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Original research article

From expertise to empathy: multi-dimensional brand perception in Czech healthcare

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Abstract
Background: Brand management in healthcare is becoming increasingly important due to marketization and rising patient expectations. However, the specific nature of this sector – including ethical norms and patient vulnerability – challenges the direct application of commercial branding models.
Objective: The aim of this study is to identify key factors influencing brand perception among Czech healthcare users, and to analyze the impact of sociodemographic and lifestyle variables on this perception.
Methods: A quantitative survey was conducted on a representative online panel of 502 Czech adults. The structured questionnaire focused on brand awareness, quality, trust, ethical reputation, and patient experience. Statistical analyses included descriptive statistics, chi-square tests, and exploratory factor analysis.
Results: The findings show that quality of care, professional competence, and communication with patients are the strongest determinants of brand perception. Significant differences were identified by education and gender – higher education emphasizes quality, while women place greater emphasis on relational and emotional aspects of care. The expected stronger role of digital resources or DEI (Diversity, Equity, Inclusion) topics among younger respondents was not confirmed. Financial aspects were less important in the metropolitan context.
Conclusion: Brand perception in Czech healthcare reflects a complex mix of professional, ethical, financial, and relational factors. Institutions should combine professional expertise with sensitive communication and ethical conduct to build long-term trust and loyalty.

Keywords: Brand management; Czech Republic; Ethical communication; Healthcare branding; Patient perception; Quality of care

Introduction

Healthcare in the Czech Republic and abroad has undergone significant transformation in recent decades, driven by population ageing, the rising costs of new medical technologies, and increasing patient expectations. Health systems are shifting from traditional pillars such as professional competence, equal access, and solidarity, toward a model shaped by market principles, competition, and the need for effective presentation of healthcare providers. Thus, healthcare embodies both the characteristics of a public good and a market commodity, creating specific tension between the social value of health and the commercial logic that influences care organization, the patient's role, and the marketing communication of providers. One of the most striking paradoxes of this development is the persistent ambivalence toward advertising and branding in healthcare. In other sectors these tools are standard means of presenting service quality and values, but in healthcare they are often perceived as potential threats to ethical principles of the profession, particularly the *lege artis* standard and equality of access. Public healthcare institutions tend to build their brands implicitly, whereas private chains and clinics employ sophisticated marketing tools, pricing strategies, and a focus on customer experience – short waiting times, individualized care, or lifetime guarantees becoming part of competitive differentiation.

In this transformed and saturated market, a healthcare brand acquires a new role: it becomes a key navigational marker that helps patients orient themselves, signals provider quality and values, and enables the creation of an emotional bond between patient and institution. At the same time, an ethical dimension comes into play – physicians are prohibited from actively promoting their services, making misleading claims, or promising unrealistic outcomes, and marketing communication must not undermine equality of access or exploit patient trust in medical authority. The process of healthcare commodification is shaped by economic, demographic, technological, and political factors, bringing both new opportunities and serious ethical dilemmas affecting patients as well as

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the professional identity of physicians. The conflict between professional responsibility and commercial pressure is thus reflected in how healthcare brands are perceived and built.

The aim of this study is to analyze the current state of brand communication in healthcare, with a particular focus on private providers and the commodification of care, and to contribute to the formulation of an ethically grounded brand model that is simultaneously strategic, sustainable, and trustworthy. The research addresses both the theoretical framing of the issue and the identification of practical implications of current strategies for different patient groups. The findings of this study may serve as a foundation for designing communication strategies for healthcare institutions, developing public health campaigns, and setting ethical boundaries for marketing in a field that fundamentally shapes the core values of society.

Theoretical background: Commodification of healthcare, branding, and ethics in healthcare

Contemporary healthcare combines the characteristics of a public good and a market commodity, creating specific tension between the social value of health and commercial logic. This paradox is most evident in the persistent distrust of advertising and branding in healthcare – tools commonly used to communicate quality in other sectors, yet often constrained here by ethical limits, particularly the *lege artis* principle and equality of access (Suomi et al., 2021).

Healthcare services are highly heterogeneous, ranging from specialized treatment to elective aesthetic care. Private chains and clinics increasingly employ marketing tools, pricing strategies, and customer experience management. In such a saturated market, the brand becomes a key navigational marker – signaling provider quality and values and enabling an emotional relationship between patient and institution. To prevent exploitation of patient trust, the Czech Medical Chamber's Ethical Code explicitly prohibits promotional behavior aimed at expanding clientele (Estate Regulation No. 10, 2025). The commodification of healthcare in the Czech Republic began after 1989 with political transformation, which allowed private entities to enter the system and created a hybrid model where public and commercial logics intersect. Commodification is shaped by economic, demographic, technological, and political factors, but also introduces ethical dilemmas tied to physicians' professional identity and patient trust (Gladkij et al., 2003; Suomi et al., 2021).

A key concept here is trust, which in healthcare exceeds the level typical for consumer sectors. It involves not only reputation but also assurances of expertise, continuity, and safety (Huang et al., 2018). In the context of commodification and declining institutional trust, the brand must act as an ethical mediator between the patient and the healthcare system. Thus, brand management in healthcare serves not only as a market differentiation tool but primarily as a mechanism for strengthening trust, transparency, and long-term relationships with patients. The brand significantly influences patient orientation in the market, signaling quality and enabling differentiation among providers, and can be a decisive success factor in competitive environments (Ackovska et al., 2020).

Theoretical models of brand equity (Aaker, 2003; Keller, 1993) and brand image (Kalieva, 2015; Raka Sukawati, 2021) emphasize the role of brand awareness, perceived quality, emotional attachment, and loyalty as key components influencing patient decision-making. A positive image of a healthcare institution enhances individuality, patient loyalty, and reputation – particularly under conditions of high personal risk and uncertainty (Kim et al., 2008). At the same time, brand development must rest on ethical values, transparency, and respect for the principles of health equity (Barták, 2010; Malina, 2013). The doctor–patient relationship is shifting from paternalism toward participation, requiring new standards of authenticity and ethical responsibility for healthcare brands (Ptáček et al., 2011).

From an organizational standpoint, brand building must be integrated with internal values and employee behavior to ensure alignment between external communication and internal culture (Harris and de Chernatony, 2001). A strong and trustworthy brand provides a competitive advantage, strengthens the financial stability of healthcare institutions, and enables innovation while maintaining ethical and professional standards (Santos-Vijande et al., 2013). Recent research confirms that patient experience has a direct impact on the business outcomes of healthcare organizations (Cochrane et al., 2015). Moreover, healthcare brand reputation is a decisive factor in patient choice – 50.8% of respondents reported selecting a provider based on reviews and ratings. In the area of DEI (Diversity, Equity, Inclusion), recent studies highlight interventions that promote diversity, equity, and inclusion in both research and operational contexts (Buh et al., 2024).

The privatization and growth of private healthcare chains in the Czech Republic have created an environment where brand strategies represent an investment not only in marketing but also in care quality, innovation, and long-term patient trust. The evolution from small private practices to large investment groups increases the importance of systematic brand management, whose success depends on maintaining balance between the commercial and ethical dimensions of healthcare.

Materials and methods

The research was designed to formulate principles of effective brand management in healthcare that are transferable across different types of institutions while respecting the ethical and institutional boundaries of the sector. The main objective was to identify key factors influencing brand perception in healthcare, assess the relative importance of these factors, and analyze the impact of sociodemographic characteristics on brand perception.

Based on these goals, several sub-objectives were defined to explore general relationships such as the influence of age, education, region, and gender on perceptions of healthcare brands.

The primary data collection tool was a structured questionnaire, developed from a systematic literature review and the results of a preliminary study. The questionnaire consisted of thematic sections focused on:

- brand perception (trust, quality, awareness, emotional relationship);
- attitudes toward the form and ethics of healthcare communication;
- value orientation (equality, diversity, empathy);
- information behavior and media habits;
- segmentation by lifestyle and decision-making strategies.

Items were mostly measured on five-point Likert scales, supplemented by multiple-choice and dichotomous questions. The instrument was pilot-tested on a sample of 30 respondents to assess clarity and reliability. Example items included: *"The physician clearly explains the treatment procedure", "The healthcare facility actively participates in community activities", "Waiting times are reasonable"*.

The empirical phase was conducted on a representative sample of 502 respondents; adult users of healthcare services in the Czech Republic. Quota sampling ensured balanced representation by gender (50.6% women), age (18–65 years; three categories), region (Prague, regional cities, rural areas), education, and experience with various types of providers. Data were collected in 2024 via a certified online panel (CAWI) with screening and validation questions. In addition to gender, age, and region, variables included education level (primary, secondary, tertiary), employment status (employed, student, unemployed, retired), and provider type (public, private, hybrid), enabling fine-grained segmentation and group comparison.

Data analysis proceeded in several stages:

- Descriptive statistics (means, frequencies, standard deviations).
- Exploratory Factor Analysis (EFA) to identify dimensions of brand equity and attitudinal constructs.
- Pearson's chi-square tests to verify hypotheses and assess relationships between categorical variables (e.g., gender, age, region).

Analyses were performed using IBM SPSS v28 and SmartPLS 4 for handling latent constructs.

The research adhered to ethical standards of social science research. Participation was voluntary and anonymous; all respondents were adults and informed about the study's purpose in advance. The research protocol was approved by the Ethics Committee.

Results

To analyze data on brand perception of healthcare institutions, Exploratory Factor Analysis (EFA) with orthogonal Varimax rotation was applied. The aim was to identify key latent dimensions influencing the choice and perception of healthcare services. The initial dataset comprised 42 variables focused on quality of care, communication, trust, social responsibility, and related aspects. The analysis revealed that the optimal solution consisted of six factors, jointly explaining 62.8% of the total variance. This value exceeds the commonly accepted 60% threshold, ensuring strong interpretability and confirming the model's validity within social science research. The factor loading matrix allowed identification of the main conceptual dimensions of brand perception. Key items and their factor assignments are summarized below:

- **Factor 1: Professional competence and clarity**
  High loadings: *"Explains what and why something will happen"* (0.780), *"Shows genuine interest in my problems"* (0.705), *"Clearly warns about possible risks"* (0.789), *"Has modern technical equipment"* (0.689).
- **Factor 2: Social responsibility and engagement**
  High loadings: *"Sponsors local community activities"* (0.775), *"Ensures equal rights for the LGBT+ community"* (0.794), *"Maintains gender equality in leadership"* (0.861), *"Cooperates with the local environment"* (0.623).
- **Factor 3: Social reputation and recommendations**
  Items: *"People in your surroundings speak well of it"*, *"It is portrayed positively online and in the media"*.
- **Factor 4: Communication and transparency**
  High loadings: *"I understand what they say; it is clear"* (0.459), *"What they say in their advertising is interesting"* (0.523).
- **Factor 5: Accessibility and pricing policy**
  Items focused on financial and temporal accessibility of services and clarity of payments.
- **Factor 6: Credibility of communication**
  High loadings: *"What they say in their advertising is trustworthy"* (0.814), *"I understand what they say; it is clear"* (0.664).

To ensure maximum interpretability and minimal overlap among factors, Varimax rotation was used, which allowed most items to be assigned unambiguously to a single latent dimension. This confirmed the multifactorial structure of brand perception in healthcare institutions (Table 1).

Table 1. Components, explained variance, and conceptual description of factors

Factor	% Var.	Components – items strongly associated with the factor	Description
1	33.7%	The factor combines *perceived quality* (expertise, technology, prestige) with the *key role of communication*, which significantly influences patients' perception of care quality (communication refers to doctor–patient or reception interactions).	Perceived quality and patient communication
2	13.0%	The factor emphasizes *ethics, public responsibility* (including the DEI agenda), and *relations with the wider community*, which are increasingly important for healthcare institutions.	Social responsibility and public relations
3	6.5%	The factor integrates both key components of *accessibility* crucial for patients: financial and time-related (e.g., service availability, appointment waiting times, or insurance coverage).	Accessibility – financial and temporal
4	3.9%	The factor focuses on *patient satisfaction*, which is directly influenced by the quality of care.	Patient satisfaction and quality of care
5	3.0%	The factor concerns *positive public reputation* (strong external image) and the influence of *recommendations and shared experiences* (WOM), which strongly affect brand perception.	Strong external image and word of mouth
6	2.6%	The factor focuses on *clear, trustworthy, and understandable communication with the public*, covering marketing and PR activities as well as transparency and effective information delivery.	Clear and trustworthy public communication

1. Factor: Perceived quality and patient communication

The first factor focuses on the perceived quality of healthcare and the communication between staff and patients, both of which are key components influencing patients' decision-making. It includes aspects such as professional competence, modern technology, and institutional prestige, as well as the clarity of communication in patient interactions at the clinic or reception. This factor explains approximately 33.7% of the total variance, confirming its dominant importance. Perceived care quality and effective patient communication are thus decisive factors when choosing a healthcare provider.

2. Factor: Social responsibility and public relations
The second factor encompasses ethical aspects, public responsibility, and relationships with the wider community, including support for gender equality, LGBTQ+ rights, and other DEI (diversity, equity, inclusion) initiatives. Respondents who emphasized this factor valued cooperation with local authorities, sponsorship of community activities, and broad support for social initiatives. This factor explains 13% of the variance, highlighting its importance in healthcare selection decisions.

3. Factor: Accessibility – financial and temporal
This factor focuses on the financial and time accessibility of healthcare, which is crucial for patients when choosing a provider. It includes elements such as affordability, reasonable copayments, appointment availability, insurance coverage, and travel accessibility. Respondents prioritizing this factor preferred healthcare institutions offering transparent pricing, shorter waiting times, and flexible scheduling. This factor explains 6.5% of the variance, indicating that accessibility is a significant criterion in healthcare decision-making.

4. Factor: Patient satisfaction and quality of care
The fourth factor centers on patient satisfaction, closely linked to the quality of care and the attitude of medical staff. It reflects patients' perceptions of empathy, helpfulness, and kindness during interactions and treatment. Findings show that satisfaction depends not only on medical competence but also on the emotional and interpersonal experience of care. Interestingly, the involvement of artificial intelligence in communication was perceived slightly negatively (statistically insignificant), suggesting that patients still prefer personal contact. This factor explains 3.9% of the total variance, making patient satisfaction a relevant but less dominant factor compared to others.

5. Factor: Strong external image and word of mouth
The fifth factor highlights the public reputation of healthcare institutions, supported by positive patient reviews and recommendations (*word of mouth*). It demonstrates how important a positive public image and peer feedback are for patients when selecting a provider. Positive word of mouth and online reviews play a decisive role in shaping brand perception. This factor explains 3% of the variance, confirming the importance of reputation and recommendations in patient choices.

6. Factor: Clear and trustworthy public communication
This factor concerns how healthcare institutions communicate with the public and how such communication influences perception. It includes aspects such as marketing and public relations, transparency, and the ability to convey information effectively about services, values, and ethical principles. Public communication plays a key role in building trust, directly impacting patient decision-making. This factor explains 2.6% of the variance, showing that patients value not only the quality of care but also how the institution presents itself to the public.

Table 2. Summary of tested hypotheses

Hypothesis	Description	Statistical test	Test result	Interpretation / key notes
H1	Younger respondents (<35 years) emphasize social responsibility and DEI more strongly.	$\chi^2 = 1.90$, $p = 0.863$	Not significant	Age and gender have no statistically significant effect on attitudes toward DEI; the agenda is perceived as less important across groups.
H2	Younger respondents rely more on online reviews and media information.	$\chi^2 = 15.95$, $p = 0.007$ (reviews); $\chi^2 = 5.46$, $p = 0.362$ (media)	Significant only for reviews	The difference is due to a higher share of "cannot assess" responses among younger respondents; the proportion of "important" responses is similar across groups.
H3	Younger respondents evaluate the use of AI in healthcare more positively.	$\chi^2 = 1.68$, $p = 0.640$	Not significant	Slightly higher positive responses among younger participants, but the difference is not statistically significant.
H4	Respondents from Prague assign lower importance to insurance and financial aspects.	$\chi^2 = 8.38$, $p = 0.0388$ (insurance)	Significant (only for the insurance item)	Respondents from Prague place less emphasis on insurance; for other items, differences are not significant but the trend remains.
H5	Respondents with higher education emphasize quality of care more.	$\chi^2 = 8.65$, $p = 0.034$	Significant	With increasing education, the importance of care quality as a selection criterion rises.
H6	Women emphasize empathy, helpfulness, and safety more strongly.	$\chi^2 = 20.89$, $p < 0.001$ (empathy) etc.	Significant for all items	Women perceive relational aspects of care considerably more strongly than men.

As shown in Table 2, hypotheses based on demographic differences were confirmed primarily for gender (H6) and education (H5). In contrast, differences between age groups (H1–H3) and regions (H4) appeared only in certain aspects, and were often not statistically significant across all examined dimensions. The results highlight the complex and multidimensional nature of patient decision-making in the healthcare market and underscore the need for a segmented approach to healthcare brand management.

Discusion

The results provide several noteworthy insights into brand perception and patient decision-making in the Czech healthcare market, many of which diverge from assumptions and findings reported in international research.

The expectation that younger respondents would place greater emphasis on social responsibility and diversity, equity,

and inclusion (DEI) was not confirmed, contrasting with international trends (Shimul et al., 2025). No statistically significant age or gender differences were found regarding the perceived importance of equality for the LGBT+ community. This outcome may reflect the still marginal role of DEI topics in Czech healthcare and their limited integration into patient expectations. It may also stem from the narrow operationalization of the DEI variable; had it encompassed a broader range of indicators (e.g., equality by age, disability, or socioeconomic status), group differences might have been more pronounced.

Another possible explanation is that younger respondents' value orientation plays a less central role in healthcare decision-making compared to other factors, such as accessibility, professional competence, or cost. We also hypothesized that younger patients rely more on digital sources, particularly online reviews and social media. This assumption was only partially supported; a statistically significant difference emerged for reviews, but a closer look revealed that younger respondents more often selected "cannot assess", while the proportion of positive ratings was similar across age groups. This cautious attitude may reflect a more critical stance toward online sources or lower trust in spontaneous reviews. These findings align partially with CivicScience (2022), which found that Generation Z (18–24) generally trusts online reviews more, while older generations show a sharper decline in trust. Similarly, Afful-Dadzie et al. (2023) observed that younger users tend to rely more on visual and video content (YouTube, Instagram) rather than text-based reviews, suggesting that our operationalization of "review" may have failed to capture younger audiences' preferred digital content forms. Regarding AI perception, younger respondents showed only a minor, statistically insignificant difference in positivity (36% vs. 30.5%). This may be due to the undifferentiated phrasing of the AI item (no distinction between chatbots, diagnostics, or treatment planning) and respondents' limited real-world experience with healthcare AI tools. Prior research confirms that both age and knowledge level are key for AI acceptance. For example, a study among Indian healthcare professionals found that greater AI literacy correlated with more positive attitudes and fewer perceived barriers, while older adults expressed higher demands for usability, trust, and privacy (Nikhil et al., 2025). Pew Research Center (2023) likewise reported that around 60% of Americans would feel uncomfortable if their doctor relied on AI, underscoring that not only age but also cultural context and presentation style influence acceptance.

Findings also confirm that financial aspects of healthcare – especially insurance coverage – play a smaller role in Prague than in other regions, consistent with foreign studies (Bryndová et al., 2023). Differences in perceptions of co-payment fairness and payment transparency, however, were not significant. Likely explanations include Prague residents' greater familiarity with self-paid or hybrid care, higher income, or different expectations toward healthcare services. Future research should consider not only regional but also institutional (public/private) and socioeconomic variations.

Respondents with higher education rated quality of care as significantly more important when choosing a healthcare provider. This finding supports the connection between education and patients' health literacy or their ability to evaluate service quality, which aligns with results from behavioral research (Marinova et al., 2017). Future studies should explore not only the education level but also the field of study, examining how various forms of health literacy influence patient decision-making.

The results also show that women assign greater importance to relational, emotional, and safety aspects of healthcare. These differences are statistically significant across all observed items and correspond with previous research (Swanson, 2013). Empathy, friendliness, and a sense of safety are essential factors for female patients and should be integrated into the communication and marketing strategies of healthcare institutions. Further research could investigate variations within the female population by age, health condition, or personal experience.

Study limitations

One major limitation concerns the operationalization of key constructs. Some important concepts, such as social responsibility (DEI) or perception of AI use, were measured by only one or a few items. Another limitation is the broad categorization of age groups; respondents were only divided into under and over 35 years. Data collection via an online panel (CAWI) may also have introduced bias toward participants with higher digital and media literacy, while individuals less active online may be underrepresented. This sampling effect could slightly limit generalizability. Finally, findings are context-dependent and reflect the specific features of the Czech healthcare system and its cultural environment. When applying these insights internationally, caution is required, as institutional frameworks and value systems may differ significantly across countries.

Conclusion

The study demonstrates that brand perception in Czech healthcare is complex and shaped by a combination of professional, ethical, financial, and relational factors. The most important determinants of brand perception include quality and professional competence of care, communication with patients, ethical reputation, and service accessibility. Significant differences were identified mainly in relation to education and gender; patients with higher education emphasize quality, while women focus more on relational and safety aspects of care. In contrast, age and regional origin play a smaller role, influencing attitudes only in specific areas (e.g., financial aspects in Prague). The findings also indicate that some assumptions from international research are only partially applicable to the Czech context. For example, the expected stronger emphasis on DEI or the greater influence of digital sources among younger respondents were only partially confirmed. Personal recommendations, perceived expertise, and trust remain the strongest decision-making criteria across all groups. In this study, the concept of "quality of care" was operationalized as a combination of an objective professional dimension (*lege artis* approach, technological equipment, staff competence) and a subjective dimension (clarity of communication, empathy, and sense of safety). This dual perspective is essential for interpreting the results. The authors recommend that future research includes qualitative methods and finer segmentation (by age, values, or type of facility). It should also monitor the impact of digital technologies, including AI, and explore how healthcare brands can be built ethically and effectively in a system where public and market principles coexist. The practical implications of this study lie in the recommendation that healthcare institutions – especially private ones – combine high professional standards and quality with a sensitive approach to relational, communicative, and ethical aspects of branding. Only this combination can sustainably foster trust, patient loyalty,

and long-term viability of the healthcare market amid growing competition and public expectations.

Ethical aspects and conflict of interest

The authors have no conflict of interest to declare.

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