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Public Health Needs Marketing: Bridging the Gap Between Health Programme Availability and Utilization

A Conceptual Review of Social Marketing as a Strategy for Strengthening Public Health Programme Implementation in India

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Abstract:

- ***Background:***

India's public health system is experiencing rapid change through digital health platforms, universal health coverage initiatives, community-based services and technology-supported models of care. Programmes such as Ayushman Bharat Jan Arogya Yojna, Ayushman Bharat Digital Mission (ABDM), Health and Wellness Centres, telemedicine, immunization services, tuberculosis elimination activities and other National Health Mission interventions have considerably increased the range of services available to the population. Nevertheless, making a service available does not automatically ensure that the intended beneficiaries will use it.

- ***Objective:***

This conceptual review examines how marketing and social marketing principles can be incorporated into public health programme implementation to narrow the difference between planned programme performance and actual service utilization.

- ***Discussion:***

Public health programmes are commonly designed around population-based targets, yet actual performance can remain below expectations. Reasons may include inadequate awareness, limited health literacy, social and cultural barriers, lack of confidence in institutions, inconvenient access or failure to recognize the value of a service. Social marketing offers a systematic way to understand audiences, divide them into meaningful groups, communicate benefits, reduce practical and psychological barriers and encourage voluntary health-related behaviour. Evidence from systematic reviews indicates that appropriately designed social marketing interventions can influence behavioural determinants and, in some settings, contribute to changes in health-related behaviour and outcomes.

The paper proposes adapting the marketing mix—Product, Price, Place, Promotion, People, Process and Physical Evidence—to public health programmes. Particular attention is given to social media, communication of service value, programme presentation, location-specific promotion, audience segmentation by age and context, frontline health workers as trusted programme representatives, and continuous measurement.

- ***Conclusion:***

Public health programmes need to progress from a predominantly supply-oriented service-delivery approach toward a combined model that also creates informed demand. Marketing in this context should not mean commercializing healthcare. Instead, it can serve as an ethical mechanism for helping publicly funded services reach the people for whom they were designed. Combining social marketing with health literacy, community participation and behaviour-change communication may help reduce the gap between expected programme achievement and actual utilization.

Keywords: *Public Health Marketing; Social Marketing; Health Communication; Health Literacy; Behaviour Change; Health Promotion; Ayushman Bharat; ABDM; Telemedicine; National Health Mission; India.*

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I. INTRODUCTION

The central purpose of public health is to improve population health through prevention, health promotion, protection, treatment and rehabilitation. Governments devote considerable financial, human and technological resources to public health programmes with the expectation that these interventions will reach eligible populations and generate measurable health benefits.

India's health system has increasingly adopted technology-enabled and population-oriented approaches. Digital health platforms, telemedicine, financial protection programmes, Health and Wellness Centres, immunization services, disease-control initiatives and community-based interventions have widened the range of health services accessible to citizens.

Yet an important implementation issue remains: what is the outcome when a service is available but the person who needs it has never heard of it, does not understand its purpose, does not trust the provider or does not see sufficient value in using it? This issue represents an important and often overlooked dimension of programme management.

A programme may possess adequate infrastructure, trained staff, funding and clearly defined targets, while utilization remains below the desired level. Consequently, a gap can emerge between service availability and service uptake.

Health literacy is especially relevant to this problem. The World Health Organization describes health literacy in terms of people's ability to access, understand, evaluate and use health information and services in ways that protect and improve health. WHO also emphasizes that health literacy is not solely an individual responsibility; health systems and information providers have a responsibility to make information clear, trustworthy and usable.

Public health programmes therefore require stronger approaches for explaining their relevance and value to communities. Social marketing is one possible strategy.

➢ *From Service Delivery to Service Utilization*

Conventional public health planning often follows a straightforward sequence: Population → Target → Service → Delivery → Achievement. In practice, however, service utilization involves several additional steps.

A more realistic pathway is: Population → Awareness → Understanding → Perceived Value → Trust → Intention → Access → Utilization → Continued Behaviour → Health Outcome.

A programme can lose potential beneficiaries at any stage of this pathway. For example, a government may introduce a digital health service, but a rural beneficiary may never hear about it; may hear about it without understanding its purpose; may understand the purpose but not know how to access it; may know the procedure but encounter technological barriers; may register but lack confidence in the system; or may complete registration without ever using the service.

For this reason, simply measuring whether a programme exists or whether infrastructure has been created cannot provide a complete picture of programme performance.

➢ *The Gap Between Expected and Actual Achievement*

Public health programmes usually establish targets using factors such as population size, disease burden, demographic characteristics and service requirements. A conceptual expression of expected performance is:

- Expected Achievement = Eligible Population × Programme Coverage Target

- *Actual Achievement may Fall Short for a Range of Reasons:*

✓ Insufficient awareness
✓ Low health literacy
✓ Geographical or transport barriers
✓ Social and cultural beliefs
✓ Misinformation
✓ Limited trust
✓ Weak interpersonal communication
✓ Inconvenient service procedures
✓ Digital exclusion
✓ Low perceived value
✓ Insufficient family or community support

The difference between planned and achieved performance can therefore be conceptualized as a Public Health Achievement Gap:

- Expected Achievement − Actual Achievement = Public Health Achievement Gap

This gap should not automatically be interpreted as a failure of frontline personnel. It can also indicate weaknesses in communication, community engagement, accessibility and demand generation.

➢ *What is Social Marketing?*

Social marketing uses marketing concepts, tools and techniques to encourage voluntary behaviours that produce benefits for individuals and society. This differs from commercial marketing, whose principal purpose is generally the exchange of products or services for financial return.

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Since the concept emerged in the 1970s, social marketing has developed into an approach that emphasizes audience understanding, segmentation, exchange, behavioural influence and the coordinated use of multiple intervention methods.

Systematic-review evidence has reported the use of social marketing in areas such as disease prevention and health promotion. Reviews of interventions addressing neglected tropical diseases have identified audience segmentation and relationship-building as recurring strategies, with many interventions reporting improvements in behavioural determinants and, in several cases, behaviour itself.

A 2023 systematic review of prevention interventions also reported generally positive associations with social marketing approaches, while noting methodological limitations and the need for stronger evaluation designs.

The implication is not that marketing automatically produces better health outcomes. Rather, carefully designed, audience-centred social marketing can strengthen the chain connecting health information with meaningful behaviour change.

➢ *Why Public Health Needs Marketing*

Many public health programmes operate, explicitly or implicitly, on the assumption that once a service is available, people will use it. In reality, utilization depends on several conditions.

People are more likely to use services when they know that the service exists, understand what it offers, consider it useful, trust the provider, believe that its benefits justify the effort involved, can reach it conveniently and receive encouragement from their social environment.

Marketing can influence several of these determinants. WHO also recognizes social mobilization as an important part of health promotion because it can increase awareness and demand while supporting sustained community participation.

Accordingly, marketing can be understood as a demand-generation function within public health rather than as a commercial activity.

➢ *Applying the Marketing Mix to Public Health*

The conventional marketing mix can be adapted to the public health context by interpreting each component in terms of service uptake and beneficiary experience.

- *Product: What is the Health Service?*

In public health, the ‘product’ is not necessarily a physical item. It may be an Ayushman Card, telemedicine consultation, digital health account, vaccination, antenatal care, family-planning service, free diagnostic service, tuberculosis screening, hypertension screening, free medicines or counselling.

Programme communication should clearly explain what the beneficiary receives and why it is useful. Instead of merely announcing that ABDM registration is available, communication could explain that creating a digital health identity can help connect and access health records through participating digital health services. The emphasis should therefore be on beneficiary value rather than administrative procedure.

➢ *Price: Communicating the Value of Free Healthcare*

One important application of marketing in public health is the concept of perceived value. A government service may be free at the point of use, yet beneficiaries may not regard it as valuable.

Communication can appropriately explain the economic protection associated with public services. For example, an eligible government health scheme may cover treatment that could otherwise require substantial private expenditure.

Such messages must remain accurate, transparent and specific to the programme. The purpose is not to exaggerate the worth of a service, but to help communities understand the financial protection and social value generated by public investment.

➢ *Packaging: Making Public Health Programmes Understandable*

Commercial organizations pay considerable attention to presentation because the way information is packaged affects attention and perception. Public health programmes can apply the same communication principle.

Effective programme packaging may include simple names, memorable slogans, recognizable visual identities, appealing IEC materials, short videos, beneficiary experiences, infographics, local-language content, QR codes and clear instructions.

Even a technically strong programme may remain underused if the information surrounding it is difficult to understand. Thus, effective public health delivery requires effective public health communication.

➢ *Place: Promote Services where People are*

Communication should reach people in locations and settings where they naturally spend time. Relevant channels may include schools, Panchayat offices, Anganwadi Centres, Health and Wellness Centres, weekly markets, community meetings, religious or cultural gatherings, workplaces, colleges, self-help groups and Village Health, Sanitation and Nutrition Days.

A digital campaign by itself cannot overcome communication barriers in populations with limited digital connectivity or literacy. Public health marketing should therefore use a hybrid approach that combines digital communication, interpersonal interaction, community platforms and mass media.

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➢ *Promotion: From IEC to Integrated Communication*

Public health has traditionally relied on Information, Education and Communication (IEC). Modern programme communication can move beyond this model by combining IEC with Behaviour Change Communication, social marketing, digital communication, community participation, interpersonal communication, social media and appropriate local influencers.

A useful programme message should answer three questions: What is the service? Why should I use it? What should I do next?

A campaign that only creates awareness may increase recognition of a programme without translating that awareness into service use. Communication should therefore guide beneficiaries from awareness toward action.

➢ *Social Media as a Public Health Marketing Tool*

Social media has substantially changed how health information is created, distributed and consumed. Platforms such as YouTube, Facebook, Instagram and WhatsApp can disseminate health messages quickly and at comparatively low marginal cost.

Systematic evidence indicates that social-media communication can influence pathways involving exposure, engagement, attitudes, knowledge and behavioural processes. However, these effects are not necessarily linear, and high engagement does not automatically indicate actual behaviour change.

Public health organizations should consequently assess more than the number of posts produced. Useful indicators include:

- Reach
- Impressions
- Engagement
- Shares
- Comments
- Enquiries
- Registrations
- Service utilization
- Repeat utilization
- Behavioural change

➢ *Age-Based and Audience-Based Marketing*

A single communication message is unlikely to work equally well for every population group. Public health programmes should segment audiences using characteristics such as age, gender, socioeconomic position, geography, disease risk, occupation, digital literacy, health literacy and cultural context.

For instance, communication about HPV vaccination may need different messages for adolescent girls, parents, teachers, healthcare workers and community leaders. Likewise, digital health campaigns for older adults may work better when families assist with communication and registration rather than relying exclusively on direct app-based messaging.

➢ *Frontline Health Workers as Programme Ambassadors*

In rural India, the most influential channel for public health communication may often be the frontline health worker rather than social media. ASHA workers, ANMs, Community Health Officers and other health personnel maintain direct relationships with communities.

Their interactions can shape trust, awareness, acceptance, utilization and adherence. Frontline workers should therefore receive training not only in technical programme implementation but also in communication, counselling, motivational interviewing, health literacy, myth management, community engagement and interpersonal marketing.

The frontline worker should become a credible and trusted messenger of the programme.

➢ *The 7Ps Framework for Public Health*

A comprehensive public health marketing framework can be organized around seven components:

- Product: Health service or programme
- Price: Financial and perceived cost
- Place: Location and accessibility
- Promotion: Communication and awareness
- People: Healthcare workers and community influencers
- Process: Ease and simplicity of service access
- Physical Evidence: Facility appearance, branding and visible quality signals

Together, these seven dimensions provide programme managers with a practical framework for examining why a service is or is not being utilized.

➢ *Proposed Public Health Marketing Model*

The proposed model places marketing within the entire programme cycle rather than treating it as a separate advertising activity:

- Population Identification
- Audience Segmentation
- Needs and Barrier Assessment
- Programme/Product Design
- Value Communication
- Promotion and Social Mobilization
- Easy Access / Simplified Process
- Service Utilization
- Beneficiary Experience
- Trust and Satisfaction
- Repeat Utilization / Advocacy
- Improved Programme Achievement
- Improved Health Outcomes

The sequence highlights the movement from identifying the population and understanding its barriers to sustained use of services and improved health outcomes.

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➢ *Marketing and Health Literacy*

Marketing cannot substitute for health literacy; the two should reinforce one another. WHO describes health literacy in terms of the capacity to access, understand, evaluate and use health information and services, while also emphasizing the responsibility of systems and organizations to communicate clearly and appropriately.

In this framework, marketing creates awareness, health literacy develops understanding, behaviour-change communication supports motivation, accessible services create opportunity, and quality services build trust. Together, these elements can improve utilization and contribute to better health outcomes.

➢ *Ethical Considerations*

Public health marketing must be fundamentally different from commercial advertising. Its purpose should never be manipulation. Ethical public health marketing should be evidence-based, transparent, culturally appropriate, inclusive, non-discriminatory, scientifically accurate, respectful of autonomy, protective of privacy and free from misleading claims.

Digital campaigns should also include safeguards against misinformation and inappropriate handling of personal health information. Marketing should therefore be viewed as ethical persuasion for public benefit rather than exploitation of behavioural vulnerabilities.

II. CHALLENGES

➢ *Limited Budget*

Communication activities may receive less priority than direct service delivery and other operational expenditures.

➢ *Lack of Skilled Personnel*

Health programmes may have technical specialists and programme managers but limited access to professionals trained in marketing, behavioural science and strategic communication.

➢ *Digital Divide*

Social media cannot effectively reach populations that lack dependable digital connectivity, devices or digital literacy.

➢ *Misinformation*

False or misleading information can spread rapidly through digital channels and undermine confidence in health programmes.

➢ *Cultural Diversity*

India's wide linguistic and cultural variation makes standardized national communication difficult and increases the need for locally adapted messages.

➢ *Measuring Behavioural Outcomes*

Counting posters, meetings or social-media posts is easier than demonstrating actual changes in knowledge, behaviour and service utilization.

III. RECOMMENDATIONS

- Establish Public Health Marketing Units. National and State Health Missions could create dedicated units combining expertise in public health, communication, behavioural science, social marketing, digital media and data analytics.
- Include Marketing Plans in Health Programmes. Major public health programmes should incorporate communication and marketing strategies into their operational plans.
- Segment the Target Population. Communication should be adapted to age, geography, risk profile and social context.
- Provide Dedicated Communication Budgets. Communication should be considered an essential programme input rather than an optional activity.
- Train Frontline Workers. Frontline personnel should receive structured training in communication and behaviour-change methods.
- Use Local Language and Culture. Messages should be linguistically accessible and culturally appropriate.
- Measure Communication-to-Utilization Conversion. Monitoring should track the sequence Awareness → Enquiry → Registration → Service Utilization → Repeat Utilization.
- Use Digital Analytics. Digital campaigns should be assessed using meaningful performance indicators rather than post counts alone.
- Strengthen Community Participation. Community members should be involved in the development and testing of health messages.
- Link Marketing with Quality Improvement. Strong promotion cannot compensate for poor service quality; communication must therefore be backed by reliable, respectful and high-quality services.

➢ *Proposed Indicators for Public Health Marketing*

- Awareness: Percentage of the population aware of the programme
- Understanding: Percentage able to correctly explain the benefit
- Perceived Value: Percentage who consider the service useful
- Trust: Percentage expressing confidence in the service
- Accessibility: Percentage reporting that access is easy
- Utilization: Number or percentage of eligible beneficiaries using the service
- Digital Reach: Social-media reach and engagement
- Conversion: Awareness-to-utilization rate
- Satisfaction: Beneficiary satisfaction
- Outcome: Programme-specific health outcome

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A useful composite measure could be the Marketing Conversion Rate, intended to show how effectively communication reaches actual service users. The indicator should be operationally defined by each programme using a consistent denominator and numerator so that results are interpretable and comparable.

Monitoring such indicators would help programme managers determine whether communication activities are contributing to service uptake rather than merely generating visibility.

IV. DISCUSSION

The central argument of this review is that public health service delivery and public health marketing should function as complementary components of programme implementation.

A programme may have strong clinical content, technology and infrastructure, yet utilization can remain low when the intended population does not understand why the service is relevant or how it can be accessed.

The available evidence supports social marketing as a potentially useful behaviour-change approach, although its effectiveness depends on intervention design, implementation quality and the strength of evaluation methods. Recent systematic evidence has generally reported favourable effects while also identifying methodological limitations and a need for better-designed studies.

Social-media campaigns can provide rapid and targeted communication, but exposure, impressions and engagement should not be treated as equivalent to actual health behaviour change.

Public health marketing should therefore be more than the production of attractive posters, slogans or social-media content. Its ultimate purpose should be to convert public health investment into meaningful public health utilization.

Achieving this requires coordinated attention to communication, accessibility, service quality and community trust.

V. CONCLUSION

Public health is entering a period in which the challenge is not simply to establish services, but to ensure that people know about them, understand their purpose, trust the system and are able to use them.

The expansion of digital health, telemedicine, financial protection programmes and community-based care creates substantial opportunities. These opportunities, however, can generate population-level benefits only when intended beneficiaries are successfully reached and supported to use the services.

Public health therefore needs marketing—not commercial marketing or aggressive advertising, but ethical, evidence-informed social marketing directed toward public benefit.

A future-oriented public health programme can be guided by the principle: Right Service + Right Person + Right Message + Right Place + Right Time = Better Public Health Outcome.

Programme success should ultimately be judged not only by the number of services established or the amount of money spent, but by whether intended beneficiaries know about the service, understand its value, can access it, trust it and actually use it.

In this sense, marketing is not an external activity added after programme design. It can function as a bridge connecting public health policy, programme delivery and public health utilization.

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