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CONSUMER DEMAND & SATISFACTION

**The Hidden Key
to Successful Privatization**

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EXECUTIVE SUMMARY

Government funding for health is under pressure throughout the Asia Near East (ANE) region. At the same time, privatization (the transfer of responsibility for health care services from public to private sources of revenue) is much more widespread than previously recognized in the region.

Marketing is the way through which privatization works: Product, Place, Price, and Promotion are a practical framework for decision making in the private sector. Marketing can have a negative impact if it is manipulative and exploitative, but modern marketing which gives priority to the consumer service over the sale of products offers real opportunities to improve efficiency and quality of service. A.I.D. has a comparative advantage in helping develop privatization schemes which promote better quality, provide more service, ensure more equitable distribution of resources, and improve the cost-efficiency of health sector programs.

Consumer satisfaction is one important key to successful privatization and responsible marketing. Actually, it's also the key to good public services as well. It means listening to people, creating beneficial products/services they want; making the positive aspects of those products/services easily recognizable, understandable, available, and attractive; helping people use products/services properly so that they have rewarding results; charging a fair price which adds value to the product/service; and then staying alert for changes in people's needs over time.

Several important issues include:

- profitability to make programs sustainable;
- pricing strategies to control inequities;
- competition to keep quality care high;
- public/private partnerships to compensate for potential inadequacies and inequalities in private sector approaches;
- consumer education to avoid pandering to trivial desires;
- consumer research to make products, distribution, and appeals attractive to people;

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- respect for community participation to help shape individual consumer choices, particularly in traditional societies;
 - training to help prepare physicians, nurses, and other providers for a more consumer-oriented interaction style with patients.

The Asia Near East Bureau already has considerable experience with various forms of privatization, including helping governments use private agencies to improve the quality of advertising and consumer research, partially subsidizing private distribution networks for family planning services, and investigating new pre-pay systems such as health care franchises. In addition, the U.S. is undergoing an enormous proliferation of private service delivery systems, with a resulting growth in models, techniques, and expertise. These early experiments are demonstrating that the real-world health system is a marketplace of consumer/provider, public/private options which offer a variety of opportunities for optimizing health benefits at lower costs through creative combinations heretofore thought impossible.

The principal lessons emerging from these shifts that relate to consumer demand and satisfaction are that:

- Piecemeal programs don't work.
- Consumer research is fundamental to success in all four marketing domains: product, place, price, promotion.
- Programs must be prepared to monitor and meet changing consumer needs.
- Simplicity of product, message, and distribution is essential.
- Offering a range of product/service options increases acceptance.
- Private sector management requires a value orientation toward the consumer, which must be created explicitly in health care professionals through training and practical experience.

Historically the Agency has invested comparatively few dollars in demand-oriented approaches to HPN programs in the ANE region. The family planning, and to a lesser degree, the child survival, communities have led the way with social marketing approaches. But these have been largely dependent on the provision of subsidized commodities such as contraceptives and ORS packets.

Three strategic options face the Agency now as it considers the future of privatization. First it may continue its present course relying heavily on subsidized commodity programs plus significant investments in improved public services. Secondly, it could abandon all private sector support in favor of programs designed to help the public sector compensate for declining services, quality, and budgets. Or thirdly, it could explore private sector and public/private sector partnerships less dependent upon subsidized commodities which use the profit motive as the key to sustainability and competition as the key to service quality.

This paper argues that, whatever the strategic choice, competition for the hearts and minds of consumers is the key to success. People already make choices. There is no monopoly on HPN services anywhere in the region. The poorest segments of society often decide to do nothing rather than go to humiliating public services, others prefer traditional homeopathic healers, many others rely on self-medication through pharmacists, while the more affluent go to an ever increasing array of private alternatives.

The resulting health care is poor for two reasons: too many of the alternatives are clinically unsound and/or too costly; and the consumer often chooses the poorest available options. Therefore, to improve the quality of HPN services we must improve the quality, and some would argue the number, of available service options, but at the same time we must motivate and educate consumers to make more enlightened choices. Indeed we argue here that the very design and selection of HPN services should emanate from a profound understanding and respect for the consumer. As privatization opens more alternatives and competition increases, understanding consumer demand and satisfaction becomes ever more critical to entrepreneurial and clinical success.

I.

INTRODUCTION: THE HEALTH MARKETPLACE AND CONSUMER DEMAND

Increasing foreign debt, growing population pressure, stagnant or diminishing health budgets, and the reallocation of limited resources to the "productive" rather than the social sector of many economies are forcing a conceptual shift in our thinking about health service delivery. While international donors have largely focused on the supply side of primary health care (vaccines, health posts, provider training, etc.), governments continue to invest heavily in curative hospital-based services. Pharmaceuticals are being used less discriminately as self-medication and over-prescribed medication, particularly antibiotics, account for an ever growing percentage of consumer expenditures. The traditional answer almost everywhere has been to invest in improving supply-side quality--training, supplies and management which support government bias toward centrally planned and managed supply oriented approaches.

Privatization means the reallocation of responsibility for health care services from public to private sources of revenue. The term implies the active transition of services dependent upon general revenues (public) to those paid for by individual consumers (private). The degree of shift, the kinds of services moved from one sector to another, and the procedures for making the transition are varied--and have significant impact on the efficiency and social equity of the resulting mix. If properly managed, privatization offers significant opportunities to improve and expand health care services. But privatization also holds the potential for increasing inequity, providing trivial services, and increasing overall cost. This suggests that A.I.D. should understand and actively support privatization efforts which meet the goals of quality, equity, and cost efficiency, but remain alert to improvements necessary in public systems to compensate for areas where privatization is clearly inadequate to meet these goals.

Three models of privatization appear to be emerging:

1. **Public Sector Improvement Model**

Government employs private sector firms to upgrade the advertising, consumer research, cost-recovery and distribution systems of public programs or adds demand-driven cost-recovery schemes to existing financial systems. Many of the Agency's child survival programs have used this approach.

2. **Subsidized Private Sector Model**

Independent, but subsidized local businesses are established to complement government programs. Much of A.I.D.'s investment in contraceptive social marketing has taken this form.

3. **Private Sector Model**

Government works with existing commercial firms to increase direct private sector participation through deregulation, tax incentives, and creative pricing supports. Child survival programs in Turkey and the Philippines are exploring this model; and new schemes, such as the creation of health care franchises, fall into this classification.

The conceptual underpinnings of the move toward privatization are two fold. First, there is now hard evidence to suggest that people, even people of modest income, are willing and able to pay for health services. Studies like those in Bangladesh show that consumer expenditures on health care can be three to ten times those budgeted for health in the public sector. Secondly, experience worldwide suggests that private systems can be more cost efficient and are more able to adjust to changing consumer needs than are public systems.

Private sector systems are no guaranteed panacea for all of our health care problems. Private consumers, like public systems, often spend in ways which are therapeutically ineffective and inefficient. Private systems often exclude those most in need and exacerbate social inequities. But the transition of some services from public to private sector systems seems both inevitable and beneficial. The challenge is to ensure that the proper services are transferred, and that the transition is as non-disruptive as possible. Our goal should be to ensure that this transfer results in new delivery systems and new purchasing practices which help improve quality of care, relieve public costs, expand popular access, and foster greater overall financial efficiency.

A new genre of health care programs, many of them pioneered in the ANE region, are opening new perspectives on this fundamental shift toward demand-driven solutions. Success in child survival efforts in Egypt, contraceptive sales in Pakistan, Bangladesh, and Sri Lanka have showed that entrepreneurship can help expand access and alleviate the public cost of programs. New programs in Indonesia, the Philippines, and Turkey are also targeting various privatization strategies. Each of these programs has been marked by a respect for demand-driven tactics. Consumers, not providers, have been placed at the center of decision making. In Egypt, consumer research guided not only the design of clever TV spots, but led to the production of a 200 ml. packet of ORS, and the decision to open a major commercial sales channel. In Pakistan, the sale of Sathi condoms was driven by sophisticated sales force management and a marketing perspective that showed consumers often respond best to face-to-face sales. In Nepal, traditional medical practitioners are being mobilized as a rural sales force. Similar work in the Philippines on ORS, and Bangladesh on contraceptives is demonstrating the power of "consumer-think."

This approach is finding expression in public as well as private sector programs. Indeed, the concept of social marketing has opened the door to public/private sector partnerships--Ministries of Health turning to advertising agencies, collaborative distribution systems established between governments and pharmaceutical

companies, the development of joint government/private agency consumer research programs, etc. Each source, whether public or private, offers differential therapeutic and economic efficiencies. These early experiments are demonstrating that the real-world health system is a marketplace of consumer/provider, public/private options which offer a variety of opportunities for optimizing health benefits at lower costs through creative combinations heretofore thought impossible.

The thesis of this issue paper is that any discussion of privatization must include a recognition that **consumer satisfaction** is central to success. As services shift from public to private sector, consumer satisfaction--what people want, how to educate their desires and make them better consumers, how to reach and motivate them to use new services correctly, how to maximize their willingness to pay for services, and how to create sustainable systems which promote consumer participation--becomes ever more critical. Indeed, we have also seen that consumer satisfaction is fundamental to public services such as increasing EPI coverage, promoting ORS, and assisting informed contraceptive choice. This movement toward greater attention to consumer satisfaction is part of the movement toward greater popular participation in health care. It is respectful, in fundamental ways, of people's rights and their ability to choose and guide their own future.

Increasingly, our experience suggests that considerable progress can be made by boldly addressing consumer satisfaction and the role of private sector providers. Studies of what people spend are useful but insufficient to guide a demand-driven shift toward privatization. Understanding the patterns and determinants of consumer demand from psychosocial, cultural, and economic perspectives will take on increased importance. We must know why people spend on some items and not on others, and more importantly, we must predict what new services people will desire as more alternatives become available through marketplace competition. Positive (health promotion, disease prevention, and curative) linkages and partnerships between public and private sources which foster greater consumer participation need to be further explored and understood.

To borrow a phrase from one of America's hottest new marketing books entitled Bottom-Up Marketing (Ries and Trout) . . .

To become a great strategist you have to put your mind in the mud of the marketplace. You have to find your inspiration down at the front, in the ebb and flow of great marketing battles taking place in the mind of the consumer.

II.

MARKETING: OPENING THE DOOR TO CONSUMER SATISFACTION

Many associated with A.I.D. think about marketing as advertising. Mass media, clever slogans, public relations, glamour and glitz leap to mind as the organizing of successful marketing. In the broader concept of "selling," distribution, pricing, and packaging also become important as organizing elements. Marketing, for almost all of us, is a way to get people to do what we want them to do--buy a condom, mix ORS properly, or use a new weaning food. We cling to the old adage that the way to make a million bucks is to "build a better mousetrap and then market it." We are attracted and repelled at the same time by the notion of innocent consumers driven into a frenzy of mousetrap-seeking behavior by a small group of clever and manipulative marketers.

But today we know that people don't buy mousetraps--even the best mousetraps in the world, promoted through the world's most creative campaign--unless they have lots of mice that they want to get rid of. Modern marketing does not begin with a product but with people we call consumers. Marketing is both a concept of exchange and a framework for decision-making that is particularly applicable to the goal of increased consumer satisfaction and participation.

Marketing and the Concept of Exchange

Marketing is not a technology for getting people to do what we want--it is a technology for identifying what we can give people that they want badly enough to take in exchange for something we want. **X for Y** is at the heart of the marketing philosophy. That may mean a condom for \$.20, an ORS packet for the extra time to prepare and give a better medicine to a sick child, or a reduction in the number of unprotected sexual partners for a sense of greater sexual satisfaction, or for less sexual anxiety.

We will use marketing in this paper as Philip Kotler uses marketing when he says:

The concept of sensitively **servicing and satisfying human needs**. . . Perhaps the short-run problem of business firms is to sell people on buying the existing products, but the long-run problem is clearly to create products that people need. By this recognition that effective marketing requires a consumer orientation instead of a product orientation, marketing has taken a new lease on life and tied its economic activity to a higher social purpose.

This is not an attempt to cop out of the hard-nosed world of cutthroat competition. It's not an oblation to social responsibility. It is the practical recognition that consumers are not stupid nor their desires totally banal. They are. . .we are . . .complex creatures who make the most extraordinary changes when the right combination of knowledge, willingness and opportunity come together, and who resist the most obvious and logical changes when they don't. The fundamental premise of this paper is that successful privatization rests, at least partially, on a healthy respect for consumers, and the belief that modern marketing offers one of the best frameworks for understanding and satisfying consumer needs.

Marketing as a Framework for Decision Making

The marketing framework is most easily characterized by the "marketing mix"--product, place, price, promotion. As we apply this framework to health, family planning, and nutrition, it takes on those special characteristics we have labeled "social marketing."

Products are the physical objects, services, benefits, persons, places, organizations, and ideas which serve as the focus of exchange between the marketer and the consumer. Products are not fixed but malleable: they should be designed to satisfy consumers. When Coca Cola thought people wanted a sweeter product, they changed a 100 year-old formula and created the new Coke--subsequently, they reinvented Classic Coke when consumers complained. In social marketing products are less malleable: the EPI cycle cannot be easily altered; flavored ORS

may have some consumer benefits but powerful public health officials oppose it; and a new weaning food is limited by both clinical and food availability constraints. Social products are far more constrained within the boundaries of technology limitations and often we are forced to promote products without optimal consumer satisfaction.

Price is the full cost of the product--including money, time, status, convenience, etc. Price is a key to increasing the volume and profitability of exchange. Monetary price should add value as well as cost to a product. Just as some people pay more for a perfume in Bloomingdale's because they feel it is "better quality," so a typical health care consumer may prefer to pay for a service rather than get it free, because it's "got to be better if I pay for it." Price, particularly the price of complex behaviors like safe sex, contraception, and growth monitoring must be calculated on the basis of prestige, time, embarrassment, and social power as well as monetary costs. These calculations are far more complex to understand, and yet equally powerful as motivators for positive change. Again, they emphasize the need to center decision making on consumer satisfaction as the key to maximized "profits."

Place is distribution. Where will the product be available and how will it get there? A great product, priced optimally and in high demand but which is not available, is an obvious loser. The social marketing aspect of the place dimension is two fold. The first goal is to expand the number of distribution points to increase easy access to the product or service. The second is to improve the quality of attention provided at the distribution point. Unless we understand where the consumer can and will go to purchase a condom, receive an immunization, or monitor their child's growth, we risk establishing useless distribution points. Unless we know what the consumer expects and values from their contact with physicians, in addition to effective treatment, we risk alienating the consumer and forcing him or her into the arms of apathy, avoidance, and competitors. Both aspects (distribution points and interaction style of distributors/providers) put consumer satisfaction in the center stage of the "place" dimension.

Promotion is not just advertising. It is any means--publicity, personal contact, incentives, atmospherics, public relations--to deliver persuasive communication about the product, its price, and its availability. Effective promotion combines various channels, builds upon existing communication networks, both modern and traditional, and concentrates efforts on a narrow set of key benefits which appeal to the intended consumer. Promotion often faces special constraints in social marketing. Mass media may be denied to controversial products like condoms or safe sex. Motivational appeals are complex and require more sophisticated consumer research than perfumes or toothpaste. And this promotion must be carried on in much more constrained societies. But A.I.D.'s experience with social marketing over the past eight years has shown that these obstacles are surmountable and that complementary, alternative approaches to supply-side support are practical and beneficial.

III.

CONSUMER SATISFACTION AND THE ISSUES OF PRIVATIZATION

Social Equity

The battle for privatization may be waged first over the issue of equity and consumer segmentation. Many physicians will argue that hospitals must serve everyone--the businessman will counter-argue that success depends upon segmenting markets, choosing a niche, and establishing predominance. The physician will accuse the entrepreneur of cream-skimming--the businessman will accuse the doctor of naivete. The answer lies embedded in the key dilemma: "can specialization based on profitability be consistent with achieving the social purpose of health care?" The answer seems to be possibly but not necessarily. Specialization can lead to increased volume and lower costs through economies of scale. That benefits everyone. But what of the unprofitable services that no one makes money on?

A rich variety of health care pricing and marketing strategies has emerged over the past 20 years which helps redress the inequitable distribution of services. The level of pricing sophistication in the West has increased dramatically as competition and cost have increased. Some of these tactics offer clues to redressing inequity and providing expanded services.

The following section introduces the reader to examples of modern day pricing jargon to illustrate that pricing is a complex but well-studied field. Lessons being learned from this experience in the West can be adapted to Asian realities (many already have been), and help reduce the social inequities of some privatization policies.

For example, differential pricing strategies such as Second Market Discounting help firms adjust the price of one service to meet the needs of different consumer groups (discounting for new members or offering both branded and generic products at different prices). These strategies help cross-subsidize segments of a market by using profits from one consumer to finance lower

profit margins from other consumers.

Competitive pricing strategies are used to exploit a firm's competitive position (for example, cheap production costs) and drive competition out of a market. The relevance here may be to force the efficient segmentation of services. Imagine a private sector offerer in Manila who develops a competitive advantage in health education materials (cheaper research costs, cheaper printing costs, etc.). This could help alleviate needless duplication of these services in public facilities and allow those public institutions to focus on their own competitive strengths.

Product line pricing such as price bundling (lower prices for treatment services if prevention services are also accepted) is a way to use costs to market less popular services by linking them with more popular ones. We can imagine a health franchise in the Philippines which gives a discount to patients on heart medication if the patient also agrees to join the affiliated health club.

Decisions about pricing strategy stem from an understanding of the marketing goal and the consumer's responsiveness to pricing elements. Pricing is one of the most powerful tools we have to influence consumer satisfaction and redress inequities as they develop. Modern pricing strategies, as this discussion illustrates, go far beyond the traditional stereotypes of "ways to make a fast buck."

Quality of Care

Quality of care is also a concern as privatization expands. As managers cut costs, will quality of health care suffer? Many critics believe it will.

Quality is a function of many inputs. The selection of physicians and care providing. Their skill and motivation to service. The time they give to patients and families. The facility, equipment and supplies available to provide care in cost-effective ways. The willingness to support outpatient and home care as well as the investment in prevention. Each of these factors carries

a cost and the degree to which corners are cut, quality can suffer. Countervailing forces--professional ethics and a belief by many health care professionals that quality is an end in itself--should not be overlooked or denigrated, however. These are powerful forces operating to maintain and improve quality and service.

But ultimately the most powerful force is marketplace competition and enlightened consumer satisfaction itself. Quality selection is after all a marketing decision. If people can choose, they will choose what they value the most. Our first task is to understand what consumers mean when they say "quality care," and then help educate them to be more intelligent consumers of health care services.

Present research in the U.S. has opened a broad range of issues which constitute quality in the eyes of the U.S. consumer. The principal ones are listed in Annex 1--convenience, friendliness, and caring rank high, along with cost. Which of these will have significance for consumers in the Philippines, Indonesia, Pakistan, or Thailand? We just don't know. We will need to study what specific evidence different consumer segments in ANE accept as indicators of quality care.

A study of 400 U.S. residents suggests the level of detailed information that may be necessary to understand consumer definitions of quality. As noted in Annex 2, in the U.S. informativeness was defined as "using understandable terms," "explaining procedures," "taking time," while availability was defined by "offers of flexible/extended hours" and "provides an answering service coverage at all times."

A telephone answering service may not be important to an Indonesian or Pakistani woman--but something will be, and it probably won't be just where her physician studied medicine. Variables such as traditional values, homeopathic beliefs, self-medication practices, and treatment expectations will play a vital role in how effectively a health service in ANE identifies the proper marketing niche and survives competitively over time. Medical ethnographies, along with targeted consumer research, will be

needed to understand the interrelationship among traditional and modern health values. Important expectations may change from one consumer culture to another--but we can fully expect that privatization will demand a much more cogent understanding and responsiveness to consumer expectations than that provided now in most public sector institutions. Again consumer satisfaction emerges as a fundamental key to successful public/private transition.

Consumer Satisfaction: Meeting Real Needs or Satisfying Trivial Desires

A rural mother really "needs" to vaccinate her child, but she "desires" to purchase a useless antidiarrheal to give her child symptomatic relief. What is the health system's response? This is the classic dilemma of public health versus commercial product marketing. The job of public health is to deliver social services that people clinically need but often don't want or don't understand, while the entrepreneur's responsibility is to give people what they want, as long as it doesn't harm them. A sensitive understanding of consumer demand can be the key to achieving both goals.

Let's take the example above. Why does a mother prefer antidiarrheals to vaccination or ORS? The answer is obviously multifaceted--behind it lies a complex chain of values, information, influentials, and constraints. If we can understand these, they may provide useful clues to helping her make a better choice. Perhaps she uses antidiarrheals because her doctor prescribed them, thereby suggesting our first task may be physician education and incentives to promote ORS. Perhaps our mother is like most of us--she likes to see firm (no pun intended) results. Antidiarrheals give her results--the diarrhea appears to stop. But perhaps she also worries when her child stops eating. One benefit of ORS is to help restore appetite. We could stress, perhaps through clever cartoon figures or attractive television advertising, that one benefit of ORS is to restore her child's appetite and activity. We might also explain about dehydration, and expect that gradually her new understanding of dehydration coupled with a benefit she already values (appetite) will motivate her to try ORS.

Real needs (clinically beneficial practices) can be transformed into things people also want--not always for the same reasons presented in medical books perhaps, but for reasons which people can understand and accept. The transformation of clinical needs into consumer desires is the business of enlightened consumer education.

Indeed, in the West we see a growing synergism between new medical knowledge and the marketing of health products--a synergism driven often by enlightened consumer satisfaction. Take the example of high fibre cereals. New data on fibre emerges from the health establishment. A small sub-set of predisposed consumers are immediately influenced and seek high-fibre products in exotic health food stores. The commercial cereal industry sees a marketing opportunity to appeal to the American health craze and develops new high-fibre cereals. A mass advertising and distribution campaign links the new cereal to better health and educates millions of people who were previously ignorant of the new medical findings. Millions benefit from the increased availability and acceptance of high-fibre cereals. It doesn't always happen this way. But it can happen this way if consumer satisfaction is interpreted to mean "enlightened" consumer satisfaction.

Promotion, Advertising, and Communication

Promotion is the bridge of persuasion between the provider and the consumer; one means of developing our "enlightened" consumer. The function of promotion is to highlight the principal benefits of a product or service in ways which reach the audience, capture the consumers' attention, appeal to their values, reduce their mental obstacles against adoption, and increase their willingness and ability to find and use the product. Promotion can be used to enlighten and guide the consumer to more educated choices, or to mislead and support fundamentally erroneous beliefs. The search for ethical standards of promotion is one of the most important challenges facing the privatization of health care today.

One important form of promotion is advertising. Once considered anathema to the health care professional, advertising in this field is now big business in the U.S. (See Annex 2). What will be the role of health care advertising in ANE as privatization increases? Obviously, it will vary from one society to another. In some countries (Philippines), advertising is already well established; in others (Pakistan), it remains largely under-exploited.

Mass media advertising is a particularly powerful tool for persuasion. It reaches millions, its entertainment value makes it highly popular, and its ability to model behavior gives it a unique educational power. These strengths are being combined to produce highly persuasive and enlightened health programming. Rock stars and hot popular music (Mexico), and cartoon figures of dehydration and diarrhea battling for a child's life (The Philippines); and the humorous anecdotes of a lovable female character promoting ORS (Egypt) are only a few examples of the new role of TV in health advertising.

But mass media advertising cannot be taken for granted. Advertising for contraceptives and branded pharmaceuticals is tightly controlled in many countries. Creative solutions to controls are emerging, however, including aggressive sales force programs such as Woodward used for the Sathi condoms in Pakistan. Direct means to break media controls are being tried as well. In Turkey, the Family Planning Foundation has agreed to use popular political pressure to help loosen legal restrictions on generic advertising of IUDs and pills in exchange for private sector (the three largest pharmaceutical companies in Turkey) agreements to use profits from increased sales to pay for generic advertising costs.

Mass media advertising alone, even if widely available, is not enough. We know the importance of face-to-face contact through detail men, physicians and nurses, and community delivery and participation schemes. Each of these channels represents an independent opportunity for health care promotion, and a special challenge as a delivery channel for enlightened consumer satisfaction.

Costs of Consumer Promotion, Advertising, and Communication

Promotion, including advertising and communication are not free. They represent a significant new cost when compared with traditional budgets for health education. Whole new cost categories have been created. Consumer research, for example, is important and often expensive. As reach and frequency have become better understood, press runs of pamphlets have gone from the thousands to the millions of copies needed to generate adequate visibility. TV has been added to radio and paid air time has replaced total reliance on public service time.

Most important, systems are being created which now depend on the sustainability of these expenditures. Many governments still hope that advertising costs are one-time expenditures, financed by outside donors. They fail to recognize that future success will depend upon sustainability of education, advertising, and communication inputs needed to meet new consumers entering the market, changing demands of existing consumers, and changing competitors.

Finally, but perhaps more importantly, we must not forget that the lack of communication, advertising, promotion, and education also have a cost: low demand and poor use. The more dependent we become on demand-driven alternatives, the more important education and communication become. To understand consumer satisfaction is not enough. To create products which meet consumers' needs, or to price and distribute them successfully will not by themselves increase demand. Some form of effective promotion which informs, educates, and motivates consumers to make wise choices is also fundamental. Enlightened consumer satisfaction is heavily dependent upon information and persuasion.

Sustaining Present Gains and the Challenge of Emerging New Priorities

We know that child survival and family planning will be ongoing battles, not one-time achievements like smallpox eradication. The extraordinary investment in building consumer demand for ORS, EPI, contraceptives, and child spacing, must give way eventually to long-term maintenance programs capable of sustaining consumer demand at lower cost than the initial program launches. Here the analogy to commercial marketing is quite striking. Coca Cola's investment in launching the new Coke was considerably higher than the annual expenditure on Coke image maintenance. But even Coca Cola, with one of the best known names in the world, spends millions a year on brand recognition alone.

The lesson here is two fold. First, the consumer is a moving target, constantly changing and requiring new marketing tactics. Secondly, the marketplace is full of competition (antibiotics, traditional remedies, or a return to doing nothing) ready to exploit any weakness in our efforts to win and keep consumer confidence. Consequently, we must create systems capable of understanding the moving target, addressing its new interests, and sustaining early health gains.

But new health priorities are emerging. AIDS is only the most visible of the new health threats. ARI and hepatitis B are also important targets. As we look towards the next century in ANE, accidents and occupational risks, environmental hazards, the diseases of aging, and lifestyle diseases such as cancer, heart disease, and drug addiction will inevitably play greater and greater roles in morbidity and mortality. The potential cost of treatment and prevention is staggering.

For many of these problems, prevention is the most cost-effective solution. Prevention is to a great extent reliant upon behavior change, and upon consumer willingness to adopt seemingly unsatisfying behaviors for some distant future benefit. Here our experience in understanding and influencing consumer

satisfaction is once again central to our success. As our ability to legislate change or provide direct financial incentives diminishes, we are left with persuasion, education, and facilitation strategies as our principal weapons. These approaches will only be successful to the degree that we link our new appeals to consumer satisfaction--providing products (condoms, weaning foods, vitamin A) in ways, at prices, in places, and through strategies that stimulate enlightened consumer demands.

Community Participation: The Consumer as Community Member

When people participate in decision making they tend to sustain their commitment to related programs for longer periods of time. Individual participation results in a sense of ownership and continuity, and helps to ensure the sustainability of programs. But how does privatization and consumer satisfaction relate to community participation?

In developing societies, individual decisions are often influenced by community decision making. The image of the lone consumer, loaded for individual decision-making as he or she enters the marketplace of products and ideas, is less applicable in ANE where rural and religious traditions support community decision making and where family ties affect individual choices, even in urban-westernized areas. Community based decision making is a powerful market force in many countries of ANE today, and the techniques and philosophy of community participation are therefore fundamental to successful marketing of health services among many consumer segments.

The family planning community, for example, has recognized the importance of community-based distribution systems to compensate for lack of commercial distribution to isolated rural areas. These systems not only open new distribution points, but also motivate community influence in favor of informed family planning. While many of these experiments have proven costly, valuable lessons have emerged about the power of community channels to promote individual decision making.

But community participation is not an inevitable consequence of privatization. Indeed, individual selling can undermine traditional systems and leave little to replace the framework of values and support they provide people. The most successful privatization efforts will be those that seek linkages with traditional values and support genuine community participation where appropriate. This will be possible only if program planning is tied to studies of consumer satisfaction which will permit planners to understand and exploit community linkages to individual decision making.

Public/Private Sector Partnership

When you ask government and industry about public/private partnerships you often get two polarized responses.

From industry: "Cut regulation, get out of our way, and let us do business."

From government: "Stop ripping off the public with price gouging and worthless, even dangerous, products."

A third response is emerging, however. A response which probes the interdependence and mutual self-interest of both parties through enlightened collaboration. Government purchases of ORS from local manufacturers in Pakistan stimulated those manufacturers to market ORS commercially and thereby expand distribution dramatically. Government use of private-sector advertising to complement traditional health education in the Philippines has resulted in a high-quality campaign on dehydration and a professional launch of their new ORS product, ORESOL.

These partnerships are not easy. They must overcome decades of suspicion and mutual distrust, as well as fundamental differences in mission and tactics. But they are possible and they are powerful when they work. They improve quality rapidly, expand distribution dramatically, and focus attention on consumer demand-driven solutions which complement traditional service delivery.



Consumer satisfaction represents the neutral ground over which both public and private sectors can meet and create a successful partnership. Studies of what consumers want and how they behave can provide the information upon which effective partnerships are forged.

IV.

THE ANE EXPERIENCE AND LESSONS LEARNED ABOUT CONSUMER SATISFACTION

A.I.D. Missions in the ANE region have already begun important forays into privatization. In all cases, these programs have placed a renewed emphasis on demand-driven alternatives and consumer satisfaction. The social marketing of contraceptives through private institutions in Egypt, Pakistan, Bangladesh, Indonesia, and Nepal are well underway and a few have already been carefully evaluated. Private sector and demand-driven strategies are also being applied to child survival efforts in Egypt, Jordan, Pakistan, and the Philippines. They have taught us much about how to research, segment, reach and educate consumers more effectively. The region has solid experience upon which to draw early conclusions about ways to increase consumer satisfaction for health-related products and services.

A set of brief descriptive summaries of the key A.I.D.-supported privatization programs in the region is attached in Annex 1. The lessons being learned from these programs are numerous. Some lessons are tactical; others are strategic. This section does not attempt to describe all the lessons being learned, but rather to focus on what we are learning about consumer satisfaction, and how to understand, promote, and evaluate it.

1. Piecemeal Programs Don't Work

A comprehensive program is needed. It must include:

- a product which meets some key consumer benefit;
- an adequate supply and distribution system;
- a pricing strategy designed to maximize profit and acceptability;
- a promotion plan which links various channels to deliver a single set of simple, noncontradictory messages on product availability, benefits, and use;

-
- a training program for distributors and health providers which emphasizes how to interact with consumers, teaches the product's benefits, and provides clinical care.

We can no longer afford to fund just service delivery, or commodities, or advertising unless we are sure that the other aspects which lead to success are also being planned, carried out, and monitored.

2. Coverage, Timeliness, and Credibility--All Three are Necessary to Influence Consumer Satisfaction

Coverage is the capability of reaching many people quickly. It is often achieved best through the mass media. In most countries, this means radio and TV, and increasingly it means TV.

Timeliness, or the availability of specific information at the moment it is needed by the consumer, is best accomplished through print and graphic material. Specifically, product labels and instructional inserts have been shown to be important.

Credibility, or the acceptability of new services to consumers, is best achieved through a well prepared "salesforce" which includes pharmacists and other distributors, as well as physicians, nurses, and primary health care workers trained to listen to and help consumers understand new product use.

3. The Plan Must be Based on Consumer Research

Consumer research is the key to understanding consumer satisfaction. Research techniques are growing in sophistication and variety. Small well-done qualitative studies are enormously helpful; but quality standards are badly needed for consumer research. Inexperienced researchers can do considerable damage and seriously distort the success of programs. Use of focus groups, for example, has mushroomed--yet training and preparation of focus group designers lags far behind the need for such services. The gap is being filled by amateurs.

4. The Program Must be Flexible, Changeable, and Monitored

Systematic monitoring is essential. Regular contact with consumers, watching how products are being used or misused, interviews with health workers and mothers, store audits, sales data, etc., provide the basis for determining if consumers are satisfied or not, and adjusting program input to address changing consumer interests.

5. Emphasize Simplicity

The temptation to complicate programs and messages should be avoided. Advice to consumers is best when it is kept straightforward--repeating a few noncontradictory appeals often. Most providers cannot be asked to do much more than they are already doing.

6. Provide a Product Mix

A range of methods, brands, and practices should be offered whenever possible. Different products and brands set at different prices appeal to different segments of the population.

7. Emphasize Modern Management

A high degree of management capability is needed to plan or organize multiple, continuing, and complex activities. Overall program management requires strong leadership, close coordination of activities, and accountability.

These are but a few of the many lessons being discussed. Unfortunately, no systematic review of program lessons looking at consumer satisfaction as the goal has yet been undertaken. We are left largely dependent on the opinions of advocates or critics. Such a review could benefit the Agency as it moves towards a decade of growing privatization.

V.

ACTION OPTIONS FOR THE ANE BUREAU

If privatization, that is, the transfer of some health care services from public to private sources of revenue--is both necessary and to some degree inevitable, what is A.I.D.'s role in such a transition? To fulfill its historic mandate, A.I.D.'s obligation is to help ensure that the transition improves quality of service, provides for equitable distribution of resources and services to the poorest segment of society, and maximizes the economic efficiency of the system. In many respects, the U.S. has a comparative advantage over many other donors, both bilateral and multilateral, in these areas. The U.S. is undergoing a public-private transformation itself and the lessons being learned, while not entirely applicable, do offer significant insights into the global problem. A.I.D. already has considerable experience with various models of privatization in the ANE region. Some of these programs are still in the planning stage, others are entering middle age, only a few are fully mature. This suggests that the region has a unique opportunity, not only to break new ground, but to improve our understanding of what works through careful but practical monitoring of these and newer programs as they emerge and mature. Specifically in the area of consumer satisfaction--in understanding and addressing the consumer as the fundamental link in successful privatization--A.I.D. has even more in-depth field experience than most donors.

At the Washington level, the Regional Bureaus sponsor more in-depth reviews of present programs bringing together the program directors with recognized U.S. experts to analyze lessons being learned in both U.S. and ANE arenas and look for new program options. At the same time a cadre of U.S. teaching experts could be recruited to support policy dialogue at the highest level of government, as Mission programs begin to develop. This might mean a major regional program on public/private partnerships and/or privatization. The Bureau could encourage existing centrally funded programs to look for demand-oriented opportunities in each of their sites.

At the Mission level bilateral activities could form on those aspects--policy dialogue, new program development, consumer research and training.

Policy Dialogue

The role of consumer satisfaction, is neither well accepted nor well understood at the highest levels of the health sector. As we have seen, suspicion persists between public and private providers, and resistance among many public health officials to the notion that people can and should pay for services, continues. Much of this resistance has a solid historical basis--but as conditions change, so must opportunities to avoid past mistakes and to create genuinely new models of greater efficiency and equity.

But for new models to emerge, policy makers on both sides of the debate must be exposed sensitively and wisely to new thinking. The dual stereotypes of private sector rapaciousness and private sector efficiency must be tempered by the reality that profit is not the only motive of the entrepreneur, and businessmen also make big mistakes. The opportunities for A.I.D. to play a role in policy dialogue include:

- Private sector internships during which key public policy makers in the host country government and USAID Mission work in private sector firms for two to three weeks at a time, for the purpose of understanding operating procedures, values orientation, and decision-making practices.
- High-level policy workshops at the country or subregional level on the implications of privatization and the role of the consumer.
- Identification of top Asia talent, experienced in consumer satisfaction approaches, able to develop presentations, models, and Q&E and issues papers for decision makers at various levels of the public system.

-
- Analysis of A.I.D. procedures presenting obstacles to private sector cooperation and practical recommendations on how to modify those procedures where possible.

Program Development

We must accept that our present models of privatization are too limited. We need new approaches not yet tried. But this means support to new, often experimental, programs.

Some of this work is already being proposed. The Philippines proposal to support health care franchises is one example. More programs which explore genuinely new ideas are also needed. Particular attention is needed in the Model 3 category of programs--programs of genuine private sector control--to understand better the obstacles and means to reduce the negative consequences in the ANE setting.

Our experience with "model" programs is often discouraging because we expect too much of them. But in an area such as privatization, openness to experimentation and failure is essential until we identify the soundness of particular directions.

Within the process of developing new programs, careful attention needs to be given to consumer orientation. Aspects such as consumer research, consumer-oriented product development, pricing studies, distribution systems, and promotional appeals should be carefully delineated, monitored, and evaluated. Incentives should be built into program design for planners who demonstrate the most creativity in consumer participation.

Consumer Research

Numerous questions remain unanswered about how to operationalize privatization. Practical field research could help provide some of the answers. A few key issues are listed below. These questions are best explored within the context of

operational programs, but this is practical only if questions are specifically identified at the outset of program development, and the means for their study is built into the program from day one.

- Do some forms of private services operate more efficiently than others (e.g., for-profit versus not-for profit or individual practice versus a staff model)? What factors account for the greater efficiency (e.g., the mix of medical personnel and performance monitoring)?
- Is there satisfaction among consumers with perceived changes in the organization, delivery, and type of medical care services they are receiving? Are patients shopping for the highest quality services, and have providers been induced to eliminate services for which there is no real patient demand?
- How has the behavior of health care institutions, with respect to the availability and provision of services for different population groups, truly been influenced by the degree of competition in the local market?
- In response to a reduction in demand because of increased cost sharing and less generous payment for services, will physicians and hospitals select the best paying patients, eliminate unprofitable services, or transfer patients with less adequate resources? Will providers attempt to win the best-off patients away from competitors with attractive "packaging" and marketing of services or other "entrepreneurial initiatives that add significant cost to the services"?
- What do different consumers want from health care, other than adequate treatment, in specific subcultures (urban poor, rural communities, women's health, etc.)?
- How do different aspects of the marketing mix (product, place, price, promotion) vary in importance across various health services (immunization, diarrheal disease control, nutrition, family planning, STDs and AIDS, etc.) and when are the best opportunities for improvement due to privatization?

-
- When privatization will not work as well, what improvements in public services can be developed by using a consumer-oriented focus?

Training

A.I.D. has several opportunities in the training area, including long-term participant training in private sector organizations, as well as short, intensive training internship. Focus should be on values orientation toward service, consumer, and profitability as well as skills acquisition. This includes opportunity for internship in the U.S. and in ANE institutions. Several models exist now, including the United States Telecommunications Training Institute (USTTI), jointly funded by USAID and 32 of America's top telecommunications firms. USTTI brings over 250 developing country specialists to the U.S. for intensive technical internships in U.S. companies for periods between 6 to 15 weeks. SOMARC is developing a similar internship program with U.S. advertising agencies.

Training targets include topics such as:

- consumer research,
- new product development,
- understanding the competition,
- pricing for equity, service, and profit,
- developing a health care salesforce,
- training physicians to be consumer oriented,
- developing affordable and effective incentive systems,
- understanding the role of public relations and advertising,
- choosing an advertising agency for health care services.

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ANNEX 1: Program Highlights

Bangladesh--CSM Program

The Bangladesh Family Planning Social Marketing Project (BSMP) has been distributing contraceptives through private sector channels since 1976. USAID funding and operational oversight were providing through Population Services International (PSI) while policy guidance is provided by the Population Control Division of the Government of Bangladesh.

The distribution network exists throughout the country of Bangladesh, placing contraceptives in over 90,000 retail outlets through 5,000 stockists and over 20 wholesalers. The current product line includes three brands of condoms, two oral contraceptives, a vaginal foaming tablet, and the Noristerat injectable.

CSM contraceptive products are distributed through an in-house sales force to wholesalers, stockists, retail outlets, and medical establishments. Promotion activities are wide ranging, including mass media, mobile film units, point-of-purchase materials, a rural medical practitioner conference, and other interpersonal approaches. Despite the constraining socioeconomic conditions of Bangladesh (extreme poverty, low literacy, and conservative and rural population), the CSM program has been notably successful. It provides one of the highest levels of couple-years of protection (1.3 million) of any CSM program, reaching nearly seven percent of the eligible couples of Bangladesh.

Indonesia--Blue Circle CSM Project

As part of its KB-Mandiri program (national cost recovery and self-sufficiency campaign), the BKKBN (National Family Planning Coordinating Board) has expanded its social marketing project to include sales of multiple contraceptive methods throughout all urban areas of Indonesia and to encourage the public use, in a substantially larger way, of private sector providers of family planning services and products (doctors and midwives). Under this project, the BKKBN will gradually reduce the supply of free

goods. Financially capable acceptors will begin paying for their own contraceptive needs, thus relieving the BKKBN and USAID of the burden of supplying all acceptors with free goods.

The project is designed to use commercially available brands, to package and promote them as a Blue circle product line (with the original brand names retained) and to sell them at considerably reduced prices to distributors. Resulting product prices to family planning acceptors should then be well below the current commercial market prices. The participating manufacturers will provide the products with agreed upon packaging and arrange for marketing through their distributors to private sector outlets in urban areas throughout Indonesia. In addition, manufacturers will return a portion of the annual sales revenue to a project revenue account which, in time, will be used to offset recurrent costs, thus contributing to the project's financial sustainability. Negotiations with the manufacturers have been successful in persuading them to reduce their prices to the distributor, thus meeting the project's objective of establishing a lower price to the consumer.

Indonesia--SOMARC Dualima Condom Project

The IKB/SOMARC project in Indonesia is a collaborative effort by the Government of Indonesia through the National Family Planning Board (BKKBN), USAID/Jakarta, and the Futures' Group of SOMARC CSM project. The project was conceived in 1985 and implemented beginning in April 1986.

PT Mecosin, a private pharmaceutical manufacturing company, is responsible for the management and administration of the project, as well as subcontracts with the advertising and research agencies (Matari Inc. and Survey Research Indonesia).

Dualima is currently sold in approximately 2,600 outlets. The project sold 50,085 gross of Dualima in 1988, and research indicates that 30 percent of users were never-before contraceptors.

Now in its fourth year, the project has widened distribution to include pharmacies in 16 additional cities and employed special task forces to increase distribution to small outlets further down the distribution chain. Plans are also underway to extend product range to include a premium condom.

Pakistan--CSM Program

The CSM project for Pakistan is implemented through a private sector manufacturing and distribution company--M/S W. Woodward (Pak.) Ltd., which was selected jointly by the GOP and USAID through competitive bidding.

Woodward operates under contract to the GOP and in turn subcontracts directly with the necessary specialized organizations; for example, an advertising agency. The NDFC through Pakistan Consultancy Services (PCS), one of its service divisions, represents the interests of the GOP, particularly in matters of fiduciary conduct and management.

The project is further served by a resident advisor, provided by PSI Marketing Associates (PSIMA) and receives technical assistance from PSIMA, which also represents the interests of USAID. The Family Welfare Division of the Ministry of Planning and Development provides direct guidance in matters related to population policy and planning. The Minister of Planning is the chairman of the advisory board and a key person in the development and implementation of the project.

Woodward distributes Sathi condoms through 160 subdistributors and 800 wholesalers. It employs (per an A.I.D. requirement) 40 sales promoters, whose primary job is to take retail orders of Sathi and manage in-store merchandising. It is estimated that Sathi is now available in about 49,000 retail outlets nationwide (151 towns), including chemist shops and general provision stores.

Nepal--CSM Program

Through a joint agreement between the government of Nepal and Westinghouse, a USAID contractor, the Nepal CRS Company began providing low cost contraceptives to the people of Nepal in 1978. Since that time, a network of approximately 10,000 retail outlets within ten regional districts has been developed. The product line has been expanded to include two condom brands, two oral contraceptives, and a foaming tablet spermicide. The level of contraceptive prevalence has risen from 7 percent in 1981 to 15 percent in 1988.

In addition to employing innovative approaches to advertising and promotion, CRS plans to increase its distribution by continuing its expansion into rural markets and reinvesting its revenue through a financial diversification strategy. Ultimately, CRS hopes to achieve a level of self-sufficiency that will significantly reduce its reliance on donor assistance and to change its structure to afford more autonomy.

Egypt--CDD Program

The National Control of Diarrheal Diseases Project (NCDDP) began activities in January 1983, with a grant from USAID. It is a semi-autonomous project headed by the Minister of Health Care and Family Health, guided by a multi-ministerial steering committee, staffed by professionals in ORS production and marketing, training, mass media, public health, clinical medicine, research, and evaluation and advised by a wide spectrum of experts, both local and foreign.

The project developed a local manufacturing capacity through the parastatal, Chemical Industries Development Company. The NCDDP included both government health facilities and private pharmacies as distribution points for ORS. There are almost 4,000 clinics and hospitals in the government health system. There are over 5,000 private pharmacies. Together, they provide a distribution network within easy access of 95 percent of the population. At the present time, approximately 60 percent of all

ORS in Egypt is purchased in pharmacies. The decision to use private pharmacies was based on their numbers, their distribution into even the smallest villages, the important role they play in health care and education, and the belief that their commercial involvement in a high demand product would guarantee the continued availability of the product when the project ends.

Jordan--CDD Program

Jordan's CDD program began local distribution of ORS by Al-Hikma Pharmaceuticals in July 1987, and an extensive public education campaign during the summers of 1987 and 1988 in support of the local ORS product, Aquasal. Both ORS production and the public education about ORS have been underwritten by UNICEF.

A.I.D.'s involvement in the private sector began in the early months of 1989 when, following the suggestion of PRITECH consultants, the Mission made a multi-year commitment to the promotion of Aquasal through Al-Hikma. The Mission will underwrite the costs incurred for advertising and detailing materials for use with physicians and pharmacists. A.I.D. recognized that the UNICEF promotion is geared to the public, and that Al-Hikma needs to promote its product directly to physicians and pharmacists through its detail force. In addition, the MOH is now mounting a strong effort to remove antidiarrheals and antibiotics specifically for diarrhea from the pharmacies, so this is an opportune time for strong ORS promotion through the private sector.

Indonesia--CDD Program

Following its noteworthy success in applying marketing and sales strategies in Indonesia's family planning program, USAID/Jakarta has now developed a comprehensive social marketing strategy for its entire health program portfolio.

The Mission has supported a major social marketing effort for diarrheal disease control in West Java, assisted by the HEALTHCOM Project. During the initial two years of this program, extensive consumer research was carried out by an Indonesian research firm, Survey Research International, and a massive training program for village health volunteers (kaders) launched. HEALTHCOM is now initiating the mass media phase of the program, through contracts with Indonesian advertising and media firms.

Initially, several pharmaceutical companies, including Ciba-Geigy and Pharos, were important partners in the West Java program, intensifying the advertising and sales force promotion of their respective ORS products. The Indonesian Ministry of Health, traditionally wary of private sector pharmaceutical activities, subsequently requested Pharos to curtail its ORS product advertising. At the present time, however, the Ministry appears ready to move ahead with several private sector initiatives for the CDD program. With support from USAID, the Ministry is discussing the launch of a new ORS product with Indonesia's largest producer and distributor of traditional medicines, the Jamu Jago Company.

The Philippines--CDD Program

In the Philippines, A.I.D. has been supporting the Department of Health's collaboration with the private sector in several important ways to strengthen the national diarrheal disease control program. Most significantly, the Mission is assisting the Department of Health's desire to expand the production and distribution of oral rehydration salts (ORS) through a commercialization strategy.

At the present time, the PRITECH and HEALTHCOM projects are working with the DOH to interest a group of pharmaceutical companies in marketing the ORS packet which the government has branded under the name ORESOL, and has been distributing through the public health system for several years. The government is considering and will likely adopt two measures

deemed necessary to attract greater private sector involvement: deregulation of the price of ORS, and declassification of ORS as an ethical drug.

The HEALTHCOM project, moreover, is assisting the DOH in conducting a nationwide promotional program on diarrhea, dehydration, and rehydration. This effort, carried out through contracts with several of the Philippines' leading private advertising firms, will serve as another important incentive to the pharmaceutical industry to expand its ORS marketing activities, as it essentially will provide free generic advertising for all ORS products.

Pakistan -CDD Program

USAID has funded the trip of a PRITECH marketing consultant to conduct a seminar on practical marketing techniques for all private ORS producers in order to pool their combined efforts and upgrade their marketing capacities.

The outcome of this seminar has been a united front of ORS producers committed to ORS. They have collectively raised a request for deregulation of ORS, so that packets can be distributed to grocery stores and other outlets. The ORS producers have also requested a return of the tax-exempt status of imported aluminum foil, the most costly component of the packet, in order to maintain a price accessible to the lower levels of the marketplace. Both of these measures have been endorsed and supported by USAID, and now are about to be implemented by the government, thus making ORS widely available and readily affordable.

USAID is prepared to continue support to the ORS-producers consortium with further technical assistance.

ANNEX 2:
What Consumers Care
About in the U.S.

Professional Inadequacy

The extent to which people are concerned with identifying competent medical practitioners.

Bureaucracy

The extent to which people believe that administrative procedures are unduly inflexible, complex, and onerous.

Treatment Access

The extent to which people believe they face unreasonable delays in gaining immediate attention to health care.

Location Convenience

The extent to which people feel disadvantaged in gaining access to local health facilities.

Geographic

The extent to which people feel disadvantaged in the handling and cost of away-from-home medical care.

Lack of Control Over Medical Decisions

The extent to which people believe that their health care program inhibits their choice of services.

Inadequate Coverage

The extent to which people believe that they are limited in the variety of medical services available to them.

Preventive Maintenance

The extent to which people believe that their health coverage program is unconcerned with activities that minimize the occurrence of medical problems.

Facility Conditions

The extent to which people believe that the buildings and equipment they are exposed to are poor in quality.

Cost

The extent to which people believe that their medical coverage is excessively expensive.

ANNEX 3: Manageable Evidence in Medical Care Marketing¹

To improve ratings on *informativeness*, respondents cited only one management-controlled feature providing written information (1.5 percent). The balance of evidence pertained to interpersonal experience with physicians:

- using understandable terms (32 percent),
- explaining procedures (31 percent),
- discussing personal problems and concerns (21 percent),
- being straightforward, open (21 percent),
- taking time (17 percent),
- volunteering information (11 percent),
- answering all questions (11 percent), and
- covering prevention (2 percent).

Suggestions for improving ratings on *trust* included mainly interpersonal behavior:

- projecting a confident, assured manner (22 percent).
- showing personal interest, going beyond immediate problems (19 percent),
- using understandable language (13 percent),
- being honest, open (12 percent),
- being thorough, taking time (12 percent),
- following throughout, checking on patients after visits (7 percent), and listening, being attentive (7 percent).

In addition, respondents cited two other perceptions: getting good results (14 percent) and being available when needed (7 percent). When asked how they could tell how *caring* physicians are, respondents cited one perception: being available when needed (1 percent). Mostly, they mentioned specific behavior patterns, such as:

- taking time with patients (30 percent),
- following through, checking on patients (18 percent),
- explaining thoroughly (12 percent),
- listening, paying attention (10 percent),
- expressing interest and concern (10 percent), and
- remembering patient's name, family, history (5 percent).

1. By Robin Scott McStravic, *JHCM*, Vol.7, No.4 (December 1987), pp. 52-59

The evidence cited for competence, informativeness, trust, and caring suggests two conclusions. First, interpersonal behavior makes the biggest difference, at least to these perceptions. Unlike management-controlled features, such behavior is often almost as intangible and "fuzzy" as the perception for which it serves as evidence. How much *is* enough time? What *does* being attentive, showing interest, and using understandable language translate to?

The second unavoidable and useful conclusion is that attributes are subject to a and satisfying their patients more. Some suggested that physicians discuss their charges before giving treatment (3 percent) or explain their charges in more detail (2 percent).

When describing what physicians can do to earn higher ratings on *availability*, people cited several management action features:

- offer flexible/extended hours (10 percent),
- provide an answering service or other coverage at all times (23 percent),
- shorten time spent in the waiting room (5 percent), and
- make house calls (2 percent).

In addition, a few suggested specific interpersonal evidence:

- return phone calls promptly (10 percent), and
- be pleasant in emergencies (2 percent).

A good proportion (24 percent) merely asked that physicians be available when needed.

Competence was judged by some respondents on the type of evidence features that management can control and communicate:

- experience, credentials (17 percent),
- continuing education, training (11 percent),
- diplomas on the wall (2 percent),
- association with hospital (1 percent),
- appearance at the office (1 percent), and
- number of patients (1 percent).

A major evidence factor in judging competence was a directly relevant perception--getting good results (20 percent). Significant also were some specific behavior patterns:

- explaining procedures (12 percent),
- being thorough, taking time (10 percent),
- reaching a diagnosis quickly (8 percent),
- admitting uncertainty, calling in consultant, second opinion (6 percent),
- being confident, assured (5 percent), and
- showing personal interest, asking about more than the immediate problem (3 percent).

These behaviors include some that seem contradictory, for example, reaching a diagnosis quickly and exuding confidence contrast with admitting uncertainty. Perhaps people want confidence and quickness on simple problems, but prefer greater prudence and consultation in more serious, risky, or expensive situations. Because such circumstances were not addressed in the survey, however, this assumption is purely speculative.

**ANNEX 4:
Examples of
Modern Health Care
Advertising and
Marketing in the U.S.**

Some issues are better illustrated than discussed. Fortunately, Health Care Advertising Review (HCAR), a bimonthly publication to the health care community, allows us to do just that.

The following examples of health care advertising highlight some of the key issues mentioned in the issues paper and show how the health care industry in the U.S., both profit and nonprofit, are using marketing--not only advertising--to address those issues.

You will see examples of:

- prevention campaigns designed to cut health care costs by reducing the need for treatment;
- segmentation strategies to target specific markets such as women;
- consumer benefit strategies which stress convenience as well as cost savings;
- referral services which help physicians identify new patients in an even more competitive marketplace.

Each example includes the analytic text which HCAR uses to educate its audience of health care providers on new marketing techniques. The text also illustrates the type of marketing mentality at work behind the scenes of apparently simple campaigns.

In each case, the goal is better service, greater market share, and increased profits through greater consumer satisfaction. Successful privatization will have to include support to these and many more elements of marketing if the entrepreneurial spirit is to flourish and prosper.

We have the cure.

Bureaucratis Runaroundus

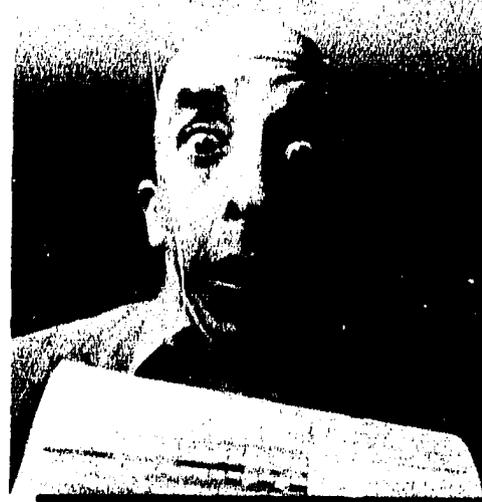
(byss-ekratis run-aroundus), n. Disease due to endless red tape and a lack of straight answers. Often accompanied by a recurring ringing or buzzing in the ears.



A common problem. We prevent it with straight talk.

Expensius Humongous

(ik-speniis hu-mongous), n. A pain in the wallet caused by constant drainage, usually followed by rising blood pressure directly proportional to the soaring cost of medical care.



Good news. Health Access members receive special discounts.

Admittance Delayus

(ad-mit-tis di-lai-us), n. Extreme fatigue and irritation brought on by over-response in hospital admitting rooms and complicated registration forms.



Finally. Express hospital admission.

Claimis Perplexis

(k-lai-mis per-plek-sis), n. A sense of diminished capacity, contracted by wading through stacks of bills and reams of fine print prevalent in medical claim forms.



Our Cure: Your personal health insurance adviser.

The cures for four common insurance ailments.

Did you ever go to a doctor for an inoculation injection and say, just as the needle was being poised, "Hold on, Doc; what's in that stuff?" Of course not. You recognized the threat of the disease and believed in your doctor for the cure. Here's a parallel: Just as we don't need or want to know just what goes into the vaccines we take to prevent illness, neither do we want to know all the technicalities of health insurance. What we want, is to trust the provider. Health access could conceivably take the time to explain the details of their plan so that consumers could understand them. But why spend forever explaining something, when

you can picture four common maladies associated with healthcare delivery ... present them humorously enough to be readable, but not so jokingly as to be irrelevant ... and simply offer Health Access as the cure! Every patient will recognize the four expressions shown in the four panels of this ad ... and they'll be only too glad to believe that anyone who offers *free* enrollment *must* have that cure.

For the center: Gerrie Shields, Director of Marketing, Merritt Peralta Institute, Oakland CA, 415-268-9014. **Agency:** Ad-Lib Creative Services, San Francisco CA.

PEOPLE STOP DOING COCAINE FOR FOUR REASONS:

1. They run out of cocaine.
2. They run out of money.
3. They get help.
4. They die.

Substance abuse: Cocaine

It may be their habit . . . but it's your choice.

This ad pointedly tells the Significant Other: "You have a choice to make . . . now!" After all, what choice will the addict make? He won't run out of coke . . . there's too much of it around. He won't run out of money . . . he'll beg/borrow/steal first. And *he* sure isn't

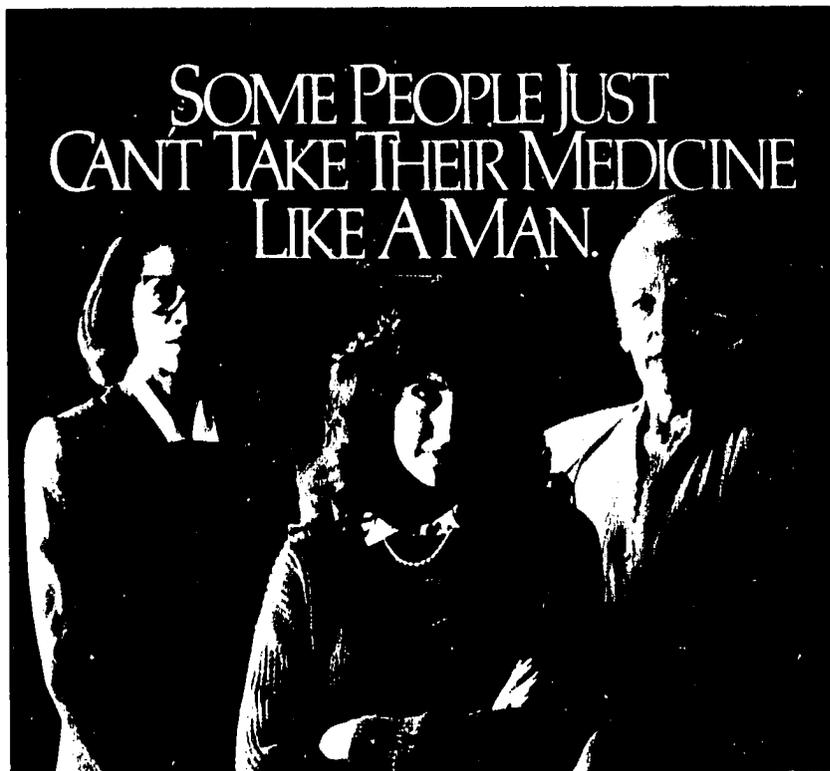
going to run for help . . . he's been running the opposite way all along. Which leaves . . . Which leaves the Significant Other with a fact that won't go away: *If you don't choose Mountain View pronto, he dies.*

For the center: Carolyn Agee, Director of Development and Public Relations, Simi Valley Adventist Hospital, Simi Valley CA, 805-527-2462.
Agency: Gilpin Peyton & Pierce, Orlando FL.

Speaking intelligently to women.

How do you tell a woman she's *special* ... without sounding like Macho Man in NOW clothing? Copywriter (Ms.) Michael Farnam solves that problem automatically by applying her principle: "Don't insult people by underestimating their intelligence; don't limit yourself by falling for the philosophy of the 'dumb consumer.'" (See *HAR*, March/April 1987, p. 5.) From such thinking (which the Art Director obviously agrees with) comes this big-news-with-a-slice-of-satire introduction to The Women's Floor ... one of the better approaches to Women's Health we've seen so far.

For the hospital: Pat Seger, Vice President of Marketing Communications, Jewish Hospital, Cincinnati OH, 513-569-2348.
Agency: Northlich Stolley, Cincinnati OH.



SOME PEOPLE JUST
CAN'T TAKE THEIR MEDICINE
LIKE A MAN.

Fortunately, they don't have to. Because we've staffed The Women's Floor with people who understand the special medical and emotional needs of a woman.

We offer technologically advanced treatments like laser surgery, and an infertility program that includes G.I.F. and in-vitro fertilization. We provide comprehensive treatment of endometriosis and other conditions that affect women.

And The Women's Floor offers same-day surgery, a 24-hour anaesthesiologist, and expertise in women's health issues.

We believe that understanding and compassion are as critical to health care as technology, so we've made The Women's Floor different in other ways, too. Small touches like terry cloth robes and warm slippers. Big differences like pre-surgery classes and symposiums. All to make it easier for you to take your medicine - like the woman you are.



THE WOMEN'S FLOOR AT
JEWISH HOSPITAL 569-2387

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Any question . . . any market.

Riverside Hospital/Newport News offers Tidewater consumers the answer to practically any medical question that might enter their minds . . . including the answer to the question that's on many patients' minds in this hotly-contested market: "How can I find the right doctor?" This ad is part of the Ask-A-Nurse service

package offered by Referral Systems Group, and it's just as relevant in Virginia as it is in California . . . which is reasonable, considering people have much the same medical questions on their minds no matter which market they live in.

For the hospital: Bud Ramey, Director of Marketing & Public Relations, Riverside Hospital, Newport News VA, 804-599-2000.

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You could call it a health club.

Fitness has its rewards. You look better. You feel better. And now there's a health plan that treats you better.

The Straub Plan rewards you for healthy living with the Straub Health Bonus—automatic reductions in your Straub medical bill. As soon as you sign up, we give you a free non-physical to determine the size of your bonus.

Then every year, as you lose weight, stop smoking, lower your cholesterol level, or take other steps to improve your fitness, we increase it—until you don't have to pay a penny for a visit to any Straub doctor or department.

But saving you money isn't the only incentive we offer you for keeping fit.

As a member of The Straub Plan* you can attend classes on Nutrition, Stress Management, Weight Control and other health topics free of charge. And unlike health insurance plans, The Straub Plan covers physicals and other preventive measures.

So if you're the type of person who takes responsibility for his or her health, ask your employer about The Straub Plan. And welcome to the club.

The Straub Plan

The Health Plan from the doctors at Straub

Power econobics.

Here's a plan that combines the most logical aspects of economics with the physical fulfillment of power aerobics... and puts the entire package into the hands of men and women who dare to seize the combined benefits. The economic logistics: increase your level of fitness as you drive down your cost of medical care. Honestly, now, what upwardly mobile healthcare consumer is going to turn down a challenge like that?

For the plan: Paula Rath, Director, Marketing & Communication, Straub Clinic & Hospital, Honolulu HI, 808-523-2311. **Agency:** Milici Valenti Park & Gabriel, Honolulu HI.