“An Exploratory Examination of the Marketing Philosophy Utilization in the Health Industry: A Case of Preventative Family Home Visiting Health Program in Australia”

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An Exploratory Examination of the Marketing Philosophy Utilization in the Health Industry: A Case of Preventative Family Home Visiting Health Program in Australia[1]

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Abstract

According to the literature the application of the marketing concept philosophy is fundamental to the success of any program run in organizations. However, despite its importance, limited research has been focused on investigating the adoption of the marketing concept philosophy in the health industry. This paper presents the results of a study that was designed to examine whether the marketing concept philosophy is being utilized in health services programs particularly in a preventative home visiting program operating in a rural community in Australia. The home visiting program investigated in this research was a two-year publicly funded program that involved recruiting and training experienced parents as volunteers to visit and support first-time parents or carers. In order to investigate whether the marketing concept was being applied within this program, a survey questionnaire was developed and distributed to all parents and carers upon entry into the program. Results of the research showed that parents/carers participating in this home visiting program came from a similar socioeconomic background and did not appear to have a need for the program. Further research is warranted to identify segments of society who have a need for such a program and to tailor their needs to these programs.

Key words: marketing, health, parents, preventative home visiting programs.

Introduction

The marketing concept philosophy states that achieving organizational goals depends on investigating the needs and wants of target markets to deliver *products* and *services* that satisfy their needs and wants (Kotler & Pearson, 2004; Cravens & Nigel, 2003; Blackwell Miniard & Engel, 2001; McCarthy Perreault & Quester, 1998; Ogunmokun & FitzRoy, 1995). This concept is important because an adequate understanding of consumers' needs and wants by organizations could lead to better performance such as growth in resources, higher customer satisfaction and growth in reputation (Gainer & Padanyl, 2002).

Health services, such as home visiting programs are like any other product or service which require the application of the marketing concept because consumers like to choose health services that fulfil their needs. That is, consumers tend to use a combination of technical and functional (Wong, 2002; Lewis, 1991; Gronroos, 1984) criteria to choose brands of health services that are important for satisfying their needs. Therefore, health service providers such as doctors, hospitals, and home visiting services should orient towards consumers' needs and wants (Laing, Fischbacher & Hogg, 2002).

However, although the literature on marketing is consistently emphasizing the benefits of adopting the marketing concept philosophy, little or no research has been devoted to determining whether the philosophy used by many of the health programs, particularly preventative home visiting services in the health industry, are in line with the philosophy of the marketing concept.

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Since one of the major objectives of preventative home visiting programs is to improve parents' knowledge of various health and social issues this paper presents the results of a study that was designed to identify whether the participants who enrolled in a preventative family home visiting program in Australia were the people who needed such a program. That is, has the health organization running this health program used the marketing concept philosophy to target the right people who could benefit from it and thereby attract more people to come to the program by their satisfaction with the program?

Background

Preventative home visiting health program is a service which involves recruiting and training community volunteers, who have previously been parents, to visit and empower new parents with children in their first year of life (The Australian Association for Infant Mental Health, 1998). This type of family health program aims to promote children's health and development through providing parenting information, social support and linkages to other services to strengthen and enhance the nurturing environment of families (Weiss, 1993). In some countries (including countries in Northern and Western Europe) this type of program is believed to be one piece of an essential network of economic and social support provided by governments to families (Kamerman & Kahn, 1993). For example, policy makers in Britain and Denmark have cited the importance of home visiting health services in accomplishing certain health goals and the European experience has suggested that home visiting services can be an effective strategy for improving the health and developmental status of children (Kamerman & Kahn, 1993).

Despite its importance and popularity, transferability of this type of program into countries and cultures outside those where the program has been successful requires caution. That is, researchers have cautioned that transferability of lessons learnt in Europe to other countries such as the United States may be complicated due to the very different perspectives and premises of policymaking in those countries (Kamerman & Kahn, 1993). In many European countries, home visiting services continue to be universal (available to all families), popular, generously supported and viewed as effective; while in the United States, the similar tradition of broad, universal supports does not exist (Kamerman & Kahn, 1993).

Therefore this paper examined whether the organization running this particular health program utilized the marketing concept philosophy to target the right people for the program. The pilot program was a two-year family home visiting program aimed to recruit and train community volunteers who had previously been parents to visit and empower new parents with children in their first year of life. During the first 12 months of the program, this aim was revisited and scope of the program was extended to include toddlers up until the second year of their life. The level of success of this program was to be gauged by the number of parents joining the program and by the level of improvement in parents' knowledge of child and other health issues. However, although the program was to run for a period two years with the aim of attracting at least 200 parents into program, the program attracted only 80 parents/carers into the program during that time.

Methodology

New parents or carers entering the program between January 2001 and November 2003 were asked to complete a questionnaire prior to entry into the program to gauge their level of knowledge about various health issues relating to child health. Questions in the questionnaire covered oral health, breast feeding, nutrition, home safety and immunization. The questions were composed based on the suggestions by a group of professional health care workers, psychologist and doctors for it appeared that there was no questionnaire addressing child health in the literature. Demographic and behavioural data were also collected separately from parents/carers. Demographic information collected included parent/carer's age, marital status, age, income, employment status, income levels and nationality. Behavioural data included birthing institution, type of support agency used by parent/carer prior to entry into the home visiting program and frequency of visit required by volunteer. The answers provided by the respondents will be used to determine whether the program attracted the right people who needed such a program. Although, survey re-

search was used for this study participation in the survey was not compulsory for parents due to ethical reasons. Out of the 80 parents in the program, only 22 completed all the questions in the questionnaire thus leading to 27.2 % response rate. Given the low response rates, this research was treated more as an exploratory study warranting further research.

Results

Regarding demographic information (Table 1), all participants were female. Additionally, the majority of women in this study were in a relationship. Furthermore, the majority (68%) of the respondents were either married or in a de facto relationship, (27.3%) were never married and 4.5 % were separated from their partners. The educational status of parents/carers was evenly distributed across educational levels. Approximately a third of all respondents (36.3%) had up to a year 11 school certificate. Another one third (31.8%) of the respondents had completed either a year 12 school certificate or a TAFE college certificate. About 32 % completed tertiary education. The majority (81.8%) of respondents were unemployed. Only 18.2% were employed either full-time or part-time. More than a half (54.5%) of the respondents earned less than $30,000 per annum while the rest (45.5%) of the respondents earned $30,000 or more.

The demographic characteristics of respondents (e.g. sex, age, marital status, education, income) were compared to those of non respondent to ensure that respondents were representative of the population of program participants. The results of using chi square statistics and Fisher's Exact test showed that there were no significant differences between the demographic characteristics of respondents and non-respondents at a 5% level of significance.

Table 1

Demographics of parents/carers in the home visiting program

Demographics	Respondents	
	Frequency	Percent
Sex		
Female	22	100.0
Parent's/carer's age		
Under 20 years	1	4.5
20 to under 30 years	7	31.8
30 to under 40 years	13	59.0
40 years and above	1	4.5
Total	22	100.0
Marital status		
Married/de facto	15	68.0
Never married	6	27.3
Separated	1	4.5
Engaged	0	0.0
Total	22	100.0
Education		
Less than year 10	5	22.7
Year 10/11	3	13.6
Year 12/ TAFE/college certificate	7	31.8
University degree	7	31.8
Total	22	100.0
Employment		
Employed	4	18.2
Unemployed	18	81.8

Table 1 (continuous)

Demographics	Respondents	
	Frequency	Percent
Total	22	100.0
Income		
Less than $16000 p.a.	1	4.5
$16001 - $20000 p.a.	3	13.6
$20001- $30000 p.a.	8	36.3
$31000- $40000 p.a.	4	18.2
$40001-50000 p.a.	3	13.6
$50001or more	3	13.6
Total	22	100.0
Nationality		
Australia	18	81.8
New Zealand	2	9.1
England	1	4.5
USA	1	4.5
Japan	0	0.0
Fiji	0	0.0
Papua New Guinea	0	0.0
Africa	0	0.0
Total	22	100.0

Behavioural data for respondents. Behavioural information for the respondents is summarized in Table 2. The results showed that the majority of respondents (63.6%) gave birth at a public hospital rather than a private hospital. Furthermore, less than a half (45.5%) of the respondents had some sort of support from professional or non professional bodies such as family and friends, church, private and public hospitals, mental health care or child health nurses. Therefore many already had links to support services, thereby negating the need for this area of support by this program for at least half of the parents/carers. Nearly all the respondents (95.5%) received visits at least fortnightly from home visiting program volunteers.

Table 2

Behavioural characteristics of parents/carers in the home visiting program

Behavioural data	Frequency	Percent	Cumulative percent
Institution of birth			
Private hospital	8	36.4	36.4
Public hospital	14	63.6	100.0
Total	22	100.0	
Support type			
Non professional	10	45.5	45.5
No support	11	50.0	95.5
Not stated	1	4.5	100.0
Total	22	100.0	100.0
Frequency of home visit			
Weekly	15	68.2	68.2
Fortnightly	6	27.3	95.5
By phone only	1	4.5	100.0
Total	22	100.0	

Participants knowledge of the child health issues prior to joining the home visiting program. Parents' responses to the various areas of child health questions are presented in Tables 3-6. The decision as to whether a participant answer (Tables 3-6) is correct or wrong is based on the solution provided by a group of professional health care workers, psychologists and doctors. The results regarding child's oral health in Table 3 show that the majority (more than 84% and in some cases up to 96%) of the respondents had a sound knowledge of child's dental health issues. However only a half (50%) of the respondents answered correctly the question that asked whether the bacteria that causes dental decay can be transferred from parent/carer to a child.

Table 4 shows breast feeding and nutrition results. Again the majority (more than 85% and in some cases up to 96%) of the respondents have a sound knowledge of these issues. Only one question (question 10 which relates to when babies should be fed meat products) had a low number but still a comfortable majority (64%) of the respondents answered the question correctly.

Table 3

Oral Health dimension– results from the parent/carer's in the home visiting program

Q	Oral Health question	Correct answer - medical	No of respondents with correct answer	
			No.	%
1.	Baby teeth are not important as they will fall out	False	21	95.5
2.	Putting a toddler to bed at night with milk in a bottle won't hurt their teeth	False	20	90.9
3.	Children with baby teeth only need dental treatment when they have a toothache	False	21	95.5
4.	Using a drink straw for sweet drinks will be better for a child's teeth	False	17	77.3
5.	Bacteria causing dental decay can be transferred from parent/carer to child	True	11	50
6.	As soon as the baby teeth come through they should be cleaned regularly	True	19	86.4

Table 4

Breastfeeding and nutrition dimension – results from the parent/carer's in the home visiting program

Q	Breastfeeding and nutrition question	Correct answer	No of respondents with correct answer	
			No.	%
7.	Breast milk is better for baby	True	21	95.5
8.	Most women can breastfeed their babies	True	20	90.9
9.	It is best to offer new foods one at a time	True	21	95.5
10.	Babies should not be given meat products until about 12 months of age	False	14	63.6
11.	Breastfed babies usually need formula too	False	20	90.9
12.	Suitable first foods to introduce include rice cereal, pureed vegetables and fruit	True	21	95.5
13.	Babies who cry a lot should be tried on solids before 4-6 months	False	19	86.4
14.	Breastfeeding may help the mother return to their pre-pregnancy figure	True	21	95.5

Table 5 shows results relating to home safety for children. With the exception of one question (question 15 which relates to installing an electric earth switch in the home), the majority (more than 85% and in some cases up to 100%) of the respondents answered the questions correctly. This

result indicates a good understanding of this topic. When parents were asked various questions about child immunisation (Table 6) the majority of the respondents gave correct answers.

Table 5

Home safety dimension – results from the parent/carer's in the home visiting program

Q	Home safety question	Correct answer	No of respondents with correct answer	
			No.	%
15.	Homes should have an electric earth switch installed in the meter box	True	16	72.7
16.	Smoke alarms should be located near the bedrooms	True	19	86.4
17.	Car baby-capsules do not need to be anchored	False	21	95.5
18.	Children can drown in less than 5 cm of water	True	21	95.5
19.	Ninety-five percent of children who drown in pools or spas lived there or were invited there	True	20	90.9
20.	Most cleaning agents, laundry products and essential oils are not poisonous to children	False	22	100.0
21.	There are no rules for safety of nursery furniture	False	21	95.5
22.	All medicines (including Panadol) should be kept in a locked cupboard	True	22	100.0

Table 6

Immunisation dimension – results from the parent/carer's in the Home Visiting Program

Q	Immunisation question	Correct answer	No of respondents with correct answer	
			No.	%
23.	Newborn babies receive their first vaccination at birth	True	18	81.8
24.	By the time a child has reached 4 years of age he/she will have had the majority of their childhood vaccinations	True	22	100.0
25.	Immunisation is very important in preventing the spread of disease	True	21	95.5
26.	Toowoomba City Council provides free vaccinations on a monthly basis	True	21	95.5
27.	Measles is not a highly contagious disease	False	17	77.3
28.	Your general practitioner also provides immunisations for children	True	22	100.0
	There is a financial incentive for parents who fully immunise their child	True	18	81.8

Discussion and Conclusion

The result of this exploratory study showed that the majority of the participants that completed the pre-entry questionnaire and participated in this preventative family home visiting program had a high knowledge of the health issues relating to parenting prior to entry into the program. Therefore, the services offered by this home visiting program appeared not to have been relevant to the actual cognitive needs of parents. This does not mean that parents did not gain from the social interaction offered by the program, however, it does not appear to meet the objectives of the program which was to enrich the knowledge of parents. However, it could be argued that if the health industry wants to have success in this type of program they should adopt the marketing concept philosophy by finding out who needs a particular program and designing the program to suit the desired need of that group prior to pilot testing it.

It can be concluded that program effort and resources in many organizations are often wasted as a result of the lack of application of the marketing concept philosophy and a poor Training Needs Assessment (TNA). According to McClelland (1993), the goal of a TNA is to identify training needs as they currently exist or have the potential to exist at a future time, and to design and develop the ways and means of addressing and satisfying those needs in the most cost-effective and efficient manner possible. Future research regarding parents currently using the program could examine:

1. Problem recognition – what factors resulted in parents wanting to join this program.
2. What are parents'/carers' needs in relation to the program (core benefit, secondary benefit, benefit providers, other aspects of services).
3. Problem recognition – what factors resulted in parents wanting to join this program.
4. What are parents'/carers' needs in relation to the program (core benefit, secondary benefit, benefit providers, other aspects of services).
5. Perceptions – what were parents' pre-entry perceptions of the program?
6. What was the level of satisfaction with the program?
7. What improvements can be made to the program?

Future research regarding new parents who have not previously used this type of program could examine:

1. Which segments of the community have the most need for parenting support programs (some areas may include teenage parents, stay-at-home fathers and disadvantaged groups)?
2. What are these segment(s) needs in relation to support programs?
3. *Perceptions* – what were parents'/carers' awareness levels and perceptions of Parenting Support programs?

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