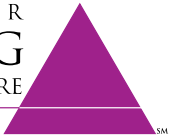


Advertising by Nonprofit Health Care Organizations

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Advertising in health care, more specifically in the nonprofit health sector, is far from new. It may appear in newspapers, magazines, and direct mail, and on Web sites, radio, TV, billboards and signs in public venues. The messages can range from the general to the specific, and be about the organization, its services or products, or ways in which people can be helped.

Advertising by nonprofit health care organizations has not received the same public scrutiny as some other management or governance practices. Why is that? What impact has competition had on advertising? And what effect is consumerism having on advertising and other marketing practices? Are there differences in the advertising practices of nonprofit organizations versus for-profit health care organizations? These are the kinds of questions explored in the following discussion, which is another in an ongoing *Inquiry* series called "Dialogue," cosponsored by the Alliance for Advancing Nonprofit Health Care to provide a variety of voices on important nonprofit health care issues.

The panelists for this discussion, held on April 15, 2008, were: **Anthony Cirillo**, principal, Fast Forward Strategic Planning and Marketing Consulting, Huntersville, N.C.; **Jeffrey Cowart**, chief marketing officer, Inova Health System, Fairfax, Va.; **John Kaegi**, group vice president of marketing, BlueCross BlueShield of Florida, Jacksonville, Fla.; and **Geoffrey Taylor**, senior vice president of communications,

Excellus BlueCross BlueShield, Rochester, N.Y. **Bruce McPherson**, president and CEO of the Alliance for Advancing Nonprofit Health Care, moderated the discussion.

Bruce McPherson: *Many use the term “advertising” interchangeably with the terms “public relations” and “marketing.” What are the distinctions?*

Anthony Cirillo: Marketing is the umbrella under which most of these other terms fall. Marketing sets the stage for some customer interaction to take place either now or in the future. That is especially true with health care delivery, where you are typically marketing something that people do not want or may not need for years, if at all. How you set the stage is where various marketing tactics come in, such as advertising and public relations.

Advertising generally involves paying for placement of a message, whether in print, on television, on radio, or on billboards. It is also increasingly being done online and through search engine optimization—such as Google AdWords. I would also include in my definition of advertising direct mail campaigns, in that you may be paying for a mailing list in addition to postage, and are likely to be using external or in-house experts in graphic design and advertising.

Another principal marketing tactic, public relations, is essentially media relations, which can have good and bad connotations. There is nothing better than a credible, favorable byline story in the local newspaper. Of course, the flip side is having to handle adverse events and negative media coverage. Often viewed as synonymous with public relations is public affairs, where the objective is to influence governmental or other changes for the benefit of the general public. Public relations typically targets specific groups to educate them or gain their acceptance of an idea or product.

John Kaegi: I agree that advertising is paid media where someone is trying to create a message they want to have portrayed. Public relations is seeking earned media—the byline example that Anthony cited.

McPherson: *To what extent do you see advertising in health care also being used today for basic branding—building an awareness or image?*

Jeffrey Cowart: Branding is as important in the nonprofit sector as it is in the for-profit sector. Whatever the mix of marketing tools used, it is all about building awareness and then loyalty.

Cirillo: Right. And brands are not created or formed overnight. Many of the brands that we’re familiar with in our culture have been passed down from generation to generation, such as Coke, or Pepsi, or McDonald’s. Knowing the hospital where your grandmother died is a generational pass-down. Branding in many ways is the sum total of all the experiences with the product or service, from word of mouth to messages communicated using various marketing tools to actual use of the product or service. As a consultant, I emphasize to clients that marketing is everybody’s responsibility, not just the marketing department’s.

When organizations do brand advertising, they are trying to build a certain image and associate certain attributes to their products or services—the most compassionate, the most technically competent, and so forth. This is usually followed by marketing specific services or products. You don’t have to look further than the Society for Health Care Strategy and Market Development publication, *By the Numbers* to see that most hospitals are spending most of their marketing dollars on mass media brand advertising rather than on public education and relationship marketing.

Kaegi: From my vantage point in the health care insurance industry, in contrast to what Anthony (Cirillo) has noted on the hospital side, I don’t see either nonprofit or for profit health insurers doing much general brand image-building advertising. Maybe the cut throat competition we are experiencing right now is causing the emphasis to be placed on aggressive promotion of specific products.

Geoffrey Taylor: As others have said, building the image is one thing. But building loyalty is where the actual customer experience comes into play. Interactions must mirror the claims that brand advertising makes. Otherwise you have a disconnect that diminishes the brand.

Kaegi: Absolutely. Don't over-promise and under-deliver.

McPherson: *How do you see competition in health care affecting advertising decisions?*

Taylor: In the simplest terms, the more the competition, the more the advertising, and the less the competition, the less the advertising. But I don't think you would ever get to the point of no advertising. You will always need some advertising to help make people aware of your existence and products or services available to meet their needs.

In the health insurance field, everyone is clearly trying to have members with good health risks to offset those with bad health risks, and that's where some targeted advertising comes into play. Unfortunately, it is wasteful, but everyone wants to make sure that they have a fair share of good risks. A plan with a disproportionate share of bad risks will quickly find itself financially challenged.

Kaegi: Being nonprofit really helps here. Without quarterly financial statements or stakeholders to worry about, we can do more advertising around public education and engagement of consumers and their health, which builds the brand faster and more effectively. If you are a for-profit, your advertising is more likely going to be aggressive promotion of a specific product or service. So we have the advantage of being able to direct our messaging where it will do the most good.

When I was in college in the '60s, we had debates on whether advertising had any social value. Advertising can be an important conduit between a product and a need. This is as true today as it was then. It can be abused. It can be excessive. But if used judiciously, particularly in health care, you can really help people improve their lot.

Cirillo: In my most cynical moments, I maintain that if a hospital didn't advertise for six months it wouldn't affect its market share. But I see advertising happening in every single hospital that I visit. Competition has hugely contributed to increased advertising expenditures, and often needless ones. There is too often the knee-jerk reaction, "If they are going to advertise, then we have to counter." Or a physician will demand an ad and the hospital will do it. You have to have a marketing strategy and plan, and stick to them.

I've seen many hospitals use the recognition calendar as the way to plan what they feature in ads. So if February is "Heart Month," they tout their cardiology services. I advise them to pick another month for heart month, or do it in a different way, rather than follow the same pattern.

I agree with Geoff and John that there will always be some advertising. If medical tourism takes off, your competition may no longer be just local. Also, it may no longer be with just the same type of organization. If you are a hospital it could be with your own physicians.

McPherson: *How is consumerism affecting your advertising and other marketing strategies?*

Cowart: Consumer-directed health care has added a whole new dimension to competition, and marketing strategies to address it. Our Marketing and Communications Department has been relabeled the Communications and Marketing Department, with patients themselves becoming a key audience for our communications. You need to look at the traffic in your facilities. How are you reaching them and what is the message? Do you publish your own newspaper or newsletter and put it in the waiting areas and communicate your message in a different way than you might have in the past? Do you use kiosks or LCD screens?

Conventional advertising has become less important. There are many information distribution channels in every community that target a variety of audiences. While we

won't ever abandon conventional advertising, we are going to be using more focused channels of communication with stronger messages to particular audiences. Similar to what Geoff described earlier, we see our Web site becoming more transactional than informational.

In northern Virginia, homeowners' associations are potentially very useful channels of communication. We need to figure out how to use them appropriately. Should we create our own YouTube? Are we going to have Inova TV or other types of video on our Web site?

As another example, Inova sponsors the National Capital Velo Club, which I believe is the second-largest cycling club in the country. The Inova logo is on the bikers' jerseys, both front and back as well as on the sides of their pants, so that they have become "rolling billboards" for us all over Maryland, Virginia, and the District of Columbia. But it's not just about marketing and advertising. It's also sponsorship of a healthy activity that reinforces our mission. We also have had for several years a department in our Community Health Division called Congregational Health that works routinely with churches in our communities on health education issues.

Kaegi: The health insurance industry is rapidly transforming toward consumerism. Because of their increased financial exposure, people are starting to really scrutinize their coverage and their own decision making as it relates to health care and lifestyles. Consequently, we spend more time and money now communicating with consumers as opposed to employer groups. We believe that we're heading toward a retail-like industry. We now have personal communication relationships with employees. We also believe that if we're going to do something about the rising costs in health care, we have to engage our members in making better health care and lifestyle decisions.

One of the ways in which we are now reaching out to the consumer is experiential marketing—getting involved in or sponsoring community events or activities that provide a lot of benefit to the people participating. Examples are health

fairs and mobile health screening units. We recently completed what we call a market contact audit to understand the effectiveness of various communication distribution channels. We found that for our health insurance business, the traditional channels of television, radio, and print were near the bottom of the list of 31 possible channels in terms of clout and credibility. At the top of the list were referrals, personal relationships with physicians or their staffs, and then experiential marketing.

We are also experimenting with a communications approach working with local African-American churches on causes that are important to health, which in a way is an extension of the experiential marketing concept. We're also getting ready to do something similar with community organizations in Hispanic communities in Florida.

Taylor: We're doing many of the same things. Like Jeff and John, we have been very involved in event advertising with a broader social purpose. An amusing, off-the-wall example was our sponsorship of a minor league baseball game where we handed out to thousands of people Groucho Marx glasses, which were tied to our campaign message that brand name drugs are just generics in disguise. We had everyone in the stadium put on the glasses between the third and fourth innings in order to beat a world record for the most people assembled wearing Groucho Marx glasses. We received coverage on all of the major news outlets that interviewed our pharmacy expert, who talked about the value and effectiveness of generic medicines. We've replicated that type of event in other markets, and we also routinely report to the community the types of savings that generics are generating, not just for our members but extrapolated to the community as a whole by using census data.

In addition, we introduced a product last year that gives back to a husband and wife up to \$1,000 combined for healthy behaviors and properly taking care of medical conditions they may have. Our advertising of this product is attracting the attention of both employees and employers. We're marketing it to both audiences.

As another example, our national group, the Blue Cross Blue Shield Association, is conducting an advertising campaign, Walking Works, to inspire the general public to do more walking to reduce weight, improve cholesterol and blood pressure levels, and so forth. The association is using paid media to get across a public education message that will benefit many. At the same time, it is helping to build a brand image for the Blue plans. In response, some of the national for-profit insurers like Aetna and Humana are now buying advertising to teach people how to make better lifestyle decisions.

Cirillo: What all of you have been saying about experiential marketing sounds a lot like the standard things we used to do when I was in a hospital—more community relations than marketing per se—but in a more strategic and sophisticated manner. So in a sense, maybe we're getting back to where it all started before we created marketing functions and departments. One of the non-health-care examples I give in one of my presentations, "Make Their Priority Your Priority," is about one large "big-box" store's series of entrepreneurial workshops. The store recognized that a lot of its customers—baby boomers—were thinking about their legacy and wanting to get out of the corporate world and start a new business or other enterprise. The workshops got people into the stores and met their needs, even though they were unrelated to the things the organization sold in the store.

I offer two notes of caution, however, about the greater focus on the consumer in advertising and other marketing efforts by hospitals. First, at the end of the day, it is still physician referrals that drive utilization. I don't think that many hospitals work as hard as they need to on their physician relationships. Secondly, I get very concerned when I see a hospital advertise its quality data or rankings from some source. The data is old by the time it is displayed. Also, because there are so many sources and metrics out there, which are the ones to be believed? The average consumer can't make sense out of all this. Even health professionals can get lost. Physicians are better equipped to understand these metrics, so if you must advertise in this area, do it to them. They are still the gatekeepers. Don't confuse the public even more than it already is.

McPherson: *We've talked about branding— "creating the promise"— and we've talked about improving consumer knowledge, behaviors, and experiences—"delivering on the promise." As a hypothetical, let's assume that you have \$100 to spend. How much of it would you devote to creating the promise versus delivering on the promise?*

Cowart: I can't give you a specific breakdown as far as our organization is concerned. If we are going to do some brand advertising— what we call service-line advertising—we carefully evaluate the operational realities on the other end of the claim. If we don't feel that the claim can be sustained, we won't do that advertising. We would be wasting the time and money.

One area in marketing departments where there tends to be a deficiency is in understanding the difference between "market" data and "marketing" data, and investing resources accordingly. If the bulk of your marketing resources are in conventional media like newspapers, radio, and TV, with a very small portion in researching and improving customer relationships, you had better shift those percentages.

Kaegi: I agree. The customer experience is crucial. We participate in the JD Powers and Associates annual survey to assess customer satisfaction with major health insurers. Nonprofit health insurers have scored much higher than the for-profits in both overall customer satisfaction and communications clarity. But as a category, communications scores were on average lower than those in the other categories of customer satisfaction. This indicates that many people see little positive benefit in many of the kinds of communications being done in our industry.

Cirillo: I can't offer an optimum percentage split for your hypothetical \$100, but I would like to see less mass media advertising. I think there are better uses of some of those expenditures like Jeff said, such as collecting the right data about your prospects and talking to your patients and influencers so that you can change their experience, connecting the dots in the process, to match their desires. Some organizations, like the Cleveland Clinic, have hired what

they are calling “chief experience officers” to actually coordinate the patient and family experience with employees and processes, even to the point of figuring out how best to announce to a family that their loved one has died.

As another example, a hospital in Oregon engaged the StuderGroup to help with its customer experiences, and it now has people from seven states coming there for cancer care. Medical tourism on a local level seems to be working for that hospital.

McPherson: *Have you advertised, or could you foresee advertising, your nonprofit status or community mission? For example, not long ago on a trip to Michigan I saw a highway billboard by the Blue Cross Blue Shield plan celebrating its longtime nonprofit status.*

Kaegi: We’ve looked at this possibility in the past, and the research that we have shows that the general public doesn’t understand or care whether you are nonprofit or for-profit. People just want their needs met. Also, there is a risk that if you ballyhoo too much your nonprofit status, you may be setting yourself up for unreasonable public expectations.

As we were talking about earlier, there are a lot of other important uses of advertising to tell people about community programs and events, and to help them become healthier people. It is also being used to collect public opinions about what’s wrong with our organization and the industry and what we can do to fix it.

Taylor: I agree. We have done some advertising around the concept of our nonprofit status, but we can’t point to any measurable results that the public “got it.” We do try to identify and correct public misperceptions about our performance. For instance, we commissioned a survey a few years ago that has subsequently been replicated by others across the country. It asked the public what share of the premium dollar goes for medical benefits versus administrative costs and profits. The average consumer thinks that the average health plan retains 50 percent of the premium dollar for itself between operations and profit, with only 50 cents of the premium dollar spent on medical benefits. That type of public perception will at times drive political agendas, and we have a public responsibility, as well as a selfish motivation, to help people understand the facts.

In meetings and other communications with policymakers and opinion leaders, we remind them of our nonprofit status, but with the general public we have had more success where we illustrate that we’re doing the right thing. For example, we set up a special Web site, “StepUp,” that anyone—members or the general public—can use to report and monitor their progress in health status improvement. We invested over \$1 million in building and promoting this Web site that benefits the community at large.

Cowart: Our communication philosophy on our nonprofit mission is like Geoff’s: “Claim It—Don’t Explain It.” Explaining it to the general public is just too difficult. Instead, we claim it by communicating the good works we are doing in the community.

Cirillo: Past surveys have indicated that about 80 percent of the public think that most hospitals are for-profit, which presents a huge educational challenge. In addition, in some cases the lines are being blurred, with nonprofits having for-profit subsidiaries.

I agree with the other panelists that you have to show how you are behaving as a nonprofit, not explain it. You also have to be careful about the frequency, media, and content of your advertising, which can reflect well or poorly on your nonprofit image. You want to avoid reactions like, “How can they be nonprofit if they have that much money for advertising?” Or, “They’re just in it to make money like everybody else.”

Kaegi: With transparency growing, you have to demonstrate what you are doing for the community. This is especially true if your earnings or reserves at any point in time are likely to be perceived by the public or policymakers as high or excessive.

Cirillo: I have seen some hospital Form 990 returns with two sentences devoted to what they have done for the community. I have seen other hospitals publish impressive community benefit reports, showcasing every year what they are doing, and sending these reports to employees, volunteers, policymakers, and opinion leaders—letting the word spread from there. This isn’t an advertising vehicle, but it is a critical communication and marketing vehicle.

McPherson: *Do you think that you explicitly or implicitly impose upon yourself, as a nonprofit, a different standard or set of expectations for your advertising practices than a for-profit does?*

Taylor: I think that there is a discernable difference, but it would be very difficult if not impossible to measure.

For example, our nonprofit health plan has run a major advertising campaign over the past few years on generic medicines. As we all know, there are billions of dollars being spent by the pharmaceutical industry on ads that always conclude with a tagline, “Ask your doctor if ‘X drug’ is right for you.” Our campaign was built on the tagline, “Ask your doctor if there’s a generic that’s right for you.” We are sharing the intellectual property of our in-house experts when we run these ads—linked to an educational campaign—because it is the right thing to do. In ways like this, we are using advertising for a greater good than simply gaining a competitive edge, and hopefully we will see even more of that trend.

We share a lot of intellectual property with the community in our public education and marketing efforts—much more so than our for-profit counterparts. For instance, one of our physicians, Pat Bomba, is a national expert on end-of-life care, advanced care planning, and so forth. A large portion of her time is devoted to educating doctors and others in the community on these issues. Our communications office is about to release a report on the results of a major—and costly—survey on the wide gap that exists between people’s desires regarding their own end-of-life care and the basic actions that would ensure that their wishes are honored. Narrowing that gap is a critical public health goal that will avoid family tragedies like the Terri Schiavo case and, at the same time, save billions of dollars in health care costs for services that people say they don’t want.

Cowart: I think the marketplace is showing signs that there are some differences in where and how we are spending our advertising and other marketing dollars. We have a different story to tell, and we have been focusing much more on public education.

As a nonprofit health system, we also spend a considerable portion of our advertising dollars in just letting people know about our health and wellness classes, HIV clinics, and other subsidized community programs.

Kaegi: In our field, public education and changing behaviors are what it is all about, and a strong nonprofit, mission-based organization is going to understand that and use advertising to help move the needle in that direction. It’s the right thing to do and smart business.

Cirillo: Public education, one can argue, is a duty that we as nonprofits are obligated to perform—educating people about health care issues and choices. While it can be carried out using various marketing tools, the question is whether it is being done as a community benefit or for marketing purposes. There is a fine line, because even when it is being done as a community benefit there can be a side benefit of creating good will with prospective clients that could factor in their choosing you down the line.

The organizations represented here are clearly approaching it from the perspective of the greater good for their communities. I want to commend you for what you are doing, particularly in the public education realm. I hope that others in the nonprofit health sector read and heed the messages conveyed here.