DOCTOR'S CONSULTATION FEES AND PATIENT'S WILLINGNESS TO PAY FOR DOCTOR'S CONSULTATION FEES IN BANGALORE, INDIA

by

Radha Thapa, B.Sc. Nursing, M.H.A, PGDMLE

DISSERTATION

Presented to the Swiss School of Business and Management Geneva

In Partial Fulfillment

Of the Requirements

For the Degree

DOCTOR OF BUSINESS ADMINISTRATION

SWISS SCHOOL OF BUSINESS AND MANAGEMENT GENEVA

MARCH, 2025

DOCTOR'S CONSULTATION FEES AND WILLINGNESS TO PAY FOR DOCTOR'S CONSULTATION FEES IN BANGALORE, INDIA

by

Radha Thapa

Supervised by

Luka Leško, PhD

APPROVED BY

Dissertation chair

RECEIVED/APPROVED BY:

Renee Goldstein Osmic

Admissions Director

Dedication

The research work done during this thesis is dedicated to all the students and researchers who has or going through the obstacles in the field of research to unfold the hidden truth and bring about evolution in the way we are living currently. I hope my work serves to provide deep insights into the less explored field of health economics and health care management to bring a change in the current crippling health care system.

I would also like to take a moment to honor the memory of my beloved mother, Late Sarita Thapa whose love, wisdom, and strength shaped the person I am today. As she is no longer with me but her guidance, belief and faith molded me during my academic journey. This dissertation is dedicated to her sacrifice, tears, sweats to educate me and I am forever grateful for the foundation she had provided me.

Acknowledgements

"The great teacher is not the man who supplies the most facts, but the one in whose presence we become different people."

This dissertation is the culmination of the help, encouragement, and guidance from several people and without me expressing my heartfelt thankfulness would not make my dissertation complete.

No amounts words can measure up to the deep sense of gratitude and thankfulness that I feel towards my teacher and Mentor **Luka Leško, PhD** for his guidance, supervision, encouragement, and constant support throughout my Doctoral course. It is a proud privilege and pleasure to work under such a learnt and respected mentor whose guidance, timely advice, wise suggestions, and never-ending support helped me immensely in my work. Thank you for giving me the opportunity to work independently, for having faith in me in letting me do this study and for always having time to discuss my work when I needed to. Thank you so much for your patience with me.

I express my deep gratitude towards **Anna L. Provodnikova, PhD**, **Dr. Jose Ramon Bronet, Iva Buljubasic, PhD**, **Mario Silic, PhD**, **Meskina Olesya, PhD**, for their encouragement and precious lectures and expertise which helped me to enhance my knowledge, skills and cultivated towards learning new and innovative methods in a field of research.

I whole heartedly thank technical and non-technical faculties in the institute for extending their help by providing journals, books, and information of my general query. Last but not

the least, I express my sincere gratitude to all those names I have not mentioned but supported and wished me all the while.

ABSTRACT

DOCTOR'S CONSULTATION FEES AND PATIENT'S WILLINGNESS TO PAY FOR DOCTOR'S CONSULTATION FEES IN BANGALORE, INDIA

Radha Thapa

2025

Dissertation Chair: <Chair's Name>

Co-Chair: <If applicable. Co-Chair's Name>

Background: Doctors' consultation is a doorway to healthcare, and this doorway should be open and accessible to all, which is a basic, uncompromised necessity. But currently, due to disorganized and unsystematic way of charging consultation fees by healthcare providers without considering the willingness to pay for doctors' consultation, the doorway to healthcare, i.e., doctors' consultation, has become inaccessible, exposing most of the population to risk. Thus, there was an insurmountable need to establish an approximate range for doctor's consultation fees considering the patients willingness to pay.

Objectives: To analyze doctors' consultation in each specialty of different hospitals, nursing homes and clinics. To measure and investigate the factors influencing patient's willingness to pay for doctors' consultation fees and, to recommend appropriate suggestions to frame a better healthcare policy.

Methodology: A cross-sectional study was carried out on 2300 doctors' working in various hospitals, nursing homes and clinics over a period of 10 months in rural and urban areas of Bangalore, India. An Observational checklist was used to analyze the exact range of doctors' consultation fees being charged. 385 patients were also included in the study to measure the actual willingness to pay towards doctors' consultation, where each patient was interviewed with a structured questionnaire. The data was tabulated, analyzed, and results were interpreted. Accordingly, recommendations were provided.

Results: The current study revealed that, consultation fees charged by General Practitioner was (Rs 885.65), Specialist (Rs 1207.91) and Sub-specialist (Rs 1190.04). Strikingly, On the other hand, the patients were willing to pay in the range of (Rs 251 to 500) for General practitioner, Specialist (Rs 501 to 750), Sub-specialist (Rs 751 to 1000), Additionally, highest average consultation fees were charged by Psychiatrists, followed by Gynecologists, and least was charged by General practitioners.

Conclusion: A stark contrast noted in the existing doctors' consultation and the actual WTP by patients in the same area. Factors influencing patients' WTP towards doctor consultation fees were observed to be income, household size, disease, area of residence, age of the doctor etc. The conclusive data can be used as an informatic tool by healthcare policymakers, hospitals, and health economist.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

Abbreviations

OPD - Out-patient Department

WTP - Willingness to Pay

CSSD - Central sterile Supply Department

GDP - Gross Domestic Product

AU$ - Australian Dollar

Rs - Indian Rupees

DKK - Danish Krone

CVM - Conjoint Valuation Method

CE - Choice Experiments

NYOP - Naming Your Own Price

UHC - Universal Health Coverage

CHAPTER I:

INTRODUCTION

"So many people spend their health gaining wealth, and then have to spend their wealth to regain their health." — Proverb

1.1 Introduction

Health is Wealth, a common linguistic concept, has become perilous in today's swiftly transforming world. It is fully endorsed among Indians with diverse names within various geographic groups. “Health is a status of functional or metabolic efficiency of a living being. It refers to a person's mental and physical condition, which is typically devoid of disease, injury, or distress” (Khan and Banerji, 2014).

“The word ‘health’ was derived from the old English word ‘hoelth’ which meant a state of being sound, and was generally used to infer a soundness of the body” (Awofeso, 2005). According to World Health Organization “health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (Svalastog et al., 2017).

Determinants of Health

Health is influenced by multiple variables (Figure1.1). The factors that influence an individual's health are both internal and external to the society in which he or she resides. Consequently, the health of the individuals and the entire communities can be viewed conceptually as the consequence of numerous interactions (Park and Park, 2023).

Income and social status: Higher income and social standing are associated with improved health. The greater the disparity between the wealthiest and poorest individuals, the greater is the disparity in healthcare accessibility.

Education: Insufficient amounts of education are associated with poor health, increased stress, and diminished self-esteem.

Physical environment: Secure drinking water and clean air, as well as healthy workplaces, secure homes, neighborhoods, and roads, all contribute to good health. Employment and working conditions – those who are employed and have greater control over their working conditions are healthier.

Social support networks: Better health is associated with increased support from family, friends, and communities. Customs and traditions, as well as the beliefs of the family and community influences overall health condition.

Genetics: There is a genetic component to longevity, health, and the likelihood of developing specific illnesses. Personal actions, coping skills, balanced nutrition, physical activity, smoking, drinking, and how we respond to life's stresses and challenges have a significant impact on health.

Health services: Access and utilization of healthcare services for disease prevention and treatment services influences overall health of an individual.

Gender - Men and women are afflicted with distinct maladies at distinct ages (WHO, 2024).

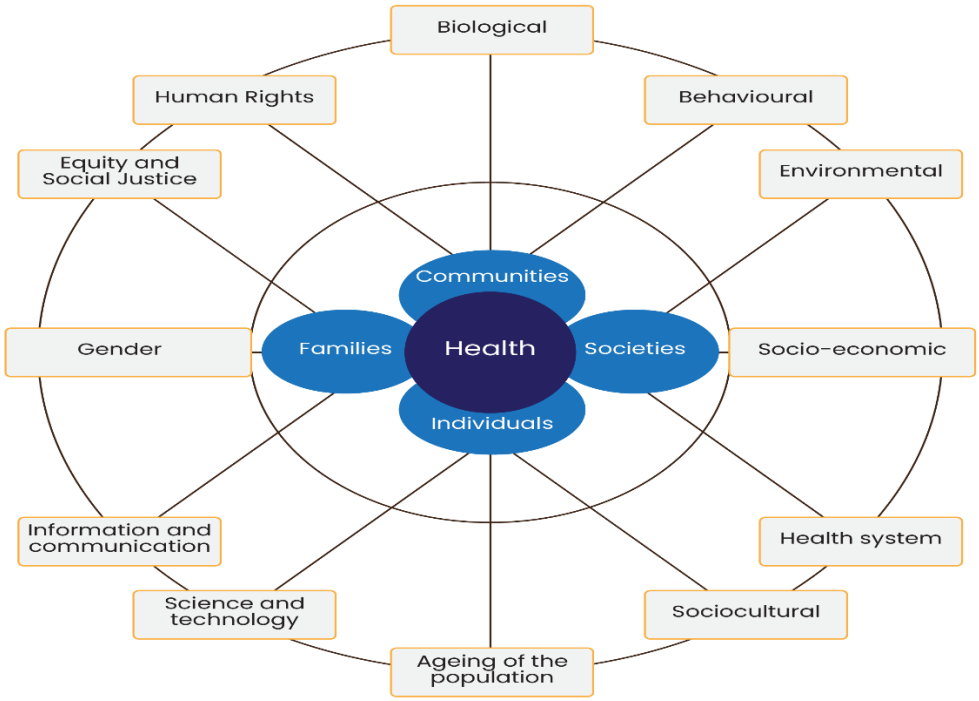

Figure 1.1 Determinants of health (WHO 2024)

THE HEALTH CARE SECTOR IN INDIA

Rural and urban India has drastically contrasted access towards health care services. Rural dwellers have fewer options than urbanites. Indians are increasingly seeking private health treatment for mild diseases like colds, fevers, and diarrhea, regardless of their ability to pay. Compared to the public sector, private health care in India is expensive and lacks qualified and skilled staff. Urban areas have better access to health care. Thus, rural residents are disproportionately miserable and incur additional disadvantages. Doctors' fees and medicine constitute most of the expense of mild diseases. However, serious disorders including hypertension, heart disease, diabetes, and other diseases demonstrate a discrepancy towards access to health care across various socioeconomic groups.

Additionally, different socioeconomic groups bear a disproportionate share of healthcare burden. Compared to the richest households, poor households spent approximately 15% of their monthly income on healthcare. Health in India is a luxury for the under-privileged. People ignore public health units and analogously seek private practitioners, paying above their means (Barik and Thorat, 2015).

The Indian health care system comprises of Allopathy, Ayurveda, Unani, Siddha, and Homoeopathy. There are two main groups in the nation's healthcare care system: the public health sector, the private health sector.

The Public Health Sector in India:

The public health sector consists of entities at the federal, state, municipal, and local levels. The healthcare system is structured into three levels: primary, secondary, and tertiary. At the primary level are Sub Centers and Primary Health Centers (PHCs). At the secondary level there are Community Health Centers (CHCs) and smaller Sub-District hospitals. Government-run health centers and hospitals constitute the public health service. It is intended to provide free or low-cost access to high-quality medical care, so that those who are impoverished can receive treatment.

The Private Health sector in India:

The private health sector comprises 'not-for-profit' and 'for-profit' health sectors. The not-for-profit health sector encompasses various health services provided by Non-Government Organizations (NGOs), charitable institutions, missions, and trusts, among others. There are numerous categories of practitioners and institutions within the privately owned health sectors. The licensed practitioners vary from general practitioners (GPs) to super specialists, as well as nurses and paramedics, and rural medical practitioners (RMPs) or

Rural Medical Officer. In other words, the private health sector consists of all providers outside the public sector whose mission is to treat illness or prevent disease, regardless of whether they are philanthropic or for-profit organizations. In addition, they constitute hospitals, nursing and maternity homes, clinics staffed by physicians, nurses, midwives, and paramedical personnel, and diagnostic facilities (Chokshi et al., 2016; Mills et al., 2002; Park and Park, 2023; Sengupta and Nundy, 2005).

Iceberg of disease

The iceberg phenomenon of disease is a concept closely related to the spectrum of disease. According to this concept, a community's disease could be compared to an iceberg. The floating tip of the iceberg depicts the clinical cases the physician encounters in the community. The enormous portion of the iceberg that is submerged represents the hidden mass of disease, which includes latent, inapparent, pre-symptomatic, and undiagnosed cases and carriers in the community. The "waterline" represents the dividing line between visible and invisible disease (Park and Park, 2023) (Figure1.2).

Even for life-threatening illnesses, there is unequivocal evidence that people consider cost while pursuing medical care. In a nutshell even in the realm of health, economic trade-offs matter. This indicates that economic analysis is applicable in the healthcare industry. If healthcare services are provided free of cost, like many nations, people will desire a great deal of care, including care that is not particularly conducive to their health. In turn, if healthcare services are not provided free of cost, some patients will either not pursue or will pursue less healthcare facilities. The most vulnerable segments of the population, such as the impoverished and the chronically ill, may perish as a result of excessive, unaffordable healthcare costs(Bhattacharya et al., 2014).

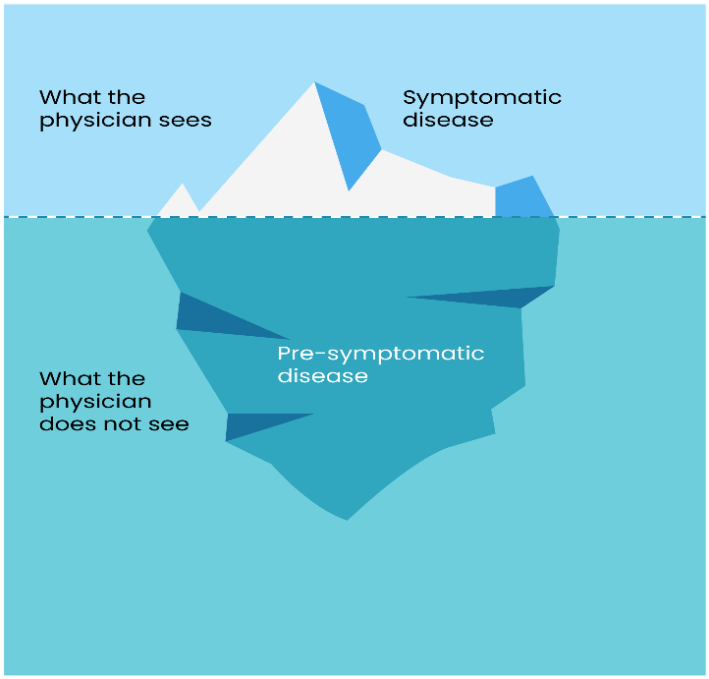

Figure 1.2 The Iceberg of disease (Park and Park 2023)

Healthcare Scenario in India

The healthcare institutions have transformed from secluded sanatoriums to places with five-star amenities. Patients and their families who visit the hospital not only anticipate world-class care, but also additional services to make their stay pleasant. This shift in expectations is a result of the rapid expansion of media and its visibility, as well as the commercialization and development of infrastructure. In addition, there is recent consensus that health services ought to be comprehensive, accessible, and acceptable, facilitating community participation, and be available at an affordable price for the community. Hospitals have diversified in terms of availability of specialties, enhanced technologies, facilities, and more competition, and patients as well as their families' expectations have risen significantly (Kulkarni, 2018). India has a shortage of medical services due to uneven

distribution of facilities and medical professionals. The rural population suffers from the lack of well-equipped tertiary health care centers in tier 3 and rural remote areas.

While bridging the gap in resource-scarce regions requires a multifaceted approach, fundamental necessities are a must. Among these necessities are fundamental laboratory and imaging capabilities, as well as critical care devices, such as ventilators, but the foremost necessity is the recruitment of a diverse healthcare workforce. Healthcare services in India is asymmetrically distributed and inaccessible to a vast majority of the population, with a substantial disparity in between rural and urban areas, that puts rural residents into disadvantage of being deprived from necessary healthcare services (Rahman et al., 2023.).

In the world of the twenty-first century, business-minded individuals disregard their moral obligations to society. In this behavioral shift, the service market, specifically the medical care service market, appears susceptible (Rahman, 2023). Business-mentality has created a vulnerable service industry, especially in medical care. Some groups argue doctors generate more money by seeing fewer patients and ordering needless tests. This has caused chaos and uncertainty in service costs, making it hard for patients to manage their budgets. The medical-care service-market is organized between a seller and a buyer through their choices and interactions. Patients may choose to visit another doctor or not due to budget constraints and risk-factors (Rahman, 2023). India's healthcare system is heterogeneous encompassing both public and private healthcare providers. The preponderance of private healthcare providers are mainly in metropolitan cities offering secondary and tertiary level treatment (Chokshi et al., 2016). The healthcare system in India offers a wide spectrum of treatment outcomes, from incredibly renowned hospitals

to institutions that give substandard low-quality care where a significant population lives underneath the neediness line which has a profound effect on the accessibility and affordability of healthcare. On one side, India's illness profile is changing, with a boom in incidence of chronic illnesses; on the other side, healthcare expenses are escalating haphazardly in turn depriving the low-income groups from accessing basic to advanced health services such as doctor consultations, screening, essential surgeries, and rehabilitation. Thus, state, and central governments of India, hospital owners, policy makers, hospital managers must coordinate with investigators and researcher to execute transparency in doctor's consultation fees which is a vitally a need of the hour to revive the current calamitous healthcare system to reduce burden of diseases and the morbidity and mortality which may have a direct or indirect impact on the GDP and improvising overall unacceptable healthcare parameters of the country.

The healthcare industry has experienced profound transformations. Because of airtight competition within healthcare market which aims mostly to maximize on profits, there are staunch price constraints to sustain in such volatile environment. Which can be outdone by determining the appropriate price for a product or service, which is one of the most challenging tasks for a marketer and inevitably the knowledge of WTP is incredibly valuable for healthcare professionals in terms of setting prices for various services. The doctors' must adhere to a reasonable price that is consistent with the market and is within the patients' budget, considering the actual willingness to pay for healthcare services (Padua Filho and Padua, 2016).

1.2 Research Problem

Danyliv et al. (2013) observed that, there are unofficial (under the table) payments made to healthcare providers in the form of cash or in-kind presents in exchange for better services. Such unregulated fees have a distorting influence on healthcare service and patient's health. Maternal Mortality in high in India as compared to other developing countries due to relatively high prenatal and postnatal care expenses which includes Doctor's consultation fee, Clinic diagnostic fees, transportation, medicines and so on (Balla et al., 2022). As Doctors' consultation is the doorway to access the perinatal care of women, exorbitantly high doctor's consultation fees will act as a barrier to crucial healthcare access which is a major cause of high incidence of mortality rate in India.

The financial burden born by patients towards general practitioner's consultation fees before being referred to an emergency care acts as a hurdle leading to life threatening sequalae, as it may lead to delay in the access to emergency care due to the incertitude (Morrow and Laher, 2022). The delay in physician visits adversely impacts the already existing unfairness in the accessibility towards healthcare due to inconsistent and disorganized doctors practicing fees (Rückert et al., 2008).

In India, between three-quarters and four-fifths of healthcare services are provided by the private sector, but no regulatory regime has been developed to monitor its activities and prices. In essence, the medical profession has taken unwarranted advantage of its privileged position, heedless to its financial commitments to the state (Duggal, 1993). Outpatient physician consultation fees are not covered by insurance companies. Within each state and

territory, consulting fees differ significantly. In the healthcare system, there is a lack of transparency in pricing (Freed and Allen, 2018).

1.3 Purpose of Research

The doctor's fee is the major proportion of delivery healthcare expenditures. Contrary to other components, the percentage of doctor's fees is rather significant. In public health facilities, the doctor's charge is minimal, although it is substantial in the private sector. Consequently, the execution of policies to preserve the standard doctor's fee in all healthcare institutions must be supervised (Balla et al., 2022).

1.4 Significance of the Study

In a developing country like India, where most individuals do not possess health insurance, even if some individuals do possess insurance, most insurers do not cover the outpatient doctor’s consultation fees jeopardizing the access to healthcare through doctors’ consultation. There is a stark contrast in the consultation fees within various geographic distribution in India along with absence in the transparency of doctor’s consultation fees in various specialties, which needs to be uncovered by in-depth analysis in this aspect. Thus, this research intended to evaluate the patient's willingness to pay for consultation fees in relation to their health and wellbeing, as well as the variables that influence this willingness.

1.5 Research Objectives

1.To analyze doctors’ consultation fees in each specialty of different hospitals, nursing homes and clinics

2.To Measure the Patients' willingness to pay for doctor's consultation fees by using quantitative methods

3.To investigate factors influencing patient's willingness to pay for doctors' consultation fees by using both qualitative and quantitative methods

4.To recommend appropriate suggestions to frame a better healthcare policy

Operational definition:

Hospital

A Hospital is an integral part of a Social and Medical organization, the function of which is to provide for the population complete health care, both curative and preventive, and whose outpatient services reach out to the family and its home environment; the hospital is also a center for the training of health workers and biosocial research. —WHO definition of Hospital.

Outpatient

A person given diagnostic, therapeutic or preventive service through the hospital's facilities and who, at the time, is not registered as an inpatient in the hospital.

Outpatient Visit

An outpatient visit is the visit of a person at the outpatient department to receive service. The visit may be:

i. new outpatient visit—outpatient visit by a person for the first time, or

ii. repeat outpatient visit—outpatient visit by a person subsequent to initial outpatient visit (Sakharkar, 2009).

Outpatient care

Outpatient care is any interaction with a physician or other medical professional that does not require an overnight stay. In general, more severe cases necessitate an overnight hospital stay for patient monitoring and recovery, whereas outpatient cases are typically less complex (Bhattacharya et al., 2014).

Patient

A patient is any individual who receives health care services from healthcare professionals. Typically, the patient is ailing or injured and requires treatment from a doctor, nurse, optometrist, dentist, veterinarian, or other health care professional.

Doctor Consultation

A doctor's consultation is a point of interaction between a doctor and a patient that consists of collecting a patient's medical history, performing a physical examination, diagnosing diseases, providing counselling, and introducing tests such as diagnostic tests related to symptoms and prescribing appropriate treatment.

Doctor

A physician, medical practitioner, medical doctor, or simply doctor is a health care professional who practices medicine, which focuses on promoting, maintaining, or restoring health through the study, diagnosis, prognosis, and treatment of disease, injury, and other physical and mental impairments.

Willingness to Pay

In health economics, willingness to pay (WTP) is defined as the utmost amount of money a person is willing to pay to avoid or reduce a specific medical issue or to obtain a

particular health benefit. Majority of the time, willingness to pay is measured by contingent valuation and indirectly revealed preferences for the purpose of cost-benefit analysis. In contrast, willingness to pay is defined as the quantity at which the loss of health care services would be acceptable (Kirch, 2008).

CHAPTER II:

REVIEW OF LITERATURE

2.1 Theoretical Framework

"A literature review surveys books, scholarly articles, and any other sources relevant to a particular issue, area of research, or theory, and by so doing, provides a description, summary, and critical evaluation of these works in relation to the research problem being investigated. Literature reviews are designed to provide an overview of sources you have explored while researching a particular topic and to demonstrate to your readers how your research fits within a larger field of study" (Fink, 2019). This chapter presents both a theoretical framework and an empirical investigation on consultation fees and the level of willingness to pay for different healthcare services. An integral part of any investigation is reviewing the existing literature on the topic. An examination of related work reveals the efforts of previous researchers and institutions, and it aids in determining whether the current study is warranted. Previous research on this topic has been attempted to be summarized.

CONCEPT OF WTP AND THEORITCAL BACKGROUND

Willingness to pay is termed as "the maximum amount of income an individual is willing to give up to ensure that a proposed service or good is available" (Javan-Noughabi et al., 2017).

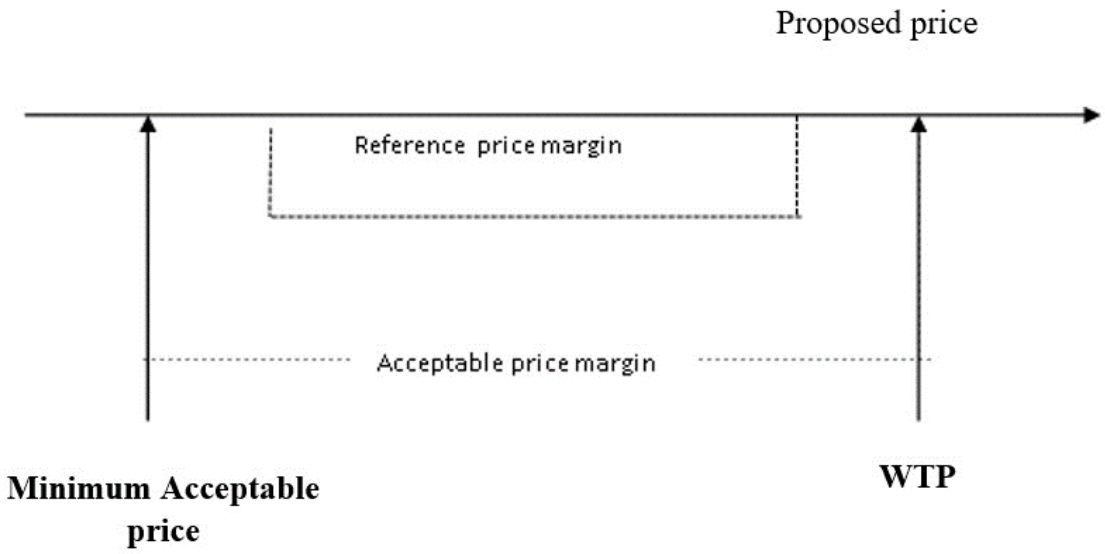

Figure 2.1: Willingness to pay, reference price and acceptable prices (Source: (Le Gall-Ely, 2009)

Table 2.1 : Willingness to pay and price concepts: a synthesis of definitions (Le Gall-Ely, 2009)

Concepts	Definition
Reference price	Price or set of prices the consumer uses to compare and evaluate the price of a proposed good or service.
Acceptable prices	Set of prices that the consumer is ready topay for a good or service.
Willingness to pay	Maximum price a consumer accepts to pay for a given quantity of goods or ser-vices.
Value	Evaluation of experiences with an object or class of objects (usage value), based on all the sacrifices and benefits associated with it (exchange value).

2.2 Theoretical Foundations of Willingness to Pay in Healthcare

"According to welfare economic theory, the benefit to an individual of a service or an intervention is defined as that individual's maximum willingness to pay for the service or intervention. The benefit to society of the intervention is the sum of everyone's willingness to pay."

Assume that a treatment is introduced that moves your health status from a specific disease state (HD) to full health (H*).

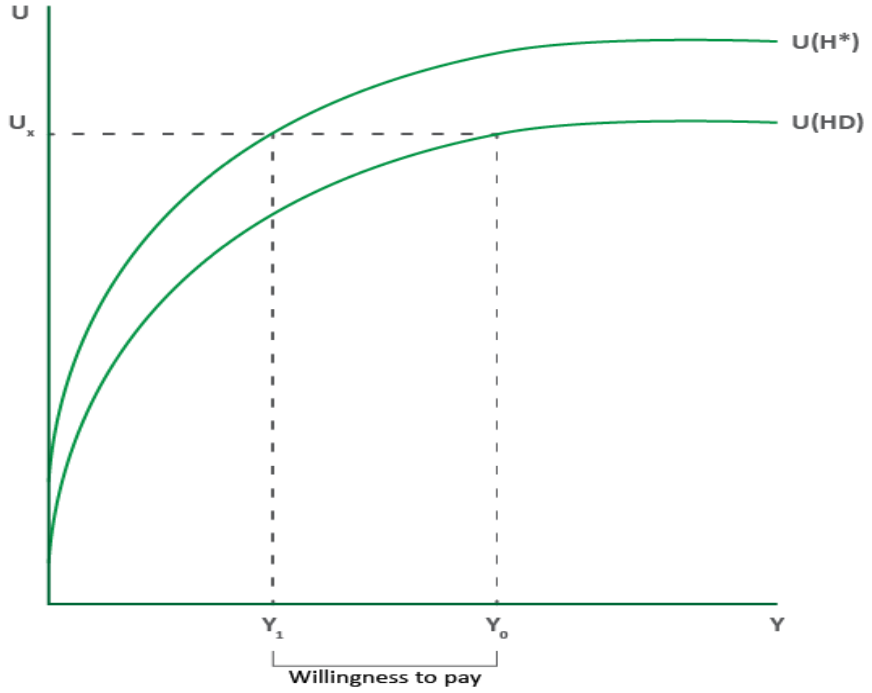

Figure 2.2 Willingness to pay measures for how much an individual values the health improvement Ogundeji et al., (2019)

Willingness to pay is the utmost amount of money you would be willing to pay for a treatment that restores you to full health while maintaining the same level of overall well-being or 'utility.' If you were required to pay more than this utmost, the loss of income

would outweigh the improvement in well-being caused by the health change. The two vectors depict how with income, well-being (or 'utility') increases under two separate health conditions (HD and H*). To evaluate a person's maximum willingness to pay for any treatment, begins with an individual in health state (HD) with an income of (Y0) and level of well being is represented by (U*). Next, determine the lower income (Y1) in perfect health (H*) that yields the same level of happiness (U*) as income Y0 in health state HD. The difference between Y0 and Y1 represents a person's utmost willingness to pay for treatment. In this instance, willingness to pay indicates how much an individual values a particular health improvement. This varies from person to person and depends on the severity of the disease as well as their inclination and capacity to trade money for health. In a private market, this means that individuals will only choose treatments if their willingness to pay for the health enhancement is greater than or equal to the treatment's cost. Therefore, in a private market, price represents a minimum amount an individual is prepared to pay.

To estimate the aggregate demand for a hypothetical medical treatment, it is presumed that each patient will purchase the treatment if the price is less than or equal to their maximum willingness to pay. At each price level, the number of patients opting for the medical treatment is proportional to the number whose utmost willingness to pay is greater than or equal to the price. Since patients' propensity to pay typically varies due to differences in preferences and income, the demand curve is downward-sloping, demonstrating that more patients will opt for the treatment at lower prices.(Bala et al., 1999).

The methods to analyze the Willingness to pay (WTP) have recently emerged to play immense role in facilitating cost-benefit analysis particularly in healthcare sector. Extensively, there have been two methods which are collectively known as conjoint analysis and they are: Conjoint valuation method (CVM) and Choice experiments (CE). These methods have been used for determining the monetary value of healthcare packages (Cookson, 2003). Consequently, a dilemma unfolds to adopt a method to measure WTP. A valid method is crucial in designing optimal pricing policies or estimating demand of new products and services. Therefore, analyzing and understanding potential sources of differences in WTP is important (Voelckner, 2006).

2.3 Classification of Methods for Measuring WTP

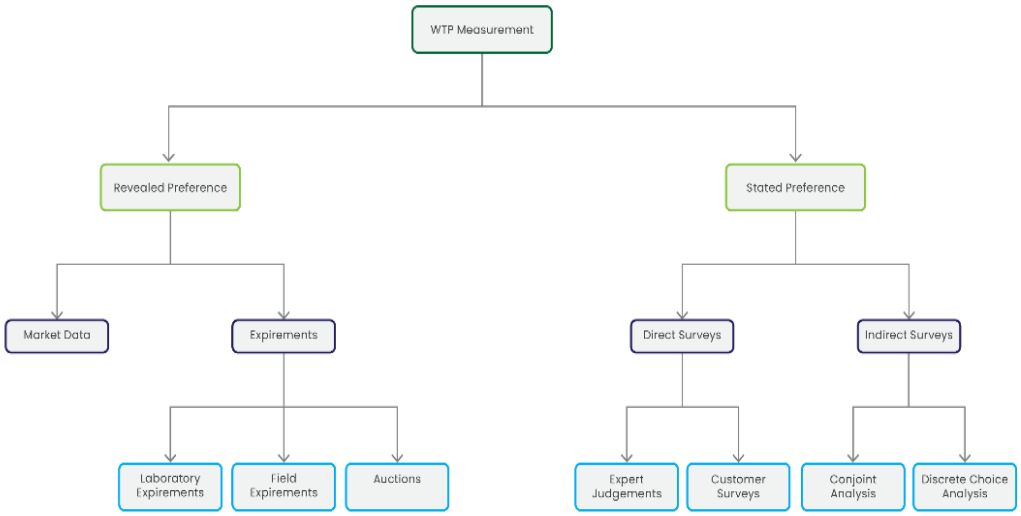

Figure 2.3 Classification of methods for measuring WTP (Breidert et al., 2006)

Market data

Market data is commonly used to estimate price, the obtained data sources are further divided into two types, i.e., panel data and store scanner data. Panel data means individual

purchase data and whereas store scanner data is records of sales from various retailer outlets. The purpose of historical market data is to predict future market behavior on the supposition of past demands and short ranges of price variations often leads to inadequate sales data to estimate WTP. Hence, it is evident that limited data will have a difficulty to estimate WTP for new products.

Experiments

Experiments method of measuring willingness to pay is further subdivided into three types:

a) Laboratory experiments

   Participants will be given a certain amount of money and asked to spend it on various products or goods whilst their behavior is recorded in this manner. Participants are aware of the experimental setting and the contrived setting in these experiments can lead to low external validity.

b) Field experiments

   Field tests are carried out in the form of test markets that are indicative of the target market. This experiment does not take place in an artificial setup but in real-life environment where different prices are set systematically and participants' response are recorded and analyzed. The biggest disadvantages of this method are that, it takes longer duration and costs more.

c) Auctions

   Auctions are more efficacious method to measure willingness to pay and find the preferred price for a product or services.

   There are innumerable auction types which can help to unfold the accurate willingness to pay. They are;

i) Vickrey or second-price sealed-bid auctions

Perpetually, this type of auction takes place where a group of potential buyers submit sealed bids, stating the amount they are willing to pay in an envelope. The second highest bid determines the buying price. The auction is won by the bidder who submits the highest bid and must pay the second highest bid price. Bidders are encouraged to bid their willingness to pay truthfully to increase their chances of winning while avoiding overpaying. This approach incentivizes bidders to reveal their genuine willingness to pay for a good if their offer wins the auction.

ii) Becker, DeGroot and Marschak or BDM lotteries

Each participant sets a highest price for the good to be sold, and the ultimate sale price is chosen at random (for example, by drawing an enclosed chit filled in a goldfish bowl with price written inside it). If the randomly chosen price is less than or equivalent to the WTP, the participant must buy the product at that price chosen randomly. The participant will not be allowed to buy the product if this is not the case. The sale price of their bids can not be influenced by the methods like Vickery auctions and BDM lottery players. Online Auctions are changing rapidly, this necessitates the study of advantages and disadvantages of the all the methods.

iii) Name your own price mechanism

Naming Your Own Price (NYOP) is a pricing strategy in which consumers have a relatively high degree of influence over the price they pay for a product or service. It is also known as a reverse auction. The buyer, not the seller, controls the price in the NYOP because the buyer is bidding for a certain amount, which the seller can accept or reject. If the seller accepts the consumer's offer, then the purchase will

take place, because the consumer's offers are binding. If the seller declines the offer, two main specific possibilities can be distinguished: Single bid and Repeated bidding.

iv) Open outcry Auction (English Auction)

A group of prospective buyers proffers an increasing bid. The buyer with the highest WTP wins the auction by bidding slightly higher than the buyer with the second highest WTP.

Direct surveys

Direct surveys further divided into

a) Expert Judgements

Sales or marketing managers are adroit in estimating consumers' WTP because sales representatives have immense exposure in the market with proximity to consumers. Thus, interviewing sales managers can be a valuable source of information for estimating demand. Nonetheless, sales managers' point of view may be skewed due to the marketing and sales managers' competing goals. This is mostly applicable in small markets, but with a larger customer or market area, the knowledge becomes critical.

b) Customers surveys

"Directly asking respondents to indicate acceptable prices is referred to as a direct approach to measure WTP." This approach can be useful in commercial markets. The price range of product and services can be obtained by asking participants directly. The major drawbacks of this approach are, participants may overstate the prices of product or services due to their pride or prestige effects or understate the

price due to collaboration effects. This approach is quite challenging where participants are unaware or lack of information about existing products or services.

Indirect surveys

Rather than directly asking respondents for their WTP, customers are shown product or service profiles with different price points systematically and asked whether they would buy the goods or services at a given price or not. This method of measurement is known as an indirect survey.

a) Conjoint analysis

WTP is developed from divergent views such as ranking or rating, expressing a preference or making a choice. Preferences can be solicited by ranking or rating all scenarios individually or in pairs. This method is susceptible to hypothetical bias. In the framework of a questionnaire, the respondent does not consider all the factors, such as available budget, financial repercussions, product or service availability, and competitor's product or service, which would influence his decision in a real situation. As a result, there is a gap between what the respondent says and what he would embrace in a real-life circumstance. Thus, health economists favor contingent valuation over conjoint analysis.

b) Discrete choice Analysis

Respondents pick between distinct product profiles in discrete choice analysis and it is a component of the choice modelling approach, which deals with difficulties such as contingent ranking, contingent rating, and paired comparisons. The utility structure is calculated using an option set, that is usually (but not always) consistent across all respondents. Every option has a set of characteristics that can be specified

in detail. Respondents are given a variety of options to pick from and are asked to indicate which one they prefer. Respondents are frequently given a no-choice option to indicate that none of the product profiles presented are appealing to them.

c) Contingent valuation Method

Contingent valuation (CV) is extensively used in WTP and price elasticity studies. In a contingent valuation, participants are asked how much they would be willing to pay for items or services. This sum can be obtained in a variety of ways, including open-ended (identify your sum), iterative bidding (increase/decrease to discover the cut-off), payment card (select the card with the closest sum to your limit), and closed-ended (say yes/no, with the sum varying between respondents). Contingent valuation is popular in environmental economics, and it's becoming more popular in health economics (Bacon-Shone and McGhee, 2007; Breidert et al., 2006; Le Gall-Ely, 2009; Rankin and Robinson, 2018; Shogren et al., 2001; Spann et al., 2004; Stobierski, 2020; Wagner and Pacheco, 2020).

2.4 Variables in the Pricing of Health Services/ Doctor Consultation

i. Local competition: The Lower rivalry enables a business to potentially charge higher prices.

ii. Availability of medical specialty: When a client cannot easily find another expert in their chosen sector, the higher the value of that expert becomes.

iii. Complexity of service: The higher the complexity and level of precision of the service, the greater the technical expertise required, and consequently the greater price. As an illustration, the significance of a routine clinical consultation is

typically lower than that of an experienced and competent neurosurgeon in cerebral aneurysms.

iv. Solvability: It is the capacity to meet customer requirements. The greater the urgency and the stakes for success, the higher the value typically is. For example, the customer is willing to pay an average price for a routine cardiology visit to measure blood pressure. However, if he is experiencing a heart attack, he will be willing to pay significantly more for the service.

v. Purchasing power of the market: It reflects the level of economic prosperity of the populace. The value of the consultation tends to increase with the quality of the company segment, population wage level, and consultation value.

vi. Complexity of infrastructure required to service: When specialized tools, resources, or personnel are needed to carry out the consultation, the associated costs rise, and so does the price.

vii. Demand from customers: In accordance with the law of supply and demand, prices can rise when there is a high demand for a service, such as a doctor's opinion; this is because a busy doctor's office implies that patients perceive the cost to be justified by the value they receive.

viii. Brand: It exhibits a professional’s dominance in the industry. The professional’s reputation is, of course, is created with time and is an outcome of his/her accomplishments. The more reputation and prestige a physician has, the more he or she should be awarded (Padua Filho and Padua, 2016).

2.5 Factors Influencing Willingness to Pay

Willingness to pay (WTP) can be influenced by few factors such as gender, age, education, income, occupation, dependency ratio/ household size, perception, Family type, healthcare services quality, locality rural/ urban ability to pay, marital status, health insurance, characteristics of diseases, current health status, hospitalization history etc. (Aizuddin et al., 2012; Audureau et al., 2019; Hsu et al., 2021; Russell et al., 1995) and WTP is directly associated with willingness to spend on health gain in terms of Quality Adjusted life year (QALY) (McDougall et al., 2020).

Table 2.2 Factors influencing willingness to pay (Steigenberger et al., 2022).

Characteristics	Factors
Sociodemographic characteristics	Age, gender/sex, marital status, education, size household/family, work activity/job type, income/wealth, geographic location/residence setting, place of birth (country or urban/rural), ethnicity (nationality/race), confession/level of religiosity
Perceived threat (= susceptibility for and severity of condition or risk)	State of health, perceived own susceptibility, affectedness/perceived severity of disease, prior use/disease history
Perceived benefit (also non-health-related benefits) and pre-knowledge	Efficacy/effectiveness, personal mindset (affected relatives)/attitude of living healthy (smoking, drinking, dental visits), pre-knowledge/information
Perceived barriers (belief about tangible and psychological cost)	Insurance status (including prior OOPP), perceived access (incl. waiting time and forgoing use), price of treatment and affordability

2.6 Meaning and Doctor's Consultation Process in India

In recent years, the healthcare industry has been rapidly growing and adopting the recent technologies to resolve the burden on healthcare system and health-related issues. In India, mostly the healthcare services are purchased privately by the patients, as the government is struggling to allocate the healthcare budget to meet the countries demand for providing even the basic essential healthcare facilities.

Doctor's consultation is a general meeting or point of contact between doctor and patient which comprises of history collection, physical examination, diagnosis of diseases, counselling and initiating investigations such as diagnostic tests pertaining to signs and symptoms and prescribing relevant treatment. The main purpose of doctor's consultation is either prevention, cure, or rehabilitation of concerned patient. Doctor's consultation may be required throughout human life cycle, right before the birth till the death and in all the phases of life such as fetal, infantile, child, adolescence, adult, and elderly. For example, children are treated by pediatrician, adults are treated by General Practitioner, Psychiatry (Mental Health), Cardiology (heart), Neurology (Nervous System), Orthopedics (joints and bones), Obstetrics and Gynecology, Dermatology (skin disease) Ophthalmology(eyes), Otorhinolaryngology (Ear, Nose, Throat) Dentistry (Teeth), Nephrology(kidney), Urology (Urinary System), Gastroenterology, General Surgery, Plastic Surgery, Oncology(cancer), Pulmonology (lungs) etc. and elderly patients are treated by geriatricians. This can take place in doctor's offices or clinics, hospital's outpatient departments or in few cases at patients' own homes. A doctor's consultation is the first and the most crucial step in the process of obtaining healthcare service. Individuals in India who seek healthcare services,

from basic health screening to emergency situations, usually incur humongous amount of healthcare expenses (Figure 2.4) in the form of registration fees, Doctor's consultation fees, investigation fees, and medication fees, Admission fees, In-patient charges including bed charges, nursing charges and surgery charges etc.

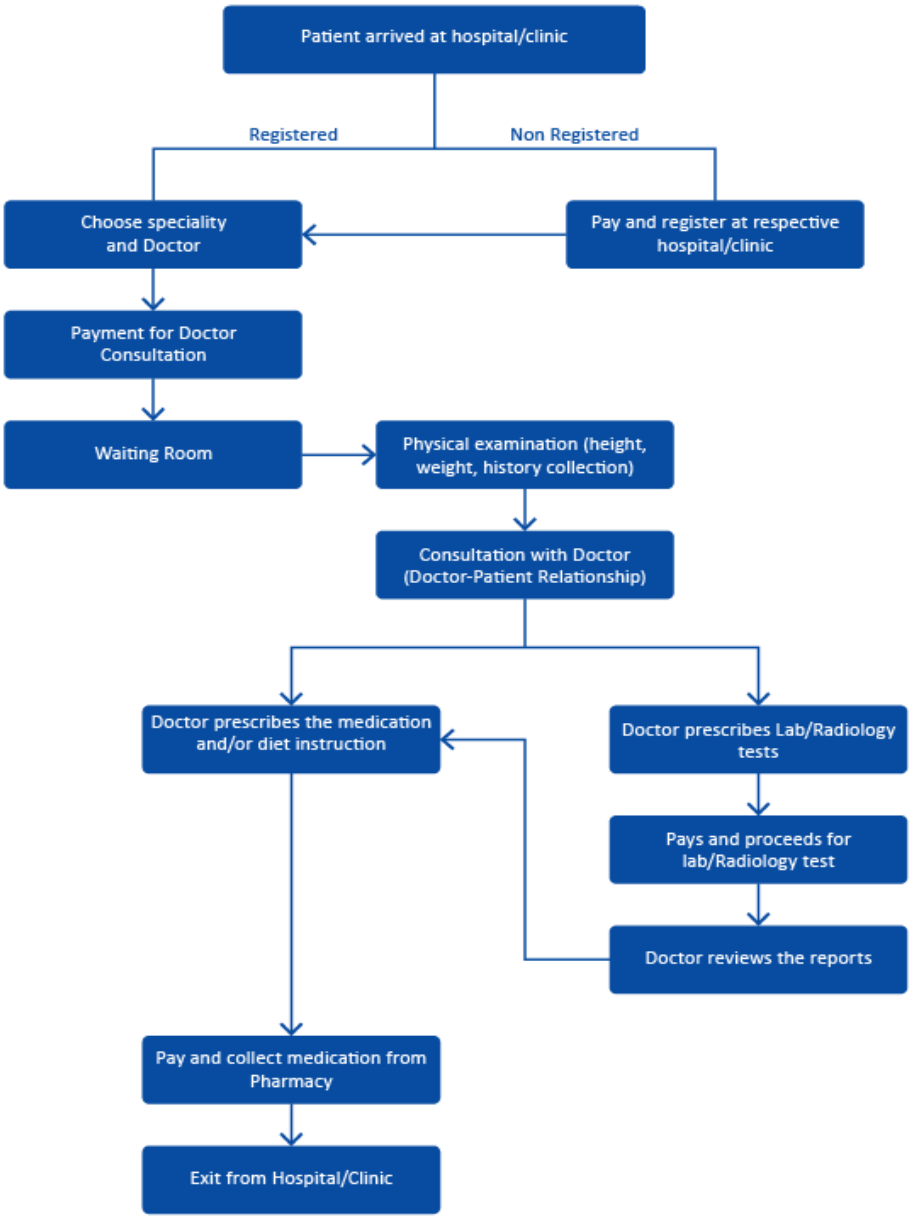

Figure 2.4 Doctor's consultation process in India (source: Author's own)

2.7 Empirical Studies in Willingness to Pay in Healthcare and Doctors' Consultation

A study conducted in Malaysian population depicts that, they are paying minimal charges MYR100 for outpatient clinic registration fees which includes all the consultations, investigations, and the medications (Noor and Junid, 2018). Where as in India the patients must incur the registration charges, consultation charges, charges for investigations and pay for the medications separately. This mandates a study to evaluate the doctor's consultation fees paid by patients in India, as there is limited insight about the consultation fees in various specialties.

When a novel healthcare provider joins the market, particularly in the private sector, it's vital to consider if the charges will be accessible, especially if the service provider proclaims to be able to give a service that's significantly less expensive than its opponents (Louw and Duvenhage, 2017). Doctors from several hospitals argue that, it is not reasonable to advise patients about their potential cost of the treatment or surgeries beforehand. However, this ideology is not justifiable pertaining to consultation fees, as the consultation fees can be fixed.

A hospital's Outpatient department (OPD) of a hospital has the most frequent and significant patient interactions. Outpatient services are essential, considering the profits generated from these individuals allow the hospital to invest in new medical technologies and mitigate potential losses from certain inpatient services. Thus, hospitals consistently view OPDs as profit-making division with the objective of maximizing revenues. The provision of quality healthcare has become a global aspiration. Due to the intangibility, time sensitivity, urgency, and high customer involvement inherent to healthcare services, they ought to face unique challenges. Globally, the Healthcare industry has experienced a

period of exceptional expansion in recent years. Simultaneously, rising health awareness among patients and demand for high-quality care have resulted in a fierce rivalry between the hospitals (Daultani et al., 2015). Similarly, a cross-sectional survey carried out by O'Reilly et al. (2007) on patients in Northern Ireland where, 11870 respondents participated in the survey, in which 18.9% of patients (4.4% were non-paying patients and 26.3% were paying patients) had a history of previous medical illness but had not consulted the doctor because of cost constraints. Even in countries with exemptions for the poor and more vulnerable, a consultation charge can deter a large proportion of poorer and unhealthy patients from visiting their general practitioner. The healthcare sector is facing similar issues in India where charges are not appositely regulated, due to the heinous culture of under the table payments in return of quality care especially in the public hospitals in a low-income country like India, due to which individuals hesitate to pursue healthcare services even in dire emergencies, debilitating the countries existing crippling healthcare ecosystem.

In a cross-sectional analysis, it was found that practice charges for physician visits and other co-payments could jeopardize healthcare utilization among low-income groups and even a small amount of cost incurred could detain patients from physician visits, which may result in an unsettling relationship between the patients and the physician(Rückert et al., 2008). Analogously, the unregulated way of charging consultation fees by doctors is deterring the already crippling healthcare system of a developing country like India where most of the population fall under poverty line, and thus a meaningful study to evaluate the current doctor's consultation fees for various specialties is critical to regularize the doctor's

consultation fees and make it more affordable which sequentially will boost the healthcare utilization and improvise the already unsettled doctor-patient relationship in India.

When doctors are unconstrained to fix the prices, they charge higher fees to high income patients in unregulated fee-setting environment (Johar, 2012). This analysis is consistent with the study conducted by Johar et al. (2017) in Australia and discovered that nearly 80% of specialists are charging their high-income individuals substantially with lofty charges. Relatively, 20% of specialists were charging at least AU$50 in excess to high-income patients as compared to low-income patients (Table 2.3) where the median price disparity was calculated at AU$24.76. Most specialists in this study charge higher costs to high-income patients in an unregulated fee-setting framework.

Table 2.3 Average fee for high-income and low-income patients by specialty (Johar et al., 2017)

Speciality	High-income patients	Low-income patients	Average fee gap
Neurosurgery	$206.14	$153.12	$53.01
Dermatology	$145.18	$107.84	$37.34
Otorhinolaryngology	$144.13	$112.81	$31.33
General Surgery	$136.29	$105.57	$30.72
Urology	$153.40	$125.01	$28.39
Ophthalmology	$134.24	$107.12	$27.12
Vascular Surgery	$140.02	$113.94	$26.08
Obstetrics and Gynaecology	$149.25	$125.41	$23.84
In vitro fertilisation	$136.57	$113.85	$22.72
Radiology oncology	$128.08	$105.66	$22.41
Cardio-thoracic Surgery	$139.50	$117.77	$21.73
Orthopaedic Surgery	$149.72	$132.25	$17.47
Plastic Surgery	$143.11	$126.16	$16.95
Oral Surgery	$121.08	$106.39	$14.69
Other specialities	$116.52	$98.26	$18.26

Freed and Allen (2018) explored that, fees charged by medical specialists variegates within and between the different medical specialties, states, and territories in Australia. The National average charges for Pediatrics consultation were found to be $239.30. The charges in new South Wales ($230.00), Victoria (241.00), Queensland ($252.00), South Australia ($230), Western Australia (252.00), Tasmania ($187.00), Australian Capital Territory ($229.00), Northern Territory ($250.00). This evidence certainly brings out an obligation to construct and conduct a study, in a way to analyze the variations in the doctor's consultation fees amongst different medical specialties in India to make the healthcare system more accessible and affordable to both low-income and high-income individuals.

Hui et al. (2023) investigated the variations in the doctor's professional fees charged towards the patients along with other facility charges levied from the patient in the outpatient department, and revealed that the doctor's professional fees dipped by 15%, out of which a considerable dip in doctors' professional fees was reported in Oncology department(23.5%), followed by General Orthopedics (23.1%), In contrast, a steep increase in the charges towards outpatient facilities was reported. The overall surge in the outpatient facilities charges stood at 72%. Notably, the outpatient facility charges levied from the patients in General Orthopedics, spine, and trauma departments, were the highest.

McRae and van Gool (2017) affirmed that the variations in doctor's consultation fee are due to differences in the supply and demand across geographic area and specialty of doctors. The cause of price variations in the market is a result of uncompetitive structure of markets where doctors are charging exorbitantly higher than the standard fee in that particular geographic area.

In a commercial market, usually consumers compare and examine the quality and price of the service provided and thereby make the purchase decision, where prices of goods and services are indicated to consumers, but this is not applicable in terms of healthcare services. Subsequently, Willingness to pay can be used as a medical marketing tool to acquire information on fair pricing and demand forecast (Yasunaga et al., 2006). Therefore, the adoption of willingness to pay is an effective technique in health economics to attain the preference of individuals who are direct beneficiaries of the proposed health services (Abbas et al., 2019). The concept of willingness to pay (WTP) has only recently been adopted in healthcare ecosystem, where the quality-adjusted life year (QALY) has been the prevalent and prominent form of benefit evaluation. The WTP technique can be used to draw values from patients, for different methods of treating an identical issue, or from the community, which will facilitate the process of determining priorities across patient groups (Donaldson, 2001).

According to Russell et al. (1995), patients' prior purchases may not signify the utmost amount they are willing to pay, which could be either higher or lower. Patients' willingness to pay for a service is influenced by a variety of circumstances and non-price factors, thus patients may be willing to pay certain amount to one provider but not the same amount to another. For example, women may be ready to pay conventional midwives or mission hospitals for delivery services, but they might not be ready to pay the same at a government hospital due to the sub-standard healthcare services received by the patient or the government hospital's accessibility, or a loss of integrity in the government hospital's staff.

A study by Farabi et al. (2020) found that, the participants who had information about prostate cancer risks and factors such as age, income, family history of cancer,

hospitalization history, and educational level have positive effects on willingness to pay for prostate cancer whereas prostate-specific antigen history, health insurance, employment status, and health status stated by subject's received less attention. Similarly, another study revealed that 44% of buyers are willing to pay a higher price. i.e., 9% rise in the purchase of health and wellness foods. Furthermore, the study reveals that factors such as age, gender, income, and education are key aspects to be considered when evaluating willingness to pay for health and wellness food products. As alertness about health and wellness has been increasing in general public, buyers with graduation and above are comparatively more likely to pay (Ali and Ali, 2020).

Sossou et al. (2021) mentioned that willingness to pay for Universal health coverage was impacted by recovery time of patients, doctor and patient relationship and medicines availability. Besides, the fact that ethnic group or religion has no relation with WTP for UHC, this study is consistent with other studies. Both ability to pay and the cost of medical care treatments influences the willingness to pay.

Another notable finding by Ogasawara and Abe (2013) in Hokkaido, Japan on WTP for tele-health consultation service with 480 respondents spotted that, mean and median for WTP towards tele-health consultation was 495 yen and 367 yen respectively. Logistic regression analysis was adopted to identify the factors that influence the WTP for tele-health consultation and found that, annual income is the significant factor to affect WTP. In concordance with other studies, a study from multi-country surveys of patients and physicians by Audureau et al. (2019) and concluded that factors influencing WTP were income, purchase of advanced treatment, Higher education level and disease-specific factors.

A study of WTP on Caregivers of Patients affected by Schizophrenia uncover that, higher the income and education, higher is the willingness to pay towards healthcare. It was also found that there was no statistically significant results consistent with clinical characteristics of patients and WTP, and also proposed to adopt WTP measures for development of mental health policies (Daltio et al., 2017).Similarly, Jarbøl (2012) employed regression analysis to discover a positive relationship between participants' self-reported health and their WTP. The author discovered that healthy adults place a higher value on excellent health in life than less healthy ones, resulting in a positive link between the two factors.

Another study using a double dichotomous choice strategy to quantify WTP in health insurance was undertaken in Iranian regions with a sample size of 300 household heads and WTP for social health insurance was 137000 Rial ($ 5.5) per month/person on average. WTP for health insurance was higher for household heads with higher levels of education, income, and those who are having fixed jobs. Furthermore, the WTP increases in accordance with the number of insured people in each household and in inverse proportion to the size of the family (Nosratnejad et al., 2014). Similarly in another study, it was found that, individuals have higher WTP for higher-level doctors, according to an analysis of different levels of doctors. Patients were also interested in spending more if they had a deeper doctor-patient relationship. Furthermore, the doctor-patient interaction is considered to be the most essential element, with a high WTP (Hsu et al., 2021).

Al-Hanawi et al. (2018) opined that, the average monthly WTP for national health insurance scheme was 50 Saudi Riyals (US $13.33) per household member. The key drivers of WTP, as per Tobit regression analysis were household size, satisfaction with the

quality of public healthcare services, beliefs about financing healthcare, education, and income.

A study conducted in the region of southern Denmark, 343 individuals participated in the study where 170(50%) were not willing to pay for a consultation and WTP was 137(S. D =140) Danish kroner (DKK). When compared to other age groups, 65 years and above were more likely to be willing to pay for general practitioner. In addition, the patients with annual income more than 200,000 DKK were more willing to pay for a consultation than other income groups (Kronborg et al., 2017). This study further illustrates that its imminent to investigate the willingness to pay for doctor's consultation fees in a low-income country like India and the factors influencing the WTP for doctor's consultation fees.

A cross-sectional web-based survey was conducted in India with a sample size of 2467 for a period of 15 days to estimate the WTP for the COVID-19 vaccine. The maximum amount that the participants were willing to pay was used to determine WTP. It was observed that the majority of participants, accounting for 2162 (88.21%), were willing to pay an amount of USD 6.81 (INR 500) (Goruntla et al., 2021).

Bhat (2020) investigated that, Indian doctors are paid the lowest consultation fees among the BRICS countries (Brazil, Russia, India, China, and South Africa), with mean consultation fees of INR 8775, INR 2500, INR 600, INR 2250, and INR 1800, respectively where consultation fees of Indian doctors were compared to prices of popular fast-food items such as burgers and Coca-Cola, as well as hair cut charges. The analysis revealed that, a general practitioner's expenses are equivalent to 3 to 3.5 burgers and 5 bottles of the Coca-Cola. The author of the study overlooked the data collection technique, total sample

size, study design, and study setting to validate the findings as low consultation fees in India.

In another research effort, contingent valuation was employed to enumerate the willingness to pay for integrative healthcare services across 17 Korean regions. The analysis of 3900 questionnaires revealed that 69.26% of respondents would pay for integrative healthcare services. The average WTP for integrative healthcare services for sleep disorders was KRW 15,535.46, or $12.95 per consultation. Research shows that, having private health insurance, a higher household income, and better health-related quality of life correlates with a higher willingness to pay for integrative services. On the other hand, age was found to have a negative influence on willingness to pay (Hyun, 2023).

A study by Wolff et al. (2020) revealed that, while most people were hesitant to pay for prevention measures compared to treatment, those who were willing to pay showed a greater willingness to pay for it. The aggregate mean WTP for prevention was roughly 85 percent higher than for treatment.

User fees may also lead to illusory economies if they discourage people from accessing primary care when they are supposed to, triggering costly delayed diagnoses (such as for cancer), or if they cause people to seek care only for acute problems, deprioritizing essential preventive and chronic care. Costs for users may also result in patients amassing health problems, with clinicians expected to address numerous issues within 10 to 15 minutes of the appointment. Preventive care and chronic disease management are likely to decline when fees are implemented, as patients tend to defer treatment until costly medical emergencies arise. To gratify patients who have paid to see them, physicians may feel compelled to provide prescriptions and referrals or conduct investigations (Majeed, 2023).

In the last two decades, physician additional fees have increased by a factor of three, heightening concerns about the affordability of healthcare in France (Montmartin and Herrera-Gomez, 2023).

The studies conducted earlier in the field of health economics pointed out the fact that the need for an intervention in the healthcare setup, along with disease severity, plays a significant role and influences the level of willingness to pay by the patients during treatment. The willingness to pay precisely plays a determining role in evaluating the cost-effectiveness towards healthcare interventions. The findings add prevention to the cost-effectiveness threshold debate by impacting health improvement demand-side value. Thus, it can assist healthcare and health promotion priority setters (Wolff et al., 2020).

Willingness to pay questions is commonly used to assess private and public decision-making processes. In numerous life-preserving scenarios, data pertaining to WTP can be utilized used to assist private decision makers in making decisions that impact their own lives or the lives of others (e.g., family) whose survival they value (Gafni, 1991)

In Qujiang District of Shaoguan City, rural Guangdong, southern China, a study was conducted, to determine if individuals with diabetes mellitus were willing to pay for diabetic retinopathy screening and what factors influenced their decision. Out of the 545 participants (mean age 64.6 years (SD10.4), 40.7% male), 327 (60.0%) who were willing to pay for screening, with 273 (83.5%) of them willing to spend RMB10–RMB30 (US$1.6–US$4.7). The study found that individuals from lower-income families and those residing in rural areas were more likely to be willing to pay. Conversely, men, city residents, and those with employer-linked insurance were more likely to pay higher amounts (Xiao et al., 2023).

Baji et al. (2012) demonstrated using regression analysis that, the factors for determining access to care in Hungary, such as the level of technology, the skills and reputation of the doctor, the waiting and travel times, and the distance to the facility, were more statistically significant. The study also revealed that patients were willing to travel further in search of a practitioner with greater experience or an outstanding reputation.

A study of 208 individuals revealed that the majority did not experience illness or had only two occurrences of morbidity over the course of three months. Malaria was the most prevalent illness, with 25% incurring no expenses and 36.32 percent incurring minimal expenditures for household health services. Nearly half of respondents were aware of the program, and over 63 percent have high hopes for its implementation. The willingness to pay decreased with age and illness frequency, but increased with awareness, anticipated operability, and preferences for a pre-paid system. The study suggests raising rural residents' awareness of prospective benefits (Binam et al., 2004).

Hospitals are the key components of healthcare systems, as they deliver primary care, act as centers of referral for more advanced treatment, and educate medical personnel. Hospitals are seen as essential community resources that ought to be handled for the community's benefit in both developed and developing nations. Hospital administrators must deliver the community's healthcare requirements at an acceptable degree of quality and at the lowest feasible cost. Thus, they must have awareness about the actual cost of the healthcare services being provided. Constructing various comprehensive healthcare policies requires the data about costs incurred at hospitals as well. As an example, information about the cost can aid the health administrators in allocating resources towards specific facilities and services, introduction or establishment of user fees, assessment of

the comparative efficacy of healthcare services across settings, and to determine the budgets for operating health services (Chatterjee et al., 2013).

In normal circumstances, health economics is concerned with efficiently allocating limited resources within a framework such as an insurance plan or a healthcare management group. This involves making decisions regarding providing various remedies, access to specialists, and compensation for various procedures. In the near past, healthcare administrators and top-level managers have become cognizant about their obligation to make suitable decisions regarding the allocation of resources. Cost data is essential for ensuring the effective distribution of healthcare expenditures, estimating potential budget allocation, and establishing user fees to initiate new finance. Cost information assists administrators and decision-makers in enhancing the quality of medical services and making cost projections to improve hospital resource allocation and performance. Furthermore, it provides fundamental information for establishing user fees at an acceptable price and quality level for the community (Than et al., 2017).

Bacon-Shone and McGhee (2007) argued that waiting time and proximity to medical facilities may play a significant role in determining health care selection. Those with a full-time job and less available leisure time may be more inclined to pay for more accessible care than those with part-time jobs or who are unemployed. The familiarity of a physician with a patient's case history is also crucial in influencing health care decisions.

In the United States, a cross-sectional study of 523 trauma centers revealed that activation fees ranged from $1000 to $61734, with an average of $9500. These results demonstrated that, the patients who sustained severe trauma will bear a significantly greater trauma

activation fee. As a result, it is essential to set trauma activation fees uniformly(Zitek et al., 2023).

Researchers discovered that due to demographic factors, certain regions of France are overlooked in terms of physician availability and services. When excessive physician fees further restrict access to healthcare, balance invoicing, which allows physicians to determine their own fees, can be more problematic (Dargaud and Jelovac, 2023).

A substantial financial toxicity is caused by not knowing the cost difference of various treatments. A large proportion of American doctor's incorrectly assume that everyone can afford high-quality cancer treatment. Doctor's often have a limited understanding of the costs associated with patient visits, prescriptions, and other medical services (Thomas and Mathew, 2022). Even privately insured individuals may have trouble paying for care due to escalating premiums, deductibles, and co-payments, as well as private plans that may not cover enough of their costs to assure access to quality health care (Weinick et al., 2005).

A study conducted in China to determine the willingness to pay for pneumonia and influenza showed that only 45 percent of individuals were willing to pay the current market price. An increased willingness to pay is correlated with a lower price barrier and a greater capacity to pay. The willingness to pay is a result of factors such as heightened perceptions of vulnerability and severity. Additionally, it was discovered that recommendations from peers and healthcare providers increase the willingness to pay (Hou et al., 2014).

According to scholars, willingness to pay is a beneficial tool for cost-benefit analysis for evaluating healthcare interventions. It can help define healthcare policies, particularly in publicly funded healthcare, and is easily determined through a simple survey. Nevertheless,

it has limitations. Society can benefit from medical researchers with a deeper comprehension of willingness-to-pay (Hojnik et al., 2021).

What people buy and how much they're willing to spend vary greatly based on their age, income, gender, level of education, and geographic location (to name just a few demographic factors) (Ahmad and Juhdi, 2010). WTP for physician access is affected by factors such as age, wealth, education, and location, as documented by (Martín-Fernández et al., 2010).

Aizuddin et al. (2012) conducted a literature review on the topic of willingness-to-pay and the factors that influence WTP for healthcare services from 1990 to 2011. This review included both published and unpublished publications. The major findings of the study were that, the factors such as age, education, income dependency ratio, household size, perception, healthcare service quality, and locality, both urban and rural, significantly influences the willingness to pay. In general, consumers who are healthier will be less willing to pay for healthcare, whereas those who stay relatively healthy will be more willing to pay for more effective dietary and treatment alternatives for their disease states.

Bellhouse et al. (2010), for instance, demonstrated that consumers who are more concerned about high cholesterol are willing to pay a premium for reduced cholesterol pork and acquire more of such a product, indicating that an individual's state of health influences his or her willingness-to-pay for a product. Asselin (2005) also elaborated on consumer qualities that influence their willingness to pay, such as their current health state and the ways in which they choose to take care of their health.

Access to healthcare can be ambiguous and difficult to define, particularly for various population segments, but consumers' current access affects their willingness to pay for better care. The less current access of care leads to higher willingness to pay, while keeping all other factors constant only available income is considered (Banerjee et al., 2004).

One measure for evaluating access to treatment is distance from the nearest facility, and the greater the distance, particularly in rural areas, the more probability that a resident will pay for access to a healthcare provider (Aizuddin et al., 2012).According to the research findings, consumers, including those from lower-income households, are prepared to pay fees for enhanced medical services if those fees correspond to increased accessibility and dependability of healthcare facilities. In addition, they revealed that the availability of fundamental healthcare has a more significant effect on low-income or low-education households, or both, than the provision of specialized services (Alderman and Lavy, 1996).

Ukraine, Romania, and Bulgarian respondents were most prepared to spend a sizable portion of their income on visiting medical specialists, while having the lowest median amount (14 USD) and highest median amount (27 USD), respectively. In Bulgaria, the average estimated hospitalization cost was between $192 and $303. Ukraine had the greatest percentage of respondents with monthly equalized incomes (58%) compared to the other two countries (Poland and Hungary, both around 24%). Not being able to pay, was the most common reason given for not wanting to pay, whereas resistance to paying was given less frequently. Both Bulgaria and Romania had very few objections. More than 40% of Polish respondents stated both disapproval and incapacity to pay, making them the most opposed country (Tambor et al., 2014).

Nyamuryekung'e et al. (2018) researched on, 1522 OPD patients in four regional hospitals in Tanzania while using open-ended willingness to pay survey as a tool. The Kruskal Wallis and Mann-Whitney tests were used to calculate the WTP for tooth extraction and filling. 2.4 US dollars and 3.5 US dollars were the average WTP for filling anterior and posterior teeth respectively. It was also discovered that the typical dentist's fee exceeded the average consumer's willingness to pay. WTP amounts varied significantly by age, income, outpatient status, and number of prior dental visits. Those who were younger (18-24 years old) and/or had greater earnings were more likely to have a high WTP evaluation across all categories of teeth treatments. Another study was carried out in Cape Town, South Africa, where among 453 people who visited two public primary health care institutions, Bothering Community Day Centre (CDC) and Goodwood CDC, all the 60% of participants expressed a willingness to pay for the services provided at PHC facilities. All participants' were willing to pay, on average, of 49.44 ZAR, with a median of 25 ZAR. The researcher further elaborated the factors affecting participants' willingness to contribute to health services, despite low amounts. Understanding the economic value of services is crucial for quality care improvements, particularly as South Africa prepares facilities for NHI (Chiwire et al., 2021).

Azhar et al. (2018) explored via face-to-face interview in Sarawak Malaysia to determine the willingness to pay for Health Insurance. It was discovered that about half (46.7%) of the respondents agreed to pay monthly health insurance premium. Among those who were unwilling to pay, 81.3% were unable to afford the monthly insurance. A regression analysis revealed that occupation, level of education, gender, marital status, monthly family income and treatment preference appeared to be potential predictors for willingness to accept

health insurance. Yu et al. (2019) also supported that Physicians with information about patients' eligibility usually raised their consultation fees by 12%. The results show that policy change has significant unintended consequences and suggest physicians' knowledge of a patient's entitlement to health services can influence service demand. According to a study by Chatterjee et al. (2013), patients were more willing to pay for healthcare services when they had a strong doctor-patient relationship, when medications were available on-site, and when they had a higher chance of recovery. In addition to the findings, patients are willing to pay more for healthcare services if they live further away from the hospital. This indicates that those living at a "very far" or "far" distance were more willing to pay compared to those residing at an "average" distance.

In Bangladesh's healthcare sector, patients are willing to pay for better staff attitudes. User fees had a significant impact on healthcare in the country. Out of seven quality attributes, consumers are willing to pay extra to enhance three: doctor-patient relationship, drug availability, and the likelihood of recovery. The findings also suggest that these three qualities are positively influenced by more educated patients and those with higher income levels were willing to pay more. Patients with acute problems were willing to pay more for these three attributes than those with chronic conditions, although there are no significant variations for the remaining attributes (Pavel et al., 2015). As a result, physicians may engage in rent-seeking behavior even if they prioritize patient health over profit. This behavior can lead to inefficient use of resources and unnecessary costs for the patients, as noted by (Müller et al., 2023).

According to a research study by Ogundeji et al. (2019), 82% of household leaders are willing to pay for insurance, with an average monthly cost of 513 Naira per person. Those

residing in rural areas tend to pay less at 463 Naira, while urban dwellers pay 611 Naira. Factors affecting willingness to pay include the size of the household, level of education, occupation, and income. Unfortunately, only 65% of people can afford the average premium, which makes it crucial to educate people about the benefits of insurance, especially in rural areas and across formal and informal sectors. Insurance providers can tailor premiums based on the willingness to pay, but subsidies may be required to improve accessibility. A survey at Hanoi Heart Hospital where patients' willingness to pay for hospital-based, home-based, and administrative services was assessed and found that those living in urban areas, employed, with higher education, and no health insurance, were willing to pay more for services. WTP for hospital-based services ranged from US$9.8 to US$21.9, home-based services from US$9.8 to US$22, and administrative services from US$1.9 to US$7.5 (Tran et al., 2018).

According to a study conducted by Gidey et al. (2019), the majority of the 381 individuals interviewed (85.3%) preferred social health insurance and were willing to pay an average of 3.6% of their monthly salary. However, 42.6% of respondents cited a lack of funds as their primary reason for being unwilling to pay. The study also found that income positively influenced willingness to pay, while age and education had negative correlations. Participants were hesitant to pay the 3% premium unless certain preconditions were met. These findings suggests that patients may not fully understand the benefits of health insurance and may not be willing to pay premiums unless they have a specific medical condition. Therefore, it is important to focus on improving the quality of health services.

According to the findings of a recent study conducted in Germany where the average monthly willingness to pay (WTP) for health insurance was estimated to be €240, which

accounts for approximately 14% of a household's net equivalent income. The study additionally discovered multiple indicators that exhibited a statistically significant association with an augmented willingness to pay (WTP) for health insurance. Several characteristics have been identified as influential in this context, namely, a younger age, a larger logarithm of household net equivalent income, increased levels of social support, and the possession of private health insurance. Moreover, the research revealed that persons exhibiting a greater willingness to pay (WTP) for health insurance demonstrated a stronger propensity for openness to experiences. Nevertheless, it is important to highlight that there were no substantial correlations found between willingness to pay (WTP) for health insurance and agreeableness, conscientiousness, extraversion, or neuroticism (Hajek et al., 2020). Another cross-sectional study was undertaken at Dr. Zainoel Abidin Banda Aceh Hospital, with a sample of 180 outpatients. The findings of the survey indicate that, a significant proportion of individuals receiving outpatient care through public healthcare facilities expressed a willingness to pay an amount lower than Rp 9,000. Likewise, it is seen that inpatients exhibit a willingness to pay a sum lower than Rp 30,000. Individuals with financial means below Rp 15000 and within the range of Rp 15000 to 219,999 exhibited a preference for public healthcare facilities as their primary choice for accessing medical services. Conversely, individuals who possess health insurance coverage exhibited a preference for private healthcare providers. The utilization of public healthcare services within the Acehnese community is contingent upon two primary determinants: their financial capacity to afford healthcare services and the presence of health insurance coverage (Rina and Rosminah, 2011).

A study conducted by Hui et al. (2023) at various hospitals in the United States from 2008 to 2021 revealed that the doctor's professional fees are declining whereas the charges of facilities in outpatient and inpatient facilities are steeply increasing. This fact brings into light the fact that warrants a study on trends in doctor's professional fees in India, considering both urban and rural areas, to better understand these trends and the factors associated with them.

Lagarde et al. (1996) investigated the impact of lowering or increasing the doctor's consultation fees in lower- and middle-income countries, highlighting the significance of healthcare service utilization by the population in those areas, which was found to be inversely proportional to the increase or decrease in the doctor's consultation fees. The lower the consultation fees, the higher the healthcare service utilization, and vice versa. It was also noted that the doctor's consultation fees also hinder the accessibility of essential healthcare services to the lower-income users. The researcher rightly pointed out that healthcare service utilization is a variable and depends imminently on doctors' consultation fees; thus, doctors' consultation is understood to be the deciding factor for healthcare service utilization. In conclusion, proportionately higher consultation fees are disastrous to healthcare utilization in lower-income countries. With this certainty, the study of trends in doctor's consultation fees in a developing country like India, where doctor's consultation fees are the doorway to healthcare service utilization becomes imminent. Irregularities and monopolies in this prospect are disastrous to the healthcare indices in India.

Yu et al. (2019) investigated the doctor's consultation fees for providing online consultations for obesity and concluded that the doctors giving online consultations for obesity in China are charging fees of up to 90% in excess as compared to the consultation

fees charged by the same doctors when consultations are given in-person. This fact stimulates the study of the variance between consultation fees for online and offline consultations and the factors affecting the charges related to such variance, and to assess if any such variance exists. The researcher also found that higher the rank of a doctor higher is the fees for online consultation. Which sounds a very legible point to be investigated in India to look for the consultation fees of higher ranked doctors, the waiting time etc. to see if the doctors who are higher ranked and who had lots of patients waiting for them for consultation are charging exuberantly high consultation fees than what is being charged by the same ranked doctors in the same geographical area. It is imminent to conduct a study to understand these trends and if any such are irregularities found, needs to be addressed for better and more fair availability of healthcare services which may bring about positive changes in the utilization of healthcare services.

A study conducted by Zin et al. (2023) to assess the cost of accessing primary healthcare in Malaysia within 3 and half years from Jan 2016 to Aug 2019 and found that, consultation fees have surged extortionately high by about 113.9 %, which in turn has led to a surge in overall total mean cost of the clinic visit, this has ensued despite the reduction in the costs of the medicines over this above mentioned period, highlighting the fact that the overall clinic mean clinic visit costs have escalated exclusively because of surge in the doctor's consultation fees, Which reveals a ground-breaking data for the policymakers to take a note on the impact of doctor's consultation fees on overall healthcare costs to identify and mastermind new outlook towards reducing healthcare costs in specific settings. These results also materialize the fact that overall healthcare costs and accessibility to healthcare depend exclusively on doctors' consultation, which further mandates a similar study in rural

and urban settings in India to identify the current doctor's consultation fees and their impact on overall healthcare costs and to identify and intervene if any similar results pertain and provide data that acts as a nidus to healthcare policymakers to intervene for better accessibility of healthcare. Barik and Thorat (2015) assessed the Issues of disproportionate access to public health in India and came across the following facts about the existing healthcare infrastructure and patterns of healthcare utilization in India across the rural and urban population. Regardless of the ability to pay for the healthcare service, most population in India are seeking private institutions for availing healthcare facilities for minor illnesses like common cold, fever and diarrhoea etc, although availing private healthcare facilities in India is expensive, and lacks the quality care as mostly the staff in private healthcare facilities are not well trained as compared to the public healthcare facilities. The rural population faces a lack of access to the healthcare as compared to urban population disproportionately along with the fact that larger share of unhealthy population stays in rural areas. In case of minor illnesses, most of the healthcare cost is derived from doctors' consultation fees and medicines. The access to healthcare facilities is prominently asymmetric when it comes to treatment of major long term debilitating illnesses when there is a need for regular follow-ups in the form of increasing number of doctors' consultation over the period. The urban population has a large variable choice of access to both the public and private healthcare services but the rural population has a very few limited options. These facts bring to the light, the gaps in the existing healthcare system in India, where most of the population is paying haphazardly for minor illnesses irrespective of the ability to pay for the access to healthcare facilities where majority of the cost goes into doctors' consultation and there is no regulation on the way doctors are charging the patients

irrespective of the level of training of healthcare professionals and the quality of the care. This disparity needs to be addressed which can be achieved by regulating the doctors consultation fees according to the level of training and quality of care and the willingness to pay for the same, not only in the rural areas where there is paucity of healthcare facilities and increased prevalence of unhealthy individuals to alleviate the unfair way of charging the consultation fees for better accessibility of healthcare services in rural population and similarly a need to assess the willingness to pay for doctors consultation is absolutely necessary in urban areas to regularise the consultation fees to bring-in more accessibility and reduce the burden of healthcare cost on the population where majority of the people still pay out of the pocket. The other reason for obligatory needs for assessing the doctor's consultation fees in case of major illness where frequent doctor's consultations may be required for long term. All this need to be done to bring-in fair policy to charge the patients with optimal and fair consultation fees according to doctor's qualification, quality of care etc. irrespective of whether it is a rural or urban area, for better accessibility of healthcare especially among the low-income population by reducing the disparity and regularising the doctor's consultation fees in lines with the willingness to pay for the same for respective specialists both in rural and urban population.

A study conducted by Brito Fernandes et al. (2020) on Outpatient care experiences found that, the overall willingness to pay for the doctor's consultation fees was directly proportional to the waiting time for the doctor's appointment, waiting time at the outpatient facility, Doctors spending enough time to provide consultation i.e. consultation time and the doctor's explanation of the patient's disease in understandable language. A similar study needs to be conducted in India to assess whether or not the willingness to pay for the

doctor's consultation was dependent on these factors, or if any new factors emerge, which the healthcare policymakers can take note of and intervene to make the doctor's consultation process more conducive and sustainable both for the providers and the patients with an optimal doctor's consultation fees which is both readily acceptable and in turn improves the overall outpatient facility experience. This consensus of reaching the optimal cost by keeping in mind the improvement of overall outpatient visiting experience and actual willingness to pay by the patients for the same services, would enhance the accessibility to healthcare, especially in financially constrained and pocket expense bearers who stand most of the population in a developing country like India.

Mavrodi et al. (2021) conducted a study in Greece to examine the WTP and zero valuations to exclude the unwilling-to-pay individuals categorized as protest responders. The following study results could be an effective method for unbiased WTP responses, which would provide more precise willingness evaluations for policymakers. A computer-assisted interview was adopted to confirm the randomized sampling. The iterative bidding technique was employed to bring out the precise willingness to pay. A pre-established questionnaire was utilized to evaluate the involved participant's attitudes towards spending on healthcare services and, in turn, come up with the willingness to pay. The study results revealed that level of education and household income play an important role, as individuals with a higher level of education and higher income were more willing to pay for healthcare services. The logistic regression method was used to highlight the effect of socio-demographic factors on the WTP intention, providing precise results after the Chi-square test analysed the variance in individuals' attitudes toward willingness to pay. It was also found that participants who believed that, the public sector already provided high-

quality healthcare services were unwilling to pay. Similarly, the inferences from the following study can be implemented in assessing the willingness to pay doctor's consultation fees in a general population to comprehend the willingness to pay on various scales like individuals' annual income, education, occupation, marital status, age, etc. In a country like India, where most of the population is young, and there is a giant economic disparity in the income of the different individuals from urban to rural India, and the implications of such factors on the accessibility of healthcare depend on the willingness to pay. Researchers should conduct a study that includes participants who are unwilling to pay, to understand the reasons behind their reluctance. Such a study would provide us with data that can be used by policymakers to optimize healthcare costs for making healthcare more affordable, which in turn will lead to better accessibility.

2.8 Summary

In the review of literature, the assessment of the existing various studies done in the field of evaluation of the doctor's consultation and the multiplicity of factors associated with it were inferenced. The detailed analysis of the existing studies on the willingness to pay for the doctor's consultation fees was also weighed up along with the diverse factors associated with it and detailed interpretation was explored in context of the study intended to be conducted i.e. Doctor's consultation fees and patients' willingness to pay for the doctor's consultation fees. The gaps and inconsistencies in the existing studies were meticulously scrutinized, along with the new avenues to be explored in this area of study which are summarized as follows-

Doctors' consultation fees:

-The same fact was highlighted by another study where in it was found that in lower-income and middle-income countries the healthcare services utilization is inversely proportional to the doctor's consultation fees, i.e. increase in the doctor's consultation fees led to reduced utilization of healthcare service and vice versa.

-Another study concluded that, there was steep surge in doctors' consultation fees by about 113.9% within 3 years in Malaysia and its direct effect on increase in the overall clinic visit cost. Thus, it becomes utmost important to study these trends in the developing country like India, to analyze whether the doctor's consultation fees are in increasing or decreasing trend in a developing lower-income country like India, where the lower income population would not utilize or opt for doctors' consultation and thus suffer a heavy burden of complications if the disease or ailment is left untreated.

-In other studies, it was observed that, doctors' consultation fees are declining whereas the charges in inpatient and outpatient facilities are steeply increasing.

-Higher ranked doctors were charging up to 90% in excess for the doctors online consultation fees , these trends needs to be studied in India to analyze if all the doctors categorized as high ranked(sub-specialist), middle-ranked(specialist) and lower ranked(general practitioner) are charging the similar amount in their specific categories or whether they are charging higher or lower than their category, analyzing this fact would bring-in insights about the current trends in the doctor's consultation fees and also would bring to the light the facts that needs to be modified for the policy making for bringing in fairness and uniformity in the doctors consultation fees being charged to the patients.

-No regulation in the way doctor's consultation fees is being charged to the patients, irrespective of the level of training of doctors and quality of care being provided to the patients with respect to the amount of doctor's consultation fees.

Willingness to pay for doctors' consultation:

Factors influencing the willingness to pay for the doctor's consultation:

In the review of literature the factors influencing the willingness to pay for doctors consultation was directly dependent on multiple factors, namely-annual income of the patient, household income, level of education, occupational status, gender, marital status, age of the patient (patients aged more than 60 years were more like to pay more in some studies whereas patients who were young were more willing to pay in other studies), awareness of the disease in question, perception of seriousness of the disease, severity of illness, stigma associated with a disease after the diagnosis of a communicable disease, financial support from family members, decreased waiting time for doctor's appointment, decreased waiting time at outpatient facility, doctors total consultation time, doctors explanation of the patients disease in patients understandable language.

After in depth analysis of the various studies available in the database, thus it becomes imperative to study the doctor's consultation fees and the patient's Willingness to pay for the doctor's consultation fees.

CHAPTER III:

METHODOLOGY

"Research Methodology is a systematic way to solve the research Problem. It describes various steps that are generally adopted by the researcher in studying the research problem which includes research approach, research design, schematic representation, Variable, setting, population, sample, sampling technique, sampling criteria, data collection instrument, development, and description of tool" (Polit, 2004).

3.1 Research Objectives

1.To analyze doctors' consultation fees in each specialty of different hospitals, nursing homes and clinics

2.To Measure the Patients' willingness to pay for doctor's consultation fees by using quantitative methods

3.To investigate factors influencing patient's willingness to pay for doctors' consultation fees by using both qualitative and quantitative methods

4.To recommend appropriate suggestions to frame a better healthcare policy

3.2 Research Approach

"Research Approach is a Systemic, Controlled, empirical and critical Investigation of the natural phenomena guided by the theory and hypothesis about presumed relation among the phenomena" (Polit, 2004).

The choice for appropriate approach for the study depends upon the purpose of the study. Based on the objectives of the study, a mixed research approach was adopted for the study

to analyze the doctor's consultation fees and patient willingness to pay for doctor's consultation fees in Bangalore, India.

3.3 Research Design

"The research design refers to the blueprint or overall plan for obtaining answers to the research questions. Research design is a set of logical steps taken by the researcher to assess the research problem." This design is used to observe, describe and document aspects of the situation as it naturally occurs and sometimes to serve as a point for theory development (Polit, 2004). The descriptive research design has been used to attain the objectives of the present study.

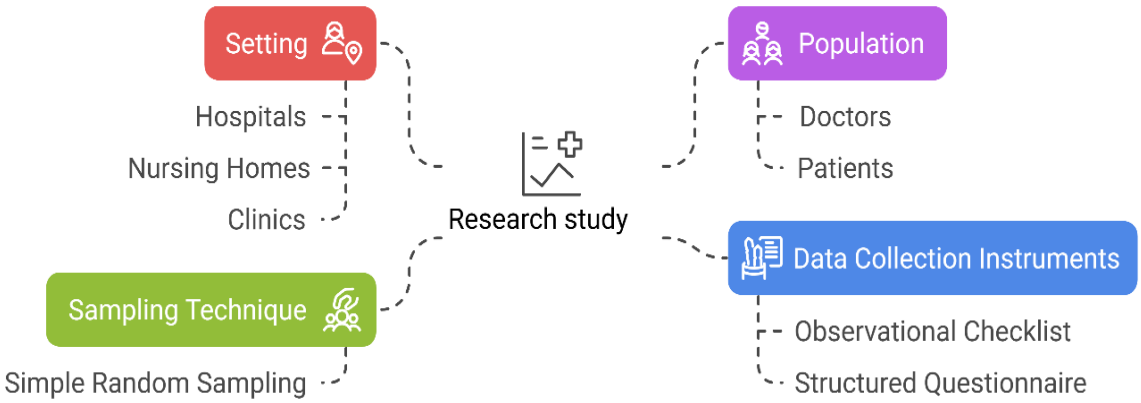

Figure 3.1 Research design of current study (Source: Author's own)

3.4 Study Design

A cross-sectional study design was conducted over a period of 10 months to assess the doctor's consultation fees being charged to the patients in each of the twenty specialties of the different hospitals, nursing homes, and clinics. Along with that, this study includes an analysis of patients' willingness to pay for doctor's consultation fees; this is being studied using quantitative methods and, to investigate factors that influenced the patient's willingness to pay for doctor's consultation fees using qualitative and quantitative methods. The study aims to recommend appropriate suggestions for framing a better healthcare policy, based on the inferences drawn from the data.

3.5 Study Setting

The study was conducted in twenty different specialties of 307 hospitals, nursing homes and clinics in Bangalore, Karnataka, India. Bangalore is a metropolitan area, divided into urban and rural areas, and has five zones- north, south, east, west, and central. Samples for studying doctor's consultation fees and willingness to pay for the doctor's consultation fees were selected from all the fives zones including the rural and urban areas.

3.6 Study population and Sample size

In this study a total of 2300 doctors were included from 20 specialties, in which 115 doctors from each of the 20 specialties were included in this study amounted to a total number of 2300 doctors. In the same geographical area, a total of 385 patients were selected who were visiting the hospital, nursing homes and clinics. Sample size was established by using the software by keeping in mind 5% of margin error and confidence level 95% which

amounted to a total sample size of 385 patients who were incorporated in the study to understand the willingness to pay for doctor's consultation fees in twenty different specialties which included General Practitioner, Psychiatry, Cardiology, Neurology, Orthopedics, Obstetrics and Gynecology, Internal Medicine, Pediatrics, Dermatology, Ophthalmology, Otorhinolaryngology, Dentistry, Nephrology, Urology, Gastroenterology, General Surgery, Plastic Surgery, Oncology, Neurosurgery, Pulmonology.

3.7 Sampling Technique and Participant Selection

Sampling is the process of selecting a portion of the population to represent the entire population, and in this study, 2300 doctors and 385 patients were selected by simple random sampling and convenience sampling, respectively. A simple random sampling technique was used to represent the doctors of twenty different specialties of the hospital, nursing homes, and clinics, whereas a convenience sampling technique was used based on the availability and readiness of the respondents, i.e. patients.

The sample were selected with the following predetermined set of criteria:

a) Inclusion criteria

-Patients in the age Group above 18 years were included in the study residing in Bangalore.

-Doctors from twenty different specialties (General Practitioner, Psychiatry, Cardiology, Neurology, Orthopedics, Obstetrics and Gynecology, Internal Medicine, Pediatrics, Dermatology, Ophthalmology, Otorhinolaryngology, Dentistry, Nephrology, Urology, Gastroenterology, General Surgery, Plastic Surgery, Oncology, Neurosurgery, Pulmonology) working in various Hospitals, Clinics and Nursing homes in Bangalore, Karnataka, India.

b) Exclusion criteria

-Patients falling under the age Group below 18 years were excluded from the study.

-Patients living in other part of Karnataka were excluded from the study.

3.8 Instrumentation and Description of the Tool

The tool consists of

Section I: Observational checklist was used to analyze doctor's consultation fees in each of the twenty different specialties of different hospitals, nursing homes and clinics. The data collection instruments had parameters like consultation charges, doctor's experience, qualification, and gender of the doctor. The doctor's qualification was further divided in to three sub-groups general practitioner, specialist and sub-specialist as depicted in (Table 3.1)

Table 3.1 Division of twenty specialties into three categories (source: Author's own)

General Practitioner	Specialist (MD/MS)	Subspecialist (MD/MS plus Specialization)
General Practitioner	Pediatrics	Cardiology
	Obstetrics and Gynecology	Neurology
	Otorhinolaryngology	Urology
	Orthopedics	Gastroenterology
	Dermatology	Oncology
	Psychiatry	Neurosurgery
	General surgery	Pulmonology
	Ophthalmology	Plastic Surgery
	Internal medicine	Nephrology
	Dentistry	n/a

Section II: A structured questionnaire was constructed which was divided into four sections i.e. Socio-demographic profile of respondents, health status of the respondents, respondents' behavior for willingness to pay for doctor's consultation and willingness to pay for doctors' consultation. Following are the contents of each section.

Part A: Socio-demographic profile of respondents

Respondents were inquired about the area of residence- whether they are residing in urban or rural area.

Age: respondents were asked about their age in years, to make the data collection of age systematic, age was divided into four options 18-25, 25-34,35-44, 45-54 and >55 years of age.

Gender: respondents' gender was marked according to three options namely male, female and others.

Marital status: respondents were asked about the marital status which included 5 options namely single, married, widowed, separated, and divorced.

Family type: respondents were asked whether they stay in a nuclear or joint family.

Household size: respondents were asked about the household size which means the numbers of members staying at respondents' residence, respondents were provided with four options like Upto 4 members, 5 to 8 members, 9 to 12 members and 13 and above members.

Educational qualification: to know the exact level of respondents' educational qualification seven options were chalked out to represent the respondent's education level which

includes illiterate, vocational training, elementary school, higher secondary, graduate and post graduate.

Occupation of the respondent: respondents' occupational status was assessed by using seven options namely self-employed, private service, government service, retired, unemployed, daily wage, student, housewife.

Monthly Household income: respondents were asked about their monthly income amounted in the form of Indian rupees, income was further divided into six options like < Rs 20,000, Rs 20,001 to Rs 40,000, Rs 40,001 to Rs 60,000, Rs 60,001 to Rs 80,000, Rs 80,001 to Rs 100,000 and > Rs 1,00,000.

Part B: Health status of the respondents.

Health insurance: respondents were asked whether they had health insurance or not and were asked to respond in the form of yes or no.

Reason for not having insurance: in case respondents did not have any health insurance, they were asked about the reason for not having insurance by using five options/reasons which includes-not aware, financial constraints, no commensurate benefits, costly premium, not required.

Illness/disease: respondents were asked if they had any underlying illness or disease currently and were asked to respond in the form of yes or no.

Name of the in case of illness/disease present: If the respondents had any disease or illness, they were asked about the name of the disease they were suffering from.

History of hospitalization: respondents were asked if they had been hospitalized over the last one year and were asked to respond the question with of two options- yes or no.

Any doctor's consultation in last one year: respondents were asked if they had consulted any doctor for any ailment in the last one year and were asked to respond in the form of yes or no.

Number of doctors consultation: if the respondent had visited any doctor for consultation in the last one year, they were asked about the number of doctors consultation in the last one year, they were provided with four options <2 times, 3 to 6 times, 7 to 10 times, and 11 to 14 times.

Reason for the doctor consultation with last year: if any of the respondent has consulted a doctor in the last one year, they were asked about the reason for the consultation with doctor, the reasons were divided into 3 options, namely health screening, curative, or rehabilitation.

Self-rating of the health status: the respondents were asked about their health status by asking them how do they feel about their health status and asked to choose one out of five options provided to them- excellent, good, average, poor, very poor.

Part C: Respondents behavior for willingness to pay for doctors' Consultation

Preference of type of health care center: respondents were asked about their preferred choice of type of healthcare center for doctors' consultation and were provided with five options of types of healthcare centers, namely-private hospital, government hospital, clinic visit, nursing homes and online consultation.

Source of information for choosing a doctor: respondents were asked about the source of information which stimulated them to choose a particular doctor for consultation and were provided with four options to choose from for the source of information for choosing a

doctor, namely-physician referral, friends and family experiences, word of mouth, advertisements.

Consideration of doctors age before consultation: the respondents were asked if they would consider the doctors age before choosing a doctor for consultation and were asked to respond in the form of yes or no, which would provide us an insight as to whether respondents would consider a young aged doctor or an old experienced doctor for consultation.

Basis of payment towards doctors' consultation fees: respondents were asked for the basis or reason for consideration of making either a lower or a higher payment towards doctors' consultation. The basis or reason was divided into seven options, namely-specialization of the doctor, age and experience of the doctor, adequate time spent with the doctor, quality of diagnosis, physical appearance of the doctor and location of the doctor.

Part D: Willingness to pay for doctor's consultation

Willing to pay towards doctors' consultation: in this question respondents were asked whether they are willing to pay any fees towards doctors' consultation or not altogether. Their response was marked either in the form of yes or no.

Reason for not willing to pay for doctor consultation: in case if the respondents were not willing to pay any amount of fees towards doctor consultation, five types of options were provided to the respondents to chalk out the specific reason for unwillingness to pay any amount of money towards doctors' consultation fees were asked. The options include- free of charges to see general practitioner, prefer to pay through taxes, cannot afford to pay current doctors' fees, should have a pay later option, and others.

For the respondents who were willing to pay for the doctor's consultation fees were provided with the options of amounts in Indian rupees to choose from. Doctors from twenty departments working in the hospitals, nursing homes and clinics working in the Bangalore region were subdivided into three categories, namely-general practitioner, specialist, and a sub-specialist. The respondents were then asked for the willingness to pay for each subdivided category of doctors specifically.

Willingness to pay towards doctors' consultation fees for a general practitioner: respondents were asked for fees willing to pay in Indian rupees towards doctors' consultation for a general practitioner and were provided with five options namely- <250 rupees, 251 to 500 rupees, 501 to 750 rupees, 751 to 1000 rupees, 1001 to 1250 rupees, 1251 to 1500 rupees and >1500 rupees. A bidding method was used, where in the respondent was asked first to choose an appropriate option of what they feel would be the optimal amount for doctors' consultation fees towards general practitioner and then they were questioned and reassessed if they were willing to pay a bit higher or lower amount than what they have considered appropriate and conclusion was arrived.

Willingness to pay towards doctors' consultation fees for a specialist: respondents were asked for fees willing to pay in Indian rupees towards doctors' consultation for a specialist (doctors for departments of Pediatrics, Gynecology, Otorhinolaryngology, Orthopedics, Dermatology, Psychiatry, General Surgery, Ophthalmology, Internal Medicine, and Dentistry) and were provided with five options namely- <250 rupees, 251 to 500 rupees, 501 to 750 rupees, 751 to 1000 rupees, 1001 to 1250 rupees, 1251 to 1500 rupees and >1500 rupees. A bidding method was used, where in the respondent was asked first to choose an appropriate option of what they feel would be the optimal amount for doctors'

consultation fees towards a specialist, and then they were questioned and re-assessed if they were willing to pay a bit higher or lower amount than what they have considered appropriate and conclusion was arrived.

Willingness to pay towards doctors' consultation fees for a sub-specialist : respondents were asked for fees willing to pay in Indian rupees towards doctors' consultation for a sub-specialist(doctors from the department of Cardiology, Neurology, Nephrology, Urology, Gastroenterology, Oncology, Neurosurgery, Pulmonology and Plastic Surgery) and were provided with five options namely- <250 rupees, 251 to 500 rupees, 501 to 750 rupees, 751 to 1000 rupees, 1001 to 1250 rupees, 1251 to 1500 rupees and >1500 rupees. A bidding method was used, where in the respondent was asked first to choose an appropriate option of what they feel would be the optimal amount for doctors' consultation fees towards a sub-specialist, and then they were questioned and re-assessed if they were willing to pay a bit higher or lower amount than what they have considered appropriate and conclusion was arrived.

3.9 Content Validity

To establish content validity of the tool, the tool was given to 2 experts in the field of health economics. The modifications were made based on suggestions and recommendation given by the experts and the mentor.

3.10 Data Collection Procedures

A. A retrospective method was adopted using a structured observational checklist to collect the data of doctor's consultation fees maintained in the records of various administrative

departments of hospitals, nursing homes, and clinics related to doctor's consultation fees in 20 specialties of 307 hospitals, Nursing homes and clinics.

B. A structured questionnaire was prepared after a meticulous analysis which was divided into 4 parameters like Socio-demographic profile of respondents, health status of the respondents, respondents' behavior for willingness to pay for doctor's consultation and factors influencing them. This well-prepared structured questionnaire was utilized to conduct an in-person interview to measure the patient's willingness to pay for doctor's consultation fees, health status of the respondents, respondents' behavior for willingness to pay for doctor's consultation and willingness to pay for doctors' consultation. Prior to the data collection of respondents included in the part of the study were explained regarding the purpose of the study and informed consent was taken.

Prior to the data collection, respondents were explained regarding the purpose of the study and informed consent was taken. Confidentiality was assured to all the respondents to get their full co-operation for the study. The time taken for the in-person interview of each patient was approximately 30 minutes. To measure the willingness to pay for doctor's consultation, the specialties were divided according to the hierarchy like general practitioner, specialist, and a subspecialist. A bidding method was introduced for each of the respondents where bidding amount was fixed in different ranges varying from Rs 250, Rs 251 to Rs 500, Rs 501 to Rs 750, Rs 751 to Rs 1000, Rs 1001 to Rs 1250, Rs 1251 to Rs 1500 and more than Rs 1500, these amounts were concluded after considering the existing current doctors consultation fees. The Contingent valuation method was adopted with a bidding game for patients' willingness to pay.

3.11 Ethical Considerations

The written consent was taken from each respondent and data confidentiality was maintained.

3.12 Data Analysis

The collected data was tabulated and analyzed using SPSS 30.0 version software. The descriptive statistics such as maximum, minimum, mean, median standard deviation was used to analyzed doctor's consultation fees in the study. Further, Chi-square test and regression analysis were used to assess the factor's influencing patient's willingness to pay.

3.13 Research Design Limitations

1. A bigger sample could be used, even though the sample size used in this study was big enough to draw a conclusion using statistical analysis to represent and include a larger part of the population.
2. Although the questionnaire was kept concise and comprehensive enough to draw conclusions pertaining to the study, keeping in mind that, it should not be exhaustive. Certain important factors might have been overlooked while preparing a questionnaire, which may have additionally influenced the patient's willingness to pay for doctors' consultation.

CHAPTER IV:

RESULTS

4.1 Analysis of Doctors' Consultation Fees in Each Specialty of Different Hospitals, Nursing Homes and Clinics

The study was conducted in twenty different specialties of 307 hospitals, nursing homes and clinics in Bangalore, Karnataka, India. A total of 2300 doctors were included in this study in which 115 doctors from each of the 20 specialities (General Practitioner, Psychiatry, Cardiology, Neurology, Orthopedics, Obstetrics and Gynecology, Internal Medicine, Pediatrics, Dermatology, Ophthalmology, Otorhinolaryngology, Dentistry, Nephrology, Urology, Gastroenterology, General Surgery, Plastic Surgery, Oncology, Neurosurgery and Pulmonology) were taken as a part of the study to assess the doctor's consultation fees. In the same geographical area to assess the willingness to pay for doctor's consultation fees, a total of 385 patients were incorporated in the study who were visiting the hospital, nursing homes, and clinics.

I. Demography of doctors'

In this study a total number of 2300 doctors were included, out of which 1644 were male doctors and 656 were female doctors (Figure 4.1). Evaluation of percentage-wise gender distribution revealed the values to be 71.5% and 28.5% for male and female doctors respectively.

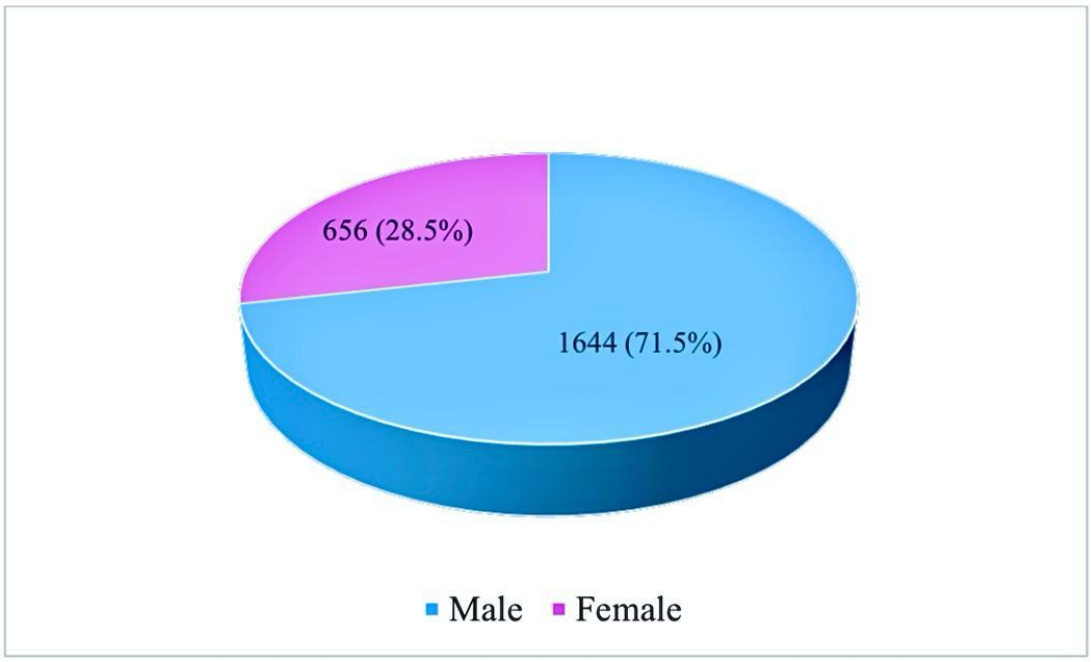

Figure 4.1 Gender Distribution of the doctors in each specialty (Source: Author's own)

Out of 2300 doctors included in the study, there were 230 (10%) doctors who had experience of less than 5 years; most of them, i.e., 617 (26.8%) doctors, had experience of 5–10 years. 407 (17.7%) doctors had experience ranging from 10 to15 years. 381 (16.6%) doctors, 269 (11.7%) doctors, and 178 (7.7%) doctors were having 15-20 years, 20 to 25 years, and 25 to 30 years, respectively. About 9.5% (218) doctors had an experience of more than 30 years of experience in their specialty. Most doctors fall under the experience group of having 5 to10 years of experience in their respective speciality (Figure 4.2).

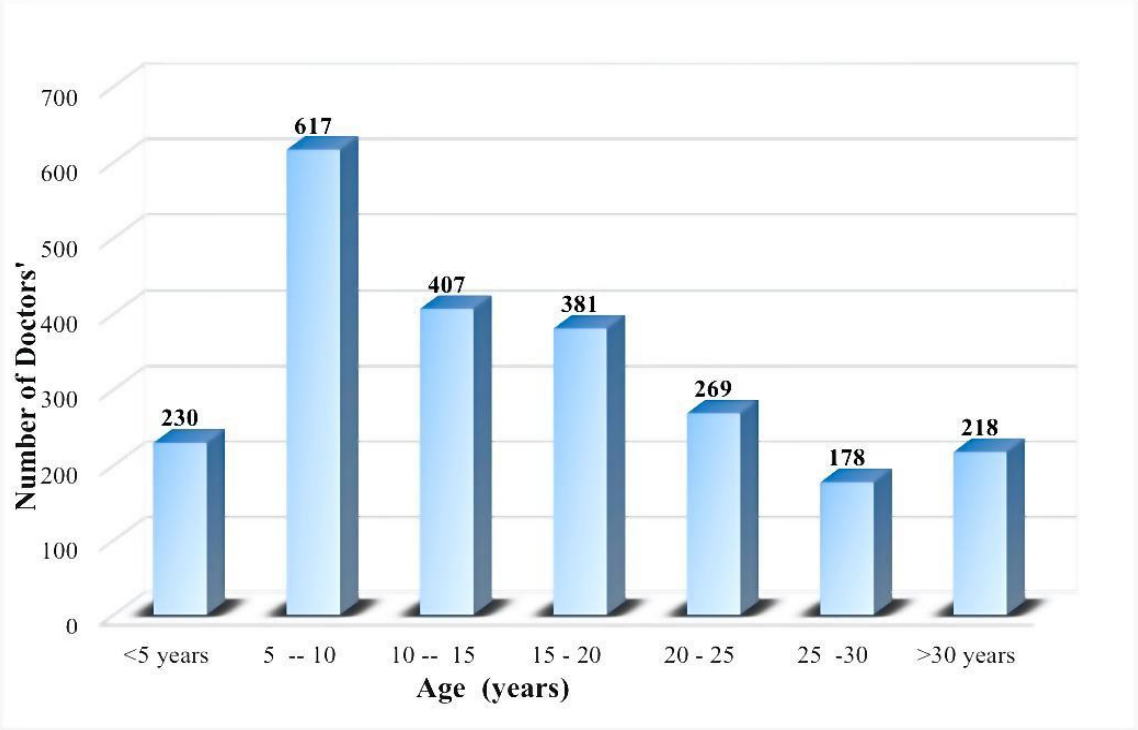

Figure 4.2 Experience of the doctor's in various specialties (Source: Author's own)

II. Analysis of doctors' consultation in each specialty

Table 4.1 Shows the analysis of doctors' consultation in all the twenty specialties using mean, standard deviation, minimum and maximum value in Rupees (Rs). It was observed that the minimum and maximum values for each specialty like cardiology(Rs 750-3000) , dentistry(Rs 200-1500), dermatology(Rs750-2500), otorhinolaryngology(Rs 650-2500), gastroenterology(Rs 650-2000), general practitioner(Rs 400-1600), general surgery(Rs 750-2000), gynecology(Rs 650-3000), internal medicine(Rs 600-3000), nephrology(Rs 650-2500), neurology(Rs 750-3500), neurosurgery(Rs 750-3000), oncology(Rs 700-3000), ophthalmology(Rs 500-2500), orthopedics(Rs 500-3000), pediatrics(Rs 700-3000), plastic surgery(Rs 400-2550), psychiatry(Rs 900-4000), pulmonology(Rs 600-3000), and urology(Rs 600-2500).

Table 4.1 Analysis of doctor's consultation fees in each specialty (Source: Author's own)

Descriptive Statistics								
Specialty	Min. (Rs)	Max. (Rs)	Mean	Std. Deviation	Skewness		Kurtosis	
Cardiology	750	3000	1316.1	442.7	1.475	0.226	2.613	0.447
Dentistry	200	1500	935.2	215.4	0.319	0.226	2.449	0.447
Dermatology	750	2500	1125.2	310.2	2.315	0.226	5.423	0.447
Otorhinolaryngology	650	2500	1190.0	356.5	0.976	0.226	0.621	0.447
Gastroenterology	650	2000	1245.2	426.0	1.041	0.226	-0.614	0.447
General Practitioner	400	1600	885.7	208.6	0.704	0.226	1.797	0.447
General Surgery	750	2000	1218.3	281.1	0.851	0.226	0.520	0.447
Gynecology	650	3000	1397.0	486.6	1.031	0.226	0.480	0.447
Internal Medicine	600	3000	1113.9	391.2	2.565	0.226	8.013	0.447
Nephrology	650	2500	1106.5	348.0	2.103	0.226	5.354	0.447
Neurology	750	3500	1228.2	402.2	2.383	0.226	9.001	0.447
Neurosurgery	750	3000	1157.4	366.3	2.419	0.226	6.920	0.447
Oncology	700	3000	1315.6	449.7	1.121	0.226	0.853	0.447
Ophthalmology	500	2500	1103.5	241.0	1.875	0.226	11.035	0.447
Orthopedics	500	3000	1302.6	420.5	1.553	0.226	3.890	0.447
Pediatrics	700	3000	1185.7	426.0	2.278	0.226	6.104	0.447
Plastic Surgery	400	2550	1017.9	273.2	2.485	0.226	10.090	0.447
Psychiatry	900	4000	1507.8	466.0	2.185	0.226	7.782	0.447
Pulmonology	600	3000	1158.7	345.0	2.079	0.226	7.196	0.447
Urology	600	2500	1164.8	356.8	1.772	0.226	3.740	0.447

SD- Standard Deviation; Max- Maximum, Min-Minimum

Table 4.2 Test of Normality (source: Author's Own)

Specialty		Kolmogorov-Smirnov			Shapiro-Wilk		
		Statistic	**df**	**p-value**	**Statistic**	**df**	**p-value**
Pediatrics	Consultation Charges (Rs).	.251	115	.000	.739	115	.000
Gynecology		.196	115	.000	.890	115	.000
ENT		.277	115	.000	.882	115	.000
Cardiology		.215	115	.000	.835	115	.000
Orthopedics		.175	115	.000	.834	115	.000
Dermatology		.292	115	.000	.665	115	.000
Psychiatry		.298	115	.000	.779	115	.000
Neurology		.263	115	.000	.754	115	.000
General Surgery		.187	115	.000	.865	115	.000
Ophthalmology		.292	115	.000	.753	115	.000
Nephrology		.281	115	.000	.757	115	.000
General Practitioner		.170	115	.000	.932	115	.000
Urology		.347	115	.000	.753	115	.000
Gastroenterology		.335	115	.000	.720	115	.000
Internal Medicine		.336	115	.000	.704	115	.000
Dentistry		.226	115	.000	.852	115	.000
Oncology		.223	115	.000	.841	115	.000
Neurosurgery		.318	115	.000	.700	115	.000
Pulmonology		.218	115	.000	.810	115	.000
Plastic Surgery		.404	115	.000	.682	115	.000

Table 4.2 reveals the results of two statistical tests used to assess the normality of data distribution for consultation charges (in Rs.) within various specialties. The two tests performed are the Kolmogorov-Smirnov test and the Shapiro-Wilk test. In both the Kolmogorov-Smirnov and Shapiro-Wilk tests, the null hypothesis is that the data follows a normal distribution. The p-values for all the specialties are extremely small ($p < 0.0001$), indicating that the data significantly deviates from a normal distribution. In other words, the data for consultation fees within the specialties is not normally distributed.

According to the Kolmogorov-Smirnov test results there is significant diversity in mean consultation fees among various specialties. It was found that psychiatry had the highest average consultation fee at (Rs 1507 ± SD 466.0), followed by gynecology (Rs 1397 ± SD 486.5), cardiology (Rs 1316 ± SD 442.7), and oncology (Rs 1315 ± SD 449.6). General practitioners had the lowest fees, averaging (Rs 885.6 ± SD 208.5), followed by dentistry at (Rs 935.2 ± SD 215.4), and plastic Surgery at (Rs 1017 ± SD 273.2).

In contrast, specialties such as general practitioners SD (Rs 208.5) and dentistry SD (Rs 215.4) exhibit reduced fluctuation, signifying more uniform pricing.

Table 4.3 Kruskal-Wallis Test (Source: Author's own)

Departments	N	Mean Rank	Kruskal-Wallis H	df	Sig.
Cardiology	115	1390.36	405.924	19.000	0.000
Dentistry	115	626.57			
Dermatology	115	1119.52			
ENT	115	1157.11			
Gastroenterology	115	1201.36			
General Practitioner	115	515.08			
General Surgery	115	1353.45			
Gynecology	115	1479.65			
Internal Medicine	115	973.47			
Nephrology	115	983.54			
Neurology	115	1215.19			
Neurosurgery	115	1098.00			
Oncology	115	1345.62			
Ophthalmology	115	1149.08			
Orthopedics	115	1412.99			
Pediatrics	115	1127.05			
Plastic Surgery	115	833.17			
Psychiatry	115	1714.41			
Pulmonology	115	1181.30			
Urology	115	1133.09			
Total	2300				

The Kruskal-Wallis H test results demonstrated (Table 4.3) a statistically significant disparity in consultation fees within different specialties ($H = 405.924$, $df = 19$, $p = 0.000$). Among twenty different specialties, psychiatry exhibited the highest mean rank (1714.41), indicating that consultation fees for psychiatric services were costliest followed by consultation fees of gynecology (1479.65), orthopedics (1412.99), and cardiology (1390.36). Conversely, general Practitioners (515.08) and dentistry (626.57) exhibited the lowest mean ranks, signifying lesser consultation fees.

III. Analysis of doctors' consultation after sub-division into categories

Twenty different specialties were further divided into three categories according to the level of qualifications. They are namely Specialist who had MBBS+MD/MS (i.e. Pediatrics, Gynecology, Otorhinolaryngology, Orthopedics, Dermatology, Psychiatry, General Surgery, Ophthalmology, Internal Medicine, and Dentistry), Sub-specialist MBBS+MD/MS + Specialization (i.e. Cardiology, Neurology, Nephrology, Urology, Gastroenterology, Oncology, Neurosurgery, Pulmonology and Plastic surgery) and general practitioner who has a qualification of MBBS. Out of the 2300 doctors, 1150(50%) are specialist and 1035(45%) were sub-specialist and only 5% (115) were general practitioners (Figure 4.3).

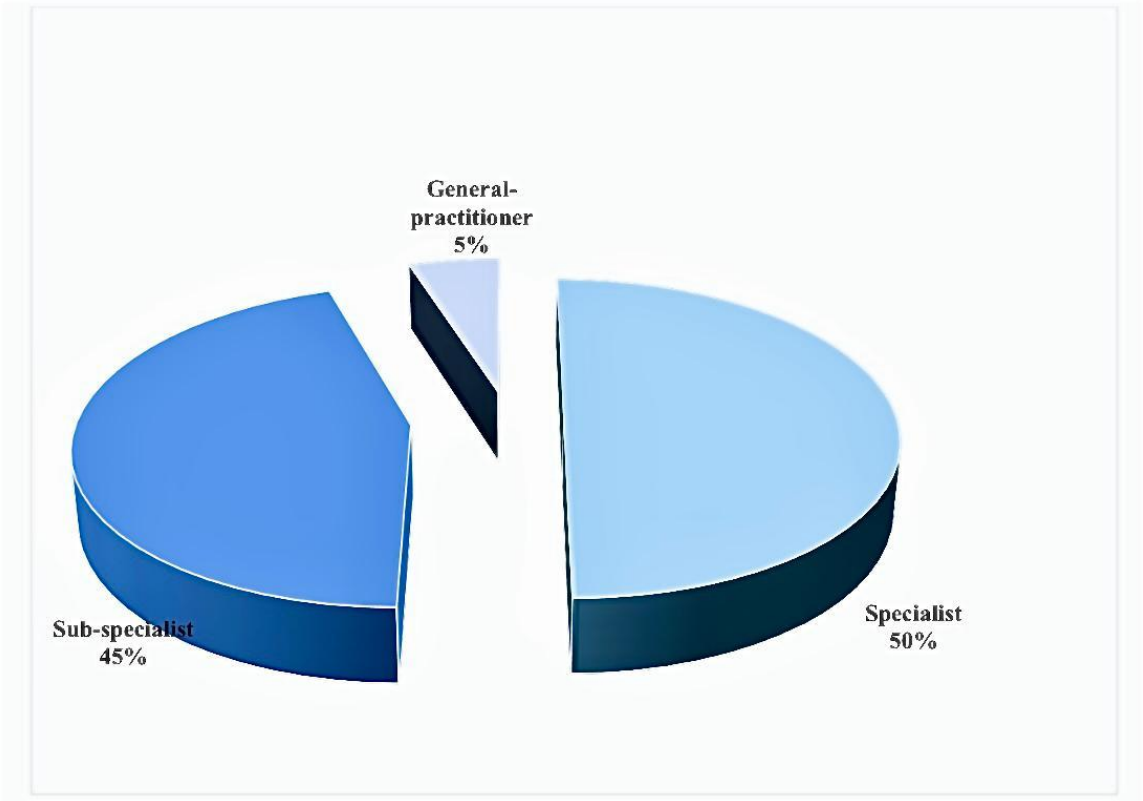

Figure 4.3 Distribution of specialties (Source: Author's own)

The divided three categories of doctors were analyzed by using mean, standard deviation, and minimum-maximum values of doctor's consultation. It was found that mean consultation fees (Figure 4.4) were highest for the specialist (Rs.1207.91) as compared to sub-specialist (Rs.1190.04), and the least was with general practitioner (Rs.885.65). Subsequently, the minimum and maximum values for consultation fees of specialist, sub-specialist and general practitioner were found to be Rs (200-4000), Rs (400-3500) and Rs (400-1600) respectively (Table 4.4). By applying One way ANOVA (Fishers F test) it was revealed that the comparison among the doctors was found to be very highly significant ($p<0.001$).

Table 4.4 Specialty-wise doctors' consultation fee (Source: Author's own)

Doctors' categories	N	Mean	Std. Deviation	Minimum (In Rupees)	Maximum (In Rupees)
Specialist	1150	1207.91	399.753	200	4000
Sub-specialist	1035	1190.04	391.997	400	3500
General practitioner	115	885.65	208.563	400	1600

F=36.133 p<0.001 vhs

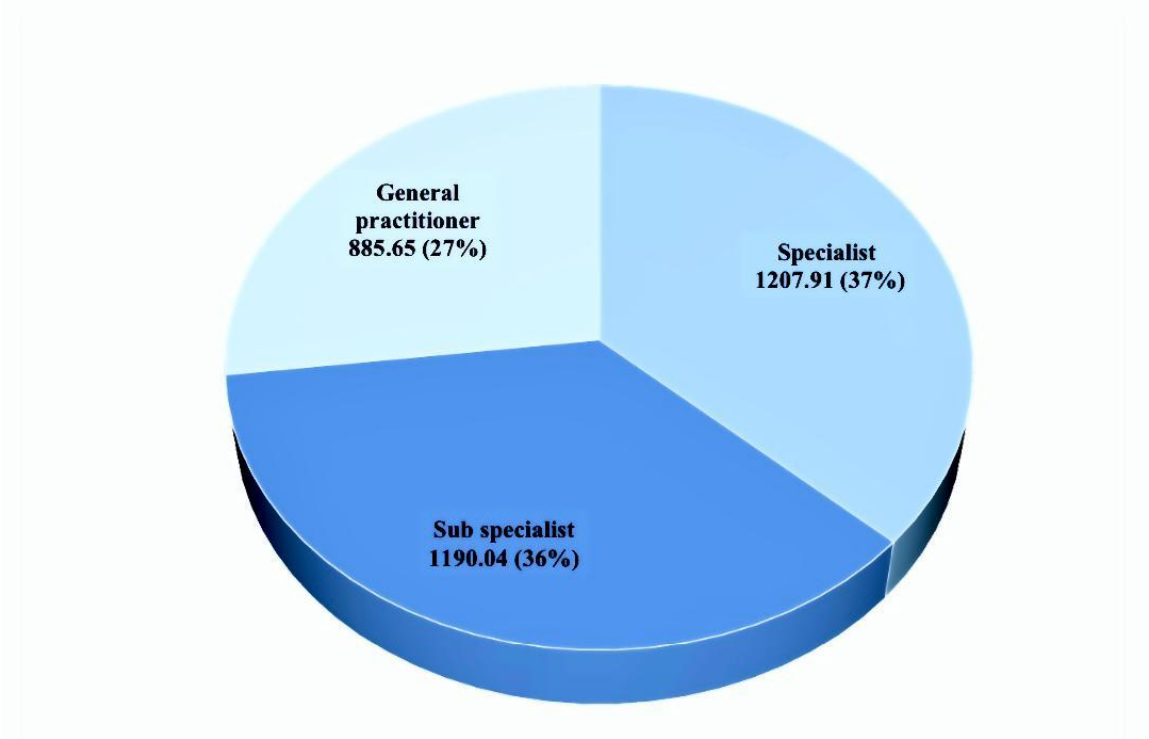

Figure 4.4 Mean value of Doctor's Consultation (Source: Author's own)

An analysis between doctors' consultation fees across categories (specialist, sub-specialist, and general practitioner) and levels of experience uncovers notable trends. The data indicates (Table 4.5) that specialists and sub-specialists routinely charge greater

consultation fees than general practitioners. The disparities in consultation fees among the three categories (specialists, sub-specialists, and general practitioners) are statistically significant for doctors with fewer than 30 years of experience ($p < 0.05$). For doctors' with over 30 years of experience, the variation in consultation fees is statistically insignificant ($p = 0.124$), suggesting that experience ceases to significantly influence the amount of consultation fees determination at this juncture.

Among the doctors with fewer than 5 years of experience, sub-specialists charge the highest average consultation fees (Rs 1203.30), closely followed by specialists (Rs 1132.22), while general practitioners charge the lowest (Rs 557.14). This pattern persists throughout several expertise levels, with specialists and sub-specialists upholding comparatively high consultation fees, although general practitioners charged least consultation fees.

Specialists with 5-10 years of expertise levy an average consultation fee of Rs 1202.40, sub-specialists Rs1164.23, while general practitioners levy Rs 921.74. The disparity in consultation fees is statistically significant ($p = 0.001$). In the 10-15 years' experience category, specialist charge the highest fees of Rs 1242.05, followed by sub-specialists Rs 1144.89 and general practitioners charge the least at Rs 883.33. The disparity in fees persists markedly ($p = 0.001$).

Further, specialists with 15-20 years of experience charge the highest fees (Rs 1222.54), followed by sub-specialists (Rs 1163.91) and general practitioners the least (Rs 902.63), with the differences remaining statistically significant ($p = 0.002$). The trend persists in the 20-25 years of experience category, with specialists levying (Rs 1207.92), sub-specialists (Rs 1180.38), and general practitioners charging the least (Rs 844.44). Nonetheless, after

25 years of expertise, the disparity in consultation fees begins to diminish. At the expertise level of 25-30 years, specialists charge (Rs 1241.25), sub-specialists charge (Rs 1289.08), and general practitioners charge the least (Rs 872.73); however, the significance level decreases ($p = 0.021$).

Following three decades of experience, the disparity in consultation fees among specialists (Rs 1206.99), sub-specialists (Rs 1289.11), and general practitioners (Rs 1046.15) is no longer statistically significant ($p = 0.124$). This suggests that after thirty years of practice, consultation fees reached a steady state.

The data indicates that experience substantially affects consultation fees during the early and mid-career phases, with specialists and sub-specialists charging the highest. Conversely, after 30 years of experience, consultation fees seem to reach a steady state across all categories.

Table 4.5 Comparison of Doctors consultation fee among the different category of specialties experience-wise (Source: Author's own)

Experience	**category of specialties**	**N**	**Consultation fees (Mean)**	**Std. Deviation**	**F**	**p**
<5 years	Specialist	135	1132.22	282.676	15.285	.001***
	Sub-specialist	88	1203.30	328.461		
	General Practitioner	7	557.14	198.806		
5-10 years	Specialist	334	1202.40	373.837	6.926	.001***
	Sub-specialist	260	1164.23	343.288		
	General Practitioner	23	921.74	185.758		
10-15 years	Specialist	195	1242.05	455.296	10.121	.001***
	Sub-specialist	188	1144.89	334.702		
	General Practitioner	24	883.33	143.456		
15-20 years	Specialist	193	1222.54	441.644	6.089	.002**
	Sub-specialist	169	1163.91	342.042		
	General Practitioner	19	902.63	160.272		

20-25 years	Specialist	120	1207.92	416.064	6.358	.002**
	Sub-specialist	131	1180.38	419.345		
	General Practitioner	18	844.44	144.394		
25-30 years	Specialist	80	1241.25	426.628	3.960	.021*
	Sub-specialist	87	1289.08	513.109		
	General Practitioner	11	872.73	196.677		
>30 years	Specialist	93	1206.99	369.826	2.104	.124
	Sub-specialist	112	1289.11	521.770		
	General Practitioner	13	1046.15	306.500		

*Significant **Highly significant *** Very highly significant

- Test applied: ANOVA-Fishers F-test

4.2 Willingness to Pay for Doctors' Consultation Fees: Patient Perspectives and Influencing Factors

This is a cross-sectional study, where an attempt is being made to discover the patient's willingness to pay towards doctors' consultation fees and the associated factors influencing the willingness to pay for the doctors' consultation fees using quantitative and qualitative techniques. It is belief of the researcher, that studying this subject matter can bring about a revolutionary change in the field of health care where currently doctors' consultation fees are being charged haphazardly supported by the present study and by assessing the actual willingness to pay for the doctors' consultation by the patients there will be fair, unbiased, and equitable compensation for the patients seeking healthcare service, by enforcing the findings of this study by policy makers.

I. Socio-demographic characteristics of respondents

Table 4.6 revealed the demographic characteristics of respondents(patients), a total of 385 patients were included in the study. Majority 198(51.4%) of the respondents reside in urban areas, while 187(48.6%) live in rural areas. Most individuals fell into the age categories of 35-44 (34.8%) followed by the age group 25-34 (22.3%). The other age groups, including <25 (5.7%), 45-54 (19.5%), and >55 (17.7%), make up the rest of the sample. Most of the respondents (58.7%) were male and, (36.9%) were female, and 4.4% fell into the "Others" category. The majority (58.2%) were married, while other categories include single (21.3%), widowed (9.1%), separated (3.9%), and divorced (7.5%). The majority (58.4%) were in nuclear families, while (41.6%) stayed in joint families. When number of households were considered, the largest group (33.8%) had up to 4 members, followed by 5 to 8 members (27.3%), 9 to 12 members (33.2%), and 13 and above members (5.7%). The highest proportion holds postgraduate degrees (31.4%), followed by graduates (17.4%), and vocational training (18.4%). Additionally, some individuals had lower or no qualifications, which included illiterate (9.1%), elementary school (6.5%), high school (5.2%), and higher secondary (11.9%). The most common occupation was into private service (33.5%), followed by self-employed/business (23.1%) and government service (21.0%). The study population also included retired individuals (8.3%), unemployed (4.7%), daily wage/unskilled workers (6.0%), and students (3.4%). Most households fell in the monthly income range of Rs 60,001-80,000 (24.4%) and Rs 80,001-1,00,000 (22.3%). There were also households in other income brackets, including < Rs 20,000 (9.1%), Rs 20,001-40,000 (11.7%), Rs 40,001-60,000 (13.2%), and > Rs 1,00,000 (19.2%).

Table 4.6 Demographic characteristics of respondents (n=385) (Source: Author's own)

Demographic characteristics	**Frequency (%)**
Area of residence	
Urban	198 (51.4)
Rural	187 (48.6)
Age (In years)	
<25	22 (5.7)
25-34	86 (22.3)
35-44	134 (34.8)
45-54	75 (19.5)
>55	68 (17.7)
Gender	
Male	226 (58.7)
Female	142 (36.9)
Others	17 (4.4)
Marital Status	
Single	82 (21.3)
Married	224 (58.2)
Widowed	35 (9.1)
Separated	15 (3.9)
Divorced	29 (7.5)
Family type	
Nuclear	225 (58.4)
Joint	160 (41.6)
Household size (in numbers)	
Up to 4	130 (33.8)

5 to 8	105 (27.3)
9 to 12	128 (33.2)
13 and above	22 (5.7)
Educational Qualification	
Illiterate	35 (9.1)
Elementary school	25 (6.5)
High school	20 (5.2)
Higher secondary	46 (11.9)
Graduate	67 (17.4)
Postgraduate	121 (31.4)
Vocational Training	71 (18.4)
Occupation	
Self-employed/Business	89 (23.1)
Private service	129 (33.5)
Government service	81 (21.0)
Retired	32 (8.3)
Unemployed	18 (4.7)
Daily wage/Unskilled worker	23 (6.0)
Student	13 (3.4)
Monthly household income (In Rs.)	
<20,000	35 (9.1)
20,001-40,000	45 (11.7)
40,001-60,000	51 (13.2)
60,001-80,000	74 (19.2)
80,001-1,00,000	94 (24.4)
>1,00,000	86 (22.3)

II. Health status of the respondents

Table 4.7 revealed the health status and healthcare-related information of the respondents. Majority 56.4% of the respondents did not have health insurance while, 43.6% of the respondents had health insurance. Among the respondents who did not have health insurance, the reasons for not having it were, 29.5% found the premium cost to be too high followed by 22.1% respondents having financial constraints preventing them from obtaining health insurance, 21.2% respondents did not see commensurate benefits in having health insurance, 16.1% respondents did not feel it was required for them and 11.1% respondents were not aware of health insurance. Each respondent was asked about their illness history and it was found that, majority (57.1%) of respondents did not have any illness or disease. Whereas, (42.9%) of the respondents had an illness or disease. Among the respondents who had an illness or disease, the specific disease conditions respondents have had (32.1%) diabetes mellitus followed by (25.5%) hypertension, (9.7%) suffered from back pain, (8.5%) anemia, (7.9%) COPD (Chronic obstructive pulmonary disease), (7.9%) suffered from chronic kidney diseases, (4.8%) alopecia and (3.6%) had met with an accident. Most (59.0%) of the respondents were never hospitalized in the last year and 41.0% of the respondents were hospitalized at least once in the last year. Majority 51.4% of the respondents had never consulted a doctor within the last year while, 48.6% of the respondents had consulted a doctor within the last year. Among those who had consulted a doctor in the last year, 45.5% respondents had less than 2 consultations followed by 29.9% respondents who had 3 to 6 consultations, 15.0% respondents had 7 to 10 consultations and 9.6% respondents had 11 to 14 consultations. Among those who had consulted a doctor in

the last year, the reasons for consultation were (49.2%) curative purposes followed by (33.7%) for health Screening and (17.1%) for rehabilitation. When asked about the self-rating of respondents' own health status, 32.2% respondents considered their health status was good, followed by 27.8% respondents who considered it as average, (24.9%) respondents considered their health status as being excellent, (11.2%) considered their health status to be poor and least (3.9%) respondents considered it to be very poor.

Table 4.7 Health status of the respondents (n=385) (Source: Author's own)

Health status of the respondents	**Frequency (%)**
Do you have Health Insurance	
No	217 (56.4)
Yes	168 (43.6)
If No (In question no. 10) specify the reason	
Not aware	24 (11.1)
Financial Constraints	48 (22.1)
No Commensurate Benefits	46 (21.2)
Costly Premium	64 (29.5)
Not Required	35 (16.1)
Do you have any illness/disease	
Yes	165 (42.9)
No	220 (57.1)
If yes (In question no. 12)	
Diabetes Mellitus	53 (32.1)
Hypertension	42 (25.5)
Back Pain	16 (9.7)
Alopecia	8 (4.8)
COPD	13 (7.9)
Anemia	14 (8.5)
Chronic Kidney diseases	13 (7.9)
Accident	6 (3.6)
Have you hospitalized over last year?	
Yes	158 (41.0)
No	227 (59.0)
Have you consult your doctors within last year	

Yes	187 (48.6)
No	198 (51.4)
Number of Doctor's Consultation within last year? if yes (in question no. 15)	
< 2 Times	85 (45.5)
3 to 6 times	56 (29.9)
7 to 10 times	28 (15.0)
11 to 14 times	18 (9.6)
Reason for doctor consultation within last year	
Health Screening	63 (33.7)
Curative	92 (49.2)
Rehabilitation	32 (17.1)
How will you rate your health status	
Excellent	96 (24.9)
Good	124 (32.2)
Average	107 (27.8)
Poor	43 (11.2)
Very Poor	15 (3.9)

IV. Respondents' behavior for willingness to pay for doctor consultation

Table 4.8 presents the respondents preferences, respondents decision-making factors, and considerations when choosing healthcare providers for doctor's consultation. 34.3% of the respondents preferred private hospitals followed by 22.9% of the respondents' preferring clinics, while 17.9% of the respondents preferred government hospitals, 13.5% of the respondents preferred nursing homes and 11.4% of the respondents preferred online consultation. The sources of information for choosing a doctor were found to be, (42.9%) friends and family experiences followed by (25.7%) word of mouth, (25.2%) physician referral and (6.2%) considered advertisements. Majority (66.8%) of the respondents did not consider a doctor's age while (33.2%) of the respondents considered doctor's age while choosing a doctor for treatment. When respondents were further inquired for the basis they

considered while paying a doctor, they were provided an option to select the multiple choices, following are the responses, (79.7%) valued the quality of diagnosis followed by (71.7%) considering the specialization of the doctor, (68.3%) opted the doctor who spent adequate time with them, (61.6%)experience of the doctor, (23.6%) location of the doctor and (7.5%) respondents considered the physical appearance of the doctor while paying a doctor.

Table 4.8 Respondents' behavior for willingness to pay for doctor consultation (n=385) (Source: Author's own)

Respondents' behavior	**Frequency (%)**
Which health care center do you prefer for a doctor's consultation	
Private Hospital	132 (34.3)
Government Hospital	69 (17.9)
Clinic	88 (22.9)
Nursing Home	52 (13.5)
Online Consultation	44 (11.4)
What are your sources of information for choosing a doctor?	
Physician Referral	97 (25.2)
Friends And Family experiences	165 (42.9)
Word Of mouth	99 (25.7)
Advertisements	24 (6.2)
Would you consider a doctor's age when choosing a doctor for treatment?	
Yes	128 (33.2)
No	257 (66.8)
What basis would you like to pay a doctor?	
Specialization of the doctor	276 (71.7)
Experience of the doctor	237 (61.6)
Adequate time spent with doctor	263 (68.3)
Quality of diagnosis	307 (79.7)
Physical appearance of the doctor	29 (7.5)
Location of the doctor	91 (23.6)

V. Assessment of willingness to pay for doctor's consultation

Table 4.9 highlights the respondents' willingness to pay for doctor's consultation fees and their reasons for unwillingness, as well as the specific fee ranges for willing to pay for different types of doctors. Majority of respondents i.e. 275(71.4%) were willing to pay for a doctor's consultation while, 110(28.6%) respondents were not willing to pay for a doctor's consultation. The respondents who were unwilling to pay for doctors' consultation were further asked for the reasons behind unwillingness to pay for doctor's consultation. It was noted that (51.8%) could not afford to pay the current doctor's consultation fees followed by (20.9%) respondents who had opinion that there should be a pay later option, (19.1%) respondents believed doctors' consultation should be free of charges to consult a general practitioner and (8.2%) respondents believed that doctors' consultation to be levied through taxes.

Furthermore, a bidding method was introduced for each of the respondents, where bidding amount was fixed in different ranges for three different categories of doctors namely, general practitioner, specialist and sub-specialist, whose consultation fees were varying from Rs 250, Rs 251 to Rs 500, Rs 501 to Rs 750, Rs 751 to Rs 1000, Rs 1001 to Rs 1250, Rs 1251 to Rs 1500 and more than Rs 1500, these amounts were determined after considering the existing current doctors consultation fees.

Henceforth, respondents were interviewed with the same ranges of consultation in different doctors' categories and respondents feedback for willingness to pay for a consultation with a general practitioner (MBBS) were following, most respondents were willing to pay in the range of Rs 251 to Rs 500 (69.8%) followed by Rs 501 to Rs 750 (15.6%), Rs 751 to Rs 1000 (6.9%), less than Rs 250 (5.8%), Rs 1001 to Rs 1250 (1.1%) and least respondents

(0.7%) were willing to pay for the fee ranges between Rs 1251 to Rs 1500. No respondents were willing to pay >Rs 1500 for a consultation with general practitioner.

Respondents were willing to pay in following fee ranges for consultation with specialists (MD/MS). Majority (73.1%) were willing to pay between Rs 501 to Rs 750 followed by (9.8%) were willing to pay between Rs 751 to Rs 1000, (7.6%) were willing to pay between Rs 251 to Rs 500 and equally (7.6%) respondents were willing to pay between the range Rs 1001 to Rs 1250, (1.1%) were willing to pay between Rs 1251 to Rs 1500 and the least respondents (0.7%) were willing to pay more than Rs 1500. but none of the respondents felt they would be willing to pay a doctor in the fee range of <Rs 250 for consultation with a specialist. Additionally, the feedback of respondents for willingness to pay for consultation fee towards sub-specialists (MD/MS+ Specialization) were as follows, (74.9%) between Rs 751 to Rs 1000 followed by (13.5%) between Rs 501 to Rs 750, (5.1%) between Rs 1001 to Rs 1250, (4.0%) between Rs 1251 to Rs 1500, (1.8%) were willing to pay more than Rs 1500 and (0.7%) were willing to pay between the range of Rs 251 and Rs 500, but none of the respondents felt they would be willing to pay a doctor in the fee range of <Rs 250 for consultation with a sub-specialist.

Table 4.9 Willingness to pay for doctor's consultation (n=385) (Source: Author's own)

	Frequency (%)
Would you be willing to pay for a doctor's consultation fees?	
Yes	275 (71.4)
No	110 (28.6)
If no (in question no. 23) then specifies the reason for unwillingness to pay for doctor's consultation	
Should be free of charges to see general practitioner	21 (19.1)
Prefer to pay through taxes	9 (8.2)

Cannot afford to pay current doctor's fees	57 (51.8)
Should have pay later option	23 (20.9)
Willingness to pay for doctor's consultation fees (General Practitioner - MBBS)	
< 250	16 (5.8)
251 to 500	192 (69.8)
501 to 750	43 (15.6)
751 to 1000	19 (6.9)
1001 to 1250	3 (1.1)
1251 to 1500	2 (0.7)
>1500	0 (0)
Willingness to pay for doctor's consultation fees for Specialist (MD/MS)- i.e., Pediatrics, Gynecology, ENT, Orthopedics, Dermatology, Psychiatry, General Surgery, Ophthalmology, Internal Medicine & Dentistry)	
<250	0 (0)
251 to 500	21 (7.6)
501 to 750	201 (73.1)
751 to 1000	27 (9.8)
1001 to 1250	21 (7.6)
1251 to 1500	3 (1.1)
>1500	2 (0.7)
Willingness to pay for doctor's consultation fees for Sub-specialist (MD/MS+ Specialization) i.e., Cardiology, Neurology, Nephrology, Urology, Gastroenterology, Oncology, Neurosurgery, Pulmonology & Plastic Surgery)	
<250	0 (0)
251 to 500	2 (0.7)
501 to 750	37 (13.5)
751 to 1000	206 (74.9)
1001 to 1250	14 (5.1)
1251 to 1500	11 (4.0)
>1500	5 (1.8)

VI. Association between demographic characteristics and WTP

Table 4.10 unveils the association between demographic characteristics and WTP using chi-square test. There was a statistically significant association (p=0.008*) between the area of residence and WTP. (56.0%) of respondents from urban areas and whereas, (44.0%) of respondents from rural areas were willing to pay. The household size up to 4 members (38.2%) followed by 5 to 8 members (28.7%), 9 to 12 members (27.6%) and 13 and above members (5.5%) were willing to pay for doctor consultation fees. When household size was considered, there was a statistically significant association (p = 0.001*) between household size and WTP. When monthly household income was considered, there was a statistically significant association (p=0.005*). The other variables such as age, gender, marital status, family type, educational qualifications and occupation were found to be insignificant (*p*>0.05).

Table 4.10 Association between demographic characteristics and WTP using chi-square test (Source: Author's own)

Demographic characteristics	**WTP (n=385)**		**p-value**
	Yes (n=275)	**No (n=110)**	
	n (%)		
Area of residence			
Urban	154 (56.0)	44 (40.0)	**0.008***
Rural	121 (44.0)	66 (60.0)	
Age (In years)			
<25	16 (5.8)	6 (5.5)	0.445

25-34	61 (22.2)	25 (22.7)	
35-44	103 (37.5)	31 (28.2)	
45-54	50 (18.2)	25 (22.7)	
>55	45 (16.4)	23 (20.9)	
Gender			
Male	161 (58.5)	65 (59.1)	0.895
Female	101 (36.7)	41 (37.3)	
Others	13 (4.7)	4 (3.6)	
Marital Status			
Single	60 (21.8)	22 (20.0)	
Married	160 (58.2)	64 (58.2)	
Widowed	22 (8.0)	13 (11.8)	0.793
Separated	11 (4.0)	4 (3.6)	
Divorced	22 (8.0)	7 (6.4)	
Family type			
Nuclear	164 (59.6)	61 (55.5)	0.452
Joint	111 (40.4)	49 (44.5)	
Household size (in numbers)			
Up to 4	105 (38.2)	25 (22.7)	
5 to 8	79 (28.7)	26 (23.6)	**0.001***
9 to 12	76 (27.6)	52 (47.3)	
13 and above	15 (5.5)	7 (6.4)	
Educational Qualification			
Illiterate	23 (8.4)	12 (10.9)	
Elementary school	16 (5.8)	9 (8.2)	0.420
High school	17 (6.2)	3 (2.7)	

Higher secondary	31 (11.3)	15 (13.6)	
Graduate	44 (16.0)	23 (20.9)	
Postgraduate	89 (32.4)	32 (29.1)	
Vocational Training	55 (20.0)	16 (14.5)	
Occupation			
Self-employed/Business	69 (25.1)	20 (18.2)	
Private service	93 (33.8)	36 (32.7)	
Government service	51 (18.5)	30 (27.3)	
Retired	21 (7.6)	11 (10.0)	0.076
Unemployed	10 (3.6)	8 (7.3)	
Daily wage/Unskilled worker	19 (6.9)	4 (3.6)	
Student	12 (4.4)	1 (0.9)	
Monthly household income (In Rs.)			
<20,000	32 (11.6)	3 (2.7)	
20,001-40,000	36 (13.1)	9 (8.2)	
40,001-60,000	31 (11.3)	20 (18.2)	**0.005***
60,001-80,000	44 (16.0)	30 (27.3)	
80,001-1,00,000	69 (25.1)	25 (22.7)	
>1,00,000	63 (22.9)	23 (20.9)	

**p<0.05.

VII. Factors influencing WTP and predictor model for WTP

Table 4.11 unearths the logistic regression analysis table showing the results of a statistical analysis of factors influencing respondents' willingness to pay for doctor's consultation fees. It was discovered that, the respondents living in urban areas were less likely to be

willing to pay for a doctor's consultation fee as compared to those staying in rural areas. This difference is statistically significant with a p-value of 0.005.

It was also identified that gender did not have a significant impact on the willingness to pay for doctor's consultation fees. Both females and individuals with other gender identities have odds ratios close to 1, indicating no strong association. Household income had a significant impact on willingness to pay. As the monthly household income increases, individuals are more likely to be willing to pay for doctor's consultation fees. This effect was particularly strong for income brackets between Rs 20,001-Rs 40,000, Rs 40,001-Rs 60,000, Rs 60,001-Rs 80,000, Rs 80,001- Rs 100,000 with p-values of 0.004, 0.002, 0.037, and 0.037 respectively. Having health insurance did not significantly impact the willingness to pay for doctor's consultation fees, as the odds ratio is close to 1. Respondents with illnesses or diseases were less likely to be willing to pay for doctor's consultation fees, and this effect is statistically significant (p-value = 0.004). Respondents who were hospitalized over the last year were less likely to be willing to pay for doctor's consultation fees, and this effect was statistically significant (p-value = 0.024). Respondents who have consulted doctors within the last year are less likely to be willing to pay for doctor's consultation fees, and this effect is statistically significant (p-value = 0.031).

Overall, the logistic regression analysis suggests that several demographic factors, including monthly household income, having an illness or disease, having been hospitalized, and consulting doctors within the last year, have a significant impact on individuals' willingness to pay for doctor's consultation fees. Other factors such as gender, and having health insurance do not appear to have a significant impact on the respondent’s willingness to pay for doctors’ consultation.

Table 4.11 Factors influencing and predictor model for WTP on WTP using logistic regression (linear). (Source: Author's own)

Demographic characteristics	**Willing to pay for a doctor's consultation fees (WTP) 0-No, 1-Yes** **Coefficient (SE)**	**Odds ratio (OR) 95% CI**	**p-value**
Area of residence			
Urban	-0.647 (0.229)	0.524 (0.334-0.821)	**0.005***
Gender			
Female	-0.005 (0.236)	0.995 (0.626-1.581)	0.982
Others	0.272 (0.590)	1.312 (0.413-4.173)	0.645
Monthly Household income			
<20,000	-0.981 (0.710)	0.375 (0.093-1.507)	0.167
20,001-40,000	-1.929 (0.668)	0.145 (0.039-0.539)	**0.004***
40,001-60,000	-1.984 (0.649)	0.138 (0.039-0.490)	**0.002***
60,001-80,000	-1.352 (0.647)	0.259 (0.073-0.920)	**0.037***
80,001-1,00,000	-1.359 (0.651)	0.257 (0.072-0.920)	**0.037***
Have health Insurance			
Yes	-0.103 (0.227)	0.902 (0.578-1.407)	0.649

Have illness/disease			
Yes	-0.664 (0.228)	0.515 (0.329-0.805)	**0.004***
Have hospitalized over last year			
Yes	-0.513 (0.228)	0.599 (0.383-0.936)	**0.024***
Consult doctors within last year			
Yes	-0.490 (0.228)	0.613 (0.392-0.957)	**0.031***

**p<0.01, *p<0.05

VIII. Analysis of respondents' behavior for Willingness to Pay towards Doctors' Consultation Fees

The multiple regression model accounts for 11.1% of the variance in the willingness to pay for doctor's consultation fees, as evidenced by the R^2 value of 0.111 (Table 4.12). The Adjusted R^2 (0.070) indicates that, after considering the number of predictors, hardly 7% of the variation is explained, suggesting that certain variables may lack predictive strength. The correlation coefficient (R = 0.333) indicates a weak to moderate association between the independent variables and the willingness to pay for a dependent variable. Hence, it can be inferenced that, there are certain independent variables which significantly affect the willingness to pay. Therefore, apart from the considered independent variables, there are few additional variables or factors which are comprehended further in the results of this

study which had a greater influence on patients' payment decisions for doctors' consultations.

Table 4.12 Model Summary of the factors associated with willing's to pay for Doctors Consultation (Source: Author's own)

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.333[a]	0.111	0.070	0.758
a. Predictors: (Constant), Physical appearance of the doctor, Experience of the doctor, have any illness/disease, Quality of diagnosis, Health Insurance, Location of the doctor, Adequate time spent with doctor, doctor's age when choosing a doctor for treatment, Specialization of the doctor, hospitalized over last year, consult your doctors within last year				

Further, the ANOVA findings indicate that, the total regression model is statistically significant (p=0.002), signifying that the independent factors collectively exert a substantial influence on the willingness to pay for doctor's consultation fees.

One way-Anova

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	18.847	12	1.571	2.730	.002[b]
	Residual	150.702	262	0.575		
	Total	169.549	274			

Furthermore, the regression analysis investigates that, there are determinants affecting the willingness to pay for doctor consultation fees. The constant (4.832) signifies the baseline willingness to pay when all other variables are null. Having health insurance (-0.275, p = 0.008) (Table 4.13) and hospitalization during the past year (-0.405, p = 0.040) were

significant predictors that reduce willingness to pay, presumably due to insured individuals and those recently hospitalized anticipating reduced out-of-pocket costs. The age of the doctor (0.256, p = 0.017) positively affects the willingness to pay, suggesting a preference for seasoned doctors. Physical appearance (-0.573, p = 0.002) and the location of doctor (-0.271, p = 0.021) adversely affected the willingness to pay, indicating that people value medical proficiency and accessibility more than appearance. Additional characteristics, such as medical history (p = 0.508), frequency of consultations (p = 0.247), area of specialization (p = 0.281), professional experience (p = 0.670), adequate time spent with doctor (p = 0.196), and quality of diagnosis (p = 0.414), did not significantly influence the willingness to pay. In summary, there are certain factors such as health insurance, hospitalization during the past year, doctor's age, physical appearance, and the physician's location of the doctor that significantly affect the willingness to pay.

Table 4.13 Coefficient Values (Source: Author's own)

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	4.832	0.597		8.095	0.000
	Health Insurance	-0.275	0.103	0.173	2.681	0.008
	have any illness/disease	-0.097	0.146	-0.060	-0.663	0.508
	hospitalized over last year	-0.405	0.196	-0.250	-2.065	0.040
	consult your doctors within last year	0.228	0.196	0.144	1.161	0.247
	doctor's age when choosing a doctor for treatment	0.256	0.107	0.155	2.403	0.017
	Specialization of the doctor	-0.121	0.112	-0.069	-1.079	0.281
	Experience of the doctor	-0.045	0.105	-0.028	-0.427	0.670
	Adequate time spent with doctor	-0.138	0.106	-0.082	-1.297	0.196
	Quality of diagnosis	0.096	0.117	0.051	0.818	0.414
	Physical appearance of the doctor	-0.573	0.183	-0.189	-3.121	0.002
	Location of the doctor	-0.271	0.117	-0.144	-2.319	0.021
a. Dependent Variable: Willingness to pay for doctor's consultation fees						

VII a. Association between reason for not having health insurance and WTP

The chi-square analysis investigates, the factors contributing to the lack of health insurance among respondents and their readiness to pay for doctors' consultation fees. The chi-square result (12.243, p = 0.016) (Table 4.14) indicated a statistically significant association between these factors and the willingness to pay for consultations, highlighting that affordability and perceived value are critical drivers in health insurance choices.

Table 4.14 Association between reason for not having health insurance and WTP (Source: Author's own)

Reason	Willing to pay for Doctor Consultation Fee		Total	Chi-Square Value	df	Sig.
	Yes	No				
Not aware	19 (8.7%)	5 (2.3%)	24 (11%)	12.243[a]	4	0.016
Financial Constraints	40 (18.4%)	8 (3.6%)	48 (22.1%)			
No Commensurate Benefits	31 (14.2%)	15 (6.9%)	46 (21.1%)			
Costly Premium	49 (22.5%)	15 (6.9%)	64 (29.4%)			
Not Required	18 (8.2%)	17 (7.8%)	35 (16.1%)			
Total	157 (72.3%)	60 (27.6%)	217 (100%)			

VII b. Association between name of the disease and WTP

In this study, chi-square test was used to investigate the impact of disease type on the willingness to pay for doctors' consultation fees.

Despite these differences in disease prevalence, the chi-square value (2.983, p = 0.887) (Table 4.15) indicates an absence of a statistically significant correlation between disease type and the willingness to pay for consultation costs. The elevated p-value (0.887)

suggests that changes in disease kind did not significantly influence respondents' decision to pay for doctor consultation fees.

Table 4.15 Association between name of the disease and WTP (Source: Author's own)

Name of the Disease	Willing to pay for Doctor Consultation Fee		Total	Chi-Square Value	df	Sig.
	Yes	No				
Diabetes Mellitus	32 (19.3%)	21 (12.7%)	53 (32.1%)	2.983[a]	7	0.887
Hypertension	29 (17.5%)	13 (7.8%)	42 (25.4%)			
Back Pain	10 (6%)	6 (3.6%)	16 (9.6%)			
Alopecia	4 (2.4%)	4 (2.4%)	8 (4.8%)			
COPD	10 (6.0%)	3 (1.8%)	13 (7.8%)			
Anemia	9 (5.4%)	5 (3%)	14 (8.4%)			
Chronic Kidney diseases	7 (4.2%)	6 (3.6%)	13 (7.8%)			
Accident	4 (2.4%)	2 (1.2%)	6 (3.6%)			
Total	105 (63.6%)	60 (36.3%)	165 (100%)			

VII c. Association between number of doctor's consultation within last year and WTP

The chi-square analysis examines the association between the frequency of doctor consultations in the last year and the willingness to pay for consultation fees. In this study it was found that, despite the differences in frequency of consultations, the chi-square value (1.274, p = 0.735) (Table 4.16) indicated an absence of a statistically significant correlation between the number of consultations and the willingness to pay. The elevated p-value (0.735) signifies that the frequency of a respondents' doctor visits did not substantially influence the respondents' willingness to pay towards consultation fees.

Table 4.16 Association between number of doctor's consultation within last year and WTP (Source: Author's own)

Number of Consultation within last year	Willing to pay for Doctor Consultation Fee		Total	Chi-Square Value	df	Sig.
	Yes	No				
< 2 Times	56 (29.9%)	29 (15.5%)	85 (45.4%)	1.274[a]	3	0.735
3 to 6 times	40 (21.3%)	16 (8.5%)	56 (29.9%)			
7 to 10 times	17 (9%)	11 (5.8%)	28 (14.9%)			
11 to 14 times	11 (5.8%)	7 (3.7%)	18 (9.6%)			
Total	124 (66.3%)	63 (33.6%)	187 (100%)			

VII d. Association between reason for doctor's consultation within last year and WTP

In the study, the chi-square value (0.668, p = 0.716) suggests that, there was no statistically significant correlation between the reason for doctors' consultation within last year and the willingness to pay for doctor's consultation fees (Table 4.17). The elevated p-value (0.716) indicates that an individual's choice to seek medical consultations for health screenings, curative, or rehabilitation were not significantly affected by their decision to incur associated consultation fees.

Table 4.17 Association between reason for doctor's consultation within last year and WTP (Source: Author's own)

Reason for Doctor's Consultation	Willing to pay for Doctor Consultation Fee		Total	Chi-Square Value	df	Sig.
	Yes	No				
Health Screening	40 (21.3%)	23 (12.2%)	63 (33.6%)	0.668[a]	2	0.716
Curative	61 (32.6%)	31 (16.5%)	92 (49.1%)			
Rehabilitation	23 (12.2%)	9 (4.8%)	32 (17.1%)			
Total	124 (66.3%)	63 (33.6%)	187 (100%)			

VII e. Association between respondents self-rating of health Status and WTP

In this study the chi-square test was utilized to assess the impact of respondents' self-assessed health status on their willingness to pay for doctors' consultation fees (Table 4.18) And the following finding was discovered by the chi-square statistic (11.214, p = 0.02) which indicated a statistically significant association between health status and willingness to pay. The low p-value (0.02) signifies that those respondents who self-rated their health status as excellent and good had a greater willingness to pay for doctors' consultation fees.

Table 4.18 Association between respondents self-rating of health Status and WTP (Source: Author's own)

Health Status	Willing to pay for Doctor Consultation Fee		Total	Chi-Square Value	df	Sig.
	Yes	No				
Excellent	80 (20.7%)	16 (4.1%)	96 (24.9%)	11.214	4	0.02
Good	86 (22.3%)	38 (9.8%)	124 (32.2%)			
Average	73 (18.9%)	34 (8.8%)	107 (27.7%)			
Poor	25 (6.4%)	18 (4.6%)	43 (11.1%)			
Very Poor	11 (2.8%)	4 (1%)	15 (3.8%)			
Total	275 (71.4%)	110 (28.5%)	385 (100%)			

VII f. Association between preference of health care center for doctor's consultation and WTP

Chi-square test was used in this study to investigate the impact of preferred healthcare center type on the willingness to pay for doctors' consultation fees (Table 4.19).

The chi-square statistic (10.228, p = 0.037) indicated a statistically significant association between respondents' preference of healthcare center for doctor' consultation and willingness to pay. The low p-value (0.037) signifies that the respondents seeking consultation at private hospitals and clinics exhibit the greater willingness to pay than those attending the government hospitals and nursing homes.

Table 4.19 Association between preference of health care center for doctor's consultation and WTP (Source: Author's own)

Preferred Health Care Centre's for Consultation	Willing to pay for Doctor Consultation Fee		Total	Chi-Square Value	df	Sig.
	Yes	No				
Private Hospital	85 (22%)	47 (12.2%)	132 (34.2%)	10.228[a]	4	0.037
Government Hospital	57 (14.8%)	12 (3.1%)	69 (17.9%)			
Clinic	62 (16.1%)	26 (6.7%)	88 (22.8%)			
Nursing Home	35 (9%)	17 (4.4%)	52 (13.5%)			
Online Consultation	36 (9.3%)	8 (2%)	44 (11.4%)			
Total	275 (71.4%)	110 (28.5%)	385 (100%)			

VII g. Association between sources of information for choosing doctor and WTP

In the study chi-square test was employed to investigate if the source of information for choosing a doctor affects the respondent's willingness to pay for consultation fees (Table 4.20).

The values in the chi-square test (0.973, p = 0.808) demonstrated an absence of a statistically significant association between the source of information and the willingness to pay for doctors' consultations. The elevated p-value (0.808) indicated that the approach in which respondents receive the information about the doctor did not substantially influence the respondent's decision towards willingness to pay for doctors' consultation fees.

Table 4.20 Association between sources of information for choosing doctor and WTP (Source: Author's own)

Sources	Willing to pay for Doctor Consultation Fee		Total	Chi-Square Value	df	Sig.
	Yes	No				
Physician Referral	67 (17.4%)	30 (7.7%)	97 (25.1%)	.973[a]	3	0.808
Friends & Family experiences	118 (30.6%)	47 (12.2%)	165 (42.8%)			
Word Of mouth	71 (18.4%)	28 (7.2%)	99 (25.7%)			
Advertisements	19 (4.9%)	5 (1.2%)	24 (6.2%)			
Total	275 (71.4%)	110 (28.5%)	385 (100%)			

4.3 To Recommend Appropriate Suggestions to Frame a Better Healthcare Policy

After analysing the doctor's consultation fees in each specialty of different hospitals, nursing homes, and clinics, it was noted that patients were willing to pay less as compared to current doctors' consultation fees and wanted to have a pay-later option. After considering the various factors along with keeping in mind the fact that India is a developing country, many people are still deprived of basic healthcare support due to the high out-of-pocket expenditures as well as the lack of proper healthcare facilities. To

address these challenges, it is essential for healthcare providers to explore flexible payment plans and subsidize services to make healthcare more accessible and economically viable for both healthcare providers and patients. Implementing community health programs and increasing government funding could also help bridge the gap for underserved populations, ensuring that everyone has access to quality medical care. The outpatient department is the first doorway to reach any healthcare services. Even today, patients are reluctant to visit any healthcare institution due to the high medical expenses starting with doctor consultation fees. The preventive services must be affordable so that every individual may not get jeopardized with severe or chronic illness due to inaccessible, unaffordable preventive healthcare services, which begin with doctors' consultation at a healthcare facility. Therefore, several suggestions can be considered to frame a better healthcare policy related to doctor's consultation fees in accordance with patients' willingness to pay. They are as follows:

i. Introduce a standardized fee structure

- Healthcare policy makers must construct, introduce, and enforce a structured guideline for charging doctors consultation fees on healthcare institutions like hospitals, nursing homes, and clinics based on the doctor's qualification, specialization, and experience.
- A flexible pricing model with a minimum and maximum fee range can be introduced to prevent healthcare institutions from overcharging patients for doctor consultations and to ensure fair and unbiased remuneration for doctors.

- Healthcare policy makers can ensure transparency in pricing by enforcing the healthcare institutions to display the doctor’s consultation fees in a prominent area.
- Senior citizens, pregnant women, and chronically ill patients who cannot afford them can receive special offers or discounts on doctor's consultation fees.

ii. Increase Accessibility, affordability, and availability of the healthcare services

- Enhance the quality of care at public health care centres like primary health and community health centre OPD services, which are free of cost, to make the healthcare services affordable to the lower-economic population.
- Online doctor consultation can be introduced with a user-friendly mobile application or telemedicine to offer affordable consultation fees to those deprived of basic healthcare support in rural areas and remote areas where quality and efficient healthcare services are inaccessible.
- The health insurance providers should cover the doctor’s consultation fees within the health insurance schemes to reduce the financial burden of out-of-pocket expenses on economically challenged patients and make the doorway to healthcare access more reachable.

iii. Health Education and awareness

- A healthcare administrator or healthcare facilitator should initiate the healthcare campaign, which must include awareness regarding healthcare costs, insurance benefits, and payment options like instalment, pay-later options, etc.

iv. Corporate Social Responsibility

- Support and embolden the initiatives like corporate social responsibility towards private healthcare providers for offering reasonably low-cost or free-of-cost doctors' consultations to underprivileged and destitute patients.

v. Monitoring the regulation and strict Penalties

- Establish a vigilance committee to monitor, regulate, modify, and optimize the consultation fees annually to ensure affordability for patients and sustainability for the healthcare providers.
- Impose penalties on healthcare providers in case of surcharging consultation fees and levying camouflaged hidden charges, which amounts to unethical practices.
- Establish standard operating policies and create awareness among healthcare staff towards maintaining an optimal consultation time, regulated consultation fees, and quality care services in the out-patient departments.

vi. Introduce the Modern Technology

- The adoption of artificial intelligence can initiate a pivotal change in healthcare economics by analysing consultation fees, patient affordability, and willingness to pay patterns.
- Implement an artificial intelligence pricing model that sets dynamic optimal consultation fees based on factors such as doctors' location, urban and rural areas, specialization, and experience.

- Inception of blockchain in the field of health economics for precise standardization and bringing in transparency of doctors' consultation fees and to bring an end to unethical practices like overcharging of doctors' consultation fees, which are haphazardly decided without a proper scientific basis or thorough research.
- Prediction of cost towards ideal and most favourable doctors' consultation fees using data analytics depending on past data related to disease prevalence and its burden in a particular geographical area, financial status in a particular geographical area, demand of the doctors, feedback of patients towards the doctor, quality of care, etc.
- Adoption of microfinancing in the form of providing instalment options and pay-later options for making payments towards doctors' consultation fees, which will make the process of doctors' consultation more accessible and affordable to the lower-income patients.

vii. Public Private Partnership

- Establishment of a public-private partnership towards well-streamlined, optimized doctors' consultation fees, where the government incentivizes and provides subsidies to the private healthcare providers who accept and abide by the policies enforced by the government diligently towards advised doctors' consultation fees.

Healthcare policy makers should design the framework of healthcare policy in such an equipoised manner, keeping in mind the facts that the doctor's consultation fees are acceptable, accessible, and affordable for the patient and that the healthcare services

providers should be profitable and doctors are remunerated in a fair manner. Additionally, the policy should encompass guidelines for standardized pricing, financial mechanisms, and current trends in digital healthcare solutions to develop an equitable healthcare delivery system.

4.4 Summary of Findings

This study was conducted to analyze the current doctors' consultation fees in each specialty of different hospitals, nursing homes and clinics, and to measure and investigate the factors influencing the patient's willingness to pay for doctors' consultation and subsequently provide appropriate suggestions to frame a better healthcare policy.

The key findings in the study were following

- It was observed that the minimum and maximum values for each specialty like cardiology(Rs 750-3000) , dentistry(Rs 200-1500), dermatology(Rs750-2500), otorhinolaryngology(Rs 650-2500), gastroenterology(Rs 650-2000), general practitioner(Rs 400-1600), general surgery(Rs 750-2000), gynecology(Rs 650-3000), internal medicine(Rs 600-3000), nephrology(Rs 650-2500), neurology(Rs 750-3500), neurosurgery(Rs 750-3000), oncology(Rs 700-3000), ophthalmology(Rs 500-2500), orthopedics(Rs 500-3000), pediatrics(Rs 700-3000), plastic surgery(Rs 400-2550), psychiatry(Rs 900-4000), pulmonology(Rs 600-3000), and urology(Rs 600-2500). This data indicates gross disparity and that there was a wide variation within each specialty for doctors' consultation fees which is an attention-grabbing point for regulatory bodies for bringing about a uniformity for fair and equitable charging of consultation fees among each specialty.

- Among the twenty different specialties, psychiatrists charged the highest average consultation fee of (Rs 1507.8), followed by gynaecologists' at (Rs 1397). Contrarily, general practitioner had the lowest average consultation fees (Rs 885.6).
- Furthermore, Psychiatrists also exhibited the highest mean rank (1714.41), indicating that the consultation fees for psychiatric services were costliest. Conversely, General practitioners (515.08) exhibited the lowest mean rank, signifying lesser consultation fees.
- The consultation fees for gynecologists SD (Rs 486.5) demonstrated a significant diversity, indicating a wide spectrum of consultation fees followed by cardiologists SD (Rs 442.7). On the other hand, General practitioners SD (Rs 208.5) exhibited the least fluctuation, signifying more uniform pricing.
- After division of doctors into three categories (specialist, sub-specialist, general practitioner), it was found that the mean consultation fees were highest (Rs 1207.91) for the Specialists (Pediatrics, Gynecology, Otorhinolaryngology, Orthopedics, Dermatology, Psychiatry, General Surgery, Ophthalmology, Internal Medicine, and Dentistry) as compared to Sub-specialists (Cardiology, Neurology, Nephrology, Urology, Gastroenterology, Oncology, Neurosurgery, Pulmonology and Plastic surgery) and least for the General Practitioners (Rs 885.65). Remarkably, indicating that the sub-specialist who were having a higher qualification (MBBS+MD/MS+ specialization) were charging lesser as compared to a specialist who were having lesser qualification (MBBS+MD/MS).
- The variations in the consultation fees among the three categories were statistically significant for doctors with less than 30 years of experience ($p < 0.05$). For doctors'

with over 30 years of experience, the variation in consultation fees is statistically insignificant (p = 0.124), suggesting that experience ceases to significantly influence the amount of consultation fees determination at this juncture. Nonetheless, after 25 years of experience, the variation within specialty in consultation fees begins to diminish.

- Additionally, the data also indicates that experience substantially affects consultation fees during the early and mid-career phases, with specialists and sub-specialists charging the highest. Conversely, after 30 years of experience, consultation fees seem to reach a steady state across all categories.
- Out of 385 patients included in this study for measuring the willingness to pay for doctors' consultation, most of the respondents 275(71.4%) were willing to pay for a doctor's consultation while, 110(28.6%) respondents were not willing to pay for a doctor's consultation fees.
- Out of the 110 respondents who were not willing to pay for doctors' consultation, (51.8%) respondents quoted the reason for not willing to pay as 'cannot afford to pay current doctors' fees' followed by the quoted reason as 'should have a pay later option' (20.9%).
- Among the patients who were willing to pay for doctors' consultation i.e. 275 patients, most of the patients (69.8%) were willing to pay in the range of Rs 251 to Rs 500 for a general practitioner. No respondents were willing to pay >Rs 1500 for a consultation with general practitioner.
- Among the patients who were willing to pay for doctors' consultation i.e. 275 patients, most of the patients (73.1%) were willing to pay in the range of Rs 501 to

Rs 750 for a specialist. None of the respondents felt they would be willing to pay a doctor in the fee range of <Rs 250 for consultation with a specialist.

- Among the patients who were willing to pay for doctors' consultation i.e. 275 patients, most of the patients (74.9%) were willing to pay in the range of Rs 751 to Rs 1000 for a sub-specialist. None of the respondents felt they would be willing to pay a doctor in the fee range of <Rs 250 for consultation with a sub-specialist.
- The respondents residing in rural areas were more willing to pay, As the monthly household income increases, individuals are more likely to be willing to pay for doctor's consultation fees. Conversely, the respondents with illness, respondents who were hospitalized over the last year and those who have consulted a doctor within the last year were less likely to pay for doctors' consultation fees. Additionally other factors like age, gender, marital status, family type, educational qualifications, occupation, having a health insurance were statistically insignificant while assessing the willingness to pay for doctors' consultation fees.
- The age of the doctor (0.256, $p = 0.017$) positively affects the willingness to pay, suggesting a preference for seasoned doctors. Physical appearance (-0.573, $p = 0.002$) and the location of doctor (-0.271, $p = 0.021$) adversely affect the willingness to pay, indicating that people value medical proficiency and accessibility more than appearance.
- Additional characteristics, such as medical history, frequency of consultations, area of specialization, professional experience, adequate time spent with doctor and quality of diagnosis did not significantly influence the willingness to pay.

- Factors like the patients having disease conditions (diabetes mellitus, hypertension, back pain, alopecia, COPD, anemia, chronic kidney disease, accident), frequency of consultations with doctor in the last year, reasons for doctors' consultation within last year (health screening, curative, rehabilitation) did not significantly influence an individual's decision to pay for doctor consultation fees.
- Respondents' self-rated health status as 'excellent' and 'good' had a greater willingness to pay for doctors' consultation fees.
- The respondents seeking consultation at private hospitals and clinics exhibit the greater willingness to pay than those attending the government hospitals and nursing homes.
- The study indicated that the respondents' sources of information while choosing doctor did not substantially influence the respondent's decision towards willingness to pay for doctors' consultation fees.

CHAPTER V:

DISCUSSION

5.1 Overview

In the past few decades, despite the immense research carried out to formulate pricing strategy towards doctors' consultation fees. Many hospitals still formulate their pricing strategy for doctors' consultation without an adequate insight and ignoring their prospective consumers i.e. patient's willingness to pay, jeopardizing the healthcare marketing environment and thereby losing the purported revenues which are being compensated by increasing the charges incurred in the healthcare set-up, this may unequivocally lead to a negative impact on the patients' health due to lack of affordability of healthcare services in India. There was a pressing need to uncover doctors' consultation fees in various specialties at numerous hospitals and clinics in India, where limited studies were conducted towards assessing the doctor's consultation fees in various departments and the variations in consultation within the same department. Thus, there was an imminent need to study the current consultation fees being charged to the patients in various specialties of hospitals, nursing homes and clinics and to measure the actual willingness to pay by the patients and factors influencing the same, to regularize and optimize the consultation fees accordingly. Therefore, the present study was aimed to assess the existing doctors' consultation fees in each specialty of different hospitals, nursing homes, and clinics. Along with measuring the patients' willingness to pay for doctors' consultation fees and investigate the factors influencing the same, furthermore, recommending appropriate suggestions to frame a better healthcare policy.

5.2 Interpretation of Doctor's Consultation Fees

In a study conducted by Bhat (2020), the results revealed that, Indian doctors are paid the lowest consultation fees among the BRICS countries (Brazil, Russia, India, China, and South Africa), with mean consultation fees of INR 8775, INR 2500, INR 600, INR 2250, and INR 1800, respectively. The claims were unverified without any authentic data to support the study. The author reportedly compared general practitioners, specialists, and sub-specialists' consultation fees with popular food items like McDonald's burger, KFC burger, Coca-Cola, and ordinary salon fees, five-star salon fees and spa fees, to represent the lower consultation fees. Additionally, the consultation fees were recorded as general practitioner (Rs 521.88), specialist (Rs 562.88), and sub-specialist (Rs 715) without any valid data collection technique, total sample size, study design, and study setting to validate the findings as low consultation fees in India. The analysis further revealed that, a general practitioner's expenses were equivalent to 3 to 3.5 burgers and 5 bottles of Coca-Cola. The findings of the results were far from reality. Conversely, the current study demystified the facts and unveiled the valid findings with a scientific basis of research and it was found that the average fees charged by general practitioner was Rs 885.65, specialists charged Rs 1207.91, and sub-specialist charged Rs 1190.04. These findings brought a light on the actual consultation fees being charged by the various specialties in Bangalore, India. Additionally, more studies required to be conducted in other areas of India for a better insight.

In a study conducted by Freed and Allen (2018) it was found that, Immunologists were charging the highest consultation fees followed by neurologists, the least consultation charges were levied by geriatricians. Additionally, a wide variation in the doctors' consultation fees charges within the specialties and variations in doctors' consultation was noted in different geographical areas of same country. The greatest variation was found in the charges levied by neurologists. Similar findings of variations in the doctors' consultations fees were discovered in the current study, with the widest variation in the doctor's consultation fees noted in gynecology department. These facts bring to the light that further research is necessary to unveil the such gross variations in consultation fees within specialties in different geographical areas and the factors associated with it.

A study conducted by Johar et al. (2017), highlighted that the Neurosurgeons were charging the highest, followed by urologist and orthopedic surgeons, along with a gross disparity in the consultation fees being charged to high-income patients and lower-income patients. The study unveiled a striking fact that the way consultation charges are being levied are grossly unregulated with a consistent profit maximization behavior of specialists due to unregulated fee setting environment. Similarly, as demonstrated by the findings of this study, the psychiatrists charged the highest consultation fees, followed by gynecologists, the general practitioners charging the lowest consultation fees. A wide variation observed in consultation fees among different specialty of doctors' is an attention-grabbing point for regulatory bodies for bringing about uniformity and minimize disparity for better utilization of healthcare services.

Interestingly, in a study conducted by McRae and Gool (2017), it was highlighted that, patients in areas with less number of doctors were likely to face higher consultation fees, huge cost variations persist as a result of noncompetition, in certain areas the doctors were conspicuously charging higher than the average consultation fees as compared to other areas, breaching the transparency in the way consultation fees is being charged, certainly bringing about transparency would create an environment for fair and affordable consultation fees across various specialties. Similarly, these findings align with the findings in the current study where it was found that there is a gross variation in the way the doctors' in various specialties are charging the consultation fees. These facts bring about a need for studying similar parameters in different areas, and create a template for framing a meticulous policy to bring about significant transparency in the doctors' consultation fees being charged in various hospitals of different areas of India.

A distinct investigation titled "Physicians with the least experience have higher cost profiles than do physicians with the most experience" was carried out by Mehrotra et al. (2012) and revealed that doctors with highest experience (>40 years) were charging the least doctor's consultation fees as compared to doctors' having less experience. These results conveyed that, one of the probable reasons for increasing healthcare costs was freshly trained doctors' charging higher consultation fees. These findings are in alignment with the current study where it was found that the doctors in the bracket of having highest experience (>30 years) were charging the least consultation fees as compared to the doctors with less experience, which indicated that the doctors' consultation fees gradually keep increasing till the 30 years, after 30 year of experience

the variations in a consultation fee reaches a steady state. These findings suggested that experience is not the sole factor to determine a doctors consultation fee alone. Therefore, other factors contributing to determining the doctors' consultation fees needs to be investigated.

5.3 Socio-Demographic Factors Influencing Willingness to Pay for Doctor's Consultation

The results of the current study indicate that higher the household income of respondent, higher was the willingness to pay for doctors' consultation fees. The results were similar when compared to a study conducted by Bacon-Shone and McGhee (2007) where, it was observed that higher the household or per capita income, lower was the relative importance of consultation fees meaning higher the household income, higher is the willingness to pay. Another recent relevant study conducted by Lamiraud and Vranceanu (2025) and a separate study conducted by Doorslaer et al. (2004) together concluded that respondents with higher income were substantially willing to pay more towards doctors' consultation with a specialist. Furthermore, other researchers stated that, the mean of willingness to pay increases when health status worsens, indicating that the respondents whose health status was poor were more willing to pay. The authors also highlighted that age, sex, marital status and education did not have a significant role in willingness to pay (Seyedin, et al., 2020).

In this study it was found that educational qualification did not influence the patient's willingness to pay towards doctors' consultation fees, whereas income of patient positively influenced the patients WTP. When compared with a study conducted by

Audureau et al. (2019), it was found that sociopsychological factors like both higher education level and higher income positively influenced the patient's willingness to pay for the treatment. Contrarily, in another study conducted by Yasunaga et al. (2006b), it was found that factors like having lower-income did not affect the WTP for doctors' consultation fees in case of common cold.

Consistent with findings of Kronborg et al. (2017) which revealed that gender, education, occupation not influencing the willingness to pay for doctors' consultation, the current studies result also affirmed the similar findings that gender, education, occupation did not influence the willingness to pay towards doctors' consultation.

5.4 Health Status of the Respondent Influencing Their WTP for Doctor's Consultation

In comparison with an earlier study conducted by Wolff et al. (2020), it was observed that the respondents were willing to pay higher towards preventive intervention rather than the curative treatment. Conversely, the current study at hand revealed that, irrespective of the reason for consultation in the last year, whether it was for health screening, curative treatment, or rehabilitation purpose, the patient's decision for willingness to pay towards doctor's consultation fees did not appear to get affected.

In a latest study conducted by Lamiraud and Vranceanu (2025) revealed that the respondents suffering from a chronic disease and respondents with poorer health status, had a higher willingness to pay. Additionally, it was found that 'self-assessed health status' and 'hospitalization during the previous year' were not associated willingness to pay towards doctors' consultation. In Contrast, in the current study, it

was observed that respondents who self-rated their health status as ‘good’ and ‘excellent’ were willing to pay more. These conflicting findings suggest that respondents self-rating of health status affecting willingness to pay varies from place to place and additional factors like having a chronic disease and having health insurance also plays a crucial role in deciding the willingness to pay for doctors’ consultation by respondents.

Another investigation was conducted by Yasunaga et al. (2006a), where it was observed that the type of disease respondent is suffering also plays an important role in determining the degree of willingness to pay, where respondents with hypertension were enrolled in the study and found that, married and male respondents were more willing to pay and household income was not found as a significant factor affecting willingness to pay for doctors’ consultation. However, contrasting findings were noted in the current study where willingness to pay for doctors’ consultation was measured for hypertension and other chronic diseases and found that marital status and gender were not a significant factor and household income was positively impacting the willingness to pay towards doctors’ consultation. Another study conducted by Liu et al. (2012) revealed that the average willingness to pay for a consistent visit towards hypertension for follow-up to a private doctor was $180 which was well below the actual reference market price bracket of $500-$1000. These findings draw attention to the fact that further studies need to be conducted to assess the willingness to pay for each specific type of disease and accordingly healthcare costs need to be fixed by policy makers as ignoring the disease like hypertension by avoiding the healthcare utilization due to multiple factors may result in increased chances of life-threatening

conditions like ischemic heart disease. It is noteworthy to provide uniformly low cost of doctors' consultation for diseases like hypertension irrespective of income to avoid further dire complications.

5.5 Respondents' Behavior Influencing their WTP for Doctor's Consultation

In this study, when choosing healthcare providers for doctor's consultation. Most respondents preferred private hospitals followed by preference to visit clinics for doctors' consultation, while very few respondents preferred government hospitals and nursing homes, least respondents preferred online consultation. Similar findings were observed in the study conducted by Haironi et al. (2011) that, most of the respondents were opting for government health centers. These findings are in alignment with the findings reported in the current study.

During the analysis of a study conducted by Noor and Junid, (2018), it was found that, most of the respondents were willing to pay more than the current fee for government clinic outpatient registration fees. Respondents with higher education and higher income and respondents having health insurance were willing to pay more, locality (urban) was found to be a statistically significant factor for willingness to pay for doctors' consultation. Additionally, most of the respondents chose government hospitals over other healthcare providers for seeking doctors' consultation. In the current study the similar facts which were uncovered were that. the respondents with higher education, and higher income were having more WTP towards doctors' consultation fees, Conversely, the results which were contradictory were, having insurance was statistically insignificant towards willingness to pay for doctors'

consultation and strikingly in the current study, it was found that the patients staying in rural areas were more willing to pay, this fact can be attributed to paucity of accessibility to comprehensive healthcare services, lack of skilled doctors' in the rural areas etc.

In a previous study conducted by Danyliv et al. (2013) which found that the willingness to pay for consultation fees was substantially higher towards specialists and general practitioner who had better physical appearance as compared to the willingness to pay towards the doctors' with less attractive physical appearance. In contrast the current study observed that Physical appearance negatively/antagonistically affected the willingness to pay, indicating that people value medical proficiency and accessibility more than appearance.

In a study conducted by Zhang et al. (2024), it was observed that, most of the respondents were influenced to choose a doctor from whom they had received treatment in the past. Other factors which had a positive influence on the respondent's decision to choose a doctor were good doctor-patient relationship, sense of trust towards treating doctor. Additionally, the severity of patient's disease condition also affected their decision to choose a doctor for consultation. These findings are consistent with the results of the current study, which derives and interpretation that factors like a 'good doctor-patient relationship' plays a crucial role in willingness to pay towards healthcare services.

5.6 Reason for Not Willing to Pay for Doctor's Consultation

The findings of Kronborg et al. (2017) also revealed that 50% of their respondents were having WTP and 50% were not having WTP for doctors' consultation fees. Patients who had health insurance were willing to pay more. The main reasons for not willing to pay for doctors' consultation were quoted as 'patients were against user charges,' 'preferring to pay for consultation through taxes,' 'should be free of charge for having consultations with a general practitioner.' In contrast to the findings of the current study where (71.4%) of respondents were having WTP and only (28.6%) respondents were not having WTP for doctors' consultation and having health insurance did not influence the WTP. In addition, the current study contrastingly revealed that, the predominant reason for not willing to pay was quoted as 'cannot afford to pay current doctors' fees' followed by very few respondents who believed 'should have a pay later option' for payment towards doctors' consultation and 'doctors' consultation to be levied through taxes.' Likewise, a different study conducted by Danyliv et al. (2013) found the similar reasons for unwilling to pay for doctor's service fees as 'Cannot afford to pay', and 'object to pay for medical services.'.

A distinct study conducted by Liu et al. (2012), which unfolded the fact that, the average maximum amount of willingness to pay towards doctors' consultation to visit a private doctor for general health conditions was found to be (Hong Kong $150) which was way within the market value range of ($100-$300). There were many respondents (21%) who were not willing to pay for doctors' consultation and quoted reasons for the same as 'they were used to seeing public doctors' and 'they were unable to pay because

private services were considered too expensive'. Whereas in the current study, noticeable contrasting findings were observed which revealed that there was stark difference in the actual doctor's consultation being charged by healthcare providers as compared to the actual willingness to pay for the same. In the current study, most of the respondents who were not willing to pay for doctors' consultation fees cited the reasons as 'cannot afford to pay current doctors' consultation. This fact is wakeup call for policy makers to bring in policies to regularize and optimize the doctors' consultation fees considering the actual willingness to pay for the same.

5.7 Inference of Existing Doctor's Consultation and Actual Patient's Willingness to Pay

Danyliv et al. (2013) conducted a study on willingness to pay on 303 respondents, and found that willingness to pay for consultation with the Specialists was much higher than that for general physicians. Additionally, it was found that respondents were either willing to pay less or not willing to pay towards consultation with general physicians as compared to other specialists. These findings are consistent in the current study where 275 respondents were willing to pay specialists to (Rs 501-750) and sub-specialist (Rs 751-1000) more than the general practitioners (Rs 251-500). Subsequently, it was also revealed that, one of the predominant reasons for unwillingness to pay for doctor's consultation was 'Should be free of charges to see general practitioner.' These findings suggest that respondents are either less willing to pay or unwilling to pay for general practitioners who are less qualified as compared to specialists. In addition, it was also observed that if the consultation fees towards general

practitioners are made free of cost, there will be a surge in healthcare accessibility, as general practitioners are first point of contact in remote areas. This fact was confirmed by the findings of a study conducted by Layte et al. (2009) where it was found that, charges for consultation with general practitioner had a significant impact on utilization of the healthcare services.

An eye-catching prominent finding of the current study was that, there was a gross disparity in the current doctors' consultation fees being charged in various specialties as opposed to actual willingness to pay towards doctors' consultation. The current study revealed that, consultation fees charged by General Practitioner was (Rs 885.65), Specialist (Rs 1207.91) and Sub-specialist (Rs 1190.04). Strikingly, On the other hand, the patients were willing to pay in the range of (Rs 251 to 500) for General practitioner, specialist (Rs 501 to 750), sub-specialist (Rs 751 to 1000). On the other hand, previous research conducted by Lamiraud and Vranceanu (2025) recently revealed that there was disparity in average WTP towards doctors' consultation vs actual consultation fees being charged by healthcare providers where the average willingness to pay towards doctors' consultation was higher (30.81 Euros) as opposed to a regulated fees of (30 euros) for a consultation with a specialist, which implies that respondents were willing to pay more than the regulated fee. Whereas in the present study, respondents were willing to pay less as compared to current consultation fees being levied, this crucial finding implies that due to such a gross overwhelming imbalance will make the doorway to healthcare i.e. doctors' consultation inaccessible and unaffordable leading to dire consequences. Such a significant discovery of imbalance can provide key insights to policy makers for regularizing and optimizing the current consultation fees,

keeping in mind all the factors associated with willingness to pay as found in the result of this study. Thereby, making healthcare more accessible and affordable along with sustainable healthcare ecosystem.

CHAPTER VI:

SUMMARY, IMPLICATIONS, AND RECOMMENDATIONS

6.1 Conclusion

This research was executed to analyze the doctors' consultation fees in each specialty of different hospitals, nursing homes and clinics, along with measuring the patient's willingness to pay for doctor's consultation fees and investigating the factors influencing patient's willingness to pay for doctor's consultation alongside recommending appropriate suggestions to frame a better healthcare policy.

The investigation highlighted that, highest average consultation fees were charged by Psychiatrists, followed by Gynecologists, and least was charged by General Practitioners. The current study also revealed that, consultation fees charged by General Practitioner was (Rs 885.65), Specialist (Rs 1207.91) and Sub-specialist (Rs 1190.04). Strikingly, On the other hand, the patients were willing to pay in the range of (Rs 251 to 500) for General practitioner, specialist (Rs 501 to 750), sub-specialist (Rs 751 to 1000).

Apparently, the patients were not willing to pay more than (Rs 1500) for consultation with General Practitioner, and not willing to pay less than Rs 250 for a Specialist and Sub-specialist. The predominant reason for unwilling to pay for consultation was quotes as ‘‘cannot afford to pay current doctors' fees’’. A wide variation was noted in the doctor's consultation fees with doctors having less than 30 years of experience, after 30 years of experience this variation diminishes.

Additionally, in this study, it was rightly pointed out that the factors influencing patients' willingness to pay for doctor consultation fees were income, household size, disease, area of residence, age of the doctor, patients who were seeking consultation at private hospitals and clinic were more willing to pay for doctors' consultation. Factors like age, gender, marital status, family type, educational qualification, occupation, health insurance, sources of information while choosing a doctor did not influence the willingness to pay for doctors' consultation fees. In addition, physical appearance and location of doctor did not play a major role in deciding the willingness to pay for doctors' consultation. Factors like Medical history, frequency of consultation, area of specialization, professional experience, adequate time spent with the doctor and quality of diagnosis did not significantly influence the willingness to pay for doctors' consultation.

The eye-opening key findings of this study served as a beacon in the darkness towards the blurry field of doctors' consultations fees in India. This study shows, the exact insight into the actual consultation charges being levied from the patients in various specialties, along with a remarkably contrasting findings of actual willingness to pay by the patients. These findings may be of paramount importance and profoundly beneficial for the healthcare providers and healthcare policy decision makers to regularize the doctor's consultation fees in alignment with patients' willingness to pay. In health care marketing perspective, this research will aid the market researcher to estimate the doctor's consultation fees to boost the patients flow by setting an optimal consultation fee. Subsequently, to provide affordable healthcare which may play a key role in strengthening the current healthcare status in a low-income, developing country like India. The critical outcomes of this study would possibly play an impregnable role to establish an approximate

range for doctor's consultation fees after scrutinizing the patients WTP considering the demography and economic status. Thus, the conclusive data can be used as an informatic tool by healthcare policy makers, hospitals, and health economists.

6.2 Implications of the study

i. **Pricing strategy**: The healthcare providers like hospitals, nursing homes and clinics can utilize the willingness-to-pay method to implement the pricing strategy. It aids any healthcare institution in making the appropriate strategies for the delivery of healthcare services at optimal cost not only in the outpatient department but also in the insurance schemes, dental services, surgery schemes, or any diagnostic services. It sets the boundaries where healthcare services will be affordable and yet sustainable for the healthcare institutions and stay afloat financially.

ii. **Appropriate Allocation of the Available Resources**: Willingness to pay studies further help healthcare institutions by identifying the limited available resources and cultivating the resources where patients value them the most and are willing to pay for them.

iii. **Service development**: Assessment of Willingness to pay in doctor's consultation fees can act as a tool for deciding the willingness to pay for other hospital services like OPD registration fees, In-patient admission fees, hospital room charges, diagnostic tests, CSSD charges etc. Such a tool can be used as a guide or manual, where healthcare administrators can develop a new standard operating procedure or can ameliorate the existing ones where tools like willingness to pay for doctors' consultation can be used to set an optimal fee which would be lucrative and

affordable to the patients and keep up the financial health of the healthcare service providers.

iv. **Marketing**: By studying the willingness to pay for doctor's consultation fees, healthcare facilitators or administrators can understand the market position of hospitals, nursing homes, and other healthcare facilities. As per the market position, the top-level management team can compare the prices and perceived value with the other healthcare institution so that they can adjust the prices and strategies accordingly to maintain competitiveness ’and meet the patient's needs, fair pricing and forecasting the demand of the patients.

v. **Policy Formulation**: This study can facilitate the healthcare policy and decision maker to national and regional levels. Additionally, the government can utilize the results of this study and use them as a tool to design the financial mechanism like Insurance schemes or subsidies to the underprivileged people to make healthcare services more accessible, affordable, and available.

vi. **Revenue Optimization**: Healthcare administrators can optimize the revenue generated in the hospitals, nursing homes, and clinics by aligning with the market prices and patients’ willingness to pay for the services like doctor’s consultation fees with the perceived value of services and therefore increasing the revenue without compromising the patient satisfaction level.

vii. **Customer Segmentation**: This study can augment the healthcare providers not only to focus on gross revenue generation, but to customize the cost or fees levied for the services. This can be done by stratifying the patients according to the needs,

behavior for willingness to pay for the healthcare services and tailoring the fees' structure according to the different groups and their behavior.

viii. **Regulatory Framework**: Analysis of the current doctor's consultation fees will act as a ladder for policy makers towards strictly regulating the healthcare pricing more transparently and ethically for a developing country like India, for optimal and better utilization of the healthcare services and for bringing in fair prices for the fees levied towards healthcare services.

6.3 Recommendations for Future Research

1. The findings in the study results instigates a need for further study with a larger sample size considering the current variation of consultation fees within the specialty at the state level and other geographical regions in India.
2. A study can be carried out on patient satisfaction level and their willingness to pay for hospital services.
3. Additional studies could investigate the "brand value of hospitals and willingness to pay for their services."
4. There is a potential for further exploration of doctors' experience vs. setting of fixed consultation fees.
5. Estimating the unit cost of outpatient registration charges and consumer willingness to pay.
6. A subsequent study focusing on the reason for variations in healthcare cost in each hospital for the same service and ability to pay.

7. Extended research is essential to ponder on “Does the hospital brand influence the doctor’s consultation fees?”
8. The current study further stimulates a study on “Impact of doctor patient relationship on willingness to pay for hospital service”
9. New research can be conducted on “Willingness to pay for counselling services in psychiatry department and assessment of counselling charges.”

APPENDIX A

SURVEY COVER LETTER

Radha Thapa
HSR 6th sector, 10th main road,
Bangalore, Karnataka, India -560102
radhaofficialmail1@gmail.com

Dear Respondent,

My name is Radha Thapa the student from Swiss School of Business Management is requesting you to have esteem participation in the research on **"DOCTOR'S CONSULTATION FEES AND PATIENT'S WILLINGNESS TO PAY FOR DOCTOR'S CONSULTATION FEES IN BANGALORE, INDIA"** as part of my partial fulfilment of doctoral degree. I am extending my communication with request you participate in this survey, which aims to analyze the doctors' consultation fees and patients' willingness to pay towards doctors' consultation fees so that better recommendation can be provided by the policy maker.

This survey will necessitate 30 minutes of your valuable insight. Your brilliant insights and experiences while visiting the different hospitals, clinics, and nursing homes would be invaluable in helping me to accumulate the crucial data that will contribute to identify the factors that influence the willingness to pay for the doctor's consultation fees.

Kindly, note that all responses given by responders will be kept confidential and used only for research purposes.

If you have any questions or need further information about the survey or the research process, feel free to contact me at radhaofficialmail1@gmail.com.

Best regards,

Radha Thapa

Doctor of Business Administration

Swiss School of Business Management

REFERENCES

Abbas, S.M., Usmani, A. and Imran, M. (2019). Willingness to Pay and Its Role in Health Economics. *Journal of Bahria University Medical and Dental College*, 9(1), pp.62–66. doi:https://doi.org/10.51985/JBUMDC2018120.

Alderman, H. and Lavy, V. (1996). Household Responses to Public Health services: Cost and Quality Tradeoffs. *The World Bank Research Observer*, 11(1), pp.3–22.

AlHanawi, M.K., Vaidya, K., Alsharqi, O. and Onwujekwe, O. (2018). Investigating the Willingness to Pay for a Contributory National Health Insurance Scheme in Saudi Arabia: a Cross sectional Stated Preference Approach. *Applied Health Economics and Health Policy*, 16, pp.259–271. doi:https://doi.org/10.1007/s40258-017-0366-2.

Ali, T. and Ali, J. (2020). Factors Affecting the Consumers' Willingness to Pay for Health and Wellness Food Products. *Journal of Agriculture and Food Research*, 2, p.100076. doi:https://doi.org/10.1016/j.jafr.2020.100076.

Asselin, A.M. (2005). Egg centric behavior—Consumer Characteristics That Demonstrate Greater Willingness to Pay for Functionality. *American Journal of Agricultural Economics*, 87(5), pp.1339–1344.

Audureau, E., Davis, B., Besson, M.H., Saba, J. and Ladner, J. (2019). Willingness to Pay for Medical Treatments in Chronic diseases: a Multicounty Survey of Patients and Physicians. *Journal of Comparative Effectiveness Research*, 8(5), pp.357–369. doi:https://doi.org/10.2217/cer-2018-0106.

Awofeso, N. (2005). Redefining 'health'. *Bulletin of the World Health Organization*, 83(11), p.802.

Azhar, A., Rahman, M.M. and Arif, M.T. (2018). Willingness to Pay for Health Insurance in Sarawak, Malaysia: a Contingent Valuation Method. *Bangladesh Journal of Medical Science*, 17(2), pp.230–237. doi:https://doi.org/10.3329/bjms.v17i2.35876.

BaconShone, J. and McGhee, S.M. (2007). An exploratory assessment of willingness to pay for health care in Hong Kong. *Hong Kong Medical Journal*, 13(5), pp.26–29.

Baji, P., Pavlova, M., Gulácsi, L. and Groot, W. (2012). Preferences of Hungarian Consumers for quality, Access and Price Attributes of Health Care Services—result of a Discrete Choice Experiment. *Society and Economy*, 34(2), pp.293–311.

Bala, M.V., Mauskopf, J.A. and Wood, L.L. (1999). Willingness to Pay as a Measure of Health Benefits. *Pharmacoeconomics*, 15(1), pp.9–18.

Balla, S., Sk, Md Illias Kanchan, Ambade, M. and Hossain, B. (2022). Distress Financing in Coping with Out-of-pocket Expenditure for Maternity Care in India. *BMC Health Services Research*, 22(1), p.288.

Banerjee, A., Deaton, A. and Duflo, E. (2004). Wealth, health, and Health Services in Rural Rajasthan. *American Economic Review*, 94(2), pp.326–330.

Barik, D. and Thorat, A. (2015). Issues of Unequal Access to Public Health in India. *Frontiers in Public Health*, 3, p.245. doi:https://doi.org/10.3389/fpubh.2015.00245.

Bellhouse, A., Malcolm, B., Griffith, G.R. and Dunshea, F. (2010). Australian consumers' Willingness to Pay and Willingness to Purchase a Hypothetical Lower Cholesterol Pork Product. *Australasian Agribusiness Review*, 18, pp.161–192.

Bhat, S. (2020). Consultation fees of Indian doctors: the myth demystified. *Journal of Dental and Medical Sciences*, 19(5), pp.57–60. doi:https://doi.org/10.9790/0853-1905155760.

Bhattacharya, J., Hyde, T. and Tu, P. (2014). *Health Economics*. New York, Ny: Palgrave Macmillan.

Binam, J., Nkama, A. and Nkenda, R. (2004). Estimating the Willingness to Pay for Community Health Prepayment Schemes in Rural area: a Case Study of the Use of Contingent Valuation Surveys in Centre Cameroon.

Breidert, C., Hahsler, M. and Reutterer, T. (2006). A Review of Methods for Measuring Willingnesstopay. *Innovative marketing*, 2(4).

Chatterjee, S., Levin, C. and Laxminarayan, R. (2013). Unit Cost of Medical Services at Different Hospitals in India. *Plos One*, 8(7), p.e69728.

Chiwire, P., Evers, S., Mahomed, H. and Hiligsmann, M. (2021). Willingness to Pay for Primary Health Care at Public Facilities in the Western Cape Province, Cape Town, South Africa. *Journal of Medical Economics*, 24(1), pp.162–172.

Chokshi, M., Patil, B., Khanna, R., Bandyopadhyay, N.S., Sharma, J., Paul, V. and Zodpey, S. (2016). Health Systems in India. *Journal of Perinatology*, 36(3), pp.S9–S12.

Cookson, R. (2003). Willingness to Pay Methods in Health care: a Sceptical View. *Health Economics*, 12(11), pp.891–894.

Danyliv, A., Pavlova, M., Gryga, I. and Groot, W. (2013). Willingness to Pay for Physician Services at a Primary Contact in Ukraine: Results of a Contingent Valuation Study. *BMC Health Services Research*, 13, pp.1–11. doi:https://doi.org/10.1186/1472-6963-13-208.

Dargaud, E. and Jelovac, I. (2023). The Pricing of physicians' Services with Distant Medicine and Health Insurance.

Daultani, Y., Kumar, S. and Vaidya, O. (2015). Improving Outpatient Flow at an Indian Ophthalmic Hospital. *Operations and Supply Chain Management: an International Journal*, 9(1), pp.15–21.

Donaldson, C. (2001). Eliciting Patients' Values by Use of 'Willingness to pay': Letting the Theory Drive the Method. *Health Expectations*, 4(3), pp.180–188.

Doorslaer, E. van, Koolman, X. and Jones, A.M. (2004). Explaining Income-related Inequalities in Doctor Utilisation in Europe. *Health economics*, 13(7), pp.629–647.

Duggal, R. (1993). User Charges and Patients' Rights. *Indian Journal of Social Work*, 54, pp.193–193.

Farabi, H., Rezapour, A., Moradi, N., Kazem, M. and Koohpayehzadeh, J. (2020). Men's Willingness to Pay for Prostate Cancer screening: a Systematic Review. *Systematic Reviews*, 9(290), pp.1–10. doi:https://doi.org/10.1186/s13643-020-01522-3.

Fernandes, B., Péntek, M., Kringos, D., Klazinga, N., Gulácsi, L. and Baji, P. (2020). Eliciting Preferences for Outpatient Care Experiences in Hungary: a Discrete Choice Experiment with a National Representative Sample. *PLoS One*, 15(7), p.e0235165. doi:https://doi.org/10.1371/journal.pone.0235165.

Filho, P. and Padua, G. (2016). How Much Should Cost a Medical consultation? a Marketing Analysis from the Viewpoint of Health Sector in Brazil. *International Journal of Healthcare Management*, 9(2), pp.127–133.

Fink, A. (2019). *Conducting Research Literature reviews: from the Internet to Paper*. Sage publications.

Freed, G.L. and Allen, A.R. (2018). General Paediatrics Outpatient Consultation fees, Bulk Billing Rates and Service Use Patterns in Australia. *Australian and New Zealand Journal of Public Health*, 42(6), pp.582–587. doi:https://doi.org/10.1111/1753-6405.12819.

Gafni, A. (1991). Willingness to pay as a Measure of benefits: Relevant Questions in the Context of Public Decision making about Health Care Programs. *Medical Care*, 29(12), pp.1246–1251.

GallEly, L. (2009). Definition, Measurement and Determinants of the consumer's Willingness to pay: a Critical Synthesis and Avenues for Further Research. *Recherche Et Applications En Marketing (English Edition)*, 24(2), pp.91–112.

Goruntla, N., Chintamani, Sai Harshavardhan, Bhanu, P., Samyuktha, S., Veerabhadrappa, Kasturi Vishwanathasetty, Bhupalam, P. and Ramaiah, Jinka Dasaratha (2021). Predictors of Acceptance and Willingness to Pay for the COVID19 Vaccine in

the General Public of India: a Health Belief Model Approach. *Asian Pacific Journal of Tropical Medicine*, 14(4), pp.165–175.

Haironi, Y., Zainab, T., Aye, A. and Khatijah, Y. (2011). *A Study on Perception of Illness and Health Seeking Behaviour among Community in Selected Villages in Samarahan District*. Universiti Malaysia Sarawak.

Hajek, A., Enzenbach, C., Stengler, K., Glaesmer, H., Hinz, A., Röhr, S., Stein, J., RiedelHeller, Steffi G and König, H. (2020). Determinants of Willingness to Pay for Health Insurance in Germany—Results of the Population based Health Study of the Leipzig Research Centre for Civilization Diseases (LIFE adult study). *Frontiers in Public Health*, 8, p.456.

Hojnik, J., Ruzzier, M., Fabri, S. and Lena, K.A. (2021). What You Give Is What You get: Willingness to Pay for Green Energy. *Renewable Energy*, 174(C), pp.733–746. doi:https://doi.org/10.1016/j.renene.2021.04.037.

Hou, Z., Chang, J., Yue, D., Fang, H., Meng, Q. and Zhang, Y. (2014). Determinants of Willingness to Pay for Self-paid Vaccines in China. *Vaccine*, 32(35), pp.4471–4477.

Hsu, W., Yang, C. and Fan, W. (2021). A Study of Patients' Willingness to Pay for a Basic Outpatient Copayment and Medical Service Quality in Taiwan. *International Journal of Environmental Research and Public Health*, 18(12), p.6604.

Hui, C.H., Kisana, H., Martin, J.R., Steecher, C., Carter, T., Lederman, E. and Hustedt, J.W. (2023). Physician Professional Fees Are Declining and Inpatient and Outpatient Facility Fees Are Increasing for Orthopaedic Procedures in the United States. *Arthroscopy: The Journal of Arthroscopic & Related Surgery*, 39(2), pp.384–389.

Hyun, M.K. (2023). Willingness to Pay for Integrative Healthcare Services to Treat Sleep disturbances: Evidence from a Nationwide Survey. *European Journal of Integrative Medicine*, 58, p.102223. doi:https://doi.org/10.1016/j.eujim.2022.102223.

Jarbøl, E. (2012). Preferences for User Fees in General Practice and the Establishment of General Practitioners in Rural Areas. *Ugeskrift for Laeger*, 174(47), pp.2940–2943.

JavanNoughabi, J., Kavosi, Z., Faramarzi, A. and Khammarnia, M. (2017). Identification Determinant Factors on Willingness to Pay for Health Services in Iran. *Health Economics Review*, 7(40), pp.1–6.

Johar, M. (2012). Do Doctors Charge High Income Patients more? *Economics Letters*, 117(3), pp.596–599.

Johar, M., Mu, C., Gool, V. and Wong, C.Y. (2017). Bleeding hearts, profiteers, or both: Specialist Physician Fees in an Unregulated Market. *Health Economics*, 26(4), pp.528–535.

Justin, S.A., Armand, S.G., Kpozehoue, A., Charlemagne, I.B. and Ouendo, E. (2021). Willingness to Pay for Universal Health Coverage Scheme for Maternal and Child Health Care and Services in Benin. *Journal of Public Health*, 7(3), pp.111–120.

Khan, M.I. and Banerji, A. (2014). Health Care Management in India: Some Issues and Challenges. *Journal of Health Management*, 16(1), pp.133–147. doi:https://doi.org/10.1177/0972063413518690.

Kirch, W. ed., (2008). Willingness to Pay Willingness to Pay. In: *Encyclopedia of Public Health*. [online] Dordrecht: Springer Netherlands, pp.1460–1460. doi:https://doi.org/10.1007/9781402056147_3749.

Kronborg, C., Pedersen, L.B., Fournaise, A. and Kronborg, C.N. (2017). User Fees in General Practice: Willingness to Pay and Potential Substitution Patterns—Results from a Danish GP Patient Survey. *Applied Health Economics and Health Policy*, 15, pp.615–624. doi:https://doi.org/10.1007/s40258-017-0325-y.

Kulkarni, S.K. (2018). A Study of Patient Satisfaction Level in out Patient Department (OPD) in a Tertiary Care Hospital in Maharashtra. *J Dent Med Sci*, 17(3), pp.31–39.

Lagarde, M., Palmer, N. and Cochrane (1996). The Impact of User Fees on Access to Health Services in Low-and Middle-income Countries. *Cochrane Database of Systematic Reviews*, 2011(4).

Lamiraud, K. and Vranceanu, R. (2025). Do Patients Value the Service Provided by Physicians Who overbill? a Willingness to pay Study Using French Survey Data. France: ESSEC RESEARCH CENTER, pp.1–17.

Layte, R., Nolan, A., McGee, H. and O'Hanlon, A. (2009). Do Consultation Charges Deter General Practitioner Use among Older people? a Natural Experiment. *Social Science & Medicine*, 68(8), pp.1432–1438.

Liu, S., Yam, C.H., Huang, O.H. and Griffiths, S.M. (2013). Willingness to Pay for Private Primary Care Services in Hong Kong: Are Elderly Ready to Move from the Public sector? *Health Policy and Planning*, 28(7), pp.717–729.

Louw, G. and Duvenhage, A. (2017). Are the Fees That the Traditional Health Practitioner Charges Generally Lower than That of the Medical practitioner? *Australasian Medical Journal*, 10(1). doi:https://doi.org/10.21767/AMJ.2017.2732.

Majeed, A. (2023). Let's Look Dispassionately at the Arguments for and against User Fees for NHS Primary Care in England. *Bmj*, 380. doi:https://doi.org/10.1136/bmj.p303.

MartínFernández, J., CuraGonzález, del, GómezGascón, T., OlivaMoreno, J., DomínguezBidagor, J., BeamudLagos, M. and PérezRivas, F.J. (2010). Differences between Willingness to Pay and Willingness to Accept for Visits by a Family physician: a Contingent Valuation Study. *BMC Public Health*, 10, pp.1–11.

Mavrodi, Afentoula G, Chatzopoulos, Stavros A and Aletras, Vassilis H (2021). Examining Willingness to pay and Zero Valuations for a Health Improvement with Logistic Regression. *INQUIRY: the Journal of Health Care Organization, Provision, and Financing*, 58, p.00469580211028102.

McDougall, J.A., Furnback, W.E., Wang, B.C. and Mahlich, J. (2020). Understanding the Global Measurement of Willingness to Pay in Health. *Journal of Market Access & Health Policy*, 8(1), p.1717030.

McRae, I.S. and Gool, van (2017). Variation in the Fees of Medical specialists: problems, causes, Solutions. *Medical Journal of Australia*, 206(4).

Mehrotra, A., Reid, R.O., Adams, J.L., Friedberg, M.W., McGlynn, E.A. and Hussey, P.S. (2012). Physicians with the Least Experience Have Higher Cost Profiles than Do Physicians with the Most Experience. *Health Affairs*, 31(11), pp.2453–2463.

Mills, A., Brugha, R., Hanson, K. and McPake, B. (2002). What Can Be Done about the Private Health Sector in Low-income countries? *Bulletin of the World Health Organization*, 80, pp.325–330.

Montmartin, B. and HerreraGómez, M. (2023). Spatial Dependence in Physicians' Prices and Additional fees: Evidence from France. *Journal of Health Economics*, 88, p.102724.

Morrow, J. and Laher, A.E. (2022). Financial Burden Associated with Attendance at a Public Hospital Emergency Department in Johannesburg. *African Journal of Emergency Medicine*, 12(2), pp.102–105.

Müller, T., Schmid, C. and Gerfin, M. (2023). Rents for pills: Financial Incentives and Physician Behavior. *Journal of Health Economics*, 87, p.102711.

Noor Aizuddin, Azimatun, Sulong, S. and Mohamed, A.S. (2012). Factors Influencing Willingness to Pay for Healthcare. *BMC Public Health*, 12((Suppl 2):A37), pp.1–1.

Noor, A.A. and Junid, A. (2018). Willingness to Pay for Outpatient Services User fees: Malaysian Community Perspective. *Jurnal Sains Kesihatan Malaysia*, 16(1), pp.145–153.

Nosratnejad, S., Rashidian, A., Mehrara, M., Sari, A.A., Mahdavi, G. and Moeini, M. (2014). Willingness to Pay for Social Health Insurance in Iran. *Global Journal of Health Science*, 6(5), p.154.

Nyamuryekung'e, Kasusu K, Lahti, S.M. and Tuominen, R.J. (2018). Patients' Willingness to Pay for Dental Services in a Population with Limited Restorative Services. *Community Dental Health*, 35(03), pp.167–172.

O'Reilly, D., O'Dowd, T., Galway, K.J., Murphy, A.W., O'Neill, C., Shryane, E., Steele, K., Bury, G., Gilliland, A. and Kelly, A. (2007). Consultation Charges in Ireland Deter a Large Proportion of Patients from Seeing the GP: Results of a Cross-sectional Survey. *European Journal of General Practice*, 13(4), pp.231–236.

Ogasawara, K. and Abe, T. (2013). WTP (willingness to pay) for Telehealth Consultation Service in Hokkaido, Japan. In: *MEDINFO 2013*. IOS Press, pp.1026–1026.

Ogundeji, Yewande Kofoworola, Akomolafe, B., Ohiri, K. and Butawa, Nuhu Natie (2019). Factors Influencing Willingness and Ability to Pay for Social Health Insurance in Nigeria. *PloS One*, 14(8), p.e0220558.

PARK, K. (2023). *PARKS TEXTBOOK OF PREVENTIVE AND SOCIAL MEDICINE*. Banarsidas Bhanot.

Pavel, M.S., Chakrabarty, S. and Gow, J. (2015). Assessing Willingness to Pay for Health Care Quality Improvements. *BMC Health Services Research*, 15, pp.1–10.

Polit, D. (2004). *Nursing research: Principles and Methods*. Lippincott Williams & Wilkins.

Rahman, A.M. (2023). Do Doctors Work for Patients in today's Business mentality world: Looking through Consumer Choice Theory lens? *Financial Metrics in Business*, 4(1), pp.263–275.

Rahman, F., Bhat, V., Ozair, A. and Detchou, D. (2024). Financial Barriers and Inequity in Medical Education in India: Challenges to Training a Diverse and Representative

Healthcare Workforce. *MEDICAL EDUCATION ONLINE*, 29, pp.1–17. doi:https://doi.org/10.1080/10872981.2024.2302232.

Rankin, J. and Robinson, A. (2018). Accounting for Protest Zeros in Contingent Valuation Studies: A Review of Literature; University of East Anglia. *Health Economics Group (HEG): Norwich, UK*, 18(2), pp.1–23.

Rina, S. and Rosminah, M. (2011). Willingness to Pay and Ability to Pay for Health Care Services at Zainoel Abidin Public Hospital Banda Aceh, Indonesia. In: *Proceedings of the Annual International Conference, Syiah Kuala University Life Sciences & Engineering Chapter*.

Rückert, I., Böcken, J. and Mielck, A. (2008). Are German Patients Burdened by the Practice Charge for Physician Visits ('Praxisgebuehr')? a Cross-Sectional Analysis of Socioeconomic and Health Related Factors. *BMC Health Services Research*, 8, pp.1–13.

Russell, S., FoxRushby, J. and ARHIN, DYNA C (1995). Willingness and Ability to Pay for Health care: a Selection of Methods and Issues. *Health Policy and Planning*, 10(1), pp.94–101.

Sakharkar, B. (2009). *Principles of Hospital Administration and Planning*. 2nd ed. Jaypee Brothers Medical Publishers.

Salles, D.C., Attux, C. and Ferraz, M.B. (2017). Willingness to Pay in Caregivers of Patients Affected by Schizophrenia. *J Mental Health Policy Econ*, 20(1), pp.3–10.

Sengupta, A. and Nundy, S. (2005). The Private Health Sector in India. *Bmj*, 331(7526), pp.1157–1158.

Seyedin, H., Safari, M. and Parnian, E. (2020). Willingness to pay for Improvement of Hypothetical Health Status in Patients Visiting the Emergency department: a Contingent Valuation Study. *Clinical Epidemiology and Global Health*, 8(1), pp.66–69.

Shogren, J.F., Cho, S., Koo, C., List, J., Park, C., Polo, P. and Wilhelmi, R. (2001). Auction Mechanisms and the Measurement of WTP and WTA. *Resource and Energy Economics*, 23(2), pp.97–109.

Siti, A. and Juhdi, N. (2010). Organic food: a Study on Demographic Characteristics and Factors Influencing Purchase Intentions among Consumers in Klang Valley, Malaysia. *International journal of business and management*, 5(2), p.105.

Spann, M., Skiera, B. and Schäfers, B. (2004). Measuring Individual Frictional Costs and Willingness to pay via Name your own price Mechanisms. *Journal of Interactive Marketing*, 18(4), pp.22–36.

Steigenberger, C., FlatscherThoeni, M., Siebert, U. and Leiter, A.M. (2022). Determinants of Willingness to Pay for Health services: a Systematic Review of Contingent Valuation Studies. *The European Journal of Health Economics*, 23(9), pp.1455–1482.

Stobierski, T. (2020). Willingness to pay: What It Is & How to Calculate. *Harvard Business School Online*. Available at: https://online.hbs.edu/blog/post/willingness-to-pay.

Svalastog, A.L., Donev, D., Kristoffersen, N.J. and Gajović, S. (2017). Concepts and Definitions of Health and Health related Values in the Knowledge Landscapes of the Digital Society. *Croatian Medical Journal*, 58(6), p.431. doi:https://doi.org/10.3325/cmj.2017.58.431.

Tambor, M., Pavlova, M., Rechel, B., Golinowska, S., Sowada, C. and Groot, W. (2014). Willingness to Pay for Publicly Financed Health Care Services in Central and Eastern Europe: Evidence from Six Countries Based on a Contingent Valuation Method. *Social Science & Medicine*, 116, pp.193–201. doi:https://doi.org/10.1016/j.socscimed.2014.07.009.

Tekie, G.M., Gebretekle, Gebremedhin Beedemariam, Hogan, M. and Fenta, Teferi Gedif (2019). Willingness to Pay for Social Health Insurance and Its Determinants among Public Servants in Mekelle City, Northern Ethiopia: a Mixed Methods Study. *Cost Effectiveness and Resource Allocation*, 17, pp.1–11.

Than, T.M., Saw, Y.M., Khaing, M., Win, E.M., Cho, S.M., Kariya, T., Yamamoto, E. and Hamajima, N. (2017). Unit Cost of Healthcare Services at 200bed Public Hospitals in Myanmar: What Plays an Important Role of Hospital budgeting? *BMC Health Services Research*, 17, pp.1–12.

Thomas, T.V. and Mathew, A. (2022). Access, Affordability, and Sustainability: Barriers to High Quality Care in a High-Income Country. *Indian Journal of Medical and Paediatric Oncology*, 43(03), pp.285–288.

Tran, B.X., Vu, G.T., Hong, T., Nguyen, L.H., Pham, D.D., Truong, V.Q., Phuong, T., Thi, M., Nguyen, T.Q. and Nguyen, V. (2018). Demand and Willingness to Pay for Different Treatment and Care Services among Patients with Heart Diseases in Hanoi, Vietnam. *Patient Preference and Adherence*, 12, pp.2253–2261. doi:https://doi.org/10.2147/PPA.S176262.

Voelckner, F. (2006). An Empirical Comparison of Methods for Measuring Consumers' Willingness to Pay. *Marketing Letters*, 17, pp.137–149.

Wagner, R.L. and Pacheco, N.A. (2020). Name your own price as Participative Pricing strategy: a Review of the Literature from 2001–2017. *Journal of Strategic Marketing*, 28(7), pp.583–600.

Weinick, R.M., Byron, S.C. and Bierman, A.S. (2005). Who can't Pay for Health care? *Journal of General Internal Medicine*, 20(6), pp.504–509.

Wolff, E., Larsson, S. and Svensson, M. (2020). Willingness to Pay for Health Improvements Using Stated preferences: Prevention versus Treatment. *Value in Health*, 23(10), pp.1384–1390.

World Health Organization (2024). *Determinants of Health*. [online] World Health Organisation. Available at: https://www.who.int/news-room/questions-and-answers/item/determinants-of-health.

Xiao, B., Gu, X., Jin, L., Chan, V.F., Li, Y., PriceSanchez, C., Liu, Y., Wang, Y., Fu, H. and Li, D. (2023). Willingness to pay for diabetic retinopathy screening in Qujiang District, rural Guangdong, southern China: a cross-sectional study. *BMJ open*, 13(4), p.e065792.

Yasunaga, H., Ide, H., Imamura, T. and Ohe, K. (2006a). Analysis of Factors Affecting Willingness to Pay for Cardiovascular Disease related Medical Services. *International Heart Journal*, 47(2), pp.273–286.

Yasunaga, H., Ide, H., Imamura, T. and Ohe, K. (2006b). Willingness to Pay for Health Care Services in Common cold, Retinal detachment, and Myocardiac infarction: an Internet Survey in Japan. *BMC Health Services Research*, 6, pp.1–10. doi:https://doi.org/10.1186/1472-6963-6-12..

Yu, S., Gool, van, Hall, J. and Fiebig, D.G. (2019). Physician Pricing behavior: Evidence from an Australian Experiment. *Journal of Economic Behavior & Organization*, 161(C), pp.20–34. doi:https://doi.org/10.1016/j.jebo.2019.03.008.

Zhang, B., Yan, Z., Song, X., Liao, Y. and Li, P. (2024). Influence of Free Consultation Services on Patients' Willingness to Pay in Online Medical Platforms. *International Journal of Crowd Science*, 8(1), pp.28–37.

Zin, C.S., Ab, Nazar, M., Kurdi, A. and Godman, B. (2023). Trends in the Cost of Medicines, Consultation Fees and Clinic Visits in Malaysia's Private Primary Healthcare System: Employer Health Insurance Coverage. *Journal of Multidisciplinary Healthcare*, 2023(16), pp.1683–1697. doi:doi: %2010.2147/JMDH.S403589.

Zitek, T., Pagano, K., Mechanic, O.J. and Farcy, D.A. (2023). Assessment of Trauma Team Activation Fees by US Region and Hospital Ownership. *JAMA Network Open*, 6(1), pp.e2252520–e2252520.

APPENDIX A:

OBSERVATIONAL CHECKLIST

Name of the Department…….

Consultation fees (Rs)	Experience (Years)	Education qualification	Gender

APPENDIX B:

QUESTIONNAIRE

Sample No……

Greetings!

This questionnaire is for research purpose. None of the replies to this survey will be made public and shall maintain confidentiality, and any information that is gleaned from it will only be used for academic purposes (DBA).

Part -A: Socio-demographic profile of Respondents

1. Area of residence
   a) Urban b) Rural
2. Age (In years)
   a) < 25 b) 25 to 34 c) 35 to 44 d) 45 to 54
   e) > 55
3. Gender
   a) Male b) Female c) Others
4. Marital Status
   a) Single b) Married c) Widowed d) Separated
   e) Divorced
5. Family Type
   a) Nuclear b) Joint
6. Household size (in numbers)
   a) Up to 4 b) 5 to 8 c) 9 to 12 d) 13 and above
7. Educational Qualification
   a) Illiterate
   b) Vocational Training

c) Elementary school

d) High School

e) Higher secondary

f) Graduate

g) Post Graduate

8. Occupation of the respondent

a) Self-employed / Business

b) Private Service

c) Government Service

d) Retired

e) Unemployed

f) Daily wage

g) Student

h) Housewife

9. Monthly Household income (In Rs)

a) < 20,000

b) 20,001 to 40,000

c) 40,001 to 60,000

d) 60,001 to 80,000

e) 80,001 to 100,000

f) > 1,00,000

Part B: Health status of the respondents

10. Do you have Health Insurance?

a) Yes b) No

11. If No (In question no. 10) specify the reason

a) Not aware

b) Financial Constraints

c) No Commensurate benefits

d) Costly Premium

e) Not required

12. Do you have any illness/disease?

a) Yes b) No

13. If yes (In question no. 12)

a) Name of the disease……...

14. Have you hospitalized over last year?

a) Yes b) No

15. Have you consult your doctors within last year?

a) Yes b) No

16. Number of Doctor's Consultation within last year? if yes (in question no. 15)

a) < 2 times

b) 3 to 6 times

c) 7 to 10 times

d) 11 to 14 times

17. Reason for doctor consultation within last year?

a) Health Screening

b) Curative

c) Rehabilitation

18. How will you rate your health status?

a) Excellent b) Good c) Average d) Poor e) Very Poor

Part C: Respondents Behaviour for willingness to pay for doctor consultation

19. Which health care centre do you prefer for a doctor's consultation?

a) Private Hospital

b) Government Hospital

c) Clinic

d) Nursing Home

e) Online Consultation

20. What are your sources of information for choosing a doctor?

    a) Physician Referral

    b) Friends and Family experiences

    c) Word of mouth

    d) Advertisements

21. Would you consider a doctor's age when choosing a doctor for treatment?

    a) Yes b) No

22. What basis would you like to pay a doctor? (Respondent can select the more than one options)

    a) Specialization of the doctor

    b) Age and experience of the doctor

    c) Adequate time spent with doctor

    d) Quality of diagnosis

    e) Physical appearance of the doctor

    f) Location of the doctor

Part D: Willingness to pay for doctor's consultation

23. Would you be willing to pay for a doctor's consultation fees?

    a) Yes b) No

24. If no (in question no. 23) then specifies the reason for unwillingness to pay for doctor's consultation

    a) Should be free of charges to see general practitioner

    b) Prefer to pay through taxes

    c) Cannot afford to pay current doctor's fees

    d) Should have pay later option

    e) Other

25. Willingness to pay for doctor's consultation fees (General Practitioner - MBBS)

Bid Amounts (Rs)	
< 250	
251 to 500	

501 to 750	
751 to 1000	
1001 to 1250	
1251 to 1500	
>1500	

26. Willingness to pay for doctor's consultation fees for Specialist (MD/MS)- i.e., Paediatrics, Gynaecology, Otorhinolaryngology, Orthopaedics, Dermatology, Psychiatry, General Surgery, Ophthalmology, Internal Medicine & dentistry)

Bid Amounts (Rs)	
< 250	
251 to 500	
501 to 750	
751 to 1000	
1001 to 1250	
1251 to 1500	
>1500	

27. Willingness to pay for doctor's consultation fees for Sub-specialist (MD/MS+ Specialization) i.e., Cardiology, Neurology, Nephrology, Urology, Gastroenterology, Oncology, Neurosurgery, Pulmonology & Plastic Surgery)

Bid Amounts (Rs)	
< 250	
251 to 500	
501 to 750	
751 to 1000	
1001 To 1250	
1251 to 1500	
>1500	