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Healthcare branding: Insights from Africa into health service customers' repeat patronage intentions

Priscilla Teika Odoom, Bedman Narteh and Raphael Odoom

Department of Marketing and Entrepreneurship, University of Ghana Business School, University of Ghana, Accra, Ghana

ABSTRACT

The study explores the relationship between branding in healthcare, brand image and customer re-patronage intentions. A survey approach was employed to gather data from 318 outpatients in hospitals in the Accra Metropolis and the data was analysed using factor analysis and regression analysis. The results indicate that the four dimensions of healthcare branding – brand elements, tangibles, medical personnel quality and critical services – predict healthcare brand image and re-patronage intentions. However, brand elements did not predict customer re-patronage intentions; and a strong significant relationship emerged between healthcare brand image and re-patronage intention. The strategic implications of the results for managing branding in hospitals are discussed in the paper.

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Introduction

Healthcare is a very essential and personalized service that is globally used. In most parts of the world, the healthcare industry is experiencing unexampled growth attended by changing cost structures, evolving healthcare laws, and the influx of private and alternative practices to the healthcare market [1–3]. As a corollary, healthcare providers are experiencing increased competitive pressures. This has provided consumers with a lot of options and has made them active decision makers as well as more selective about their healthcare choices [4]. It is argued by some scholars [5] that, in a changing and highly competitive healthcare field, branding is a marketing imperative to influence consumer choice and differentiate healthcare organizations from the competition. This assertion finds support in Kotler and Keller's [6] position that branding can be applied anywhere consumers have choices. For this reason, hospitals and more healthcare organizations have become cognizant of the relevance of branding as a marketing principle [7,8], and are making a concerted effort to employ such initiatives in their operations [9] due to the desire to influence consumers in an increasingly crowded marketplace. In spite of this, healthcare organizations still fall behind other service sectors in the practice of branding as they do in almost all other facets of service marketing [10].

The growing scholarly and practitioner-based interests regarding branding in the healthcare context have been in the areas of brand equity, hospital brand-image and consumer brand relationships [2,11]. Additionally, healthcare studies vis-a-vis consumer perceptions and concerns have been dominated by themes such as service quality and patient satisfaction [10,12,13]. The few available studies in the domain of healthcare branding include the works of Kim et al. [1], Kemp et al. [2], Kumar et al. [4] and Wu [14]. The results of these studies indicate that customer/patient satisfaction, perceived quality, brand awareness, trust and brand image perceptions of healthcare services, physical facilities and reputation contribute to healthcare brand equity. However, the explicit influence of these factors on consumer repeat patronage intentions has drawn limited attention in the literature. Furthermore, the intervening mechanism through which the effects of these factors could be transmitted have likewise been largely ignored.

What is more, the few available studies have focused on developed countries and some developing countries (such as Asia and Eastern Europe) with arguably no focus on healthcare branding in emerging Sub-Saharan African economies. The purpose of this study, therefore, is to investigate the relationship between healthcare branding, brand image and customer repeat patronage intentions. In our view, such a study is opportune as it will provide managers of hospitals with decision points that could help build strong hospital brands in the wake of intensifying competition among healthcare organizations to help attract and retain customers. Correspondingly, the study contributes to the healthcare marketing literature by assessing the role played by branding in the consumers' re-patronage decisions through brand image from the perspective of an emerging Sub-Saharan African market.

CONTACT Priscilla Teika Odoom menscilla@gmail.com Department of Marketing and Entrepreneurship, University of Ghana Business School, University of Ghana, Legon, Accra 00233, Ghana

The rest of the study is structured as follows. First, the study draws on available research literature to identify the healthcare branding factors that influence the components of brand equity in hospitals. Second, a conceptual framework that explains the interrelationships among these factors, brand image and repeat patronage intention is developed; and research hypotheses generated to guide the empirical investigation. Third, the research design, methods employed, and mode of data analysis are presented and justified. Fourth, findings are discussed, and the implications for theory and practice are provided. Finally, limitations of the results are presented as well as directions for future studies.

Literature review

Branding and healthcare services

According to branding theory, branding is a competitive strategy that distinguishes and positions products/services and organizations in order to build added value for consumers and owners of the brand [15]. Although unanimity on a comprehensive definitional scope and the dimensional borders of branding as a managerial term is still minimal [16], the concept goes beyond the use of just a name and logo, differentiation and perceptions to include a whole process involving research, identity creation, relationships and continuous assessment of the brand [17,18]. Chahal and Bala [19] argue that to make a brand competitively different, the key objective of service firms should be to give attention to activities that contribute to service quality brand development. Also, the literature suggests that a strong services brand is developed and sustained largely by customers' interactions with the service provider [18]. These interactions mould their perceptions and motivates their eventual behaviour towards the brand [15].

For this reason, in the healthcare field, branding holds relevance for health service providers along several strands. Given that healthcare is considered a high-risk service that consumers find challenging to objectively assess [2], branding provides an identity for healthcare organizations [5] and reduces the effect of credence properties associated with health service interactions; for example, a surgical operation performed on a patient [20]. In addition, with the shifting competitive landscape, healthcare consumers are increasingly focusing on a strong reputation as a selection criterion for hospitals and physician practices. Owing to this, healthcare organizations are struggling to create consumer value, target desired consumer segments, stake their share of the market, and enhance profitability by creating consistency and service personalization [2]. Evidence suggests that these organizations are also beginning to compete on the basis of care and quality outcome [4,12]. The success of such initiatives, according to Corbin et al. [20], requires branding, a major constituent to overall consumer demand, trust, and patient satisfaction. Thus, in order to be recognized, differentiated and be reliable in the view of patients, to maintain a desired client base and to attract new ones, branding becomes crucial for healthcare providers. Moreover, because health service consumption requires high interaction between clients and service providers, brand image perceptions are formed by patients through their interaction with service providers, activities they observe, what they have read about the hospital, and visual symbols they recognize through treatment experiences [1].

Gleaning from the available literature, activities related to consumer convenience, hospital environment, and professional demeanour are relevant to healthcare providers' branding efforts. Factors including competence of medical staff, nature of the physical facilities and environment, availability and accessibility of services, name and reputation were found to shape healthcare consumers' hospital image perceptions and influence their behavioural intentions [21]. These emergent factors provide an understanding of what consumers consider as important in a healthcare institution, which guided the conceptual foundation for the study.

Brand image

Considered an essential concept in brand building, brand image describes consumers' thoughts and feelings towards the brand reflected in consumers overall impression [14]. It is also considered a set of beliefs held about a particular brand, which plays important roles in the consumer's decision process when they evaluate alternative brands [22]. According to Shanthi [23], image plays an essential part in distinguishing the services of a healthcare provider from those of its competitors and so a patient's idea of hospital image is considered relative to brand images of competing hospitals. Patients form specific thoughts about any hospital quickly through their own medical examination and treatment experiences [1]. For this reason, Kolade et al. [24] submit that hospital brand image is based on the impression perceived by patients via interactions with services, and activities from their time of arrival through treatment experiences to departure.

Repeat patronage intention

Intentions are subjective judgment regarding a person's future behaviour and generally function as outcome variables in service research. Hellier et al. defined re-patronage intention as 'the individual's judgement about buying again a designated service from the

same company, taking into account his or her current situation and likely circumstances' [25, p.1764]. Mandhachitara and Poolthong [26] referred to it as customers' intention to further purchase services of a provider and the intent to increase both the scale and scope of the relationship. Repeat patronage intention is regarded as a behavioural intention and a sound service outcome that is measurable. According to Pollack [27], repeat patronage intention is considered in terms of customer inclination to revisit a service provider and to recommend the service to others. In the current study, repeat patronage intention is conceptualized as customers' inclination to visit a hospital in the future and for different medical purposes as well as recommend the hospital to others.

Model and hypotheses development

Figure 1 depicts the conceptual framework for this study. The framework assumes that healthcare branding is made up of four components that directly or indirectly (through brand image) predict consumers' repeat patronage intention of hospitals. In the next section, these relationships are discussed, and hypotheses formulated to guide the empirical investigation.

Brand elements (name and signage)

For services, the branding effect of a company name is fundamentally important because it is the brand name and it 'tangibilizes' the firm's offering [28]. A brand name is one of the most important components of branding as it identifies the brand in general, distinguishes the organization, clarifies the nature of services performed and captures the consumers' focus [29]. Brand name provides customers with a representative meaning that aids product/service recognition and the decision-making process. The tendency to use brand name, as a selection criterion, has been studied largely from the perspective of brand equity. Keller [29] affirms that brand names that are recognized more quickly and easily are liked more and, ultimately, chosen often. Davis [28] likewise points to the role of brand names in serving as a source of information for consumers in making a purchase decision.

What is more, healthcare facilities are among the most complex of any settings used by the public [30], and the people who visit hospitals are those compelled to do so by disease, injury and sickness. Hence for patients, the ability to effectively navigate in healthcare facilities is a vital goal. Studies on the influence of consumer disorientation within healthcare facilities confirm that the ability to find one's way contributes significantly to patients' perceptions and satisfaction levels [31]. For instance, in an experimental study, Nelson-Shulman [32] found that patients exposed to posted signs or who had the advantage of an information system such as orientation aids were more self-reliant, in contrast to uninformed patients who were stressed and rated the hospital less favourably. Bidhan et al. [31] argues that health facilities that leave their visitors confused and stressed out can deter clients from revisiting. Accordingly, although consistent and pleasing design is appreciated, the physical signs themselves may not essentially be a factor in a patient's brand perception but getting lost may be [33]. The reasoning is that patients are likely to relay their negative thoughts and emotions toward the hospital; and the effect on brand, image perceptions, confidence, and eventually loyalty, can be significant. A good, effective and simple signage system is thus, an efficient way to enhance the image of the hospital as well as keep the public abreast of the services available. This makes the visit to the hospital more impressionable, pleasant and encourages revisit [31]. In view of these, it is proposed that:

H_{1a}: There is a positive and significant relationship between brand elements and repeat patronage intention.

H_{2a}: There is a positive and significant relationship between brand elements and brand image.

Quality of medical personnel

For healthcare providers, employees are one of the main assets of the organization [34]. Personnel quality

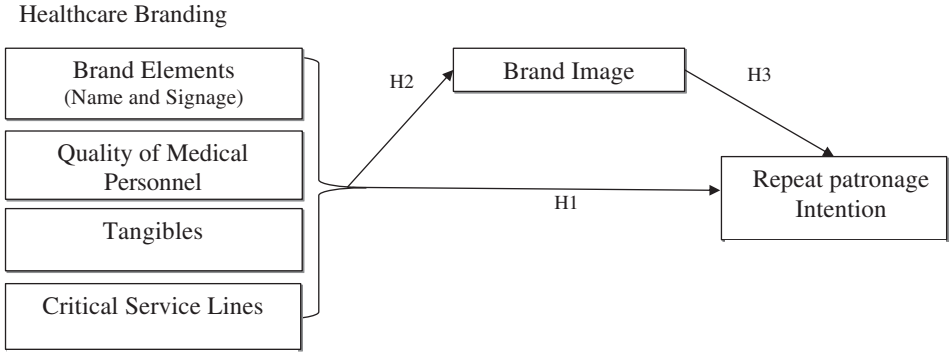

Figure 1. Conceptual framework.

is crucial in modelling a positive image and a certain degree of trust for healthcare institutions [35]. Although healthcare consumers may be at a knowledge disadvantage in assessing medical personnel competencies, studies [e.g. 34,36] have shown the influence of the medical personnel quality on patients' perceptions and satisfaction toward healthcare facilities. Consequently, today's increasingly knowledgeable, empowered, and well-informed healthcare consumers place relevance on the expertise their physicians and clinicians have exhibited in the field [37], which therefore puts the technical competence of medical personnel or physicians at the centre of patient healthcare decisions.

Wilson and McNamara [38], in their simulation of doctor-patient interactions, established that physicians' good manners do not compensate for their poor technical competences. The reasoning here is that, although patients may find it difficult to assess the practical abilities of medical staff, it does not reduce its relevance to them [36]. As it would seem, the presence of skilled and knowledgeable care providers is a fundamental expectation patients hold when they make hospital care choices [39,40]. Owing to the high credence nature of healthcare services, Moorthi [41] recommends advanced skill sets and professionals with a broad comprehension who deliver esteemed experiences as a means of setting the facility apart. Illustratively, an interviewee in Kemp et al. [2, p.129] conveyed the intent to revisit the hospital where she had a surgical procedure and affirmed:

> I had my surgery performed at (my hospital) mostly because it was where my physician had admission privileges. However, I did really appreciate the anaesthesiologist I had. He was very competent, and I would go there again because of him.

As indicated, a consumer's personal valuation of quality can influence perception of a healthcare provider and purchase intentions as well as the image of the facility hence the hypothesis is stated:

> H_{1b}: There is a positive and significant relationship between quality of medical personnel and repeat patronage intention.

> H_{2b}: There is a positive and significant relationship between quality of medical personnel and brand image.

Tangibles

Services are grounded on several intangible aspects that communicate their uniqueness in the market. Healthcare services are basically intangible as the core benefits of medical diagnosis, treatment, and patient education largely stem from performances [36]. Scholars therefore point to the need to endow service brands with tangibility to provide consumers with a favourable set of perceptions [42,43]; and to effectively differentiate them from the competition. From the perspective of Chahal and Bala [34], the applicability of 'tangibles' in the healthcare context is reflected in the general atmosphere, waiting and examination rooms, up-to-date medical equipment, adequate stock of medicine, parking spaces and written materials. For Swan et al. [44] tangibles in a service setting are atmospherics that impact consumers' patronage intentions and word-of-mouth recommendations. Moreover, the physical surroundings and sensory stimuli of healthcare facilities have been found to impact patients' behaviour. More specifically, a positive experience with such environment enhances patients' satisfaction, how they evaluate the quality of service provided, and the prospect of revisiting the facility in the future [10,45,46]. In hospital settings, the state and effectiveness of facilities, the physical environment and other peripherals have been found to significantly impact patients' experiences with and perceptions of a healthcare facility [12,34]. Against this background, the next hypothesis states:

> H_{1c}: There is a positive and significant relationship between tangibles and repeat patronage intention.

> H_{2c}: There is a positive and significant relationship between tangibles and brand image.

Critical service lines

The function of service lines is to coordinate the patient's journey through service-associated activities with the aim of attaining optimum clinical and business results [43]. Service lines are specified clinical areas with particular functional and operational concerns [45]. The fundamental purpose of healthcare consumers visiting a health facility is to receive medical care; and so, access to a full range of appropriate healthcare services has become a vital reason for patients' choice of healthcare facilities [44]. Because expediency in availing medical care is essential to patients, the collection or range of medical services available in a hospital is a vital consideration in their choice of hospitals [47]. Arab et al. [48], in a study of service quality and patients' loyalty in private hospitals in Tehran, confirm the influence of availability of medical tests and pharmacy facilities among other factors within the hospitals on patients' willingness to return to the same hospital and reuse its services or recommend them to others. Vinodhini and Kumar [49] also posit that the strength of the healthcare service or product builds a distinctive image for hospitals. The range of services provided within a healthcare facility is argued to be a decisive factor in the formation of patients' perceptions towards the hospital largely because patients expect timely, convenient and effective services from their hospitals. In view of this, the study

proposes these testable hypotheses in examining the influence of critical service lines as an element of healthcare branding on repeat patronage intention and hospital brand image in the healthcare sector.

H_{1d}: There is a positive and significant relationship between critical service lines and repeat patronage intention.

H_{2d}: There is a positive and significant relationship between critical service lines and brand image.

Brand image and repeat patronage intention

Image is an important variable that influences consumers' perceptions of an organization's products/services offering [50]. In essence, brand image is an essential determinant of consumers' buying behaviour [51,52], and a positive and well-known image is considered a powerful purchase influencer [22]. A positive brand image increases such various outcomes as customer satisfaction, service quality, loyalty, and repurchase intentions [53,54].

Several studies have shown the impact of brand image on purchase intentions [55,56] and others [14,57] have suggested that brand image has both direct and indirect effects on revisit intentions. For instance, Kandampully and Suharanto [58] have shown that a favourable hotel image positively correlated with customers' intention to recommend and revisit the hotel. Similarly, in retail, Esch et al. [59] confirmed the direct and indirect influence of brand image on current and future purchases. Much more relevantly, Chahal and Bala [34] reported that favourable patients' perceptions towards a brand reflected their preference to patronize the same or different medical services from the same hospital as well as in the future. Therefore, in the healthcare context, a positive hospital brand image appears to stimulate repeat patronage intention. Following this line of argument, the next proposition states:

H_3: There is a positive and significant relationship between brand image and repeat patronage intention.

Methodology

Survey instrument

The study employed a quantitative approach in which a survey was conducted with the use of close-ended questionnaires. Comprising of 25 scale items, all of the variables were measured on a 5-point Likert scale (1 = strongly disagree to 5 = strongly disagree). The first segment of the questionnaire obtained information on demographic variables such as gender, age, educational qualification, occupation, monthly income as well as hospital type and time-length of patronage. The second segment elicited information relating to patients' perceptions of branding activities of the hospitals, as well as hospital brand image and repeat patronage intentions. Brand elements were measured with five items adapted from literature [60,61]. Quality of medical personnel was drawn from literature [34,36,38] and measured with four items. The tangibles construct used in this study was measured with six items, based on a mix of the work of Chahal and Bala [34] and modification of the tangible dimension of the SERVQUAL instrument [57] to better reflect the hospital setting. Critical service lines' scales were culled from the literature [62–64] and measured with three items. The brand image construct was drawn from the literature [1,14] and operationalized with four items. The repeat patronage intention construct was measured with three items, which consisted of intention to revisit the hospital in the future, and for different treatments, and recommending the hospital to others. These scales were drawn from the works of Pollack [27] and Kim et al. [1]. We controlled for age of respondents, levels of education, income levels, number of years with the hospital and the nature of hospital, measured by the hospital dummy (0 = Private hospital versus 1 = Public hospitals). Measurement details can be found in the Appendix.

Population, sample and data collection

We purposively sampled two private and two public secondary-type hospitals in a major metropolitan area (Accra Metropolis) in the southern part of the country. These hospitals were chosen on the basis that they offer both general and specialized services as well as exhibit, to a large extent, all the healthcare branding factors espoused in the literature. First, formal letters were sent to these sample hospitals requesting to use their customers as participants for the study. After consent was given by the hospitals, the research questionnaire was initially pre-tested on 25 EMBA students of the University of Ghana Business School following which minor modifications were made. Subsequently, a convenience sample was drawn from the clientele (outpatients) of these hospitals since there is no sampling-frame for healthcare service brand patrons. With the aid of research assistants, respondents were approached on the hospital premises (hallways, waiting/sitting, and parking areas) as well as bus stops in cases where the hospitals had such, and asked if they were willing to participate in the research. A qualifying question was first asked to ensure that respondents were customers or clients of the hospital and thus, fell within the sample population. They were then given a two-page questionnaire to fill-out and return on the spot to the research assistants. It must be iterated that the study focused on patients in the outpatients units or departments (OPD) as such

in-patients (patients on admission), patients seeking emergency care, and extremely ill patients were excepted from the study since they may not be in the right frame of mind to provide lucid and/or needed responses. After five weeks, 322 responses were retrieved but 318 were fit to be included in the analysis. Exploratory factor analysis and multiple regression analysis were employed as key analytical tools using SPSS version 22.0.

Results

Descriptive statistics

Results from the descriptive analysis show that respondents were mainly females (52.5% females and 47.5% males). The average age bracket of the respondents was 18–30 years; the bulk of them (76%) had higher education while 24% had up to secondary education; and 20% were unemployed while 75% were employed and 5% were pensioners. The majority of them have been with their hospitals between 3 and 5 years. In order to provide a snapshot of the scale items included in the questionnaire, a descriptive analysis (mean and standard deviation) was conducted and is presented in Table 1. Since the questionnaire was scaled 1–5 with the survey scale midpoint (3) representing uncertainty towards the statements, the results show moderate and a few high mean scores. The highest mean score was 4.2201 (I will recommend this hospital to friends and relatives) while the lowest (3.6667) was shared by three scale items (hospital staff are knowledgeable to answer my questions; the hospital has a good parking area; the hospital offers specialist medical services).

Exploratory factor analysis (EFA) – rotation and reliability

The 25 scale items measuring the constructs were subjected to factor analysis. Before the PCA was done, suitability tests, namely the Bartlett test of Sphericity (Approx.: Chi-square = 4548.375, df. 496, sig. 0.000), and the Kaiser-Meyer Olkin measure of sampling adequacy (0.937) confirmed the factorability of the variable matrix, and the multivariate normality of the dataset. The principal component analysis (PCA) indicated six components with eigen values of one (1) and above, hence were chosen for analysis [65]. The six-factors explain an overall 69.38 percent of the variance in re-patronage intentions.

The 25 scale items were later rotated using the extraction methods of Varimax and Direct Oblimin. To be retained for analysis, variable loadings for EFA should be 0.5 or greater [66]. On this basis, six scale items that failed to meet the 0.5 loadings were dropped from further analysis resulting in 19 variables measuring the six constructs. Since the factor loadings were above 0.50, construct validity was established among the scale items. The internal reliability of the remaining scale items was subsequently assessed using Cronbach's alpha. The alpha scores show acceptable levels, with coefficients between 0.711 and 0.801; all exceeding the 0.70 recommended limit [66,67]. On the basis of

Table 1. Descriptive statistics.

Variables	Code	Mean	SD
Brand elements (name & signage)			
The name of this hospital is unique and easy to recall	BE1	3.786	.952
The hospital's name tells me what services to expect	BE2	3.752	.820
Well-positioned signboards provide easy directions to this hospital	BE3	3.937	.755
Signs and written directions in hospital premises ease way-finding	BE4	3.887	.770
Signposts/brochures have adequate information on hospital services	BE5	3.881	.813
Personnel quality			
Hospital has competent medical staff and specialists for services offered	QMP1	3.802	.750
Health problems are accurately identified by clinicians	QMP2	3.742	.751
Hospital staff are knowledgeable to answer my questions	QMP3	3.667	.708
Medical staff at the hospital provide services right the first time	QMP4	3.774	.770
Tangibles			
The physical facilities of the hospital are visually appealing	TAN1	3.764	.824
The hospital is furnished with modern medical equipment	TAN2	3.723	.817
There are adequate stocks of medicine in this hospital	TAN3	3.670	.724
The waiting room is well-designed and provides relaxation	TAN4	3.695	.813
The hospital has a good parking area	TAN5	3.667	.755
Hospital premises, rooms and washrooms are usually clean	TAN6	3.755	.776
Critical service lines			
This hospital offers basic medical services to patients	CSL1	3.833	.758
The hospital offers specialist medical services	CSL2	3.667	.823
Hospital provides support services (e.g. pharmaceuticals, diagnostics, etc.)	CSL3	3.821	.751
Brand image			
The hospital has a positive image in my mind	BI1	3.903	.758
There is an array of medical services at this hospital	BI2	3.903	.754
This hospital has competent personnel	BI3	3.884	.804
The hospital offers reliable medical services	BI4	3.969	.678
Re-patronage Intentions			
I will always visit this hospital for all my treatments in the future	RP1	4.054	.741
I will visit this hospital for different medical purposes	RP2	3.997	.726
I will recommend this hospital to friends and relatives	RP3	4.220	.763

these rules, Factor 1 had five items related to tangibles; Factor 2 had four items all relating to brand elements; Factors 3 and 4 both had two items each, all relating to quality of medical personnel and critical service lines respectively. Factors 5 and 6 represented the dependent variables; Factor 5 had two elements both related to repeat patronage intention and Factor 6 had four items all relating to brand image. The principal component extraction and internal consistencies are depicted in Tables 2 and 3.

Pearson's correlation of principal components

In order to define the association among the resultant principal components or factors, their standardized correlations were assessed. The essence of this was to avoid violating certain assumptions (e.g. multicollinearity) required for major statistical analysis as well as to verify the distinctness of the factors from one another. The Pearson's correlation (r) values among the six principal components are shown in Table 4. The inter-construct correlations ranged from $r = 0.244$ to $r = 0.653$. The lowest correlation was between 'brand elements' and 'critical service lines' while the highest was between 'brand image' and 're-patronage intentions'.

Multiple regression analysis

To test and validate the stated hypotheses of the study, a series of multiple regression analyses were carried out. Results from the regressions were used to analyse the relationship between healthcare branding factors, brand image, and repeat patronage intention among hospital clients. Brand image and repeat patronage intention were used as dependent variables while the healthcare branding factors were used as independent variables. Specifically, in the first regression, the factors of healthcare branding were used as the predictors while repeat patronage intention was the outcome

Table 2. Rotated component matrix and internal consistencies (independent variables).

		Principal component loadings			Internal consistencies		
Items	Variables	Orthogonal (Varimax)	Oblique (Direct Oblimin)	Variance explained	Cronbach's alpha	Item-total correlation	α if item is deleted
Factor 1	TAN1	.570	.513	55.898	.801	.672	.735
	TAN2	.727	.748			.622	.751
	TAN4	.715	.743			.461	.799
	TAN5	.523	.508			.589	.762
	TAN6	.669	.699			.580	.765
Factor 2	BE2	.757	.806	58.988	.768	.602	.694
	BE3	.693	.704			.562	.717
	BE4	.660	.686			.530	.733
	BE5	.658	.658			.581	.706
Factor 3	QMP1	.698	.683	77.629	.711	.553	–
	QMP3	.707	.681			.553	–
Factor 4	CSL1	.745	.777	77.844	.715	.557	–
	CSL3	.803	.858			.557	–

Extraction method: Principal component analysis. Rotation method: Varimax and Direct Oblimin.

Table 3. Rotated component matrix and internal consistencies (dependent variables).

		Principal component loadings			Internal consistencies		
Items	Variables	Orthogonal (Varimax)	Oblique (Direct Oblimin)	Variance explained	Cronbach's alpha	Item-total correlation	α if item is deleted
Factor 5	RP1	.664	.664	77.685	.713	.554	–
	RP3	.705	.690			.554	–
Factor 6	BI1	.723	.679	60.779	.784	.629	.710
	BI2	.673	.652			.568	.742
	BI3	.720	.701			.592	.731
	BI4	.547	.504			.575	.740

Extraction method: Principal component analysis. Rotation method: Varimax and Direct Oblimin.

Table 4. Inter-construct correlation.

	Constructs	1	2	3	4	5	6
1	Brand elements	1					
2	Personnel quality	.352**	1				
3	Tangibles	.506**	.581**	1			
4	Critical service lines	.244**	.333**	.429**	1		
5	Brand image	.481**	.488**	.583**	.458**	1	
6	Re-patronage intentions	.305**	.441**	.444**	.359**	.653**	1

**Correlation is significant at the 0.01 level (2-tailed).

variable. However, in the second regression, brand image was the outcome variable while the healthcare branding factors were still maintained as the predictor variables. The final regression had brand image as the predictor and repeat patronage intention as the outcome variable. Table 5 provides the graphical presentations of the regression analysis.

The regression results show a strong and significant reliability between variables used for the six constructs. The first model summary had ($F = 30.326$, Prob. F-stats < .05); the second had ($F = 65.657$, Prob. F-stats < .05); whereas the third had ($F = 235.089$, Prob. F-stats < .05). Results in model 1 indicate that, from the individual factors, quality of medical personnel was found to be the highest contributor of healthcare branding components that leads to repeat patronage intention ($\beta = 0.247$, $t = 4.144$, $P = 0.000 < .05$); followed by critical service lines ($\beta = 0.179$, $t = 3.347$, $P = 0.001 < .05$); while the third was tangibles ($\beta = 0.182$, $t = 2.733$, $P = 0.007 < .05$). Albeit 'brand elements' was positively related to repeat patronage intention, it was statistically not significant ($\beta = 0.082$, $t = 1.475$, $P = 0.141 > .05$). This shows that, in this study, the brand elements construct was not a significant contributor to consumer repeat patronage intention of hospital services.

In the second model however, critical service lines was found to be the highest contributor ($\beta = 0.229$, $t = 4.935$, $P = 0.000 < .05$); the second was brand elements ($\beta = 0.228$, $t = 4.695$, $P = 0.000 < .05$); the third was tangibles ($\beta = 0.267$, $t = 4.601$, $P = 0.000 < .05$); while the fourth was quality of medical personnel ($\beta = 0.177$, $t = 3.416$, $P = 0.001 < .05$). Here, all the healthcare branding components had a positive and significant association with perceived brand image of hospitals.

In the third model, brand image was regressed on repeat patronage intention as a dependent variable. The statistical results revealed a very strong positive and significant nexus between the two constructs ($\beta = 0.653$, $t = 15.333$, $P = 0.000 < .05$). Thus, for clients of hospitals used in the sample, the perceived brand image of a hospital plays a key role in their patronage of the hospital's services. Results for the controls on demographic profile, measured by the hospital dummy (0 = Private hospital versus 1 = Public hospitals) were insignificant (See Appendix for measurement details).

Discussion

The study examined the relationship between branding, brand image and customer repeat patronage intentions in hospitals. Findings indicate both direct and indirect (through brand image) influences of healthcare branding on repeat patronage intention with a stronger indirect path. The study established the fact that brand elements do not, to a significant extent, influence consumer repeat patronage intention of hospitals, but significantly influence consumers brand image perceptions. This finding is in contrast to assertions in the literature of the ability of an established brand name to preserve some form of loyalty. It as well appears inconsistent with Keller's [29] view that brand names that are recognized more quickly and easily are liked more and ultimately chosen frequently. This result is likewise indicative of the fact that elements such as visible and easy-to-understand signs, written directions and ease of way-finding both within and outside hospital premises, and available consistent information on services, have no significant influence on clients' revisit decisions.

Evidently, the finding regarding brand element is in sharp contrast to Gümüs and Sönmez [13] who found that information regarding navigation and provider details among other things are essential in customer decisions. From the earlier study by Bidhan et al.

Table 5. Multiple regression results.

			S. E	β	T	Sig.
Model 1	(Constant)[a]		.264		5.313	.000
	Brand elements		.061	.082	1.475	.141
	Quality of medical personnel		.061	.247	4.144	.000
	Tangibles		.074	.182	2.733	.007
	Critical service lines		.053	.179	3.346	.001
	R	.528			S. E of estimate	.56634
	R-square	.519			F-statistics	30.326
	Adj. R-square	.507			Prob. (F-stats.)	.000
Model 2	(Constant)[b]		.202		3.601	.000
	Brand elements		.047	.228	4.695	.000
	Quality of medical personnel		.047	.177	3.416	.001
	Tangibles		.057	.267	4.601	.000
	Critical service lines		.041	.229	4.935	.000
	R	.675			S. E of estimate	.43311
	R-square	.656			F-statistics	65.657
	Adj. R-square	.649			Prob. (F-stats.)	.000
Model 3	(Constant)[c]		.191		6.439	.000
	Brand image		.048	.653	15.333	.000
	R	.653			S.E of estimate	50276
	R-square	.527			F-statistics	235.089
	Adj. R-square	.525			Prob. (F-stats.)	.000

$N = 318$

Dependent variables: [a]Repeat patronage intentions; [b]Brand image; [c]Repeat patronage intention.

[31], healthcare facilities that leave their visitors confounded and worn-out could keep clients from revisiting. This, on the one hand, affirms that health service consumers may not avail a hospital's services just because of its brand elements. Such elements as the hospital name as well as the signage may not necessarily pull clients toward a hospital since most of these clients visit for peculiar health needs [45]. During a consumer's initial deliberations for a medical solution, though the hospital's name may frequently come to mind, it merely indicates awareness [1] but may not essentially engender intentions to re-patronize the health services of that hospital. On the other hand, the significant positive relationship found between brand elements and clients' brand image perceptions of hospitals confirms other perspectives [68,69] that the name is a vital core sign of the brand, which serves as the basis for awareness and an instrument that affects consumers' perceptions of a company's attributes. The finding also agrees with Bhidan et al. [31] and Devline and Arneill [70] who are of the view that, although the physical signs themselves may not make an impact, getting lost and confused may cause clients to direct their negative feelings and frustrations towards the hospital, which may ultimately affect their service quality judgment.

Furthermore, quality of medical personnel was found to significantly influence repeat patronage intention as well as brand image. This confirms the views of Kemp et al. [2] and Leonard et al. [39] who submit that competent care providers form a vital footing upon which patients make healthcare decisions, and that physician task capability influences actual patient patronage decisions. The finding is also consistent with literature that

> argues that the quality of personnel is of vital importance in shaping a favourable image and some level of trust for healthcare organizations because patients will commonly form competency impressions of the staff as they experience various services during their hospital visit. [35]

Particularly, physicians have been known to have a central role in healthcare, because they enhance clinical services, and influence health service management via their positions of responsibility [11].

Also of significance to consumer repeat patronage intention and brand image of hospitals is the element of tangibles. The finding in this regard is concordant with previous studies [10] that physical evidence (relating to clean, safe and pleasing environment and effective facilities) communicate to customers that the hospital provides satisfactory services. This assertion, according to previous researchers, may significantly improve patients' healthcare experience; and impact perceptions and revisit decisions [71,72]. This finding also resonates with McDonald et al. [38] that physical evidence 'tangibilize' service brands and provide consumers with a favourable set of perceptions toward the organization.

Additionally, critical service lines surfaced in this study as a major factor influencing clients' repeat patronage intention of hospitals and also brand image perceptions; this jibes with previous studies [44,45,63,64] who have considered availability of a wide range of services (pharmaceuticals, laboratory, specialized services etc.) to be influential to patients' choice of hospitals and the impressions they form about the facility. Healthcare clients are mostly inconvenienced by sickness and injuries and within this period, their autonomy is temporarily reduced, which amplifies their expectation of convenience. For this reason, within the healthcare domain, such services as basic medical services, specialist services and support services like pharmaceuticals, ambulatory etc. hold relevance to patients of hospitals. Further, results suggest that perceived brand image strongly predicts repeat patronage intention of hospitals. Congruent with Wu [14] and Burmann et al. [51], brand image is an important determinant of a buyer's behaviour and a favourable hospital brand image helps strengthen the intentions patients have for selecting a hospital. Consistent with other previous studies on brand image, it is reasonable to state that, for clients to revisit a hospital, they must have a favourable perception about the hospital.

Theoretical implications

The study makes a modest addition to the healthcare marketing literature, given that research on healthcare branding is sparse. First, the findings extend the healthcare branding literature by establishing a positive relationship between hospital branding factors (brand elements, tangibles, personnel quality and critical service lines) and repeat patronage intentions. Second, the study establishes an indirect relationship between hospital branding factors and repeat patronage intentions through brand image. The study demonstrates that hospitals stand a better chance of being revisited by clients if their branding efforts result in a favourable brand image perception relative to other hospitals. Although context-specific, the findings of this study suggest somewhat interesting perspectives, which could be validated by other researchers. The branding variables identified and confirmed in this study, call for further examination of such in other study settings. Given that consumer behaviour (even in the healthcare domain) in developing settings varies from those in developed settings, the findings presented in this study provide evidence from a developing country perspective, which may bring further enlightenment to the literature for theory advancement.

Implications for healthcare management practice

The study also offers insightful implications for healthcare practice that are of managerial interest. Essentially, in order to enhance repeat patronage of hospitals and gain a competitive advantage, as more healthcare options become available, marketers must focus on building and maintaining a strong and positive hospital brand image through their services, medical personnel, facilities and brand elements.

Following from the significant influence of critical service lines on clients' brand image perceptions of hospitals, it is imperative for hospital managers to enhance service lines that provide convenience for patients in their search for medical solutions. Patients tend to form favourable perceptions about hospitals when essential services they require on visits are provided within the same facility. For instance, such support services as pharmaceuticals, laboratories, diagnostics etc. send signals of a wholesome and comprehensive healthcare provider. Similarly, with brand elements playing a major role in clients' perceived brand image, hospital managers could leverage this by making information on the hospital and its services clearly available to clients as well as easing way-finding both outside and within hospital premises via signs, written directions, etc. Digital signage is presently one of the huge trends in healthcare that can immensely boost clients' hospital experiences. Given that all through the day in hospitals and healthcare facilities, patients sit in the waiting rooms and loiter in hallways and lobbies, hospital managers can seize these moments as opportunities to deliver informative materials and relevant content to educate patients and visitors through digital signage that benefits each specific audience. This can be used to enhance direction/way finding, check-in appointments and education on hospital procedures etc.

This study as well highlights the need for hospital marketers to focus on improving the status and performance of the physical health facilities. Hospitals must strive to maintain a clean and neat environment; waiting rooms and wards should be pleasing and fashioned to provide patients a sense of comfort and relaxation. Likewise, hospital managers must make available state-of-the-art and effective medical equipment and a good parking area since this were found to be important in forming patients' impressions. Furthermore, raising and keeping the standards of medical staff competence and practices in the hospitals is a commitment hospital managers should make. In order to gain and keep patients' confidence in the hospital, medical staff have to consistently demonstrate technical skills, excellent professionalism and efficacy. This could be achieved through proper recruitment practices, training and motivation of medical personnel to ensure that they adhere to the etiquette of the profession. Importantly, hospital managers and marketers in settings with similar economic and customer characteristics, and healthcare providers seeking to enter such developing setting could use the findings of this study in fine-tuning their marketing or branding efforts for optimum realization of customer patronage.

Limitations and directions for future research

As with any study, the present research was conducted amid certain limitations, pointing out avenues to be tackled by future research. Foremost, the study focused on a single geographical area, the Accra metropolis and elicited responses from only outpatients. Future research could extend the geographic scope of the study, and views of inpatients could be captured as well to provide extra insight and allow for stronger generalizability.

In addition, the constructs explored in this study are considered illustrative but not exhaustive; extra variables such as patient engagement can be incorporated into the model to establish its link with hospital brand image and consumer repeat patronage intention. The framework can similarly be replicated with a diversity of hospital types and/or in other settings so as to verify its applicability. Such future studies may adopt a more confirmatory approach to examining the research model using second-generational statistical techniques such as Structural Equation Modelling. Finally, cross-sectional data are limited in their ability to establish actual causal relationships, consequentially this study's conclusions would have been sturdier using a longitudinal design and, as a result, generalization should be carefully done. In spite of all these, the results of the study are deemed reliable and representative of hospitals in the study setting.

Disclosure statement

No potential conflict of interest was reported by the authors.

Notes on contributors

Priscilla Teika Odoom is a PhD student in the Department of Marketing and Entrepreneurship at the University of Ghana Business School. Her research interests are in the areas of service branding, health service marketing and communication, advertising, and corporate social responsibility practices among firms.

Bedman Narteh (PhD) is a professor in the Department of Marketing and Entrepreneurship at the University of Ghana Business School. His research interests lie in relationship marketing, branding, knowledge management, developed–developing country-based strategic alliances and bank marketing.

Raphael Odoom (PhD) is a research associate at the Department of Marketing Management, University of Johannesburg and currently with the University of Ghana Business School. He has published in the International Journal of Contemporary Hospitality Management, and Journal of Enterprise Information among several others. He can be contacted at mailto: rafaelodoom@gmail.com

ORCID

Raphael Odoom http://orcid.org/0000-0001-7765-0851

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Appendix

Repeat	Coef.	Std. Err.	T	$P > t$	[95% Conf.	Interval]
Elements	0.102866	0.063922	1.61	0.109	−0.02294	0.228670
Quality	0.252754	0.063674	3.97	0.000	0.127438	0.378071
Tangibles	0.191201	0.076220	2.51	0.013	0.041193	0.341208
Critical	0.196477	0.054157	3.63	0.000	0.089891	0.303063
Hospital type						
Public	0.036334	0.076150	0.48	0.634	−0.11354	0.186204
Age						
18–28	−0.06247	0.143475	−0.44	0.664	−0.34484	0.219907
29–39	−0.05961	0.165086	−0.36	0.718	−0.38452	0.265293
40–50	−0.13141	0.168257	−0.78	0.435	−0.46256	0.199732
Above 50	−0.28025	0.190783	−1.47	0.143	−0.65573	0.095226
Education						
Professional	−0.16808	0.113206	−1.48	0.139	−0.39088	0.054720
Graduate	−0.19382	0.101920	−1.9	0.058	−0.39441	0.006768
Postgraduate	0.026119	0.145385	0.18	0.858	−0.26001	0.312251
Employment						
Salaried employee	0.143477	0.117560	1.22	0.223	−0.08789	0.374845
Self employed	0.192982	0.126027	1.53	0.127	−0.05505	0.441016
Pensioner	0.737980	0.189269	3.9	0.000	0.36548	1.110480
Income						
500–1000	−0.02391	0.101393	−0.24	0.814	−0.22346	0.175640
1100–1500	0.017456	0.125189	0.14	0.889	−0.22893	0.263839
1600–2000	0.021873	0.145350	0.15	0.880	−0.26419	0.307936
Above 2000	0.120569	0.132148	0.91	0.362	−0.13951	0.380649
Years with hospital						
1–2 years	0.075534	0.099226	0.76	0.447	−0.11975	0.270821
3–5 years	0.003017	0.087749	0.03	0.973	−0.16968	0.175714
6–10 years	−0.03400	0.106667	−0.32	0.750	−0.24393	0.175935
Above 10 years	0.019623	0.138609	0.14	0.888	−0.25317	0.292419
_cons	1.324264	0.332970	3.98	0.000	0.668948	1.979581