A Brand Equity Model for Healthcare Practitioners

Brands continue to be valuable assets that successful healthcare organizations and marketers develop and manage over time. But how can marketers quantify the value of the organization's brand? One way to calculate brand equity starts by measuring a brand's attraction to nonusers and brand attachment to current users.

The power of a brand is derived from the goodwill and recognition that its name and symbol have earned over time, which, for the organization, can translate into higher patient volumes and profit margins, the ability to more easily extend the brand, increased levels of customer commitment and employee engagement, and more efficient and effective marketing programs. To healthcare consumers, a strong brand reduces their information-gathering and decision-making efforts, increases their confidence in their decisions, and ultimately improves their satisfaction with and commitment to the organization they use.

Marketers regularly attempt to quantify the strength of their brands—often referred to as brand equity—for a variety of reasons. First, by establishing a numeric brand value, change can easily be tracked to understand consumers' commitment to the brand and to provide insights into whether the brand is on target or not. Measuring brand equity and its elements also allows for benchmarking against competitors and can be a tool to understand the key drivers of a brand.

Measuring Brand Equity

But quantifying brand equity can be difficult. It's a complex concept, and it's not easy to develop and collect reliable metrics. One review of academic brand equity models found more than 20 different concepts that contribute to a brand equity score.[1]

Many of the academic models are also conceptual and don't offer concrete insights into how marketers should focus resources to grow brand equity. So, the value of measuring brand equity has not been demonstrated to marketers or the C-suite as well as it should or could be. What's needed is a brand equity model that is simple, practical, and easy to measure and use.

One proposed model—the KGB Brand Equity Model, developed by the authors—starts by measuring a brand's attraction to nonusers and attachment to current users (see figure 1). The model includes six key driver categories that explain Brand Attraction and Attachment, and ultimately brand equity.

[1]Chieng Fayrene Y.L., Goi Chai Lee, "Customer-based Brand Equity: A Literature Review." *Researcher's World: Journal of Arts Science & Commerce.* Vol. 2, Issue 1, January 2011, pp. 33-42.

Evaluating the Model

The KGB Brand Equity Model was tested on five healthcare systems in Kentucky using an online survey of 405 consumers between June 21 and July 8, 2013. Respondents were 21 or older and responsible for healthcare decision making and did not work in healthcare or marketing industries. The total sample of 405 yielded a sample error of +/-4.1 percent at the 90 percent confidence level.

Most of the hospitals in the geographic area covered by the survey fall into one of five health systems. A composite Brand Equity score for each organization was developed by a weighted average of scores for brand attraction (nonpatient interest in using that brand) and brand attachment (patients' emotional commitment to that brand). Based on this scoring methodology, a brand can have an attraction or attachment score between -100 and +100.

Brand Attraction

Brand attraction was defined as consumer interest in trying a health system brand that they haven't used recently. Attraction was measured by asking:

- If you needed medical care—whether for inpatient, outpatient, or urgent care—or to see a doctor, which healthcare organizations really appeal to you for any reason?
- Now, which ONE of these healthcare organizations appeals to you the most for whatever reason?
- And in contrast, which healthcare organizations do not appeal to you for any reason?

Based on responses, four segments were created: Strongly Attracted, Somewhat Attracted, Somewhat Unattracted, and Strongly Unattracted. The scores for each segment were given a weight and a weighted index attraction score was produced. Interestingly, two of the brands had negative attraction scores—and all the brands were found to have significant potential to grow their brand attractiveness.

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Brand Attachment

Brand attachment was defined as the level of emotional commitment a patient feels for the healthcare brand, along with how well the brand fills their needs. It was measured by asking respondents to describe their emotional connection to the health systems by choosing one of the following:

- I feel an emotional connection with X that I just don't feel with another healthcare organization.
- I share an emotional connection with X along with another healthcare organization.
- I feel more of an emotional connection with another healthcare organization than I do with X.
- I don't really feel an emotional connection with any particular healthcare organization.

Respondents were also asked to complete the following sentence based on all of their experiences with a given system: "X is [everything I look for/most of what I look for/some of what I look for/a little of what I look for/none of what I look for] in a healthcare organization."

Based on responses, four segments were developed: Strongly Attached, Somewhat Attached, Somewhat Unattached, and Strongly Unattached. The scores for each segment were given a weight and a weighted index attachment score was produced.

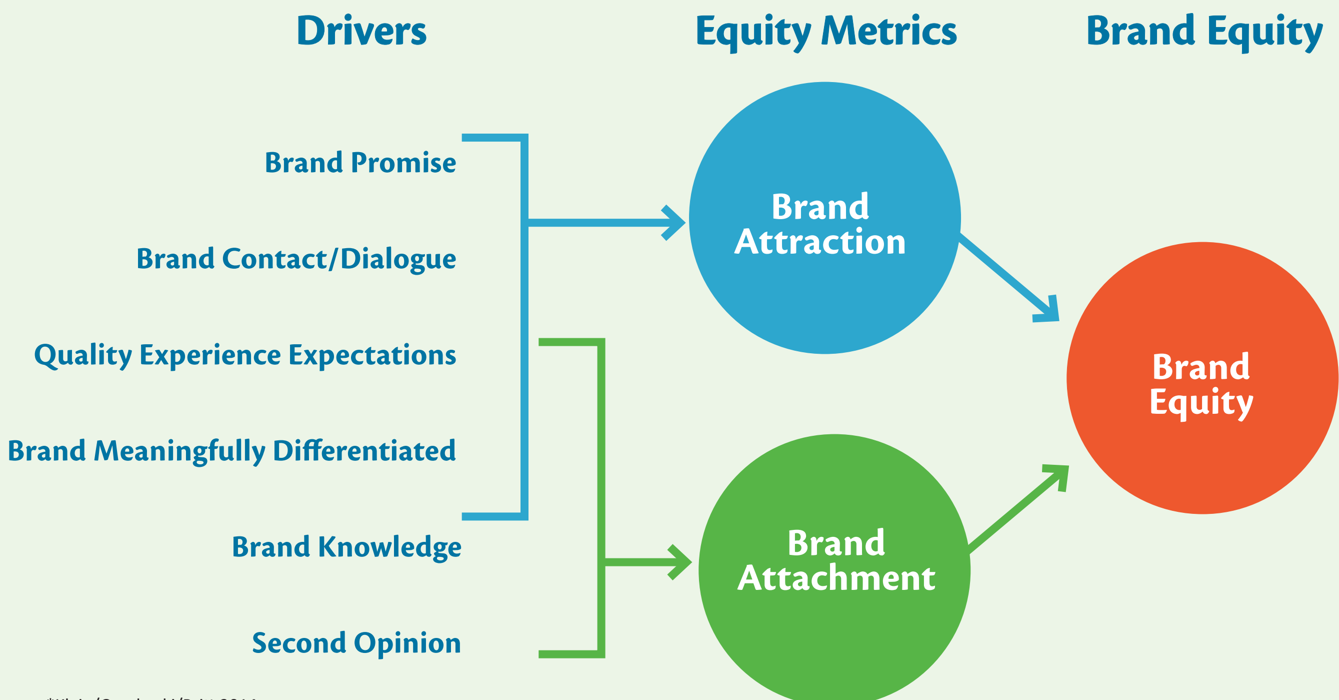
Once again, there was a major difference in attachment from the top to bottom brands and potential for all brands to improve their attachment scores.

Key Drivers

Key drivers, or constructs, were assessed as follows:

- **Brand promise** was based on key attributes that an organization can promote as its brand position in the marketplace, such as "has the most advanced technology," "caring nursing staff," and "the place to go for life-threatening cases."
- **Brand contact/dialogue** was defined as all the ways in which a consumer could come in contact with the brand. Respondents were asked what hospitals they had come in contact with in the past couple of months and which hospitals in Kentucky they or a member of their immediate household had ever been to for any type of care.
- **Quality experience expectations** was defined as the type of experience consumers expected to have if they used a particular hospital. It was based on such perceptions as "has doctors who are caring," "treats patients with respect," and "provides great customer service."
- **Brand meaningfully differentiated** was defined as a brand being relevant to consumers and differentiated from the competition. Consumers rated the applicability of statements such as: "I would pay more to have access to a 'Health System A' facility for care," "It is the best health

Figure 1.
The KGB Brand Equity Model*



*Klein/Gombeski/Britt 2014

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system for people like me," and "My physician speaks highly of it."

◆ **Brand knowledge** was defined as how well consumers know and understand the brand. For instance, do consumers think they know a lot about the organization and what it stands for? Does it appear to have positive momentum? And does it consistently deliver on what it promises?

◆ **Second opinion** was measured by the following question: "X is known as the place to go for a second opinion."

Using the Model

Figure 2 highlights the brand equity metrics for Brand A. The scores in the boxes below each key driver indicate the relative weight of impact that each key driver has on changing the outcome variable, which is either attraction or attachment. The higher the weight, the more impact it has. For example, Quality Experience Expectations has the biggest impact on attraction, while Brand Knowledge has the biggest impact on attachment.

By knowing which drivers have the greatest impact on attraction and attachment, marketers can determine what to emphasize in their messaging to achieve marketing goals. For Brand A, highlighting Quality Experience Expectations significantly—with added emphasis on Brand Contact/Dialogue and Brand Promise—would be the most powerful way to attract new patients.

Meanwhile, messaging aimed at increasing Brand Knowledge would have the greatest impact on building brand attachment. Additional messaging around Brand Differentiation and Quality Experience Expectations would be valuable as well, if resources allow.

In sum, the KGB Brand Equity Model is a relatively simple model that can help healthcare marketers understand where to place their resources and focus. The data collection effort requires just 14 questions, and the model has a high predictive value. Whether this model is used or another, understanding brand equity is a critical starting point for planning marketing strategy and tracking progress toward goals.

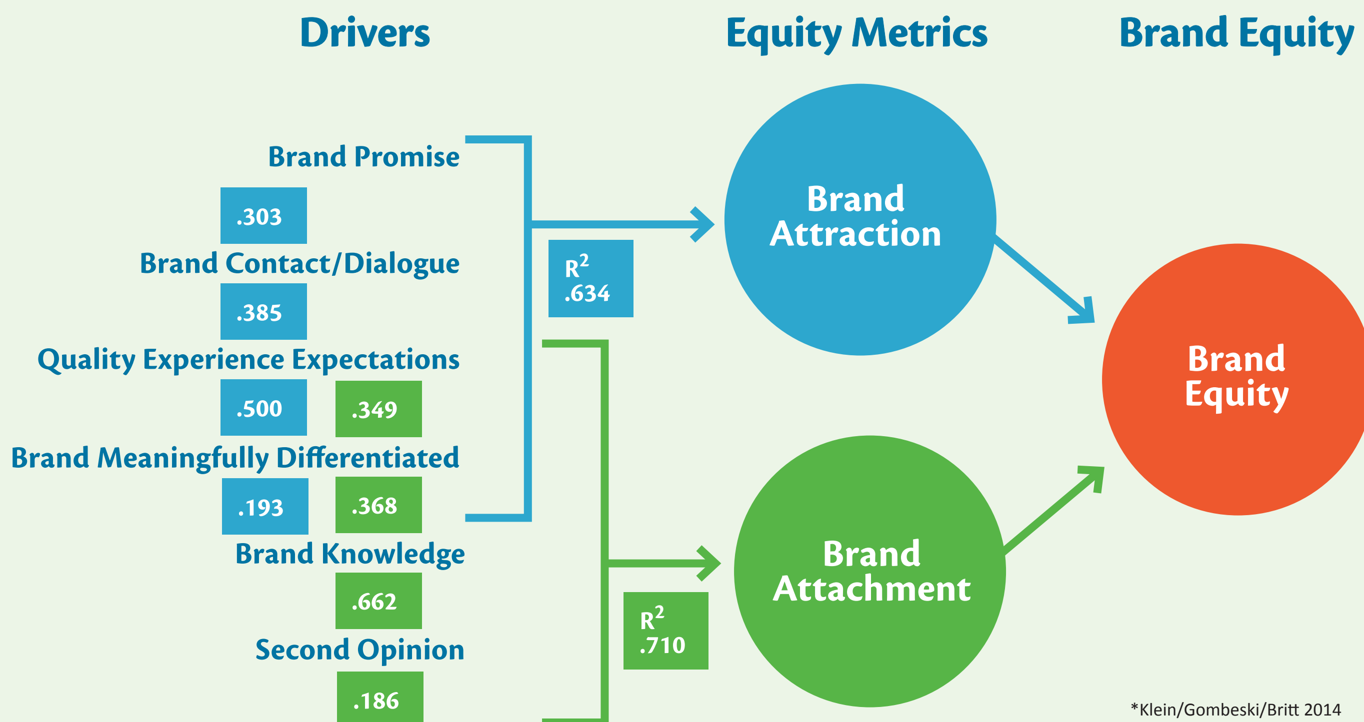
By

William R. Gombeski, Jr.
Director, Strategic Marketing
UK HealthCare (Lexington, KY)
He can be reached at william.gombeskijr@uky.edu.

Rob Klein
Founder & CEO
Klein & Partners
He can be reached at rob@kleinandpartners.com.

Jason Britt
Director, Market Research
UK HealthCare (Lexington, KY)
He can be reached at jmbrit00@uky.edu.

Figure 2.
The KGB Brand Equity Model and Brand Driver Weight—Brand A*



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