

Beyond Overall Value: The Role of Perceived Value Dimensions in Patient Decision-Making in Private Healthcare

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Abstract

India's healthcare sector has witnessed rapid expansion, intensifying the need to deliver superior service value at sustainable costs to attract and retain patients. As patients become increasingly informed and value-conscious, providing superior perceived value has become essential for private healthcare providers. This study investigates the impact of patients perceived value on behavioral intention in selected private hospitals in the Union Territory of Jammu and Kashmir. Data was collected from 550 inpatients and outpatients across ten private hospitals using systematic sampling and a structured questionnaire. The proposed relationships were examined through structural equation modeling (SmartPLS v4). Findings reveal a significant positive effect of perceived value on behavioral intention. All dimensions of perceived value, except installations, exert a positive and significant influence on behavioral intention. These results provide empirical evidence on how value perceptions shape patient behavioral outcomes in private healthcare settings, offering insights for hospitals seeking to enhance patient loyalty and satisfaction.

Keywords: Perceived Value, Customer Value, Behavioural Intention, Installations, Service Quality, Professionalism, Non-Monetary Cost, Monetary Cost, Private Hospitals

Introduction

Private hospitals have emerged as dominant providers of India's healthcare delivery system (Dublin, 2022). The rapid expansion of the private healthcare sector has intensified competitive pressures, compelling hospitals to move beyond price-based competition toward value-based differentiation strategies. As healthcare services are predominantly credence-based and difficult to evaluate prior to consumption, selecting a healthcare provider becomes inherently complex and risk-intensive (Parasuraman et al., 1985; Zeithaml, 1988; Sweeney & Soutar, 2001). Patients often lack the technical expertise to objectively assess clinical quality, thereby relying on experiential cues, institutional reputation, and interpersonal interactions as proxies for value. Given that medical decisions directly affect patients' physical and psychological well-being, behavioural sensitivity in this context is particularly high (Berry & Bendapudi, 2007). Consequently, patients rely heavily on their assessment of perceived value when choosing among providers (Lapierre, 2000). Perceived value represents an overall evaluation of benefits relative to monetary and non-monetary sacrifices and is, therefore, central to healthcare marketing effectiveness and long-term relationship development (Cronin et al., 2000; Nguyen & Leblanc, 1998; Sanchez et al., 2006). In private hospitals, these benefits extend beyond clinical outcomes to include responsiveness, empathy, transparency in billing, and infrastructural quality. Simultaneously, sacrifices may encompass not only financial cost but also waiting time, psychological stress, and uncertainty. As health awareness increases, patients' expectations regarding service quality, professional competence, and cost justification have become more pronounced (Hu et al., 2009). This evolving expectation structure necessitates a systematic examination of how multidimensional value perceptions shape patients' behavioural intentions, particularly in emerging healthcare markets where private providers play a pivotal role.

From a strategic standpoint, identifying the drivers of perceived value is critical for strengthening loyalty and sustaining competitive advantage (Rahman et al., 2015; Zeithaml, 1988). However,

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despite its acknowledged importance, empirical research on the conceptual clarity and behavioural consequences of perceived value remains limited, particularly within healthcare and developing economies such as India (Caruana et al., 2000; Chahal, 2012; Kondasani, 2016; Pevec & Pisnic, 2018). Existing studies often treat perceived value as a unidimensional construct, thereby overlooking the differential effects of its functional, emotional, and social components on behavioural outcomes. Moreover, insufficient attention has been devoted to disentangling how these specific value dimensions operate within private hospital settings and collectively shape patient decision-making. Addressing this gap, the present study advances a multidimensional perspective by empirically examining the distinct and combined influence of perceived value dimensions on patients' behavioural intentions in the private healthcare context, thereby contributing to both theoretical refinement and managerial relevance.

Objectives of the study

1. To assess the impact of perceived value on behavioural intention.
2. To examine the influence of various dimensions of perceived value on behavioural intention.

Review of Literature

Perceived Value

Perceived value is widely regarded as a central construct in marketing, particularly within service contexts, due to its role in enhancing customer satisfaction, loyalty, and long-term profitability (Kumar & Reinartz, 2016; Leroi-Werelds, 2019). Notwithstanding its importance, the conceptualization of perceived value remains fragmented and theoretically contested (Tanrikulu, 2021; Blut et al., 2024). Foundational work defines perceived value as the customer's overall assessment of utility based on a comparison between benefits received and sacrifices incurred (Zeithaml, 1988; Monroe & Krishnan, 1985). These sacrifices include both monetary and non-monetary costs, such as time and effort, while benefits encompass perceived quality and other intrinsic and extrinsic attributes (Zeithaml, 1988; McDougall & Levesque, 2000). However, some scholars argue that value cannot be reduced to a simple quality-sacrifice trade-off, highlighting its inherently complex nature (Bolton & Drew, 1991).

In response, subsequent research has advanced a multidimensional perspective of perceived value, advocating the use of multi-item measures to capture its diverse benefit and sacrifice components (Sweeney, 1996; Cronin et al., 1997; Petrick, 2004). Unidimensional operationalizations have been criticized for oversimplifying the construct and limiting managerial relevance (Bolton & Drew, 1991; Woodruff & Gardial, 1996). Consequently, perceived value has been conceptualized as comprising multiple dimensions, such as installations, service quality, professionalism, and monetary & non-monetary costs, thereby reflecting consumers' holistic evaluations (Moliner, 2009).

Importantly, value is inherently subjective and varies across individuals, shaped by personal experiences and contextual information (Holbrook, 1994; Hu et al., 2009; Zeithaml et al., 2020). As a result, it is constructed by customers rather than objectively determined by firms. Empirically, perceived value is a robust predictor of consumer choice and a cornerstone of relationship marketing (Cronin et al., 2000). It underpins loyalty (Reichheld, 1996; Parasuraman & Grewal, 2000), influences word-of-mouth (Matos & Rossi, 2008), and contributes to satisfaction and future behavioural intentions (McDougall & Levesque, 2000; Vieira, 2013). Moreover, it is closely associated with quality, trust, and satisfaction, reinforcing its role as a source of competitive advantage in service markets (Nguyen & LeBlanc, 1998; Tam, 2004).

Despite its demonstrated relevance, the literature on perceived value remains at a relatively early stage of conceptual refinement, with limited empirical attention devoted to clarifying its dimensional structure and behavioural consequences, particularly within service contexts (Caruana et al., 2000; Sanchez-Fernandez & Iniesta-Bonillo, 2006; Smith & Colgate, 2007; Durrah et al., 2015).

Behavioural Intention

Behavioural intention is widely employed as a dependent variable in marketing research due to its strong predictive validity for actual behaviour (Westaby, 2005; Ibrahim & Najjar, 2008). Defined as an individual's commitment or readiness to perform a specific behaviour (Ajzen & Fishbein, 1977), it is commonly treated as a proxy for customer loyalty and retention in service contexts (Chen & Tsai, 2007). Empirically, behavioural intention is operationalized through indicators such as repurchase or revisit intention and willingness to recommend (Ramkissoon & Uysal, 2011; Som et al., 2012).

Extant research demonstrates a consistent positive relationship between behavioural intentions and subsequent consumer actions, underscoring their value as signals of future purchasing behaviour (Morwitz & Schmittlein, 1992; Zeithaml et al., 1996). Accordingly, understanding behavioural intentions enables firms to anticipate demand patterns and refine strategic decisions related to segmentation and positioning (Ibrahim & Najjar, 2008). This explanatory capacity has made behavioural intention a central construct in models examining consumer responses (Anderson & Mittal, 2000; Cronin et al., 2000; Parasuraman & Grewal, 2000).

Behavioural intentions may be favourable or unfavourable in nature (Zeithaml, 1996; Ladhari, 2009). Favourable intentions strengthen relational bonds, increase usage levels, encourage positive word-of-mouth, and enhance willingness to pay premium prices. In contrast, unfavourable intentions are associated with switching behaviour, reduced patronage, and negative word-of-mouth (Zeithaml, 1996). Consequently, fostering favourable behavioural intentions is critical to long-term financial performance and service sustainability (Dabholkar et al., 2000).

Development of Research Hypotheses

A substantial body of empirical research demonstrates a positive association between perceived value and behavioural intention (Khan & Kadir, 2011; Jin et al., 2015; Coudounaris & Sthapit, 2017; Meeprom & Silanoi, 2020). In evaluating whether to revisit a service provider, customers assess the extent to which the benefits received justify the sacrifices incurred, thereby shaping their future intentions (Bolton & Drew, 1991).

Grounded in the theory of consumption values, consumer choice is understood as a function of multiple value dimensions that collectively influence decision-making. This perspective suggests that behavioural intentions are shaped by distinct yet interrelated value components (Sheth et al., 1991). Accordingly, the present study conceptualizes perceived value as a multidimensional construct comprising installations, professionalism, service quality, monetary cost, and non-monetary cost, and posits that each dimension exerts a direct influence on behavioural intention. Given this evidence, we formulated following actionable hypotheses with corresponding sub-hypotheses:

H1: Perceived Value has a significant influence on Behavioural Intention

H1a: Installations have a significant influence on Behavioural Intention

H1b: Professionalism has a significant influence on Behavioural Intention

H1c: Service Quality has a significant influence on Behavioural Intention

H1d: Monetary Cost has a significant influence on Behavioural Intention

H1e: Non-monetary cost has a significant influence on Behavioural Intention

Research Instrument

The study adopts the GLOVAL scale, which offers a comprehensive approach to evaluating value and measures the overall perceived value of a purchase. The reliability and validity of the GLOVAL scale have been demonstrated in diverse contexts, including banking (Roig et al., 2006), tourism (Sanchez et al., 2006), and healthcare (Moliner, 2009; Orgev & Bekar, 2013). Recognizing the significance of non-monetary costs such as waiting time and effort in the healthcare sector, relevant

items from the scales of Moliner (2009) and Orgev and Bekar (2013) have also been integrated. Additionally, one quality-related item has been adapted from Chahal and Kumari (2011). To gauge behavioural intention, four items proposed by Zeithaml et al. (1996); one from Choi et al. (2004), and one from Boshoff and Gray (2004). have been adapted. These items have been validated across various contexts, including restaurants (Slack & Singh, 2020), retail firms (Yu & Ramanth, 2012), banks (Amin et al., 2013), tourism (Baker & Crompton, 2000), business-to-business settings (Lam et al., 2004), and healthcare (Qin et al., 2014; Mendes & Criz, 2019). A five-point Likert-type scale, ranging from 1 'strongly disagree' to 5 'strongly agree,' is employed to assess customer perceptions regarding the value received and their behavioural intentions.

Pilot Study

A two-stage pretesting procedure was implemented to refine the scale items before initiating data collection for the pilot study. In the initial stage, the questionnaire was distributed to two marketing professors, five patients, and three hospital managers to assess the relevance and appropriateness of the scale items. Subsequently, in the second stage, pretesting was conducted with 120 patients who had visited a private hospital at least once, using a debriefing technique to confirm that respondents comprehended the scale items in a single iteration. Feedback received was carefully incorporated to address any ambiguity present in the questionnaire.

Defining the Population and Sample

The study encompassed a target population consisting of all patients aged 18 and above who had undergone treatment at private hospitals within the Jammu and Kashmir region over the past year. The accessible population comprised patients from ten specifically chosen private hospitals. The selection of these ten hospitals considered factors such as substantial bed capacity, patient influx, and a wide array of available multi-specialities, with five hospitals being selected from each division.

The sample respondents/elements were drawn from both outpatients and inpatients. Outpatients included individuals who had made a minimum of three visits to the hospital, while inpatients were those admitted and treated at the private hospital. Due to the unavailability of a sampling frame for patients within each hospital, a simple random sampling technique was not feasible. Consequently, systematic random sampling was adopted for data collection, as it is both time and cost-effective and aids in mitigating bias in respondent selection.

Data collection involved targeting every fifth outpatient in the waiting area, meeting the criteria of having made at least three visits and expressing willingness to participate. For inpatients, every fifth patient listed in the register, who had spent at least one day in the hospital or was on the verge of discharge, was selected after obtaining approval from the staff, provided the patients were in a condition to respond. Critically ill patients were excluded from the survey.

Sample Size Determination

Cochran (1963) proposed that a sample size of 385 is sufficient for large populations. Thus, sample size was calculated using the Cochran formula, which considers the desired level of precision (e), confidence level (represented by a z score), and the estimated proportion (p) of the attribute present in the population. The sample was calculated as follows:

$$N = z^2 pq / e^2$$

$$N = 1.96 * 1.96 * 0.5 * 0.5 / 0.05 / 0.05$$

$$N = 0.9645 / 0.0025$$

$$N = 384.16$$

However, to compensate for potential non-response and risk of outliers (Malhotra, 2010), the sample size was increased to 550. The sample size of 550 was allocated proportionately among the selected 10 hospitals based on their daily patient inflow.

Demographic Profile of Respondents

Demographic information, including income, age, gender, education, types of patients, and the number of visits, was collected from the respondents to ensure a balanced representation of the sample. The sample comprised 48.57% males and 51.42% females, indicating that female respondents slightly outnumbered male respondents. In terms of age distribution, most respondents belonged to the 36–50 years group (34.28%), followed by 51–65 years (24.61%), 18–35 years (21.97%), and above 65 years (19.12%). Regarding educational qualifications, most participants were graduates (37.14%), followed by postgraduates (30.10%), those with higher secondary education (27.25%), and a smaller proportion with high school education (5.49%). Income-wise, the largest group of respondents reported a monthly income between ₹30,000 – ₹60,000 (36.04%), followed by ₹61,000 – ₹90,000 (31.20%), less than ₹30,000 (23.51%), and the smallest group earning above ₹90,000 (9.23%). Occupationally, 34.28% were private employees, 32.08% government employees, 12.08% self-employed, 11.64% unemployed, and 9.89% retired. Hospital visitation patterns revealed that most respondents had visited 3–5 times (44.17%), followed by 6–8 times (28.13%), and 9 or more times (27.69%). Finally, in terms of patient type, the majority were outpatients (59.34%), while 40.65% were inpatients.

Exploratory Factor Analysis of Perceived Value

To verify the factor structure, assess sample adequacy, and evaluate the data sets suitability, a three-stage exploratory factor analysis (EFA) was conducted on a dataset comprising 150 cases. Initially, the Kaiser-Meyer-Olkin measure of sampling adequacy (KMO) and Bartlett's test of sphericity were employed to gauge the appropriateness of the data. Subsequently, factor extraction utilized the principal component method (eigenvalues >1) to identify factors characterized by high factor loadings, employing the Varimax method. The outcomes, including KMO and Bartlett's test results, communalities, total variance explained, and the rotated component matrix for Perceived value, are presented in Table 1.

KMO and Bartlett's Test of Sphericity							
Kaiser-Meyer-Olkin Measure of Sampling adequacy						0.813	
Bartlett's Test of Sphericity			Approx. Chi-Sq/Df			2180.661/372	
			Significance			0.000	
Communalities			Rotated Component Matrix				
Item Code	Scale Items	Extraction	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
INST1	The interior of this hospital facilitates confidentiality and privacy.	0.716	0.802				
INST2	This hospital is neat and well organized.	0.506	0.605				
INST3	This hospital is spacious and modern.	0.545	0.615				
INST4	This hospital is well located (easily found, central and/or with good transport links).	0.602	0.718				
PROF1	The staff of this hospital is well aware of all the services offered.	0.704		0.704			
PROF2	The staff of this hospital know their job well.	0.714		0.814			
PROF3	The staff of this hospital are knowledgeable and well trained.	0.806		0.772			
PROF4	The information provided by the staff has been very valuable to me.	0.602		0.614			
QLTY1	The quality of the service was maintained throughout.	0.672			0.677		
QLTY2	Every stage of service in this hospital was well-organized.	0.504			0.792		
QLTY3	This hospital has an acceptable level of quality if we compare it to others.	0.516			0.554		
QLTY4	The medical team provided an accurate treatment and diagnosis	0.688			0.765		
QLTY5	Good medical advice is given to patients	0.502			0.774		
NMC1	The waiting time in the waiting hall is reasonable.	0.722				0.776	
NMC2	The waiting lists are reasonable in this hospital.	0.734				0.784	
NMC3	I was able to get an appointment with the doctor concerned in the desired department within reasonable time.	0.864				0.832	
MC1	In this hospital the services are reasonably priced.	0.772					0.814
MC2	The cost of services in this hospital is not high.	0.756					0.874
MC3	The service received is worth the price I paid in this hospital.	0.810					0.734
Eigen Value			6.172	2.189	1.724	1.530	1.034
Percentage of Variance			14.432	13.524	13.413	11.126	10.587
Total Variance Explained			63.083				

Table: 1 KMO and Bartlett's Test, Communalities, Total Variance Explained and Rotated Component Matrix of Perceived Value

Table 1 provides clear evidence that the Kaiser-Meyer-Olkin (KMO) measure yielded 0.813 score (>0.5), and Bartlett's test of sphericity was significant at $p < 0.001$, indicating the data's

appropriateness for factor analysis. Moreover, the reduction of 19 items to five factors explained a total variance of 63.083%. These factors were identified as installations, professionalism, service quality, non-monetary costs, and monetary costs, explaining variances of 14.432%, 13.542%, 13.434%, 11.126%, and 10.587%, respectively. All communalities ranged from 0.504 to 0.864, surpassing 0.50, signifying that the solution captured a substantial amount of variance.

Exploratory Factor Analysis of Behavioural Intention

For the Behavioural Intention construct, a similar EFA was conducted on six items to assess suitability, sample adequacy, and factor structure. The results are presented in Table 2.

KMO and Bartlett's Test of Sphericity			
Kaiser-Meyer-Olkin Measure of Sampling adequacy		0.865	
Bartlett's Test of Sphericity		Approx. Chi-Sq/Df	876.384/15
		Significance	0.000
Communalities		Sig	Rotated Component Matrix
Item Code	Scale Items	Extraction	Only one component was extracted. The solution cannot be rotated
BI 1	I will tell others positive things about this hospital.	0.687	
BI1	I will recommend this hospital to anyone who seeks my opinion.	0.714	
BI3	I will encourage my friends and relatives to visit this hospital.	0.774	
BI4	I intend to return and receive services again from this hospital in future.	0.873	
BI5	If I need medical services in future, I would consider this hospital as my first choice.	0.764	
BI6	In an emergency this is the hospital I would like to be admitted to.	0.696	
Eigen Value		5.125	
Percentage of Variance		71.315%	

Table:2 KMO and Bartlett's Test, Communalities, Total Variance Explained and Rotated Component Matrix of Behavioural Intention

Table 2 illustrates that the Kaiser-Meyer-Olkin (KMO) measure yielded 0.865 score (>0.5), and Bartlett's test of sphericity was significant at $p<.001$. Communalities for all items ranged between 0.687 and 0.873, surpassing 0.5, indicating that the solution effectively captured a substantial amount of variance. The factor solution successfully grouped all six items into a unidimensional construct labelled as 'behavioural intention' and the percentage of explained variance is 73.315% which is above 60%.

Measurement model (First order)

In accordance with the guidelines provided by Hair et al. (2017), the researcher initiated the evaluation process by examining reliability, followed by an assessment of convergent and discriminant validity through the partial least squares structural equation modeling approach. Reliability assessment involved the assessment of the Cronbach's alpha coefficient and composite reliability, with a threshold limit of 0.6 or 0.7. Convergent validity was established by scrutinizing factor loadings and the average variance extracted (AVE), with a minimum threshold of 0.5. Similarly, discriminant validity was scrutinized through the Fornell and Larcker Criterion and Heterotrait-Monotrait Ratio (HTMT), as presented in Table 5. The factor loadings, AVE, and reliability metrics are detailed in Table 3 and Fig. 1

	Constructs		Reliability			Convergent validity
Perceived value	Installations	Items	Loadings	Cronbach Alpha	Composite Reliability	AVE
		INST1	0.726	0.690	0.807	0.513
		INST2	0.754			
		INST3	0.765			
		INST4	0.608			
	Professionalism	PROF1	0.822	0.873	0.912	0.723
		PROF 2	0.935			
		PROF 3	0.874			
		PROF4	0.762			
	Service Quality	SQ1	0.778	0.816	0.871	0.575
		SQ2	0.806			
		SQ3	0.684			
		SQ4	0.733			
		SQ5	0.782			
	Non-monetary costs	NMC1	0.838	0.808	0.886	0.722
		NMC2	0.861			
		NMC3	0.851			
	Monetary costs	MC1	0.820	0.934	0.958	0.884
		MC2	0.685			
		MC3	0.864			
Behavioural Intention	Behavioural Intention	BI1	0.887	0.898	0.921	0.661
		BI2	0.862			
		BI3	0.880			
		BI4	0.724			
		BI5	0.715			
		BI6	0.791			

Table: 3Factor Loadings, Reliability and Convergent Validity

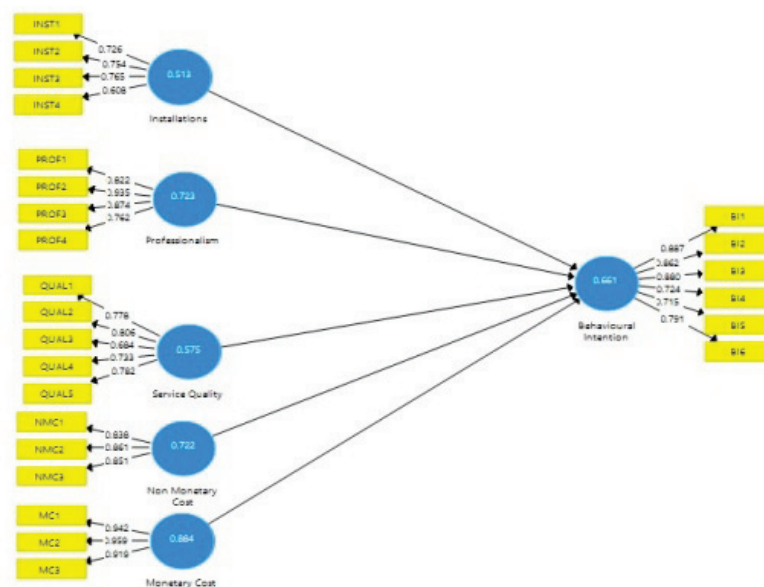


Fig.1 Factor loadings and Average Variance Extracted

The alpha coefficient and composite reliability for all variables within both constructs surpass or are in close proximity to the 0.7 threshold, indicating that the scale items for the respective constructs exhibit satisfactory internal consistency of data. Moreover, the AVE and factor loadings significantly exceed the minimum level of 0.5, affirming the establishment of convergent validity. In the context of discriminant validity, adherence to the Fornell and Larcker Criterion is crucial, where the square root of AVE for each latent construct should surpass the correlations among the latent constructs. Additionally, for the HTMT ratio, it is imperative that all correlations remain below 0.85 (see Table 4&5)

	Behavioural Intention	Installations	Monetary Cost	Non-Monetary Cost	Professionalism	Quality
Behavioural Intention	0.813					
Installations	0.365	0.716				
Monetary Cost	0.497	0.193	0.940			
Non-Monetary Cost	0.373	0.302	0.512	0.850		
Professionalism	0.572	0.418	0.323	0.499	0.851	
Quality	0.596	0.370	0.355	0.462	0.499	0.758

Table: 4 Fornell and Larcker Criteria (Latent variables correlation off diagonals vs Square root of AVE)

	Behavioural Intention	Installations	Monetary Cost	Non-Monetary Cost	Professionalism	Quality
Behavioural Intention						
Installations	0.426					
Monetary Cost	0.549	0.223				
Non-Monetary Cost	0.676	0.368	0.590			
Professionalism	0.605	0.548	0.361	0.599		
Quality	0.666	0.491	0.409	0.569	0.588	

Table 4 distinctly illustrates, in accordance with the Fornell and Larcker Criterion, that the square root of AVE for each variable is notably lower than the correlation between the constructs. Similarly, Table 5 presents that all inter-construct correlations are below the 0.85 threshold. Consequently, discriminant validity for all variables is conclusively established.

Measurement model (Second order)

Given that perceived value is a second-order reflective-formative construct, its validity as a second-order construct was assessed in accordance with the guidelines proposed by Hair et al. (2017). The examination involved evaluating indicator collinearity using the Variance Inflation Factor (VIF) approach, followed by the assessment of the statistical significance and relevance of outer-weights through the disjoint two-stage approach employing bootstrapping procedures. For indicator collinearity, VIF values below 3 were deemed satisfactory. Additionally, outer weights were considered valid if they exceeded 0.5 or were statistically significant at a p-value of < 0.05, with corresponding factor loadings surpassing the 0.5 threshold.

Formative Indicators	VIF
Installations	1.270
Monetary costs	1.391
Non-monetary costs	1.710
Professionalism	1.623
Service Quality	1.522

Table: 6 Variance Inflation Factor Scores of the Second-order Formative Indicators (Perceived Value)

	Original Sample (O) or outer weight	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (O/STDEV)	P Values < 0.05
Installations -> Perceived value	0.076	0.077	0.056	1.370	0.171
Monetary costs ->Perceived value	0.258	0.257	0.056	4.591	0.000
Non-monetary costs ->Perceived value	0.309	0.308	0.065	4.735	0.000
Professionalism ->Perceived value	0.307	0.305	0.066	4.681	0.000
Service Quality ->Perceived value	0.385	0.384	0.065	5.901	0.000

Table:7 Significance Test of the Outer Weights of the Second-order Formative Indicator

	Original Sample (O) or loadings >0.5	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (O/STDEV)	P Values<0.05
Installations - Perceived value	0.490	0.488	0.054	9.056	0.000
Monetary costs - Perceived value	0.667	0.663	0.046	14.635	0.000
Non-monetary costs -Perceived value	0.796	0.791	0.039	20.552	0.000
Professionalism ->Perceived value	0.768	0.765	0.037	21.005	0.000
Service Quality ->Perceived value	0.801	0.797	0.037	21.460	0.000

Table: 8 Significance Test of the Outer Loadings of the Higher Orders' Formative Indicators

Table 6 illustrates that the Variance Inflation Factor (VIF) values, ranging from 1.270 to 1.710, are well within the acceptable limit (<3), indicating that collinearity is not a source of concern. Additionally, outer-weights exceeding 0.5 are statistically significant for all variables, except for installations (refer to Table 8). Consequently, outer loadings were computed to determine whether to retain the formative indicators. As shown in Table 8, the outer loadings of all indicators are significant at a p-value < 0.001, affirming the retention of all formative indicators and establishing their validity (refer to Fig 2, Fig 3)

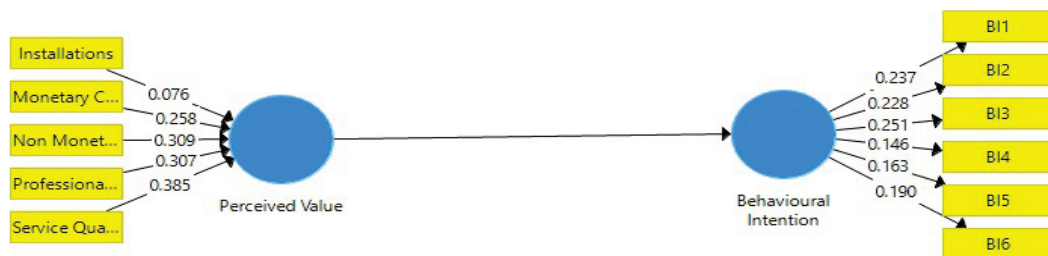


Fig. 2 Outer weights

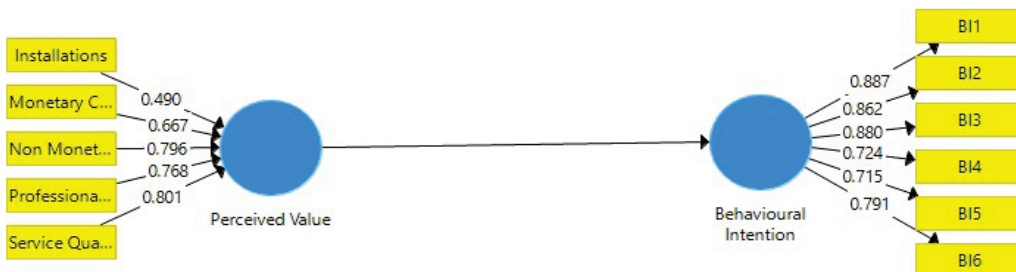


Fig. 3 Outer loadings

Structural Model

To evaluate the formulated hypotheses, the structural models underwent scrutiny to assess their overall robustness, utilizing measures such as R-square, f-square, and Q-square, in accordance with the recommendations of Hair et al., (2017). The comprehensive 5000 sub-sample bootstrapping procedure revealed an R-square value of 0.555 for behavioural intention, surpassing the required

level of 0.25 and indicating satisfactory explanatory power for the model (Hair et al., 2017). R-square of 0.555 denotes that 55.5% of the variance in behavioural intention is explained by perceived value. Likewise, the f-square value for perceived value (1.246) on behavioural intention indicates a substantial effect, surpassing the 0.35 threshold and emphasizing the strong influence of perceived value on the R-square value of behavioural intention (Hair et al., 2017). Furthermore, the blind-folding procedure based on Q-square (cross-validated redundancy) revealed a value of 0.355 for behavioural intention, exceeding zero and signifying strong predictive relevance for endogenous variables in the model (Hair et al., 2017).

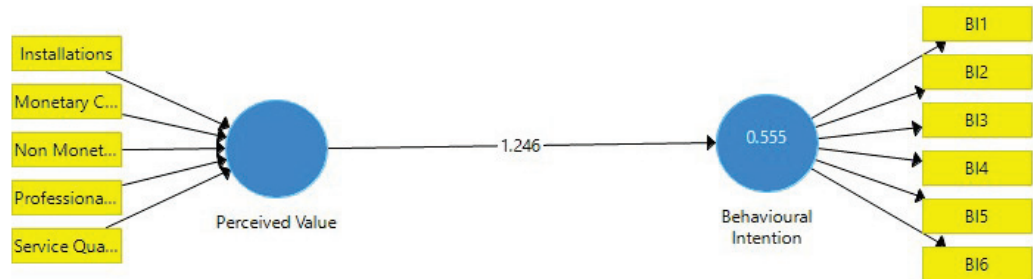


Fig. 4 F^2 and R^2 values

Testing of Hypotheses

The examination of hypothesized relationships was conducted using the complete bootstrapping procedure with 5000 sub-samples and 500 iterations via SmartPLSv4. This bootstrapping procedure also generated bias-corrected confidence intervals. The presence of non-zero confidence intervals indicate the significance of the relationships. Table 9 provides details on the significance of path coefficients, including t-statistics, p-values, and confidence intervals, with additional visualization presented in Figure 5 and Figure 6

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (O/STDEV)	P Values	95% Bias Corrected Confidence Intervals	
						2.50%	97.50%
Perceived value-> Behavioural Intention	0.745	0.749	0.020	37.781	0	0.696	0.777
Installations -> Behavioural Intention	0.057	0.061	0.043	1.328	0.184	0.031	0.134
Monetary Cost -> Behavioural Intention	0.192	0.192	0.041	4.636	0	0.112	0.275
Non-Monetary Cost -> Behavioural Intention	0.230	0.231	0.048	4.795	0	0.136	0.322
Professionalism -> Behavioural Intention	0.228	0.226	0.047	4.864	0	0.139	0.323
Service Quality -> Behavioural Intention	0.287	0.287	0.050	5.743	0	0.185	0.379

Table:9 Hypotheses Testing Results

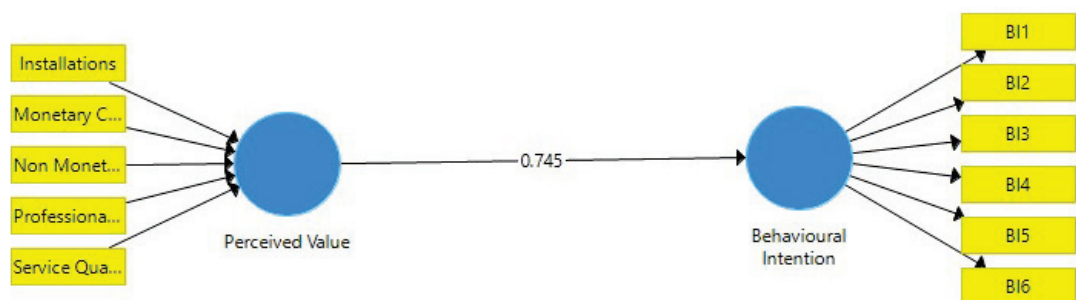


Fig. 6 Path coefficient of inner model



Fig. 7 Path coefficients of outer model

The application of the bootstrapping technique unveiled a noteworthy influence of perceived value, service quality, professionalism, monetary cost, and non-monetary cost on behavioural intention. However, the impact of installations on behavioural intention appears to be insignificant. Table 9 presents the beta coefficients, t-values, and p-values for Hypothesis H1 and its sub-hypotheses (H1a to H1e).

For Hypothesis H1, stating that perceived value has a significant impact on behavioural intention, the beta coefficient is 0.745, with a t-value of 37.781 and a p-value of 0.000. This suggests that a higher perception of value received from the hospital correlates with a stronger intention to revisit and recommend the hospital to others. Regarding H1a (Installations having a significant impact on behavioural intention), the beta coefficient is 0.057, the t-value is 1.328, and the p-value is 0.184, indicating that the appearance of the hospital and its facilities does not significantly impact patients' behavioural intentions. This finding contrasts with Parasuraman et al. (1993). For H1b (Professionalism having a significant impact on behavioural intention), the beta coefficient is 0.228, the t-value is 4.864, and the p-value is 0.000. This implies that hospital employees being professional and knowledgeable in their field positively affects patients' intentions. In the case of H1c (Service quality having a significant impact on behavioural intention), the beta coefficient is 0.287, the t-value is 5.743, and the p-value is 0.000, signifying that higher service quality positively impacts behavioural intention. For H1d (Non-monetary cost having a significant impact on behavioural intention), the beta coefficient is 0.230, the t-value is 4.795, and the p-value is 0.000. This implies that less time and effort patients have to invest in receiving services leads to more favourable intentions. Lastly, for H1e (Monetary cost having a significant impact on behavioural intention), the beta coefficient is 0.192, the t-value is 4.636, and the p-value is 0.000. This indicates that as patients perceive the prices of services to be fair and reasonable, their behavioural intentions strengthen. These findings align with research studies conducted by Coutinho et al. (2019), Bayin and Onder (2015), Yandinget al., (2011), and Sahadevan (2019), respectively. Overall, it is evident that service quality and non-monetary cost have a significant impact on behavioural intention, followed by professionalism and monetary cost. The reason for the large impact of service quality may be because the primary reason for attaining hospital services is to receive treatment. As such service quality is the primary predictor of behavioural intention for hospitals. Furthermore, there is a switch of patients from government hospitals to private hospitals because less time and efforts are

required for attaining services in private hospitals. Thus, low non-monetary costs consequently strengthen patients intention to return to hospital and recommend it to others.

Discussion and Implications

The study highlights a significant positive impact of perceived value on behavioral intention, consistent with prior research (Khan & Kadir, 2011; Jin et al., 2015). This suggests that hospitals should focus on delivering maximum benefits at reasonable costs to encourage patient loyalty and recommendations.

The insignificant effect of installations on behavioral intention aligns with Roig et al. (2009), likely because patients prioritize treatment quality over facility aesthetics. Nonetheless, hospitals can enhance the role of installations by ensuring clean, well-maintained wards, modern infrastructure, accessible layouts, and supportive amenities such as green spaces, parking, privacy options, and clear signage. These measures improve comfort, safety, and navigation, thereby strengthening the overall patient experience.

Professionalism emerged as a strong determinant of behavioral intention. Hospital staff must demonstrate compassion, expertise, and proactive assistance to build trust and satisfaction. Continuous professional development, effective communication, and adaptability are essential for maintaining excellence. Tailoring interactions to patient needs, fostering teamwork, and increasing female staff presence can further enhance patient comfort and confidence.

Service quality exerts a strong positive influence on behavioral intention, as patients are more likely to revisit and recommend hospitals when they perceive treatment as satisfactory and well-coordinated (Chahal & Sharma, 2004; Chahal, 2008; Demirel et al., 2009; Gallan et al., 2013). Hospitals should invest in advanced medical technologies, establish specialized departments, and ensure staff approachability. Automation systems for scheduling, follow-ups, and communication, alongside telemedicine services, can standardize care and improve accessibility. Robust feedback mechanisms are vital for continuous improvement.

Monetary costs also positively affect behavioral intention when patients perceive services as fairly priced. Hospitals should adopt equitable pricing strategies that balance affordability with financial sustainability. Transparent communication of costs, regular process reviews to reduce inefficiencies, and benchmarking against industry standards can enhance patient trust and satisfaction.

Non-monetary costs significantly shape behavioral intention, as patients value reduced time, effort, and administrative burdens. Efficient appointment scheduling, triage systems, simplified registration, and electronic health records can streamline processes and minimize delays. Clear communication of wait times, cross-trained staff, and workflow optimization further improve patient experience and reinforce positive behavioral intentions.

Limitations and Future Research Directions

This study explored the impact of perceived value on behavioral intention within selected private hospitals. While the findings offer meaningful insights, several limitations should be acknowledged. First, the model primarily examined perceived value and behavioral intention; future research should incorporate additional relational constructs such as customer satisfaction, trust, and commitment to provide a more comprehensive understanding of behavioral outcomes. Second, the study was confined to private hospitals in Jammu and Kashmir, which may restrict the generalizability of results. Replicating the model across different regions and a wider range of healthcare institutions would enhance external validity. Finally, given structural differences across service industries, future studies could test the robustness of the model in other contexts—such as hospitality or aviation—to evaluate cross-sector applicability and identify potential contextual variations.

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