

## **Health Promotion Meets Social Marketing: The Monash Preschool Dental Program (MPDP)**

Railton Hill and George Bell, Swinburne University of Technology  
Anne C. Hill, MPDP

### **Abstract**

Social marketing principles have long been employed in the field of health promotion, although often without full and strategic inclusion and integration of all elements of the marketing mix. Typically, large population segments are targeted for behavioural change via mass media campaigns. A recent study concluded that while professionals self-identifying as 'health promoters' can enhance their effectiveness by such increased strategic inclusion and utilisation of mix elements, they can also offer models of social marketing practice from which other marketers can learn. The Monash Pre-school Dental Program (MPDP) is offered as a case study exemplifying the successful application of a 'community development' approach we can recognise as incorporating strong elements of relationship marketing, within social marketing principles. Marketing network theory is suggested as one key framework that may be expanded through further study of such cases. The case exemplifies the mutual learning available between health promoters and other marketers.

### **Introduction**

#### **Health Promotion and Social Marketing**

'Social marketing' - often associated with health issues - was an early application of the 'marketing concept' (Kotler & Zaltman, 1971). The term 'social marketing' implies that marketing concepts and techniques, usually framed in the traditional Ps framework, are applied to obtain socially desirable outcomes (Lefebvre & Flora, 1988). A recent review and analysis of 'health promotion' literature from the period 1982 to 1996 concluded that some social marketers, even while often operating programs without full and strategic employment and integration of all elements of the marketing mix, have moved into very effective forms of relationship marketing (Hill, 2001b).

'Health promotion' has been described as an eclectic but distinct discipline, based in the 'primary health care' movement (Wass, 1994, p1), with a range of supportive courses, professional associations and both scholarly and practitioner oriented journals. It embraces a range of approaches, including, but not limited to, applications of social marketing (Egger, Spark, & Lawson, 1992). Other approaches commonly recognised include 'community development', advocacy, behaviour change and others (Naidoo & Wills, 1994, chapter 5). This paper documents a dental health promotion program which not only incorporates many traditional social marketing elements, but which features a highly effective application of relationship marketing principles.

#### **Case Methodology**

The methodology used involved a series of six depth interviews with key stakeholders in the MPDP. These included program officer, management committee member, dental therapist, dentist, municipal officer with responsibility for health promotion and parents. In general these were conducted in the workplace. These half hour interviews were in some cases reiterated over a period of eighteen months, such that a longitudinal perspective was obtained. In addition, annual reports covering the full period of program operation, the summary final report, and reports to particular stakeholders (e.g. dentists) were accessed as well as the relevant publicly available literature. Analysis was prepared from these sources. While the study is essentially qualitative and interpretive in nature and intent, it makes use of proprietary data, some of which is empirical in nature.

### **MPDP Background and Objectives**

Good oral health is important for young children to help them eat, talk, smile and develop positive self-esteem. It is beneficial to children's general health. Deciduous teeth play an important role in guiding the development and eruption of permanent teeth. If deciduous teeth are lost prematurely due to decay, orthodontic problems may occur later with the erupting permanent teeth (DHS, 2000, p. 5). Despite steady improvements in the oral health of children which have been evidenced over the past 20 years (DHS, 1999), many young children still suffer from dental decay. Pain, sleepless nights and sometimes the need for major dental treatment including the extraction of teeth under general anaesthetic, can be an outcome of this. Over half (53 percent) of the five year olds enrolling in the (Victorian) School Dental Service in 1998 had dental decay, almost 80 percent of this untreated (DHSV, 1999). This situation is completely preventable.

The Monash Preschool Dental Program (MPDP) is a preventive, early access program, which aims to enhance the oral health of 'at risk' preschool children within the City of Monash. The (Victorian Government) Department of Human Services (DHS) and the City of Monash fund the program. A working group comprising members from the Dental Health Services Victoria (DHSV), the City of Monash and the DHS jointly manage it. A Project Officer seconded on a .4 basis from the DHSV is responsible for the actual operation of the program.

Specific Program objectives are: 1) To improve the *knowledge, attitudes and practices* of *preschool staff* and *parents* relative to optimum oral health of preschool children 2) To develop a *collaborative approach* among *health and education providers* to promote oral health in preschool children and 3) To assist key *organisations* in *providing positive environmental influences* upon oral health. A further objective was to pilot *strategies that could be generalised* through state preschool oral health policy.

### **Program Methodology**

Five 'initiatives' addressed these objectives:

#### **1. Private Practitioner Initiative**

A register of 26 'preschool friendly' dentists was developed by the Program Officer, a school 'dental therapist' (a dental professional employed in School Dental Service, trained and licensed in 26 aspects of dentistry for patients aged up to 17). She addressed meetings of a

regional branch of the Australian Dental Association, recruiting this panel. The register is circulated to preschool parents around the City of Monash through all the partners in the MPDP. This encourages parents to take their child along for a free or low cost dental check-up.

## **2. Nursing Caries Awareness Initiative**

This initiative consists of a nursing caries kit of 16 photographs and labeled messages. This is circulated to Maternal & Child Health (M&CH) Centres for zero to three-and-a-half-year-olds on a monthly rotational basis. The objective is to inform new mothers about risk factors for infant feeding caries, recommendations for bottle/dummy use and dietary suggestions. Private dentists or DHSV dental therapists were available during this time to give talks to new mothers/parents.

## **3. Preschool (kindergarten) Resource Kit Initiative**

This consists of a portable dental chair, costumes for role-play, dental related activities, videos, books and puzzles. It is circulated amongst all preschools throughout the City of Monash, with preschools considered 'high risk' for oral disease specifically targeted and offered talks to for parent groups. Sessions with children highlighted 'a visit to the dentist'. The dentist register was promoted to all preschools.

## **4. Childcare Centre Resource Kit Initiative**

A kit similar in design to the Preschool Kit is made available to childcare centres, but with the contents tailored for the younger age group. This kit supported the Dentally Friendly Childcare Centre and Private Practitioner Initiatives.

## **5. Dentally Friendly Childcare Centre Initiative**

Childcare centres were encouraged to adopt oral health promoting practices including the development of oral health policies and tooth-brushing programs. Centres meeting set criteria were issued with a 'dentally friendly' certificate, signed by both the Mayor of the City of Monash and the Minister for Health.

## **Program Evaluation**

A major review of the program was completed in August 2001. This took the form of a 'qualitative impact evaluation' focussing on each of the initiatives and with specific consideration of issues of 'sustainability and reproducibility' (DHSV, 2001a, p.8). While most evaluation reported is 'process' focussed, a measure of behavioural outcome is achieved in the strong growth in numbers of children recorded as actually presenting for dental visits via the private practitioner register. This grew from 37 in 1999 to 243 in 2001, a 650 percent increase. Participation measures in the various initiatives achieved are very positive. For example, the resource kits were used by 47 of 69 eligible preschool and childcare services (68 percent) in the 2001/2002 period. Twenty-one childcare centres used the childcare centre resource kit during 2001/2002, up from 12 during 2000/2001. Reintroduction of the Dentally Friendly Childcare Centre Award in 2000 resulted in 86 percent of such centres being awarded this at the end of the 2001/2002 financial period, up from 34 percent in 2000/2001 (Hill, 2001a; Hill, 2002). By such measures, the Program has been very successful. The major

evaluation completed in 2001 (DHSV, 2001b) explains that due to the sample sizes involved, movement of families in any given cohort into and out of the area and limitations on the actual dental disease information available, hard data on the impact of the program on rates of caries and the like is not available. This would obviously provide the ultimate 'outcome' evaluation.

### **MPDP Marketing Mix**

As noted, the MPDP has zero advertising content. It does however include virtually every other element of traditional social marketing programming.

#### **Positioning**

There are a number of campaigns, services and providers currently targeting preschoolers and their parents. These include *Sunsmart*, *Safety House*, *Filling the Gap* (nutrition), programs addressing issues such as meningitis, skin disorders, and others. The MPDP is concerned to offer very clear differentiation from the plethora of good causes looking for the attention of common targets. MPDP differentiation seems to stem from the *localised* (cf. statewide) nature of the program, the *range* of initiatives which are being used, and the seamless *integration* achieved between these. It also appears that the availability of a *dedicated (specialist) local representative* who is located (and also lives) locally, and who exhibits very high level skills in communication, planning and facilitation is the fulcrum on which this localisation, range of initiatives and seamless integration moves.

#### **Product**

The core product which is the subject of this program is on one level, 'preschool dental health' - essentially the *absence of disease*. In line with principles of the Ottawa Charter (WHO, 1986) however, the core product is also knowledge and a degree of *proactive, self-directed management* of one's own dental health, or more correctly, that of one's preschool children by parents. A further conceptualisation of the product on offer is as a bundle of learning (by various stakeholders, for example by parents concerning the importance of infant oral health) and specific behaviours, primarily oral health care behaviours such as healthy eating and cleaning, plus visiting the dentist. The *product line* offered can also be classified as a range of five service products. These include each of the initiatives outlined.

#### **Price**

As a government (state and local) funded program, with pro bono input from dentists, exchange is not primarily monetary in nature. Parents, teachers and other stakeholders contribute significantly in terms of *time, psychological and physical* effort and social cooperation, to achieve learning and behavioural change, and ultimately the core product of oral health and empowerment which is offered.

#### **Communication**

The program actually significantly utilises the whole communication mix, with the exception of paid advertising. Much interpersonal communication can be conceptualised as *personal selling*. *Publicity* is an important part of full leveraging of the dentally friendly child-care centre and dental visit initiatives. Extensive use of data bases in the manner of *direct*

*marketing* is also important in the maintenance of relationships with the 27 preschools, 19 dentists, 29 childcare centres, and 13 M&CH centres. Sales promotions have been utilised.

### **Placement (Distribution)**

The MPDP can be seen as an integrated *network* designed to distribute the core product described above. The Program Officer directs *resource* and *information* flow.

### **Discussion**

An 'exchange' - of some effort, time, learning etc. - is necessary to satisfy a 'need' for proactive, self directed management of the preschool dental health of one's children. Such parenting is easily seen as a felt need. This lends some credibility to marketing's claim to address basic 'needs'. Social marketing offers a definite challenge to this fundamental marketing tenet, in that we can reasonably ask in many social marketing campaigns '...do I 'need' (say) a course in healthy eating for which I *feel* absolutely no need, but which *is* 'needed' by government if it is to cut health care costs?' (Hill, 2001b, p. 44)

A basic tenet of relationship marketing is a focus on the 'lifetime' value of a relationship (Gronroos, 1994). The MPDP is clearly based on this approach. This is evident at the end consumer level and at the business-to-business level, where the sophisticated network of channels which delivers the five 'initiatives' was developed over several years, and maintained by careful ongoing management. Further, Wilkinson (2001) has provided a series of questions for application to networks. For example, he asks why networks are structured the way they are, with activities divided amongst stakeholders in various ways. Another question asked is to what extent and how are the activities of different organisations in a network coordinated, managed and controlled? The article poses a range of economics and behaviour based theory that can be brought to bear to answer such questions. Of immediate research relevance are the influence of *proximity* and *channel leadership* within the network.

### **Conclusions**

The program incorporates key elements of both *social* marketing and *relationship* marketing approaches in an approach springing from *public health/health promotion* precepts. These approaches have been successful, in terms of process and behavioural outcomes. Hard epidemiological evidence should now be sought. Social marketing techniques and analysis are valid in a micro context such as the MPDP, not just in society wide campaigns featuring mass advertising. The case exemplifies Australian relationship based marketing activity in support of health promotion objectives at municipal level - a major level of service delivery to Australians. Finally, the case exemplifies the conceptual similarities between approaches which health promotion professionals would identify as exemplifying *community development* (for example, see Jackson, Mitchell & Wright, 1989). and *relationship marketing* in a *social marketing* context. Cases such as this may facilitate productive dialogue between distinct but kindred disciplines.

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