

Evaluating the Multidimensional Drivers of Hospital Choice: A Structural Equation Modelling Approach.

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Abstract

Purpose: This paper examines how patients select healthcare providers in an increasingly competitive environment. Specifically, it evaluates the direct effects of eight distinct hospital service attributes on patient trust and determines whether trust functions as an underlying mediating mechanism that drives patient preference and repeat facility choice.

Methodology: A quantitative, cross-sectional survey was administered to 214 adult healthcare consumers across Surat, India. Measurement items were adapted from validated scales in healthcare service quality and relationship marketing literature. Covariance-based structural equation modeling (SEM) was used to validate the measurement properties and test the hypothesized structural pathways.

Findings: Clinical care quality, doctor–patient communication, and a strong hospital reputation serve as the primary drivers of patient trust, whereas perceived treatment costs substantially erode that confidence. Notably, clinical excellence and physician communication do not directly influence future hospital choice on their own; instead, their impact depends entirely on first establishing patient trust. In contrast, hospital reputation and clear, upfront billing directly guide a patient’s decision to return to or recommend a facility.

Practical Implications: Clinical excellence and advanced equipment alone do not guarantee patient retention. Hospital administrators must actively convert technical competence into interpersonal trust by training clinicians in communication and running post-discharge engagement initiatives. Furthermore, management should eliminate hidden medical fees and adopt itemized, upfront pricing, as financial transparency serves as an immediate behavioral trigger for patient loyalty.

Originality/Value: Rather than analyzing hospital selection factors in isolation, this study establishes a unified structural framework demonstrating that patient trust serves as an indispensable psychological bridge linking clinical delivery to institutional loyalty in an emerging healthcare market.

Keywords: Hospital Choice, Patient Trust, Structural Equation Modeling, Healthcare Marketing, Service Quality, Billing Transparency, Doctor-Patient Communication, Patient Loyalty.

Introduction

The global healthcare landscape has undergone a profound paradigm shift over the past few decades, transitioning from a purely welfare-driven sector to a highly competitive, consumer-oriented market (Bernstein & Gauthier, 1999; Kolstad & Chernew, 2009). Driven by rising health awareness, increased

privatization, and the expanding availability of healthcare options, patients are no longer passive recipients of medical care. Instead, they have evolved into active, informed consumers who exercise significant autonomy in selecting their healthcare providers (Boscarino & Steiber, 1982; Castro et al., 2016; Costa-Font & Zigante, 2016). In this demand-driven environment, hospital administrators face dual pressures: fulfilling their core social mission of delivering superior clinical outcomes while simultaneously operating as financially viable entities capable of retaining market share in an increasingly crowded industry (de Cruppé & Geraedts, 2017; Jackson & Jensen, 1985). Consequently, understanding the complex, multidimensional determinants of "hospital shopping" and patient preference has become a critical imperative for healthcare managers and policymakers alike.

While traditional theories of hospital competition posited that clinical quality and physician expertise were the sole drivers of patient choice (Hibbard et al., 2005), contemporary research reveals that clinical quality is often viewed by modern patients as a baseline expectation rather than a unique differentiator (Wu & Hsieh, 2015). When evaluating comparable institutions, patients heavily weight non-clinical and experiential factors (Goldman et al., 2010). However, despite the breadth of existing literature identifying these various isolated determinants of hospital choice, significant gaps remain in understanding the holistic architecture of patient loyalty.

Most prior studies have examined hospital selection factors in isolation or utilized basic regression models that fail to capture the complex, interdependent relationships between multiple service dimensions (Che et al., 2023; Kamra et al., 2016). Furthermore, while factors like infrastructure, transparent billing, and medical quality are known to influence hospital choice, the underlying psychological mechanism translating these attributes into long-term patient retention remains underexplored. In healthcare—a sector characterized by high perceived risk, information asymmetry, and vulnerability—Patient Trust emerges as a vital psychological bridge (Barnea et al., 2022; Ward et al., 2015). Trust mitigates perceived risk and is hypothesized to be the primary mediating mechanism through which hospital attributes translate into a patient's future preference and willingness to recommend the facility to others (Wu et al., 2022).

To address these gaps, this study proposes a comprehensive, multidimensional framework to evaluate the determinants of hospital choice. By shifting the analytical focus from mere patient satisfaction to the development of Patient Trust, this study provides a deeper behavioral understanding of healthcare consumerism. Methodologically, this research contributes to the literature by employing Structural Equation Modeling (SEM). Unlike traditional exploratory models, an SEM approach allows for the simultaneous testing of multiple latent constructs and their complex interrelationships while accounting for measurement errors.

Therefore, the primary objectives of this study are twofold:

1. To identify and quantify the direct impact of eight multidimensional hospital attributes—including Doctor-Patient Communication, Treatment Quality, and Reputation—on Patient Trust.
2. To empirically evaluate the mediating role of Patient Trust in driving Patient Preference and Future Choice.

The findings will provide evidence-based, actionable insights for hospital administrators to optimize resource allocation, enhance service delivery, and design targeted marketing strategies in a highly competitive healthcare ecosystem.

Literature Review and Hypothesis Development

Multidimensional Hospital Attributes and Patient Trust

In the high-risk, information-asymmetric environment of healthcare, patient trust is a critical psychological state characterized by the belief that a hospital and its staff will act in the patient's best interest (Wu et al., 2022). The development of this trust relies heavily on a patient's evaluation of multifaceted hospital attributes, ranging from clinical expertise to interpersonal dynamics and physical infrastructure.

Interpersonal factors are among the strongest drivers of trust. Clear doctor-patient communication and shared decision-making empower patients, reduce medical uncertainty, and foster a strong sense of reliability (Castro et al., 2016; Joosten et al., 2008). Because patients often find objective quality data difficult to navigate, they rely heavily on their physician's recommendations and communication to act as a bridge to a trusted facility (Ejaz et al., 2016).

Similarly, the professional, polite, and empathetic behavior of hospital staff acts as a critical safety indicator, reassuring patients and building deep-seated confidence in the care process (Derksen et al., 2013; Kraft-Todd et al., 2017). The "human" side of care—specifically the interpersonal skills and communication style of the staff—dictates a patient's holistic evaluation of the hospital's integrity (Aljarallah et al., 2023; van der Geest & Varkevisser, 2018). Beyond interpersonal dynamics, administrative transparency—particularly regarding clear billing and the absence of hidden charges—signals institutional honesty, which is foundational to establishing trust (Strumann et al., 2022).

Furthermore, clinical and structural attributes heavily influence patient confidence. The perceived quality of medical treatment and the visible expertise of doctors provide the primary assurance of safety (Lie et al., 2011). However, patients also use tangible cues to evaluate intangible medical quality. A hospital's physical infrastructure, including modern equipment, cleanliness, and hotel-like amenities, serves as a heuristic for organizational competence, thereby enhancing trust (Suess & Mody, 2017). Additionally, a hospital's external reputation and branding function as critical proxies for clinical quality. Positive brand image,

academic affiliations, and a strong digital presence act as social proof, significantly lowering a patient's perceived risk before they even enter the facility (Demir et al., 2024; Górska-Warsewicz, 2022; Wang et al., 2020). Finally, accessible locations and fair, justifiable treatment costs demonstrate a hospital's commitment to patient-centric care, further solidifying the trust relationship (Al-Hanawi et al., 2018; Moscelli et al., 2016; Fifield et al., 2022). Therefore, it is hypothesized that:

H1: Multidimensional hospital attributes have a significant positive impact on Patient Trust.

H1a: Doctor-patient communication positively influences patient trust.

H1b: Transparency in treatment and billing positively influences patient trust.

H1c: Positive hospital staff behavior positively influences patient trust.

H1d: Perceived quality of medical treatment positively influences patient trust.

H1e: Availability and accessibility of services positively influence patient trust.

H1f: Hospital reputation and image positively influence patient trust.

H1g: Affordable and justified cost of treatment positively influences patient trust.

H1h: Modern hospital facilities and infrastructure positively influence patient trust.

Hospital Attributes and Future Choice (Patient Loyalty)

The ultimate goal of healthcare marketing and administration is to drive patient preference, secure revisit intentions, and generate positive word-of-mouth recommendations (Kamra et al., 2016). Extensive literature indicates that the same clinical, administrative, and experiential factors that build trust also directly drive a patient's future choice. For instance, geographic proximity and ease of access remain dominant predictors of hospital selection across all types of care, particularly for emergency admissions where speed is paramount (Fabbri et al., 2023; Varkevisser & van der Geest, 2007).

Conversely, for elective procedures, demographic nuances emerge: younger and more affluent patients often bypass local options, demonstrating a willingness to travel further to reach facilities with superior reputations or advanced technology (Gutacker et al., 2016; Moscelli et al., 2016). Furthermore, financial constraints, such as insurance network status and out-of-pocket costs, frequently limit patient autonomy, making affordability a direct driver of facility selection (Sinaiko et al., 2016; Wang et al., 2022). Ultimately, an environment that offers physical comfort, combined with efficient administrative procedures and a strong reputation, directly correlates with higher overall patient satisfaction and the likelihood of returning to the same facility for future needs (Christina Cantika et al., 2023; Han, 2013).

While previous studies have frequently examined these factors in isolation or within specific clinical contexts, there remains a need to evaluate their collective impact within a comprehensive structural framework. Consequently, to quantify how these diverse dimensions concurrently influence behavioral intentions, this study posits:

H2: Multidimensional hospital attributes have a significant positive impact on Patient Preference and Future Choice.

H2a–H2h: Hospital attributes (communication, transparency, staff behavior, medical quality, accessibility, reputation, cost, and infrastructure) individually have a significant positive impact on future choice.

The Mediating Role of Patient Trust

While hospital attributes directly influence patient satisfaction, satisfaction alone does not guarantee long-term loyalty or future choice. In the healthcare sector, vulnerability necessitates a deeper psychological bond: trust (Barnea et al., 2022). Trust mitigates the perceived risks associated with medical treatments and transforms a satisfactory episodic encounter into enduring institutional loyalty (Ward et al., 2015).

According to relational marketing theories applied to healthcare, tangible hospital attributes (such as infrastructure and accessibility) and intangible attributes (such as staff empathy and reputation) function as critical prerequisites. However, their ultimate impact on a patient's behavioral intention—specifically future choice and the willingness to recommend the facility—is best realized when these attributes successfully cultivate patient trust (Wu et al., 2022). In this context, trust acts as the vital psychological mechanism bridging a hospital's service delivery with the patient's future loyalty. Therefore, the following hypotheses are proposed:

H3: Patient Trust has a significant positive impact on Patient Preference and Future Choice.

H4: Patient Trust significantly mediates the relationship between multidimensional hospital attributes (H4a–H4h) and Patient Preference and Future Choice.

Drawing upon the preceding literature and formulated hypotheses, a comprehensive conceptual framework was developed for this study. As illustrated in Figure 1, the proposed model evaluates the complex decision-making pathways of healthcare consumers. It posits that eight multidimensional hospital attributes exert both direct and indirect effects on the ultimate dependent variable, Patient Preference and Future Choice. Furthermore, the model isolates Patient Trust as the central endogenous variable, functioning as the critical psychological mediator between a hospital's service delivery and long-term patient loyalty.

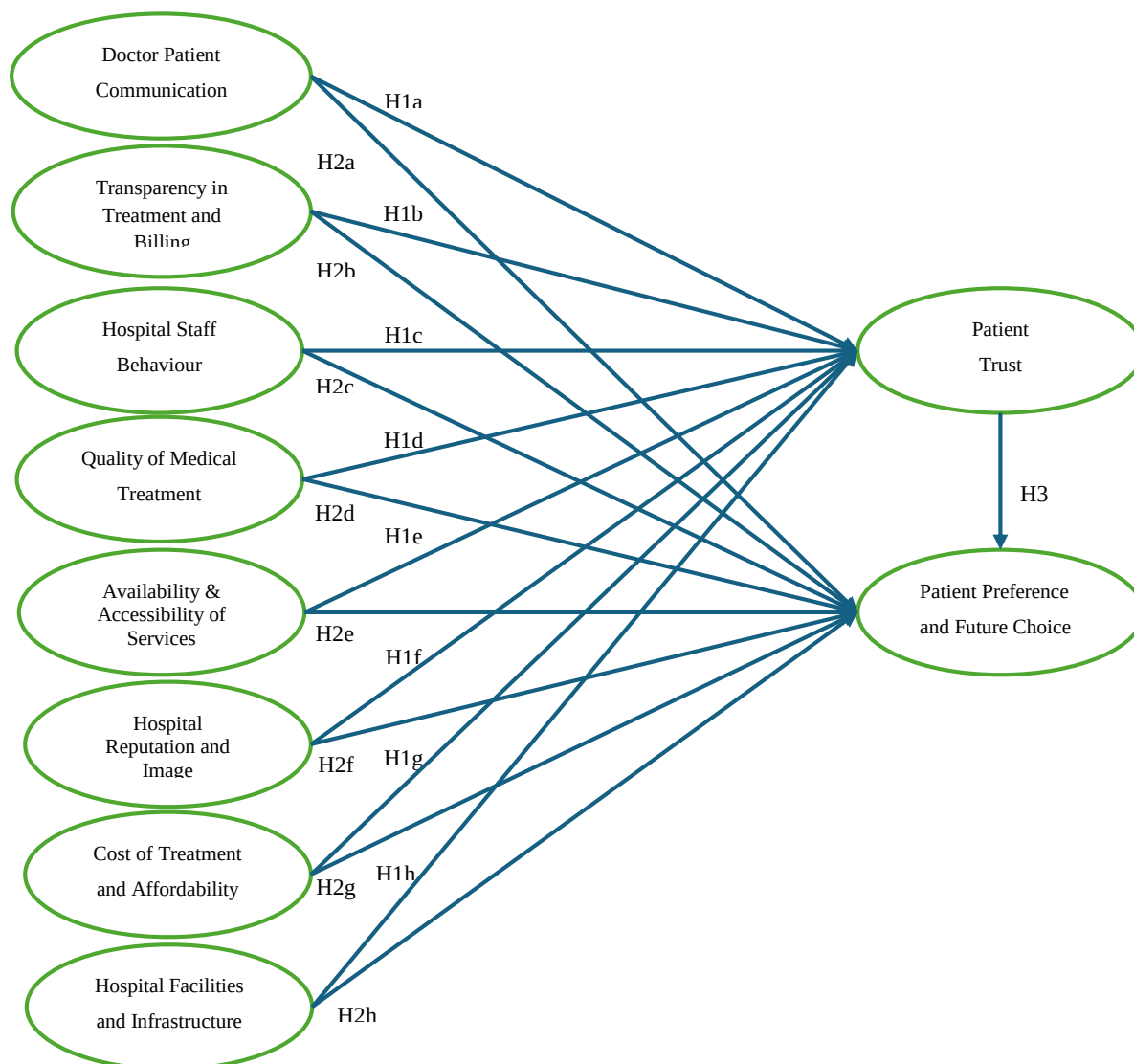


Figure 1 Proposed Conceptual Model and Hypothesized Structural Relationships

Methodology

Ethical Considerations and Informed Consent All participants were provided with an introductory statement detailing the study's objectives and were required to provide electronic informed consent prior to accessing the survey instrument. Respondents were explicitly assured of data confidentiality, anonymity, and compliance with standard ethical research protocols. The primary data was securely managed, and participation was strictly voluntary.

Research Design and Data Collection Procedure This study employed a quantitative, cross-sectional research design targeting the adult healthcare consumer population in Surat, Gujarat, India. As a rapidly developing urban and commercial hub, Surat provides an optimal setting to evaluate modern healthcare consumerism in emerging economies. Inclusion criteria were strictly limited to individuals aged 18 years or older.

To effectively capture a diverse demographic profile, data collection was executed via a structured, self-administered online survey. The survey was strategically disseminated across various digital channels, including social media platforms, professional networks, and community-based instant messaging applications. A hybrid sampling strategy, integrating convenience and snowball sampling techniques, was adopted.

Sample Size Determination and Statistical Power To ensure the statistical robustness of the preliminary factor analyses and the subsequent Structural Equation Modeling (SEM), sample size adequacy was rigorously evaluated prior to data estimation. Following established methodological guidelines for multivariate data analysis, a minimum item-to-response ratio of 5:1 is recommended to achieve reliable factor structures (Hair et al., 2010). Given that the structured questionnaire comprised 38 observable items, a theoretical minimum of 190 respondents was required.

Furthermore, prominent SEM literature indicates that an absolute minimum sample size of 200 is generally necessary to achieve stable goodness-of-fit indices, adequate statistical power, and reliable Maximum Likelihood (ML) estimations for complex structural paths (Kline, 2015; Wolf et al., 2013). The final data collection phase yielded 214 valid responses. This comfortably exceeds both the proportional item-to-response ratio and the absolute SEM baseline, thereby ensuring robust, stable, and highly reliable parameter estimates for the hypothesized model.

Survey Instrument and Measurement The structured questionnaire was carefully designed to capture both the demographic profiles of the respondents and their perceptions regarding the latent constructs under investigation. The survey instrument was divided into two primary sections. The first section gathered demographic and general healthcare utilization data. The second section comprised the core measurement model, which included 38 observable items designed to evaluate the ten latent constructs.

To ensure high content validity, these 38 items were adapted from well-established scales in both the services marketing and healthcare management literature. Specifically, items measuring Hospital Staff Behaviour and Hospital Facilities were adapted from the foundational SERVQUAL framework (Parasuraman et al., 1988; Fatima et al., 2018). Doctor-Patient Communication and Quality of Medical Treatment items were drawn from Dagger et al.'s (2007) scale on healthcare technical and interpersonal quality. Attributes relating to Cost, Transparency, Accessibility, and Reputation were synthesized from contemporary empirical studies on healthcare consumerism (Fabbri et al., 2023; Strumann et al., 2022). Finally, the mediating variable of Patient Trust and the dependent variable of Patient Preference and Future Choice were adapted from relational marketing paradigms validated in clinical settings (Morgan & Hunt, 1994; Wu et al., 2022; Zeithaml et al., 1996). All items were contextualized for the Indian healthcare sector and measured on a 5-point Likert scale.

Instrument Pre-testing and Content Validity Prior to large-scale data collection, the draft instrument was subjected to a rigorous pre-testing phase to ensure linguistic clarity, cultural appropriateness, and face validity. A panel of three academic experts in healthcare administration and two senior hospital managers reviewed the questionnaire. Based on their feedback, minor adjustments were made to the phrasing of specific items (e.g., standardizing medical terminology for laypersons) to eliminate ambiguity. Subsequently, a pilot study was conducted with a small sub-sample ($n = 25$) of healthcare consumers. The pilot data was not included in the final analysis, but it confirmed that the survey took an average of 8 to 10 minutes to complete and that no items suffered from high non-response rates.

Analysis and Result

Prior to factor extraction, the suitability of the data for structure detection was evaluated. The Kaiser-Meyer-Olkin measure of sampling adequacy was 0.823, exceeding the recommended value of 0.60, indicating sufficient item correlations for factor analysis. Additionally, Bartlett's Test of Sphericity was highly significant ($\chi^2 = 7475.97$, $df = 703$, $p < 0.001$), successfully rejecting the null hypothesis that the correlation matrix is an identity matrix.

Table 1 KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.823
Bartlett's Test of Sphericity	Approx. Chi-Square	7475.970
	Df	703
	Sig.	.000

Collectively, these preliminary diagnostic statistics confirm that the dataset possesses adequate internal correlations and is exceptionally well-suited for subsequent factor extraction and structural modelling.

Measurement Model Assessment: Reliability and Convergent Validity

The measurement model was rigorously evaluated to ensure both internal consistency and convergent validity. Internal consistency was assessed using Composite Reliability (CR). As presented in Table 2, the CR values for all latent constructs range from 0.75 to 0.96. These values comfortably exceed the recommended minimum threshold of 0.70, indicating robust internal consistency across all dimensions of the survey instrument.

Table 2 Reliability and Convergent Validity of the Measurement Model

Construct	No. of Items	Range of Factor Loadings	CR	AVE
Doctor–Patient Communication	4	0.863 – 0.915	0.94	0.79
Transparency in Treatment and Billing	4	0.880 – 0.926	0.95	0.82
Hospital Staff Behaviour	4	0.908 – 0.935	0.96	0.85
Quality of Medical Treatment	4	0.882 – 0.923	0.95	0.82
Availability and Accessibility of Services	4	0.904 – 0.927	0.95	0.84

Hospital Reputation and Image	4	0.906 – 0.933	0.96	0.85
Cost of Treatment and Affordability	4	0.891 – 0.913	0.95	0.81
Hospital Facilities and Infrastructure	4	0.899 – 0.919	0.95	0.83
Patient Trust	3	0.660 – 0.758	0.75	0.50
Patient Preference and Future Choice	3	0.659 – 0.754	0.76	0.52

Furthermore, convergent validity was established by examining the Standardized Factor Loadings and the Average Variance Extracted (AVE). The factor loadings for all items ranged from 0.659 to 0.935, demonstrating strong indicator reliability. Additionally, the AVE values for all constructs met or exceeded the strict baseline threshold of 0.50 (ranging from 0.50 to 0.85). Notably, while the AVE for Patient Trust sits exactly at the 0.50 boundary, its corresponding Composite Reliability of 0.75 confirms that the construct possesses adequate convergent validity and internal consistency. Collectively, these results confirm that the measurement model effectively and reliably captures the intended latent constructs.

Discriminant validity was evaluated using the Fornell-Larcker criterion, which requires the square root of the Average Variance Extracted (AVE) for each latent construct to exceed its correlations with all other constructs. As shown in **Table 3**, the square roots of the AVE (represented in the bold diagonal) range from 0.704 to 0.920.

Table 3 Discriminant Validity (Fornell-Larcker Criterion)

	DPC	TTB	HSB	QMT	AAS	HRI	CTA	HFI	PT	PPF
DPC	0.89									
TTB	-0.07	0.91								
HSB	-0.03	-0.09	0.92							
QMT	0.01	-0.02	0.01	0.91						
AAS	-0.14	0.01	0.00	0.06	0.91					
HRI	-0.12	-0.14	0.10	0.02	0.02	0.92				
CTA	0.12	0.02	-0.18	-0.05	-0.04	-0.08	0.90			
HFI	-0.03	0.02	0.08	-0.01	0.04	0.03	-0.06	0.91		
PT	0.229	-0.02	0.117	0.396	0.053	0.202	-0.391	0.1	0.704	
PPF	0.04	0.366	-0.015	0.198	0.061	0.376	-0.157	0.079	0.422	0.720

(Note1: The bold diagonal elements represent the square root of the Average Variance Extracted (AVE). The off-diagonal elements represent the correlations between constructs.)

(Note2: DPC = Doctor Patient Communication; TTB = Transparency in Treatment and Billing; HSB = Hospital Staff Behaviour; QMT = Quality of Medical Treatment; AAS = Availability and Accessibility of Services; HRI = Hospital Reputation and Image; CTA = Cost of Treatment and Affordability; HFI = Hospital Facilities and Infrastructure; PT = Patient Trust; PPF = Patient Preference and Future Choice.)

These values are consistently higher than the inter-construct correlations, which reached a maximum absolute value of 0.422 (between Patient Trust and Patient Preference). This confirms that all ten latent variables are statistically unique and satisfy the rigorous requirements for discriminant validity.

Structural Model and Goodness-of-Fit

Table 4 Structural Model Fit Indices

Fit Index	Recommended Threshold	Observed Value	Interpretation
CMIN/DF	< 3.00	1.113	Excellent Fit
CFI	> 0.90	0.95	Excellent Fit
TLI	> 0.90	0.94	Excellent Fit
IFI	> 0.90	0.93	Excellent Fit
RMSEA	< 0.08	0.048	Excellent Fit

Following the validation of the measurement model, the structural model was estimated to evaluate the hypothesized relationships. The goodness-of-fit was assessed using a combination of absolute, incremental, and parsimonious fit indices to ensure model robustness. As presented in Table 4, the Chi-square to degrees of freedom ratio (CMIN/DF) was 1.113, well below the conservative threshold of 3.00, suggesting a highly parsimonious model.

Furthermore, all incremental fit indices, including the Comparative Fit Index (CFI = 0.95), Tucker-Lewis Index (TLI = 0.94), and Incremental Fit Index (IFI = 0.93), comfortably exceeded the recommended strict threshold of 0.90, indicating a strong fit relative to a baseline model. Finally, the Root Mean Square Error of Approximation (RMSEA) was recorded at 0.048. Because this value falls below the stringent 0.05 threshold for a "close fit" (and well within the standard 0.08 limit), it confirms that the model's error of approximation is highly acceptable. Collectively, these indices demonstrate a robust and excellent fit between the proposed theoretical model and the empirical data.

Hypotheses Testing and Path Analysis

As depicted in the standardized structural path model (Figure 2), the explanatory power of the proposed framework was assessed by examining the squared multiple correlations (R^2) of the endogenous variables.

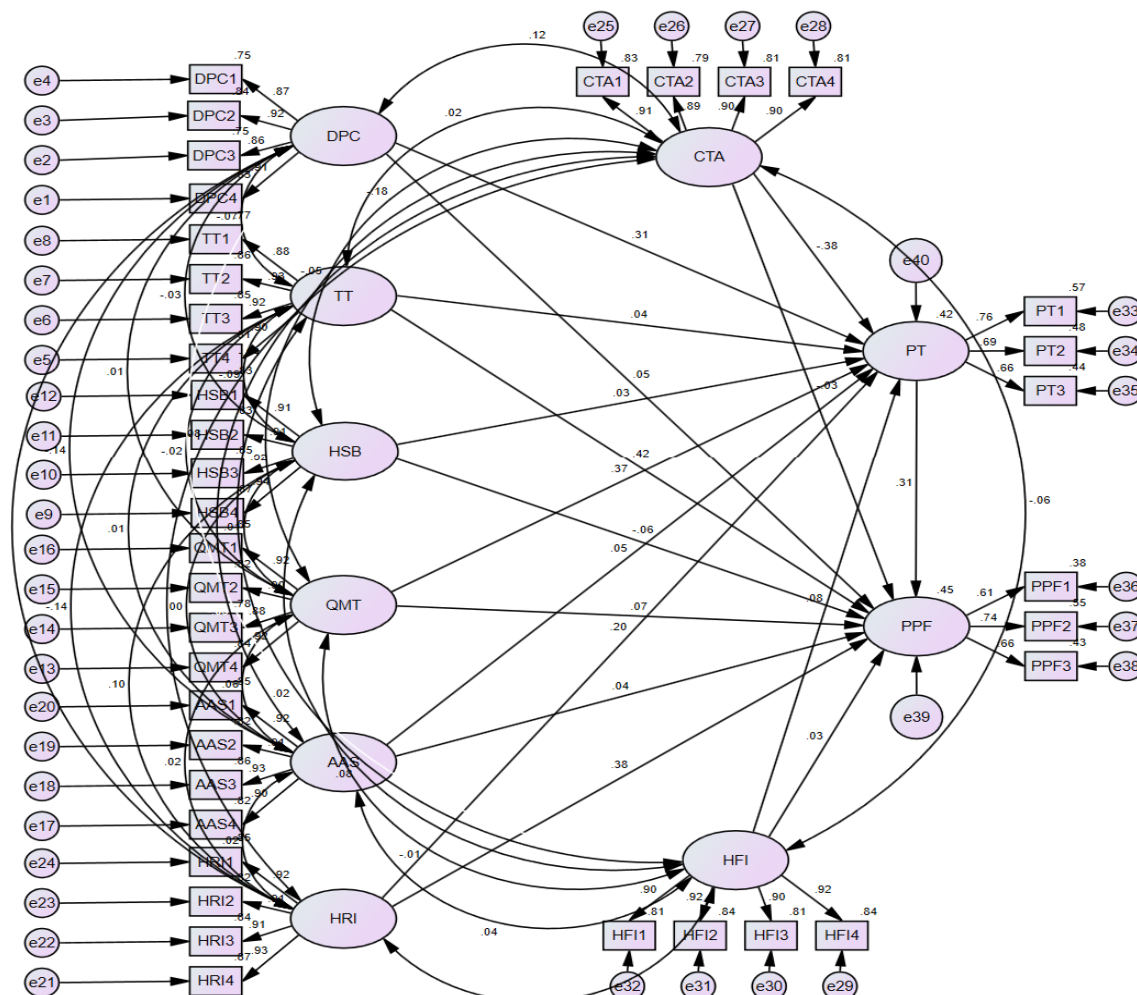


Figure 2 Standardized Structural Path Model

The analysis reveals that the exogenous multidimensional hospital attributes collectively account for 42.0% of the variance in Patient Trust ($R^2 = 0.42$). Furthermore, the complete model—incorporating both the direct effects of the hospital attributes and the mediating influence of Patient Trust—successfully explains 45.0% of the total variance in Patient Preference and Future Choice ($R^2 = 0.45$). These substantial variance figures indicate that the conceptual model possesses strong predictive capacity in determining healthcare consumer behavior. Having established the model's structural explanatory power, the individual standardized path coefficients were subsequently evaluated to test the specific formulated hypotheses.

Table 5 Structural Path Estimates and Hypothesis Testing

Hypothesis	Structural Path	Standardized Estimate (β)	p-value	Decision ($p < 0.05$)
H1a	DPC $\rightarrow$ Patient Trust	0.18	< 0.001	Supported
H1b	TTB $\rightarrow$ Patient Trust	0.04	0.537	Not Supported
H1c	HSB $\rightarrow$ Patient Trust	0.03	0.692	Not Supported
H1d	QMT $\rightarrow$ Patient Trust	0.37	< 0.001	Supported
H1e	AAS $\rightarrow$ Patient Trust	0.05	0.433	Not Supported
H1f	HRI $\rightarrow$ Patient Trust	0.2	0.005	Supported
H1g	CTA $\rightarrow$ Patient Trust	-0.38	< 0.001	Supported
H1h	HFI $\rightarrow$ Patient Trust	0.08	0.228	Not Supported

H3	Patient Trust → Future Choice	0.31	0.011	Supported
H2a	DPC → Future Choice	-0.09	0.523	Not Supported
H2b	TTB → Future Choice	0.31	< 0.001	Supported
H2c	HSB → Future Choice	-0.05	0.423	Not Supported
H2d	QMT → Future Choice	0.42	0.373	Not Supported
H2e	AAS → Future Choice	-0.06	0.595	Not Supported
H2f	HRI → Future Choice	0.38	< 0.001	Supported
H2g	CTA → Future Choice	-0.06	0.768	Not Supported
H2h	HFI → Future Choice	0.03	0.657	Not Supported

(Note: DPC = Doctor Patient Communication; TTB = Transparency in Treatment and Billing; HSB = Hospital Staff Behaviour; QMT = Quality of Medical Treatment; AAS = Availability and Accessibility of Services; HRI = Hospital Reputation and Image; CTA = Cost of Treatment and Affordability; HFI = Hospital Facilities and Infrastructure)

As detailed in Table 5, the structural path analysis yielded mixed results for the hypothesized relationships. Regarding the antecedents of Patient Trust, Hypothesis 1a, predicting a positive impact of Doctor-Patient Communication on Trust, was supported ($\beta = 0.18$, $p < 0.001$). However, Transparency in Treatment and Billing (H1b, $p = 0.537$) and Hospital Staff Behaviour (H1c, $p = 0.692$) did not exhibit significant effects, meaning these hypotheses were not supported. H1d was strongly supported, identifying Quality of Medical Treatment as a highly significant driver of trust ($\beta = 0.37$, $p < 0.001$). Availability and Accessibility of Services (H1e) was not supported ($p = 0.433$). Conversely, Hospital Reputation and Image (H1f) demonstrated a significant positive effect on trust ($\beta = 0.20$, $p = 0.005$) and was supported. Hypothesis 1g, regarding Cost of Treatment and Affordability, was supported, revealing a significant negative relationship with trust ($\beta = -0.38$, $p < 0.001$). Finally, the impact of Hospital Facilities and Infrastructure (H1h) was not statistically significant ($p = 0.228$).

Following the logical flow of the structural model, the mediating role of Patient Trust was evaluated. The analysis strongly supported Hypothesis 3, confirming a significant positive relationship between Patient Trust and Patient Preference and Future Choice ($\beta = 0.31$, $p = 0.011$).

Finally, the direct effects of hospital attributes on Patient Preference and Future Choice (Hypothesis 2) were assessed. Doctor-Patient Communication (H2a, $p = 0.523$) showed no significant direct effect. However, Transparency in Treatment and Billing (H2b) was fully supported as a significant direct predictor of future choice ($\beta = 0.31$, $p < 0.001$). The subsequent hypotheses regarding Hospital Staff Behaviour (H2c, $p = 0.423$), Quality of Medical Treatment (H2d, $p = 0.373$), and Availability and Accessibility of Services (H2e, $p = 0.595$) were all found to be statistically insignificant. Hospital Reputation and Image (H2f) was strongly supported as a direct driver of future choice ($\beta = 0.38$, $p < 0.001$). The remaining direct paths for Cost of Treatment and Affordability (H2g, $p = 0.768$) and Hospital Facilities and Infrastructure (H2h, $p = 0.657$) were not supported.

Managerial Implications

The empirical findings of this study provide critical, actionable insights for healthcare administrators, hospital managers, and policymakers aiming to thrive in an increasingly competitive, consumer-driven

healthcare landscape. The structural validation of the proposed model highlights that securing long-term patient loyalty requires a paradigm shift from purely clinical operational metrics to holistic, trust-centric relationship management.

1. The "Trust-First" Mandate for Clinical Excellence. The discovery of full mediation regarding the Quality of Medical Treatment (QMT) is perhaps the most crucial strategic takeaway for hospital management. Administrators must recognize that clinical excellence, state-of-the-art equipment, and successful medical outcomes are no longer sufficient to guarantee patient retention. Because QMT only influences future choice by successfully building trust first, hospitals must invest heavily in Patient Relationship Management (PRM). This involves post-discharge follow-ups, personalized care plans, and empathetic patient engagement strategies that bridge the gap between a successful medical procedure and a patient's long-term psychological confidence in the institution.

2. Financial Transparency as a Behavioral Trigger. The findings clearly delineate the dual financial concerns of the modern healthcare consumer. The strong negative impact of the Cost of Treatment (CTA) on Patient Trust, coupled with the significant direct impact of Transparency in Treatment and Billing (TTB) on Future Choice, dictates an urgent need for financial predictability. Hospital administrators should eliminate opaque pricing structures and hidden fees. Implementing digital cost-estimators, providing itemized and easy-to-understand billing, and offering dedicated financial counseling prior to treatment can serve as powerful competitive advantages. Transparency acts as an immediate behavioral trigger for loyalty, effectively neutralizing the anxiety associated with healthcare costs.

3. Enhancing Doctor-Patient Communication (DPC). The significant role of Doctor-Patient Communication in building trust indicates that hospitals must prioritize the interpersonal skills of their medical staff alongside their technical expertise. Management should implement mandatory soft-skills and empathy training programs for physicians and nursing staff. Encouraging doctors to spend adequate time explaining diagnoses, actively listening to patient concerns, and involving patients in shared decision-making processes will yield substantial returns in institutional trust.

4. Strategic Brand and Reputation Management. Hospital Reputation and Image (HRI) emerged as the most versatile asset in the structural model, successfully driving both Patient Trust and direct Future Choice. In a digital era where healthcare consumers extensively research providers before visitation, administrators must proactively manage their institution's public image. This involves actively curating online patient reviews, showcasing clinical success rates, engaging in community health initiatives, and ensuring that the hospital's marketing communications align with the actual patient experience. A strong reputation acts as both an initial attractor and a long-term retention tool.

Limitations of the Study

While this study offers robust empirical insights and methodological rigor, certain limitations must be acknowledged. First, the research employed a cross-sectional design. Consequently, while the structural equation model strongly implies causal relationships between hospital attributes, trust, and future choice, definitive causality can only be established through longitudinal research tracking patient behavior over time. Second, the sample was geographically restricted to the adult population of Surat, Gujarat. While Surat is a rapidly growing urban hub representative of emerging healthcare markets, the findings may not be entirely generalizable to rural populations or differing socio-cultural demographics within other Indian states. Finally, the study relies on self-reported data to measure behavioral intentions (Future Choice), which, despite assurances of anonymity, may be susceptible to inherent social desirability or recall biases.

Directions for Future Research

The findings of this study open several promising avenues for future academic inquiry. Future researchers are encouraged to adopt longitudinal study designs to track how patient trust evolves from the initial consultation through post-treatment recovery, providing a dynamic view of loyalty formation. Additionally, comparative studies expanding the geographic scope to include a multi-city analysis (e.g., comparing Tier-1 metropolitan cities with Tier-2 or Tier-3 cities) would yield valuable insights into how geographic and economic factors moderate patient expectations.

Furthermore, future models could incorporate patient-specific moderating variables—such as health literacy, income levels, and the severity of the medical condition—to understand how different demographic segments weigh hospital attributes. Finally, extending this model to explicitly compare private corporate hospitals against public healthcare institutions could provide nuanced policy implications for national healthcare frameworks.

Conclusion

As the healthcare sector undergoes rapid commercialization and digitalization, understanding the precise mechanisms of patient loyalty has become an imperative for institutional survival. This study empirically validates that while superior clinical outcomes and modern infrastructure are foundational prerequisites for a healthcare facility, they do not automatically generate patient retention.

By employing a rigorous Structural Equation Modeling approach, this research demonstrates that **Patient Trust** acts as the definitive psychological bridge in the healthcare consumer's decision-making process. The discovery of full mediation indicates that critical factors, such as the Quality of Medical Treatment and Doctor-Patient Communication, only secure long-term loyalty if they successfully cultivate an environment of absolute trust first. Conversely, Financial Transparency and a strong Hospital Reputation act as powerful, direct behavioral triggers for future choice. Ultimately, hospital administrators must pivot from purely

transactional, clinical metrics toward comprehensive, trust-centric relationship management. Institutions that successfully integrate clinical excellence with transparent, empathetic patient engagement will not only secure a sustainable competitive advantage but will fundamentally elevate the standard of patient-centric care.

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