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Original article

A Model for Health Branding Based on a Service Providers Approach

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SUMMARY

Introduction/Aim: A strong brand reduces costs, increases customer satisfaction with the quality of services and the effectiveness of services. Therefore, this study was conducted to present a model for health branding with a service providers' approach.
Methods: This qualitative-quantitative study was conducted in 2020. The statistical population of the study was selected for the qualitative stage and included 20 academic and organizational experts using the Delphi technique and the quantitative stage included 415 service providers of the staff health centers. The validity of the questionnaire was confirmed by face, content, construct validity and its reliability was confirmed by Cronbach's alpha of 0.96. Quantitative data were presented by EQS software version 6.1 with confirmatory factor analysis and using structural equations.
Results: The results of factor structure in healthcare branding based on six main themes of competitive position, brand equity, brand accessibility, brand consolidation in the minds of clients and the market, branding strategies, and consumer-brand relationship with 19 sub-themes based on the perspective of service providers (CFI = 0.9, TLI = 0.8, RMSEA = 0.08, SRMR = 0.05) had a good fit and the internal consistency of the items reached significant levels.
Conclusion: To take an effective step in health branding, one can achieve competitive advantage and provide high-quality and profitable health services with the help of service providers through adopting and strengthening competitive position, equity, accessibility, brand consolidation in the minds of clients and the market, branding strategies, and consumer-brand relationship.

Keywords: **health services, service providers, urban health centers, branding**

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INTRODUCTION

In a modern competitive environment, a good name or brand that represents the identity, credibility and reminder of all the functions of the company's interaction with customers plays an important role. In this case, the brand is now one of the main approaches in manufacturing organizations (1). Transparency of the organizational brand leads to a special type of change in the behavior of employees. If an organization is willing to gain fame, branding provides a transparent definition of the organization which leads to a better understanding of the identity and objectives of the organization, facilitates recognition and makes the organization famous. An organizational brand makes the unique aspects of the organization such as the recruitment process prominent (2). In this regard, the behavior of employees, especially voluntary behaviors when providing services can have a significant impact on customers' perception of services quality (3). Furthermore, patients' perception of the knowledge and expertise of the treating physician and nurses increases his/her confidence in the medical staff, and this confidence makes it possible to create satisfaction and a favorable image in his/her mind (4). Most commercial organizations consider targeted branding as a competitive strategy and align themselves with a specific goal or a social issue (5). In this regard, it seems that health service provider centers can increase their market share and ensure their profitability by creating personal identity through brand image (6). Since the branding of health services is different, especially in health centers and hospitals (7), and due to the importance of branding management and extraction of related value, health services of organizations should be directed towards branding initiatives based on perseverance (8). Research shows that damage to a brand's product can reduce consumer evaluation of competing brands in the same industry, known as negative effects (9), so branding of medical groups can be an effective way to create a competitive advantage and provide opportunities to attract more patients to their centers. Today, brand appearances can become irrelevant over time like changes in tastes, preferences, policies, or they can be, in terms of experience, the feeling they create (10). Many health centers provide excellent services; however, due to not being familiar with the science of marketing and not taking the topics of this science seriously, they do not have the power to become a brand and even after a while, they fall and leave the level of competition (8). A strong brand can help an organization achieve its goals, which usually include lower costs, increased customer satisfaction, and greater return on investment and profitability (11). Furthermore, companies that invest in employers' branding activities may not only attract new and valuable employees, but most of all, gain a competitive advantage in terms of the participation of their current employees (12). A study by Bastug S, Şakar G D, and Gulmez S showed that for branding, geographical location plays a significant role in the brand image (13). The findings of Dumom G and Ots M consider branding as a completely social method in which stakeholders provide three types of material, informational and symbolic resources to prepare the brand (14). Ernawaty E et al. stated that there is an effect between brand equity and the use of health services. Brand equity significantly affects patient visits (15). Odoom T et al. also introduced four dimensions of health branding including brand elements, tangibles, medical personnel quality and critical services effective in brand promotion (16). Poor branding, on the other hand, can lead to a mismatch between what the demandant expects and what is the cold and tough reality (17). Researchers believe that choosing a brand name for a product can change the consumer's judgment about the product and their purchasing decision process (18). Therefore, for the sake of provision of distinctive and quality health services by service providers and creating competition and achieving the desired position, this study was conducted with the aim of providing a model for health services branding based on a service provider approach.

MATERIAL AND METHODS

Study design

This study was conducted using a mixed-method approach in two main quantitative and qualitative phases in Iran; the research can be considered a field research whose time domain was from April 2020 to March 2021. In terms of the applied objectives, in terms of method, which is qualitative-quantitative (A mix method) and in terms of data collection, this research can be considered as a type of field research, conducted in 2020. This research was conducted in several stages.

The literature review

First, after identifying the initial dimensions by reviewing the texts for this purpose, articles published in national and international journals from January 1, 2002 to March 30, 2020 were searched and indexed in the databases of Pubmed Scopus, ISI web of Science, Springer, Google Scholar, Ebsco, ProQuest, ScienceDirect, Google, Willey, Scientific Information Database (SID), Iranmedex, and ISC. All keywords were obtained through a basic search. Then, with the help of two subject-matter experts to improve the pattern and search terms, studies related to the topic of health branding were searched based on English and Persian keywords: health services, branding, brand, health branding and due to non-compliance with the purpose of the research, studies related to branding in subjects not related to health services were excluded. In the next step, with the help of two other researchers, it was randomly shown that no study was missed. In the final step, using a list of extracted study sources, and to expand the scope of the search, a number of articles that we could not find in various databases were reviewed and entered to increase the sensitivity of the research. As a result, by reviewing the previous literature, the initial formulation of the questions for the interview was obtained. In designing the questions, in addition to reviewing the texts, the experiences of several experts in this field were also used.

Inclusion and exclusion criteria in qualitative phase

Then, the qualitative stage of interviews with experts included: 1. university experts (professors in the field of healthcare service management and business management) and 2. organizational experts (university presidents and deputy director generals of health services). The inclusion criteria in the qualitative stage were having a specialized doctoral degree, general doctorate or being a specialist with at least 5 years of experience in health organizations. Exclusion criteria were lack of sufficient information of branding and also lack of willingness and satisfaction to participate in the research process.

Qualitative phase

The interview questions were semi-structured, less specific and open-ended, and were sometimes less structured, and in-depth interviews were conducted. For example, questions were asked in the form of "what", "why", "how" and "what". Interviews were conducted individually. The order of the questions asked varied and the design of the questions changed based on the concepts and answers of the interviewee. However, we tried to start the interview with questions that the interviewee answered more easily, and we gradually came to more difficult and sensitive questions. Interview sessions were scheduled in advance and lasted from 30 to 60 minutes. Interviews were done by phone call or in person. A written consent form was also completed for participants. During the interviews, to avoid possible problems, the topics of the meetings were recorded by a tape recorder and simultaneous note-taking, and the interviews were compiled immediately after the end of each session in order to know the data saturation time and also to increase the accuracy and precision of the interview. After listening to each recorded file several times, the interview text was written and typed. In addition, since the key points of the interviewees' words and their facial expressions and non-verbal signs were recorded at the time of the interview, these points were also taken into account during the compilation of the files. Finally, in order to increase the consistency and accuracy of the data, after the end of each part of the interview implementation, the transcriptions were seen and approved by the interviewees and were reviewed. Based on experts' opinions, the main themes (competitive position, brand equity, brand accessibility, brand consolidation in the minds of clients and the market, branding strategies, and consumer-brand relationship) and sub-themes (optimal design, advertisement, innovation, variety, loyalty to clients, performance and efficiency, existing images and beliefs, justice in access, physical access, social investment, competitive advantage, individual and ethical competence of providers, providers' communication skills, training to providers, performance evaluation, provider flexibility, providing resources, patient's rights charter, and satisfaction survey) were pres-

ented and the proposed initial theoretical model was presented in a hybrid form based on a semi-structured questionnaire with 109 questions to receive expert opinions using the Delphi technique in four rounds. The questionnaire was sent in person and by email. Using Delphi technique, the questions of the questionnaire in the fourth round were saturated with 83 questions and the Delphi technique was examined after the fourth round and reaching a consensus based on statistics and Kendall's correlation coefficient.

Quantitative phase

To evaluate the face validity, a quantitative questionnaire was given to 20 experts and each question of the questionnaire was assessed in terms of importance based on a five-point Likert scale: very high (5 points for the importance of 9 - 10), high (4 points for importance of 7 - 8), moderate (3 points for importance of 5 - 6), low (2 points for importance of 3 - 4) and very low (1 point for importance of 1 - 2). After completing the questionnaires, the score for each question was calculated using the item effect relation.

To evaluate the content validity in a quantitative way, content validity coefficient and content validity index were used. The questionnaire was provided to the experts and they were asked to determine how much the questions cover the desired areas and can assess the content of the questionnaire. If there is agreement between different people on the content validity of the questionnaire, that question has content validity. Therefore, in order to check the validity of the qualitative content, a questionnaire (manually or electronically) was given to 10 - 20 specialists with at least five years of work experience and their opinions were obtained. In order to evaluate the validity of quantitative content and to ensure that the most correct and important content (question necessity) has been selected, a questionnaire was provided to the panel of experts and they were asked to rate each questionnaire in terms of necessity criteria in three ranges: "necessary", "not necessary but useful" and "not necessary". It should be noted that according to the number of expert panels, the minimum acceptable value of content validity index for this study was 0.69.

Data collection and sampling quantitative phase

The statistical population of the quantitative stage included the staff of health centers of Iran as service providers. Cluster sampling was used in this study and to determine the sample size, the country was divided into five regions (north, south, center, east and west). To determine the sample size of service providers, the number of questions was multiplied by 5; since the questionnaire included 83 questions, the sample size of service providers was determined to be 415 (83 × 5) (19), and the share of each region was 83 people (center: 83 people, north: 83 people, south: 83 people, east: 83 people, and west: 83 people). In each of these areas, based on the list of health centers throughout the country, 6 health centers were randomly selected and in each health center, on average, there were about 14 people as service providers. After obtaining the necessary permits in the quantitative stage, the researcher referred to the health centers under investigation and explained the purpose of the research to the target employees, and after obtaining informed consent and ensuring that the information about their answers remains confidential, the designed questionnaire was given to them while strictly observing the inclusion and exclusion criteria.

Inclusion and exclusion criteria in quantitative phase

In the quantitative stage, the inclusion criteria for health services providers were: working in health centers under the auspices of the University of Medical Sciences with at least a high school diploma; willingness and satisfaction to participate in the process of research and urban bases and health department and having an experience of at least 5 years. Exclusion criteria for health services providers were: unwillingness to continue cooperation and participation in research; incomplete answers to the questionnaire.

Data analysis

In addition to the questions in the main section, the subject's demographic information in-

cluding age, gender, occupation, work experience, level of education, field of study, place of residence and name of health center were also assessed. In Table 1, the number and count of items related to each of the dimensions are specified in the research questionnaire.

Evaluation of the items related to each of the dimensions was based on 5-point Likert scale (strongly disagree (1), disagree (2), neutral (3), agree (4), strongly agree (5)). To evaluate the theoretical model of branding, confirmatory factor analysis was performed with EQS software version 6.1 and the internal consistency of the items was used as the reliability of the questionnaire based on Cronbach's alpha method.

Table 1. *Items, dimensions, and Cronbach's alpha of the questionnaire in the quantitative stage of health services branding*

Row	Model dimensions	Item count	Item number	Cronbach's alpha
1	**Competitive position**	14	1 - 14	0.91
2	**Brand equity**	19	15 - 33	0.93
3	**Brand accessibility**	10	34 -43	0.88
4	**Brand consolidation in the minds of clients and the market**	18	44 - 61	0.93
5	**Branding strategies**	15	62 - 76	0.95
6	**Consumer-brand relationship**	7	77 - 83	0.91
7	**Branding of health services in total**	83	1 - 83	0.96

RESULTS

According to the research findings, 75% of the surveyed faculty experts had 5 to 15 years of work experience and 85% of them had a specialized doctoral degree. In the quantitative stage, 32% of providers had 5 to 10 years of work experience, and 55% of providers had a bachelor's degree (Table 2).

Table 2. *Frequency distribution and percentage of the demographic variables of respondents*

Variables	Frequency and percentage of providers	Cumulative percentage of experts	Frequency and percentage of experts	Cumulative percentage of providers
Gender	10 (50%) men & 10 (50%) women	50%	211 (51%) women	51%
Age	45 - 49 years 7 (35%)	65%	36 - 43 years	66%
Job	Faculty member 15 (75%)	90%	Health staff 415 (100%)	100%
Work experience	5 - 15 years 9 (45%)	45%	5 - 10 years 131 (32%)	32%
Education	Specialized doctoral degree 17 (85%)	95%	Bachelor's degree 230 (55%)	56%

Table 3. *Main and sub-themes of health services branding from the point of view of the participants in the qualitative and quantitative stage of health services branding*

Main themes	Sub-themes	CVR
Competitive position	Optimal design	1
	Advertisement	9/0
	Innovation	1
Brand equity	Variety	1
	Loyalty to clients	1
	Performance and efficiency	1
	Existing images and beliefs	1
Brand accessibility	Justice in access	1
	Physical access	1
	Social investment	1
Brand consolidation in the minds of clients and the market	Competitive advantage	1
	Individual and ethical competence of providers	1
	Providers' communication skills	1
Branding strategies	Training to providers	1
	Performance evaluation	1
	Provider flexibility	1
	Providing resources	1
Consumer-brand relationship	Patient's rights charter	1
	Satisfaction survey	1

Table 4. *6-Factor descriptive indicators of health services branding from the perspective of service providers*

Row	Variable	Mean	Skewness	Kurtosis	Standard deviation
1	**Optimal design**	26.95	-1.16	1.17	3.04
2	**Advertisement**	21.93	-0.92	0.48	2.78
3	**Innovation**	13.35	-0.97	0.41	1.72
4	**Variety**	17.54	-0.97	0.52	2.41
5	**Loyalty to clients**	13.21	-0.88	0.32	1.82
6	**Performance and efficiency**	17.21	-0.78	0.31	2.35
7	**Existing images and beliefs**	35.34	-1.54	4.22	4.54
8	**Justice in access**	13.23	-1.39	2.98	1.92
9	**Physical access**	12.86	-0.94	0.64	2.05
10	**Social investment**	16.42	-0.52	-0.11	2.65
11	**Competitive advantage**	39.6	-0.77	0.52	4.53
12	**Individual and ethical competence of providers**	22.13	-1.05	1.21	2.69
13	**Providers' communication skills**	17.43	-1.02	1.08	2.42
14	**Training to providers**	17.44	-0.84	0.57	2.26
15	**Performance evaluation**	17.4	-0.91	0.77	2.46
16	**Provider flexibility**	17.37	-0.92	0.73	2.51
17	**Providing resources**	13.47	-1.09	0.87	1.71
18	**Patient's rights charter**	18.09	-1.11	0.83	2.21
19	**Satisfaction survey**	13.19	-1.43	2.65	2.11

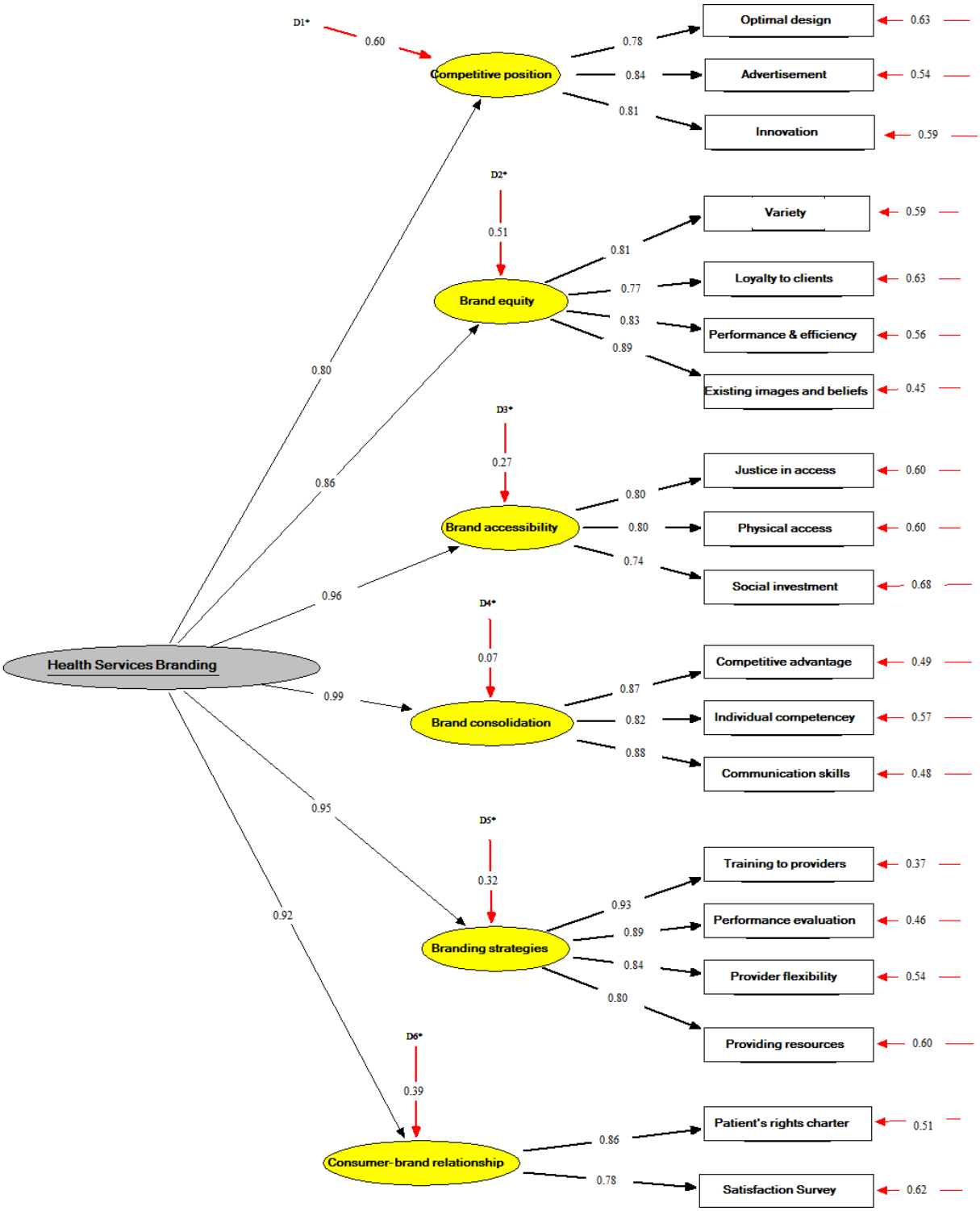

Figure 1. *6-Factor diagram of health services branding from the perspective of service providers*

Table 5. *6-Factor fit indices of health services branding from the perspective of service providers*

Variable	χ^2	Df	CFI	IFI	TLI	RMSEA (90% CI)	SRMR	Cronbach's Alpha
Competitive position	234.14	74	0.9	0.9	0.9	0.08 (0.07, 0.09)	0.05	0.91
Brand equity	583.47	146	0.8	0.8	0.8	0.08 (0.07, 0.09)	0.06	0.93
Brand accessibility	129.71	32	0.9	0.9	0.9	0.08 (0.07, 0.1)	0.055	0.88
Brand consolidation in the minds of clients and the market	361.53	132	0.9	0.9	0.8	0.065 (0.057, 0.073)	0.049	0.93
Branding strategies	413.77	84	0.9	0.9	0.8	0.097 (0.088, 0.107)	0.06	0.95
Consumer-brand relationship	56.44	13	0.95	0.95	0.9	0.09 (0.067, 0.114)	0.04	0.91
Health services branding based on the 6-factor	576.27	145	0.9	0.9	0.8	0.085 (0.077, 0.092)	0.056	0.95

In the qualitative phase, 6 main areas and 19 sub-themes of health service branding were extracted, which are shown in Table 3.

In the table below, descriptive indicators of 6-factor health services branding with 19 sub-themes related to service providers show that there is a slight degree of skewness and kurtosis, which is not great (Table 4)

Confirmatory factor analysis in evaluating the proposed theoretical model has provided an acceptable fit. As shown in Table 4, all fit indices are within the acceptance range, and the Cronbach's alpha value of the model of service providers indicates a high internal consistency of the items (Table 5). Figure 1 also shows the load factor of each item whose values are above 0.4 (Figure 1).

DISCUSSION

In health services branding, the six main themes of competitive position, brand equity, brand accessibility, brand consolidation in the minds of clients and the market, branding strategies, and consumer-brand relationship with 19 sub-themes were approved from the perspective of service providers.

The results of the study showed that the main theme of competitive position with sub-themes of optimal design, advertainment, and innovation, is an effective component of health services branding from the perspective of service providers. A study by Miller and May (20) showed that patient preferences in choosing a hospital include being famous and the number of hospital stars, providing consultation services, hospital history, good hospital design, having one bed rooms, suitable environment, good food, the existence of parking and high cleanliness standards. A study by Nazir et al. (21) on the relationship between the activities of online social networking services on brand selection and brand perception in health-related jobs showed that the activities of online social networking services have a significant impact on brand selection by customers in health-related jobs. A study by Bastug, Sakar and Gulmez (13) on the application of brand personality dimensions based on place branding model showed that for place branding, the geographical location of distinct personalities is created along with the brand image. These are in line with the findings of the present study. However, the study by Martey and Frempong (22) on the impact of celebrities on the business position of mobile telecommunications users showed that innovation is not a component of brand's competitive position. A study by Gil et al. (23) on family as a source of consumer-based brand equity showed that the shape of the product, how it is displayed, especially the price of the product, has an effect on customer reaction. These are not in line with the findings of this study. The competitive position of health centers is that a brand stays with a high brand equity in the minds of patients. This can create a special position among the many health centers for itself. To increase awareness and promotional activities in order to create a positive public image, further investment is necessary. The features of organization, innovation and creativity in providing novel services compared to competitors must be

determined and further activities must be considered regarding welfare facilities.

The results of the study showed that the main theme of brand equity with the sub-themes of variety, loyalty to clients, performance and efficiency, and existing images and beliefs, is an effective component of health services branding from the perspective of service providers. A study by Skaalsvik (24) on services branding showed that loyalty to clients affects brand equity. A study by Dalaki et al. (4) on health services branding showed that loyalty affects the brand equity. These are in line with the findings of the present study. However, the study of Zhang et al. (25) about the impact of organizational capabilities including marketing capabilities, networking capabilities and innovation capabilities on brand equity showed that marketing and networking capabilities both directly and indirectly affect the equity of the industrial brand through the mediating role of equity creation as well as customer equity. Innovation capabilities only indirectly affect the employer's brand equity by facilitating equity creation and increasing customer equity. This is not in line with the findings of this study. Brand equity is a set of specialized services and a variety of services to meet different needs that can be added to a brand. These services can lead to an increase in the equity for consuming a product and create real equity in the minds of customers.

The results of the study showed that the main theme of brand accessibility with the areas of justice in access, physical access, and social investment, is an effective component of health services branding from the perspective of service providers. A study of Muda et al. (26) on celebrity entrepreneur endorsement and the effectiveness of advertising on social and behavioral sciences showed that the use of celebrities can have a positive effect on consumer attitudes and this positive attitude can encourage consumers to buy more. This is in line with the findings of this study. However, the study by Adhikari et al. (27) on new forms of developing innovative branding ideas and foreign tenders to help Nepali mothers and children's health services showed that foreign aid to provide services to children's health projects in Nepal is increasing in their favor, not through the government system, but through intermediary organizations, using processes of branding and tender. This is not in line with the findings of this study. Easy access to health care services leads to adequate use of health services to maintain or improve health, as well as increase in the quality of life and lower inequalities in terms of health and macroeconomic growth of the country. Since people's condition affect their ability to access health care, arrangements must be made so that all service distribution policies are fair to all members of society.

The results of the study showed that the main theme of brand consolidation in the minds of clients and the market with sub-themes of competitive advantage, individual and ethical competence of providers and communication skills of providers, is an effective component of health services branding from the perspective of service providers. A study by Turan and Hoxhaj (28) entitled "Corporate Social Responsibility: Attitudes of Foreign Enterprises in Post-Communism Society" showed that the competitive advantage of companies is very important for companies to create the desired imagery in the minds and superiority in market share. A study by Toscano and Gomes (29) entitled "Hospital Branding as a strategy for differentiation: Does Hospital Branding Leverages Hospital Units in the Portuguese Market?" showed that hospital brands are expected to be more innovative in the technologies used and more likely to show a clear culture to patients. These are in line with the findings of this study. Health centers staff need to learn how to communicate effectively with patients, otherwise the acceptance of medical and health care recommendations as well as patient education will decrease, and what can pave the way for the success of a health centers is having a competitive advantage. This competitive advantage may be the brand of the health centers, the quality of services provided, etc., which in turn affects customer behavior and attitude.

The results of the study showed that the main component of branding strategies with sub-themes of training to providers, performance evaluation, provider flexibility, and providing resources, is an effective component of health services branding from the perspective of service providers. A study of Hotez (30) about building a scientific brand showed that communication skills are effective in brand building. A study of Toscano and Gomes (29) about hospital branding as a way to differentiate in the market showed that the provision of resources has an impact on hospital branding. A study of Aracil and Forcadell (31) entitled "Sustainable Banking in Latin American Developing Countries" showed that paying attention to the training of human resources and bank customers is a prerequisite for implemen-

tation of social responsibility of banks. A study of Kalińska-Kula and Staniec (12) about employer branding and organizational attractiveness: current employees' views showed that internal and external branding methods of employers directly affect the employer's attractiveness. From the perspective of current employees, internal branding, including group activities, internal communication, surveys of employees, training and development, internal hiring methods, individual performance appraisal system and external branding, including advertisement, job postings on the company website, public relations activities, and financial support, all affect employer attractiveness. These are in line with the findings of this study. However, the study by Bai et al. (32) entitled "Why Small & Medium Enterprises (SME) in Emerging Economies are Reluctant to Provide Employee Training" showed that the interest of employee in the organization is influenced by factors related to organizational culture and environment including personal and professional development, job opportunities, learning through training and workshops. This is not in line with the findings of this study. Efficient organizations have more flexibility in providing new services and special conditions such as epidemics, and can quickly react to environmental changes. In such organizations, there is a positive relationship between strategic thinking and providers' flexibility, assessment of the providers' performance, securing resources in times of market turmoil, and rapid changes in technology that can affect branding strategies.

The results of the study showed that the main theme of consumer-brand relationship with subthemes of patient's rights charter and satisfaction survey is an effective component of health services branding from the perspective of service providers. A study by Skaalsvik (24) on health services brand showed that brand communication with clients has an impact on branding. A study by Toscano and Gomes (29) on hospital branding as a way to differentiate in the market showed that patient satisfaction has an effect on hospital branding. A study by Ningsih and Segoro (33) on the effect of customer satisfaction, cost change and brand trust on customer loyalty showed that satisfaction is a unique form of the concept of quality and it is assumed to affect customer loyalty directly and will lead to repurchase. These are in line with the findings of this study. However, The study by Martey and Frempong (22) entitled "The Impact of Celebrities' Endorsement on Brand Positioning on Mobile Telecommunication Users in Ghana" showed that brand communication has no effect on branding. A study by Fan et al. (34) entitled "Impact of CSR Dimensions on Consumer Satisfaction and Brand Loyalty in the Formation of Purchasing Goals" showed that social responsibility has a positive relationship and significant impact on consumer satisfaction and their loyalty to the brand. These are not in line with the findings of this study. Establishing a long-term relationship with customers will bring many economic benefits to the organization. That's because satisfied and loyal customers will not only buy continuously from the organization, but also serve as an advertising symbol for the organization and attract customers. Providing health services as soon as possible and free of any ethnic, cultural, religious, disease and gender discrimination, having a separate reception room for clients in order to respect the privacy, providing health services to groups with special priorities, including children, pregnant women, the elderly, the mentally ill, prisoners, the mentally and physically disabled and unattended people, providing timely services and health care in a timely manner and providing welfare facilities for health centers and appropriate behavior of service providers can improve consumer-brand relationship.

Limitations of the study

One of the limitations of this research is that the results of this research cannot be generalized to other parts of providing health and medical services.

CONCLUSION

The results showed that from the perspective of service providers, 6 main themes of competitive position, brand equity, brand accessibility, brand consolidation in the minds of clients and the market, branding strategies, and consumer-brand relationship and 19 sub-themes of optimal design, advertisement, innovation, variety, loyalty to clients, performance and efficiency, existing images and beliefs, justice in access, physical access, social investment, competitive advantage, individual and ethical competence of providers, providers' communication skills, training to providers, performance evaluation, provider flexibility, providing resources, patient's rights charter, and satisfaction survey all had an impact on health services branding. By observing

patient's rights charter and conducting customer satisfaction surveys, optimal design of services, appropriate advertising and innovation in the quantity and quality of provided services, creating a competitive advantage, empowering employees and improving communication skills, etc., we can take effective steps in health services branding. In this regard, trustees and managers of health centers are recommended to plan, and innovate and be creative in providing new health services, maintain the current status of the health service branding and fill the gaps in possible branding of health centers in the country, monitor the provided services such as the quality of devices, equipment, health services, holding training classes about communication with clients and the market and teaching psychological methods of communicating with patients, so we can achieve a favorable position in competition and provide quality and profitable health services.

Abbreviations

CFA Model: Confirmatory Factor Analysis Model; RMSEA: Root mean square error of approximation; SRMR: Root mean square error; CFI: Comparative fit index; IFI: incremental fit index; TLI: Tucker Lewis index.

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Conflict of interest

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Model za brendiranje zdravlja zasnovan na pristupu pružalaca usluga

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SAŽETAK

Uvod/Cilj. Snažan brend smanjuje troškove, povećava zadovoljstvo kupaca kvalitetom i efikasnošću usluga. Stoga je ovo istraživanje sprovedeno kako bi se predstavio model za brendiranje zdravlja sa pristupom pružalaca usluga.
Metode. Ova kvalitativno-kvantitativna studija sprovedena je 2020. godine. Statistička populacija studije odabrana je za kvalitativnu fazu koja je uključivala 20 akademskih i organizacionih eksperata koristeći Delfi tehniku, dok je kvantitativna faza obuhvatila je 415 pružalaca usluga zdravstvenih centara. Validnost upitnika potvrđena je validnošću lica, sadržaja i konstrukcije, a njegovu pouzdanost potvrdio je koeficijent Kronbahova alfa od 0,96. Kvantitativni podaci predstavljeni su pomoću EQS softvera, verzija 6.1, sa potvrdnom faktorskom analizom i korišćenjem strukturnih jednačina.
Rezultati. Rezultati faktorske strukture u brendiranju zdravstvene zaštite zasnovani na šest glavnih tema: konkurentne pozicije, jednakosti brenda, pristupačnosti brenda, konsolidacije brenda u svesti klijenata i na tržištu, strategijama brendiranja; i odnosu potrošača i brenda sa 19 podtema zasnovanih na perspektivi pružalaca usluga (CFI = 0,9; TLI = 0,8; RMSEA = 0,08; SRMR = 0,05) dobro su se uklapali, dok je unutrašnja konzistentnost stavki dostigla značajne nivoe.
Zaključak. Da bi se napravio efikasan korak u brendiranju zdravlja, treba dostići konkurentsku prednost i pružiti visokokvalitetne i profitabilne zdravstvene usluge uz pomoć pružalaca usluga usvajanjem i jačanjem konkurentske pozicije, pravičnosti, pristupačnosti, konsolidacije brenda u svesti klijenata i na tržištu, strategije brendiranja i odnosa potrošača i brenda.

Ključne reči: **zdravstvene usluge, pružaoci usluga, gradski zdravstveni centri, brendiranje**