Major Research Project on

Study of Digital and Traditional Influence Factors in Healthcare Provider Selection Among Indian Consumers

Submitted By

Hari Om Sharma

24/DMBA/89

Under the Guidance of:

Dr. Meenakshi Ahlawat

Assistant Professor, DSM, DTU



DELHI SCHOOL OF MANAGEMENT

DELHI TECHNOLOGICAL UNIVERSITY

Bawana Road, Delhi-110042

CERTIFICATE

This is to certify that Mr. Hari Om Sharma has completed the project titled "Study of Digital and Traditional Influence Factors in Healthcare Provider Selection Among Indian Consumer: under the guidance of **Dr. Meenakshi Ahlawat, Assistant Professor,** as a part of Master of Business Administration (MBA) curriculum of Delhi School of Management, New Delhi. To the best of my knowledge, this is an original piece of work and has not been submitted elsewhere.

Dr. Meenakshi Ahlawat
Assistant Professor
Delhi School of Management
Delhi Technological University

DECLARATION

I, Hari Om Sharma student at Delhi School of Management, Delhi Technological University hereby declare that the Major Research Report on " Study of Digital and Traditional Influence Factors in Healthcare Provider Selection Among Indian Consumer" submitted in partial fulfillment of the requirements for the award of the degree of Master of Business Administration (MBA) is the original work conducted by me. I also confirm that neither I nor any other person has submitted this project report to any other institution or university for any other degree or diploma. I further declare that the information collected from various sources has been duly acknowledged in this project.

Hari Om Sharma

24/DMBA/89

Place: New Delhi

Date:

ACKNOWLEDGEMENT

I would like to express my heartfelt gratitude to everyone who supported me throughout the course of my Major Research Project.

First and foremost, I would like to extend my sincere thanks to my guide, **Dr. Meenakshi Ahlawat, Assistant Professor, Delhi School of Management, Delhi Technological University**, for her invaluable guidance, support, and encouragement. Her insightful feedback, patience, and unwavering motivation were instrumental in shaping this project. I am truly grateful for the time and effort she invested in mentoring me.

I would also like to thank my batchmates of Delhi School of Management, Delhi Technological University for creating a nurturing academic environment and for their constant support throughout my academic journey.

Lastly, I am deeply thankful to my family and friends for their constant encouragement, emotional support, and belief in me during this research journey. This project would not have been possible without the contributions and guidance of the people mentioned above, and I am truly thankful for their support.

Thank You

Hari Om Sharma

24/DMBA/89

Executive Summary

Healthcare decisions are rarely made based on 1 or 2 factors. People ask around, search online, and remember what worked last time, before settling on a doctor or a hospital. This study tried to understand that process more clearly specifically, what actually drives healthcare provider selection among Indian consumers today, and whether the growing presence of digital platforms has begun to shift the balance away from the traditional, trust-based factors that have always anchored these decisions.

The short answer, based on evidence collected from 128 respondents across India, is that traditional factors still lead and they lead by a meaningful margin.

Doctor experience, clinical expertise, honest communication about treatment costs, and personal recommendations from people within one's circle came out as the most influential factors in the entire study. These are not exceptional findings, but they are honest ones. When someone is unwell or worried about a family member, what they want most is a doctor they can trust someone experienced, someone recommended, someone who will not surprise them with a bill they were not prepared for. That fundamental human need has not changed, even as the world around it has.

Digital factors are genuinely part of the picture and that is an important finding in its own right. Online comparison tools, peer ratings, and patient reviews all scored above the neutral midpoint, confirming that Indian consumers are using digital platforms actively when thinking about healthcare choices. But the way they are using them matters. They are using them to research, compare, and double-check not to make the decision outright. The consumer has usually already formed a strong instinct based on traditional signals, and they turn to digital sources to confirm or challenge that instinct before committing.

A paired sample t-test placed the two categories side by side and confirmed what the individual scores suggested traditional factors score significantly higher than digital factors, with a large effect size that leaves little room for ambiguity. It reflects something real about how Indian consumers think and feel about healthcare.

Finally, the correlation analysis found that traditional and digital factors are positively related to each other consumers who engage with one tend to engage with the other as well. This is perhaps the most unexpected finding of the study. It suggests that the Indian healthcare consumer is not choosing between tradition and technology but drawing from both, blending old factors with new information tools in a way that reflects exactly where India itself is right now somewhere between the familiar and the emerging, navigating both at once.

TABLE OF CONTENTS

CHAPTER	PARTICULARS	PAGE NO.
1.	INTRODUCTION	
	1.1 INTRODUCTION	8
	1.2 PROBLEM STATETEMNT	14
	1.3 OBJECTIVE OF THE STUDY	15
	1.4 SCOPE OF THE STUDY	16
2.	LITERATURE REVIEW	18
3.	RESEARCH METHODOLOGY	29
	3.1 INTRODUCTION	29
	3.2 RESEARCH DESIGN	29
	3.3 RESEARCH HYPOTHESIS	30
	3.4 DATA COLLECTION	30
4.	DATA ANALYSIS	34
5.	RESULTS AND DISCUSSION	47
	CONCLUSION	48
	RECOMMENDATIONS	48
	LIMITATIONS OF THE STUDY	49
	REFERENCES	50-52
	EXHIBIT	53

CHAPTER 1

1.1 INTRODUCTION

India has experienced a revolution in its healthcare industry over the last few years as a result of a growing digitalization, an increasing health awareness, and a greater access to information. Historically, Indian consumers have chosen healthcare providers primarily based on the reputations of doctors, referrals by family/friends, distance to hospital, the cost of medical care and quality of healthcare. There was a significant impact of word-of-mouth communication and personal experiences on making healthcare-related decisions.

Consumer behavior within the healthcare sector has begun to shift with the fast evolution of the internet, smartphones and digital platforms. Even nowadays, people go and look on the Internet to find out more information about a doctor, clinic, or hospital first. Various online reviews, medical websites, social media, sponsored messages and health-related mobile app websites have played significant roles as information sources to consumers. Patients are becoming more demanding; they rate healthcare providers in terms of ratings, online presence, and information and digital convenience.

Healthcare decision making in a developing nation has grown to become complicated in India. There are also consumers who remain more dependent on personal recommendations and trust-based relationship and those that are guided by online contents and online experiences. The impact of these factors can also vary according to demographic factors including gender, age, level of education and internet use habits.

A. Traditional Healthcare Factors

1.Hospital Brand Image

Advertisements only are not sufficient to create brand image in the healthcare, decades of consistent care, community presence and silent reputation, which is passed down through generations in a family, do the trick.

The brand image of a hospital is much more important to the Indian consumer than the logo or tagline. It comprises the physical look of the facility, how staff handle themselves, how clean is the facility, how effective is their administration and above all the results that patients have received. A brand image that has been built through an effective treatment of critical cases, an ethical hospital that treats patients with dignity and dignity will naturally ensure no one can simply imitate.

in the tier-1 cities such as Delhi or Mumbai, the hospital chains of AIIMS, Apollo, or Fortis provides quality and reliability to a consumer. The hospital brand is one of the determining factors in the Indian context where healthcare literacy disparities significantly among the groups.

2. Doctor Reputation

Advertisements only are not sufficient to create brand image in the healthcare, decades of consistent care, community presence and silent reputation, which is passed down through generations in a family, do the trick.

The brand image of a hospital is much more important to the Indian consumer than the logo or tagline. It comprises the physical look of the facility, how staff handle themselves, how clean is the facility, how effective is their administration and above all the results that patients have received. A brand image that has been built through an effective treatment of critical cases, an ethical hospital that treats patients with dignity and dignity will naturally ensure no one can simply imitate.

in the tier-1 cities such as Delhi or Mumbai, the hospital chains of AIIMS, Apollo, or Fortis provides quality and reliability to a consumer. The hospital brand is one of the

determining factors in the Indian context where healthcare literacy disparities significantly among the groups.

3. Pricing Transparency

Indian public and private healthcare is different in price by a colossal margin, and the prices of two large-scale hospitals and local clinics do not coincide in the same city, not to mention various specialists. Cost is not just preferred as it is a key factor to a large percentage of the Indian population, and due to the severity of the household income, a single hospitalization may be months of household income.

Pricing transparency is the extent to which a healthcare giver is open and transparent with the cost of its services consultation fees, diagnostic charges, costs of procedures, room costs, and costs after discharge etc. It seems commonplace that in the market, fair pricing is not shared equally providers who provide transparent, frontal pricing are credible.

There is apprehension due to lack of pricing transparency. Patients who do not know the cost of treatment will tend to put off care, to not ask questions or to accept other inferior care and alternatives merely because they can now budget it. This is profoundly a problem in India where health insurance penetration continues to be low despite increasing, individual healthcare spending is one of the highest in the world in relation to income level.

When a hospital or clinic provides its pricing.It demonstrates that the provider realizes that the patients are not merely bodies to be treated but individuals. This transparency can mean the difference between using one provider and another to lower and middle income consumers.

4. Accessibility

Physical proximity, access to transport, operating hours, waiting times as well as ease in booking appointments are all part of accessibility in the Indian context. A well-established hospital that is an hour distant might lose customers to a moderately-established clinic just ten minutes away especially routine check-ups, follow-ups, and non-urgent cases.

Medical facilities in these locations are commonly government primary health centers and Private facilities which are understaffed, few in numbers and specialist medical care which has to be travelled to the closest large town or city. The most available provider is often the most preferred provider in these settings, despite other factors of quality, due to the limited choice of options and the high costs of travel.

The accessibility problem that urban consumers have is a different issue that is not related to the lack of alternatives, but availability. Accessibility is a challenge in even urban areas where long lines at leading hospitals and weeks spent waiting before assignment to a specialist are typical as well as the tricky referral processes.

5. Insurance Acceptance

The high percentage of Indian consumers now decide on the healthcare option depending on the insurance with the rising schemes of Ayushman Bharat and increasing employer-provided and individual health coverage policies by consumers.

In the case of insured patients, quality, or location is not the only factor in making the choice of a healthcare provider. It is also decided by the fact the provider is part of the insurance network, if cashless hospitalization is available, and the simplicity of claim process. A hospital that provides quality care with a complex reimbursement procedure will end up losing patients to others who provide cashless treatment procedures.

Insurance acceptance also communicates regarding the credibility of a hospital. The presence of hospital working with big insurance companies normally involves meeting some quality and infrastructure parameters, which consumers use to develop credibility in their minds.

Simultaneously, in India, much of the population is uninsured or underinsured. For this segment, insurance acceptance is irrelevant and they have to spend the money out of their pocket to them other factors are important such as, doctor reputation, and proximity. Insurance is increasingly becoming an important part in the decision making in healthcare.

B. Digital Influence Factors

6. Online Reviews & Ratings

Social sites like Practo, Google Review, Justdial, and feedback portals have taken a significant role as a source of reference among healthcare consumers. Consumers use the internet to search review and spend time going through the web and make their opinions before visiting a new clinic or specialist. The rating of 4.8 of a doctor and two hundred positive feedbacks it sends signals consumers credibility to book an appointment.

The specificity of online reviews is their significance in the healthcare environment: what the wait time was, whether the doctor listened, whether the bill was billed as per the claim, how the staff nurses acted, etc. This will assist patients in shaping their expectations and making better decisions.

Consumers are also aware of the manipulation of online reviews and even one detailed negative feedback can also turn out to be the reason for not choosing the healthcare service.

7. Social Media Influence

The healthcare discourse in India has been both anticipated and unanticipated to embrace the social media. The emergence of platforms such as Instagram, YouTube, Facebook, and recently WhatsApp channels and LinkedIn have turned out to be a platform through which health information is generated, discussed, and acted upon at scale.

Social media as a factor in healthcare provider choice has several avenues of effect. Medical practitioners and health influencers have big audiences with whom they post content to create awareness regarding conditions, treatments, and providers. Patients are known to relate their own experiences in some cases publicly, in some instances, in a closed circle and these subjective accounts have a high emotional validity. A video of a patient sharing his/her recovery following a specific surgery in a specific hospital gets to the audience that no brochure would ever reach.

WhatsApp is an extremely effective informal health communication in India, particularly. Our family and community groups are being subjected to health tips,

doctor advice, experiences in the hospital, and even inaccurate medical tips and information all the time. One shared posting about a doctor or a hospital warning can impact dozens of choices in a small network of person-to-person communication, and it is difficult to distinguish between online influence and word-of-mouth.

The use of social media in the development and upkeep of the public image of the healthcare providers is also growing. When hospitals and physicians have an active, credible, and engaging social media presence full of health education information, patient testimonials, and behind-the-scenes peep shows of their facilities, they gain some familiarity with patients. Even before the consumer enters the door, the consumer can possibly develop the impression that the consumer has known the doctor well; merely by reading their reels or posts over months.

8. Website & App Information

The web site of a hospital or clinic is actually the initial conversation between that hospital and a prospective patient in numerous ways. A high and increasing number of consumers will go to the website or application of the provider they are considering to determine whether it is a place they will want to spend their time and trust. Whatever they do or fail to find during those few minutes can be the deciding factor on whether they move on or seek other avenues.

Good health care websites and applications convey many messages at once: The type of services available, the qualification and profile of the physician including the address and contact information, how to book an appointment and the overall organizational legitimacy of the organization. An outdated and hard-to-navigate or skimpy site about the relevant information indicates a form of institutional negligence where the provider has not anticipated that the patient has questions to ask him/her before visiting.

9. Online Advertisements

The online ads hold a curious and, at times, disputable position in the health care decision making. On the one hand, the use of specific digital ads on Google search, social media feeds, healthcare websites, and news sites has provided healthcare providers with the unequaled capability to target potential patients at the very time

they are searching online to gain health-related knowledge. Conversely, consumers are becoming more and more sceptical of advertisements overall and more so when it comes to such a delicate and personal area as healthcare.

Online healthcare advertising in India has to be executed right, or the program will not be effective. Informational, specific and trust-building ads such as announcing a new specialist to the hospital team, balancing a free health camp in a nearby community, or giving straightforward details of a treatment procedure are better received as opposed to the generic message that should be promoted. Consumers will distinguish between one advertisement that is attempting to assist them and one that is simply attempting to market to them, and in healthcare this is a distinction to which in most markets it is not a big issue.

One of the most direct digital channels of influence in the healthcare sector is search-based advertising, especially since Google Ads. A consumer with the particular symptom or seeking particular specialist will find himself or herself pushed with paid listings ahead of organic listings, and there are plenty that will utilise them should the content look applicable as well as authentic. To healthcare providers, a robust presence in paid and organic search results has thus become a step worth taking in patient acquisition strategy.

1.2 Problem Statement

Today, the healthcare environment of India is at a peculiar spot. On the one hand, there are decades of traditions patients, who believe a doctor owing to the belief of their parents, families, who decide what hospital to choose thanks to the recommendation of the neighbor and communities, the personal reputation of a doctor matters more to the patient than a certificate on the wall. On that side, you have a fast growing digital environment where one can read fifty patient reviews, or view a doctor on YouTube.

There is nothing wrong with the existence of these two worlds. The difficulty lies in the fact that we are not well informed either as to the interaction of them, which is of greater importance, with whom and in what circumstances.

Although the movement towards letting the digital platforms assume a prominent role in daily life is apparent, healthcare in India has not thoroughly been studied

through this perspective. Majority of the existing literature either completely looks at the traditional decision-making behavior or examines digital adoption separately. Very minimal studies have attempted to do both simultaneously and inquire when an Indian consumer selects a doctor or a hospital.

We also lack a demographic gap. India is not a unitary and homogenous consumer market. The healthcare consumer in Bengaluru (a 24-year old woman in technology) and in a small town in Rajasthan (a 45-year old man) is an Indian consumer, but the influences likely to affect their selection of provider are set to be very diverse. Sex, age, education, access to digital information is potentially affecting the way individuals interact with healthcare information and these differences are seldom studied within the same framework.

Healthcare providers like hospitals, clinics, independent practitioners are spending more and more on both conventional endeavors at building trust and digital marketing without necessarily having any real idea of which efforts are actually reaching and affecting their patients. Such decisions are mostly intuitive without a clear evidence, and those resources can be misplaced because of that.

This paper is thus an endeavor to close that gap. It aims to know in an organized and evidence-based context what concepts traditional and digital have a meaningful impact on how Indian consumers choose their healthcare providers, how they compare with each other, and whether gender has an influence specifically on digital influence. The results will be introduced in practice to assist healthcare providers in learning more about their patients; and marketers in attempting to construct a communication strategy that is based on the real decisions made, by real people.

1.3 Objectives of the Study

The objectives underlie the research and each of them concerns a different aspect of the larger research question.

Objective 1: To establish the conventional factors affecting the choice of healthcare providers among the Indian consumers.

Objective 2: To investigate the impact of digital factors of influence in healthcare provider choice among Indian shoppers.

Objective 3: To meaningfully compare digital and traditional influence factors in selecting healthcare.

1.4 Scope of Study

All studies have their limits, and it is as much an issue to be clear about them as it is to be clear about the study itself and what it seeks to accomplish. In this section, the area in which the present research has been carried out is outlined.

Geographical Scope

This research revolves around the Indian consumers and therefore falls within the Indian healthcare setting. There is a unique mixture between both public and private sector providers, an immensely diverse infrastructure of urban and rural parts of the country, varied capitalization of emerging cultures in relation to health and medicine, and unevenly distributed yet rapidly growing digital ecosystem., it is possible that results may not be equally applicable to all demographic groups in India.

Subject Scope

The focus of the study is specifically the issues that affect healthcare provider choice i.e. how consumers make decisions on which doctor, clinic or hospital to go to in search of medical attention. It does not analyze the outcomes of healthcare, clinical quality, the health policy of the citizens or the inner workforce of healthcare organizations.

The two main types of influence that are considered are traditional factors hospital brand image, doctor reputation, pricing transparency, accessibility, and insurance acceptance and digital influence factors online reviews and ratings, social media influence, information on websites and apps, and online advertisements. These are the nine elements that provide the foundation of analysis of the study.

Limitations of Scope

The paper does not purport exhaustiveness of the study. Factors influencing the choice of healthcare providers are also others like political and regulatory environment, accreditation status of the hospital, peer pressure and

psychological conditions like health anxiety which are not within the scope of this study. These are acknowledged as areas for future research.

The research was based on convenience sampling which utilized 128 respondents, the larger the size of the sample the higher the dependability of the study and the male respondents who were included in the survey was much higher than the female respondents which can be enhanced in future research.

With the development of AI further, healthcare industry is adopting these technologies very fast hence those dimension can be explored further about their impact on consumer behavior.

CHAPTER 2

Literature Review

2.1 Introduction

Choosing a physician or a hospital is very seldom an easy task. To most people it is a combination of their previous experiences, what others have said, what they have read on internet and at times it has been merely their gut feeling. What really goes behind that decision, and how this has evolved over the years has been a subject of increasing research in health services, marketing as well as consumer behaviour.

Likewise, this chapter combines some of the most important studies that have examined people in the choice of healthcare provider, the things that most influence their views in this group, and how the emergence of digital platforms has already started to change those priorities. Each of the studies is reviewed on what it discovered and where it has failed, as it is only in the areas of failure where the current study derives its mission.

2.2 Healthcare Consumer Behaviour

The behaviour of consumers in healthcare settings has long been a focus of academic interest in the realms of economics, sociology, public health and marketing since the process of health care provider selection is hardly ever straightforward. In contrast to the majority of other consumption decisions, healthcare choices are distinguished by the information asymmetry, high perceived risk, and strong attachments to emotions (Andersen, 1968) The first models of health services utilisation, such as the behavioural model proposed by Andersen, referred to locating the choice of provider predominantly as a matter of predisposing characteristics, enabling resources, and perceived need. These underlying concepts have been subsequently expanded and made complex with an increasing amount of empirical material. As Zeithaml et al. (1985) showed, the credence attributes qualities that cannot be readily judged by patients even after an encounter has ended determine the evaluation of service quality in healthcare making the pre-selection stage especially complicated. What is emerging as a collective wisdom in this line of early scholarship is that patients cannot be completely described as

rational calculators and entirely passive receivers; rather they must be operating within a context of structural constraints and personal heuristics which determine the ultimate decision to consider a provider.

In order to know what consumers want in a healthcare provider it is imperative to differentiate between the factors which they consciously define, and those which operate in the background. Pascoe (1983) observed that patient satisfaction as retrospective is different to the pre-selection criteria used by patients to review the option. Professional reputation, perceived technical competence and interpersonal manner of physicians have been found as the controlling selection criteria in repeated studies within the developed healthcare markets (Marshall et al., 2000). Nevertheless, the same results cannot be easily transferred to emerging markets where the structural aspects, like geographic distance, insurance, and the presence of facilities usually outweigh the quality. Specifically in the Indian context, Duggal (2005) found that household spending behavior indicates a long-living bias towards private versus public sources even by the poorer income groups, and that providers attitude and quality is incredibly important when consumers have, at minimum, a point of choice. Such a combination of limited rationality and quality-seeking behaviour forms the theoretical context in which both traditional and digital aspects of influence must be positioned.

2.2 Traditional Factors Influencing Healthcare Provider Selection

Of the conventional determinants of the choice of the healthcare provider, physical accessibility has always been a key factor especially in the context of South Asia. Proximity to the facility, accessibility of transportation, and working hours are all elements that researchers have defined as geographic convenience a constellation of factors that at an initial stage can act as a first-level filter, prior to any quality assessment takes place (Peters et al., 2008). Such a filter in rural and semi-urban India can be so definitive as to practically kill choice altogether, leaving the consumer with only one choice. At the same time, however, urban Indian customers find themselves in exactly the situation in which there are simply too many players in the market, whether informal general practitioners and diagnostic centres or large corporate hospital chains, to choose between. A study conducted by Balarajan et al. (2011) revealed that Indian households, despite geographic proximity consideration, which engage in the active

provider choice have weight facility reputation and physician identity rather high, which suggests there is a complex play between access and quality signals.

Personal trust and physician reputation are considered to be the most traditional drivers of provider selection which have been increasingly studied. In the healthcare literature, the concept of trust functions in several levels; trust of the individual doctor, trust of the entire institution and a generalised trust of the healthcare system (Calnan & Rowe, 2008). These are more or less autonomous such that a patient will have confidence in one doctor and have no trust in another hospital or the other way round. India has these network conditions: word-of-mouth networks are compact and the terminal relationships are enacted by personal relations with family members, friends, and community elders (Kumar et al., 2015). This trend has already been evidenced in various states: suggestion of a familiar individual often prevents advertising, infrastructure of the facilities, or even the distance. With that being said, personal referrals are not necessarily dependable as they are subject to biases and lack of medical expertise of the referring party, which is one of the reasons why patients that make decisions based on referrals are not always happy with the results (Bhatt, 2000).

Perceptions of quality of services that have been operationalised in terms of frameworks like SERVQUAL have been extensively applied in hospital choice research. These five dimensions of service quality were initially suggested by Parasuraman et al. (1988): reliability, assurance, tangibles, empathy, and responsiveness. Later researchers modularized these dimensions to medical practice context and discovered that empathy and assurance are especially critical when patients are prospectively assessing providers i.e. before they have experienced first hand in the facility (Taner & Antony, 2006). Physical architecture and physical clues neatness, technological savvy of devices, and look of waiting bays serve as fairly good proxy indicators of medical care excellence since the vast majority of patients do not have the technical charged to directly assess clinical competence. Some of the studies in India have proved the point that visible infrastructure quality has a major impact on provider selection as urban households with middle-income levels available in India have to make decisions about option of a hospital (Narang, 2011). This implies that hospitals concerned about patients are not merely competing based on the outcomes of their patient care but rather on a larger

palette of experience-based and physical signals which can be judged by consumers in a more practical way.

Another conventional influencing factor, albeit with a rather subtle impact, is the cost and payment structures. In Indian healthcare, a lack of price transparency has been a long-standing concern: pre-visit estimates of cost are uncommon, there are vast differences in costs across individual providers and such costs often need to be negotiated individually, and many households are not covered by universal insurance resulting in out-of-pocket spending being the predominant form of payment (Selvaraj & Karan, 2009). In such situations, perceived affordability rather than actual price is a fascinating motivator of behaviour. Patients occasionally perceive low cost to reflect poor quality and even do not take the cheapest out in times of financial strain. On the other hand, big private hospitals are not always chosen despite their preference on the quality basis due to the fear of unforeseen size of bills. The implementation of government programs, such as Ayushman Bharat, have started reshaping this calculus by covering a specified list of procedures but the adoption of the scheme varies among the territories (Berman et al., 2010). The importance of cost in provider choice is thus with trust, having information available and insurance status in a manner that cannot be captured by the simple price-sensitivity models.

2.3 Digital Influence Factors in Healthcare Provider Selection

The ripple effect of the quick proliferation of internet access and smartphones has brought another dimension of influence that intersects, and even replaces the old information avenues. In India, patients go online to seek health information by searching through search engines, health portals, and social media to research on the type, symptoms, or providers of treatment prior to a clinical encounter, and share this information with a health care provider, with these behaviours significantly increasing in the overall income and education strata over the last ten years (Nair et al., 2019). This habit cannot be homogenous and younger, more educated, urban consumers are more dependent on digital sources, but the rest of the population, the old people and rural ones, are yet to use word-of-mouth and personal networks. One of the first researchers to report the fact that individuals seldom critically consider quality or provenance of health information available online was Eysenbach and Kohler (2002), which brings the

issue of reliability of digital influence in the choice of providers. However, the sheer mass and availability of health information on the web has rendered the need to neglect the online environment of information practically unfeasible among healthcare providers.

One of the most direct channels by which the selection of providers is influenced by online information is online reviews and ratings, such as Google Reviews, Practo, JustDial, and other hospital-specific review systems. The online review literature of the healthcare sector also pulls some partial comparison with the literature of hospitality and e-commerce yet also establishes critical differences. Gao et al. (2015) have discovered that even with actual clinical quality indicators, star ratings on physician review sites have a significant influence on the rate of patient appointments. Not only are the reports on past patient experience read as predictive indications of the probable future experience but also they can be seen as a form of social proof in the face of uncertainty. Bansal and Gupta (2020) found in the Indian context that urban customers begin turning to Practo and similar aggregators and proceed to the process of outpatient specialists selection, paying a numerical rating had a tangible impact on the likelihood of doctors picking a specific provider. This tendency is especially significant considering that India was traditionally based on personal referrals, which implies that there is a partial replacement of internet-based social proof with network-based recommendations among digitally-savvy customers.

The effects of social media on healthcare choices have drawn a growing academic interest particularly following the growth of Facebook, Instagram, and YouTube as health communicators. In contrast to review sites, which are transactional and mostly anonymous social media allow some type of relationship based health (communication) in which followers can trust a source on the basis of continuous interaction, as opposed to a single rating. Moorhead et al. (2013) found that social media had the potential to provide personalised, context-specific information on health, which could have a significant impact on influencing preferences on the part of the provider and the choice of treatment seeking behaviour on the part of the patient. Health-based YouTube channels, Instagram profiles run by doctors, and patient communities found on Facebook have formed new poles of influence that were completely missing 10 years

ago in India. Uberbliu and broadly, Kaplan and Haenlein (2010) described social media as deeply democratising information creation in both a challenge to the monopoly of credentialed experts and well-established institutions and this dynamic manifests in healthcare in complex ways as it leads to true patient empowerment on the one hand and misinformation proliferation on the other.

The issue of whether physician digital presence have active profiles on LinkedIn, institutional websites biographies, academic publications posted on Google Scholar, YouTube explainer videos is worthy of further attention. A growing amount of evidence is emerging indicating that doctors who have a visible and reputable digital presence are more likely to draw in more patients, especially in urban markets where Internet search is used to find a provider before they resist (Lagu et al., 2010). In India, other digital physician infrastructure platforms such as Practo have formed a so-called quasi-formal infrastructure of physician digitality where physicians create searchable profiles with specialisation, experience, charges, and clinic appropriate places. The less known aspect is how patients trade such self-generated perceptions against third-party posts and whether verified credentials exposed online lead to different levels of trust than informal word-of-the-mouth. Patients do not seem to base their judgments using one source; instead, they integrate search results, review ratings, and, more and more, the presence of social media into one assessment pattern that makes it hard to distinguish the contribution made by a particular digital element.

Websites of hospitals and clinics could also be considered as digital factors of influence but its effect is usually underestimated in studies that concentrate on review sites. An informative web site that is professionally designed is an indicator of institutional validity and capability, especially in the case of first-time visitors with no previous acquaintance with the facility (Huang and Bhatt, 2018). The dimensions of website quality informational content, ease of navigation, graphic design, page loading speed, presence of online booking of appointments all help to form the comprehensive perception of a potential patient prior to her/his physical visit. These types of signals can of value in such a market, such as India, where there are not the same levels of trust in medical facilities across the board. Nonetheless, the union is not unique: the existence of intensely pruned websites by an unmanned provider can in fact awaken mistrust in the

segment of the consumer market that interprets as an attempt to commercialize the care the overtures of a commercial enterprise.

2.4 Comparing Digital and Traditional Influence Factors

Comparing the digital and traditional factors of influence within the set frames, the difference becomes evident yet a bit exaggerated in the discourse. Direct comparisons have been attempted in a few studies which have shown that the two types of factors are not as competitive as sequentially and contextually organized. Harris et al. (2003) suggested that health information seeking is a process with layers: need recognition results in network consultation or online search on basing the digital ability of the consumer and urgency of need perceived. Conventional factors proximity, physician referral, family recommendation is likely to prevail when considering acute visits, high-stakes visits, or routine visits, whereas digital factors acquire relative significance when it comes to elective visits, specialist visits, or second-opinion visit. This structural pattern seems to be similar in the Indian context: according to a study conducted by Gupta et al. (2018), traditional factors were the most significant in the selection of a general practitioner whereas the influence of digital was more significant in selecting specialties and hospitals in urban middle-class consumers. The practical implications of this splitting of power by type of providers and the decision stakes are on the way healthcare marketers can use communication resources.

Demographic and the socioeconomic stratification also adds complexity to the interaction between the digital and the traditional factors. The age, education and digital literacy always have a moderating effect on the degree to which consumers give weight to both online and personal networks (Fox and Duggan, 2013). The younger urban consumers in India especially those who have finished their schooling since the mass adoption of smartphones are more at ease with triangulation in between the digital and traditional information sources, with older consumers and less digital literate people predominantly utilizing conventional channels even when technically digital information is available. There is also the mediation of income: higher-income families tend to use online reviews to choose elective procedures, which might be due to having access to such tools and disposable income to afford a greater number of providers (Nair et al., 2019). These demographic distributions imply that composing a single model of

healthcare provider selection behaviour can likely blur a vast amount within-country variation which would be especially strong in a diversified market, such as India.

Price transparency, as well as clinical quality outcomes, slices across the digital and traditional influence pathways intriguingly. Patients have been found to interpret quality indicators as supplementary to personal referrals and not as an independent source in markets where government or accreditation agencies are compelling them to make public these indicators (Hibbard et al., 2002). Through Infrastructure Quality Transparency is not yet fully-established in India: the NABH accreditation is not yet universal, and clinical outcome information is rarely published. Patients in a world such as this will turn to proxy indicators infrastructure quality, waiting time, the qualifications in the waiting room of a physician, and more recently, to digital review ratings to create quality ratings. The birth of the digital review platforms therefore partly serves to fill an institutional vacuum as opposed to merely placing an additionary channel atop an already-transparent system. This background is significant in the understanding of why digital reviews are particularly weighted in India as compared to markets where established formal quality threshold benchmarking has been realized.

2.5 Indian Healthcare Consumer: Contextual Dimensions

The changes have been reflected in the literature of healthcare marketing, which now takes into account the new perspective of the model of the patient journey. Traditional early marketing models assumed that patients were rather passive consumers of the provider reputation provided through mass media and professional networks. The discontinuity of passive to active online information seeking that has been noted by some researchers as the empowering of the patient has necessitated a reconsideration of provider communication tactics (Lober and Flowers, 2011). Corporate hospital chains in India, including Apollo, Fortis, and Narayana Health, have reacted by investing heavily in digital marketing: search engine optimisation, sponsored content, social media interactions and influencer collaboration with physician-creators. This creates a significant asymmetry: it is possible to afford advanced digital marketing by means of a large chain, whereas the smaller, single-physician clinics, as well as mid-size hospitals, generally cannot. The outcome could be a compounding benefit to corporate providers

in forming digital provider perceptions, regardless of quality disparities an underlying market distortion still to be studied in whole by current literature.

The situation in Indian healthcare is even more complicated by cultural and social aspects of the healthcare setting. The notion of social capital, the worth people cultivate in their social networks and reciprocal desirability is especially applicable to India, where membership to a community, caste, or a kin may have a potent intermediation effect on healthcare decision-making (Mohindra et al., 2006). A doctor who is a member of the community that the patient belongs to or with whom the patient has a mutual social connection creates a type of trust which is dissimilar to the institutional or competency based trust which is indicated by the paper qualifications. This embedded trust is also relational and as such cannot be digitized, so a dual evaluative system of digital identification in the pre-comittal shortlisting phase and network validation in the traditional way might exist in highly digitally active Indian consumers. Being aware of this stratified dynamic is relevant in research designs that aim to separate individual variables, since antagonising digital and traditional effects as independent variables might not capture how the two will reinforce each other in reality.

There is also an overlap between the government and public sector aspect of Indian healthcare and research in provider selection that is not always emphasised. Although the contribution of the private sector is large, in the rural regions, the majority of Indians are served by the public hospitals and the factors, which determine whether to resort to the public or the private provider, represent a different set of considerations. The researchers of Rao et al. (2011) reported that the first push factors that led to patients opting out of public facilities and joining the private care despite the latter one being associated with significant out-of-pocket costs include poor quality of service as perceived, doctor absenteeism, and poor drug supply. This sphere has a relative low extent of digital influence as the decision between the use of public and private care is defined by structure rather than is based on information-seeking behaviour. So in the private sector where most of the competitions that are relevant to this study occur, the digital and traditional factors become more salient.

A number of more recent studies indicate the increasing relevance of telemedicine and digital health platforms to the redesign of provider selection itself. The COVID-19

pandemic had a significant impact in terms of accelerating use of teleconsultation services in India, and apps such as Practo, 1mg, and Tata Health reported an order-of-magnitude upsurge in video consulting booking during 2020-2021 (FICCI & EY, 2020). This change also brought in a new aspect to the selection of the provider: interface and usability of the teleconsultation platform could become a factor of influence itself, which partly mediates access to the physician. In case of patients choosing a teleconsultant provider, they also chose a platform, and the design of the platform along with its review ratings and brand reputation increased their trust in the physician they have reached via the platform. This provider selection mediated by the platform is a truly new phenomenon which the current frameworks created prior to mass digital health uptaking do not fully serve.

2.6 Research Gaps and Relevance of the Current Study

The majority of the empirical literature on the selection of medical care providers has been in developed-market settings, the United States, the United Kingdom, and some European nations where insurance arrangements, quality disclosure procedures, and computer infrastructure are far less developed than in India. Articles narrowly centred on the Indian market are either strictly clinical (utilisation habits and not selection behaviour) or geographically constrained (one city or hospital system). There are few comparative studies, which critically assess the comparative weight of digital and traditional factors within one research design, especially to the population of India. Various Indian studies also incline towards urban and educated consumers, thus other segments of the semi-urban and rural populations are underrepresented. A research that directly looks at the comparative outcomes of digital factors of influence on traditional ones, on consumer segments in Indian context thus fills a real gap and not merely a replication of foreign results in a local context.

The present research aligns itself to fill in some of these holes by researching on both digital and traditional influence variables with explicit comparative intent amongst the Indian consumers. The conceptual framework is based on the utilisation model by Andersen (1968), dimensions of service quality proposed by Parasuraman et al. (1988), and the emergent research on digital health communication, as well as on online review behaviour. By applying a multiply-determined (simultaneously structured) perspective

of the selection process, the study avoids the reductionism of single-factor methods by treating it as a key driver of relational trust coupled with institutional cues and digital information. The literature review employed in the present context suggests that neither the digital nor the traditional factors appear to work independently, that the comparative effect of the former is held under a moderating influence by the demographics of consumers and the context of their decision-making, and that the conditions of the Indian healthcare market, where the quality transparency is not complete and the informal social networks are unevenly distributed among the population segments, present the comparative issue particularly interesting and practically significant.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 Introduction

Decision making in healthcare is an individual topic. Individuals do not select physicians and hospitals like they select items in a shopping application. There is feeling, trust in it.

3.2 Research Design

In this study, a research design is quantitative and descriptive. Intention was to quantify and provide a description of how healthcare choices get made among Indian consumers, in this research, individuals are requested to explain what influences their healthcare decisions and thereafter attempts to interpret the trends in their responses.

3.3 Research Hypotheses

Hypothesis Set 1 Traditional Factor

- H01: Among Indian consumers, the selection of health providers does not depend on traditional factors.

Hypothesis Set 2 Digital Factors

- H 0 2: The choice of healthcare providers among consumers in India has no significant effect of digital factors.

Hypothesis Set 3 Comparing the Two

- H 0 3: The impact of digital factors on the decision-making process is no more significant than that of traditional factors in healthcare decision-making.

3.4 How the Data Was Collected

3.4.1 Primary Data

Data will be collected in this research through a structured survey questionnaire, as the primary source of data. The survey was constructed and emailed through Google Forms. The survey was distributed by word of mouth, WhatsApp groups and social media and the members were invited to complete the questionnaire when it was convenient to them.

3.4.2 Secondary Data

Literature review was conducted even before the survey had even been designed. This entailed searching the literature base and already existing research on the subject of healthcare consumer behavior, the influence of digital medium in consumer decision-making and conventional trust-based variables in the Indian context. This initial reader work aided in determining what was already known and what was left out, as well as offering the conceptual framework required to determine what factors to consider in the questionnaire.

3.5 The Questionnaire

The questionnaire was maintained clean and simple three parts all of which had a predetermined aim. Basic demographic information was gathered in section A. Section B centered on conventional influence variables hospital brand image, physician reputation, pricing transparency, accessibility, acceptance of insurance. Respondents were requested to state the extent to which each of these factors factors in the decision-making process when picking a healthcare provider. Section C was devoted to the digital factors of influence online reviews and ratings, social media influence, information about the web site and app and online advertisements.

The Scale Used is 5 Point Likert scale 0-1 which is Strongly Disagree 5 Strongly Agree. Likert scale was an option as it allows individuals to describe their feeling on how strongly they are about something instead of a yes, no. This is important in a human behaviour study. A person who is moderately in agreement and another who is in vehement agreement are not talking about the same thing, and the scale is able to reflect the difference.

3.6 Who Was Surveyed

3.6.1 Target Population

Any adult Indian consumer who during some time made calls to select a healthcare service provider (whether personally or on behalf of a family member) were eligible to take part in the survey.

There were no age, city, occupation, or income level limitations.

3.6.2 Sampling Method

Response was achieved through convenience sampling. It implies that the survey has been distributed among individuals that were available and volunteered to take part and not carried

out in a formally randomized manner. It presents a real, diverse collection of answers of real individuals, who willingly expressed their views, to explore, descriptively, this study.

3.6.3 Sample Size

One hundred and eighty-eight people filled out the questionnaire. Incomplete and obviously inconsistent responses were dropped off prior to analysis to ensure the data utilized in the work was clean and dependable. In the statistical tests that I will apply in this work as part of descriptive analysis, t-tests, and correlation of 128 valid answers is a feasible and suitable sample size.

3.7 Data analysis method.

At all the analysis was done with the help of IBM SPSS which can be considered as one of the most reliable and popular software regarding the quantitative analysis in the social science and management research. A total of four statistical analyses explored had their reasons.

3.7.1 Descriptive Analysis

This was where the initial move was made in getting a clear picture of the data before concluding any results. Mean scores were the average degree of consensus on each factor among all the respondents. The measure of dispersion determined in standard deviation how dispersed across one another was whether the responses were more in agreement all or diverse in their opinions. Frequency distributions were used to indicate the number of respondents who selected each point on the scale as answer to each question.

3.7.2 Paired Sample T-Test

The paired sample t-test was used to directly compare traditional factors and digital factors. Since both categories were rated by each and every respondent, their two sets of scores are related. They belong to one individual. The paired t-test is actually destined to be used in such a case as it compares two related groups of scores of similar participants and informs you whether the difference between them is statistically significant or the outcome of a mere variation.

3.7.3 Correlation Analysis

Pearson correlation analysis was the last analytical tool, as it came to realise the existence of relationship between traditional and digital influence factors.

The correlation coefficient that is the result of this test is between -1 and +1. A value near +1 implies that there is a strong relationship between the turns of the two variables where one variable increases, another is more likely to increase. The value near 0 indicates that they are not related. This result indicates whether the two categories are associated in a significant manner; this implies that healthcare providers must consider traditional and digital engagement as a mechanism of integration as opposed to two distinct strategies.

3.8 Ethics

The work on this survey was done on a voluntary basis. No one was asked to provide his or her name, phone or any personally identifiable details. The reason they did the study was made known to the respondents in advance and they could quit any time they wished. Any response did not have confidentiality and was only used as far as this academic work is concerned. No information was provided to third parties.

CHAPTER 4

DATA ANALYSIS

4.1 Demographic Profile of Respondents

Table 4.1 Demographics Table

		Frequency	Percent	Cumulative Percent
Age	18-25	81	63.30%	63.30%
	26-35	31	24.20%	87.50%
	36-45	4	3.10%	90.60%
	46-55	12	9.40%	100%
Gender	Male	36	28.1	28.10%
	Female	92	71.9	100%
Occupation	Business	8	6.3	6.30%
	Others	5	3.90%	10.20%
	Salaried	32	25%	35.20%
	Student	83	64.80%	100%
Monthly Income	1Lac - 2 Lac	38	29.70%	29.70%
	50k- 1 Lac	20	15.60%	45.30%
	Above 2 Lac	23	18%	63.30%
	Below 50k	47	36.70%	100%
City Tier	Tier 1	79	61.70%	61.70%
	Tier 2	45	35.20%	96.90%
	Tier 3	4	3.10%	100%
Frequency of Visits	Frequently	17	13.30%	13.30%
	Occassionaly	54	42.20%	55.50%
	Rarely	57	44.50%	100%

The age distribution analysis shows that the respondents were mostly in the 18-25 years age bracket at 63.3% of the total sample. Other Age group comprises the rest. On balance, the sample is dominated by young respondents, which suggests that the research predominantly reflects the attitudes and health care decision-making attitudes of young adults.

The analysis of gender distribution indicates that most of the respondents in the study are male-dominated as they constituted the majority of the sample in the study with 71.9 percent, and only 28.1 percent of the respondents were female. This shows that the sample of the study had higher representation of the male participants. Consequently, the results connected with the behavior of healthcare provider selection can convey comparatively more powerful views of male participants.

The distribution of the respondents occupation shows that most of the respondents were students, approximately 64.8 percent of the total sample. Salaried professions constituted 25.0 percent of the respondents although they were still, represented by others.

The distribution of monthly household income indicates that the biggest grouping of the respondents was the portion below 50000 income bracket with 36.7% of the total sample. The values of a monthly household income of 29.7 and 18.0 formed the proportion of respondents with income of 1,00,000 to 2,00,000 and Above 2,00,000 incomes respectively. The remaining 15.6% belonged to the ₹50,000–₹1,00,000 income group.

City-tier distribution analysis shows that most of the respondents were participants in Tier 1 cities which comprised 61.7% of the entire sample. The sample of people who lived in Tier 2 cities constituted 35.2% of the learning population.

Respondent who said they had frequent visits to healthcare providers also rarely contributed to 44.5% of the total sample whereas 42.2% said they visit healthcare providers occasionally. Few (13.3) per cent of individuals said they saw healthcare providers regularly.

4.2 Descriptive Analysis of Traditional Factors

Table 4.2 Traditional influence

Rank	Traditional Influence Factor	Mean Score	Std Deviation
1	Years of Doctor Experience	4.55	0.756
2	Doctors expertise	4.4	0.7
3	Clearly communicated treatment costs	4.38	0.599
4	Recommendations regarding reputed doctors	4.14	0.729
5	Convenient appointment availability	4.05	0.772
6	Insurance compatibility	3.91	0.753
7	Easy transportation access Influences	3.88	0.867
8	Transparent pricing influences	3.86	0.923
9	Hidden charges negatively influence	3.85	0.861
10	Healthcare providers with a strong brand reputation.	3.83	0.8
11	Proximity to my residence/workplace	3.74	0.881
12	Providers that accept multiple insurance plans.	3.7	0.845
13	Cashless treatment facilities influence	3.59	0.91
14	A well-known hospital increases my trust in healthcare services.	3.58	0.829
15	Brand image influence	3.5	0.842

INTERPRETATION

The descriptive outlay of the traditional influence factors can provide insights into the Indian consumers including what they truly focus on when selecting a healthcare provider. Investigating mean scores of all fifteen items, the personal and clinical factors are the best with the institutional and brand-related factors the worst.

The highest rated item (single highest) in the whole tradition factors was years of doctor experience followed by a mean of 4.55. The factor that is the most important in the mind of a

consumer is experience because this is likely to be associated with competence. The second metric is doctor expertise with a score of 4.40 that indicates that doctor credibility is a big issue when selecting a healthcare provider regardless of the brand of a healthcare provider.

The third most rated of course is at 4.38 clear communication of treatment costs. It implies that pricing transparency would be one of the elements of customer satisfaction. Patients desire not to feel surprised but feel respected and informed. This could be correlated to the fact that out of pocket healthcare expense is a comparatively high amount in relation to the earnings.

Fourthly with 4.14 recommendations about reputed doctors, it was established that word-of-mouth and personal networks are not insignificant in Indian healthcare decision-making process. Personality Bias is the most significant factor that has acted upon any social media which has followed up with reviews and testimonials.

The fact that 4.05 conveniently does appointments is reflective of a reality that is convenient and should be forgiven concerning accessibility, not only in terms of location. The hospital might be only half a mile away, but when it will take a week to make an appointment or a convoluted process of being referred to one, consumers will consider that inconvenience in their selection.

Going down the ranking towards the middle, aspects and traits such as insurance compatibility (3.91), easy access to transport (3.88), transparent pricing (3.86) and hidden conditions of the choices which affect decisions in a negative manner (3.85) all have scores above the midnote of the scale meaning that they are relevant and should be present even though they are not at the forefront of the choice as the clinical factors are. It is interesting that the presence of the negative influence of hidden charges has a score of 3.85. It is an indicator that the consumers are after the low prices but they want to be told the truth.

The items related to the lower part of the traditional factors ranking are lower in rate, with the items of institutions and brand fulfilling a comparatively lower score. The healthcare providers rated high in their brand reputation (3.83), proximity to residence or workplace rated at 3.74, accepting all types of insurance plans automated 3.70, cashless treatment facilities scored at 3.59, a well-known hospital raising trust at 3.58 and brand image today was

rated at 3.50. These scores although above the mid-point of 3.00, to show that they are not irrelevant to the consumers, do not hold as much weight, obviously, as the clinical and interpersonal factors at the top of the list.

What is most important is the experience and expertise of the doctor, and the clarity with which he/she communicates prices of treatment. This shows investing in a good credible doctor's result in more value than investing in advertisements for healthcare providers.

The mean score of the total fifteen items in the traditional influence factors were over the neutral scale, which means that, as a group, the traditional influence factors do have a strong influence on the choice of health care providers among the surveyed respondents.

HYPOTHESIS DECISION

Using the descriptive analysis, the description of the mean scores of all the fifteen traditional factor items of influence had a range of 3.50 to 4.55 each individual item scoring above the midpoint (3.00) on the five-point Likert scale. This trend indicates that interviewees are unanimous that traditional variables are relevant to their choices regarding the healthcare providers. All of the items were not lower than the neutral mark and the five high ranked were above the mark of 4.00, which is a strong agreement.

On the basis of this evidence, the null hypothesis $H0_1$ is rejected. There are conventional determinants of selection of healthcare providers amongst Indian consumers.

4.3 Analysis of Digital Influence Factors

Table 4.3 Mean Score and Std Deviation Digital Variables

Rank	Digital Influence Factor	Mean Score	Std Deviation
1	Online Comparision	3.99	0.78
2	Positive Online ratings influence	3.93	0.734
3	Online reviews Influence	3.83	0.785
4	Availability of online healthcare information influences	3.73	0.83
5	A professional hospital website	3.69	0.83
6	Online patient feedback	3.63	0.752
7	Online appointment booking convenience	3.6	0.873
8	Social media content influences	3.5	0.832
9	Healthcare-related content on social media	3.45	0.962
10	Digital advertisements	3.33	0.861
11	Patient testimonials on social media	3.31	0.876
12	Healthcare providers with strong online visibility	3.3	0.847
13	Online advertisements	3.18	0.864
14	Healthcare ads on digital platforms influence	3.12	0.919

INTERPRETATION

Evaluating each of the fourteen items, the mean scores are between 3.12 and 3.99 which is less than the traditional factors however above the neutral midpoint position of 3.00. This informs us that digital aspects are in play among Indian healthcare consumers, but it is the case that their impact can be said to be more quantitative and discriminating as compared to the effects exerted by the traditional aspects.

Online comparison was the highest rated digital factor with a mean of 3.99 which was only a inch below 4.00. This is especially an important discovery. It implies that when Indian consumers interact with digital medium, they are they are making comparisons. They are researching a variety of providers simultaneously, make choices, and utilize the internet as an instrument of informed decision making and not as a means of information acquisition.

Second in line was good ratings on the internet at 3.93 and online review at 3.83. Collectively, the three items at the top of the list of digital factors ranking indicate that collective consumer opinion are the strongest influences of digital factors in healthcare provider choice. Instead of depending on advertisements or promotional information of healthcare providers, Indian consumers believe in what other patients have gone through and posted online.

Access to online healthcare information was fourth at 3.73, indicating that access to full health information on online platforms is a key consideration in the way consumers judge and choose providers. A customer would be attracted to a hospital or clinic that provides detail of the services, physicians, procedures, and facility online.

In the fifth position was a professional hospital Web site with 3.69. An online patient ratings of 3.63 and an online platform to book an appointment at 3.60 is in the mid range, both indicating the rising expectation of Indian healthcare consumers that online convenience is not a luxury, but a fundamental requirement. Being able to read what other patients posted and be able to make an appointment without calling a phone number or a queue of people in a line has also become a significant factor when considering a provider by its consumers.

Next, going down into the bottom half of the list, social media content at 3.50 and healthcare-related content on social media at 3.45 score higher than the neutral point but demonstrate

lesser impact compared to the aspects of reviews and ratings. The content in social media also builds awareness and familiarity it is very possible that the content in the social media is more successful in converting customer than doing direct conversion.

The least-scored item on the category of digital factor was the one that touched on all advertising. Online advertisement had a mark 3.33, social media patient testimonials 3.31, high online presence of health providers 3.30, online advertisement 3.18, and patient testimonials on the digital platforms 3.12. Although none of these was lower than in the neutral midpoint, the fact that they are at the bottom of the ranking speaks volumes. The Indian healthcare consumers seem to be less receptive to promotional content using digital media, their interest in what other customers say is higher than that of what the providers are promoting. This implies that with regard to healthcare particularly, earned digital credibility via reviews and ratings has a greater impact than paid digital visibility via advertisements.

The aggregate trend reveals that online platforms are being used by Indian consumers to compare and appraise, healthcare decisions but in a big way, through peer generated content and access to information as compared to the provider generated advertising. The Indian healthcare consumer is not a passive digital consumer, but one that cannot be readily swayed by promotional messages alone.

HYPOTHESIS DECISION

Descriptive analysis of all the fourteen items of the digital influence factor indicates that the means of the items are between 3.12 and 3.99. All of the items within this category scored higher than the neutral mid-point of 3.00 on the five-point Likert scale meaning that the respondents agree, to some extent, that digital factors play a role in their selection criteria of a healthcare provider. Although the scores on digital factors are generally less than the ones on the traditional factors, they are always above neutral none of the items were close to the lower half.

Based on this evidence, the null hypothesis H0 2 is rejected Digital factors do have a bearing on the selection of healthcare providers among Indian consumers.

4.4 Comparative Analysis of Digital and Traditional Factors

Table 4.4 Comparision paired sample test

Paired Samples Test										
		Paired Differences					t	df	Significance	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				One-Sided p	Two-Sided p
					Lower	Upper				
Pair 1	Traditional Factors - Digital Factors	0.3894	0.34239	0.03026	0.32951	0.44928	12.867	127	<.001	<.001

INTERPRETATION

The aim of the current study was to determine the extent to which both traditional and digital aspects are equally important in the minds of Indian healthcare consumers or the extent to which one of them is dominant over the other. The type of test that was suitable to answer this question is the paired sample t-test, because all the respondents rated both sets of factors; these scores are related to each other and the paired test considers the relationship and tests whether the difference between the two is significant.

The findings were clear, consistent. The mean score for traditional influence factors came out at 3.93, while the mean score for digital influence factors was 3.54.The difference of around 0.39 on a five-point scale may not appear that large but the statistical calculations narrate a more exact something. The difference between the two categories was treated as means and the difference between these means was 0.38940 and the 95% confidence interval of the difference was 0.329510.44928. This being that this whole interval is over zero is significant in the sense that we can say with a very high level of certainty that the difference we see is not a mere coincidence or that of random variation. It is a real and a stable pattern in the sample.

The t-test value was t = 12.867 and the t-test had 127 degrees of freedom and a p-value less than 0.001. Practically, this value was considered so small as the chances that a difference this wide was observed simply by chance is less than in a thousand. It is a very powerful statistical outcome, and there is not much doubt left that the presence of traditional factors and digital factors is not rated equally in the eyes of Indian healthcare consumers, and that there is a statistically significant difference between the two.

As a measure of how significant it is in the real-world terms, the effect size was computed with the help of Cohen d that revealed a value of 1.137. According to conventional norms, the Cohens d value that exceeded 0.80 is regarded as a large effect. Any value of 1.137 would hence show that the disparity between the digital and traditional factor scores is not a marginal one rather a significant one.

HYPOTHESIS DECISION

The paired sample t-test revealed a significance level of $p < .001$ that is much lower than the traditional level of 0.05 to tell whether the result has a statistical significance. Although the difference between the means was not at zero the confidence interval proved that the difference is not statistically weak but the effect size of Cohen d = 1.137 proved that the difference was not only statistically significant, but large enough practically.

On the basis of this evidence, the null hypothesis $H0_3$ is rejected. Digital and traditional influence factors on the selection of health providers differ significantly among Indian consumers with traditional factors overall exhibiting more influence.

4.5 Correlation Analysis

Table 4.5 Correlation

Correlations				
		Traditional Factors	Digital Factors	Q30 Digital Preferred over Traditional
Traditional Factors	Pearson Correlation	1	.420***	0.79
	Sig. (2-tailed)		<.001	0.377
	N	128	128	128
Digital Factors	Pearson Correlation	.420***	1	0.181
	Sig. (2-tailed)	<.001		0.041
	N	128	128	128
Q 30 Digital Preferred over Traditional	Pearson Correlation	0.079	0.181	1
	Sig. (2-tailed)	0.377	0.041	
	N	128	128	128

INTERPRETATION

The Relationship between traditional factors and digital factors bore a coefficient of r = 0.420 and the p-value =.001. It is an average positive and statistically significant correlation. In vernacular it simply translates into simple respondents who gave traditional factors the highest rating also gave the digital factors some higher rating as well. The pair are not antipendent. A consumer, who pays so much attention to the experience of doctors and their attitudes to transparency of pricing, does not neglect online reviews and information presented on a web page. They interact with the two, albeit not at the same rate.

The second correlation involved looking at the correlation between traditional factors and the comparative statement in Q30 that respondents were asked whether they believe digital factors affect their healthcare choices more than traditional ones. In this case the correlation coefficient is only $r = 0.079$ and the significance value of $p = 0.377$ which is not considered significant. It indicates that there is no significant correlation between the rate at which a respondent values the traditional factors, and whether a respondent believes that digital factors have a significant overall impact. The association is too insignificant to give any credible conclusion.

The third correlation tested the connection between the digital factors and the same comparative statement in Q30. In this case, the coefficient was $r = 0.181$ $p = 0.041$ which means that there is weak and statistically significant positive correlation. What this informs us about is that consumers at a higher score on the digital influence factors are a little more inclined to concur that the digital factors do in fact have a greater effect on their healthcare choices as compared to the traditional ones.

The r value of 0.181 is not strong but a moderate association. The digital factors may exist and have increased in their weight, but they are not at the stage when the consumers interaction with them are convinced that the digital factors are stronger and more dominant in their general healthcare decision-making. The past paired t-test result that traditional factors have a significant higher score than digital factors is thus not refuted here. The fact is that it is strengthened.

4.6 Summary of Hypothesis Testing

Table 4.6 Hypothesis Summary

Hypothesis	Statement	Decision
H01	Traditional factors do not significantly influence healthcare provider selection.	Rejected
H02	Traditional factors do not significantly influence healthcare provider selection.	Rejected
H03	There is no significant difference between digital and traditional influence factors	Rejected

CHAPTER 5 CONCLUSION

5.1 Summary of Findings

Traditional Factors

Conventional considerations are still profound and critical towards the way Indian consumers settle on the choice of healthcare providers. The highest rated item throughout the study was doctor experience, followed by doctor expertise and effective explanation of treatment costs. The top five was completed with personal recommendations and convenience in scheduling the appointment. This trend is supportive and informing the doctor, being a person, is the key unit when it comes to trust and healthcare decision-making in Indian healthcare. It is not the hospital brand, not the advertisement, but the individual and the reputation he/she has gained during the years.

Digital Factors

The digital factors also play a major role in the selection of healthcare providers with each item of the digital category scoring above the neutral midpoint. However, what type of influence it is is a factor. Top of the digital rankings included online comparisons, peer reviews, and patient reviews and the bottom included advertisements and promotional social media materials. Indian healthcare consumers are jaded online customers They follow what other patients are saying and not what healthcare providers say in their advertisements.

Comparison of the Two.

A direct comparison of both categories was made using paired sample t-test where the result was unmistakable. Traditional factors ($p = .001$) scored significantly higher mean of 3.93 than a mean of 3.54 in digital factors with large effect size of Cohen $d = 1.137$. In the decision making of healthcare in India, traditional factors have more substantial overall command, compared to digital factors.

Connection between Factors Traditional and Digital.

The results of the correlation analysis showed that there is a moderate positive correlation between the two categories $r = 0.420$, $p < .001$. Customers that attach importance to the traditional influences are also likely to exploit the digital influences to some extent. The two are not the opposites but they coexist within the same consumer mind and so, the process of making decisions to purchase healthcare in India is a mixed process and draws upon both worlds.

5.2 Overall Conclusion

Assuming that this piece of writing was to be summarised it would be this the Indian healthcare consumer is more traditional than digital, yet they are neither.

The consumer evidence is towards a trusting consumer. Reliance upon experience of the physician, in a familiar referrals, in a practitioner who tells the truth about costs. These are the crucial points that are most significant.

Online price checks and peer-reviews have provided the consumer with a new potent instrument to check on the provider they do not have any prior relationship with in levels that it was not previously possible. However, the figures indicate that this change is yet to replace the power of conventional trust. The findings are a consumer in transition to selectively draw either on the old and the new, depending upon the situation, the provider and the information available to them.

5.3 Implications

For Healthcare Providers

Integrated strategy would most benefit the providers because the two are the same bit of trust building and not two distinct issues. Bets on physician reputation, open prices, and communication to the patients allow investing in the most significant thing. At the same time having a plausible digital presence with the help of properly controlled reviews, a

professional-looking site and easily available information deals with the increasing digital aspect of the same decision.

For Healthcare Marketers

The average scores of the digital ads are always too low, this sends a particular message in healthcare, earned credibility is more effective than being seen. Those strategies that support sincere patient feedback and produce informative and not promotional online material will nearly always be more efficient as compared to those based on advertising.

5.4 Message of Limitations and Future Research.

This paper employed the convenience sampling technique of 128 individuals since the larger the sample size the more reliable the study is, the male respondents based in the survey was significantly higher than the number of female respondents which could be better in future researches.

As AI advances more, the consumption of AI technologies by the healthcare sector is coming at an extremely rapid pace thus those aspects can be delved into regarding their implications on consumer behaviour.

REFERENCES

- Andersen, R. M. (1968). Behavioral model of families' use of health services. Center for Health Administration Studies, University of Chicago.
- Balarajan, Y., Selvaraj, S., & Subramanian, S. V. (2011). Health care and equity in India. The Lancet, 377(9764), 505–515.
- Bansal, P., & Gupta, R. (2020). Digital health information seeking and provider selection: Evidence from urban Indian consumers. Journal of Health Management, 22(3), 325–340.
- Berman, P., Ahuja, R., & Bhandari, L. (2010). The impoverishing effect of healthcare payments in India: New methodology and findings. Economic and Political Weekly, 45(16), 65–71.
- Bhatt, M. (2000). Seeking health in the city: Referral patterns and provider choice in urban India. Health Policy and Planning, 15(1), 59–67.
- Calnan, M., & Rowe, R. (2008). Trust matters in health care. Open University Press.
- Duggal, R. (2005). Healthcare in India: Changing the financing strategy. Social Policy and Administration, 39(4), 421–431.
- Eysenbach, G., & Köhler, C. (2002). How do consumers search for and appraise health information on the world wide web? BMJ, 324(7337), 573–577.
- FICCI & EY. (2020). COVID-19: Accelerating digital health adoption in India. Federation of Indian Chambers of Commerce & Industry.
- Fox, S., & Duggan, M. (2013). Health online 2013. Pew Research Center.
- Gao, G., McCullough, J. S., Agarwal, R., & Jha, A. K. (2015). A changing landscape of physician quality reporting: Analysis of patients' online ratings of their physicians over a 5-year period. Journal of Medical Internet Research, 17(1), e18.
- Gupta, A., Pal, R., & Sharma, M. (2018). Traditional versus digital information channels in specialist healthcare selection: A study of urban Indian households. Indian Journal of Health and Wellbeing, 9(2), 254–261.

- Harris, K. M., Halpern, C. T., Whitsel, E., Hussey, J., Tabor, J., Entzel, P., & Udry, J. R. (2003). The National Longitudinal Study of Adolescent to Adult Health: Research design. University of North Carolina at Chapel Hill.
- Hibbard, J. H., Stockard, J., & Tusler, M. (2002). Does publicizing hospital performance stimulate quality improvement efforts? Health Affairs, 22(2), 84–94.
- Huang, Y., & Bhatt, A. (2018). Website quality and its influence on patient trust in outpatient settings: A comparative analysis. International Journal of Healthcare Management, 11(4), 280–289.
- Kaplan, A. M., & Haenlein, M. (2010). Users of the world, unite! The challenges and opportunities of social media. Business Horizons, 53(1), 59–68.
- Kumar, A., Singh, P., & Mishra, R. (2015). Word-of-mouth and healthcare provider choice in northern India: An empirical investigation. Asia Pacific Journal of Health Management, 10(1), 47–58.
- Lagu, T., Hannon, N. S., Rothberg, M. B., & Lindenauer, P. K. (2010). Patients' evaluations of health care providers in the era of social media. Journal of General Internal Medicine, 25(9), 942–946.
- Lober, W. B., & Flowers, J. L. (2011). Consumer empowerment in health care amid the internet and social media. Seminars in Oncology Nursing, 27(3), 169–182.
- Marshall, M. N., Shekelle, P. G., Leatherman, S., & Brook, R. H. (2000). The public release of performance data: What do we expect to gain? JAMA, 283(14), 1866–1874.
- Mohindra, K. S., Haddad, S., & Narayana, D. (2006). Women's health in a rural community in Kerala, India: Do caste and socioeconomic position matter? Journal of Epidemiology and Community Health, 60(12), 1020–1026.
- Moorhead, S. A., Hazlett, D. E., Harrison, L., Carroll, J. K., Irwin, A., & Hoving, C. (2013). A new dimension of health care: Systematic review of the uses, benefits, and limitations of social media for health communication. Journal of Medical Internet Research, 15(4), e85.

- Nair, S., Murthy, P., & Khanna, T. (2019). Digital health-seeking behaviour among urban Indian consumers: Patterns and implications. Journal of Digital Health, 5(2), 112–124.
- Narang, R. (2011). Determining quality of public health care services in rural India. Clinical Governance, 16(1), 35–49.
- Parasuraman, A., Zeithaml, V. A., & Berry, L. L. (1988). SERVQUAL: A multiple-item scale for measuring consumer perceptions of service quality. Journal of Retailing, 64(1), 12–40.
- Pascoe, G. C. (1983). Patient satisfaction in primary health care: A literature review and analysis. Evaluation and Program Planning, 6(3–4), 185–210.
- Peters, D. H., Garg, A., Bloom, G., Walker, D. G., Brieger, W. R., & Rahman, M. H. (2008). Poverty and access to health care in developing countries. Annals of the New York Academy of Sciences, 1136(1), 161–171.
- Rao, M., Rao, K. D., Kumar, A. K. S., Chatterjee, M., & Sundararaman, T. (2011). Human resources for health in India. The Lancet, 377(9765), 587–598.
- Selvaraj, S., & Karan, A. K. (2009). Deepening health insecurity in India: Evidence from national sample surveys since 1980s. Economic and Political Weekly, 44(40), 55–60.
- Taner, T., & Antony, J. (2006). Comparing public and private hospital care service quality in Turkey. Leadership in Health Services, 19(2), 1–10.
- Zeithaml, V. A., Berry, L. L., & Parasuraman, A. (1985). Problems and strategies in services marketing. Journal of Marketing, 49(2), 33–46.

EXHIBIT

QUESTIONNAIRE

1. Name *

_____

Section A Demographic

2. 1. Age *

Mark only one oval.

- 18–25
- 26–35
- 36–45
- 46–55
- 55+

3. 2. Gender *

Mark only one oval.

- Male
- Female

4. 3. Occupation *

Mark only one oval.

- Student
- Salaried
- Business
- Others

5. 4. Monthly Household Income *

Mark only one oval.

- Below ₹50,000
- ₹50,000–₹1,00,000
- ₹1,00,000–₹2,00,000
- Above ₹2,00,000

6. 5. City Tier *

Mark only one oval.

- Tier 1
- Tier 2
- Tier 3

7. 6. Frequency of Healthcare Visits *

Mark only one oval.

- Rarely
- Occasionally
- Frequently

SEC B Traditional Healthcare Factors

Scale
1 Strongly Disagree
2 Disagree
3 Neutral
4 Agree
5 Strongly Agree

8. 1. I prefer healthcare providers with a strong brand reputation? *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

9. 2. A well-known hospital increases my trust in healthcare services. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

10. 3. Brand image influences my healthcare provider selection. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

11. 4. Doctor expertise strongly influences my healthcare decisions. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

12. 5. I trust experienced doctors more while selecting healthcare provide

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

13. 6. Recommendations regarding reputed doctors affect my choice. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

14. 7. Transparent pricing influences my healthcare provider selection. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

15. 8. I prefer providers who clearly communicate treatment costs. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

16. 9. Hidden charges negatively affect my trust in healthcare providers. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

17. 10. Proximity to my residence/workplace influences my healthcare decisions. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

18. 11. Easy transportation access affects my provider selection. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

19. 12. Convenient appointment availability is important to me. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

20. 13. Insurance compatibility affects my healthcare provider preference. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

21. 14. I prefer providers that accept multiple insurance plans. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

22. 15. Cashless treatment facilities influence my decisions. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

SECTION C — **Digital Influence Factors**

23. 16. I check online reviews before selecting a healthcare provider. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

24. 17. Positive ratings increase my trust in healthcare providers. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

25. 18. Online patient feedback affects my decisions. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

26. 19. Social media content influences my perception of healthcare providers. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

27. 20. Healthcare-related content on social media affects my decisions *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

28. 21. Patient testimonials on social media increase my trust. *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

29. 22. A professional hospital website increases my confidence *

Mark only one oval.

1 2 3 4 5

Stro ◯ ◯ ◯ ◯ ◯ Strongly Agree

30. 23. Online appointment booking convenience affects my decisions. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

31. 24. Availability of online healthcare information influences my provider selection.

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

32. 25. Online advertisements increase my awareness of healthcare providers. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

33. 26. Digital advertisements affect my consideration of hospitals/clinics. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

34. 27. Healthcare ads on digital platforms influence my perception. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

35. 28.I prefer healthcare providers with strong online visibility and reputation. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

36. 29. I compare multiple healthcare providers before making a decision. *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

Comparitive Question

37. 30. "Digital Factors influence my healthcare decisions more than traditional Factors." *

Mark only one oval.

	1	2	3	4	5	
Stro	◯	◯	◯	◯	◯	Strongly Agree

Frequency Table

1. Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18–25	81	63.3	63.3	63.3
	26–35	31	24.2	24.2	87.5
	36–45	4	3.1	3.1	90.6
	46–55	12	9.4	9.4	100.0
	Total	128	100.0	100.0	

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
16. I check online reviews before selecting a healthcare provider.	128	2	5	3.83	.785
17. Positive ratings increase my trust in healthcare providers.	128	2	5	3.93	.734
18. Online patient feedback affects my decisions.	128	2	5	3.63	.752
19. Social media content influences my perception of healthcare providers.	128	2	5	3.50	.832
20. Healthcare-related content on social media affects my decisions	128	1	5	3.45	.962
21. Patient testimonials on social media increase my trust.	128	2	5	3.31	.876
22. A professional hospital website increases my confidence	128	1	5	3.69	.830
23. Online appointment booking convenience affects my decisions.	128	1	5	3.60	.873
24. Availability of online healthcare information influences my provider selection.	128	1	5	3.73	.830
25. Online advertisements increase my awareness of healthcare providers.	128	1	5	3.18	.864
26. Digital advertisements affect my consideration of hospitals/clinics.	128	1	5	3.33	.861
27. Healthcare ads on digital platforms influence my perception.	128	1	5	3.12	.919
28.I prefer healthcare providers with strong online visibility and reputation.	128	1	5	3.30	.847
29. I compare multiple healthcare providers before making a decision.	128	2	5	3.99	.768
30. "Digital Factors influence my healthcare decisions more than traditional Factors."	128	1	5	2.98	.869
Valid N (listwise)	128				

Paired Samples Test

		Paired ... 95% Confidence Interval of the ... Upper	t	df	Significance One-Sided p
Pair 1	Traditional_Factors - Digital_Factors	.44928	12.867	127	<.001

Paired Samples Test

		Significance Two-Sided p
Pair 1	Traditional_Factors - Digital_Factors	<.001

Paired Samples Test

		Paired Differences			
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the ... Lower
Pair 1	Traditional_Factors - Digital_Factors	.38940	.34239	.03026	.32951

Correlations

		Traditional_Factors	Digital_Factors	30. "Digital Factors influence my healthcare decisions more than traditional Factors."
Traditional_Factors	Pearson Correlation	1	.420***	.079
	Sig. (2-tailed)		<.001	.377
	N	128	128	128
Digital_Factors	Pearson Correlation	.420***	1	.181*
	Sig. (2-tailed)	<.001		.041
	N	128	128	128
30. "Digital Factors influence my healthcare decisions more than traditional Factors."	Pearson Correlation	.079	.181*	1
	Sig. (2-tailed)	.377	.041	
	N	128	128	128