

UNIVERSITY OF GHANA

HEALTHCARE BRANDING AND CONSUMER PATRONAGE IN GHANA

BY

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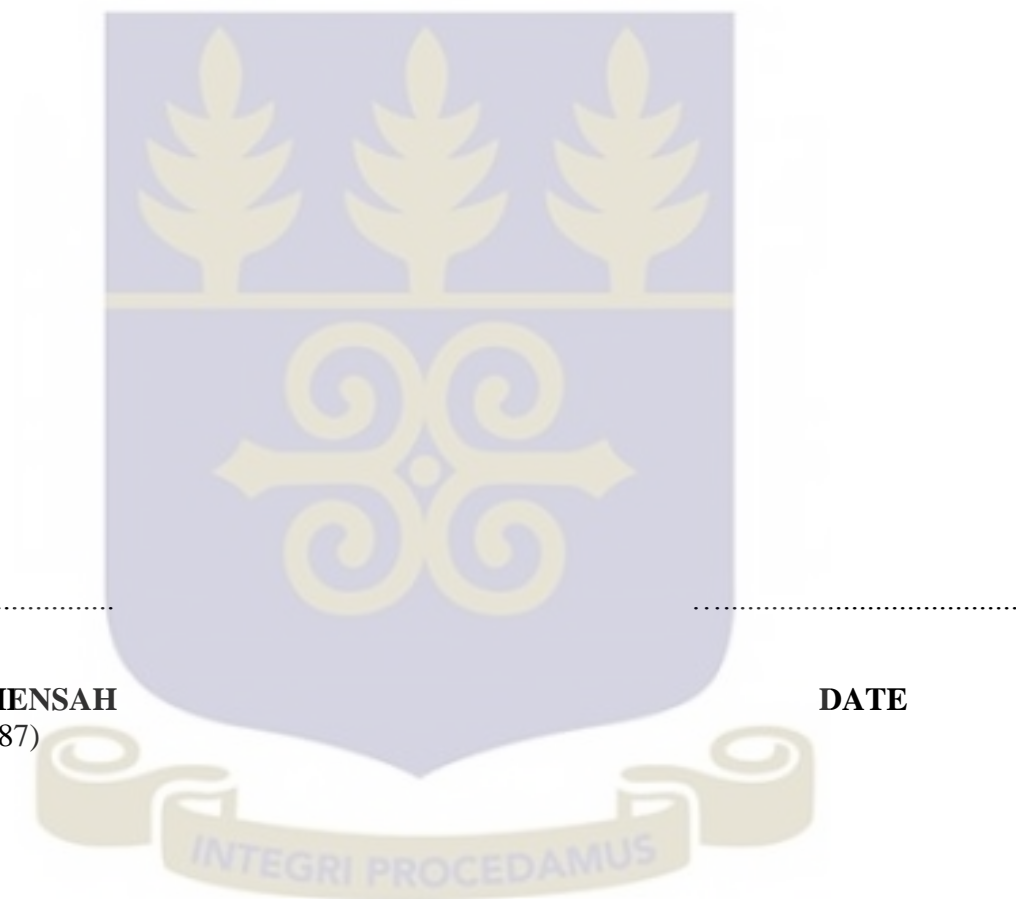
**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
PARTIAL FULFILMENT OF THE REQUIREMENT FOR THE AWARD OF MPhil
MARKETING DEGREE.**



JULY, 2015

DECLARATION

I hereby declare that this study is my original work and has not been presented anywhere for academic award either in this University or any other University.

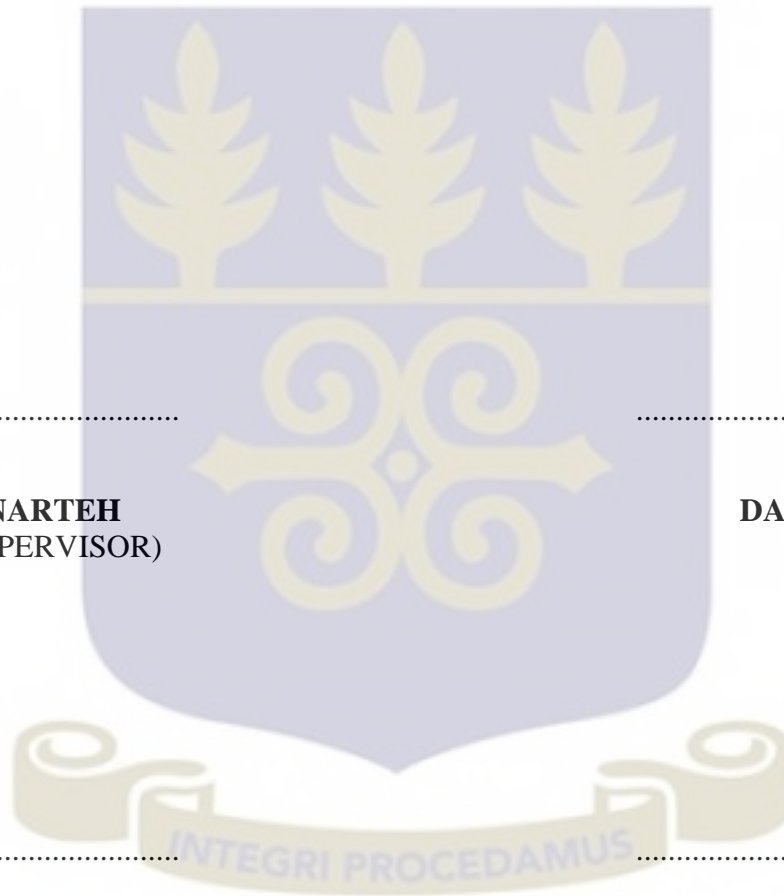


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CERTIFICATION

I hereby certify that this work was duly supervised in accordance with procedures laid down by the University.



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DEDICATION

This work is dedicated to my family for their immeasurable sacrifices, irreplaceable roles in my life and timeless counsels which helped in shaping my dreams and to my friend, Raphael Odoom for his support and concern.



ACKNOWLEDGEMENT

My foremost gratitude is to God almighty for his sustaining grace throughout my course of study. I express my sincerest appreciation to my research supervisor, Dr. Bedman Narteh for his striking patience, immense guidance, enlightenment and critical review. I'm also thankful to my co-supervisor, Dr. Samuel Buame for his contribution and faith in me. Finally, I'm truly grateful to Raphael Odoom, for his contribution.



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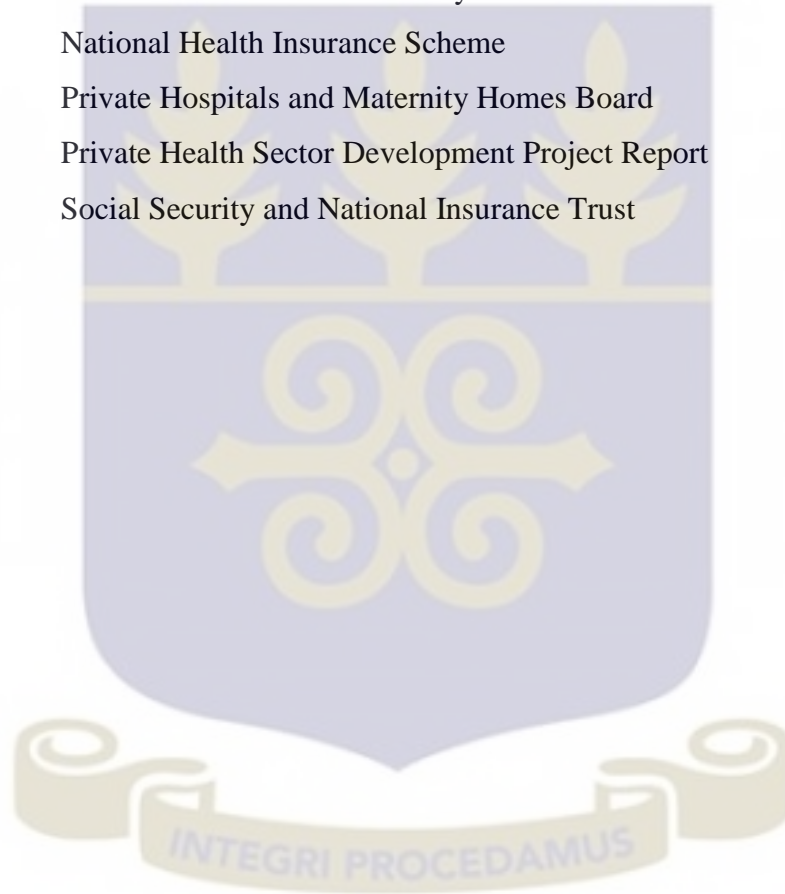
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LIST OF ABBREVIATIONS

DMHIS	District Mutual Health Insurance Schemes
GHS	Ghana Health Service
GOG	Government of Ghana
MOH	Ministry of Health
NHIA	National Health Insurance Authority
NHIL	National Health Insurance Levy
NHIS	National Health Insurance Scheme
PHMHB	Private Hospitals and Maternity Homes Board
PHSDP	Private Health Sector Development Project Report
SSNIT	Social Security and National Insurance Trust



ABSTRACT

Healthcare is a very personalized and important service that is globally used which considerably affects economies and the quality of daily lives. In most parts of the world and Ghana, healthcare is experiencing unprecedented growth with changing cost structures and healthcare laws are also evolving. As a corollary, healthcare providers are experiencing increased competitive pressures providing consumers with a lot of options and making them active decision makers in their healthcare choices with insistence on greater quality of service. Though healthcare providers especially those located in metropolitan areas are making a concerted effort to apply the concept of branding to differentiate their services from the competition in order to enhance patronage for their hospitals, they still lag behind other service industries in this regard. Several studies have been conducted on service branding especially in the banking and telecommunication sector. However, scanty attention is given in literature to branding and clients' re-patronage in the healthcare industry as a whole and particularly in Ghana. On this premise, this study sought to investigate the relationship between healthcare branding and consumer re-patronage in Ghana. A quantitative approach was employed and structured questionnaire was used to gather data. The study was a cross-sectional survey of 318 outpatients (respondents) of 4 (2 public and 2 private) hospitals who were purposively and conveniently sampled. Data was analyzed using Exploratory Factor Analysis and multiple regression models. The findings revealed both direct and indirect influence of branding on clients' re-patronage. Specifically though branding influences client's re-patronage of hospitals services, it does so more through the hospital brand image. These findings therefore brought to light the need for hospital managers to focus on building strong and positive hospital brand image by focusing on services, brand elements (name and signage), facilities and personnel. Particularly, by enhancing their array of services, improving the status and performance of the physical health facilities and environment, and raising and keeping the standards of medical staff competence and practices, hospitals create impressions of a wholesome healthcare provider, with reliable services which form the basis for consumer re-patronage decisions in healthcare.

CHAPTER ONE

INTRODUCTION

1.0 Background of the Study

Healthcare is not only very complex and costly but is also a generally used service that influences the quality of daily life and considerably affects economies (Berry and Bendapudi, 2007). Most countries have become service-dominated economies (Klaus & Maklan, 2007) because of the significantly huge contribution made by the service sector to their economic growth relative to other sectors (Bateson, 1995; Skaalvik and Oslen, 2014). Research (Andaleeb, 1998; Corbin, Kelley, & Schwartz, 2001; Berry and Bendapudi, 2007) points to healthcare as the largest industry in the service sector and one of the world's fastest growing industries and is conceivably the purest form of a service industry. For example, In India, healthcare has emerged as one of the largest service sectors both in terms of revenue and employment (Deloitte, 2014; IBEF, 2015). In the United States as well, there are expectations of unparalleled growth in the healthcare industry (Kemp, Jillapalli & Baccera, 2014) as nearly 60 million Baby Boomers have moved into the mature market segment and will require healthcare services (Larkin, 2007); and governmental healthcare reforms such as the US Patient Protection and Affordable Care Act (PPACA) will plausibly increase the number of insured consumers by over 30 million (Sparer, 2011). In Ghana healthcare forms one of the most rapidly growing services subsectors (IFPRI, 2012). The Healthcare Industry largely represents a crucial sector because of its global trend of strong economic performance, and also due to its significant role in increasing quality of life via the provision of services to citizens and improving public welfare (Andaleeb, 1998; Atinga, Abekah-Nkrumah & Domfeh, 2011).

The increasing growth of the healthcare sector has been complemented by a host of intense changes, presenting healthcare providers with opportunities and challenges (Kim et al., 2008; Kemp et al., 2014). These forces of change encompass the increased competitive pressures owing to the influx of private practices to the healthcare market (Andaleeb, 1998; Devries & McKeever, 2008); and substitute health care delivery means providing consumers with a lot of options (Kemp et al., 2014). Worth mentioning are changing cost structures making consumers active decision makers in their healthcare choices (Kemp et al., 2014); with increased insistence on greater quality of service (Abousi and Atinga, 2012). Similarly, literature point to the exceptional information availability, where patients now have resources to learn more about their health, different diseases, treatments and service providers resulting in a significantly well informed healthcare consumer market with higher expectations (Lim & Tang, 2000; Mangini, 2002; Devries & McKeever, 2008). These dramatic transformations in their individual and collective ways provide much reason for concern. The upshot is that; healthcare organizations have discovered that disregarding the market is at their own risk and that they must take into consideration the fast evolving requirements of the market they serve (Howgill, 1998; Mangini 2002, Chahal & Bala, 2012). Healthcare providers and managers are therefore, stimulated to effectively and efficiently deliver health care (Bakar, Akgun, & Al Assaf, 2008); and to also find alternative ways to stay financially and operationally viable (Mangini, 2002; Kemp et al., 2014).

Consequently, healthcare providers are in search of alternative means of attracting and retaining patients (Corbin et al., 2001; Kemp et al., 2014) due to the desire to reach consumers in an increasingly congested marketplace (Basu and Wang, 2009). To this end, Mangini (2002) suggests influencing consumer choice and differentiating the healthcare organization from the competition as crucial to success in a changing and highly competitive healthcare field; and states

that branding can be a way accomplish this. This suggestion not only lends credence to Kapferer's (2002) view of branding as an integrated process to serve consumers to create an identity for products/services and differentiate them from competitors, but also finds support in Kotler and Keller's (2006) position that branding can be applied anywhere a consumer has a choice. Additionally, the inherent intangibility of services which stresses the crucial importance of service branding and image creation (Berry, 2000, Moorthi, 2002; Davis 2007), is even more amplified for healthcare services given their high credence nature with complex and unique features (Hariharan et al., 2004); and their performance being dependent on a synthesis of qualitative factors such as quality of services by highly skilled personnel, provider demeanor, hospital environment, nature of treatment, availability of general as well as specialized services at a competitive price, availability of latest technical equipment etc. (Thantry et al., 2006, Kay, 2007; Atinga et al, 2011). In the opinion of (Chahal and Bala, 2010; Wu, 2011), such context as depicted by the healthcare industry requires providers to know what sources build a healthcare brand and to understand that a well-defined brand image for healthcare providers is an essential prerequisite to thrive and survive. The increased efforts in the past years by renowned healthcare organizations in the western worlds including the Mayo Clinic, Cleveland Clinic and Johns Hopkins to reinforce their brands (Thomaselli, 2010) give weight to the authors' views.

Notwithstanding the huge potential for the application of branding in the healthcare domain, research has generally given measly attention to this subject in comparison to other services (Basu & Wang, 2009; Chahal & Bala, 2012). Marketing literature is replete with branding subjects but the prevailing emphasis rests on tangible products (O'cass and Grace, 2003; Leone et al., 2006; Buil et al., 2013). Likewise, most studies in the healthcare sector from Ghana and other developments have also been dominated by quality management, service quality and patience

satisfaction issues (Rose et al., 2004; Lee et al., 2006; Raja et al., 2007; Bakar et al., 2008; Nketiah-Amponsah and Hiemenz, 2009; Atinga et al., 2011). Moreover, though today, more healthcare organizations have begun to incorporate branding initiatives into their company marketing strategy (Thomas, 2010), healthcare organizations still lag behind other service industries in the use of branding (Corbin et al., 2001; Mangini, 2002) and have not fully embraced the practices and processes of branding (Kennet & Henson, 2005, Thomas, 2010). This study is therefore a reaction to Berry and Bendapudi's (2007, p. 111) call to researchers, whom the authors said have much to offer to "a critically important, intellectually challenging, but deeply troubled health care service sector".

Not surprisingly, Ghana's healthcare situation is not so distant from the aforementioned as the industry is characterized by intense competition between the public sector and a private sector that serves approximately 40 percent of all healthcare needs (Atinga et al., 2011). Today, healthcare organisations face significant pressures on costs, quality and clinical appropriateness (Abousi and Atinga, 2012). Due to the introduction of the National Health Insurance Scheme, outpatient and inpatient utilization of healthcare services increased over forty-fold and fifty-fold respectively between 2005 and 2011 (NHIA, 2011). This indicates growing patient demand and increased utilization; leveling the playing field between the private and public healthcare organizations. Additionally, consumers are becoming more selective about their healthcare and the availability of options due to the indirect payment system (of NHIS) makes this possible (Sparer, 2011). As a result of the reduction in financial barriers to accessibility (Atinga et al., 2011) providers are yet to come to grips with how to convince consumers of the value proposition of obtaining care from their facility. Healthcare organizations have therefore become sentient to the importance of promoting their services to increase public awareness as well as

increase market share and reimbursement (Chahal & Bala, 2012); and so many hospitals, especially those located in metropolitan areas, are making a concerted effort to apply the concepts and principles of marketing to their daily operations. This is more so for the private healthcare organizations because a widely shared view is that the role of the public sector has been to maximize the sum of benefits to society, while the role of the private sector is maximizing profits, share or volume (Lega, 2005).

However, healthcare organizations in Ghana are limited in their ability to disseminate desired branding information because they are not legally permitted to run any commercial advertising. The Food and Drugs Act, 1992:15 states: “A person shall not advertise a drug, cosmetic, device or chemical substance to the general public as a treatment, preventive or cure for a disease, disorder or an abnormal physical state specified in the Second Schedule.” Additionally, the Public Health Act, 2012, (Act 851) schedules diseases for which advertisement for treatment, prevention or cure is prohibited. The principal job of advertising is to build brand awareness and it is through advertising that marketers expose the potential consumer to the brand and give them the opportunity to accept it (Rooney, 1995). Against this background, investigating the application of a marketing concept such as branding to healthcare organizations thus, setting them apart from others and creating preference in patients’ mind to enhance patronage seems warranted especially given the availability of alternatives and the increasing role of customers in their healthcare choices.

1.1 Problem Statement and Research Gap

Healthcare to consumers is one of the most intimate and personalized services and arguably one of the most important services they buy (Kemp et al., 2014; Berry Bendapudi, 2007). Research

indicates that healthcare consumers are increasingly becoming active decision makers in their healthcare choices (Nketiah-Amponsah and Hiemenz, 2009; Abousi and Atinga, 2012). More so, more healthcare options are becoming available to consumers such as pharmacies, minute clinics in drug stores, herbal/traditional medicines and treatment, and a lot of alternatives among hospitals owing to the suppression of the “cash and carry” system. Healthcare organizations are therefore struggling to create some form of consumer value, secure market share, target desired consumer segments (Brakus et al., 2009) and improve profitability by creating consistency and personalization of service (Corbin et al., 2001); and are also beginning to compete on the basis of care and quality outcome (Atinga et al., 2011). The success of these initiatives according to Corbin et al (2001) requires branding, a key ingredient to overall consumer demand, trust, and patient satisfaction. On such premise, identifying factors that impact favourable brand perceptions and re-patronage seems timely and appropriate.

Although a considerable number of works have been done in service branding from both pre-millennial (Taylor, 1987; Dibb and Simkin, 1993; Turley and Moore, 1995) and post-millennial scholars (de Chernatony and Segal-Horn, 2001; Davis, 2007; Skaalsvik and Olsen, 2014) its application in healthcare has not been very well established. It appears there is paucity of research in this area comparative to other service branding areas such as banking (Abou Aish et al., 2003; O’loughlin and Szmigin, 2005; Farquhar, 2011), and hospitality and tourism (Olsen et al., 2005; Hosany et al; 2006; Gnoth et al., 2007; Harish, 2010). Extant research on healthcare in services marketing literature has examined a number of themes mostly including healthcare/health service marketing (Corbin et al. 2001; Rooney, 2008; Kay 2007), service quality and customer satisfaction in healthcare (Rose et al., 2004; Scotti et al., 2006; Abousi & Atinga, 2012;), as well as relationship marketing in healthcare (Wagner et al. 1993; Wright and

Taylor, 2005), and brand equity in healthcare (Kim et al. 2008; Chahal and Bala, 2012; Tuan, 2012). The central concern of these branding studies has been to ascertain what constructs influence brand equity and the relationship among these constructs.

Much of the research albeit valuable, indicate that healthcare branding is a fairly novel idea in services literature and healthcare organizations are grappling with how to essentially implement the process in order to gain a competitive edge. Besides, the regulatory restriction on healthcare organizations in Ghana from running commercial advertisements leaves Ghanaian healthcare providers more woes to contend with because advertising serves as a means to disseminate desired branding message (Berry & Seltman, 2007); and plays a part in informing consumers directly and indirectly (Grossman and Shapiro, 1984; Milgrom and Roberts, 1986) about brand attributes; and is also a key to developing and sustaining appeal of brands (O'Malley, 1991). What is more, the few studies done in this regard have focused more on the developed economies/western economies (Basu & Wang 2009; Kemp et al., 2014); and Asia (Chahal & Bala, 2012; Wu, 2011) rather than developing economies. Very little or arguably no work however, has been done on healthcare branding in Sub-Saharan Africa.

Additionally most hospitals still grapple with the practice and implementation of the branding process to differentiate their services from those of other hospitals in order to provoke favorable reactions from current and prospective consumers/patients. This study therefore investigates from a developing country (Ghanaian) context factors of hospital branding that drive patients' re-patronage and shape their perception of hospitals in healthcare, a service industry that has received sparse scholarly attention, its global growing importance notwithstanding. It is hoped that determination of the right factors would help all hospitals particularly private self-financing

hospitals whose sources of operational cost are mainly from out-of-pocket payments and NHIS reimbursement and also public hospitals whose aim is to provide services for the well-being of citizens through effective identity and image creation.

1.2 Research Objectives

This study seeks specifically:

1. To determine the factors of healthcare branding
2. To establish the relationship that exists between healthcare branding and consumer repeat patronage
3. To examine the relationship between hospital brand image and consumer repeat patronage

1.3 Research Questions

1. What are the factors of healthcare branding?
2. What is the relationship that exists between healthcare branding and consumers' repeat patronage?
3. What is the relationship between hospital brand image and consumer repeat patronage?
4. What are the implications of the study for achieving repeat patronage of hospitals in Ghana?

1.4 Significance of the Study

The current study is expected to make both theoretical and practical contributions to the understanding of branding and consumer patronage in healthcare specifically for hospitals. Regarding research, this study will add to the body of knowledge on branding and will transcend existing research on healthcare branding by examining factors of healthcare branding and their

influence on patient re-patronage in a developing country context because literature on healthcare branding is arguably non-existent on Ghana and plausibly in West-Africa despite the growing changes that the sector is witnessing. The study is hence, pertinent as it responds to the dearth of literature on healthcare branding in sub-Saharan Africa and also contributes to the academic debates on service branding.

With reference to practice, the study will uncover what drives consumers' patronage of a health facility and how they perceive hospital brands and thus serve as a reference document to hospital managers and administrators to help them develop clear directions to position their hospitals based on patients' preference. This could also facilitate the development of strategies that could help build strong hospital brands in the wake of intensifying competition among healthcare organizations and help attract customers in spite of the promotional regulatory restriction. Additionally, the study has the potential of helping hospital management appeal to "one-time" patients and turn them into customers who would keep coming back.

1.5 Chapter Disposition

The study is organized into six chapters. Chapter one introduces the study by highlighting the research background, the problem and research gap, research objectives, research questions, significance of the study and also outlines the nature of each chapter. Chapter two presents a review of relevant literature on branding, service branding and healthcare branding and develops the conceptual framework for the study. Chapter three entails the context of the study, which highlights the development of modern healthcare and provides a brief overview of the Ghanaian healthcare industry. Chapter four examines the methodological approaches used for the study, sample, data collection and data analysis techniques. Chapter five focuses on the data analyses,

discussion and presentation of findings. Chapter six summarizes the findings, draws conclusions and makes recommendations (implications) to research and practice and future research directions.



CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter is dedicated to the review of relevant and contemporary literature in relation to the concepts and theory underpinning the study. Following from the objectives and theoretical considerations delineated in the previous chapter of this study, this chapter presents a discussion on branding, brand equity, branding in the service sector and healthcare branding. The issues from the various reviews were integrated into a broader conceptual framework for investigating healthcare branding and customer patronage behaviour in Ghana.

2.1 Branding

2.1.1 A Historical Outlook

In order to appreciate branding, an exploration into the evolution of brands and what a brand is, become germane to this study. Research suggests that branding has its background in history dating back to the 16th century (Whisman, 2009). Anecdotal evidence indicates that branding originated in Ancient Greek with the marking of clay pottery by potters to signify their source and the painting of walls by Romans as pronouncement of war (Whisman, 2009); the initial marking of cattle to signify ownership (Aaker in Bertilsson, 2009) and later to signed work of artists (Clifton et al., 2004). According to Whisman (2009), historical documentations show that skilled pottery was the popular occupation and source of wealth in the olden days. Coupling this fact, was the rising need for artistic craftsmen to distinguish their pottery wares from mediocre ones, thus the genesis of some form of branding which led to a period of increased inscribed initials on pottery wares by craftsmen with unique identity (Hieronimus, 2003). Consequently,

these initials became identifiable symbols and particularly sought after in the purchase decisions (Hieronimus, 2003). As a result, most definitions of a brand have a certain basic premise of identifying something to belong to someone.

Similarly, researchers have shown proof of branding in the then Roman Empire based on historical ancient archives where gladiatory contests had similarities to branding (Hardy et al., 2012; Mann, 2009; Fagan, 2011) with gladiators in effect, being branded in regards to their weapons of choice and schools of training. More so, scholars including Adamson (2006) also note the word brand to originate from an Old Norse word “brandr” meaning “to burn” as brands historically illustrated ownership. This submission is buttressed by Kotler and Armstrong, (2009) who suggest that livestock farmers in ancient times had recourse to the use of steaming hot branding iron to burn their initials on livestock as a way of identification and to help buyers to distinguish the healthier cattle providers from inferior ones.

Nonetheless, it was until the early twentieth century, specifically late in the 1930’s that the significance of branding gained corporate focus. To this, Aaker (1991, p. 7) suggests that “although brands have long had a role in commerce, it was not until the twentieth century that branding and brand associations became so central to competitors.” Successively, branding became a popularized concept through predominant placement of labels on products to help consumers differentiate one product from the other. Some pioneers of successful branding included soap makers (Sunlight, Ivory), car builders (Ford, Cadillac) and technology providers (IBM, Xerox) (Klaus and Maklan, 2007). As markets became more competitive and customers more sophisticated, simple designations of ownership and quality became insufficient (Klaus and Maklan, 2007) owing to the fact that in recent times, brands have increasingly become valuable

assets and sources of differentiation (Lim and O'Cass, 2001); are renowned for offering consumers a unique set of perceived benefits not found in other products (Boyle, 2007); sources of added value such as emotional attachment, services, distribution, relationship and trust (Klaus and Maklan, 2007) and are essential for firms to develop in order to compete successfully (Aaker in Bertilsson, 2009).

2.1.2 The Concept of a Brand

Kotler et al. (2006) defined a brand as a name, term, sign, symbol, design or a combination of these that identifies the makers or seller of the product or services. Similar to and extending this definition is that of the American Marketing Association (AMA), which defines a brand as a “name, term, sign, symbol or design or a combination of them, intended to identify the goods and services of one seller or group of sellers and to differentiate them from those of competitors” (Keller, 2008, p.2). These definitions however, have been scrutinized by scholars like Keller et al. (2008), and de Chernatony (1999) who believe the definitions do not cover all aspects but just some elements of a brand; and limit the function of a brand to the mere identification and differentiation of products and services from others of their sort.

As a result, many academics have also attempted to provide definitions that transcend these limitations. Southgate (1994) states that a brand is not only a name, logo or graphic device, but also a set of intangible values in the mind of consumers. Prasad and Dev (2000) align with this view and note that a brand is all tangible and intangible attributes that the business stands for which also includes how people think about the company. Kotler and Armstrong (2009) likewise opine that a brand goes beyond an identifier to represent consumers' sensitivity and emotional

attachment to the product while Feldwick (1996) sees a brand as a distinguishable symbol of origin and an assurance of performance. According to Schilhanek (2008), it is a picture of a product or service anchored in the minds of the consumer resulting from both direct (purchase, usage,) and indirect (advertising, promotion) experiences with the brand. In addition to these definitions, other researchers link other attributes such as organizational processes (Heding et al., 2009) and more emotional aspects such as consumer associations (Keller, 2008). It is similarly based on this background that Schmitt (1999) writes that a good image and name is insufficient; delivered experience is also important and further suggested two ways to branding:

- The brand has to be viewed as an identifier where the brand elements form a particular image and awareness for the consumer.
- The brand has to be viewed as an experience provider where the brand elements, event and contacts by consumers provide them with affective, sensory, lifestyle and create relation with the brand.

A related definition, which has been emphasized in the service branding literature, defines a brand as a promise of attributes that someone buys (de Chernatony and Segal-Horn, 2003). According to Gronroos (2007), Kotler's (2006) and the AMA's definition suffice for physical products, but not for services for two reasons. First, the definitions do not reflect that services are processes (Hoffman and Bateson, 1997; Lovelock and Wright, 1999; Kandampully, 2007). Second, the definitions exclude the role of customers as co-creators of services (Kay, 2006). Gronroos (2007, p. 330) therefore, suggests a brand definition which seems to be suitable for both physical goods and service. The author contends that "a brand is created by continuously developing brand relationships, where the customer forms a differentiating image of a physical

product, a service or a solution including goods, services, information and other elements, based on all kinds of brand contacts that the customer is exposed to”.

Heding et al. (2009) examined branding literature and introduced seven approaches which all provide a differential definition and are summarized in table I. For the purpose of this study, the economic, identity, consumer-based, and relational approaches that reflect the healthcare organizations’ point of view will be used, and these will be investigated from service customers’ perspective.

Table I. Approaches to brand definitions

The economic approach	The brand as part of the traditional marketing mix
The identity approach	The brand as linked to corporate identity
The consumer-based approach	The brand as linked to consumer associations
The personality approach	The brand as a human-like character
The relational approach	The brand as a viable relationship partner
The community approach	The brand as a pivotal point of social interaction
The cultural approach	The brand as part of the broader cultural fabric

Source: (Heding et al., 2009, p.3)

According to de Chernatony and Dall’Olmo Riley (1998), though a brand might initially come into existence with nothing more than a distinctive name, over time it becomes recognized by consumers for its functional capabilities and ultimately develops into a representation that is associated with several unique values. From a customer’s point of view, brands are seen as purveyors of advantages in terms of both economic and symbolic values (O’Cass and Grace, 2003). In this respect, brands not only serve as a rich source of information which might signal the quality of a product and reduce consumers’ search costs and risks of transaction (Biswas, 1992; Janiszewski and Van Osselaer, 2000) but further act as a symbol that directs meaning to the

consumer and thus represent a form of promise regarding future purchases (Keller, 1998); and serve as a signal of consistency and in a way, control the customer experience from start to finish (Davis, 2007). A brand is therefore argued to be one of the most essential concepts in marketing due to its ability to create a perception of superiority in consumers' minds (Levine, 2003) and is one of the most important intangible assets of a firm (Leone et al., 2006).

Consequently, brands have become an integral part in most companies' marketing strategies since they are increasingly understood as valuable assets and a major source of competitive advantage (O'Cass and Grace, 2003; Skinner in Grace and O'Cass, 2002); through offering recognition, security and exclusivity, contributing to brand image and identity, mutual development and strengthening of trading relationships, and legal protection (Jones, Shears, Hillier and Clarke-Hill, 2002). It is based on this understanding that branding has been highlighted as a mechanism to engage both buyer and seller in long-term trusting relationships (Fournier, 1998; Keller, 1993) and as a process of creating value which, in turn, will satisfy customers and ultimately keep them coming back (Gad, 2001; Aaker, 1991).

Aaker (as cited in Skaalsvik and Olsen, 2014) notes that, largely, branding is a strategy that aims to differentiate and position a business's products and services from those of its competitors in order to provide added value to the brand owner and the customer. According to branding theory, branding is a competitive strategy that differentiates and positions products, services and companies in order to build economic value for customers' and the brand owner (Tsotsou and Ratten in Skaalsvik and Olsen, 2014). Though there still remains little unanimity on an overarching umbrella definition of the scope and the dimensional confines of branding as a

managerial term (Mitchell, Hutchinson and Bishop, 2012), branding however, transcends the logo, differentiation and perceptions. The relevant points of branding theory is captured in Greenawalt's work (as cited in Dominiak, 2004) that branding is not limited to creating a logo or trademark, but is a full process that includes research, identity development, and continuing evaluation of the success of the brand. According to Berry (2000), the essence of branding is to leverage brand equity in order to build strong relationship between the brand and its stakeholders, particularly customers (Berry, 2000). In view of this, the concept of brand equity is discussed in the next section.

2.2 The Brand Equity Concept

Due to the increased appreciation of branding as one of the most important issues for the success of a firm especially in a very competitive business environment (Leone *et al.*, 2006), combined with the rising need for marketers to justify the effect of their marketing activities and programs (O'Sullivan and Abela, 2007); brand equity as a central business concept has received much attention in research and seen rapid developments since its emergence in the 1980's (Leone *et al.*, 2006). As a result, accountability and return on investment which has been the central tenet of brand equity research led to two prevailing perspectives on the brand equity measurement discussion (Asamoah, 2014; Kapferer, 2002).

The financial perspective supports the measurement, where interest lies in exactly how much a brand contributes to the firm's total asset (Christodoulides and de Chernatony, 2010). Simon and Sullivan (1993) in this regard define brand equity as the incremental cash flows which accrue to branded products over and above the cash flows which would result from the sale of unbranded products. In line with this, brand equity is understood in the financial context to be the monetary

outcome a firm can elicit as a result of its brand exposure to consumers (Christodoulides and de Chernatony, 2010). According to these authors a firm's brand equity is estimated by deriving financial market estimates from brand-related profits. Taking the financial market value of a firm as a base, they extract the firm's brand equity from the value of the firm's other tangible and intangible assets, which results in an estimate based on the firm's future cash flows. Along the same line of thought, Doyle (2001b) argues that brand equity is reflected by the ability of brands to create value by accelerating growth and enhancing prices. This measurement approach suffers a deficiency of quantifying only partial indicators of performance (Mizik and Jacobson, 2008). For example, immediately and quantitatively determining the value and measuring the outcomes of investment made in building relationships with customers and the community seems infeasible.

Counterpoising this standpoint is the marketing perspective which is of the view that the power of brands exist in the minds of consumers (Buil et al., 2013; Leone et al., 2006), and can only be determined by the strength of relationship consumers have with the brand. Ambler (2003) argues in favour of the marketing approach, stating that it provides a richer understanding of marketing performance, by reconciling both long and short term marketing performance. In marketing literature, brand equity has been defined diversely by academics in certain dimensions; first in terms of the relationship between customer and brand (consumer-oriented definitions), where Keller (1998) defines brand equity as the differential effect of brand knowledge on consumer response to the marketing of that brand. Second, as something that accrues to the brand owner (company-oriented definitions) and in this regard, Aaker (1991, p.15) defined brand equity as "a set of brand assets and liabilities linked to a brand, its name and symbol, that add to or subtract from the value provided by a product or service to a firm and/or to that firm's customers". Third, other researchers like Farqhar (1989), and Winters (1991) also relate brand equity to added value

by suggesting that brand equity involves the value added to a product by consumers' associations and perceptions of a particular brand name. However, Leuthesser (1988) offers a broad definition of brand equity as: the set of associations and behaviour on the part of a brand's customers, channel members and Parent Corporation that permits the brand to earn greater volume or greater margins than it could without the brand name.

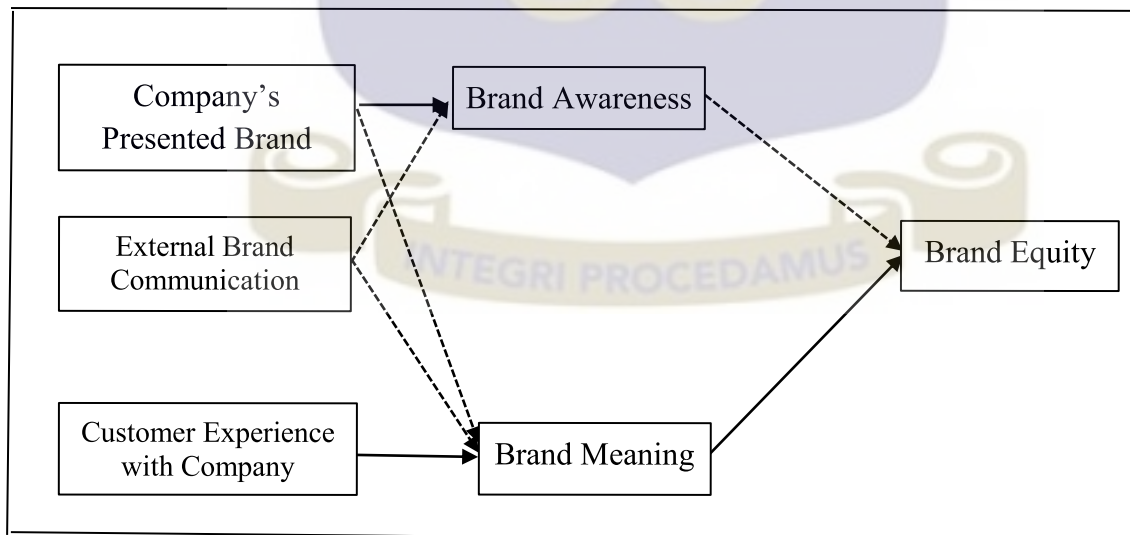
In marketing, though the consumer aspect of brand equity, which focuses on the cognitive aspect of consumer, is frequently followed; it is conceptualized differently by different authors (Chahal and Bala, 2012). Brand equity is defined by Aaker (1991) in terms of a set of assets associated with the brand and these assets include brand loyalty, brand awareness, brand association, and perceived quality. Other scholars such as Atilgan et al. (2005) and Pappu et al. (2005) tested and verified these assets. However Keller (1993) considers brand equity in terms of brand knowledge that is, brand awareness and brand image. On the other hand, Lassar et al. (1995), associate brand equity with five dimensions such as performance, social image, value, attachment, and trustworthiness. According to Srivastava and Shocker (1991), any way that brand equity is considered, it can be understood as the incremental value a brand name grants a product.

Though most traditional theories (Aaker 1991, Keller 1993) focus on product branding and base their theories on consumer goods, they offer a basis applicable for service brand equity. Keller (2008) also includes services in his holistic definition of a product that can be branded: *“a product is anything we can offer to a market for attention, acquisition, use, or consumption that might satisfy a need or want”* (p.3). Mainly the unique characteristics of services, calls for tailored approaches in branding them (Berry 2000, McDonald et al., 2001). To that end, one notable service brand equity model is presented by Berry (2000) where he uses Keller's (1993) definition of brand equity (using brand meaning as brand image), and shows the relationship of

different components specifically designed to create service brand equity. In Berry's (2000) service branding model, brand equity is comprised of the presented brand, customer experience, external brand communications, brand awareness, and brand meaning. Each of these creates value in different ways and must be taken into account when making decisions about brand building.

Berry (2000) points to the human performance (element) for services as the main difference in brand equity building between products and services. Certain similarities exist between Keller's (1993) work and Berry's model. For instance, both authors used brand awareness as a base of brand equity. However, despite the semantic difference, Keller uses the term brand image as the other basis for brand equity while Berry uses the term brand meaning, but both refer to the customer's perception of the brand.

Figure1: The Service Branding Model (Berry, 2000, p.130)



The presented brand has the greatest impact on brand awareness and has to do with how the company intentionally presents its brand through for instance, name, advertising and different symbolic associations (Berry, 2000); and these need to be consistent and present the same image of the brand through all channels (De Chernatony and Segal Horn, 2003; McDonald et al., 2001). Brand awareness is also influenced by external brand communications which are messages about the company that are not fully controlled by the company itself. The external brand communications consist of word of mouth and publicity (Berry, 2001). Even though these are seen as uncontrolled by the company, in the end, there are ways for the company to influence these. Word-of-mouth can be encouraged through satisfied customers (Gremler et al., 2001), the use of references or incentives (Gronroos, 2004). Publicity on the other hand can be influenced by approaching the press and using press releases (Wirtz and Chew, 2002). External brand communication does not only influence brand awareness, but also brand meaning. Even the presented brand has some influence on brand meaning to the customer despite these two influencing the brand meaning, it is the customer experience with the company that finally has the greatest impact (Berry, 2000). This experience with the company is mainly dependent on the role of both staff and the customer (de Chernatony and McDonald, 1998; McDonald et al., 2001; Ind, 2001). For the experience to be good, first, recruiting, training and educating the right people to deliver the desired branding message becomes an imperative for a service company (de Chernatony and McDonald, 1998; Ind, 2001). Second, since the customer is a part of the service delivery system, it is important that the customer knows his/her role. (de Chernatony and McDonald, 1998; Bitner et al., 1997).

Existing studies have associated firms' ability to charge premiums; increase in customer demand; ease of brand extension; effective communication campaigns; better trade leverage; greater

margins; and less vulnerability of firms to competition with brand equity (Asamoah, 2014; Buil et al., 2013; Bendixen et al., 2003). Stated differently, high brand equity generates a differential effect, higher brand knowledge, and a larger consumer response/preference and purchase intentions (Cobb-Walgreen et al., 1995; Keller, 2003a), which normally leads to better brand performance, both from a financial and a marketing perspective.

2.3 Branding in the Service Sector

The growing importance of the services sector has generated awareness among firms and marketers that the creation and development of service brands represents a source of sustainable competitive advantage (de Chernatony and Segal-Horn, 2001; McDonald et al., 2001). Taking the rapid growth of the service industry into consideration, many authors have pointed to the lack of attention that has been given to the field of service branding by criticizing that existing studies predominantly conceptualized brands in terms of physical products (Moorthi, 2002; O’Cass and Grace, 2003; Davis, 2007). According to de Chernatony and Segal-Horn (2001), the unique characteristics of services influence the branding of services. Other studies throw more light on this issue by arguing that the inherent differences that exist in the marketing principles of goods and services makes the issue of service branding worth the attention (Davis, 2007) and the application of conventional branding approaches to a service setting questionable (Berry, 2000). As a consequence, there have been several attempts by scholars to conceptualize the branding of services.

Notably, a study by de Chernatony and Dall’Omo Riley (1999) in which 20 leading-edge brand consultants were interviewed found these practitioners and consultants agreeing that branding efforts are common between products and services based on a brand’s overall role in linking a

firm's developed rational and emotional values with consumers' perceptions; but indicated that service branding might differ in its execution with respect to the emphasis given to specific elements. In their study, de Chernatony and Dall'Omo Riley found that due to the intangible nature of services, consumers may not understand the detailed technicalities of complex services brands, and may be unable to differentiate between alternatives. They stressed that in such instances, a strong identity and reputation of the "company as brand" is an essential way of enhancing consumers' perceptions and trust in the firm's range of services and as the basis for differentiation, an opinion shared by (McDonald et al., 2001). De Charnatony and McDonald (1998) agree with this position by emphasizing the importance of the distinctive characteristics of services, the importance of symbols in brand building, empowerment of staff and consumer participation in developing the brand.

In contrast, the academic community often believes in a much stronger impact of the unique characteristics of services and therefore ascertains that various concepts from traditional product branding need to be adapted in order to be effective within the service sector (Berry, 1980; Turley and Moore, 1995; Stuart in McDonald *et al.*, 2001). De Charnatony and McDonald (1998) in agreement with Levy (1996) believe that the FMCG model can be used with modifications to build service brands. In this regard, McDonald et al. (2001) in their study illustrated how "NatWest" adjusted the FMCG model to take the specific nature of the financial services sector into account for a successful brand launch. For instance, according to McDonald et al. (2001) with *brand differentiation* (a principle of FMCG branding), FMCG marketers strive to differentiate their brands by communicating a competitive edge or Unique Selling Proposition. Conversely, marketers in financial services focus on building long-term relationships with their customers in several possible ways (Zeithaml and Bitner, 1996). Also with *measurement of*

brand strength (another principle of FMCG branding), FMCG marketers rely on such methods as awareness and propensity to repurchase to measure brand strength. However with financial brands, repeat purchase is a less meaningful concept because it requires measurement over a time period. Accordingly, McDonald et al. (2001) stress the usefulness of focusing on qualitative data about the interactions with existing consumers.

Equally, Moorthi (2002) in his study, presents an application of Aaker's brand identity framework to the 7Ps of marketing (Booms and Bitner, 1981) and the three-fold economic classification of goods (Darby and Karni, 1973) and proposes that depending on the identity of the brand and the type of service (services tend to fall in the 'experience' and 'credence' category), the 7Ps could be manipulated for a successful branding strategy. Illustratively, with credence good (such as medical examination) and experience goods (such as a restaurant), the physical evidence needed is low in the case of the former and relatively high for the latter. Dobree and Page (1990) also list five steps for effectively branding services which are: building a brand proposition; overcoming internal barriers; measuring delivery against the proposition; continual improvement; and expansion.

What is more, Skaalsvik and Olsen (2014) proposed an interactive (circular) model to services branding anchored on the believe that there is no starting or ending point of the service brand development process thus, contrasting Boyle (2007), who suggests a process model of service brand co-creation featuring a linear process of services branding. From a systemic perspective, Skaalsvik and Olsen submit that, to be successful in services branding, a service provider may start with any of the three key actors in a company. First by initial identification of *customers'* key requirement followed by service provision and the development of an appropriate

communication mix fusing brand slogans, messages, values and brand promises. An alternative is the service employee approach, which emphasizes services brand development via improving the service roles of employees since their knowledge, skills, attitudes and actions represent the brand's functional and emotional values (Kimpakorn and Toquer, 2009). The last alternative is the management approach to brand development, which highlights the top leadership team's responsibility for and authority to developing competitive branding strategies (Tidd et al., 2005; Trott, 2005), which need to be aligned with the organisation's vision and mission (Daft, 1999).

A communal concern found in the literature raises the question of how branding theories and models can be adjusted to comply with specific service characteristics such as intangibility, heterogeneity and inseparability (O'Loughlin and Szmigin, 2007). As a consequence, a common belief has evolved among academics that further research in the domain of branded service offerings is warranted (Moorthi, 2002; Grace and O'Cass, 2005a; Davis, 2007).

Services are more firm-specific, and depend on the culture of the firm and the attitude of the employees involved in delivering this service to the customer (de Chernatony and Segal Horn, 2003). That notwithstanding, similar to product-based brands, a service brand is the basis on which to build trustful customer relationships and, as such, is frequently seen as a consumer-directed informational device that serves as a promise regarding the future service experience (Berry, 2000; Davis *et al.*, 2000). However, due to the intangibility and the perceived risk that is often associated with service offerings, a customer's image or perception of a branded service is particularly crucial since it motivates his/her ultimate behavior toward the brand (Davis *et al.*, 2000). Consequently, branding is equally important for service providers as compared to producers of physical goods (Arora and Stoner, 1996; Berry, 2000; McDonald *et al.*, 2001)

although the significance of certain branding aspects is supposed to vary between these two types of offerings (Berry, 2000).

Fundamentally, within the service sector, the company name becomes the brand name since consumers usually view the whole firm as the provider of the service experience for instance, airlines and insurance companies (Berry, 2000). As such, the strength of a service brand is mainly determined by organizational attributes like the quality of the service, a company's employees and the relationship between the firm and its customers (Berry, 2000). In this regard, Vallaster and de Chernatony (2005) point to the emotional bond customers have with service brands and explain that this bond is created from the relationships customers build with employees. On the other hand, the resulting multitude of interactions between consumers and staff at various points of a service firm might cause disparate experiences (i.e. heterogeneity) with a service brand and thus pose a major challenge to service marketers and managers (Bitner *et al.*, 1994 in Berry, 2000). Therefore, a brand name and its equity may increase the efficiency with which the consumer makes a services purchase decision by acting as a heuristic for pre-assessing service quality prior to purchase and consumption; and brand-level associations facilitate the use of brand names as a heuristic for service quality (Davis, 2007).

In a similar way, the intangible nature of services stresses the crucial importance of service brands as opposed to brands in physical goods markets. Since services often lack the tangibility that would allow for packaging, labeling or displaying, strong brands are a particularly powerful instrument for service organizations to increase consumers' trust and confidence in such "invisible purchases" (Berry, 2000, p.128) and to enable customers to better visualize and make sense of these intangible products (Onkvisit and Shaw, 1989; Turley and Moore, 1995) which are

difficult to evaluate prior to consumption, (Berry, 2000). Keeping in mind that service branding is concerned with communicating the benefits of an offering (Moss *et al.*, 2008), a strong brand is considered to be a key element in a service provider's effort to distinguish itself from competition (Arora and Stoner, 1996).

In a nutshell, service brands provide an assurance of potential satisfaction (Berry, 2010); assures consumers of a uniform level of service quality (Krishnan and Harline, 2001); tangibilize the service offering (Berry, 2000); clarify the nature of the service performed, and act as a mechanism to capture consumers' focus and loyalty (Chajet, 1991); and service companies through distinctiveness, performance; message consistency and by appealing to consumers emotionally are able to build strong brands (Berry, 2000; Berry and Seltman, 2008).

2.4 Healthcare Branding

Healthcare is a unique form of a service and has been qualified diversely in literature: as an extremely complex and expensive service (Berry and Bendapudi, 2007), debatably, the purest form of a service (Corbin *et al.*, 2001) one of the most personalized and intimate service (Kemp *et al.*, 2014); and a universally used service that impacts the quality of daily life and considerably affect economies (Berry and Bendapudi, 2007). Over a decade ago, Corbin *et al.* (2001) hinted that the healthcare industry appears to be the largest sector in the services industry with tremendous progressions over the last 5 decades in regards to the technical areas of procedure and delivery in order to meet the needs of patients. However, Less than 3 decades ago the concept of marketing healthcare services was alien and also seen as a questionable activity (Thomaselli, 2010); hence healthcare organizations, as well as individual physicians, only begun to widely recognize the need to market their services in the last two decades (Kemp *et al.*, 2014). Though

today more healthcare companies recognize the importance of branding and have begun to incorporate these initiatives into their company marketing strategy (Thomas, 2010), healthcare organizations still fall behind other service industries in the practice of branding as in almost other aspect of service marketing (Corbin et al., 2001; Mangini, 2002; Kennet and Henson, 2005).

Considering that healthcare branding is not an entirely novel idea, few studies are available in this field. Extant research on healthcare branding in services literature focused predominantly on brand equity in healthcare (Kim et al. 2008; Tuan, 2012; Chahal and Bala, 2012; Karbalaei et. al., 2013). These studies have documented the importance of branding in healthcare. For instance, a study by Kim et al. (2008) considered trust, customer satisfaction, relationship commitment, brand loyalty, and brand awareness as major factors affecting healthcare brand equity and an empirical test of the relationships among these factors suggests that hospitals can be successful in creating positive image and brand equity if they can manage their customer relationships well.

Similarly, a study by Chahal and Bala (2012) examined three significant components of service brand equity and found that perceived quality and brand loyalty have positive influence on brand equity in healthcare. The findings report that customers with high and positive perceptions of loyalty prefer to use services of the hospital in the future as well as share their experiences and recommend the hospital to others, which subsequently helps in building positive hospital image in the minds of the users and potential users. Additionally, staff behavior, assurance, and tangibility were reported to contribute to perceived service quality. Specifically, tangible factor items that were found to contribute to perceived quality include adequate stock of medicine, availability of state of art technology equipment and availability of parking facility. More so, a

recent study by Kemp et al. (2014) also found that trust, referent influence and corporate social responsibility are positively related to consumer emotional commitment for a healthcare provider's brand. The authors therefore suggest that developing strong, emotional attachments with consumers will be invaluable to healthcare providers in the growing competitive marketplace.

These provide an indication that branding and building strong brand in healthcare is essential and holds a lot of prospects for healthcare organizations given the transformations the industry is facing in most countries. Healthcare providers and marketers face unique challenges around the world partly on account of the role the healthcare field plays in contributing to public welfare; and the extremely competitive environments an increasing number of hospitals face due to open-door policies in the medical service markets (Kim et al., 2008). Additionally, expectation in the US is that the healthcare industry will experience unparalleled change and growth (Kemp et al., 2014) as Baby Boomers mature and governmental healthcare reform results in millions of newly insured patients (Weiss, 2010; Sparer, 2011). Moreover, other researches (Lim and Tang, 2000; Devries and McKeever, 2008) point to the availability of information and a better-educated population about diseases and treatments; intensified competition owing to the influx of private practices to the healthcare market; and the outsourcing and buying of services from the private sector, as contributors to the changing healthcare industry.

Lim and Tang, (2000) therefore suggests the need to measure up and stand out as a necessity rather than a choice in meeting the rising expectations and demands of the market. Consequently, healthcare organizations and practitioners have become aware of the significance of promoting their services to increase public awareness, market share and reimbursement (Corbin et al., 2001;

Chahal and Bala, 2012); and in response to the aforementioned current and imminent challenges, leading healthcare organizations find it pertinent to reinforce their brands (Thomaselli, 2010).

For health care organizations, branding is critical and the rewards can be great as it provides an identity for an organization because according to Basu and Wang (2009), It is the perceptual entity that resides in the minds of the consumers but is rooted in reality. Healthcare branding can help organizations achieve the goal of differentiating their products and services from those of competitors given today's savvy healthcare consumers (Mangini 2002; Devries and McKeever, 2008) who have more choices than ever (Mangini, 2002; Sparer, 2011) by using their name, products, services, , and facilities (Thomas, 2010). Mangini (2002, p. 22) reinforces this viewpoint by succinctly stating “When consumers are faced with a variety of choices, a strong brand tends to produce confidence in the products and services they choose”.

Drawing from services branding literature, Berry (2000) points to the special role of branding in increasing customers trust in service firms. In the words of Morgan and Hunt (1994, p.23) “...trust exists when one party has confidence in an exchange partner’s reliability and integrity”. From the patient's perspective, trust has a significant impact on the experience of being a receiver of healthcare (Thom et al., 2004). Accordingly, trust is one of the major factors Kim et al. (2008) found as influencing brand equity in healthcare. Kim et al. stress the importance of building high levels of trust and patient confidence in order to have a successful healthcare organization. Brands offer some measure of assurance that the provider of the good or service will deliver consistently on its promises, and is therefore worthy of trust (Kemp et al., 2014). Moreover, Kim et al. (2008) notes the role of branding in enabling consumers to better visualise and understand service offerings. This helps to overcome barriers of uncertainty that might otherwise prevent

people from becoming customers; and also reduces customers perceived monetary, social, or safety risks in buying health services (Ritchie et al., 1998; Mangini, 2002).

Likewise, Kemp et al. (2014) argue that a brand is a promise to consumers that the hospital will deliver on the sort of care needed; and it can drive business and growth for the organization, particularly when levels of satisfaction and emotional commitment are high. Corbin et al. (2001) in their study additionally note that branding healthcare services can provide a platform for consumers/patients to reduce the influence of credence properties associated with such interactions (i.e. the property in which one cannot evaluate healthcare service even after consumption or purchase, for example, surgery performed on a patient). Branding efforts may provide healthcare professionals with a controlled means of creating awareness rather than relying on current or former patients to deliver the marketing message (Corbin et al., 2001); and branding efforts related to consumer convenience, practice environment, and professional demeanor may help consumers to focus on their salient healthcare needs and desires (Chalal and Bala, 2012; Corbin et al, 2001).

To this end, research suggests that successful branding strategy must tackle how to preserve equity, build trust and also how to manage consumer perceptions and emotions regarding the healthcare organization (Speak, 1996; Mangini, 2002). Magini's (2002) also suggests as a requirement for healthcare branding, the strong and organized commitment to delivering unique standards of consistency through an organization's products and service. They further add that in delivering unique and differentiated brand experiences, healthcare providers should effectively position the organization and its brand as a valued contributor to health (Kemp et al., 2014).

2.4.1 Building Healthcare Brand Equity

Brand equity according to Keller (1998) is the power of the brand that is built in the minds of the consumers based on what they have learnt, seen, felt, and heard about the brand. Therefore, brand equity is considered an amalgam of advantages and disadvantages, inherent in a brand that drives the value of a product or service (Bauer et al., 2005). As mentioned in previous sections, brand equity measurement has been dominated by two perspectives; marketing and financial. However, for the purpose of this study, the marketing dimension would be considered. Though the literature reveals that quality, loyalty, image, association and awareness are the important service brand equity components; a study by Kim et al. (2008) considered trust, customer satisfaction, relationship commitment, brand loyalty, and brand awareness as major factors affecting healthcare branding. These components are:

Trust

Scholars (including Berry, 2000; Gummerus et al., 2004) point to the intergral role brands play in fostering trust from consumers for intangible performances in service organizations. According to Berry (2000) and Beckham (2000) branding in healthcare is very dependent on trust. Berry and Bendapudi (2007) illustrates this by stating that the buyer surrenders completely to the seller and in many cases even temporary lives in the healthcare facility. In the health care context, trust can create an exchange environment in which a hospital can provide better care to its patients, or customers, while becoming or remaining profitable. Morgan and Hunt (1994, p. 23) conceptualized trust as the perception of “confidence in the exchange partner’s reliability and integrity.” Moorman et al. (1993) defined trust as “a willingness to rely on an exchange partner in whom one has confidence” (p. 82). These definitions suggest that confidence and reliability are

vital elements of trust. Subsequently, trust and commitment promote efficiency, productivity, and effectiveness (Kemp et al., 2014). Built on management capability, trust is a standard that hospitals and their employees offer patients. When patients complain about service, the hospital and its employees must do their best to respond to the complaints and thereby maintain or rebuild trust (Kim *et al.*, 2008). Kemp et al. (2014), in their study found that trust in a healthcare brand will be driven by the display of competence and customer-oriented behavior by the attending staff and physicians at the healthcare facility among other things. Relationships characterized by trust will often result in the desire for long-term commitment between two parties (Morgan and Hunt, 1994).

Customer Satisfaction

In the service environment, customer satisfaction is considered as a special form of customer attitude. Woodside et al. (1989) described it as a phenomenon of post-purchase reflection on how much the customer likes or dislikes the service after experiencing it. The strategic importance of customer satisfaction for organizations is more highlighted (Wang and Pho, 2009; Khattak and Rehman, 2010) for services. Patient satisfaction is deemed one of the important factors which determines the success of healthcare organizations (Musunuru, 2011). In the field of healthcare, Kim et al. (2008b) adopted the concept of customer satisfaction and defined that patient satisfaction is the judgment of perceived value and sustained response toward service related stimulus before, during or after the consumption of medical services by a patient. Patient satisfaction is concerned with the degree to which the expectations of a patient are fulfilled by the medical services. Furthermore, patient satisfaction is a critical indicator for medical service industry (Wu, 2011) and providers of medical services need to understand patients' expectations and try to meet those (Lee et al., 2010). Studies (Sharma and Chahal, 1999; Mryyan, 2006;

Mpinga and Chastonay; 2011) found that patient satisfaction depends on the performance of doctors, atmospheric distinguishers like comfort, cleanliness and the facilities. These studies therefore concluded that customer satisfaction is the degree to which healthcare meets patients' expectations in terms of technical quality which includes competent health personnel, physical environment and facilities, and availability and accessibility of health services. Satisfied patients prefer the same hospital for same or different treatments and may recommend it to their friends and relatives unlike dissatisfied patients who may discontinue their treatment from the same hospital (Corbin et al., 2001) which can be detrimental to the hospital's competitive position (Atinga et al., 2011). Similarly, according to Hekkert et al. (2009), for hospitals, satisfied patients are important because they are more likely to keep using medical services, follow the prescribed treatment plan, and maintain the relationship with a specific health care provider. Patient satisfaction is therefore seen as a gateway to profitability in the hospital setting (Atinga et al., 2011).

Brand loyalty

Brand loyalty is defined as the attachment of a consumer towards a brand even when an organization makes changes in the price or other product features (Aaker, 1991); and is considered as the strongest path leading to brand equity (Atilgan et al., 2005). Scholars (including Aaker, 1991; Mellens et al., 1996; Chahal and Bala, 2010) conceptualize it as basically a function of behavior (i.e. repeat purchases of the brand) and attitude. In the healthcare sector, service brand loyalty means loyalty of consumers who continue to prefer the services from the same healthcare service provider, who has positive influence on them (Chahal and Bala, 2012). Several studies used re-visit intention as a substitute for patient loyalty in the health care environment (Boshoff and Gray, 2004; Kim et al., 2008). Chahal and Bala (2010) also equate service brand

loyalty with positive attitude (attitudinal loyalty) and repeat purchase behavior (behavioral loyalty) of consumers toward the hospital. In other words, loyalty of patients is the service brand loyalty of the healthcare institutions. Thus, according to Chahal and Bala (2012), loyal patients generate a solid financial basis for future activities because even after discharge they may continue to support the healthcare organization through positive word of mouth, donation or some other form of co-operation. The authors however point to public healthcare organizations' disposition of not paying much attention to the value loyal patients can add to their success. In essence, patients' loyalty is critical for healthcare units to retain patients and to survive in the competitive market. Hence, patient loyalty acts as a competitive asset for hospitals (Wu, 2011).

Brand Awareness

Brand awareness is a component of the brand that can add to its value. The value is based on how easy the brand comes to a customer's mind (Riezebos, 2003). According to the author, there are four different levels that show how aware a customer is of a certain brand: unawareness, passive awareness, active awareness and top-of-mind awareness. The higher the level of brand awareness, the more likely the consumer is to make a purchase decision in favour of that particular brand (Keller, 1993). Riezebos' (2003) passive awareness is similar to Keller's (1993) brand recognition and active awareness to brand recall. Brand awareness is an important component of service brand equity (Berry, 2000) and as depicted in the service branding model (see figure 1), is influenced by the company's deliberate presentation of its brand through its name, advertising and different symbolic associations. In the healthcare setting, Scholars such as Mangini (2002) stress the importance of awareness for hospitals. A strong brand identity for a healthcare organization according to Mangini (2002), is created by deciding what to brand (for instance, an entire health service or an outpatient services); defining the message to communicate

about the service to be branded (such as quality care, convenience); and finally communication this brand both internally (to ensure staff acceptance and enthusiasm necessary for brand success) and externally. Keller (2008) point to the ability of brand elements (particularly the name) to build awareness. Creating and building brand awareness, helps reach consumers mind and encourage them to develop a preference for the brand which ensures a successful brand (Keller, 2003; Ross and Harradine, 2004).

Relationship commitment

A common understanding exists among marketing scholars and practitioners that building a valuable brand transcends particular product features and benefits, to include the ability of the brand to penetrate people's emotions (Berry, 2000; Aiello, 2010; Kemp et al., 2014). A relationship of attachment and commitment develops between consumers and the brand when they connect emotionally with a brand (Park et al., 2009). Besides the frequent willingness to remain in an exchange relationship, consumers also put forth effort to maintain such relationship (Kemp et al., 2014). Commitment has been discussed as an essential ingredient for successful long-term relationships (Beatty and Kahle, 1988; Morgan and Hunt, 1994). Researchers have identified the emotional nature and the economic structure components of commitment (Allen and Meyer, 1990; Bansal et al., 2004). The economic type of commitment referred to as calculative, or continuance commitment stems from cost- based calculations and results in commitment because of a need to stay in the relationship when no other similar alternatives exist, or the costs of switching to other options are too high (Allen and Meyer, 1990). However, the emotional type called affective commitment results in an emotional attachment to the brand or organization (Allen and Meyer, 1990); and involves the desire to maintain a relationship that the customer perceives to be of value (Morgan and Hunt, 1994). Consumers who are affectively

committed to a brand are less expensive to retain; less vulnerable to loss from competitive efforts, brand blunders, or service failures; and are willing to pay a price premium (Bolton et al., 2000). To attain the trust and satisfaction of patients, physicians need to establish a relationship that meets patients' expectations in term of being supportive and actively involving them in decision-making (Wu, 2011). Clearly, this suggests that patient commitment should be linked to empowering patient- physician relationships (Kim *et al.*, 2008). When such a connection develops, a consumer is highly likely to become an advocate for the brand and passionately promote it to others (Kemp et al, 2014) which can be invaluable outcomes to the organization.

2.5 Antecedents to Healthcare Branding

According to Chahal and Bala (2010), to tread the path to brand equity and to make a brand competitively different, the key objective of the service firms should be to give attention to activities that contribute to service quality brand development. Furthermore, there seems to be unanimity in the literature that a strong services brand is developed and sustained largely by customers' interactions with the service provider (Berry and Seltman, 2007; Skaalsvik and Olsen, 2014). The literature therefore, tells that within the healthcare setting, general areas of concern for customers include the services, the health personnel, the facilities and the factors that aid easy recognition.

The first thing that customers come into contact with is the company's name (Berry, 2000). Literature suggests that for services, the "branding effect" of a company name is essential (Davis, 2007) because it is the brand name and is fundamentally important because it provides a means of tangibilizing the firm's offering (Berry, 2000), distinguishing the organization, clarifying the nature of services performed and capturing the consumers focus (Turley and Moore, 1995;

Chajet, 1991). Brand name according to Keller (2008) is one of the most important components of branding. Berry *et al.* (1988) further stated that a well-chosen name can give a company a marketing edge over comparable competitors.

Furthermore, healthcare facilities according to studies (including Staricoff and Loppert, 2003; Staricoff, 2004; Ulrich, 2008) are among the most complex of any environments accessed by the public. More so, the people who visit the hospital are those compelled by disease, injury sickness and other unavoidable circumstances (Bidhan, Pritindira and Pranita, 2004). The ability to successfully navigate in healthcare facilities is an important goal for patients (Bidhan, 2004). As hospitals endeavor to enrich user experience and increase efficiency, successfully guiding people to their destinations and providing relevant information regarding hospital procedures and services should be a vital concern (Devlin, 2014). Bidhan *et al.* (2004) further points to the ability of signage programs in hospitals to reduce the number of enquires made by the patient before reaching their endpoint in facilities and lowers the average time taken by the users to reach a particular service area, thus shaping their experience and perceptions of healthcare facilities

The product is the central component of any marketing mix which is the set of attributes offered to consumer. Most products of the hospitals are services which can be core or specialist services which determine the quality of medical services or support services which may include ambulatory services, dietary services, pharmaceutical services etc. which all help in making hospital services effective (France and Grover, 2002). The fundamental purpose of healthcare consumers visiting a health facility is to receive medical care (Berry and Bendapudi, 2007). The increased awareness, education and empowerment of healthcare consumers place them in a position to assess healthcare facilities on bases, which hitherto was not the case. Access to full

range of appropriate healthcare services has become a criterion for patients' choice of healthcare facilities (Dubey and Sharma, 2013). The role of service line is to coordinate the patient's journey through services related activities with the goal of achieving optimal clinical and business outcomes (France and Grover, 2002).

Moreover, according to Herstein and Gamliel (2006), services are grounded on several intangible dimensions that impart their uniqueness in the market. Healthcare services as such reflect typically, this characteristic of services, as they are basically intangible; in that the core benefits of medical diagnosis, treatment, and patient education stem largely from performances (Berry and Bendapudi, 2007). Services are based on series of performances and one of the most challenging aspects associated with service brands is that consumers have to deal with intangible offerings (McDougall and Snetsinger, 1990) which intensifies the perceived risk for customers (Berry and Bendapudi, 2003). As a remedy, scholars (McDonald et al., 2001; Klaus and Maklan, 2007) point to the need to make service brands tangible to provide consumers with a favourable set of perceptions; and to effectively differentiate organizations from the competition (Herstein and Gamliel, 2006). In the words of McDonald et al. (2001), using physical components/elements associated with the service that can be associated with the brand is an effective way to make brands tangible. Within healthcare, the state and effectiveness of health facilities, the physical environment of the healthcare facility and other peripherals have been found to significantly impact patients experiences in and perceptions of a healthcare facility (Atinga et al., 2011; Chahal and Bala, 2012).

For healthcare providers, employees are one of the main assets of the organization (Chahal and Bala, 2012; Wu, 2011). The quality of personnel is of vital importance in shaping a favourable

image and some level of trust for healthcare organizations (Rao et al., 2006). As such in other developments, hospitals and physician groups often advertise where their clinicians were trained, and insurance companies attempt to provide information about physician attributes to prospective patients. Leonard et al. (2007) in their study concluded that ability is a significant determinant of physicians' adherence to steps required to diagnose their patients' illnesses properly and to communicate the diagnosis and treatment to the patient appropriately. Studies have found that physicians who have more experience with a particular surgery have lower errors and fewer complications than physicians with less experience (Woolf et al., 2004). This therefore puts the technical competence of medical personnel or physicians at the center of patient healthcare decisions. Though healthcare consumer may be at a knowledge disadvantage in assessing medical personnel competencies, studies (Berry and Bendapudi, 2007; Chahal and Bala, 2012) have shown the influence of the medical personnel quality on patients' perceptions and satisfaction toward healthcare facilities.

Conclusively, competence of medical staff (Sharma and Chahal, 1999), the nature of the physical facilities and environment (Mryyan, 2006), availability and accessibility of health services (Mpinga and Chastonay, 2011) and the name and information/message the hospital presents to the patients (Cinaroglu, 2014) are factors found to influence healthcare consumer perception and intentions. Similarly, Nguyen and Leblanc (2001) found that hospital image and reputation are shaped mainly by the physical elements, the name, services and the competence of personnel. The literature indicates the implicit role of these factors in generating brand equity, customer brand preference, and willingness to continue using the service brand (Wu, 2011; Chahal and Bala, 2012).

2.6 Hospital Brand Image

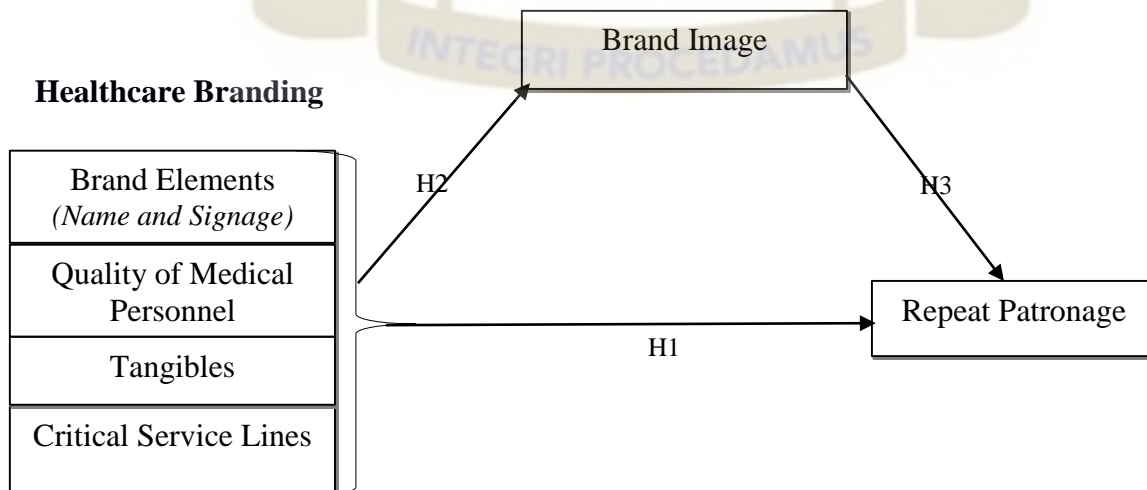
Brand image has been an important concept in consumer behavior research since the early 1950s and plays an important role in brand building (Mao, 2010). According to Shanthi (2006), image plays an important role in differentiating the service of a healthcare provider from that of its competitors. Brand image is a composite of perceived quality and esteem dimensions (Kumar et al., 2014). Kotler and Armstrong (1996) define brand image as a set of beliefs held about a particular brand. This set of beliefs play an important role in the buyer's decision process, when customers evaluate alternative brands (Alhaddad, 2015). Brand image describes the consumers' thoughts and feelings towards the brand (Lee et al., 2011) and also consists of symbolic and functional beliefs about the brand (Low and Lamb, 2000). Stated alternately, brand image is a perception of a brand held in customer memory which reflects a consumers overall impression (Wu, 2011). A positive brand image can be considered as a key ability of an organization to maintain its market position (Wu, 2011; Kumar et al., 2014). Illustratively, a company with a favourable corporate image about its offers can bring in individuality and differentiation that lead to high awareness, loyalty, and reputation (Heerden and Puth, 1995) and will definitely be in a position to attract consumers (Chahal and Bala, 2012). In the health care environment, Kotler and Clarke (1987) submitted that hospital brand image is the sum of beliefs, ideas, and impressions that a patient holds toward a hospital. The authors further point out that patients' idea of hospital image is not absolute but is relative to brand images of competing hospitals. According to Kim et al. (2008) patients are able to form a specific thought about any hospital within a rapid time. The patients often form a brand image of a hospital from their own medical examination and treatment experiences (Kim et al., 2008). Kolade et al. (2014) submit that hospital brand image is based on the impression perceived by patients via interactions with services, activities; what they have read about the hospital and visual symbols they recognize from their time of arrival through

treatment experiences to departure. Thus, a favourable hospital brand image is built by patients' trust in the treatment, services and by knowledge of the hospital (Kim et al., 2008), which help in attracting and retaining patients (Kolade et al., 2014); strengthening the intentions of patients and improves their tendency to select that hospital in the future (Kim et al., 2008; Wu, 2011).

2.7 Conceptual Framework

Drawing from healthcare brand equity literature, services branding literature and health service delivery/quality literature, a conceptual framework was developed to guide the study. The conceptual framework provides a graphic view of the study highlighting and integrating the factors found to influence healthcare brand equity components for predicting hospital branding activities and repeat patronage among patients. The framework assumes that healthcare branding has four major dimensions (brand elements (name and signage), quality of medical personnel, tangibles and critical service lines) which directly and/or indirectly (through brand image) predict customers' repeat patronage of the hospitals. Section 2.7.1-2.7.5 is used to discuss these variables and their interrelationships.

Figure 2: Conceptual Framework for Healthcare Branding and Consumer Patronage



2.7.1 Brand Elements (Name and signage)

According to Keller (2008), the various brand elements particularly, the name, can be chosen to enhance brand awareness, identify the brand in general, as well as to differentiate it from other brands. Lau et al., (2006) assert that established brand name helps in preserving brand loyalty. Aaker (1996) also points out that brand name dominance is the crucial part of brand awareness; because the more attention a product or service receives, the more likely it is to be chosen (Keller, 1993). According to Herbig and Milewic (1993) and McNeal and Zerren (1981), brand name can provide a customer with a symbolic meaning which assists in both the recognition of the product/service 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. Researchers (Reber et al, 1998) affirm that brand names that are recognized more quickly and easily are liked more and ultimately chosen often. Davis (2007) likewise points to the role of brand names in serving as a source of information for consumers in making a purchase selection.

Furthermore, studies on the impact of user disorientation within healthcare facilities confirm that the ability to find one's way contributes significantly to patients' satisfaction levels (Bidhan et al., 2004). For instance, in an experimental study, Nelson-Shulman (1984) found that patients exposed to posted signs or who had the benefit of an information system such as welcome sign, hospital information booklet, patient letter and orientation aids were more self-reliant and made fewer demands of staff, in contrast to uninformed patients who were stressed and rated the hospital less favourably. A crucial aspect for patient satisfaction is their comfort levels with the facility itself which can be boosted by an appropriate guidance and information system in the hospital (Ulrich, 2008; Bidhan et al., 2004). Health facilities that leave their visitors confused and stressed out can alienate their client base (Bidhan et al., 2004). According to researchers

(including Bidhan et al., 2004; Devlin 2014), although consistent and pleasing design is appreciated, the physical signs themselves will not essentially be a factor in a person's perception of brand but getting lost will as patients quickly redirect their negative feelings toward the organization and the impact on brand, image perceptions, confidence, and ultimately loyalty can be significant. A good, effective and a simple signage system is an effective way for enhancing the image of the hospital as well as keeping the public informed of the services available and makes the visit to the hospital more impressionable, pleasant and encourages revisit (Bidhan et al., 2004). In view of these, it is proposed that:

H1a: There is a positive and significant relationship between brand elements and repeat patronage.

H2a: There is a positive and significant relationship between brand elements and brand image.

2.7.2 Quality of Medical Personnel

Unlike most industries, the consumers (i.e. patients) of healthcare organizations are considered to be "at risk," (Berry and Bendapudi, 2007) because among other things, millions of patients are harmed by medication errors (Institute of Medicine, 2006); and communication errors of one type or another frequently results in wrong diagnosis and treatment (Woolf et al., 2004; Berry and Bendapudi, 2007). According to Kemp et al. (2014) and Kay (2007), today's increasingly savvy, empowered, and data-laden patients value the knowledge that their physicians have demonstrated expertise in the field. This makes the quality of clinicians a focal point of healthcare service evaluation; however, patients are at a considerable knowledge disadvantage in judging physician quality (Berry and Bendapudi, 2007; Kemp et al., 2014; Chahal and Bala, 2012). Berry and Bendapudi (2007) and Bendapudi et al. (2006) in their studies found that, patients tend to

presume a doctor is clinically capable. These studies also suggest that patients' concern relates to the "physician bedside manner" (interpersonal skill) rather than the physician's technical skills or expertise. However in an earlier study, Wilson and McNamara (1982) simulated doctor-patient encounters and established that good bedside manners of physicians did not guise their poor technical competence. The import is that though evaluating medical personnels' technical quality is difficult for patients, it does not underscore its importance to them (Berry and Bendapudi, 2007). Similarly, Hall et al.'s (1988) meta-analysis of 41 independent studies also showed that physician task competence strongly influenced actual patient decisions and assessment about quality. Seemingly, an essential expectation that patients have when they choose hospital care is that of competent care providers. (Leonard et al., 2007; Andaleeb, 1998). Given the high credence nature of healthcare services, Moorthi (2002) suggests that advanced skilled sets and specialists with very broad comprehension are required; to differentiate the organization by delivering valued experiences (Brakus et al., 2009) because customization and judgment in service delivery are higher in the case of health services (Lovelock, 1992).

Undoubtedly, there is an assumption that the quality of physician is important to patients even if the effects on the outcome are not measured. For instance in Kemp et al, (2014), one of the interviewees expressed intentions to return to the facility where she had surgery and stated:

"I had my surgery performed at (my hospital) mostly because it was where my physician had admission privileges. However, I did really appreciate the anesthesiologist I had. He was very competent and I would go there again because of him" (p.129)

As indicated, a consumer's subjective assessment of quality can influence perception of a healthcare provider and purchase intentions hence the proposition that:

H1b: There is a positive and significant relationship with quality of medical personnel and repeat patronage

H2b: There is a positive and significant relationship between quality of medical personnel and brand image

2.7.3 Tangibles

The customer's first point of interaction or contact with a service organization, such as car parking, design of building and appearance of the reception area, and location all intermingle to give consumers evidences about what the service brand will be like (McDonald et al, 2001; Yoo et al., 2000). According to Zeithaml and Bitner (1996), "tangibles" is applicable in the healthcare context in respect to waiting room, examination room, equipment, and written materials. In a similar vein, Herstein and Gamliel (2006), opine that improving service quality in the healthcare sector in regards to tangibles requires attention to dimensions such as aesthetic qualities of waiting rooms, general "atmosphere", and medical equipment and instrumentation. This assertion is substantiated by Ulrich (2008) and Vuong et al. (2012) who found that waiting for a healthcare appointment is part of the overall experience of a healthcare service and so to provide consumers with more pleasant experience of the healthcare service, hospital waiting environments should incorporate design attributes which make this as pleasant as possible. Furthermore, Chahal and Bala (2012) in their study also found tangible dimensions such as adequate stock of medicine, availability of state of art technology equipment and parking facility to be essential in strengthening patients' perception of quality. Swan et al. (2003) considered tangibles or physical aspects in a service environment as atmospherics that influence customers' purchasing intentions. They further posited that service providers can use atmospherics to increase the satisfaction, patronage, and word-of-mouth recommendations of customers.

Moreover, Hutton and Richardson (1995) found that the physical surroundings and sensory stimuli of healthcare facilities have an impact on patients' behaviour and that a positive experience with this environment will increase their satisfaction, their evaluation of the service quality, and any likelihood to return to this setting in the future. This implies that in the quest to build a strong brand, one cannot lose sight of the perceived quality associations of the brand to command the desired attention from and influence the intention of the target audience. Against this background, the next propositions state:

H1c: There is a positive and significant relationship between tangibles and repeat patronage

H2c: There is a positive and significant relationship between tangibles and brand image

2.7.4 Critical Service Lines

The array of medical services available in a hospital is an important consideration to patients' choice of hospitals as convenience in accessing medical care is particularly important to patients (Razzak et al., 2008). Parakoyi et al. (2001) points out that though the perceived quality and patient satisfaction with care provided affect patients' choice of health facilities, availability and accessibility of services of the health facilities largely affects or impact these choices. Similarly, Arab et al. (2012) in a study of service quality and patients' loyalty in private hospitals in Tehran confirmed the influence of availability of medical tests and pharmacy facilities within the hospitals on patients' willingness to return to the same hospital and reuse its services or recommend them to others. Vinodhini and Kumar (2010) also posit that a strong healthcare service/product creates a different brand image for hospitals. The range of services provided within a healthcare facility is argued to be a decisive factor in formation of patients' perception toward the hospital largely because patients expect timely, convenient and effective services from

their hospitals. The study proposes these testable hypotheses in examining the influence of critical service lines as an element of healthcare branding on repeat patronage and hospital brand image in the Ghanaian healthcare industry.

H1d: There is a positive and significant relationship between critical service lines and repeat patronage

H2d: There is a positive and significant relationship between critical service lines and brand image

2.7.5 Brand Image and Repeat Patronage

According to Chang et al. (2008), brand image is a body of brand-related information developed by consumers over time. Similarly, Keller (1993) defined brand image as the perceptions about a brand reflected by the associations held in consumer's memory. These associations according to Semnani et al. (2012) refer to any brand aspects within the consumers' memory. Succinctly stated, brand image reflects consumers' perception about a brand based on their experience and knowledge. An organization's image according to (Zeithaml and Bitner, 1996) is an important variable that positively or negatively influences consumers' perceptions of goods and services offered. A positive and well-known image is an asset to organizations because the image is a powerful purchase influencer that affects the consumer's perception of the organization (Alhaddad, 2015). In essence, image can have an impact on consumers' buying behaviour (Semnani et al., 2012) because if consumers hold the belief that an organization is more credible and trustworthy than another, they develop a favourable image of that organization (Fournier and Yao, 1997). According to Porter and Claycomb (1997), a strongly positive brand image allows a corporation to gain reputational value and competitive advantage. A favourable brand image increases various outcomes such as customer satisfaction, service quality, loyalty, and

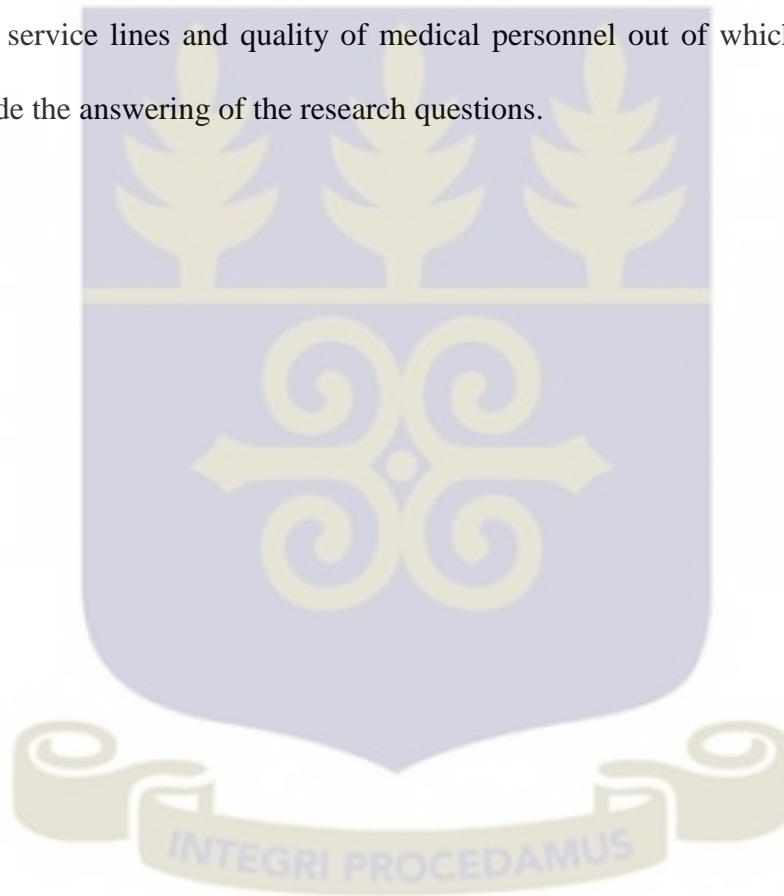
repurchasing intention (Bloemer et al., 1998; Da Silva and Syed Alwi, 2008; Lai et al., 2009).

Merrilees and Fry (2002) point to the direct impact of brand image on loyalty. Yoo et al. (2000) also found a positive relationship between brand image and the level of brand loyalty displayed by consumers. In the healthcare environment, several studies used re-visit intention as a surrogate for patient loyalty (Boshoff and Gray, 2004; Kim et al., 2008b). Furthermore, several studies have shown the impact of brand image on purchase intentions (Batra and Homer, 2004; Ataman and Ulenjin, 2003). Studies (including Andreassen and Lindestad, 1998; Wu, 2011) have suggested that brand image has both direct and indirect effects on revisit intentions. For instance, Kandampully and Suharanto (2000) have shown that a favourable hotel image positively correlated with customers' intention to recommend and revisit the hotel. Similarly in retail, Esch et al. (2006) confirmed the direct and indirect influence of brand image on current and future purchases. Burmann et al. (2008) also said that brand image is an important determinant of a buyer's behaviour. In a similar Vain, Chahal and Bala (2012) in their study reported that high and positive consumers' perception towards a brand reflected the preference of patients to avail the same or different medical treatments from the same hospital in future as well. Therefore, in the hospital context, a positive hospital brand image appears to stimulate repeat patronage. Following this line of argument, the next proposition states:

H3: There is a positive and significant relationship between hospital brand image and repeat patronage.

2.8 Chapter Summary

This chapter reviewed literature related to answering the objectives set. The concept of branding was extensively discussed highlighting the concept of a brand, branding activities, brand equity and service branding. Healthcare branding and equity was as well discussed drawing out the factors of healthcare branding. Following the review of literature, a conceptual framework was developed to guide this research. The chapter also discussed constructs such as brand elements, tangibles, critical service lines and quality of medical personnel out of which hypotheses were formulated to guide the answering of the research questions.



CHAPTER THREE

CONTEXT OF THE STUDY

3.0 Introduction

This chapter describes the setting within which the study was conducted. It provides an overview of healthcare in Ghana, how it has evolved over the years and the challenges through which modern healthcare system is produced in Ghana. It highlights certain forceful changes that the industry has witnessed and finally, throws light on the institutional and regulatory framework for the healthcare industry.

3.1 Healthcare System in Ghana: A Historical Trail

Before the advent of colonialism, native health practitioners were the single recognized and established health experts in the Gold Coast with traditional knowledge regarding herbal treatment for both curative and preventive purposes (Patterson 1981; Twumasi and Warren, 1986). However, colonialism relegated the development of traditional health care system to the background as the practice of a foreign health care system was introduced (Twumasi, 1982), Today, modern healthcare forms the major part of the healthcare sector in Ghana but is still complemented by traditional medicine which is quite popular among rural dwellers (Nketiah-Amponsah and Hiemenz, 2009).

3.1.1 The Colonial Milieu

The dawn of scientific/modern healthcare in Ghana remains a debated claim among scholars however, Senah (2001) in his study “In sickness and in health: globalization and healthcare delivery in Ghana,” provided a cogent account of the development of modern healthcare system

in Ghana. According to the author, this development can be classified into three stages. The first phase witnessed the emergence and the resulting establishment of biomedicine to protect the colonial masters from the probable contraction of infectious diseases from the “unhygienic” conditions of the “natives’ environment” with whom they interacted on a diurnal basis; and hence was the sole preserve of these colonial masters (Senah, 2001). The signing of the bond of 1844 as stated in Senah’s (2001) account marked the start of the second phase of colonial health care system in Ghana. This ratification stimulated the realization that the colonial masters could not enjoy good health without ensuring that the health needs of the natives were also met (Twumasi, 1975; Senah, 2001). On that premise, colonial health services and also other sanitary facilities were extended to domestic servants; civil and military personnel that were constantly interacting with their colonial masters (Senah, 2001). The third phase began in 1868, with the building of the first hospital in Cape Coast, as well as dispensaries in several rural communities (Senah, 2001). Eventually, in 1923, the first national hospital, the Korle-Bu Teaching Hospital as part of a new national health structure was purposely built to serve the health needs of Ghanaians, and also to serve as a research center for tropical diseases (Senah, 2001). According to Dummet (as cited in Frimpong, 2013), funding of healthcare these periods before independence was the exclusive prerogative of the colonial government or missionaries involved in its provision at the time.

A major issue of concern during this era was in regard to insufficient health workers and severe lack of finances to pay medical officers (Patterson, 1981). Colonial masters were absorbed in establishing more health facilities rather than training natives as health professionals to manage these facilities. Consequently, only a few health facilities could be built and managed efficiently and most of these hospitals and clinics were continually understaffed, which resulted in the closure and/or the downgrading of most clinics and medical stations (Patterson, 1981). According to

Patton (1996), colonial officers also mostly concentrated on improving health facilities in urban centers where they lived. For example, in 1927 and 1928, 28 out of the 39 hospitals in the country, were based in the colonial seat of government (Patterson, 1981). Furthermore, there were merely 25 African doctors by 1934, all based in the urban centers (Patterson, 1981). Colonial Ghana however, only saw an increase in the number of native health workers and health programs in the 1940s (Patterson, 1981; Osei-Boateng, 1992; Addae, 1997).

Basically, this colonial health project established a strict legacy of cost-sharing in health care services; central government as the largest provider of health care service; urban-bias health care structure etc. (Senah, 2001). These legacies have transcended time and trickled into current Ghanaian health care practices and continually shape the contents of public health policy.

3.1.2 The Post-Colonial Milieu

At independence in 1957, the healthcare sector was in a deplorable state owing to the devastating effect of colonialism (Frimpong, 2013). Realizing the demand for health infrastructure, the first national government established a government-sponsored and free medical school to locally train Ghanaians in biomedicine; and also expanded and modernized the Korle-Bu hospital as a teaching hospital for the use of the trained physicians (Dovlo and Nyongator, 1999; Opare and Mill, 2000; Brobby and Ofosu-Barko, 2002). According to Senah (2001), while the health care sector was financed by the state, the services provided by this institution were made free of charge to citizens. Senah (2001) submitted that “between 1957 and 1963 the number of health centers increased from 1.0 to 41”, and of the £144 million that government budgeted, between 1963 and 1964, for projects, as part of public expenditure, about 31 % went towards the social services with much attention given to the health sector (p.85). Additionally, government’s health

expenditure increased from 6.4% in 1965 to 8.2% in 1969 (Patterson, 1981). This was an indication that; in relation to other departments, the government spent more on healthcare and human resource development (Frimpong, 2013).

Opare and Mill (2000) point out that the failure of successive governments to invest in the health care system; coupled with the shaky economic state during this period severely affected the already troubled health sector (Senah, 2001); and had a compounding effect by placing hefty financial loads on both the health care delivery system and the patients accessing these delivery facilities (Senah, 2001). Hence, user fees were introduced in 1969 and practiced in various forms until it was replaced with the Hospital Fees Regulation, 1985, (LI 1313) commonly known as the “Cash and Carry” system in 1985 (Frimpong, 2013) as part of the IMF and the World Bank’s Structural Adjustment Program (SAP) prescription (Frimpong, 1997; Aryeetey and Harrigan, 2000).

Opong (2001) investigated the condition of the health care sector under the SAP and concluded that cutbacks in government expenditure and the withdrawal of subsidies from the already degenerating health sector as compliance to the IMF and the WB conditionalities affected the healthcare system. For example, around 1990s, there was a reduction in the percentage (of 1%) of GDP allocated through Ministry of Health from government revenue to public health care expenditures (GoG, 2001).

3.2 National Health Insurance Scheme (NHIS)

Following from the ongoing discussion, the challenges of the prior financing systems resulted in the search for alternative health financing mechanisms (Addae-Korankye, 2013). As a result in

2003, the Government of Ghana initiated and passed the National Health Insurance Law, 2003 (Act, 650) and the National Health Insurance Regulations, 2004 (L.I. 1809) directed at abolishing the “Cash and Carry” system and limiting out-of-pocket payments at the point of service delivery (Agyepong and Adjei, 2008), consequently, removing the financial barrier to accessing healthcare (Atinga et al., 2011; Frimpong, 2013). The NHIS is based on District Mutual Health Insurance Schemes (DMHIS), which operates in all 170 districts of the country which covers both formal and informal sectors of the economy. Financing for the NHIS according to (Frimpong, 2013), is obtained from four main sources: a value-added tax on goods and services, a reserved portion of social security taxes from formal sector workers, individual premiums and miscellaneous, and other funds from investment returns, Parliament and donors. The National Health Insurance Levy (NHIL), which is the 2.5% tax on selected goods and services, is the largest source, comprising about 70% of revenues (Frimpong, 2013, Adda-Korankye, 2013). Social security taxes account for an additional 23%, premiums for about 5%, and other funds for the remaining 2% (Yankah, 2009).

The National Health Insurance Scheme (NHIS) since its implementation has exceeded its target of 40 percent nationwide coverage as membership coverage stood at 45 percent, with one hundred and forty five (145) accredited and operational district schemes established by 2008 (MoH, 2009; Addae-Korankye, 2013). Furthermore, NHIS has also realized an upsurge in the number of accredited providers and has experienced key advancements including the introduction of the free maternal policy, establishment of regional coordination offices and introduction of new national membership card and ICT platform within five years (2003-2008) of operation (Addae-Korankye, 2013). The Scheme has also seen increased utilization for out and in- patient services (NHIA, 2011, Frimpong, 2013) and this increase corresponds with government subsidy

funding to schemes which has increased significantly from GH¢7.7m in 2005 to GH¢108m in 2007 (MoH, 2008).

The admission of these successes does not cloud or invalidate the various challenges threatening the NHIS. Notably, contrary to its goal of universal coverage, NHIS practice indicates that economic and financial barriers still exist with membership tilted against the poor and marginalized. Procedures for identification of the poor unto NHIS have proved inefficient and ineffective resulting in decreasing indigents' enrolment over the years (Addae-Korankye, 2013). Moreover, increase in coverage puts financial strain on NHIS as NHIS income is largely tax based (90-95% from SSNIT & VAT levy) and will grow with national income and not membership numbers (MoH, 2008). The implication hence is that, success of NHIS in terms of coverage, comes with greater financial un-sustainability (Addae-Korankye, 2013). Furthermore, the application of the institutional framework as provided for in the NHIS Act (Act 650) has led to governance, operational, administrative and financial challenges (GoG, 2009). Addae-Korankye (2013) points to the difficulty District schemes face with operational issues particularly on claims processing and payment. Given the volume of claims submitted by providers, coupled with manual vetting systems, delay in release of subsidy and reinsurance, many schemes are unable to process claims for timely payment to providers (Addae-Korankye, 2013). Additionally, there exist issues of weak system and human capacity for claims management, audit and fraud control which in turn create some setbacks and for this reason, the argument has been made for recentralization of claims processing to fewer key centers (GoG, 2009). Lastly, although health insurance is a social protection policy and a fund into which citizens contribute (Frimpong, 2013; Addae-Korankye, 2013), consumer voice on its operations is very limited. Even as provisions have been made for establishment of such structures as complaints system and community

insurance committees, many schemes never established and regularly used them. Relating to this is also the issue of limited community involvement, knowledge and information on NHIS operations (Addae-Korankye, 2013).

3.3 Institutional and Regulatory Framework for the Healthcare Sector in Ghana

The institutional responsibilities and relationships in the health sector are guided by the Civil Service Act 327; the Ghana Health Service and Teaching Hospitals Act 525, 1996; the National Health Insurance Act 650, 2003; and the Ministry of Health Organisational Manual 1998. In Ghana, healthcare is provided by the government and largely administered by the Ministry of Health (MOH) and Ghana Health Service (GHS) (Nketiah-Amponsah and Hiemenz, 2009).

Ghana's healthcare system according to Abor et al. (2008) is organised into four main categories of delivery systems: public, private-for-profit, private-not-for-profit and traditional systems and self-medication. However, arrangements for service delivery in the Ghanaian health sector in regards to modern healthcare follow a three-tier system: primary, secondary and tertiary levels; and corresponds with the three levels of administrative management: District, Regional and National levels (Addae-Korankye, 2013). Stated alternately, following a typical pyramidal structure, Ghana's healthcare services are provided through tertiary, secondary and primary institutions. Teaching hospitals operate in an autonomous manner; however, the GHS oversees the operation of the secondary and primary level hospitals. Healthcare services are provided by the central government, Christian missions (private nonprofit agencies), and a relatively small number of private for profit practitioners. The healthcare system has five levels of providers: Health posts – which are first level primary care for rural areas: Health Centres and Clinics, District Hospitals, Regional Hospitals and Tertiary Hospitals. These providers are funded by the

government of Ghana, financial credits, Internally Generated Fund (IGF), and Donors-pooled Health Fund (Addae-Kornkye, 2013).

Figure 3: Levels of Healthcare Providers (Private/Public) in Ghana

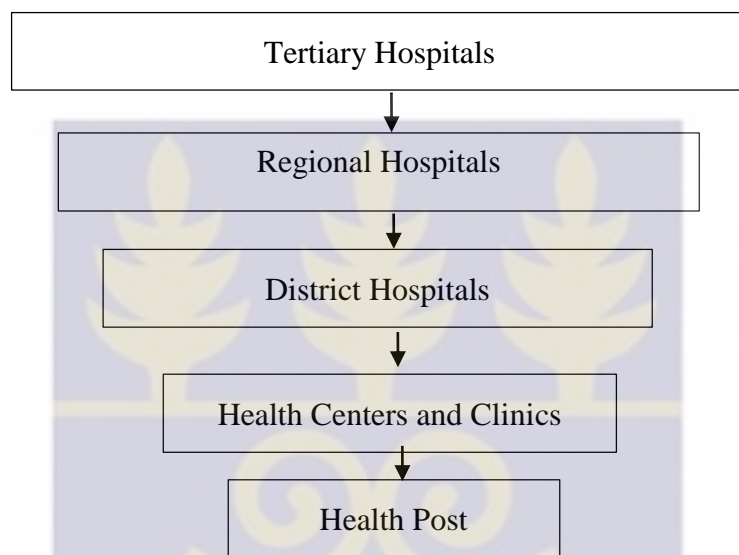
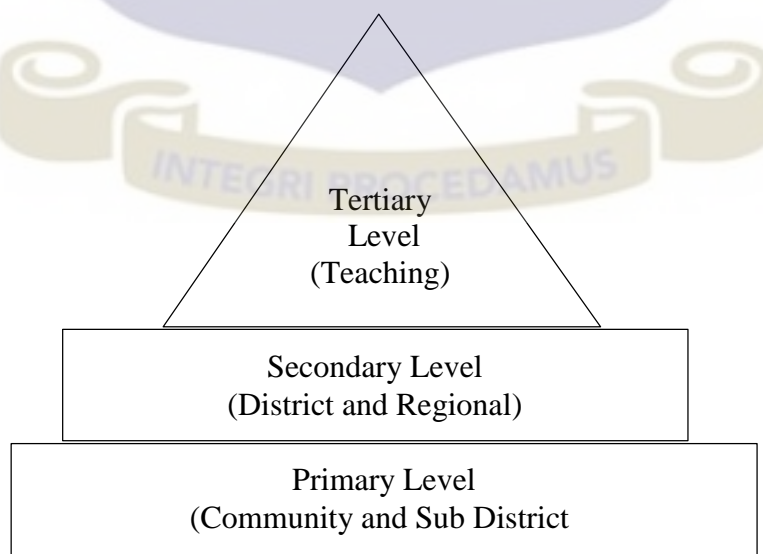


Figure 4: Health Industry Structure in Ghana



3.3.1 National Health Policy

Within the context of Ghana's vision of achieving middle-income status by 2015, the National Health Policy was designed in 2007. The Policy places health at the centre of socio-economic development and presents a clear shift in the role of health in the national and international development framework; based on the recognition that health is not only a human right issue, but also a key driver of development, and ultimately of wealth creation. The purpose is to build on the experiences from the 5-year Program of Work through certain range of activities. Specific objectives that the policy seeks to promote include:

- healthy lifestyles and reduce risk factors that arise from environmental, economic, social and behavioural causes
- equitable access to good quality and affordable health, population and nutrition services – services that will improve health outcomes, respond to people's legitimate expectations and are financially fair.
- strengthen the capacity of the health system by investing and mobilizing resources, allocating them equitably and ensuring their efficient utilization.
- generation and use of evidence for decision-making, programme development, resource allocation and management through research, statistics, information management and deployment of ICT.
- development of a local health industry that supports service delivery and creates jobs in Ghana, and contributes more broadly to the economy through its national and possibly regional activities.
- mobilize resources and ensure equitable and sustainable financing of the health sector.
- To ensure an enabling policy environment, incorporating accountable and performance oriented institutions; and to provide effective collaborative partnerships within the health sector and with other MDAs, private sector, NGOs and communities.

3.3.2 Ministry of Health

The Ministry of Health is the central government institution in charge of sector-wide policy development, financing, regulation, monitoring and evaluation (Amponsah and Hiemenz, 2009). The Ministry of Health and its agencies are together responsible for the formulation of health service policies, provision of health services and the regulation of activities in the health sector. The Ministry of Health translates government policies on health into sector policies to guide implementation by the agencies. It also has the responsibility for monitoring the implementation of such policies from a sector-wide perspective. The ministry has as its mission “to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry.”

3.3.3 Ghana Health Service

Ghana Health Service (GHS) is an executing agency of the MOH responsible for health service delivery (Atinga et al., 2011). The GHS was established under Act 525 of 1996 as required by the 1992 constitution. The Service is specifically responsible for the delivery of primary and secondary care services in Ghana. The Ghana Health Service has as its mandate, the objectives to

- Implement approved national policies for health delivery in Ghana.
- Increase access to good quality health services, and
- Manage prudently resources available for the provision of the health services.

The Regulatory Agencies in the health sector focus mainly on consumer or client protection by ensuring that the requisite and appropriate human resources for service delivery are available at recognized service delivery points. They also ensure that products for service delivery are safe, efficacious, and of good quality, and that service delivery outlets and practices meet prescribed

standards.

3.4 Current Outlook of the Healthcare Sector

Presently, Ghana's healthcare industry is characterized by a government sector that serves the majority of the population and a growing private sector that serves 40 percent of healthcare needs (Atinga et al., 2011). The country has about 3,217 public and private health facilities (Ghana Health Service, 2009) and around 50% of these healthcare facilities, which includes hospitals and clinics, are Ministry of Health Institutions, with 40% being private sector, 9% mission institutions and the remaining 1% quasi-governmental institutions (Nketiah-Amponsah and Hiemenz, 2009). There is an extensive network of about 300 mission (religious/charitable) hospitals, which receive subventions from the government, some of which serve as the District Hospitals in areas where there are no public hospitals. These mission health facilities are greatly supported by government through staff salary and other facilities. There are a growing number of private profit-based facilities, including an estimated 140 hospitals, 910 clinics, 108 company clinics, and nearly 400 maternity homes. Even though Government provides some support to the private not for profit providers there is no such support and/or partnership arrangement with the self-financing private sector in that, the private sector receives very little funding from Government or development partners (MOH, 2012).

According to the MOH, about 63 percent of the country's total population in 2010 depended on government or quasi-government health centers for medical care. Mission hospitals represented 35%, while private hospitals constituted about 2 percent of modern medical care facilities. With regard to service provision, however, the private sector, both formal and informal together is estimated to cover up to 60% of the population (Abor et al., 2008). At the district level, over 50%

of the 281 districts and other hospitals are private or mission hospitals. At the sub district level, over 98% of health facilities are public.

The formal private sector, made up of privately owned medical facilities such as hospitals, clinics and maternity homes emerged largely as a result of the limited coverage of the public sector and charitable healthcare facilities. Currently over 90 percent of for-profit providers are located where there is market and a higher ability of clients to pay. As at 2009, there were over 1,000 registered physicians in Ghana with about 700 engaged in the public sector and around 300 in the private sector. About 55 percent of private sector providers are found in the Greater Accra Region (Abor et al., 2008). Among the many challenges confronting the health sector in Ghana, inequitable distribution of health professionals and financing issues seem severe.

3.4.1 The Public Healthcare Sector

Public sector health services are primarily provided through hospitals (teaching, regional and district level) and clinics. The organization of the public health sector is decentralized, with health districts carrying considerable management responsibility and teaching hospitals functioning as autonomous institutions. The public sector is organized according to national (four teaching hospitals), regional (9 regional hospitals), district (281 district public and other hospitals), sub-district (622 public health centres) and about 1658 Community Health Planning Service Zones (about 31% of the projected 533 zones) and maternity homes at the community level (GHS, 2010).

3.4.2 The Private Health Sector

The private healthcare sector in Ghana is a large and important actor in Ghana's healthcare system. The main body that governs the private sector of the health industry in Ghana is the Private Hospitals and Maternity Homes Board (PHMHB), established by Act 1958 (No. 9) of the Ghanaian constitution. The private health sector controls a significant portion of the health industry but is inadequately leveraged or supported (MOH, 2012). Access to loans and financial equities is a major challenge for all private health sector industry operators (MOH, 2012). The self-financing private health sector is concentrated in the urban and peri-urban areas, with low rural penetration. Self-financing private providers in rural areas face more challenges given the higher poverty rate of the population, though the National Health Insurance Scheme has helped raise the effective purchasing power of rural populations.

Not long ago, private sector operational costs were financed solely from patient payments. The health financing reforms brought instantaneous change in healthcare seeking behavior of the people – dramatic increase in the number of clients seeking health services (Atinga et al., 2011), and private healthcare service which beforehand were the sole preserve of a very few and the wealthy in the society, became open to everyone. This provided the opportunity for the private healthcare providers to maintain their existing clients and also to gain as much market share as possible to increase their NHIS reimbursement (Addae-Korankye, 2013), which became another source of financing their operations. Given that private hospitals have some level of autonomy and can easily implement any innovations in medical practice compared to government establishments certainly requires private facilities to improve their marketing efforts in order to compete favourably with their public counterparts.

CHAPTER FOUR

METHODOLOGY

4.0 Introduction

This chapter outlines the methodology used for the research. The chapter provides description on the method employed in the study and discusses how the study was conducted in order to achieve the objectives delineated in chapter one. Hence the chapter discusses methodological issues such as philosophical perspectives, research purpose, research approach, research strategy and design, data collection methods and method of data analysis.

4.1 Philosophical Perspectives and Paradigms

Philosophical perspectives are the bases on which all academic researches are grounded (Holden and Lynch, 2004; Proctor, 2005). On this premise, Amaratunga et al. (2002) contend that ignoring philosophical issues can affect the quality of research. Blaikie (2010) posit that social researchers either explicitly or implicitly work within the context of a particular set of theoretical ideas and ontological and epistemological assumptions. In the most basic sense, a philosophical position allows the researcher to define incisively, the 'why' for the research contrary to merely choosing the 'how' (Holden and Lynch, 2004). A cogent summary of the importance of a philosophical position in any research is provided by Easterby-Smith et al. (2002) in their book "management Research". The authors state that a philosophical position in the main helps to explicate the research design in regards to its general approach and exposes the researcher to the research design that would work best or differently. Kuhn (1970) earlier defined a paradigm as a set of beliefs, values and techniques which is shared by members of a scientific community, and which acts as a guide or map, dictating the kinds of problems scientists should address

and the types of explanations that are acceptable to them”. According to Creswell (2014), there are different paradigms based on certain assumptions (epistemological, ontological and methodological) which act as a guiding structure.

Ontological assumptions concern the nature of social reality and make claims about what kinds of social phenomena exist, the condition for their existence, and the ways in which they are related (Blaikie, 2010). Epistemological assumptions concern what is to count as accepted truth by specifying the criteria for deciding when knowledge is both adequate and legitimate (Blakie, 2010). Methodology on the other hand refers to the framework used to conduct research, within the context of a particular paradigm (Wahyuni, 2012). Considering the various existing philosophical perspectives, the most dominant paradigms that reflect the major theoretical directions in social science research are realism, relativism, critical realism, interpretivism, and positivism (Downward and Mearman, 2004; Beverland and Lindgreen, 2010; Jernigan, 2010).

Realism assumes that social phenomenon is understood through hypotheses which are tested to establish patterns of associations and hence the most possible explanation (Bickerton, 2000). Realism from an ontological perspective holds the belief that reality is “real” and only imperfectly and probabilistically apprehensible (Boteng, 2014).

Relativism has the view that the construction of Knowledge is influenced by the worldview and research paradigm of a researcher. Hence researchers should focus more on creating and developing new ‘useful’ theories – useful solutions to specific problems (Downward and Mearman, 2004).

Critical Realism however, is based on retroductive reasoning and assumes that researchers seek to deconstruct and understand the structures and mechanism underlying the subjective realities that exist (Kim, 2003). This paradigm according to Boateng (2014), of the view that two worlds exist – transitive and intransitive. The former is what we observe and learn with our mind which represent perceptions of reality and the latter embodies the reality which is independent of what the mind thinks.

Interpretivism is of the view that social reality is a world that is interpreted by the meanings participants produce and reproduce as part of their everyday activities together (Blaikie, 2010). According to Malhotra and Birks (2007), interpretivist researchers are value-laden with an inclination to biases and interaction with respondents. Interpretivism holds the opinion that knowledge is created through researchers identifying the various interpretations and constructions of reality that exist, and attempting to establish patterns (Jernigan, 2010).

Positivism - Among other features, the central belief of the positivism approach is the view that the social world exists as an external environment where definite structures affect people in similar ways and vice versa (Proctor, 2005) and therefore its properties should be measured through objective methods, rather than being inferred subjectively through sensation reflection or intuition (Easterby-Smith et al., 2002). Positivism seeks unbiased findings through value-free approach and ensures that the researcher is independent from the respondent (Malhotra and Birks, 2007). Furthermore, a positivist approach entails the need to reduce the problems into coherent sub-units, operationalize the concepts in order to make measurements, select appreciable large samples to increase validity, and develop hypotheses to demonstrate and test their authenticity (Easterby-Smith et al., 2002).

4.2 Research Purpose

A research purpose offers the fundamental route for conducting the research. The main purposes of conducting research according to Robson (2002) are exploratory, descriptive and explanatory. Stated alternately, in social research, there are three categories of research purpose: exploratory, descriptive and explanatory (Saunders et al., 2009). The major emphasis of *exploratory research* is on the discovery of ideas and insights (Saunders et al., 2009); and so is mostly used when a researcher examines a new interest or when the subject of study itself is relatively new. Because the phenomenon of interest within this domain is considerably new and unfamiliar to the researcher, more information is needed to clarify the concept and scope of the study and to put the phenomenon into comely perspective. A research purposed on an exploratory basis could be conducted through a number of techniques including literature review, interviews, focus group and case study.

Descriptive research systematically describes a phenomenon, situation or problem and usually asks the ‘what’ question (Boateng, 2014). According to Babbie (2004), the researcher observes and then describes what was observed and these descriptive accounts can be expressed in words or numbers and may involve the development of sets of categories or types (Blaikie, 2010). Descriptive research is frequently used when a problem is well structured. *Explanatory research* however, focuses on studying and understanding specific situations or problems in order to explain the relationships among variables (Saunders et al., 2009). Explanatory research aims to develop precise theory that can be used to definitively explain the phenomena, which leads to generalization from the research. Therefore in order to investigate the implication of healthcare

branding on consumer re-patronage decisions, this study is purposed on an explanatory basis with the intent of explicating the nature of relationship between hospital branding factors and consumer re-patronage decisions.

4.3 Research Approach

Two general approaches have been discussed by researchers viz; quantitative and qualitative research (Denzin and Lincoln, 2000) and both approaches are widely used in business research. However, Creswell (2014) advances a third approach – mixed methods; and points to the fact that the three approaches are not discrete. Alluding to Newman and Benz (1998) who are of the view that quantitative and qualitative approaches represent different ends of a continuum, Creswell argues that a mixed methods resides in the middle of this continuum since it incorporates elements of both qualitative and quantitative approaches. Quantitative research is primarily concerned with number and representativeness and has highly structured methods for data collection (Hair et al., 2009). According to Cooper and Schindler (2006), where there is a limited understanding of the phenomenon under investigation qualitative research is best; since it provides the researcher more descriptive space. The dichotomy between these two lies in the number of participants and the way data is collected and analyzed (Creswell, 2014). It is imperative to mention that researchers approach the building and testing of theory from two directions; deductive and inductive (Neuman, 2006). The former aims at finding an explanation for an association between two concepts by proposing a theory, the relevance of which can be tested (Blaikie, 2010); and the latter may have researchers begin with specific observations and measures, to detect patterns and regularities, and then formulate some tentative hypotheses that

can be explored. Some scholars therefore refer to the quantitative approach as deductive and the qualitative approach as inductive. These approaches are discussed below:

Quantitative Approach

Quantitative research is a means for testing objective theories by examining the relationship among variables (Creswell, 2014). The quantitative approach has been associated with the positivist or empiricist paradigm in the literature (Smith, 1983). According to Boateng (2014), quantitative research seeks to determine the extent of a problem or the existence of a relationship between aspects of a phenomenon by quantifying variations. Quantitative research often seeks to test to support or disprove a proposed relationship between two or more aspects of a phenomenon. A quantitative method means that the data collection techniques and data analysis procedures generate or use numerical data; and statistical calculations and inferences geared toward establishing correlations between certain stated variables. Quantitative research is structured because it begins with specific hypotheses or questions derived from theories and previous studies and uses objective instruments to gather data from a carefully chosen sample (Boateng, 2014). This approach allows for the study of a larger sample of the population making it possible to draw general conclusions. For quantitative study, the essential skills needed for the researcher as suggested by Saunders et al. (2009) are the ability to develop proper hypotheses, test them with proper statistical techniques, and interpret statistical information into descriptive information. Certain downsides to this approach as argued by researchers (Wiskers, 2001; Yin, 2003) are that it is characterized by generalization and analysis does not apply to peculiar situations. It is also criticized on the grounds of lacking the ability to give an in-depth insight or understanding into a given phenomenon (Wiskers, 2001).

Qualitative Approach

Qualitative research is an approach that studies the social world, and seeks to describe and analyze the culture and behaviour of humans and their groups from the point of view of those being studied (Bryman, 2007). Put differently, qualitative technique calls for researchers to assume the role of a participant to describe a social reality from the perspective of the subject(s), rather than observers. According to Blaikie (2010), qualitative research is designed to help researchers to understand people and the social and cultural contexts within which they live. This approach therefore involves a close contact with a small purposive sample over an extended period of time (Amaratunga et al., 2002; Herington et al., 2005). Malhotra and Birks (2007) argue that qualitative research is often used to generate hypotheses and identify variables that should be included in quantitative approaches. Qualitative technique also allows the researcher to learn more about people's feelings, thoughts and experiences which may be analyzed and shared with others through publications (Rubin & Rubin 1995). Researchers who engage in this form of inquiry support a way of looking at research that honours an inductive style.

Mixed Methods Approach

Researchers have the option of choosing between quantitative and qualitative approaches however, collecting, analyzing and mixing both quantitative and qualitative data in a single study or series of studies or using both approaches so that the overall quality of a study is greater than either approaches alone constitute a mixed methods (Creswell and Plano Clark, 2007; Creswell, 2014). According to Malhotra and Birks (2007), this approach could precede, be used subsequent to, or in conjunction with quantitative approaches. Creswell (2009) explains three types of mixed methods approaches; sequential, concurrent and transformative. Sequential mixed methods

elaborate on the findings of one method with another method and may involve beginning with a qualitative interview for exploratory purposes followed by a quantitative survey method in order to generalize results; otherwise, the study may begin with a quantitative method to test a theory and following up with a qualitative method for detailed exploration with a few cases. Concurrent mixed methods fuse quantitative and qualitative data which are collected simultaneously in order to provide a comprehensive analysis of the research problem. Transformative mixed methods however, use a theoretical lens which provides a framework for changes anticipated by the study where data collection could be sequential or concurrent (Boateng, 2014).

On the basis of the foregoing discussion, a quantitative approach was deemed appropriate for this study and was employed to achieve the research objectives. In developing a suitable measure for healthcare branding and consumer re-patronage, employing the quantitative approach helped test and established the relationship among these variables by formulating specific hypotheses, generating or utilizing numerical data; and employing statistical calculations and inferences. The quantitative approach was also thought appropriate for the study as it allows for generalization of results.

4.4 Research Strategy

The research strategy refers to the research procedure used to answer research questions in order to fulfill the purposes of the research. According to Saunders et al. (2009), the research questions and objectives, the extent of existing knowledge, the amount of time and availability of other resources, and the researcher's philosophical foundation form the basis for the choice of research strategy. Some research strategies include case study, experiment and survey.

Case Study

Case study as a research strategy according to Yin (2009) is appropriate if the phenomena to be examined are complex and deeply integrated in the organizational context of a company. A case study avails itself to both quantitative and qualitative techniques for data collection and analysis (Yin, 2009) and is mostly used in explanatory and exploratory research with the ability to answer 'why', 'what' and 'how' questions (Saunders et al., 2009).

Experimental

Like case study, experiment is also used in explanatory and exploratory research (Saunders et al., 2009). Experimental research typically involves two groups sharing akin characteristics with one as the experimental and the other as the control group. The researcher then subjects the experimental group to some form of manipulation (independent variable) after which the dependent variable is re-measured for both groups so as to compare outcomes before and after the manipulation. Though typically conducted in either laboratory or field experiments, experimental research could be used in business disciplines but is usually intricate and expensive (Saunders et al., 2009).

Survey

A survey is a means of obtaining information about the characteristics, actions, or opinions of a large group of people, referred to as a population (Malhotra and Birks, 2007). Survey Strategy is largely associated with the deductive research. Survey is typically preferable for researchers who

are interested in gathering primary data to describe a population that may be too large to observe directly. Survey Strategy allows for samples with characteristics that may reflect those of the larger population, and carefully constructed standardized questionnaires elicit responses (data) in the same form from all respondents (Babbie 2004). The data are typically quantitative and can be easily compared and analyzed using various statistical techniques (Creswell, 2014). Though questionnaires are the most commonly utilized data collection instrument in the survey research strategy, structured observation and interviews can also be employed in survey research (Malhotra and Birks, 2007; Creswell, 2014). Following this line of argument, this study adopted the survey strategy on the bases that it sought to elicit responses directly from a cross-section of healthcare consumers regarding their perception of hospital branding factors and re-patronage decisions at one point in time.

4.5 Research Design

Research design refers to the blueprint, plan or framework for conducting research (Malhotra and Birks, 2007). Creswell (2003) points to the ability of such framework to put together claims made about what constitutes knowledge, a strategy of inquiry and specific methods. According to McGivern (2006), a research design essentially aims to structure the research to answer research problems as accurately and explicitly as possible. This is buttressed by Kumar (2005) who states it as a plan that is adopted by the researcher to answer questions validly, objectively, accurately and economically. Guy et al. (1987) earlier submitted that the use of research design is to ensure that the objectivity of the research is assured. Moreover, Churchill and Iacobucci (2009) contend that besides facilitating the collection and analysis of data, a research design also helps to specify the details of the procedures necessary for obtaining the information needed to structure or solve

marketing research problems. In this study, the research design focused on such issues as research paradigm, research approach, research purpose, research strategy, and data collection methods.

4.6 Research Design for the Study

In view of the above and earlier discussions, it is evident that this research is conducted from a positivist perspective because grounded on Gill and Johnson's (1997) argument, the study was based on structured methodology and quantifiable responses which led to statistical analysis. Besides, research hypotheses were formulated from existing literature and were empirically tested. Furthermore, premised on the position of Saunders et al. (2009) that explanatory research attempts to clarify the understanding of a specific research problem, this study is purposed on an explanatory basis as it aims at understanding what customers consider the best and most important factors (hospital branding activities) in availing hospitals' services and the interrelationship among these variables. A quantitative approach was employed to enable the study test the relationship among some latent variables and their relevance in brand image perceptions and patients' intentions to revisit a hospital. The study adopted the survey method via the use of structured questionnaires designed to elicit information from respondents in order to help the study identify and explain statistically, the role of certain factors in customers choice of hospitals and image perceptions; and also on the basis that the study is cross-sectional in nature and previous cross-sectional studies (Chahal and Bala, 2012; Wu, 2011) have mostly employed the survey strategy.

4.7 Sources of Data and Data Collection Methods

There are two basic sources of data for every research; primary and secondary data sources Saunders et al. (2009). Primary data are data collected with a specified purpose in mind (Yin, 2003). Primary data sources consists of data originated by the researcher for the specific purpose of addressing the research problem, whereas secondary data refers to data collected for purposes other than the problem at hand (Malhotra, 2007). Primary data is typically gathered in such ways as observations, experiments, surveys, and interviews, depending on the research design/approach adopted for the study (Ghauri & Grønhaug, 2005). Secondary data essentially includes data from government publications, personal records and censuses which provide information which may have been collected for other purposes (Malhotra, 2010). In line with the research design, the study employed primary sources of data for the data collection since it was relevant to get information directly from clients on their opinions and perceptions regarding factors that drive their patronage of hospital services.

The study employed the survey approach via a structured questionnaire. The questionnaire was self-administered and was considered appropriate particularly because the researcher wanted to test relationship between variables using the quantitative approach, and also because it is usually cheaper especially when data collection involves large sample size. According to Saunders et al. (2009), the standardized nature of self-administered questionnaire makes it more suitable relative to other methods of data gathering. Peterson (2000) points to the ease and simplicity to tabulate and analyze as an upside of the use of questionnaires. Smith and Albaum (2005) also opine that it offers reliability as a result of the framework of fixed alternatives. However, considering certain downsides associated with questionnaires, such as misconstruction and misinterpretations and

restriction of respondents to select options which may not be the exact representation of the real situation, the questionnaire was pre-tested following the recommendation of DeVellis (2003) in order to minimize the errors associated with written questionnaires by allowing respondents to seek clarification regarding questions and to evaluate their understanding of the research area. The next section discusses in details the questionnaire design for the study.

4.7.1 Questionnaire Design and Administration

Based on the research questions and the objectives of the study, questions were developed following the procedures outlined by Malhotra and Birks (2007) for designing survey questionnaires. The initial activity was a careful synthesis of the literature in areas relevant to the current study from which certain concepts in the current research model were drawn. The subsequent activity entailed the development of new construct variables and their measurement items based on the literature that underpins and supports these concepts and variables. Consequently, a foremost draft of the questionnaire was designed followed by a pretest involving twenty (20) MBA students of the University of Ghana Business School. The pre-test sample was guided by the suggestion by Fink (in Saunders et al., 2007) that the minimum of ten (10) members for pre-testing is adequate. The pre-test was carried out with focus on the content, wording, sequence and question difficulty in order to determine the practicality, suitability and reliability of the questions, and to eliminate ambiguity after which final revisions and discussion with the supervisor were made with respect to phrasing and clarity of measurement items.

The first section of the questionnaire captures demographics (such as gender, age, educational qualification, occupation and monthly income) and other general information pertaining to

consumer patronage. The second section examined issues pertaining to respondents' perceptions of branding activities of the hospitals which focused on four major factors; brand elements, quality of medical personnel, tangibles and critical service lines; and also hospital brand image perceptions and revisit intentions which were all informed by the conceptual framework for the study.

Regarding the constructs in the framework of this study, brand elements was measured with five items adapted from O'cass and Grace (2004) as well as Vuong et al. (2012;). Quality of medical personnel was measured with four items drawn from literature (Andaleeb, 1998; Kay, 2007; Chahal and Bala, 2012). The tangibles construct used in this study was measured with six items, based on a mix of the work of Chahal and Bala (2012) and modification of the tangible dimension of the SERVQUAL instrument (Parasuraman et al., 1991) to better reflect the hospital setting. Additionally, critical service lines scales were generated by the researcher from the literature (Abodurin et al., 2010; Dubey and Sharma, 2013; Singh and Shah, 2011) and measured with three items. Furthermore, the brand image construct was measured using four items drawn from the literature (Kim et al., 2008; Wu, 2011). Moreover, the repeat patronage construct was measured by 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 Yousapronpaiboon and Johnson (2013) as well as Kim et al. (2008). Consisting of a total of 25 items, all of the variables were measured on a 5-point likert scale with "5" as "strongly agree" and "1" as "strongly disagree".

The researcher visited the premises of the selected hospitals and after seeking the approval of the appropriate hospital authorities (administrators, managing directors and public relations officers) stood at the outpatient departments and also walked around the premises in order to get a more representative sample of the target population. Within the premises, the researcher approached persons who had experienced the hospitals services and sought their consent to help fill a questionnaire by explaining to them the purpose of the study, which is to ascertain their perception about the hospital, and factors that drive their patronage of the hospitals. This lasted between the periods of 13th April and 15th May 2015.

4.7.2 Population, Sample and Sampling Technique

Target population of a study is the collection of elements or objects that possess the information sought by the researcher and about which inferences are made (Malhotra, 2007). According to Salant and Dillman (1994), a requirement to sample selection is to define the target population as narrowly as possible. Defining the sample population helps focus the research and puts the findings and recommendations of the study into a comely perspective for the intended audience. On the basis that knowing the true population may not always be plausible, Attewell and Rule (1991) suggest the use of theoretical sample. Theoretical samples purposively select cases that display desired features of prime relevance to the study. Hence the target populations for this study encompassed clients of secondary-type public and private hospitals within the Accra Metropolis. In the absence of a credible database that explicitly list the hospital by facility types, 6 secondary hospitals were contacted to partake in the study out of which 4 hospitals were used for the study on the basis of willingness. The rationale behind the choice of facility types is that most secondary hospitals within Accra, offer some specialist services (which holds some

relevance to the study) alongside general services whereas primary facilities typically offer general services. Furthermore, tertiary hospitals were excluded due to their complex nature (teaching and referral centers) and the chances of responses being skewed since only one of the four tertiary hospitals in Ghana is located within the Accra Metropolis. The choice of Accra for the study is strategic in that with a population of about 3.5 million, Accra is the nation's capital and the most populous city. Accra has 326 health facilities with 69 hospitals, of which 55 (representing 79.7 percent) are private for profit hospitals.

In researches with interest in a small group, there is the plausibility to gather and analyze data from every member of the target population. Nonetheless, most studies (such as the current study) employ sampling procedures because the group of interest is typically large; containing too many cases which makes it unfeasible to collect data from all of them (Malhotra, 2010). There are two general categories of sampling techniques; probability and non-probability sampling. The former is often associated with survey and experimental research strategies; and the latter though more generally used in case study research, is employed by some scholars in quantitative studies especially when the sample to choose from seems larger (Saunders et al, 2009). In probability sampling, each element in the sample frame has an equally known possibility of being included in the sample, which allows researchers to answer research questions and to achieve purposes that require them to estimate statistically the characteristics of the population inferred from the sample (Saunders et al., 2009).

In direct contrast, is non-probability sampling, in which the possibility to make valid inferences about the population is limited. All non-probability samples rely on personal judgments somewhere in the process, which implies that samples gotten using non-probability sampling techniques are not necessarily representative of the entire population but generalizations may still be made about the population (Malhotra, 2010). Non-probability sampling can be classified under techniques such as quota, purposive, snowball and convenience sampling. Quota sampling involves selection of cases within strata that are entirely non-random (Saunders et al., 2009). Purposive sampling involves selecting cases based on the researcher's judgment. Snowball sampling involves randomly selecting initial respondents who provide referrals for subsequent respondents (Malhotra and Birks, 2007), and convenience sampling involves selecting indiscriminately those cases that are easiest to obtain for a sample (Saunders et al., 2009). The current study intends to gather responses from hospital clients and since the population is large, using non-probability sampling was deemed suitable. Data for this research was obtained from clients of four (4) secondary-type private and public hospitals within the Accra Metropolis using specifically, a combination of convenience and purposive sampling techniques since proportionality was not the primary concern and availability of respondents was rather considered a priority in the questionnaire administration.

According to Malhotra and Birks (2007), several qualitative and quantitative considerations are involved in sample size determination. Research scholars including (Burns, 2000; Gray, 2009; Hair et al., 2009) recommend from a quantitative perspective that researchers use large sample sizes as much as possible. Hair et al. (2006) consider sample sizes of 100 and above appropriate for quantitative studies. According to these scholars, large sample sizes increase the chances that

the mean, percentages and other statistics will reflect the actual estimates of the population. Malhotra and Birks (2007) also submit that large sample sizes allow for the effect of randomness and reduced chances of errors as the sample size increases. Accordingly to achieve accuracy, it is of import to use a large sample size in a survey study and so response were elicited from a total of 318 clients of 4 hospitals (consisting 2 private and 2 public hospitals) and were considered an appropriate sample size based on the aforementioned recommendations.

4.7.3 Mode and Instrument for Analysis

This study adopted a deductive method of analysis since the hypotheses tested were based on a review of extant literature on branding, service branding, healthcare service quality/management and healthcare brand equity. The units of analysis in this study were clients of the selected hospitals thus agreeing with the literature that customers represent the final consumers of brands and purposes served by brands are better reflected from their perspective. The analytical instrument used in this study is the Statistical Package for Social Sciences (SPSS), version 22.0. An initial data screening was carried out on each of the variables for inconsistencies such as missing or wrongly input scores and out of range scores to be rectified.

The study employed descriptive statistics, and multivariate data analysis such as factor analyses and multiple regression models. Following Pallant's (2011) suggestion, data was foremost subjected to descriptive analysis using measures of central tendency such as mean. An exploratory factor analysis was subsequently performed to check for internal consistencies among the variables used. In order to establish and test the relationship between the main constructs in

the conceptual framework and that the objectives stated in the study are achieved, a multiple regression analysis was employed given that the study involved four main independent variables (Brand Elements (BE), Quality of Medical Personnel (QMP), Tangibles (TAN) and Critical Service Lines (CSL)) with two dependent variables (Repeat Patronage (RP) and Brand Image (BI)). Multiple Regression analysis was deemed appropriate for this survey because according to Malhotra and Birks (2007), it represents techniques that can be used to explore the relationship between one continuous dependent variable and a number of independent variables by determining how well a set of variables are able to predict a particular outcome; which variable among the set is the best predictor of an outcome; and whether a particular predictor variable is still able to predict an outcome when the effects of another variable are controlled.

4.8 Reliability and Validity

Reliability denotes the extent to which a scale is free from random error (Pallant, 2011). According to Hair et al. (2006), reliability is considered as the assessment of the degree of consistency between multiple measurements of a construct. Among the several approaches for assessing reliability, internal consistency and test-retest (temporal stability) are the most generally used (Malholtra and Birks, 2007; Hair et al., 2009). The test-retest reliability calculates the correlation between two scores obtained after a scale is administered to the same group of people at different times; and internal consistency is the degree to which the items that make up the scale are all measuring the same underlying element (Malhotra and Birks, 2007). The most frequently used indicator of reliability is Cronbach's alpha (Cronbach, 1951), which Ghauri and Gronhaug (2005) suggest can be considered as a measure of the inter-correlations between the various items used to represent the construct. Calculated Cronbach alphas should not be less than

0.70 in order to exhibit an acceptable reliability; however, in exploratory research, the value might decrease to 0.6 (Hair et al., 2009). In other words, though the generally accepted lower limit for Cronbach's alpha values is 0.7, literature backs values that are greater than 0.50 as acceptable for exploratory research (Peterson 1994; Hair et al., 1998). In this study, Cronbach's alpha is employed to test and confirm the reliability of the research instrument. Evidence reliability measures are presented in chapter 5.

The validity of a scale refers to the degree to which it accurately measures what it represents or the construct it is intended to measure (Hair et al., 2009) and is a significant gauge in assessing the quality of a research by checking and verifying the quality of the data and the results (Creswell & Plano Clark, 2007). The main categories of validity identified in the literature are - content validity, criterion validity and construct validity (Ghauri & Gronhaug, 2005; Malhotra, 2007; Streiner and Norman, 2008). In this study, content validity was used to confirm the research instrument. Content validity sometimes referred to as face validity, is a subjective but also a systematic evaluation of how well a scale represents the measurement task at hand (Malhotra and Birks, 2007). Heeding the suggestions of some scholars that a simple test for face validity is to ask for the opinion of others conversant with the actual topic (Ghauri and Gronhaug, 2005); and pre-test of measuring instrument can likewise be employed in checking content validity (Hair et al., 2009), the questionnaire was reviewed by the research supervisor and pre-tested among students of the University of Ghana Business School as stated in earlier sections of the chapter.

4.9 Ethical Consideration

Ethical issues are important considerations in every research (Malhotra and Birks 2007) and on such premise, the researcher sought the permission and approval of the hospitals before contacting the respondents; and the aims and objectives of the study were made known to the hospitals as well as the respondents through introductory letters and personal explanations. Given that clients of hospital are mostly those compelled by sickness and injuries, it was considered inappropriate to target inpatients as they were considered vulnerable and may not be in the right frame/state of mind to provide accurate responses, as such responses were elicited from outpatients. Participants were neither coerced nor persuaded by any means but were instead encouraged to willfully participate and the researcher ensured that personal or demographic information were kept confidential. Participants (both hospitals and respondents) were as well assured of the fact that the study is solely for academic purposes with no ulterior motives.

4.10 Chapter Summary

The above discussions have cogently established the research design used for this study. It has also described the methods used in the development of questionnaire, selection of respondents, and collection and analysis of data. The major analytical methods used in this research were suitable and the assumptions required for their use were supported thus, the next chapter presents the analysis of the empirical data collected.

CHAPTER FIVE

DATA ANALYSIS AND DISCUSSION OF FINDINGS

5.0 Introduction

Following from the previous chapter, which discussed the research methodology for this study, this chapter deals with the output and presentation of the analysis of the empirical data collected through self-administered questionnaires on clients of hospitals in Ghana. The chapter provides preliminary discussions on profile of the sample hospitals, demographic profile of respondents, reliability of the various scale items and the descriptive statistics. It further presents the results of multivariate analysis to establish the relationship between the predictor and outcome variables of this study.

5.1 Overview of Sample Hospitals

37 Military Hospital

The 37 Military Hospital is a public specialist hospital and the largest military hospital in the Republic of Ghana after the Korle-Bu Teaching Hospital. Situated in Accra, about 4km from the Accra International Airport on the main Airport-Accra-central Road, the 37 Military Hospital is very accessible by vehicle. In 2011, the Ministry of Health donated GH ₵230,000 of medical supplies to the hospital to enable it to continue treating an increased number of patients. Overall, the hospital has about 400 beds, a 24-hour accident and emergency, and pharmacy department and X-ray facilities. The hospital has been organized into working units or sub-units, which has created a good standard of structure within the facility. The Divisions and Departments (the units) are developed and joined according to medical, paramedical and administrative lines and each of these units has its own departmental head.

Nyaho Medical Center

Nyaho Medical Center was established in March 1970 by the late Dr. Kwame Nyaho Tamaklo with the singular purpose of starting a modern private hospital, equipped to provide the highest standards of health care services to the Ghanaian general public. As the first private group medical practice established in Ghana, Nyaho Medical Center has been in operations for over 40 years. Presently, Nyaho Medical Centre operates with over 30 different specialists alongside six (6) full-time general practitioners. Nyaho Medical Centre provides Out-Patient, In-Patient and Paramedical and Ambulance Services. The Centre has a 32 bed In-patient department and has also recently added an Express Medical Service (EMS) for clients wishing to be seen immediately upon arrival. The Centre also provides 24-hour service for Pharmacy, Laboratory and Medical Imaging and ambulance services. In 2011, Nyaho Medical Center received the Ghana Customer Service award for excellence customer service. The Centre continues to make important strides in the arena of quality healthcare delivery as it pursues its vision of giving the best in medicine and nursing care.

Ridge Regional Hospital

Ridge hospital is the Greater Accra regional hospital located at North Ridge in Accra, Ghana. The hospital, which was built in 1928 and has kept running ever since because of a 'culture of maintenance', is currently undergoing a refurbishment/ reconstruction in line with Government of Ghana's quest to provide every Region in Ghana with an ultra-modern secondary level referral Regional Hospital. The project is expected to be completed in 2016, and is being financed with Government of Ghana mixed credit facility of 250 million US dollars from Exim Bank and the HSBC Bank. The rehabilitation works is expected to provide the hospital with ultra-modern

facilities and a 420-bed capacity (increasing it to a 620-bed capacity) to improve quality and expand access to health care delivery, particularly to its immediate catchment area. The Hospital is designed to contain components, such as the Civil, mechanical and electrical works for covering a comprehensive Diagnostic and Treatment block to ensure a 24- hour surgical service.

Del International Hospital and Fertility Center

Del International hospital is an ultra-modern hospital providing varying in-patient and outpatient services to the Accra Metropolis in Greater Accra Region, Ghana. Located in East Legon, the hospital is about 30 minute drive from the Kotoka International Airport. Del International Hospital was birthed on June 6, 2011 and in June 2013, DEL Hospital celebrated two years of operation with the commemoration of a new hospital block with state of the art facilities which includes: Catheter Laboratory Operating Theatre (Heart/Plastic & Cosmetic), Optical Services/ Optometry Department, Dental Services Department, and CT-Scan/X-Ray Department. The hospital provides diagnostic services, general consultation, general surgery, maternity and child welfare services and IVF (In Vitro Fertilization) services. The hospital also offers a 24-hour ambulance, pharmacy and laboratory services.

5.2 Demographic Profile of Respondents

This section takes a look at the biographic data of the respondents that participated in the research. Respondents for the study have been profiled according to gender, age grouping, educational qualification, average monthly income and time length of patronizing hospital. The table below provides the results of the demographic statistics obtained from the study.

Table II – Demographic Profile of Respondents

Profile	Measurements	Frequency	Percent
<i>Nature of hospital</i>	Public	188	59.1
	Private	130	40.9
<i>Gender</i>	Male	151	47.5
	Female	167	52.5
<i>Age</i>	Below 18	25	7.9
	18-28	124	39.0
	29-39	75	23.6
	40-50	63	19.8
	Above 50	31	9.7
<i>Educational Qualification</i>	SHS and below	76	23.9
	Professional	84	26.4
	Graduate	127	39.9
	Postgraduate	31	9.7
<i>Occupation</i>	Unemployed	62	19.5
	Salaried	166	52.2
	Employee	74	23.3
	Self Employed	16	5.0
	Pensioner	16	5.0
<i>Monthly income</i>	Below 500	91	28.6
	500-1000	111	34.9
	1100-1500	50	15.7
	1600-2000	24	7.5
	Above 2000	42	13.2
<i>Length of patronizing hospital</i>	Less than 1 year	24	7.5
	1-2 years	78	24.5
	3-5 years	143	45.0
	6-10 years	49	15.4
	Above 10 years	24	7.5

N =318

In terms of gender, the females represented in the sample slightly outweighed the males; there were 47.5 percent of males and 52.5 percent of females. Regarding age, the lowest number of respondents (7.9%) were below 18 years followed by 9.7% who were above 50 years. However, 39 percent, 23.6 percent and 19.8 percent were within the age brackets of 18-28, 29-39 and 40-50 respectively; an indication that respondents within 18-28 years were the dominant age group

within the sample. With respect to educational qualification, majority of the respondents (76%) had more than secondary education which signifies their ability to comprehend and provide accurate responses to questions. On the basis of occupation, table II shows that more than half of the respondents surveyed were salaried workers (52.2%) with very few being self-employed (23.3%) and unemployed (19.5%). Furthermore, the income levels signify that because majority of the respondents were employed either as salaried workers or self-employed, a lot of them (71%) earn monthly incomes between GHC 500 and above GCH 2,000 with a few earning below GHC 500.

In addition to these demographic factors, the nature of hospitals patronized by these respondents and the time-length of their patronage were also presented. As indicated in table II above, the public hospitals had the highest representation of 59.1% as against 40.1% for the private hospitals. It is worth mentioning that responses were obtained from respondents on the bases of availability and willingness to participate in the study with no biases toward any hospital type. Concerning the time-length of patronage of respondents, 45% of them have availed the services of the hospitals between 3-5 years, 24.5% have patronized the hospitals between 1-2 years, 15.4% have been clients of the hospitals between 6-10 years and 7.5% have been visiting the hospitals for 10 years and above and below 1 year. In the researcher's view, these descriptions signify that a large chunk of the respondents have been clients of the hospitals for a long time and could make judgments on the issues being studied and provide accurate responses to questions asked.

5.3 Descriptive Statistics

For research involving human participants, scholars suggest the need to first subject the data to descriptive analysis before any further data validation and analysis (Malhotra and Birks, 2007; Hair et al., 2010; Pallant, 2011). These descriptive statistics include the mean, standard deviation, range of scores, skewness and kurtosis. The table below displays the descriptive statistics of the variables used in survey instrument particularly based on mean results of the scale variables. Since the questionnaire were scaled 1-5 (from strongly disagree to strongly agree with 3 being neutral), the mean values here indicate the extent to which the respondents disagreed or agreed with the statements in the questionnaire. From the table the highest mean was 4.2201 (I will recommend this hospital to friends and relatives) while the lowest was 3.6667 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). The 25 variables displayed in Table III below represented the components of the constructs depicted in the conceptual framework for the study.

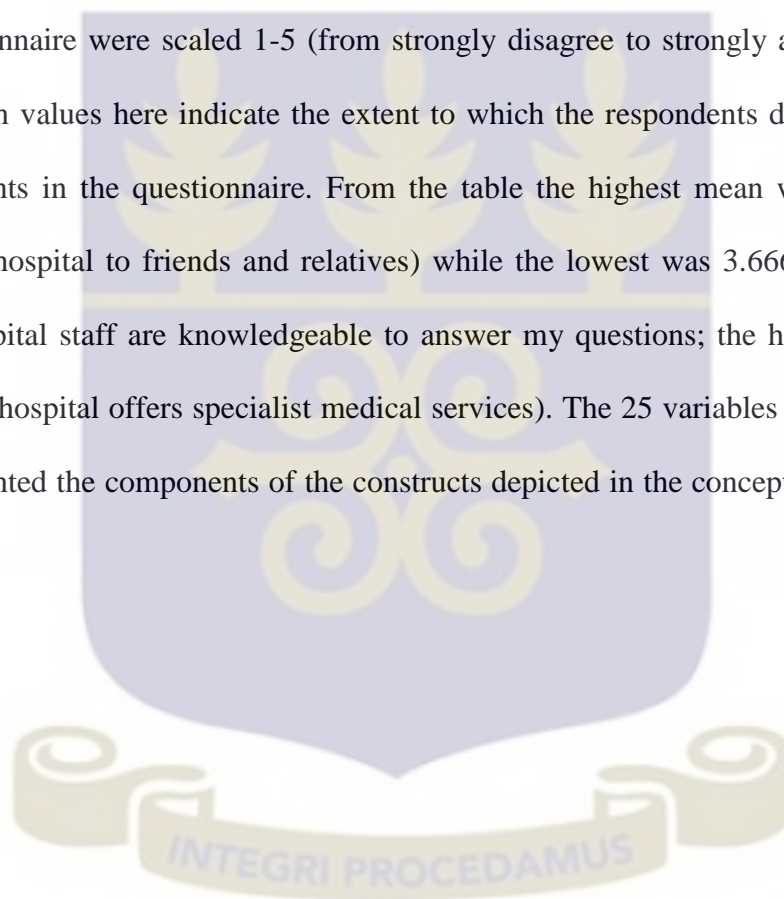


Table III – t test (descriptive statistics)

Variables	Code	N	Mean
The name of this hospital is unique and easy to recall	BE1	318	3.7862
The hospital's name tells me what services to expect	BE2	318	3.7516
There well-positioned signboards which provide easy directions to this hospital	BE3	318	3.9371
Signs and written directions within the hospital premises ease way-finding	BE4	318	3.8868
Signposts and brochures have adequate information on the hospital services	BE5	318	3.8805
This hospital has competent medical staff and specialists for services offered	QMP1	318	3.8019
Health problems are accurately identified by clinicians	QMP2	318	3.7421
Hospital staff are knowledgeable to answer my questions	QMP3	318	3.6667
Medical staff at the hospital provide services right the first time	QMP4	318	3.7736
The physical facilities of the hospital are visually appealing	TAN1	318	3.7642
The hospital is furnished with modern medical equipment	TAN2	318	3.7233
There are adequate stocks of medicine in this hospital	TAN3	318	3.6698
The waiting room is well-designed and provides relaxation	TAN4	318	3.6950
The hospital has a good parking area	TAN5	318	3.6667
Hospital premises, rooms and washrooms are usually clean	TAN6	318	3.7547
This hospital offers basic medical services to patients	CSL1	318	3.8333
The hospital offers specialist medical services	CSL2	318	3.6667
Hospital provides support services (e.g. pharmaceuticals, diagnostics, etc.)	CSL3	318	3.8208
The hospital has a positive image in my mind	BI1	318	3.9025
There is an array of medical services at this hospital	BI2	318	3.9025
This hospital has competent personnel	BI3	318	3.8836
The hospital offers reliable medical services	BI4	318	3.9686
I will always visit this hospital for all my treatments in the future	RP1	318	4.0535
I will visit this hospital for different medical purposes	RP2	318	3.9969
I will recommend this hospital to friends and relatives	RP3	318	4.2201

5.4 Exploratory Factor Analysis

The 25 items used for the scales for the constructs were factor analyzed and subjected to principal components analysis (PCA) using SPSS version 22. Prior to performing PCA, the suitability of data for factor analysis was assessed. Inspection of the correlation matrix revealed the presence of many coefficients with acceptable values of 0.3 and above. The Kaiser-Meyer-Olkin (KMO)

value was .937, exceeding the recommended value of 0.6 (Kaiser, 1974) and Bartlett's Test of Sphericity (Bartlett 1954) reached statistical significance (Approx.: Chi-square= 4548.375, df. 496, sig. 0.000), supporting the factorability of the scale variables. The principal components analysis also revealed the presence of six components with eigenvalues exceeding 1. The six-component solution altogether explained a total of 69.38% of the variance, with the highest component contributing 32.64% and the lowest component contributing 4.26%.

5.4.1 Rotation and reliability of the EFA

To aid in the interpretation of these six components, a combination of Orthogonal (Varimax) and Oblique (Direct Oblimin) methods of rotation were performed on the 25 variables to examine the number of strong loadings and ascertain the specific variables which loaded substantially onto the various components. Particularly for social (consumer-based) research, the variable loadings for exploratory factor analysis are considered high if they are all .5 or greater to be retained for analysis (Velicer and Fava, 1998; Hair et al., 2010). On the basis of this, variables which failed to meet the .5 loadings were dropped from further analysis. This resulted in 19 new variables measuring the constructs. A further assessment of the internal reliabilities (which evaluates the extent to which measurement reproduces consistent results particularly if the process of measurement is to be repeated) of the remaining 19 construct variables was conducted (Malhotra and Birks, 2007). Substantiating the essence of reliability, Pallant (2011) postulates that the scales used for analysis should be checked for reliability to ensure that the items that make the scale "hang together" (i.e. internal consistency). The most commonly used indicator of internal consistency, Cronbach's alpha coefficient, was employed to check the reliability of the scales used for this survey. Researchers such as Pallant (2011) and Hair et al (2010) admonish that ideally this value should be greater than 0.7 for managerial decisions although a threshold level

of 0.6 could be used in exploratory research. As a result, the internal reliabilities of the construct variables were assessed using Cronbach's coefficient alpha. Only factors that meet the minimum value of 0.6 as postulated by (Hair et. al, 2010) were accepted. Also, in order to test the value of the variables that loaded onto the factors, item-to total correlation was set above 0.3 (Parasuraman et al, 1988; Tabachnick and Fidell, 2007). On the basis of these rules, Factor 1 had five items and were related to tangibles; factor 2 had four items all relating to brand elements; factor 3 had two elements all related to repeat patronage; factor 4 had four items all relating to brand image; factor 5 and 6 both had two items each, all relating to quality of medical personnel and critical service lines respectively. Table IV below presents a comparison of the Principal component extraction of the various rotation methods as well as the internal consistency measures on the final retained variables of the various constructs.

Table IV: Rotated Component Matrix and Internal Consistencies

Items	Variables	Principal Component Loadings			Internal Consistencies		
		Orthogonal (Varimax)	Oblique (Direct Oblimin)	Variance Explained	Cronbach's Alpha	Item-total Correlation	Alpha 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	RP1	.664	.664	77.685	.713	.554	-
	RP3	.705	.690			.554	-
Factor 4	BI1	.723	.679	60.779	.784	.629	.710
	BI2	.673	.652			.568	.742
	BI3	.720	.701			.592	.731
	BI4	.547	.504			.575	.740
Factor 5	QMP1	.698	.683	77.629	.711	.553	-
	QMP3	.707	.681			.553	-
Factor 6	CSL1	.745	.777	77.844	.715	.557	-
	CSL3	.803	.858			.557	-

Extraction Method: Principal Component Analysis. **Rotation Method:** Varimax and Direct Oblimin.

The above table indicates the final retained variables which emerged out of the preliminary exploration of the measuring items for the constructs. The rationale for reducing an initial pool of 25 measurement items included in the questionnaire for the testing the conceptual framework has been explained in the EFA above. Following from this, 19 items out of the original 25 items remained for further analysis. These were computed to represent the various constructs that they measured in the conceptual framework. The final scales used to measure Tangibles, Brand Elements, Quality of Medical Personnel, Repeat Patronage, Brand Image, and Critical Service Lines, are assessed thoroughly alongside their measurement properties. Internal consistencies have also been checked using the Cronbach's Alpha and item-to-total correlation values.

5.5 Multiple Regression Analysis

In order to assess the propositions made earlier in this research, a series of multiple regression analyses were performed. These were done to test and validate the stated hypotheses of the study. Results from the multiple regressions were used to analyze the relationship between healthcare branding factors, brand image, and repeat patronage among hospital clients. This was done to extract the independent variables that can better explain the dependent variables. In the first regression, the factors of healthcare branding were used as the independent variables whilst repeat patronage was the dependent variable. However in the second regression, brand image was the dependent variables whilst the healthcare branding factors were still maintained as the independent variable. The final regression had brand image as the independent variables and repeat patronage as the dependent variable. Table V provides the graphical presentations of the regression analysis.

Table V: Multiple Regression Analysis Results: Healthcare Branding Factors & Repeat Patronage

		S. E	B	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

Table VI: Multiple Regression Results for Healthcare Branding Factors and Brand Image

		S. E	β	t	Sig.
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

Table VII: Multiple Regression Results for Brand Image and Repeat Patronage

		S. E	β	t	Sig.
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

^a Dependent variable: Repeat Patronage^b Dependent variable: Brand Image^c Dependent variable: Repeat Patronage

The results from the regression indicate that there is a strong and significant reliability between variables used for the six constructs. The first model had ($F = 30.326$, Prob.F-stats <0.05); the second had ($F = 65.657$, Prob.F-stats <0.05) whereas the third had ($F = 235.089$, Prob.F-stats <0.05), all confirming significant reliabilities of constructs (see Costello and Osborn, 2005; Field,

2005). The R-Square value in the model summary depicts the degree of variance in the dependent variable which is explained by the independent variables. From the first regression model, the R-squared of .519 gives an indication that the factors of healthcare branding (Tangibles, Brand Elements, Quality of Medical Personnel, and Critical Service Lines) explain 51.9% of the variance in Repeat patronage. In the second model the same healthcare branding factors explained 65.6% of variance in customers' perception of hospital brand image. In the final regression model, perceived brand image explained 52.7% of the variance in customers' repeat patronage of hospital services.

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 repeat patronage ($\beta=0.247$, $t=4.144$, $P=0.000 < 0.05$); the second was Critical Service Lines ($\beta=0.179$, $t=3.347$, $P=0.001 < 0.05$) while the third was Tangibles ($\beta=0.182$, $t=2.733$, $P=0.007 < 0.05$). Although Brand Elements was positively related to repeat patronage, it was statistically insignificant ($\beta=0.082$, $t=1.475$, $P=0.141 > 0.05$). This reveals that in the present study, the brand elements construct was not a significant contributor to consumers repeat patronage of hospital services. In the second model however, Critical Service Lines was found to be the highest contributor ($\beta=0.229$, $t=4.935$, $P=0.000 < 0.05$); the second was Brand Elements ($\beta=0.228$, $t=4.695$, $P=0.000 < 0.05$); the third was Tangibles ($\beta=0.267$, $t=4.601$, $P=0.000 < 0.05$) while the fourth was Quality of Medical Personnel ($\beta=0.177$, $t=3.416$, $P=0.001 < 0.05$). Here, all the healthcare branding components were positively and significantly related to perceived brand image of hospitals. The third model looked at the regression between perceived brand image as an independent variable and repeat patronage as a dependent variable. The statistical results revealed a very strong positive and significant relationship between the two factors ($\beta=0.653$, $t=15.333$,

$P=0.000 < 0.05$). Thus, for clients of hospitals in Ghana, the perceived brand image of a hospital plays a major role in their patronage of hospital services. The results from the regressions reveal some findings to be discussed in relation to extant empirical works.

5.6 Summary of Hypotheses Tests

Results regarding the relationship between the variables in the study signify that not all the hypotheses stated were confirmed. Table VIII below summarizes the results of the hypotheses tests.

Table VIII – Summary of Hypotheses Tests

	Hypotheses		Hypothesized effect	Findings
Brand Elements	---->	Repeat Patronage	+	Unconfirmed
Quality Medical Personnel	---->	Repeat Patronage	+	Confirmed
Tangibles	---->	Repeat Patronage	+	Confirmed
Critical Service Lines	---->	Repeat Patronage	+	Confirmed
Brand Elements	---->	Brand Image	+	Confirmed
Quality Medical Personnel	---->	Brand Image	+	Confirmed
Tangibles	---->	Brand Image	+	Confirmed
Critical Service Lines	---->	Brand Image	+	Confirmed
Brand Image	---->	Repeat Patronage	+	Confirmed

5.7 Discussion of Findings

The focus of this study was to investigate the extent of relationship among healthcare branding (comprising four constructs), repeat patronage and brand image. Result demonstrates both direct and indirect influences of healthcare branding on repeat patronage. Evident from the analysis, all the healthcare branding factors (quality of medical personnel, tangibles and critical service lines) except brand elements have a positive and significant relationship with repeat patronage in healthcare. Furthermore, all four healthcare branding factors have a significant positive relationship with brand image and so does brand image with repeat patronage. These are

subsequently discussed in relation to existent literature surrounding the areas of branding, service branding and healthcare branding.

Findings from the sampled clients in the study brought to light the fact that brand elements do not to a significant extent influence consumer patronage of hospitals in Ghana but significantly influence consumers brand image perceptions. This on the one hand is to affirm that healthcare consumers in Ghana may not avail hospitals 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. The name of the hospital often comes to mind during the consumer initial consideration of medical solution which constitutes awareness (Kim et al., 2008) but does not typically engender repeat patronage. Such views are posited by scholars such as (Kashinath et al., 2010; Kim et al., 2008) who opined that customers usually revisit hospital which are able to provide solutions to their health needs. This current finding is in contrast to previous studies (Lau et al., 2006; Reber et al., 1998)) who pointed to the ability of established brand name to preserve some form of loyalty; and Keller's (1993) view that brand names that are recognized more quickly and easily are liked more and ultimately chosen frequently. Likewise, the results in the current study are indicative of the fact that elements such as visible and easy-to-understand signs, written directions, and available consistent information on services have no significant influence on clients revisit decisions in a Ghanaian context. This finding seem conflictive with that of Bidhan et al. (2004) who postulated that healthcare facilities that leave their visitors confounded and worn-out could keep clients from revisiting.

On the other hand, the significant positive relationship found between brand element and clients' brand image perception of hospitals in the Ghanaian context confirms (Yorkston and Menon,

2004; Klink, 2001; Aaker, 1991) who point out that the name is a critical core sign of the brand which serves as the basis for awareness and an instrument that affects consumers' perceptions of a company's attributes. Kim et al. (2008) argue that patients are able to form a specific impression about any hospital within a rapid time and according to Keller (2003) the brand name can be noticed and its meaning registered or activated in memory within seconds leading to the formation of judgments. Similarly, signage which connotes issues regarding ease of way-finding both without and within hospital premises and availability of information about hospital services influence clients' hospital brand image perceptions. This agrees with (Bidhan et al., 2004; Devlin and Arneill, 2003) who are of the view that though 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 judgment.

Furthermore, Quality of medical personnel was found to significantly influence repeat patronage as well as brand image perceptions. This relates to competence of medical staff, availability of specialists for services provided and the ability of medical personnel to educate and provide answers to clients' questions (knowledgeableness). This confirms the views of (Kemp et al., 2014; Leonard et al., 2007; Andaleeb, 1998) who posit that competent care providers form an essential basis on which patients make healthcare decision. This finding is likewise in line with (Dubey and Sharma, 2013; Singh and Shah, 2011; Hall et al., 1988) who found availability of specialist's doctors as a key reason for patients' choice of hospitals and that physician task competence strongly influenced actual patient patronage decisions. In practical terms, this suggests that since healthcare is a personalized and highly sensitive service which puts patients at risk to medication, diagnosis and treatment errors; clients seeking some form of specialized

medical attention rely on the expertise demonstrated by physicians and medical personnel in the field.

Typically within the Ghanaian context, clients may form judgments about the quality of medical personnel through personal experiences which establishes confidence in the healthcare provider and keeps them coming back. The results with regard to the significant positive relationship found between quality of medical personnel and brand image is also consistent with what is in literature that the quality of personnel is of vital importance in shaping a favourable image and some level of trust for healthcare organizations and patients will generally form an impression of the level of competence of the staff as they experience various services during their hospital visit (Rao et al., 2006; Andaleeb, 1998). Essentially, any information encountered in association with a brand, can become linked to the brand name in memory and thus become part of the brand image (Keller, 2003). This may also hold true within the Ghanaian setting as hospitals herald their medical staff according to years of practice, track records and places of training etc. in an attempt to create impressions of quality and competence in the minds of clients.

Also of significance to consumer repeat patronage and perceived brand image of hospitals is the element of tangibles. This comprises visually appealing nature of the physical facilities, availability of modern medical equipment and parking area, comfort level of waiting rooms and general cleanliness of hospital premises/environment. Generally, patients derive their first impression of the hospital through the physical evidences and for healthcare consumers who are already depressed, traumatized and mostly on edge, ambient conditions, effective and well-functioning amenities could make a great deal of difference. The finding in this regard is concordant with previous studies that physical evidence (relating to clean, safe and pleasing

environment and effective facilities) communicate to customers that the hospital will provide satisfactory services. This assertion, according to previous researchers, may significantly improve patients' healthcare experience; and impact perceptions and revisit decisions (Atinga et al., 2011; Hair, 1998; Andaleeb, 1998). Findings from the current study also appear congruent with McDonald et al. (2001) that physical evidences '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 affecting clients repeat patronage of hospitals and also significantly influencing brand image perceptions. Convenience is an expectation every rational customer holds and this is likely to be amplified in healthcare where clients' are inconvenienced by sickness and injuries and their autonomy is temporarily reduced. 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' decisions. Previous studies (Abodurin et al., 2010; Dubey and Sharma, 2013; Singh and Shah, 2011) have posited that availability of a wide range of services (pharmaceuticals, laboratory) influenced patients' choice of hospitals and the impressions they form about the facility. This assertion in the literature has been confirmed within the Ghanaian context as the study's result indicated a significant positive relationship between critical service lines and both repeat patronage and brand image. The implication is that for healthcare consumers in Ghana, the array of essential services provided by hospitals is a necessary factor in their decision to revisit a health facility and in shaping their perceptions about the hospital.

The results of the study also established a significant positive relationship between brand image and repeat patronage; demonstrating that perceived brand image strongly predicts repeat

patronage of hospitals in Ghana. In the health care environment, hospital brand image is the sum of beliefs, ideas, and impressions that a patient holds toward a hospital and it's not absolute but relative to the brand image of competing hospitals (Kim et al., 2008; Kotler and Clarke, 1987). A favourable hospital image is therefore built by patients' knowledge of the hospital and trust in treatment and services which help in attracting and retaining patients (Kolade et al., 2014; Kim et al., 2008). According to some researchers (Burmam et al., 2008; Wu, 2011) 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.

In a similar vein, Chahal and Bala (2012) in their study reported that high and positive consumers' perception towards a brand reflected the preference of patients to avail the same or different medical treatments from the same hospital in future as well. Brand image is therefore, extremely relevant to healthcare providers more so in enhancing consumer re-patronage. Consistent with previous studies on brand image and hospital brand image (Andreassen and Lindestad, 1998; Esch et al., 2006; Wu, 2011), it is reasonable to posit that for clients to revisit a hospital, they must have knowledge of, encounter and interact with the hospital and develop a favourable image about the hospital. This finding conforms to previous empirical outcomes and therefore provides a concrete basis for generalization that brand image is a strong predictor of clients' repeat patronage in healthcare.

5.8 Chapter Summary

This chapter presented the results of the research findings in line with the objectives as well as research questions as discussed in chapter one of the study. Results of the quantitative analysis support the applicability of the conceptual framework presented in chapter two of the study.

Tables and suitable wordings have been used to interpret the findings of the survey to give graphical clarification.



CHAPTER SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.0 Introduction

The previous chapter presents the results of the quantitative analysis and a discussion of the results of the study. This chapter summarizes the major findings and implications of the study, draws conclusions based on the objectives of the study, and proffers recommendations for further research.

6.1 Summary of the Study

The study inquired into healthcare branding and consumer patronage in Ghana. Specifically, the study investigated the healthcare branding factors that drive consumers' patronage of hospital services, the relationship that exists between healthcare branding and consumer repeat patronage and the relationship between hospital brand image and repeat patronage. An essential rationale for the study is the increased competitive pressures healthcare facilities are experiencing and the active role consumers have taken in their healthcare choices given the abundant options and alternatives among hospitals that are available to them.

Pursuant to these objectives delineated in chapter one, the study reviewed extant literature on branding, service branding, healthcare service quality/management, patient satisfaction and healthcare branding (Davis, 2007; Keller, 2008; Atinga et al., 2011; Abousi and Atinga, 2012; Kemp et al., 2014) from which four (4) factors were identified to have influence in healthcare delivery and are cardinal to patients' perception of healthcare facilities. These factors were thus integrated into a conceptual framework for predicting hospital branding activities and patronage

among patients resulting into the formulation of applicable hypotheses. Subsequently, the study's context was discussed, providing an overview of the healthcare industry in Ghana.

A survey strategy was adopted and questionnaires were used as the instrument for data collection. The questionnaire was developed based on the theoretical framework and the objectives of the study. Three hundred and eighteen (318) outpatients of four (2 public and 2 private) hospitals within the Accra metropolis were purposively and conveniently selected as the study's sample. Furthermore, data was analyzed using descriptive statistics, exploratory factor analysis and multiple regression analysis on the bases that quantitative data analysis techniques allow for numerical representation and manipulation of data for the purpose of explaining the phenomenon mirrored by the data; and also for the testing of hypotheses and generalization of results.

6.2 Summary of Major Findings

This section concisely discusses findings from the analysis in relation to the stated objectives of the study.

Objective 1: to determine the factors of healthcare branding

This was the foremost objective of the study. The study revealed that within the Ghanaian context, critical service lines, quality of medical personnel, tangibles and brand elements are the healthcare branding factors that propel consumers to avail a hospital's services. This implies that such factors as the competence of the medical staff, the wide range/array of medical services offered by the hospital, the nature of the physical facilities such as modern medical equipment,

clean/hygienic environment or general ambience and brand elements particularly the name and signage of the hospital form the bases for consumer decision to patronize a hospital.

Objective 2: to establish the relationship that exists between healthcare branding and consumer repeat patronage

The second objective aimed at identifying the extent of association and relationship that exist between the four independent variable constructs (BE, QMP, TAN and CSL) and repeat patronage (RP) as the dependent variable. It was found from the study that all healthcare branding factors had a significant positive relationship with consumer repeat patronage except brand elements (BE) which was not a significant contributor to consumers' repeat patronage of hospital services. The reasoning here is that given that healthcare consumers in their search for medical solutions are mostly temporarily incapacitated by sickness; are considered to be at risk to medication, diagnosis and treatment errors; and are largely depressed and stressed, it makes a lot of sense that such clients would make re-patronage decisions based on such relevant factors (as quality of medical personnel, critical service lines and tangibles) which provide solutions to their needs rather than the hospital (brand) name and ease of way-finding and information availability on the hospital.

Objective 3: to examine the relationship between hospital brand image and repeat patronage

The study's findings with regard to the third objective revealed a very strong positive relationship between hospital brand image and consumer repeat patronage. This indicates the strong predictive power of hospital brand image on clients' repeat patronage of hospitals in Ghana. This seems logical because though clients may patronize hospitals based on the quality of medical

personnel, critical service lines, tangibles and brand elements, the chances of them revisiting the hospital are extremely higher if these factors result in the formation of favourable impressions and judgments about the hospital (brand image). Stated alternately, relative to competing hospitals; consumers' perceived brand image which is formed through their encounter and interaction with the hospitals' branding factors (personnel, services and facilities) bear a stronger influence on their re-patronage than the direct influence of hospital branding factors.

6.3 Conclusions

The study established that healthcare branding influences clients' re-patronage of hospitals. From the foregoing discussion and analysis so far, it is rational to conclude that, hospitals can differentiate their facilities in today's competitive and volatile business environment when they focus on the four factors (service lines, personnel, brand elements and tangibles) to ensure consumer re-patronage and general profitability. The study also established that the brand image resulting from the healthcare branding activities has a stronger influence on clients' re-patronage decisions. With the shifting competitive landscape where healthcare consumers are increasingly focusing on strong reputation as a selection criterion for hospitals and physician practices, creating a distinct brand image becomes crucial for healthcare providers. In order to be recognized, differentiated and reliable in the view of patients to maintain client patient base and to attract new ones, hospitals must build strong positive brand image.

6.4 Implications for Management and Practice

The findings of the study suggest that hospitals stand a better chance of being revisited by clients if their branding factors result in a favourable brand image perception relative to other hospitals. The inference therefore is that in order to enhance re-patronage of hospitals and gain a

competitive advantage, managers must focus on building and maintaining a strong and positive hospital brand image. Following from the significant influence of critical service lines on clients' brand image perception 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 visit 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 well available to clients and easing way-finding both without and within hospital premises via sign & written direction etc. Digital Signage is presently one of the huge trends in healthcare which can immensely boost clients' hospital experiences. Given that all through the day in hospitals and healthcare facilities, patients sit in the waiting rooms and visitors 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/ wayfinding, check-in appointments and education on hospital procedures etc.

Also of significance, is the need for hospital managers to focus on improving the status and performance of the peripheral 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 to patients' impressions. Furthermore, raising and keeping the standards of medical staff competence and practices in the hospitals is also 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.

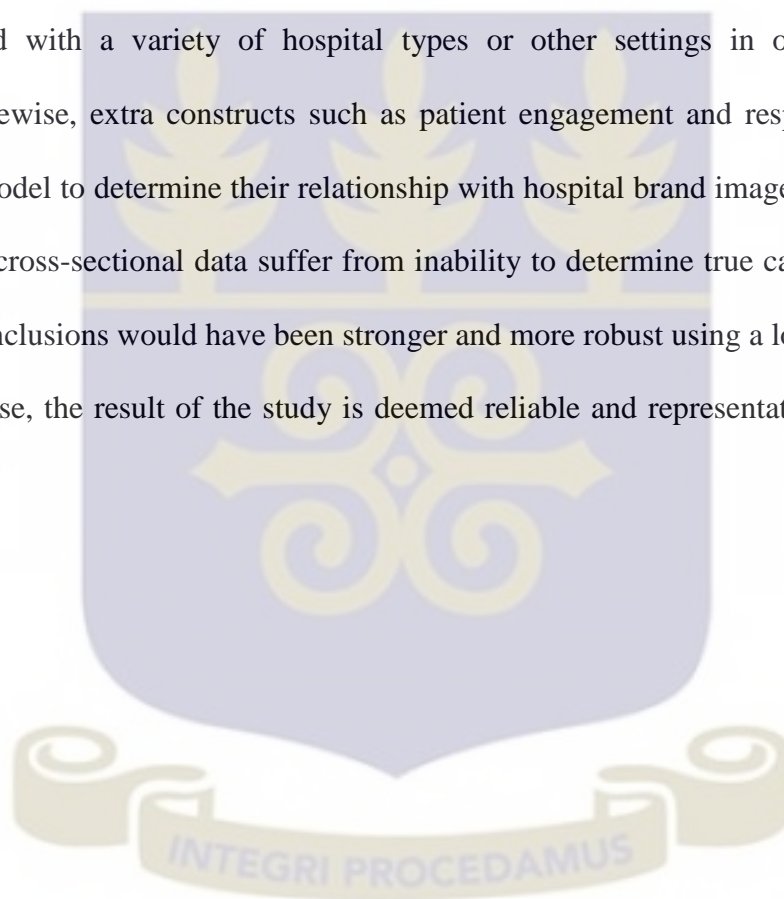
6.5 Implications for Theory

The overarching aim of this study was to establish the relationship between healthcare branding and consumer repeat patronage of hospitals in Ghana. The empirical findings were valuable in that they add significance to previous healthcare branding literature. The result found that healthcare branding influences patient repeat patronage both directly and indirectly (through brand image). The study therefore, specifically contributes a developing economy (Ghanaian) perspective to literature on healthcare branding and consumer patronage issues.

The findings in this study lend empirical grounds to assertions in the literature that a well-defined brand image for healthcare providers is an essential prerequisite to thrive and survive since they revealed that healthcare consumers in Ghana re-patronize hospitals based on the perceived brand image of the hospital. Similarly the study contributes to the service branding literature by revealing that within the healthcare domain, the service employee (medical personnel), range of services (critical service lines) and facilities (tangibles) are factors that require explicit focus to differentiate a healthcare organization.

6.6 Limitations of the study and Future Research Directions

As with any study, the present study was conducted amid certain limitations. First, 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 by surveying clients of various hospitals from other regions of the country and views of inpatients could be captured as well to provide extra insight and allow for stronger generalizability. Furthermore, the model can be replicated with a variety of hospital types or other settings in order to verify its applicability. Likewise, extra constructs such as patient engagement and response time can be included in the model to determine their relationship with hospital brand image and consumer re-patronage. Also, cross-sectional data suffer from inability to determine true causal relationships, so this study's conclusions would have been stronger and more robust using a longitudinal design. In spite of all these, the result of the study is deemed reliable and representative of hospitals in Ghana.



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APPENDIX

UNIVERSITY OF GHANA BUSINESS SCHOOL DEPARTMENT OF MARKETING & CUSTOMER MANAGEMENT

Dear Sir/Madam,

I am an MPhil marketing student of the University of Ghana Business School. This survey seeks to elicit response on the topic *“Healthcare branding and consumer patronage in Ghana.”* Information provided for the purposes of this research will be treated confidentially and used for academic purposes only. Please take a few minutes to fill out this questionnaire by ticking (✓) where appropriate. For any questions, kindly contact me via my details provided below:

Email: menscilla@yahoo.com

Section A: Background Information

Name of hospital: _____

1. **Gender:** Male Female
2. **Age:** Below 18 years 18-28 years 29-39 years 40-50 years Above 50
3. **Educational Qualification:** SHS and below Professional Graduate
 Postgraduate
4. **Occupation:** Unemployed Salaried employed Self-employed
 Pensioner
5. **Monthly Income:** Below 500 500-1,000 1,100-1,500
 1,600-2,000 Above 2,000
6. **For how long have you patronized this hospital:** Less than 1 year 1-2 years 3-5
years 6-10 years Above 10 years

Section B: On a scale of 1-5, please indicate by ticking (√), the extent to which you agree or disagree with the following statements regarding your hospital.

1=Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree

No	Statement	1	2	3	4	5
	Brand Elements (Name and Signage)					
1.	The name of this hospital is unique and easy to recall					
2.	The hospital's name tells me what services to expect					
3.	There are well-positioned signboards which provide easy directions to this hospital					
4.	Signs and written directions within the hospital premises ease way-finding					
5.	The signposts and informational handouts have adequate information on services provided by the hospital					
	Quality of Medical Personnel					
6.	This hospital has competent medical staff and specialists for services offered					
7.	Health problems are accurately identified by clinicians					
8.	Hospital staff are knowledgeable to answer my questions					
9.	Medical staff at the hospital provide services right the first time					
	Tangibles/Ambience					
10.	The physical facilities of the hospital are visually appealing					
11.	The hospital is furnished with modern medical equipment					
12.	There are adequate stock of medicine in this hospital					
13.	The waiting room is well-designed and provides relaxation					
14.	The hospital has a good parking area					
15.	Hospital premises, rooms and washrooms are usually clean					
	Critical Service Lines					
16.	This hospital offers basic medical services to patients					
17.	The hospital offers specialist medical services (e.g. ophthalmology, Ear, Nose & Throat (ENT), cardiology etc.)					
18.	The hospital provides support services (e.g. pharmaceuticals, diagnostic imaging etc.)					
	Brand Image					
19.	The hospital has a positive image in my mind					
20.	There is an array of medical services at this hospital					
21.	This hospital has competent personnel					
22.	The hospital offers reliable medical services					
	Repeat patronage					
23.	I will always visit this hospital for all my treatments in the future					
24.	I will visit this hospital for different medical purposes					
25.	I will recommend this hospital to friends and relatives					