Establishing Brand Loyalty in Health Care—What to Learn from Other Industries

By Daniel K. Zismer, PhD

In this article...

Read about ways to set up a patient loyalty campaign in your health system or practice in order to retain patients and keep them from going to a competitor.

With the Patient Protection Act of 2010, the notion of health systems assuming financial risks for “covered lives” is back. For some in the business this movie is a re-run (the PHO era), for others it’s a new release. Either way it is more likely than not that the future of health systems is the assumption of financial risk for populations—groups with various health conditions and related service and financial risk profiles.

However, unlike before, these “lives” may not be “stuck to” a health system by contract, rather they may be attributed to a health system or be encouraged to use a narrow panel of providers by way of health insurance policy benefits redesign.

The challenge for health systems under such terms and conditions: “How do we (community health systems) create patient (enrollee) “stickiness?” Stated otherwise, how do health systems create and maintain brand loyalty in a new and changing competitive marketplace?

In a soon-to-be bygone era of health care delivery in the U.S., the pattern of demand behavior management was straightforward. A patient had a trusted physician. That physician directed health care flow to a variety of likely independent, affiliated referral physicians and affiliated hospitals.

The patient’s health insurance allowed freedom of movement in a market of providers. Independent physicians directed the referral flow and patterns of use. Community hospitals viewed the independent physicians as their principal customers and the business model was relatively straightforward, efficient, and highly leveraged—create brand loyalty with a couple hundred customers (physicians), and they find tens of thousands of patients and direct them in to buy services.

That was yesterday. Health costs, health policy, economics market cycles, and health services supply and demand shifts (such as those stemming from health insurance related benefit re-designs) have changed everything.

What will tomorrow bring?

Payer and provider sides of the health care marketplace are in a violent consolidation phase. Fewer, larger payers (insurers) and fewer larger integrated delivery systems are the logical result of this consolidation.

A principal strategy for the larger, more sophisticated, integrated health system is to be a “first mover” with contracted financial risk assumption strategies; i.e., assumption of financial risk for larger cohorts of covered lives.

The reason why is that less well-organized competitors may not be prepared to assume the risk, though leaders in the industry believe that the assumption of financial risk on patient populations may be a capital-efficient way to move markets from competitors.2

But, in any analysis of covered lives contracting strategies, the chink in the armor is the inability or unwillingness of the payer/insurer (governmental or commercial) to eliminate full freedom of choice from the enrollee (the patient).

However, payers are willing to re-jigger incentives in favor of influencing health system preference (especially financial incentives redesign), but there are no guarantees that patients will use health systems reliably, over time.

Here’s where effective brand loyalty strategies come into play. Brand loyalty is an area of market behavior management not well understood or developed by health care providers.

Other industries are far advanced here. Take for example the airline industry. Why do Delta airline customers fly a four-leg round trip on December 31st to qualify for their Diamond Card the next day? Other airlines are available, and fares may be less, but brand loyalty prevails. What are the lessons learned by other industries?
• **Lesson #1:** No amount of effort will create loyalty to a bad product (or service). Before a brand loyalty effort is initiated, leaders must critically examine the quality of their products as perceived by target markets. Any desirable customer base should be given credit for its ability to discern good from bad quality.

• **Lesson #2:** A differentiating value proposition precedes a brand loyalty campaign. It’s extremely difficult to create loyalty to a perceived commodity, unless brand loyalty is focused on “lowest price all the time.”

• **Lesson #3:** Trust precedes loyalty and few, if any, customers will trust a product or service with a disappointing first encounter (or transaction) where effort expended in the transaction is greater than the value received.

• **Lesson #4:** It’s the customers’ perceptions of value that counts. Brand loyalty can turn on features, organizational behaviors, or transactional nuances that are unknown to or unappreciated by the seller. It doesn’t matter what the organization believes about itself.

• **Lesson #5:** Buying once is no guarantee that a buyer is actually a customer after the initial purchase. Organizations often lay claim to a one-time buyer as a “customer.”

• **Lesson #6:** Don’t make the customer work too hard. Deepening or broadening the relationship is critical to long-term loyalty. It’s not the job of the customer to determine how to understand the “full-value opportunity” available from interactions with the organization.

• **Lesson #7:** Turn the passive customer into an engaged and active participant in the relationship. The relationship should be two-way. Cause the customer to interact (seek to interact) with the organization on a routine and regular basis even when no purchase is involved.

• **Lesson #8:** Raise the stakes of disloyalty—the high price of buying from someone else. Create a sense that the value of the relationship extends beyond the scope of the individual transactions and increasing value derives from ongoing loyalty.

• **Lesson #9:** Customers can have short attention spans and short memories and can be distracted by the next new product or service. There is an important rhythm and cadence to relationship management. Brand loyalty is a behavior, and it will extinguish if ignored.

• **Lesson #10:** Whenever possible, anchor the best relationships to a personal contact (or personalized service center). Banking will have the private banker for wealthy customers; airlines have the 24-hour helpline for the best card-carrying customers. A few health systems have created concierge care centers.

**Branding health care**

The overarching goal of a brand loyalty program for a health system is the commitment of future demand; a commitment of an individual (or population of covered lives) to use a health system whether that future demand is prepaid, i.e., with a transfer of pre-payment for contracted covered lives, or by traditional methods of reimbursement such as pay as you go.
The less obvious opportunity (and goal) is the ability of the health system to shape the behaviors (service demand patterns and rates) of the contracted population to the benefit of consumers (patients) and suppliers (the health system).

Effective brand loyalty programming has two principal functions:

1. To engage consumers with the health system for recommended and required future use.
2. To effectively shape health behaviors of the consumers to optimize health status as well as the efficiencies and effectiveness of health system encounters and to best ensure that the economic performance of the health system.

The second function bears further attention since such brand loyalty tactics are not customary within the arsenal of marketing capabilities of health systems, especially when it comes to shaping demand behaviors of patients to the advantage of all.

Goals in this category fall into at least two buckets:

a) Appropriate demand creation: Encouraging the covered lives toward interactions with the system that benefit their health status as well as the economics of the underlying contractual arrangement. An example of appropriate demand creation would be preventive health interactions, especially those at-risk for chronic illness complications.

b) Appropriate demand suppression: On the other side of the coin is the suppression or “destruction” of unnecessary and unhealthy demand—demand that’s unhealthy for the patient and health system. Two examples are useful here. The first is unnecessary hospital admissions and readmissions; events preventable with the proper health information, effective interactions with physicians and the health system, and evidence-based care management. The second is unproductive interactions with the health system that consume resources with little positive benefit for the patient. An example here is a primary care physician office visit for acute, low back pain of short duration with no neurological symptoms. Here, the patient likely gets better with no physician visit; rest and over-the-counter medications are the remedy. This type of visit consumes patient time unnecessarily as well as physician health system productivity.

The psychology of brand loyalty

Brand loyalty experts build their programming strategies largely on sound social psychological theories and principles such as:

- The desire or need to “belong” (be a member of a group).
- Increasing reward for demonstrated loyalty (privilege comes with membership).
- Recognition (someone is noticing me).
- Reinforcements for the “right” behaviors (conformity to norms/expectations) rules.
- Personal achievement (“I’m winning”).
- “I’m in control”—what I do influences outcomes that affect me.

Practitioners of brand management will frequently employ “game theory” in their tactical plans; the “gamification” of brand loyalty management. Other industries have recognized that playing a game resonates across cultures and socio-economic strata. Motivating rewards can be tangible or intangible.

Sounds deceptive? No, it’s simply sound social psychology.

So, how might U.S. health care providers implement successful brand loyalty strategies from other industries? To answer this question, it may be useful to set opportunity in a framework. Irrespective of how market realities actually pan out, it seems rational to assume the following:

- The provider side of the industry continues to consolidate in response to market pressures.3
- Market share (loyal patients) becomes increasingly important as a principal health system strategic goal.
- Payers (governmental payers and commercial health plans) are unlikely to force patient assignment to health systems by contract (i.e., restrict freedom of choice) although financial incentives design may cause enrollees to favor one health system over another.
- Financial incentives at play for health care providers (who accept financial risk) will cause them to encourage suppression of unproductive demand (utilization) while productive demand (e.g., preventive care) is encouraged.

If these assumptions hold, brand loyalty strategies become necessary and financially productive, provided sufficient returns on related investments are quantifiable and sufficient.

Where might brand loyalty strategies be most productive in a reforming marketplace? Perhaps if they are embedded as a function of the patient-centered medical home.4

Why? What is the theory that underpins the construct of the medical home?

The patient-centered medical home is established with the primary care environment of the health system. Primary care is, at the same time,
Physicians and health systems will lay claim to hundreds (and perhaps thousands) of patients who do not intend to be repeat customers.

But brand loyalty programs aren't free. No kidding. Losing customers with service demand potential in their future is expensive and since a lost opportunity is impossible to quantify, you'll never know the value of opportunity lost.

The return on investment analyses for brand loyalty programs for health systems is calculable. It is revealed in:

• The calculation of the revenue value of those who are "sticking" with the organization (sorted by disease category).

• Health care services consumption rates as compared with demand goals established by the health system (i.e., target use rates per patient type).

• Overall use rate trends by patient type cohort.

• Clinical marker trends for cohorts with chronic disease (e.g., A1C, lipids and blood pressure levels for diabetics).

• Use rates within the health system—i.e., the patients “deepening” the health use relationship with the health system.

• Health system providers’ referral patterns—their internal referral and internal health system use patterns.

While it is impossible to argue against the value of patient loyalty for health systems, patient loyalty cultivation is not a core competency of most health systems. Other industries have figured this out.

The goals are:

1. Establish a solid connection (engagement) between the patient and a primary care physician and related care team.

2. Provide the patient with a long-term health care plan based upon individualized needs.

3. With this plan, set measurable health-related goals, together with methods and means to attain these goals.

4. Assure the patient(s) that the primary care team will help them successfully navigate through the rest of the health system, as needs arise, and will ensure they receive the very best care, efficiently.

5. In addition to medical care requirements, the system will support needs beyond treatments, including holistic approaches to mind, body, and spirit care and social support.

6. Offer networking opportunities to patients with specific issues such as chronic illnesses.

7. Provide online connections with the care team; a 24/7 electronic connection capability, including online responses to health questions.

8. Give online e-reports of progress toward health goals, including graphics presenting key diagnostic data and physiologic markers of health status results.

9. Create an environment of engagement, including individualized rewards for ongoing, positive interactions with the medical home and care team.

Additionally, one can imagine the medical home as a clearinghouse for involvement in communities (“people like me”). The creative potential for this is virtually limitless:

• Online social networking and support group formation.

• Rewards programs for achieving care plan objectives and healthy behaviors.

• Routine online health education content feeds and webinars.

• Introductions to other health system services (based upon patient needs profiling).

How does brand loyalty pay off?

As with other industries, it costs less to retain a customer (patient) then it does to acquire a new one. Health systems and physicians often assume erroneously that a patient served is a customer for life. Physicians and health systems will lay claim to hundreds (and perhaps thousands) of patients who do not intend to be repeat customers.

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While it is impossible to argue against the value of patient loyalty for health systems, patient loyalty cultivation is not a core competency of most health systems. Other industries have figured this out.
Unfortunately, good patient care (as defined by providers) is not sufficient to maintain loyalty. Perhaps it’s time to learn customer loyalty programming from other industries.

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