A LOCAL GUIDE TO:
SOCIAL SEGMENTATION (PART OF SOCIAL MARKETING) – 2016

This purpose of this profile is to introduce the concept of social marketing and social segmentation.

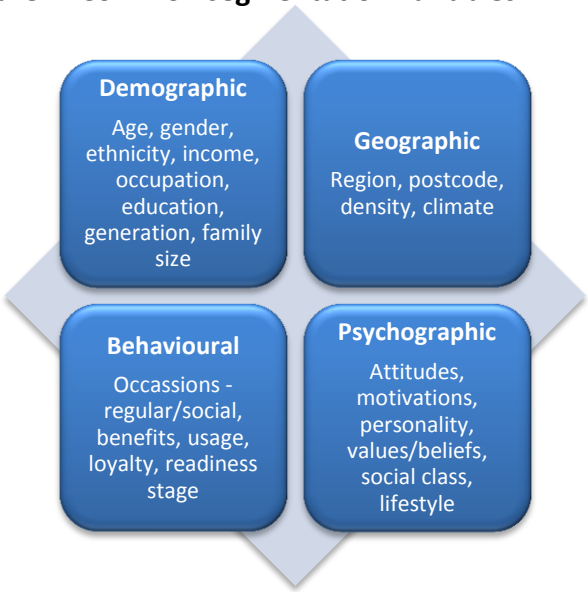
The National Social Marketing Centre (NSMC), the international centre of behaviour change expertise, defines social marketing as: "an approach to develop activities aimed at changing or maintaining people's behaviour for the benefit of individuals and society as a whole". Social marketing focuses on behaviour – if your goal is only to increase awareness or knowledge, or change attitudes, this is not social marketing.

A key part of a successful social marketing intervention is creating an audience or customer orientated understanding. One method is to identify customer 'segments' that have common characteristics, then tailoring interventions to these characteristics. This profile seeks to describe the process of segmentation, give local examples of segmentation output using a social marketing tool and illustrating how knowledge of segment preferences can be used to better tailor interventions for behaviour change.

What is segmentation? – It is the process of dividing a market or population into distinct subsets that behave in similar ways or who have similar needs.

Social segmentation – does not solely rely on traditional demographic, geographic or epidemiological targeting. It also draws upon behavioural and psychographic data to segment a population (Fig 1 - NSMC). Segments are then prioritised and selected based on criteria such as segment size and readiness to change behaviour.

Figure 1: Common segmentation variables



Segmentation tools – There are many social segmentation tools on the market such as MOSAIC, Acorn and P². These are designed to sharpen the process of social segmentation by synthesising masses of UK demographic, lifestyles, preferences and behaviours data to form distinct subsets/segments of the population or customers. The tools give additional information on these segments such as: their communication preferences, average income and whether not they are early or late adopter of new technology. This means that interventions can be better targeted to their characteristics and are therefore more likely to alter behaviour.

Cost-effective segmentation – To maximise return on investment, limited resources can be focused on segments whose characteristics make them most likely to change behaviour. The TARPARE method (Table 1) can be used to identify optimum segments to target. Behaviour and audiences matrices can also be used (impact on the problem vs. probability of influencing).

TARPARE method	
T	Total number: is the segment large enough?
AR	Proportion of at-risk people in the segment (greatest reduction in costs if behaviour changed)
P	Is the segment easily persuaded? Are they likely to persuade other people in the segment? Less resource will be needed to effect change.
A	Is the segment easy to access? Again, fewer resources are needed to make an impact.
R	Resources required to meet the needs of the segment.
E	Equity, the need to target specific disadvantaged segments.

Source: Adapted from Donovan, Egger & Francis, 1999

Experian MOSAIC – Locally the South Devon and Torbay Clinical Commissioning Group (CCG) and Torbay local authority have a licence for the Experian MOSAIC segmentation tool. If you are an employee of Torbay Council and wish to register to use MOSAIC, please contact: publichealth@torbay.gov.uk

Example of local MOSAIC output – As in indication of patients who may be misusing local A&E provision; data for South Devon and Torbay CCG which met the following criteria was input into the MOSAIC tool and compared to the A&E attendance population:

- *Had self-referred to A&E;*
- *Had no 1st investigation;*
- *Were 1st treated with guidance/advice only;*
- *Discharged and did not require further follow up treatment.*

The top three MOSAIC groups for this population as proportion of A&E 'misuse' attendances were:

- *Senior security (12.9%);*
- *Country living (12.3%); and*
- *Aspiring homemakers (11.2%).*

The top three MOSAIC groups which are above what we would expect to see in the A&E 'misuse' population as compared to total attendances at A&E were:

- *Country living (8.3%);*
- *Rural reality (6.4%); and*
- *Domestic success (5.4%).*

Using the TARPARE method, this indicates that 'Country living' would be an advisable group to target based on the size of the segment **[T]** and an estimated overrepresentation of the segment **[AR]** based on total A&E attendances.

'Country living' are described as well-off homeowners in rural locations. They are more likely to be self-employed, own a car, have no dependent children and be in the retirement age bracket (66-70 years). They are more likely to be late adopters when it come to new technology but do use the internet as their preferred means of communication **[A, R]**. In terms of health, smoking is less common and they are the most likely group to eat their 'five a day' **[P]**. Despite this, they are regular drinkers and are the most likely group to consume alcohol daily **[E]**.

MOSAIC has helped to initially segment the population, however, further engagement and orientation with this group will be required to gain insight into why A&E is used or misused by them. For example, access to primary care may be limited due to their rural location therefore it may be deemed more efficient to make one trip to A&E. Only engagement would unearth this.