MAKING MARKETS FOR HEALTH SERVICES WORK BETTER: THE CONTRIBUTION OF SOCIAL MARKETING (SM)

NOTE OF SM ORGANISATIONS AND DONOR MEETING, APRIL 22-23 2004

Introduction and summary

1.1 In January 2003, DFID commissioned an independent review of its social marketing (SM) activities in the health sector[1]. The report's findings and recommendations were discussed at a workshop in April 2004, attended by major financing and implementing agencies involved in social marketing (see Annex 1 for participants).

1.2 This note summarises the conclusions and main issues in four areas:

- the wider health policy context and framework;
- the importance of understanding the 'total market' (in terms of both supply and demand) and designing interventions to strengthen health markets (including addressing market failures);
- implications of this approach for the roles and capacities of the main actors - governments, donors, providers (including social marketing organisations) and consumers; and
- specific issues arising for the procurement and contracting of social marketing services.

Lastly, the note suggests next steps and opportunities for advocacy and consultation.

2 Key conclusions and findings include:

2.1 Towards the total market approach

a) Social marketing has proved to be successful as a cost-effective intervention for improving access to some essential health commodities, and for changing behaviour. For example, SMOs are believed to make available around 50% of all condoms. SM makes a significant contribution to meeting the MDGs.

b) Distribution through commercial retail outlets, NGOs and community-based channels enables access by vulnerable and often stigmatised groups. This can be especially important for HIV prevention. The track record of SM in serving the needs of the very poorest is more questionable.

c) SM addresses some government and market failures, and increases demand for, and the use of, otherwise under-used goods with public health benefits. However, it is only one of a range of interventions that can address the needs of the poor. Moreover, SM programmes can have unintended, and possibly undesirable, impacts on the market, which can go unnoticed. These include: the

[1] The review was undertaken on behalf of DFID by the DFID Health Systems Resource Centre, with a team of three consultants with expertise in the private sector and health economics as well as social marketing. The team consulted with a panel of DFID staff, independent experts and representatives of major donors (KfW, Germany, the Netherlands development ministry and USAID). The main social marketing organisations (SMOs) provided information on general issues of policy and practice, as well as details of individual projects. The review included eleven country case studies, including Kenya (insecticide treated nets, ITNS), Mozambique (ITNs and condoms), Tanzania (ITNs), Pakistan (oral and injectible contraceptives, condoms), and China (condoms). It should also be noted that many of the report's recommendations reflect those highlighted in a similar review undertaken by KfW in 2003.
See full DFID report at http://www.healthsystemsrc.org/know_the/publications.htm#dfid

risks of market distortion; shifts in investment patterns; positive or negative effects on business confidence; inefficiencies; and possible 'crowding out'[2].

d) Social marketing programmes have typically been designed and operated without full attention being paid to the wider market for health services[3]. Market strengths and failures vary greatly with the type of product or service, and with existing demand and supply patterns in different market segments.
e) A more comprehensive approach might be called a 'total' or 'integrated' market approach, sometimes known as the third generation model in social marketing programmes. Such an approach aims to assess the wider health market, in terms of public and private systems. It defines the comparative advantages of major participants in terms of competence, value for money, and sustained roles in delivering and/or facilitating access to a range of products, information or services to different groups (or market segments), including the poorest.
f) In a total marketing approach, the potential overall market impact of proposed 'market interventions' is assessed at the planning stage. This includes whether the targeting of public subsidies to specific product brands and market segments is an appropriate means of market intervention and use of subsidy.
g) Developing a total market approach will have significant implications for the stewardship role of national governments, and for the policy, legislation, regulation and other 'market intervention' implementation capacities that they will need in order to discharge these responsibilities. These capacities may also need to be strengthened in donor agencies.
h) Other independent capacity building may also be required, to meet the needs of governments and health policy makers for detailed health market assessments and audits.
i) In line with current policy objectives for increasing donor harmonisation and government ownership of national poverty reduction and health strategies, a total market approach provides a platform for strengthening donor-government collaboration, as well as consultation and information sharing with other stakeholders. It will facilitate:
    - an overall approach to market assessment and to comparative analyses of the cost-effectiveness of different interventions; and
    - the generation of data on utilisation and impact, disaggregated according to socio-economic status.

2.2 Implications for social marketing

a) Whether or not a total market approach is adopted, some strengthening is required in the way many SM programmes are designed and tendered. (See section 6).
b) Where there is, or has been, significant public investment in brand development, intellectual property rights (including brand ownership) should be clearly articulated at the time of tendering and contract negotiation. Normally, such rights should be with the financing agency.
c) Social marketing techniques have great potential and should be much more widely disseminated and used, in the health sector and beyond. There is great scope in expanding social marketing to new health needs (such as ORT, essential drugs, and sanitation and the treatment of water). There is also significant potential in scaling up social franchising – where a branded model for

[2] 'Crowding out' can occur when public sector subsidy enables a provider to undercut market prices of existing products of equivalent quality. 'Crowding in' takes place as providers come into a competitive and attractive market with growing demand.
[3] Although there are an increasing number of SM examples where a broader market perspective is being pursued.

delivery of quality assured and affordable services (TB, HIV) is contracted by the franchisor to private sector providers. Several donors are already financing and developing initiatives in social franchising in the reproductive health field, but experience and the evidence base in other services are still limited. For example, the Health Franchise Initiative is carrying out pilot activities for TB and some HIV services in two African countries.

The wider policy context

3.1 The wider aid and development policy context is shaping public (and private) sector investment in health interventions, including social marketing programmes. Achieving the health MDGs is a significant challenge for all of the international aid community, national governments and non-governmental organisations. There is growing interest in scaling up proven interventions in the public and private sectors for improving coverage (access, quality and affordability) of goods and services related to sexual and reproductive health, HIV/AIDS and communicable diseases. These include social marketing and social franchising. New financing mechanisms, such as the GFATM, PEPFAR and the Millennium Challenge Account are providing opportunities for innovative programmes at national level, and for involving new participants from civil society and the private sector.

3.2 Improving aid effectiveness is of equal policy importance. The OECD DAC is focusing on improving donor harmonisation, including for the procurement of goods and services and for increased aid allocation through sector and national budgets.

3.3 At the same time, approaches to poverty reduction and to health policy are being increasingly defined by national governments, in the context of the PRSP process. National health strategies are beginning to integrate social marketing and other private sector interventions in order to improve coverage.

3.4 In the context of donor harmonisation efforts, the total market approach provides a significant opportunity for governments to develop both vision and strategy, for strengthening their stewardship role in the total market and for ensuring that poor people's health needs are met (as opposed to focusing mainly on public sector delivery).

3.5 There is an (re)emerging interest in lessons on how markets work – globally and locally. This includes understanding how markets may operate to the advantage and disadvantage of the poorest[4].

3.6 This parallels a longer standing growth in interest in public-private partnerships and relationships across the health sector. This reflects both the wider acceptance by governments and donors of the significant extent to which people are using the private sector for health services and products (for example, for the prevention and treatment of malaria), and of the need to revitalise the key regulatory roles that governments have to play.

[4] DFID is launching a "Making markets work for the Poorest" initiative. This initiative may, inter alia, cover health markets.

Towards a 'total market approach'

4.1 In many contexts, current support to social marketing programmes is largely taking place in isolation from other interventions in the public or private sector, and in the absence of a strategic analysis of the wider market. This can lead to inefficiencies and missed opportunities. There are risks of market distortion, damage to business confidence (including the inclination to invest in building up local production and distribution), and of amplifying the 'crowding out' affects of targeting public subsidy to specific product brands and segments.

4.2 The degree of market failure tends to vary with the type of product or service, market segment and existing demand and supply patterns. Different approaches are required for different commodities and their specific market structures. For example, the existing market in untreated nets in most African countries needs to be taken into account when planning a market intervention to increase both the use of treated nets and of new insecticide products. Where there are contraceptive providers already supplying wealthier market segments, there may be a need for generic promotion and brands aimed at lower income groups, and for support to strengthen social marketing by the public sector or to existing commercial distribution channels for operations in isolated areas.

4.3 As noted in 2.1 (e) above, this more comprehensive approach to understanding the overall market for the products or services is increasingly referred to as the 'total' or 'integrated' market approach (also the third generation of social marketing). Such an approach aims to assess the characteristics of existing, and likely future markets, and to define the comparative advantage of commercial, social marketing, NGO and public sector actors in terms of competence and value for money in delivering a range of products or services to different market segments, including the poorest. It can enable closer and more structured linkages with commercial, public and NGO sectors, and aid the gradual shifting of consumers with sufficient purchasing power out of the public sector. The approach also helps long term planning and the design of strategies for exit and for sustainability in its various forms (including of the market and the building of local capacity). In additionally, it provides an overall framework for the independent engagement of SMOs and other providers within government strategy, and to build local capacity.

4.4 Independent 'total' market assessments are needed to provide more information on how existing markets work. Likewise, independent monitoring and evaluation strategies are needed to provide comprehensive data on market penetration of relevant products and their utilisation. In particular, disaggregated socio-economic data is required on product utilisation and health benefits. Nationally representative data from Demographic and Health Surveys (DHS), for example, are likely to be valuable sources of information. Such routine surveys can already provide information about type of net (untreated or treated with insecticide) used, which can be disaggregated across socio-economic groups. Discussions are underway on including the brand of oral contraceptive used in the relevant DHS module.

4.5 Several governments and donors have already adopted variations around such approaches, for example in Indonesia (reproductive health commodities), Tanzania (insecticide treated nets), South Africa (condoms), the Philippines, Turkey and northern India (oral contraceptives).

4.6 In such cases, overall policy and strategy are determined in line with the analysis of market strengths and weaknesses, and incentives are designed to shape service provision as required.

4.7 The TMA approach would encompass the following:

- Developing the overall vision for the sector or sub-sector (reproductive health, malaria etc), including strategic consultations and development of common ground with key participants.
- Understanding the need, the market (supply, demand and segmentation), and the strengths and weaknesses of participants – using market assessments and analysis, user surveys etc.
- Setting evidence-based policy, strategy, objectives and targets, and allocating funds within the financial envelope to deliver a cost-effective mix of interventions.
- Identifying and planning for relevant changes in legislation and regulation.
- Designing and tendering projects according to the agreed strategy and objectives.
- Agreeing an overall framework for monitoring and evaluation, using a set of agreed indicators that are consistent between programmes and donors and that go beyond sales.

4.8 There are risks to developing these approaches, in terms of limited capacities, poor co-ordination, low understanding of how the market works, and weak incentives. For example, governments (and donors) may be keen to increase control of the market, or reluctant to expand their role as stewards of public health.

4.9 The TMA does not necessarily imply direct government financing to, nor contracting of, social marketing providers. The necessary degree of independence is an important characteristic of the market. Some governments may prefer donors to continue direct contracting of SMOs – especially where the government's procurement procedures and capacities are not felt to be conducive to effective contractual relationships.

4.10 There is substantial experience on which to draw in other sectors, such as the development of micro-finance. This developed from a narrow supply-led intervention to a demand-led market approach for the provision of a wide range of financial services – involving different products for different consumers, and intelligent targeting of a reducing level of public subsidy.

What kinds of functions and capacities are needed?

5.1 The application of a total market approach will require considerable shifts in the functions and capacities of the major stakeholders, in government, donor agencies, providers and consumers. This includes the introduction of new participants, such as central statistical offices, and consumer organisations to strengthen consumer awareness, and for-profit private sector providers through which value can be added. New functions and capacities are needed for policy-making and policy analysis, design of contracts to include performance-based incentives, and operational implementation (covered in the next section).

5.2 Wider consultation and information-sharing with stakeholders at strategic planning meetings is needed, with strong leadership to determine and take forward strategy. However, as a government shifts from its current role as public service provider

to a wider stewardship role, messy transitions are to be expected. Legislative and regulatory capacities tend to be very weak. Experience in the field of private sector/enterprise development had identified the need for amending relevant rules and regulations and for both enabling and supporting institutions. Consumer policy, and the capacities of consumer 'watchdog' and other civil society organisations, are still at a very early stage of development. Both the private sector, and private sector policy tend to be weak. SMOs are also repositioning themselves as one essential part of a market policy advocacy process – both individually and collectively.

5.3 The majority of current health policy making and analysis concentrates on the health system (and overwhelmingly on the supply side and public sector). Health market analyses, and health policy-making vis-à-vis markets, are uncommon and generally selective in their focus. This is seen clearly in the case of social marketing, where the policy focus has been on SM as an alternative or allied means of distributing commodities and service, as opposed to identifying the strengths and weaknesses of the health service market as a whole – and identifying if, where and how governments should intervene to fulfil their stewardship role. The importance of involving the relevant local government agencies in this process is also stressed.

5.4 The primary responsibilities for such policy making must rest within governments (and within donor agencies - to the degree that these wish to engage with governments on 'health markets' as one aspect of health policy dialogue.) The core functions of defining the overall vision for health policy and strategy, medium term planning and making financial allocations for selected interventions will require some strengthening (in almost all developing countries). However, many governments (and most donors) do not yet have the methodologies and expertise to pursue such a 'stewardship' approach. This applies particularly to ministries of health and to the cadres of health specialists in donor agencies. Such capacities may, however, exist elsewhere in governments and donor agencies, with technical expertise on understanding markets and how to make them work.

5.5 The development of such functions and capacities will require a change in ways of working – for all parties. In particular, governments and donors will need to be aware of how and where they can buy in the required market analysis skills and methodologies from independent sources. Rapid assessment methodologies are being developed (e.g. Institute for Development Studies, UK; London School of Hygiene and Tropical Medicine, UK; and Harvard School of Public Health, USA) to map the range and use of providers. Likewise, independent monitoring and evaluation activities provide extensive data on market penetration of relevant products and their utilisation. Routine household surveys are also a critical source of data. However, drawing on SMOs as a source for such skills may be increasingly inappropriate, in the light of their interest in supplying goods and services.

5.6 At present it is not obvious where such independent skills and capacities are (to conduct market analyses, and to weigh up the merits of alternative policy options) – or, indeed, where and how these might be developed. Health and non-health research institutions in both public and private sectors have a role to play. Experience of other sectors is of value, for example the role of the independent FinMark Trust in South Africa to assess and evaluate the effectiveness of the financial service market.

Social marketing: issues for procurement and management

6.1 There is wide agreement that the procurement and management of social marketing services need to evolve – in line with good international practice in the procurement and management of all health services [5] - and, in some respects, to be strengthened.

6.2 The lead responsibility lies with those procuring and managing the services – currently predominantly donors but also, to an increasing extent, developing country governments. SMOs are adapting to this changing world.

6.3 These changes can be largely independent of the wider application of a total marketing approach. However, such an approach will be conditional on defining transparent relationships (and trust) between governments and SM and other private sector service providers (in various roles). Sound procurement and management systems are integral elements in building and sustaining such relationships and trust.

Procurement of SM Services

6.4 The principal shifts in the procurement of SM services[6] include:

a) Donors and developing country governments specifying with greater depth and clarity exactly what they expect to see delivered – in terms of access and coverage, poverty focus, service quality improvements, changes in market conditions (e.g. to address such market effects as 'crowding-out' etc), IP rights, overall costs and unit costs, etc and how they will be monitored and evaluated. Such specifications should also identify out how and where any trade-offs between the above (e.g. between greater poverty focus on the one hand and increasing costs/affordability on the other should be resolved).

b) One key aspect of such specifications is identifying the right to intellectual property (including the ownership and the possible transferability of SM brands).

c) Another central aspect of such SM programme specifications will be the contracting options at the end of any contract – including whether future contracts will be for all of the specified SM service package, or for certain aspects or functions. For example, a second phase option might be to contract only for specific core management functions.

d) Both donors (working collectively where appropriate donor co-ordination mechanisms exist) and developing country governments being involved in the above – with each taking on agreed roles and responsibilities in this process.

e) SMOs being offered the chance to tender/bid for 'design and run' contracts to deliver the specified services, and fulfil the required objectives.

f) Any exceptions to tendering would be rare, and justified in detail by the market circumstances in which the SM programme is to operate. There should be no

[5] Such changes include: expanded use of contracting out; moves towards the harmonisation of procurement procedures (for both goods and services) – as part of wider development partner harmonisation efforts; use of procurement agents, third party monitoring, etc.

[6] 'SM services' are defined here as including all the actions necessary to operate a SM programme – whether involved in SM commodity sales, SM service provision (and/or social franchising, and/or BCC).

exceptions in respect of the status of the SMO – i.e. no distinction between for-profit or not-for-profit organisations.

g) Future SM contracts would be typically for a period of at least 5 years - with the option of 7 year contracts being considered routinely as part of drawing up the SM contract specifications in a) above.

h) Where competition between SMOs is being sought, or contemplated, the processes for managing competition or establishing rules of engagement would be specified in advance – including what post-tendering negotiations may be considered legitimate.

i) Contracts should specify how earned income would be used.

6.5 Allied to the procurement strengthening, the management of SM service contracts will be enhanced by:

- SMOs reporting against wider but focused targets and indicators – to reflect the spectrum of objectives set out in 6.4. a) above. The distinction between supplying low cost commodities through retail outlets, as opposed to the higher cost strategies required to reach the poor, needs to be explicit and measurable at project purpose and output level.
- SMOs reporting in greater detail on the costs of individual components of their programmes – to facilitate progressively more refined intervention/cost assessments – and to enable assessments to be made of the relative effectiveness of SM programmes in comparison to other possible health market interventions. Activities such as behaviour change communication and both NGO and community based delivery require separate cost centres and monitoring, in order to demonstrate value for money.
- Donors and developing country governments arranging for periodic third party (independent) monitoring – through a separate contract.

6.6 Significant changes, as noted above, will also be required in the arrangements and processes for capacity strengthening in relation to service procurement and management.

The way forward

7.1 There was broad agreement amongst participants at the meeting about the benefits of developing a total market approach. As part of the approach, the contribution of social marketing would be considered within the wider health service requirements of the countries concerned. The roles of different parties would be defined more clearly and consideration would be given to programmes lasting 5-7 years – avoiding the sporadic approach that sometimes occurs at present.

7.2 There was also recognition that the future lies increasingly with health services, of which commodities are a part, rather than using commodities in isolation and with increased focus on generic IEC. There was also recognition that further work will be needed to translate the approach into a format that can be applied in the field.

7.3 Possible next steps proposed by participants include:

- Developing a short paper on the key features of the total market approach to support further consultation and consensus building among major bilateral and multilateral donors and developing country partners – in particular seeking the feedback of the developing country governments as to their support and requirements in terms of building their own capacity.

- Using opportunities for advocacy opportunities within and among the major players – for example at DFID's initial meeting on 'Making markets work for poor people'; at the Bangkok AIDS conference; at the GFATM Partners Forum; at the EU health experts group; and at the High Level Forum on service delivery issues; and in the 2005 World Health Report.

- A group of donors working together with an interested government and other partners at national level to develop a 'testbed' pilot approach (e.g. a market analysis linked to the HIV/AIDS basket in Malawi, the Malawi ITN project). The new Social Franchise Initiative for TB and HIV also provides an opportunity to review the value of a total market approach.

- Developing guidelines and templates for DFID's (and others') use for establishing clearer, consistent and transparent approaches to programme planning, to procurement, to the management of services and to output to purpose reviews of SM programmes.

- Sharing experience in good contracting practice (involving donors and global initiatives such as STOP TB and RBM) and to support processes at country level (where contracting out is a major component of most GFATM funding).

Note prepared by DFID Health Systems Resource Centre
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Annex 1
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