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SOCIAL MARKETING AND COMMUNICATIONS FOR HEALTH

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Blended Models of Health Supply Starting To Show Promise in Developing Countries

Strategies Such As the "Total Market Approach" Are the Way of the Future

Years of experience have shown that there is no single way to be successful in international development. What works depends on country conditions: the manner, number and capability of partners on the ground, and the state of the markets for health-related goods and services.

Those markets generally mature over time. They may change as a result of political and social factors or new players entering the scene. When such conditions change, consumers generally become better educated and more discerning, and strategies for reaching those consumers must also evolve.

This phenomenon is true of social marketing as well as the private sector. PSI is taking advantage of such changes in a number of countries to alter its market positioning in order to improve the cost-efficiency of its programs.

Insecticide-treated net distribution in Malawi is one example of health supply where a blended approach seems to be working.

Four Models of Health Supply

There have historically been four main approaches to the supply of health-related goods and services — the public sector, social marketing, the manufacturer's model and the private sector.

In the public sector approach, government-run facilities deliver goods and services, often for free, to target populations. The potential benefits include an integrated approach and greater equity. Possible disadvantages are poor infrastructure, lack of quality control and the absence of incentives for providers. Furthermore, demand for "free" health goods and services generally overwhelms supply, and the profile of those served does not always match with health requirements. Channeling products through the public sector creates strains on an already overburdened system and takes time that could be spent on other critical interventions.

In social marketing, an NGO typically arranges the supply of subsidized goods and services via the private and public sectors. The incentive of the profit margin tends to ensure that goods are always in stock, and diversion to the black market is minimized. Low prices help ensure access and increase demand. The downsides are that the subsidy must persist until the country becomes wealthy enough for goods and services to be sold at cost recovery, leading to a lack of the rapid exit route that some donors require, and a distortion of the market due to limited investment by the commercial sector. The very poorest outside of the cash economy may be excluded. Supply may also be constrained by access to the private and public sectors, whose reach may not extend to the most marginalized.

In the manufacturer's model, a private sector agent is given incentives to supply goods and services at subsidized prices via the public and private sectors. Gradually, as consumers are recruited, the subsidy is reduced until the agent can turn a profit. The benefits are a clear donor exit strategy and the creation of a market where none previously existed. The downsides are that price increases may marginalize the poorer over time, and the agent may ignore equity by maximizing profits.

In the private sector model, a private agent creates and satisfies a market. The benefits are that most people in developing countries already access health products and services through the private sector and that public funds are not required. The downsides are that the private agent will likely seek to maximize returns on investment and thus will market to the wealthier in society, and exclude the poor.

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A Blended Approach Is Often Needed

Too often, these approaches have been applied one at a time, to the exclusion of the others. This has not always produced the returns expected because, as stated above, each of the models has its downsides.

In addition, donors or health ministries have sometimes imposed the method to be attempted. For instance, some have decried private sector provision to the poor, even though this is illogical. If the poor are willing to buy from the private sector, why should they not be allowed to do so? They may buy from the private sector as it averts long waits at public health clinics, for example, where such a wait may be more "costly" than the price of the goods or services.

There is likely no single answer to the supply of health-related goods or services. Blended approaches are needed, and must be dependent on country and market conditions with agents operating in a coordinated fashion. Such programs have been referred to as the *Total Market Approach* (TMA), the *Market Development Approach* (MDA) and, in the case of the Academy for Educational Development (AED), *Full Market Impact©* (FMI), though TMA and MDA are still in their relative infancy and there is much debate as to what the terms themselves actually mean. Nevertheless, experiences on the ground seem to suggest that blended approaches may work best.

Promising Results in Malaria Prevention…

Programs distributing insecticide-treated nets (ITNs), which are expensive, provide a case in point. In Malawi, PSI sells ITNs with the support of the U.K. Department for International Development (DFID), UNICEF and the U.S. Agency for International Development. These nets are sold via antenatal clinics at a highly subsidized price (approximately US $0.40 to the consumer). A profit margin motivates clinic staff to promote purchase of ITNs and ensure efficient management of ITN stock. At the same time, PSI sells nets at a profit to wealthier urban Malawians, ensuring that the subsidies are targeted in rural areas where the risks and needs greater. The system is so efficient that the total sales revenue pays for most of the program's operating costs.

In Tanzania, PSI's SMARTNET program partners with the Ministry of Health, net manufacturers, insecticide suppliers, retailers, NGOs, research and evaluation agencies, advertising and promotion agencies, DFID and the Royal Netherlands Embassy. SMARTNET has provided support to ITN suppliers through transport subsidies, guaranteed payment systems, and marketing support in the form of generic promotion campaigns. SMARTNET also supplies a retreatment kit with every commercial ITN to ensure the endurance of its potency against mosquitoes. Availability for the poorest is ensured through voucher-based redemption systems. Tanzania now has a vibrant ITN culture, producing some 90% of ITNs made in sub-Saharan Africa.

FMI's similar approach provides free ITNs to the poorest directly and through vouchers (a strategy pioneered by AED in Zambia.) It is characterized by market segmentation, joint investment with the private sector and the improvement of the private sector's supply potential, by lobbying for duty exemptions and identifying local distributors, for example. AED says it has implemented its FMI model in seven countries over the last four years with great success.

…and in the Nigerian Condom Market

PSI and its partners are also experimenting with blended approaches in other health areas. Nigeria is a huge and potentially lucrative market, but the challenging commercial and legal operating context discourages many companies from marketing goods there. PSI nevertheless has a strong and experienced indigenous partner, the Society for Family Health (SFH), which understands how to operate in the Nigerian environment.

SFH has a virtual monopoly on the local condom market, having grown it from a very low base of just over seven million units per annum in 1993 (including private sector supply) to over 150 million units today. Though it does offer opportunities to sub-segment its own market to increase cost recovery, SFH has no desire to have such a monopoly. Instead, it prefers to decrease the need for donor support by encouraging the entry of other private sector partners. Therefore, PSI, SFH and the condom manufacturer Ansell will soon launch a for-profit condom under Ansell's brand Lifestyles, distributed and marketed by SFH. All parties benefit: PSI and SFH reduce dependence on donor funding, Ansell gains a new market with minimal risk and market development costs and the Nigerian public gets a greater choice of products.

Blended Approaches Are the Future

There are bound to be hiccups along the way with blended approaches, and some recent discussions have highlighted where and how these may arise. Core among them are how actors define success. In South America, for instance, some previously donor-supported clinics "graduated" to self-sufficiency, but they did so by shifting their client base to serve the wealthier. If the goal was pure graduation and nothing more, then this was indeed a success. If the goal was increased equity, it was a failure.

The key is to be explicit as to what success will be and how it will be measured, and then choose the blend that will deliver the goal. This will vary by country — what is viable in Ethiopia will be very different in Indonesia. Careful account needs to be taken of the local situation, the strengths and weaknesses of partners, their likely motivations and how they react to incentives.

TMA, MDA and FMI are likely the way of the future. However, they may stumble at the hurdle of definition (in terms of what does and does not constitute these approaches), the tendency towards unitary ways of working regardless of conditions and overly high expectations. That said, blended approaches are showing success, and actors such as PSI, SFH and AED and their respective donors and partners are helping, however modestly, to show the way forward.