# New Ways of Looking at Loyalty and Advocacy

More-sophisticated questions adapted from the packaged-goods industry can help healthcare marketers discover the "why" behind the "how" when measuring likelihood to use again and to recommend to others.

Traditionally, likelihood to use again (i.e., loyalty) and likelihood to recommend to others (i.e., advocacy) have been measured using a simple 5- or 10-point rating scale. But do these metrics provide useful information beyond how a hospital scored? That is, do they provide any insight into why the hospital received the score it did and what it can do about it? Typically not. We have explored how other industries view loyalty and advocacy and have developed a different way of asking these questions that uncovers the "why" as well as the "how."

## Share of Wallet: A New Way to Measure Loyalty

The traditional method of measuring hospital loyalty is an interval-level scale (for example, "On a 1–10 scale, where 10 means very likely and 1 means very unlikely, how likely are you to use this hospital again?"). So when your organization gets a mean score of 8.2 (on a 1–10 scale) on likelihood to use again, is that good? What exactly does it mean? What can you do with that?

Packaged-goods companies refer to loyalty as share of wallet. They look for how many times out of X times someone purchases their product (for example, "Think about your next 10 purchases of cereal. How many times out of 10 will you purchase Brand X?"). The resulting score tells the company's marketers not only the likelihood the customer will purchase their brand again but also, quantitatively, how loyal customers are to the brand. They can also ask what other brands the customer is buying to understand who their competitors are and how many are in the choice set.

This is not even close to the typical likelihood-to-use-the-hospital-again scale. We have attempted to integrate this thinking into a new type of loyalty question, one that measures not just "will you use us again" but also "for how many types of situations." Here is the wording of the question:

*Q: When you think of **all the reasons why** you would use {HOSPITAL} in the future, would you say you have good reasons to use this hospital again for____ ?*

Table 1 illustrates just how different "share of wallet"–type loyalty is and how useful this type of information can be. Clearly, Hospital F has the strongest level of loyalty, with six in ten recent patients

*(Continued on next page)*

## Table 1. Patient Responses to Loyalty Questions by Hospital

| | Recent utilization | | | | | |
|---|---|---|---|---|---|---|
| Loyalty (Total) | Hospital A | Hospital B | Hospital C | Hospital D | Hospital E | Hospital F |
| Every medical situation (20%) | 38% | 36% | 9% | 10% | 4% | 61% |
| Most situations, but not all (39%) | 30 | 52 | 39 | 32 | 64 | 20 |
| Some medical situations (25%) | 24 | 9 | 25 | 28 | 11 | 12 |
| A few specific situations but that's it (11%) | 4 | 1 | 17 | 18 | 11 | 7 |
| Nothing/would not use hospital again (3%) | 5 | 1 | 5 | 10 | 6 | 0 |
| Not sure (2%) | 0 | 1 | 6 | 2 | 4 | 0 |

Source: Klein & Partners

## New Ways

*(Continued from page 3)*

saying they would use the hospital again for everything. But while the same proportion of recent patients of Hospitals A and B say they would use them again for "every" medical situation, patients of Hospital B are significantly more likely to say they would use it again for "most" situations, while Hospital A's patients are more likely to be more comfortable using it again for some or just a few specific situations.

What is different about these two hospitals? Is it the patient mix? The patient experience? The hospital's reputation for certain procedures? The real power to make specific improvements comes when two key follow-up questions are asked:

- *Why are you not comfortable using this hospital again for every medical situation?*
- *For which medical situations would you not be comfortable going to Hospital X?*

### Advocacy (Behavior vs. Intentions)

The traditional method of measuring advocacy is an interval-level scale (for example, "On a 1–10 scale, where 10 means very likely and 1 means very unlikely, how likely are you to recommend Hospital X to others?"). Such scales have one thing in common: They all ask about future behavioral intentions—that is, how likely a person is to recommend your hospital in the future. But with so many things that can happen between now and then, how confident can we be in a future number like that? If your organization has a recommend-intention score of 8.4 on a 1–10 scale, is that good? What can you do with it?

Our experience in the packaged-goods industry led us to develop an advocacy metric that brings actual behavior into the equation, blended with reasons people would not recommend (people are able to tell you in a more concrete fashion why they will *not* do something than why they will).

Here is the wording of the question:

***Qa:*** *Have you ever recommended {HOSPITAL} to anyone?*

1. Yes
2. No (GO TO NEXT QUESTION)
3. Not sure

***Qb:*** *Have you NOT recommended {HOSPITAL} because…*

1. you just haven't had the opportunity but definitely would if it came up, or
2. you don't want to recommend this hospital because you don't like something about it, or
3. you're just not someone who recommends companies to others whether you like them or not
4. not sure

Table 2 illustrates how useful this information can be. Eight in ten recent patients have already recommended Hospitals B and F to others. By contrast, Hospitals C, D, and E have much lower levels of recommendation. But there are big differences among them. Four in ten patients of Hospital E just aren't the type of person who recommends companies to others (yes, there are many folks like that out there, and the traditional scale question does not account for them!), while Hospitals C and D have a real problem—about one-third of their patients have not recommended them because they specifically do not want to. Instead of having a scale question that gives us one aggregate number—the mean, for example—we have several key categories of respondents we can profile. For example, what do the 36 percent of Hospital C's patients who didn't like something about the hospital look like? What about their experience didn't they like? See how useful this type of advocacy question can be?

### Market Barriers: When Life Gets in the Way of Preference

Oftentimes, preference does not lead to utilization. Why not? If someone prefers your brand, why wouldn't they choose you? Let's take a look at what we call market barriers and see how they can get in the way of preference's connection to utilization.

First, a few definitions. *Brand strength* can be thought of as "pulling" the brand through distribution channels, while *market strength* can be thought of as "pushing" the brand through distribution channels. What do we mean by push/pull?

**Pull**. A strong brand creates interest in itself through marketing, communication, and experience efforts that make

## Table 2. Patient Responses to Advocacy Question, by Hospital

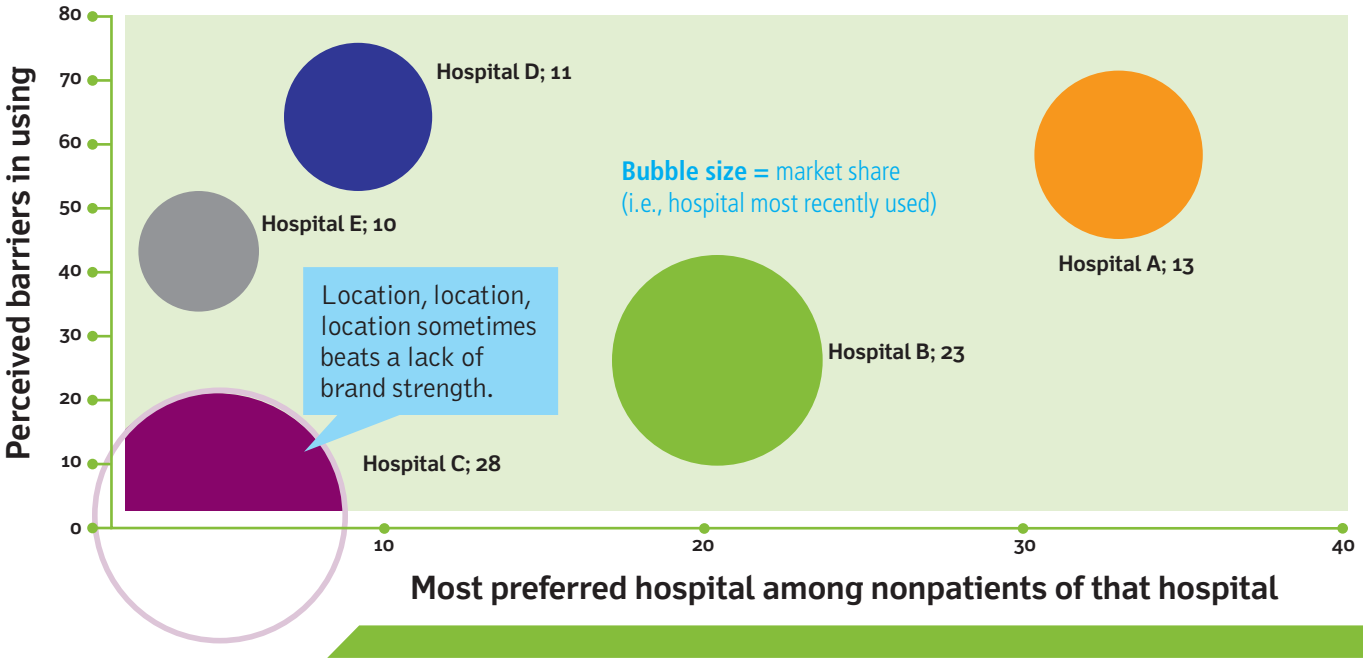
| | Recent utilization | | | | | |
|---|---|---|---|---|---|---|
| Advocacy (Total) | Hospital A | Hospital B | Hospital C | Hospital D | Hospital E | Hospital F |
| % Yes (53%) | 65% | 83% | 25% | 36% | 30% | 82% |
| Didn't recommend because didn't like something about hospital (15%) | 7 | 2 | 36 | 30 | 10 | 0 |
| Didn't recommend because not the kind of person who recommends (10%) | 12 | 4 | 10 | 5 | 41 | 10 |
| Didn't recommend because haven't had the opportunity to, but would (9%) | 6 | 4 | 5 | 8 | 11 | 2 |
| Didn't recommend and not sure why (13%) | 10 | 7 | 24 | 20 | 8 | 6 |

Source: Klein & Partners

## Figure 1. Impact of Market Barriers on Correlation Between Performance and Utilization

Even with less brand appeal, Hospital B has a larger market share than Hospital A because it has much lower perceived barriers to use. This illustrates how location-sensitive people in this market are. Hospital A's barrier is mostly location driven, while Hospital B's barrier is more insurance driven.

Source: Klein & Parners




people want to use it (again). Joel English, managing director of a healthcare marketing communications agency based in Milwaukee, calls the resulting preference *brand craving*. Essentially, with this strategy, consumers "pull" the brand through distribution channels with their interest or satisfaction. Brands accomplish this by creating a strong brand promise and experience—that is, through brand strength.

**Push**. Consumer attraction to a hospital brand can be undermined if the service or facility is not readily available or some other hurdle gets in the way of consumer interest and behavior—that is, if there is some market barrier. For example, physicians without a strong relationship with the hospital in question can undermine a brand in which consumers are interested; likewise, a hospital that isn't in key insurer networks or has inconvenient locations can cause people to go elsewhere. These examples of lack of market strength are a major reason consumer preference doesn't always lead to increased market share.

Although preference and utilization questions have been around for a long time, metrics to assess the impact of market barriers have been underutilized. When preference does not lead to market share, it may simply be a matter of "life getting in the way." The best intentions of any organization can be undermined when barriers emerge at the time of hospital choice. Your hospital can create strong brand craving among consumers, but when a patient goes to his or her physician and says, "Doctor Smith, I would like to go to Hospital A," and Doctor Smith replies, "I think you would be better off at Hospital B because…," most often that patient still says, "OK, you're the doctor."

We have developed a series of questions addressing the impact that market barriers can have on preference. For the hospital that is most preferred among nonpatients, we ask:

*Q: If you wanted to go to {HOSPITAL}, are there any factors—such as inconvenient location, health insurance restrictions, physician not admitting there, scheduling hassles, or anything else you can think of—that could hinder you in using this hospital?*

If the respondent says yes, we ask:

*Q: What would you say is the single biggest barrier to using {HOSPITAL}?*

Figure 1 illustrates how market barriers can have an impact on people's preference. For example, Hospital B has a much larger market share than Hospital A, even though Hospital B's overall preference among nonpatients is much lower. Notice that barriers-to-use for Hospital A are much larger than those for Hospital B, contributing to a lower market share.

Conversely, a lack of market barriers—that is, market strength—can positively influence market share even when preference is low. In Figure 1, Hospital C has the largest utilization share in this market, yet its overall preference among nonpatients is the lowest of all competitors. For Hospital C, having almost no market barriers—for example, it is the most conveniently located—creates market strength, which can overcome weaker brand strength. However, over time, competitors can combat market strength and use weaker brand strength against you. Successful brands create both market *and* brand strength.

**Written by:**
**Rob Klein,** President
Klein & Partners
Orland Park, IL
**630.455.1773**
*rob@kleinandpartners.com*
*www.kleinandpartners.com*