow of foreign capital from developing countries into India
- inward flow of foreign capital from developed countries into India

III - Analytical Framework: PEEST analysis

➤ 3.5.3.4 *Movement of Health Personnel*

- outward flow of health personnel into developing countries
- outward flow of health personnel into developed countries
- inward flow of health personnel into developing countries
- inward flow of health personnel into developed countries

➤ 3.5.4 **Exploiting New Synergies: a Model for Corporate and Public Cooperation: the Example of Global Alliance for Vaccination and Immunisation (GAVI)**

- GAVI is a worldwide partnership and a historic alliance of public and private sector partners assembled in a global network; partners include: Bill and Melinda Gates Children's Vaccine Program, a NGO in Seattle called Program for Appropriate Technology in Health (PATH), International Federation of Pharmaceutical Manufacturers Association (IFPMA), UNICEF, World Bank, World Health Organisation (WHO), the Rockefeller Foundation and various public and research institutions...

III - Analytical Framework: PEEST analysis

➤ 3.5.5 Health Information Systems:

- *is an umbrella term used to encompass the rapidly evolving discipline of using computing, networking and communications methodology and technology to support health related fields such as medicine, nursing, pharmacy and dentistry (Mandil, 1992)”*

➤ 3.5.6 e-health

- *“is the practice of health care using the Internet as a mode of audio, visual and data communication; this includes health care delivery, consultation, diagnosis, treatment, education and transfer of health related data (Gupta et al, p.86)”*

➤ 3.5.7 Narrowing the digital divide: two examples of Local Development Initiatives

- A) e-commerce way to lift a village (www.villageleap.com)
- B) Eye-camps in India (Dr Venkataswamy) comparison with Mac Donald's:
“Mc Donald's have been able to provide good, inexpensive food all over the world. They are using modern management techniques to do everything inexpensively and very efficiently. If a poor man can afford a hamburger, why can't we do the same for clean water and basic health care? (Marseille, 1994)”

Conclusion: *“If we walk together, a path will emerge”*

Local saying in the Indian State of Andhra Pradesh, translated from Telugu

It is only through rapid economic growth that India will be able to generate the resources to invest in its people and reduce poverty. Investment in health care is positively linked to productivity growth and will lead in return to sustainable growth. There is further scope for social marketing in rural India, which requires the set-up of an appropriate institutional framework as well as new partnerships between the public and the private sector. The effective social marketing of health care in rural India requires the involvement and the cooperation of society as a whole. The profit-motive is not the sole driver of socio-economic change. Government policies, business growth and innovation all have an active role to play. At the interface between the public and the private sector, there is also scope for synergies between small-scale industries (SSIs), transnational corporations (TNCs) and non-governmental organisations (NGOs).