

**Social marketing:  
Evidence of (in)effectiveness and  
when it might be useful**

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## **Introduction**

A common response to increased drinking and alcohol related problems is to call for more education and public information. We need to teach our young people about the risks of alcohol and to drink more responsibly, we say. And now that us Palangi have increased the alcohol available to Pacific people, we need to teach Pacific youngsters to drink responsibly too. The alcohol industry agrees (Stewart 2000; ICAP 2004). So governments throw money at television campaigns taking moderation messages into every home and feel they have done something. Something largely ineffective, in the view of policy researchers.

The New Zealand government has just raised the small levy on alcohol that funds the Alcohol Advisory Council (ALAC) to provide an additional \$NZ 3 million for a high profile social marketing campaign. Some of you may look at this budget and think, how can small island nations possibly afford this kind of thing?

I've been asked to briefly present the evidence on why mass media and social marketing campaigns are considered less effective than other policies, such as taxation and restrictions on availability. We'll look at how mass media can be used more usefully in combination with other policies. And we'll look at how people working in the community can use the media in a more cost-effective way to raise alcohol issues and to support effective alcohol policies.

## **What is social marketing?**

Health promotion campaigns in the mass media – television, radio, newspapers and magazines – aim to educate the public about alcohol issues and influence individuals to change their drinking behaviour. Campaigns usually focus on issues and causal factors identified from broad population data and aim messages to broad general or youth audiences. They are often about things like responsible drinking and the risks of drink driving but can also provide information, such as what a standard drink is, or raise awareness about alcohol laws. In the USA, mass media public information campaigns, often using airtime donated by broadcasters, are called 'public service announcements'.

'Social marketing' is an approach that identifies and targets particular population groups. Research investigates what motivates the group's behaviour and health promotion messages are tailored for this.

In the USA the term 'counter-advertising' is usually used for health promotion that directly attacks alcohol products or the industry, including its advertising strategies. Warning labels are also a form of counter advertising. But all publicly-funded health promotion messages about excessive drinking or reducing alcohol related harm aim to counter the hugely well-resourced, one-sided messages that come from the alcohol industry.

As the World Health Organization has stated, changes in individual behaviour 'would seem to require both the provision of accurate information and the reduction of misinformation' (WHO 2002: 27).

## **The bad news is...**

Most mass media campaigns on alcohol and other drugs increase knowledge but appear to have little impact on actual behaviour. *Alcohol: No Ordinary Commodity* (Babor et al. 2003), the recent review of alcohol policy research sponsored by the World Health Organization, looked at the effectiveness of different strategies. For public information campaigns in the mass media, a high level of evaluation research was noted but the review gave this policy strategy a zero rating for effectiveness. In fact, it gave a low rating for all education and persuasion strategies that target individual behaviour.

Evaluation research shows school-based or community based promotions targeted to particular groups of teenagers can result in some improvements, but effects are short lived and seldom do more than delay the increases in drinking that typically occur through the teenage years (see also Foxcroft et al. 2003; Midford and McBride 2001).

Mass media campaigns targeting a general audience or audiences of young people show little effectiveness (Babor et al. 2003; Agostinelli and Grube 2002; DeJong and Hingson 1998). Using local media for advertisements targeting teenagers influenced low level users only (Kelly et al. 1996). Babor et al. (2003: 190) concluded that:

“Despite their good intentions, [they] are an ineffective antidote to the high quality pro-drinking messages that appear much more frequently as paid advertisements in the mass media.”

Some studies showed changes in knowledge or in campaign awareness and recall – but little change in behaviour. Overall, Babor et al. (2003) found the weight of the negative evidence was more convincing than some small positive findings in some studies.

This is not news – the evidence has been around for some time (e.g. Boots and Midford 2001; Wallack and DeJong 1995). The World Health Organization’s review of strategies for reducing substance abuse also found little evidence that mass media campaigns have been effective, or cost effective (WHO 2002).

### **Limitations**

Why aren’t mass media campaigns more effective, when they cost so much?

Part of the problem may be the difficulty of *measuring* the impacts of media messages (WHO 2002; DeJong and Hingson 1998; Agostinelli and Grube 2002; Boots and Midford 2001), whether of health promotion messages or alcohol advertising itself. One difficulty is that the baseline and outcome data may be limited. Effectiveness has to be measured against whatever relevant statistics are available. Most statistics that we want to reduce – total alcohol consumption, youth drinking, drink-driving – are outcomes at a considerable distance from a response to a particular message or a particular campaign on television. This is why evaluation of media campaigns often looks at responses rather than behaviours. A second difficulty is that drinking outcomes are influenced by a great many other factors in life, including policies. It is difficult to isolate the impact of any one factor or strategy.

Health promotion campaigns are generally short and effectiveness needs to be demonstrated quickly to justify spending public money. But it may require thousands of exposures with cumulative effects to reshape a drinking culture. Research indicates that this is how commercial advertising works (Kelly et al 1996; Gerbner et al. 1986; Petty and Caccioppo 1981).

Individuals seldom change their behaviour if nothing around them changes. Drinking, including excessive drinking, is social behaviour imbedded in communities and cultures. As teenagers grow up in a drinking culture, each year brings a new cohort of young risk-takers into the alcohol market. Wagenaar and Perry (1994) point out that, for this reason, targeting young people for alcohol education and health promotion is less cost-effective than environmental changes that, once set in place, can shape the behaviour of successive groups of young people.

A key problem in industrialised countries is that public health messages about alcohol are swimming against the stream of a long-standing drinking culture constantly fed by the marketing strategies of the alcohol industry. The industry is also a drug educator whose messages compete with those of health promoters (Stewart and Casswell 1990). Those same messages and marketing strategies are now being used in countries without no strong culture of drinking and no strong policies to reduce harm.

Media campaigns portraying heavy drinking among young people may inadvertently reinforce heavy drinking norms, say US researchers, unless the message includes a clear positive action to be taken. Media messages about individuals drinking more responsibly may reinforce a view that serious injuries or death result from an error in individual behaviour rather than as a predictable consequence of large quantities of alcohol. Messages about the negative effects of alcohol may have less effect on young people because they do not understand risk in the same way as older people. They take good health for granted and overestimate their capacity to change their behaviour at any time (Dejong 2002). The same risk may look different to parents, who know that the worst that can happen probably will.

## Social marketing

A recent approach to public information campaigns, termed 'social marketing', borrows commercial techniques to address social goals. The idea is to 'start where people are' and identify the 'consumer orientation' of the particular market group (Buchanan et al. 1994) – say, young teenagers, or rural male drivers in their 40s, or males aged 18-24 who go to night clubs on the weekend. Research is undertaken on the needs and motivations of the target group to identify determinants of behaviour and barriers to change. Their perception of different prevention strategies or campaign slogans is tested, so as to create the right message for that group. Decisions are then made about the best way of getting the message to them (Burns and Thompson 1998; MacStravic 2001; Buchanan et al. 1994).

Is this new social marketing approach more effective? It is often assumed that well-packaged information alone will improve health status, but there is not a lot of evidence. Most social marketing research investigates reasons for alcohol 'demand' among young people, rather than monitoring any impacts on their behaviour (MacStravic 2001). Population data on drinking is not a good measure of whether social marketing messages contributed to changed behaviour or affected the age at which young teenagers start to drink (Buchanan et al. 1994).

To be effective, messages must be just right for the targeted person and reach them at a point when they are acknowledging a problem and are ready to change (Boots and Midford 2001; Agostellini and Grube 2002). As an example, some messages targeting pregnant women about Foetal Alcohol Syndrome have been successful. The message matched circumstances in which the women were willing to change their drinking behaviour.

A social marketing approach is being used in campaigns to discourage smoking among New Zealand Maori, but has not yet been used for alcohol. 'Whanau' (family/extended family) is a traditional value among Maori and has been identified by social marketers as a key motivator. For example, a current ad depicts a pregnant young Maori woman who quits smoking because 'It's no longer just about me'. Evaluation shows Maori responded more to the 'It's about whanau' ad series than to the more individualistic message 'Every cigarette is doing you harm'. However, a follow-up survey showed improvement in the quit rates being obtained before the campaign (Quit Group 2003).

Research shows heavier drinkers tend to overestimate how much most other people drink (DeJong 2002; Kypri 2002). Many US colleges now focus on giving students information about drinking norms among their peers, rather than focusing on negative consequences. A well-designed evaluation of 'social norms' information campaigns in 37 colleges, based on 1997, 1999 and 2001 data from the Harvard College Alcohol Study, showed no decreases on seven measures of drinking and significant increases on two measures, 'alcohol use in the past month' and '20 or more drinks in the past month'. Colleges with higher drinking rates at the beginning of their campaign were still higher afterwards. Colleges that did not have social norms programmes show no increase (Wechsler et al. 2003). This suggests that messages about norms may encourage drinking among those who drink little, but is not effective in persuading heavy drinkers to drink less.

Health promoters are trying to persuade people to give up drinking products that the market sells them only too successfully, and to do so whether or not the drinker believes there is any risk or problem. For this reason, parallels between 'social marketing' and commercial marketing have come under criticism (Brenkert et al. 2002; Buchanan et al. 1994). Questions have been raised about the ethics of using manipulative commercial techniques. For example, if it is unacceptable for alcohol advertisers to imply that drinking brings sexual success, isn't it unethical for social marketers to suggest that boys who don't get drunk will be more attractive to the opposite sex? A moral perspective is more appropriate than a marketing one, in the view of these critics. This should include questioning whether it is appropriate to see the individual as the 'problem' to be fixed, or whether more focus should be placed on the social and policy context that shapes drinking behaviour.

As the European Health Ministers declared in 2001, that context includes the commercial pressures on young people to drink, including alcohol advertising, sponsorship and other marketing.

Some evaluation research shows that teaching children to be sceptical about alcohol advertisements and industry motivations can increase resistance for some months or years (Anon.2000; Austin and Johnson 1997). There is strong evidence that a US campaign against the tobacco industry was effective (Babor et al. 2003). Teenagers may resist parental views or education about health risks but did show a significant response to hard-hitting television ads about how the tobacco industry tries to manipulate them into an addictive smoking habit (Farrelly et al. 2002; Sly et al. 2001). This campaign lasted only a year, however, for reasons of cost.

This response by young people in the USA goes beyond one ad campaign against tobacco. Alcohol as well as tobacco are among the examples of manipulative brand marketing cited by anti-globalisation campaigners (Klein 2001). Many of the techniques of modern marketing were developed by these industries (Clark 1989; Buchanan and Lev 1989).

### **Can social marketing campaigns counter alcohol advertising?**

Babor et al. report that, in most countries, mass media campaigns about alcohol are a fraction of the total volume of alcohol advertising and are seldom seen on television.

New Zealand does have frequent alcohol health promotion ads on television and radio. Free broadcasting time is provided for ads about moderation and drink-driving as part of the 1992 deal that allowed alcohol brand advertising on television after 9 pm. But these are swamped by commercial messages promoting alcohol. In 1997 alcohol advertising exposure in all media was around 10 times greater than alcohol health promotion exposure (Hunter 1997). In 2000 a sample of weekend television showed a ratio of one alcohol health promotion ad to every five alcohol ads. This count did not include alcohol brand logos at the beginning and end of each segment of alcohol sponsored sports programmes, which may be shown at any time (Hill 2000).

In New Zealand, alcohol advertising is 'self-regulated' by an industry organisation representing advertisers and broadcasters. There is a voluntary code of advertising standards that says, for example, that alcohol ads should not imply sexual success or depict violence, and should not use actors aged under 25 or 'heros of the young'. Public health organisations have helped refine the rules and lodge complaints about infringements. But these rules are largely irrelevant to the way alcohol advertisements actually work. Advertising does not need to infringe the rules to link alcohol products to the young adult lifestyles that teenagers aspire to. Alcohol brand names and drinking are also embedded into teenagers' everyday experiences by other forms of marketing, such as alcohol sponsorship of sports and music events (Hill and Casswell 2001).

In 2003 the advertising industry reviewed its code and changed the start time for alcohol ads on television from 9 pm to 8.30 pm. This was opposed by public health organisations, including the Ministry of Health and the Alcohol Advisory Council. One objective of the government's National Alcohol Strategy is 'to minimise the exposure of young people to alcohol messages'. At that time, 26 percent of 10-17 year olds are watching television, dropping to around 10 percent by 11 pm.

Clearly, industry self-regulation has not been satisfactory. It takes an important public health policy out of the hands of government and leaves those who profit from alcohol promotions to make the decisions.

There is now a large body of evidence showing how alcohol advertising influences young people's attitudes towards alcohol and their later drinking behaviour (Babor et al. 2003; Hill and Casswell 2001; Saffer 2002; Gentle et al. 2001). All industrialised countries regulate alcohol sales and many countries ban some forms of alcohol marketing, particularly alcohol advertising on television and radio. Some broadcasting bans are partial – limiting the hours they may be broadcast, or the type of beverages, or on privately-owned channels only. Although there are not many studies, there is evidence that advertising bans are effective in reducing consumption and harm (Saffer and Dave 2002; Saffer 1991; 1997). Babor et al. (2003) recommend that government policy on alcohol advertising should be guided by the Precautionary Principle.

Another way of countering alcohol promotion is to require health warnings on alcohol containers or on alcohol advertisements.

As with other education and persuasion strategies, there is little evidence that warning labels on alcohol containers change most drinking behaviour (Babor et al. 2003). US warning labels on alcohol and tobacco do reach target audiences. They have been shown to increase awareness of foetal alcohol syndrome among pregnant women, but not awareness of risk among student drinkers (Babor et al. 2003). One study tested students' responses to drink-drive messages in print ads for bars offering free snacks, 'happy hours' or other cheap alcohol promotions. The messages made the students think the managers cared about their customers, but *reduced* their perceptions of drink-drive risks. Students who usually drank heavily responded to the price cuts more strongly than moderate drinkers and largely ignored the responsibility messages (Christie et al. 2001).

Alcohol companies support policies that focus on individual behaviour. Global corporations attribute responsibility for alcohol related harm to everyone except the product itself (eg Diageo in Keane 2004). Offering to provide their own 'responsible drinking' messages may forestall health warning labels or other regulations imposed by government. In the USA, alcohol companies are now a main source of television messages about alcohol abuse. An analysis of television industry data looked at all alcohol ads in 2001 with a clear message about drinking responsibly, drink-driving or underage drinking. The amount alcohol companies spent on these was 2.9 percent of what they spent on product advertising. Audience exposure (age 12+) was 45 times greater for alcohol ads than for the 'responsibility' ads. The two types of ad were shown at different times. The alcohol companies were better at reaching 12-20 year olds with their alcohol ads than with their responsibility ads. Adults were twice as likely to see the responsibility ads (Center on Alcohol Marketing & Youth 2003). Perhaps adults were the real audience for messages about corporate responsibility.

A precautionary approach should be taken to alcohol companies or industry funded organisations who propose a 'partnership approach' with health promotion agencies (ICAP 2000). Experience shows that their purpose is to secure a place at the table so as to influence strategies. With industry involvement, social marketing campaigns and local health promotion will focus on individual responsibility, 'problem' drinkers and changing the 'culture', ignoring the industry's direct interest in 'normalising' and increasing consumption (Anderson 2000; McCreanor et al. 2000; Buchanan and Wallack 1998).

### **Multiple policies in a consistent direction**

Mass media campaigns on their own, or as a main strategy, show poor cost-effectiveness and cost-benefit. Research on policy effectiveness shows clearly that restrictions on availability, taxation and enforcement of alcohol laws are stronger strategies. Using several strategies together, to try and change the whole environment around drinking, is likely to be more effective than a single strategy (Babor et al. 2003).

Mass media campaigns do show more effectiveness if supported by community action (WHO 2002) and can be useful as one part of a multi-policy package. New Zealand took this approach with drinking driving, using hard-hitting advertisements to support increased enforcement, with police breathalysing every driver at road-side checkpoints. Deaths involving drunk drivers fell from 40 percent of all road deaths in 1991 to 26 percent in 2002 (Guria et al. 2003).

Over the same period that drink-drive policies were strengthened, alcohol availability and alcohol promotion were liberalised. Mass media campaigns promoted moderate drinking, but consumption surveys showed no shift to moderation among adult males, who drink most, and teenagers and women of all ages began to drink larger amounts and more frequently (Habgood et al. 2001; Casswell and Bhatta 2004; Moewaka Barnes et al. 2003). Total alcohol had been declining but began to rise again from 1998 (Statistics NZ). This liberalisation culminated in lowering the minimum age of purchase from 20 to 18 in December 1999. In the next two years, the proportion of alcohol-related fatal crashes involving 15-17 year old drivers increased to 35 percent of all drivers, compared to 14 percent for the two years before the age was lowered (Guria et al. 2003).

As the World Health Organization (2004) stated in its *Global Status Report: Alcohol Policy*, alcohol related harm can be reduced by a comprehensive set of alcohol policies – provided all the policies are pointing in the same direction.

### **Using the media more strategically**

One reason for the ineffectiveness of social marketing campaigns is that they often start from a wish to use the mass media and may look no further than similar campaigns for ideas and objectives. The value of television ads reaching millions of viewers is sometimes regarded as self-evident. This then dictates decisions about objectives, audiences, messages and budgets (DeJong 2002).

A lesson from US public health campaigns is that the first step for public health organisations should be to pick a clear strategic objective related to their entire programme. Health behaviour is shaped by many influences – individual factors, interpersonal and social processes, communities, institutional arrangements and public policies. The strategists need to decide which of these areas, at a given point in time, will provide the greatest leverage for change. The decision about leverage and objective will inform further decisions about the target audience and the choice of media and tactics (DeJong 2002).

In some situations, it may be decided that educating people is less important than using the media to stimulate action or public support for community, institutional or policy change. The media can be used to raise awareness of the issues and increase the legitimacy of policy strategies being put in place, such as increased law enforcement.

### **Media advocacy**

Instead of high-cost social marketing campaigns, communities with limited resources may find media advocacy more cost-effective.

Media advocacy uses media *content*, rather than advertisements, to raise the awareness of communities and policy makers about alcohol issues. Concern about alcohol-related harm can be channeled into support for policies that address the problem. Building this support may mean attacking the assumptions and beliefs that sustain current drinking and policy norms (DeJong and Hingson 1998). News items and other articles in the local media can bring attention to problems or keep issues alive. Media advocacy can influence the way alcohol is defined and conceptualised in public debate by framing it as a policy issue, not just an individual choice. It can advance the importance of policies known to be effective for reducing alcohol related harm and put pressure on politicians and other decision makers to change their policies and priorities. It can translate academic research and statistics into forms more easily grasped by the public and be a means of supplying research findings to decision makers (Holder and Treno 1997; Wallack and Dorfman 1996; Wallack and DeJong 1995).

Media advocacy is often part of community action projects. Media advocacy was evaluated in a five-year controlled study of community action projects in the USA that the World Health Organization cites as 'exemplary' (WHO 2002). Evaluators documented how media training for community workers led to increased news coverage and assessed effects that could be linked to that increased coverage. It was shown that print and television each reached different audiences for different purposes, with both contributing to community prevention. Community awareness of drink-drive enforcement increased in the project cities but not the control cities as a result of mass media campaigns of varying intensity and media advocacy work that began part way through the period (see Table 1). Evaluation showed that media advocacy increased community awareness independent of the professional media campaigns and at a much lower cost (Holder and Treno 1997). Media advocacy was also used in a 5-year California-wide to prevent violence involving young people. In this case, training included educating journalists about relevant policy areas (Wallack and Dorfman 1996).

The effectiveness of community action and media advocacy was also shown by a controlled study in New Zealand in the early 1980s. This compared the effects of mass media campaigns, mass media plus community action including media advocacy, or no intervention in six roughly matched cities. Relative effectiveness was measured by two random population surveys using face-to-face interviews

about individual beliefs and behaviour and about support for policy interventions. There were also six-monthly in-depth interviews with a wide range of informants and small scale street interviews targeting young males. The study showed that public attitudes to alcohol use were influenced by the media campaign but there was a slightly greater impact in the cities that had both media campaigns and community action. On policy issues, both mass-media and media-plus-community campaigns appeared to prevent a decline in support for state intervention (occurring nationally at that time). On some points, community action had a greater effect than the mass media (Casswell, Ransom and Gilmore 1990) (see Table 2). In the media advocacy cities, key informants shifted from seeing alcohol problems as a personal matter to viewing it as an issue with serious social implications affecting the public purse, public health and community well-being (Stewart and Casswell 1993).

The objective of community action in this study was to increase support for policies that could reduce alcohol related problems. In the 'intensive intervention' cities, community action was led by a local organiser who worked with community organisations and agencies through the local Safer Community Council. The organiser's job included media advocacy. The ongoing relationship with evaluators and the funding agency in an advisory role helped maintain this focus. Relationships and credibility were established with the local media, and comment was provided or publicity initiated on alcohol issues from a public health perspective. Tactics included 'issue piggy-backing' by adding a local angle to a national event or news story. Objections were lodged to some liquor licence renewals, raising local debate about sales to minors and host responsibility issues. Creative ways were found of translating epidemiology into photo opportunities. To keep up media attention, new angles were continually needed.

In one community, a paid advertisement that was objective, balanced and wordy prompted a advertisement in response from the liquor industry that was visual, simple and one-sided. The lesson learned was that messages are more effective if they are pithy and hard-hitting (Stewart and Casswell 1993). Some of the television and print ads about alcohol policies that were planned for the mass media campaign proved controversy, however, and opposition from vested interests led to them being withdrawal or refused (Casswell, Ransom and Gilmore 1990; Casswell 2000). Hard-hitting points about alcohol policy may be more easily achieved in news stories than through paid advertising – and at lower cost.

The above examples relate to media opportunities in the US and New Zealand. Small Pacific nations may have few television channels and newspapers. Local radio may be more important. 'Media' are in fact any vehicle for sharing community news and views. Health promoters may need to think creatively about what media are available to them to influence public opinion and public health policy. One example of creative communicators is the Vanuatu drama group Wan Smolbag Theatre, who address difficult social issues such as domestic violence. Perhaps there is a way that Pacific actors and playwrights in Aotearoa New Zealand could get together with public health people in the Islands and help take public health perspectives on alcohol around the Pacific.

## **Conclusion**

The ineffectiveness of education and persuasion via the mass media should not surprise to people in the public health field. Historically, public health work has focused on the environmental factors that contribute to health-related problems. Attributing problems to poor personal choices and the need for education is a more recent perspective. Research shows, however, that the most effective strategies for reducing alcohol related problems are those that change the physical, social and economic environment for drinking. Media campaigns alone are unlikely to change the drinking culture against a flood of alcohol marketing. Their best contribution may be to create a climate of support for more effective policies.

Table 1: Community awareness of drink-drive enforcement, media expenditure and news cover in project and non-project communities in South Carolina, 1992-96 (Holder and Treno 1997)

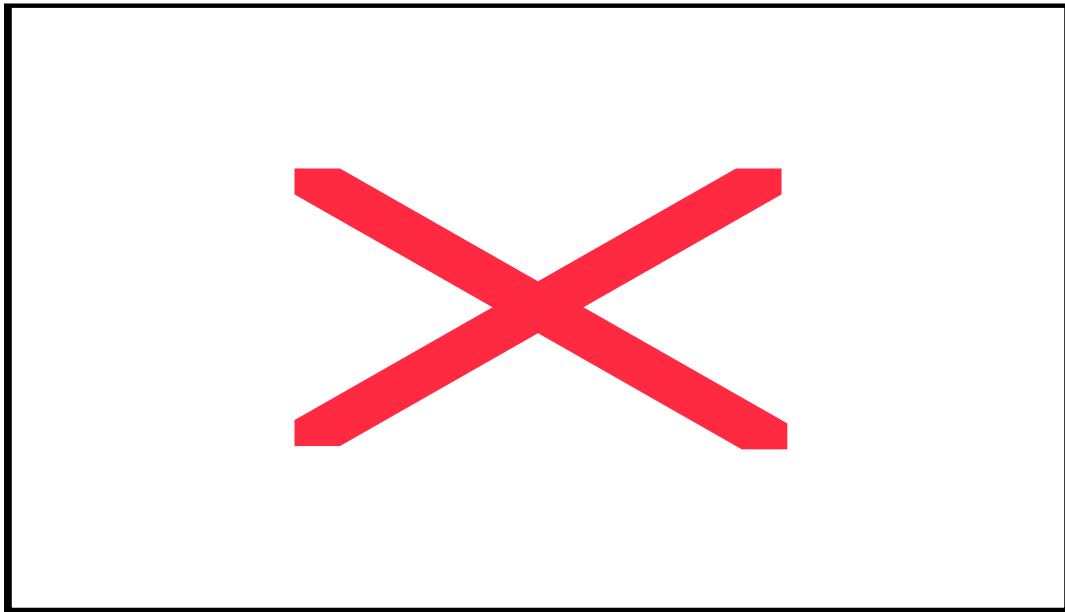
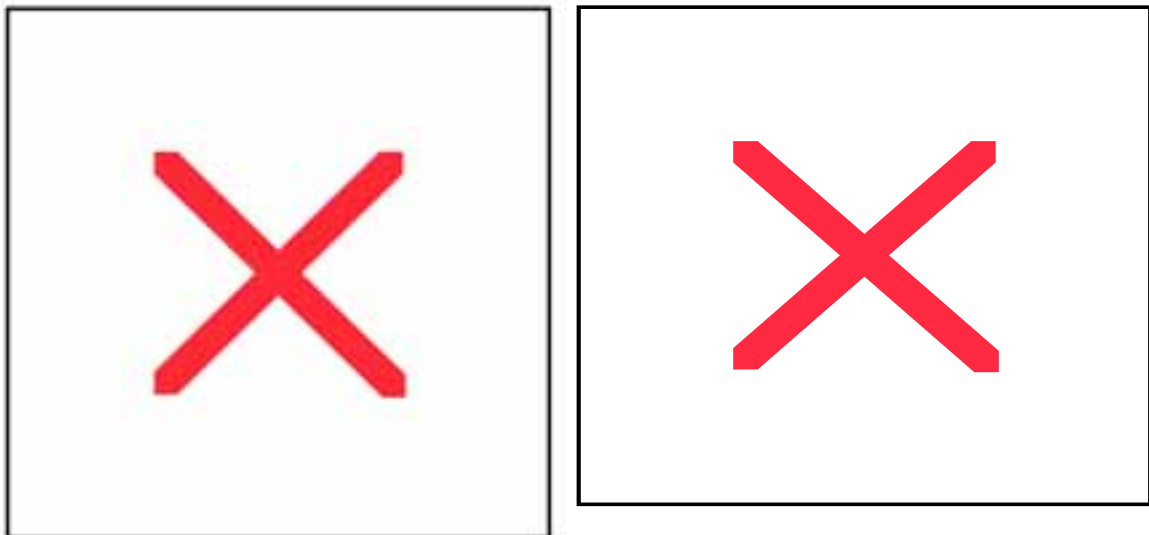


Table 2: Before and after survey results for public support on two alcohol policy issues in New Zealand cities receiving mass media campaigns ('media'), media and community action including media advocacy ('intensive') and no intervention ('reference') (Casswell, Ransom and Gilmore 1990).



**Shifting the blame for unsafe products**

"The ultimate responsibility lies with the consumer. Awareness about alcohol and its inherent good things and dangers if abused are widely known in society."

Guy Smith, Executive Vice President for External Affairs,  
Diageo International.

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