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PERCEIVED VALUE AS A DETERMINANT OF BEHAVIOURAL INTENTION: EVIDENCE FROM PRIVATE HEALTHCARE SETTINGS

Huzina Sahal*, Prof. Mushtaq Ahmad Bhat

[1] *Huzina Saheal is Senior Research Fellow at Department of Commerce, University of Kashmir, Srinagar, J&K, India. Her areas of interest include Customer Relationship Marketing, Services Marketing, Healthcare marketing, Customer Value.*

[2] *Dr. Mushtaq Ahmad Bhat is professor at Department of Commerce, University of Kashmir. Dr. Mushtaq is in the field of research from the last 30 years. He has to his credit more than 50 research articles published in national and international journal of repute. His research interests include: Service Quality, Tourism Marketing, Brand Engagement, Relationship Banking, Customer Relationship Marketing, Social Media Marketing, Service Recovery, Customer Value and the like.*

ABSTRACT **DOI No: 10.36713/epra25044** **Article DOI: https://doi.org/10.36713/epra25044**

The healthcare sector in India has experienced rapid growth in recent decades, primarily driven by the imperative goal of providing care and meeting the diverse needs of patients. Delivering high service value at reasonable costs stands as a crucial determinant for the advancement and progress of healthcare establishments. This research endeavours' to examine the influence of patients' perceived value on the behavioural intentions within selected private hospitals in the Union Territory of Jammu and Kashmir. To gather relevant data, a sample of 450 respondents, comprising both inpatients and outpatients, was collected from ten private hospitals using a systematic sampling technique and a structured questionnaire. The data was then subjected to analysis through structural equation modelling using Smart PLS. These results contribute valuable insights into the dynamics of patient perceptions and their consequential impact on the behavioural intentions within the context of private healthcare facilities.

KEYWORDS: ***Perceived Value, Customer Value, Behavioural Intention, Service Quality, Non-Monetary Cost, Monetary Cost, Private Hospitals***

INTRODUCTION

Private hospitals play a crucial role within India's healthcare landscape, catering to around 70% of the rural population and 80% of urban residents (Dublin, 2022). The expansion of the private hospital market can be attributed to factors such as increasing disposable income, population growth, and shifting disease patterns. In 2021, the private hospital sector in India was valued at INR 9,995.06 billion. This market is projected to witness substantial growth, with its valuation expected to reach INR 25,429.49 billion by 2027. This upward trajectory corresponds to a compound annual growth rate (CAGR) of approximately 20.53% over the forecast period from 2021 to 2027. Thus, the competition among private hospitals is on rise in India.

Choosing a healthcare facility is a complex and highly deliberative process, largely determined by the nature of treatment required. Because healthcare decisions directly affect an individual's life, customers are highly sensitive, making the decision-making process crucial and heavily influenced by the perceived value of services. Perceived value plays a vital role in healthcare marketing and in building long-term patient relationships. Patients increasingly select institutions based on the value they perceive for their overall health needs. As health consciousness rises, preferences shift toward institutions offering higher perceived value. Hospitals must therefore understand the factors that shape value perceptions and develop strategies to prevent customer attrition. A sustainable competitive advantage stems from delivering value that exceeds that of competitors (Dubey, 2018).

Despite its importance, the services marketing literature offers limited insights into the precise nature of perceived service value and its influence on customer behaviour (Caruana et al.,

2000; Kondasani, 2016). Value has also been relatively overlooked in customer experience research, particularly within healthcare (Cengiz & Kirkbir, 2010; Pevec & Pisnic, 2018), and studies on perceived value in developing countries such as India remain scarce (Chahal, 2012). Notably, no research has examined the impact of perceived value on behavioural intention in the context of private hospitals in India. This study addresses this gap by investigating the relationship between perceived value and behavioural intention.

Perceived value is a critical driver of business success, enhancing customer satisfaction, loyalty, and long-term profitability (Kumar & Reinartz, 2016). It represents a central concept in marketing, especially within service sectors (Leroi-Werelds, 2019). Yet, its conceptualization remains fragmented and ambiguous (Tanrikulu, 2021; Blut et al., 2024). Zeithaml (1988) defines perceived value as the customer's overall assessment of a product's utility based on a comparison of what is received and what is given. It reflects a trade-off between perceived quality and costs—both monetary and non-monetary (Monroe & Krishnan, 1985). McDougall and Levesque (2000) extended this perspective, viewing perceived value as a holistic evaluation of the exchange.

Customer value is a strong predictor of consumer choice and a core component of relationship marketing (Cronin et al., 2000). Reichheld (1996) describes perceived value as the foundation of true customer loyalty, a view supported by Parasuraman and Grewal (2000). Matos and Rossi (2008) note that, after commitment, perceived value exerts the strongest influence on word-of-mouth, surpassing quality, trust, and satisfaction. Despite its significance, customer value research remains in early conceptual stages, with limited efforts to clarify its nature and behavioural implications (Sanchez-Fernandez & Iniesta-Bonilla, 2006; Smith & Colgate, 2007; Caruana et al., 2000; Durrah et al., 2015).

Behavioural intention is widely used as a dependent variable due to its strong predictive power for actual behaviour (Westaby, 2005; Ibrahim & Najjar, 2008). Ajzen and Fishbein (1977) define it as an individual's commitment to perform a specific behaviour. In marketing, behavioural intention is often equated with customer loyalty or retention (Chen & Tsai, 2007). Common indicators include repurchase or revisit intention and willingness to recommend (Ramkissoon & Uysal, 2011; Som et al., 2012). Behavioural intentions signal actual purchasing behaviour and are therefore essential to monitor (Zeithaml et al., 1996). Numerous studies confirm a strong positive relationship between behavioural intentions and subsequent consumer behaviour (Morwitz & Schmittlein, 1992).

Extensive empirical investigations within the literature indicate a direct association between perceived value and behavioural intention (Khan & Kadir, 2011; Jin et al., 2015; Coudounaris & Sthapit, 2017; Meeprom & Silanoi, 2020). When contemplating a return to the service provider, customers are likely to assess whether they received 'value for money,' thereby influencing their future intentions (Bolton & Drew, 1991). Given this evidence, we formulated following actionable hypotheses.

H1: Perceived Value has a significant influence on Behavioural Intention

For perceived value study adopted items from which Sanchez et al., (2006), Moliner, (2009); Orgev & Bekar (2013) and Chahal and Kumari (2011).

To gauge behavioural intention, six items proposed by Zeithaml et al. (1996); Choi et. (2002) and Boshoff and Gray (2004) have been adapted. 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.

Sampling Process

The study encompassed a target population consisting of patients who had undergone treatment at private hospitals within the Jammu and Kashmir region over the past year. The selection of these ten hospitals considered factors such as substantial bed capacity, patient influx, and a wide array of available multi-specialities.

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. Systematic random sampling was adopted for data collection, as it is both time and cost-effective and aids in mitigating bias in respondent selection.

Cochran (1963) proposed that a sample size of 385 is sufficient for large populations. Thus, sample size was calculated using the Cochran formula, which takes into account 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:

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

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 450. The sample size of 450 was allocated proportionately among the selected 10 hospitals based on their daily patient inflow.

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 6. The factor loadings, AVE, and reliability metrics are detailed in Table 1 and Fig. 1

Table: 1 Factor Loadings, Reliability and Convergent Validity

	Constructs		Reliability			Convergent validity
		Items	Loadings≥ 0.6	Cronbach Alpha≥ 0.7	Composite Reliability≥ 0.7	AVE≥ 0.5
Perceived value	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	0.837	0.808	0.886	0.722
		NMC2	0.861			
		NMC3	0.851			
	Monetary costs	MC1	0.942	0.914	0.938	0.884
		MC2	0.959			
		MC3	0.919			
Behavioural Intention		BI1	0.883	0.898	0.921	0.662
		BI2	0.858			
		B13	0.874			
		BI4	0.731			
		BI5	0.722			
		BI6	0.797			

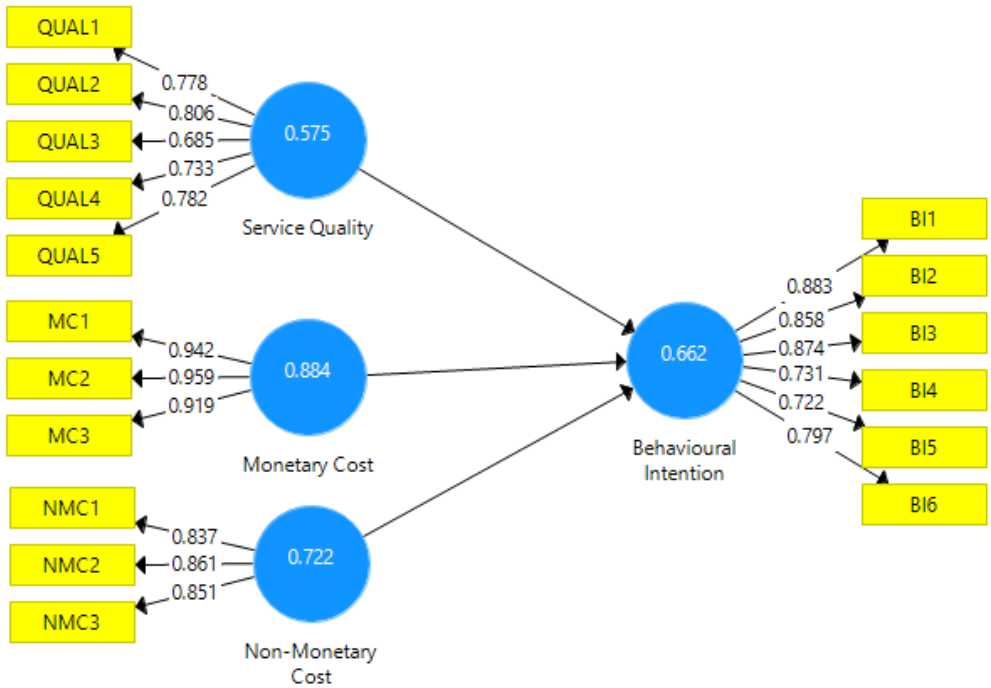

Fig.1 Factor loadings and Average Variance Extracted

The alpha coefficient and composite reliability for all variables within both constructs surpass 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 2 & 3)

Table: 2 Fornell and Larcker Criteria

	Behavioural Intention	Monetary Cost	Non-Monetary Cost	Quality
Behavioural Intention	0.814			
Monetary Cost	0.498	0.940		
Non-Monetary Cost	0.590	0.512	0.850	
Quality	0.595	0.355	0.462	0.758

Table:3 HTMT Ratio (<0.85)

	Behavioural Intention	Monetary Cost	Non-Monetary Cost	Quality
Behavioural Intention				
Monetary Cost	0.549			
Non-Monetary Cost	0.676	0.590		
Quality	0.666	0.409	0.569	

Table:4 Cross Loadings

	Behavioural Intention	Monetary Cost	Non-Monetary Cost	Service Quality
BI1	0.883	0.392	0.56	0.573
BI2	0.858	0.397	0.534	0.551
BI3	0.874	0.411	0.592	0.566
BI4	0.731	0.397	0.312	0.342
BI5	0.722	0.401	0.391	0.362
BI6	0.797	0.458	0.424	0.442
MC1	0.461	0.942	0.531	0.362
MC2	0.46	0.959	0.496	0.325
MC3	0.483	0.919	0.42	0.315
NMC1	0.477	0.41	0.837	0.362
NMC2	0.515	0.406	0.861	0.43
NMC3	0.511	0.489	0.851	0.383
QUAL1	0.529	0.299	0.348	0.778
QUAL2	0.483	0.212	0.282	0.806
QUAL3	0.366	0.283	0.319	0.685
QUAL4	0.35	0.271	0.362	0.733
QUAL5	0.483	0.288	0.444	0.782

Table 2 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 3 presents that all inter-construct correlations are below the 0.85 threshold. Table 4 shows that factor loading of all the items is stronger on the underlying construct to which they belong instead of other construct in the study. Hence, based on the evaluation of cross loadings, discriminant validity is attained. 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.

Table:5 Variance Inflation Factor Scores of the Second-order Formative Indicators (Perceived Value)

Formative Indicators	VIF
Monetary costs	1.380
Non-monetary costs	1.544
Service Quality	1.312

Table: 6 Significance Test of the Outer Weights of the Second-order Formative Indicator

	Original Sample (O) or outer weight	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)≥ 1.96	P Values < 0.05
Monetary costs -> Perceived value	0.295	0.292	0.060	4.908	0.000
Non-monetary costs -> Perceived value	0.437	0.437	0.063	6.953	0.000
Service Quality -> Perceived value	0.520	0.519	0.061	8.496	0.000

Table: 7 Significance Test of the Outer Loadings of the Higher Orders' Formative Indicators

	Original Sample (O)or loadings >0.5	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values<0 .05
Monetary costs -> Perceived value	0.701	0.698	0.049	14.280	0.000
Non-monetary costs -> Perceived value	0.830	0.827	0.037	22.710	0.000
Service Quality -> Perceived value	0.829	0.827	0.035	23.852	0.000

Table 5 illustrates that the Variance Inflation Factor (VIF) values, ranging from 1.312 to 1.544, 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 (refer to Table 6). Also, outer loadings were computed to determine whether to retain the formative indicators. As shown in Table 7, 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)

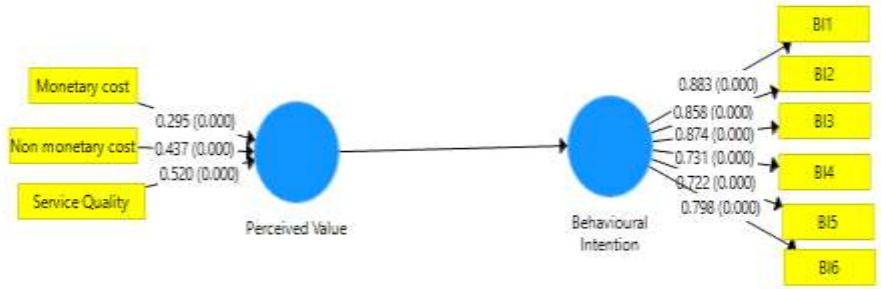

Fig. 2 Outer weights and P-values

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 0.505 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 0.505 denotes that 50.5% of the variance in behavioural intention is explained by perceived value. Likewise, the f^2 value for perceived value (1.020) 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 Q2 (cross-validated redundancy) revealed a value of 0.326 for behavioural intention, exceeding zero and signifying strong predictive relevance for endogenous variables in the model (Hair et al., 2017).

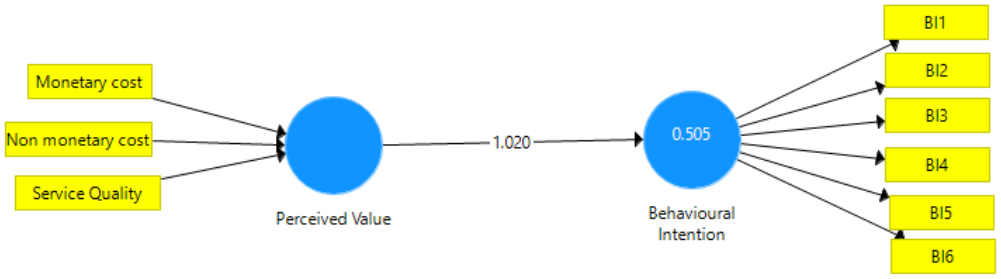

Fig. 3 F^2 and R^2 values

The examination of hypothesized relationships was conducted using the complete bootstrapping procedure with 5000 sub-samples and 500 iterations via SmartPLS. This bootstrapping procedure also generated bias-corrected confidence intervals. The presence of non-zero confidence intervals indicates the significance of the relationships. Table 8 provides details on the significance of path coefficients, including t-statistics, p-values, and confidence intervals, with additional visualization presented in Figure 4.

Table:8 Hypotheses Testing Results

	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	0.711	0.716	0.024	29.779	0	0.653	0.748

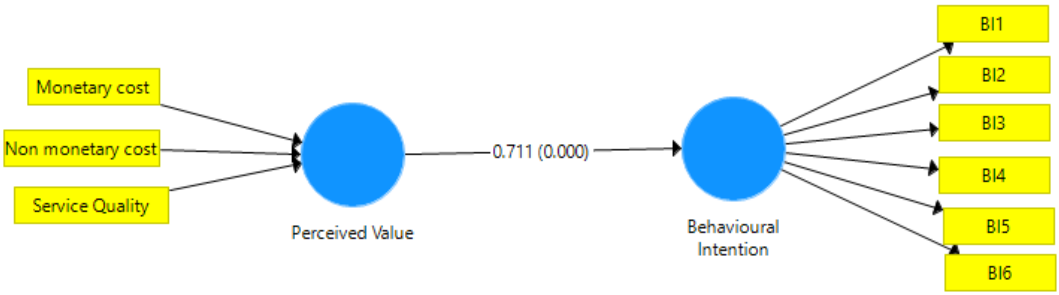

Fig. 4 Path coefficient of inner model and P value

The application of the bootstrapping technique unveiled a noteworthy influence of perceived value on behavioural intention. However, the impact of installations on behavioural intention appears to be insignificant. Table 8 presents the beta coefficients, t-values, and p-values for Hypothesis H1.

For Hypothesis H1, stating that perceived value has a significant impact on behavioural intention, the beta coefficient is 0.711, with a t-value of 29.779 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. When patients perceive that the quality of services received is justifiable for the perceived cost of offering and the time, effort and search costs are reasonable, patients are likely to recommend and revisit the hospital.

Discussion and Implications

Aligned with the study's objective, the findings indicate a significant positive impact of perceived value on behavioural intention. This finding is in line with the research studies of Khan & Kadir (2011); Jin et al., (2015) who state that higher the value, the higher the chances of a customer repurchasing the product or services and recommending it to others. This finding suggests that hospitals should aim to deliver maximum benefits to patients at reasonable prices to bolster their behavioural intentions.

Patients are more likely to revisit and recommend a hospital when they perceive care as satisfactory and well-coordinated (Chahal & Sharma, 2004; Chahal, 2008; Demirel et al., 2009; Gallan et al., 2013). Hospitals should therefore enhance service quality by investing in advanced diagnostic and treatment technologies, improving record-keeping systems, and establishing specialized departments. Ensuring the

approachability of medical and administrative staff, and adopting computerized systems for follow-ups, appointments, and communication can standardize service delivery. Telemedicine can further improve access, while robust feedback mechanisms are essential for continuous improvement.

Perceived fairness of cost strengthens satisfaction and positive behavioural intentions. Hospitals should adopt equitable and competitive pricing strategies, balancing affordability with operational sustainability. Clear communication of all costs and regular review of internal processes can reduce unnecessary expenditures. Benchmarking against industry standards can identify areas for improvement.

Because patients also consider non-monetary costs, minimizing time, effort, and search costs can enhance perceived value. Efficient appointment scheduling, triage systems, simplified electronic registration, and accurate communication of wait times reduce patient burden. Cross-training staff increases flexibility during peak demand, while workflow analysis and technologies such as electronic health records (EHRs) streamline processes and support coordinated care.

Limitations and Future Studies

The present study has examined the influence of perceived value on behavioural intention within both inpatient and outpatient context. Nevertheless, it is recommended that subsequent investigations should consider scrutinizing this relationship independently for inpatients and outpatients, acknowledging the potential variations in perceptions, particularly as inpatients spend an extended period in the hospital compared to outpatients. To enhance the comprehensiveness of the model, future research endeavours could introduce additional variables such as customer satisfaction and trust. This would contribute to a more nuanced understanding of the model. It's essential to note that the current study was confined to selected private hospitals in Jammu and Kashmir. To establish broader generalizability future studies should encompass a more extensive array of hospitals across the country, allowing for a comprehensive examination of the relationships under consideration. Given the diverse nature of service industries, researchers are encouraged to explore the applicability of these findings in various service sectors such as hotels and airlines. The model's effectiveness across different service categories should be investigated to discern potential variations and similarities. Furthermore, the findings would benefit from validation through additional evidence from other countries, considering the distinct values and cultures that prevail in different global contexts. Subsequent research should aim to corroborate and extend the current findings in varied cultural settings to enhance the robustness and applicability of the model.

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