

# Hospital search and evaluation behaviours of rural Australian health consumers – an exploratory study

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## Abstract

This paper investigates the impact of health attitudes (as measured by consumers' perceived control over their health outcomes) on information search and alternative evaluation of rural Australian consumers when selecting a hospital. A self-administered mail questionnaire was sent to 1790 households within three rural communities returning 309 (17.3 per cent) useable questionnaires for analysis. Results showed that while consumers' perceived control over their health outcome, does influence information search and evaluative behaviours, this influences may not be strong enough to warrant segmenting markets for marketing strategy development.

**Keywords:** information search, alternative evaluation, hospital choice, health attitudes, locus of health control, rural Australia, health consumer.

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## **Introduction**

The role of the health consumer has been changing since the 1980s with a trend away from total acceptance of a physician's advice to more independent decision making (Bekowitz and Flexner 1980/81; Javalgi, Rao & Thomas 1991; Tudor and Carley 1995; Dutta-Bergman 2004). That is, consumers have become more health conscious and better informed over the last two decades and as a result some consumer segments are taking a more proactive stance in the information search and alternative evaluation stages of this process (Stewart, Hickson, Pechmann, Koslow and Altemeier 1989).

Although changes in decision making behaviours of some segments of health consumers are taking place, investigation of these changes in relation to the information search and alternative evaluation stages of the decision making process has been limited (Woodside, Sertich and Chakalas 1987; Moorman & Matoolich 1993; Smith Gooding 1995; Tudor and Carley 1995; Root 2004) within the Australian context. This limited research is not surprising given that the application of marketing concepts to this industry is relatively new (Root 2004). Furthermore, available research tends to investigate either information search or alternative evaluation behaviours on their own but not together to provide a more comprehensive picture. Finally, with the exception of a few authors (for example, Moorman & Matoolich 1993; Dutta-Bergman 2004) researchers have mainly studied the impact of demographics rather than health attitudes on search and evaluative behaviour.

In order to extend the literature, this paper investigates the level of importance placed by rural Australians on various information sources and evaluative criteria when selecting a hospital, and investigates whether the importance levels of these sources and criteria are influenced by consumers' health attitudes.

## **Background**

### **The Australian context**

This research is based on Australian health consumers because an understanding of their decision making process is important if private hospitals are to succeed in capturing and retaining the increasing number of consumers who are moving towards the private health care system (MBF 2003). In 2000, the government encouraged the move towards private health care by introducing a 30 per cent rebate on private health insurance. This move combined with the lengthy waiting periods for public health care has led more and more Australians to take up private health insurance thus reversing the decline in private memberships which was evident in the 1980s and 1990s (MBF 2003). In fact in 2003, 9.1 million Australian (almost half of the Australian population) used some form of private health service. (MBF 2003)

In brief, with the increasing interest in private health care, health care services such as private hospitals will need to attract and retain customers in order to stay competitive in the market place, hence justifying the need to better understand health consumers' decision making processes. This paper contributes to the literature by expanding knowledge of two of the steps in the decision making process and provides research to help guide health industry practice.

## **Literature survey and development of objectives**

**Information search behaviour.** The consumer decision making process consists of five stages of problem recognition, information search, alternative evaluation and selection, choice and purchase, and post purchase processes (Neal, Quester & Hawkins 2002). Information search, the second step in the decision making process involves searching for information from one or more sources about various alternative ways to solve the problem at hand (Summers, Gardiner, Lamb, Hair, Mcdaniel 2003; Widing, Sheth, Pulendran, Mittal & Newman 2003). Information sources can be broken down into internal and external components. Internal source constitutes memory, while external sources constitute marketing, non-marketing and experiential sources (Neal et al. 2002). Although an investigation of internal information source is as important as external sources, this research focuses only on external sources but investigates internal sources in later research. Information search is particularly important in the health care context because some health consumers' involvement in this step of the decision making process increases their satisfaction rate with a hospital (Woodside, Sertich and Chakalas 1987).

Previous research about healthcare information search has focused on three main areas. The first two areas involve identifying information sources used to select health care providers (for example, Freidon & Goldsmith 1989; Harrell and Fora 1989; Stewart et al. 1989) and measuring search effort (for example, Moorman & Matoolich 1993; McColl-Kennedy & Fetter 1999). For example, Freidon and Goldsmith (1989) showed that friends and doctors were important sources for consumers searching for a medical practitioner or dentist. Moorman and Matoolich (1993) investigated search effort for health care services based on the amount of time spent on information search for books, magazines, newspapers, television, radio and product labels. The other area of search behaviour that has received attention in the health literature includes the impact of various factors on both information sources deemed important (for example, Berkowitz and Flexner 1980-81; Stewart et al. 1989; Harris 2003; Dutta-Bergman 2004; Root 2004) and on search effort (Moorman & Matoolich 1993). For example, Stewart et al. (1989) showed that behavioural factors such as the type of physician visited (for example a GP or a gynaecologist) and the type of patient (child or adult) influenced importance levels of various information sources used to select a physician. Berkowitz and Flexner (1980-81) showed that demographic variables such as age, education and occupation influenced the number of information sources used to decide on a hospital. That is, younger, well educated, technicians and professionals are more likely to rely on additional information sources other than their doctor. Dutta-Bergman (2004) found that health attitudes such as health-consciousness impacted on importance of information sources. It was found that interpersonal communication such as print readership and internet communication serve as primary health information sources for health-conscious, health-information oriented clients while passive communication channels such as TV and radio are more relevant for consumers who are not health oriented.

In relation to the impact of factors on search effort, Moorman and Matoolich (1993) showed that health attitudes, such as one's perceived level of control over one's health (that is, one's locus of health control), impacts on search effort. They found that consumers who felt they were in control of their health outcomes (that is, those with a high locus of health control) were more motivated to search for information compared to those who felt less in control of their health outcomes. However, because the focus of the research was on search effort, only a limited range of information sources were used thereby excluding sources such as experiential sources (such as observation of the health facility) and non-marketing controlled sources (such as word of mouth of family and friends, and employee provided health information).

Given the above literature, it can be surmised that search effort and information sources used to select health services are influenced by elements of demography, attitudes and behaviour. However, there is still scope to further this research area by investigating the relationship between one's locus of health control and the importance placed on information sources. If Moorman and Matoolich (1993) showed that locus of health control impacts on search effort, then the next question is whether this factor also impacts on the level of importance placed on each information source. One would assume that if consumers with a high locus of health control exerts more effort during search, then it is logical that they may also place more importance on individual information sources compared to their counterparts because they are motivated to do so. This issue requires investigation because it can assist marketing practitioners to better target their promotional mixes to different segments. Therefore, this research aims to build on previous findings by investigating the following objective:

**Obj 1:** How important are various information sources to rural Australian consumers' selection of a hospital and do their attitudes towards their health (in terms of locus of health control) influence the level of importance placed on each information source?

**Alternative evaluation of hospitals.** Information gathered through the information search step enables consumers to develop a set of criteria with which to judge alternative courses of action and select the best alternative. These evaluative criteria are attributes and features associated with benefits desired, or costs that may be incurred by the consumer for that product. (Neal et al. 2002)

Research into the alternative evaluation stage of health care selection has focused on identifying criteria used in deciding on a healthcare service provider, and the factors that impact on the importance levels of these criteria (for example, Boscarino and Stelber 1982; Javalgi et al. 1991; Smith Gooding 1995; Carpenter and Mueller 2001). For example, Carpenter and Mueller (2001) identified criteria such as proximity to clinic and the cost free nature of the clinic to be most important in the final decision to use a school clinic. Smith Gooding (1995) showed that quality was less important than cost in the selection of health care services for patients requiring minor versus major treatment. Boscarino and Stelber (1982) identified seven criteria that influence choice for general, specialized and emergency care.

Although past research has identified evaluative criteria used for selection of various health care services and examined its relationship to demographic and situational factors, further research is required to investigate the impact of attitudinal factors on evaluative criteria. For instance, what is the impact of the locus of health control on the importance levels of decision criteria? Since previous research has shown that consumers' perceived control over their health outcomes impacts on their information search behaviour, is it then logical to also assume that consumers with high perceived control over their health (that is, those with a high locus of health control) place more importance on hospital selection criteria compared to their counterparts? This issue will be resolved through the following objective:

**Obj 2:** How important are various evaluative criteria to rural Australian consumers' selection of a hospital and do their attitudes towards their health (in terms of locus of health control) influence the level of importance placed on each selection criteria?

## Methods

The results of this research are part of a larger survey which was conducted as a consultancy for a rural health hospital in one of the communities surveyed. Specifically, the residents of three small rural Australian communities that are in close proximity to one another and share the same health care facilities were surveyed. A list of residents was obtained from the local post office ensuring that the sampling frame was comprehensive. In total, the sampling frame comprised 1790 residents. A comprehensive sample was taken in which all units on the sampling frame were mailed the questionnaire. A total of 322 questionnaires were returned giving a 18 per cent response rate. Another 13 questionnaires were discarded because they were not correctly completed leaving a total of 309 questionnaires. A copy of the questionnaire is available on request.

**Measures.** The items used in the questionnaire were based on the literature. For example, the inventory of information sources and evaluative criteria in the health care sector was developed based on the academic literature and a past commercial surveys of hospitals (for example, USQ 2002; Stewart et al. 1989). A five point scale was used to rate the level of importance placed on each information source and evaluative criterion when selecting a hospital. This scale is in line with that used by Freidon & Goldsmith (1989) in measuring importance levels placed on information sources for two health care services.

Next, consumer's health attitudes were measured by using some of the questions from the locus of health control scale. Locus of health control refers to consumers' enduring beliefs that health outcomes are controllable (Rotter 1966; Moorman & Matoolich 1993). A person who believes that their personal behaviours and qualities control health outcomes is known as an internal (and has a high locus of health control) and those who believe that luck or external forces control their health outcomes are known as externals (and have a low locus of health control). This scale measures respondents' control over their health using a seven point scale (Lau & Ware 1981 in Bruner & Hensel 1991). However, in order to maintain consistency in the scales used for this questionnaire, a five point scale was used instead of the seven point scale since five point scales are also interval in nature.

Also, only some of the questions in the scale were used for this research because this research consultancy had to focus on the needs of the client, and measuring respondents' locus of health control was not as important to the client's needs as other issues. Therefore, in the interest of keeping the questionnaire short and concise (so as to increase response rate), some of the questions from the scale was dropped (see appendix for list of questions used in this survey). These questions were only dropped after pilot testing, when respondents complained that some questions were too similar and so were confusing. In conclusion, this research provides only an indication of respondent's locus of health control (the limitation of not using the entire scale is further discussed in a later part of this paper). Anyhow, an understanding of these issues is still important because of its relationship to importance levels of sources and criteria within the Australian health context.

Finally, demographic questions were included about respondents' gender, age, number of children, education level, household income and whether or not respondents had private health insurance.

## Findings

This section is divided into three sub-sections. The first section provides a demographic profile of respondents and their attitudes towards their health, and the other two sections discuss findings for each of the research objectives.

With regards to demographics (shown in table 1), the results show that that the majority of respondents (75.8% of or 229 respondents) were female and above the age of 25 years (97.4% or 297 respondents). Approximately half of respondents had postsecondary (21.7%) or tertiary (22.7%) qualifications. Approximately half of the respondents (57.5%) had no children. About 42% of all respondents had a total household income under \$31,200. Finally, the majority of respondents (84.6%) had private health insurance.

(Table 1 here)

In brief, the results show that respondents came from a somewhat heterogeneous group because although they were mainly female, with health insurance, the range of ages, educational attainment and income levels varied.

Next, results for respondents' attitudes towards their health is shown in table 2. Scores for each respondent's answers to the 12 Likert scaled questions were tallied to give a total score. A median based on all respondents' totals was calculated and used as a cut-off point for low and high total scores. Low total scores represented a low locus of health control (otherwise labeled externals) and high scores represented a high locus of health control (otherwise referred to as internals). A median was used to categorise respondents because there is no actual cut-off point suggested in the literature and categories were needed to conduct tests for differences. Also, since tests for normality showed that most of the questions were skewed and/or had kurtosis it was decided that a median rather than a mean score would provide a more accurate description.

Results in table 2 show that the majority of respondents had a high score. Of the 287 respondents answering this question, 62% scored equal to or above the median indicating that they were internals with a high locus of health control. Only 38% scored below the median.

(Table 2 here)

### **Obj 1: Importance levels of information sources and impact of attitudes on the level of importance of information sources?**

A Mann-Whitney U test for differences was calculated to investigate whether the two groups (internals and externals) differed on the level of importance placed on each information source. This test was selected instead of its parametric alternative of an independent t-test because most of the items violated the assumption of normality.

Results showed that there were significant differences between the two groups for most but not all sources (refer table 3), with externals placing a higher level of importance on every source where significant differences were found. For example, information sources such as doctor's recommendations, observation of a hospital's facilities, hospital promotional literature and phone

call to health service provider were significantly more important to internals than to externals. Note however that just because some sources were statistically more important to internals, this does not mean that externals did not find these sources to be important too. For example, although doctor's recommendations was significantly more important to internals (with a mean of 4.59) than to externals, this source rated the highest of all sources for externals with a mean of 4.48. Other information sources such as word of mouth by family and by friends, and newspaper editorials were not significantly different between the two groups. Interestingly, word of mouth by family and by friends were quite important sources to both groups regardless of their locus of health control.

**(Table 3 here)**

Having established differences between the two groups, the next step was to investigate whether significant differences existed within groups. For example, did internals believe certain sources to be significantly more important than other sources? To answer this question, a Wilcoxon signed-rank test was calculated separately for each group (internals and externals) to find out whether differences in importance levels of sources were significant (refer table 4).

**(Table 4 here)**

Table 4 shows that some sources were significantly more important than others and that the same results were obtained for both internals and externals. For example, both groups found doctor's recommendations to be significantly more important than word of mouth by family and by friends, and first hand observation of a hospital's facilities. In turn, these three sources were more important than sources such as hospital promotional literature and phone call to a service provider. In brief, while internals and externals may be two different segments, their ranking of sources were the same.

## **Obj 2: Importance levels of evaluative criteria and impact of attitudes on the level of importance of criteria?**

Objective 2 was analysed using the same statistical techniques as those used for objective 1. That is, a Mann-Whitney U test for differences was calculated to investigate whether the two groups (internals and externals) differed in the level of importance placed on evaluative criteria (refer to tables).

The findings mirrored those for objective 1. That is, some criteria were equally important to both groups; however, internals placed more importance on those criteria where significant differences were found. For example, confidence in hospital staff, explanation of treatment and the opportunity to ask questions were important to both internals and externals. Other sources such as quality of emergency care and availability of after-hours care were significantly more important to internals than to externals. Again, these significant findings should be interpreted in light of means for each criterion for each group. That is, just because some criteria are statistically more important to internals, it does not mean that externals do not find these criteria to be important too. For example, although the quality of emergency care is significantly more important to

internals (with a mean of 4.91) than to externals, this source rates highly for externals with a mean of 4.75.

**(Table 5 here)**

Next, a Wilcoxon signed- rank test was performed to test whether certain criteria were more important than others for each of the two groups; however, no clear groupings could be distinguished. For example, ‘confidence in doctors and staff at hospital’ (with the highest mean of 4.94 for internals) was not significantly more important than ‘health professional explaining treatment (with the second highest mean of 4.92 for internals) but it was significantly more important than ‘the opportunity to ask questions’ (with the third highest mean of 4.89 for internals). As a result, the criteria of ‘health professional explaining treatment’ could not be classified as either first, second or third most important source. This pattern of finding was evident throughout the analysis and it occurred because of small variations between the means of criteria. Therefore, it was not possible to clearly distinguish criteria in terms of their importance levels.

### **Discussion and conclusion**

This research investigated the impact of health attitudes (based on the locus of health control) on importance levels placed by rural, Australian health consumers on various information sources and evaluative criteria when selecting a hospital. Firstly, the results showed that although the locus of health control impacts on the importance of information source, it does not do so for all sources, that is, some sources are equally important to internals and externals. These findings are somewhat different from Moorman and Matoolich’s (1983) findings which showed that internals exert significantly more effort during search for all information sources studied. This contradiction could have occurred for two reasons. One reason is that Moorman and Matoolich (1983) studied 5 main sources only while this study investigated 13 and therefore, the larger range of sources provided a more comprehensive picture of consumers’ behaviours. Another reason could be that Moorman and Matoolich (1983) studied search effort rather than information sources deemed important and as was studied in this research and so the differences in research foci could account for the differing outcomes. Further research should investigate both importance of information sources as well as search effort when selecting health services. Nevertheless, although a relationship between locus of health control and importance of information sources holds exists, one must still question its validity from a practical perspective. Although internals placed significantly more importance on certain sources than externals, ultimately, these differences were insignificant since both groups ranked all sources from most important to least important in the same hierarchy. Therefore, from a practical perspective, although it should be acknowledged that externals are different from internals in their attitudes, these differences may not translate into meaningful differences for information sources. As a result, the best strategy would be to treat internals and externals as one group for the purpose of promotional mix development, and to promote to this market using information sources that are most important to them (that is, doctor’s recommendations, followed by word of mouth and observation of health care facilities). Where financial resources are available, a hospital could expand its promotional mix to include sources that ranked third in importance levels (hospital promotional literature, phone call to service provider, newspaper editorials/news stories and Council provided information).



Next, it was shown that statistically, internals place more importance on certain evaluative criteria than externals. But again, these findings were questionable from a more practical sense since most criteria were quite important to both groups even when internals placed significantly more importance on certain criteria. Also, the importance levels of most criteria were so similar that it was statistically difficult to order them from most important to least important. In summary, the internals were different from externals but from a managerial standpoint, these differences did not appear to be large enough to warrant treating the two groups as separate segments for service and promotion strategies. What this study did show though is that a large number of criteria are quite important to rural health consumers and that hospitals should consider as many of them as possible in their services mix development. For example, factors such as confidence in staff, effective communications, cleanliness, after hours care, quality emergency care, quality staff, reputation and cost were all deemed important to consumers and should be incorporated into hospital service. In contrast, types of specialist services such as hearing aid specialists, physiotherapy services and others should be provided based on the level of need within the community since they may not be as relevant to the majority of consumers.

Nevertheless, the fact that so many criteria were considered important to respondents in this research does call for further investigation to compare attitudes against actual behaviours. This research investigated attitudes of consumers by asking them about criteria they deemed important in hospital selection. Further research could vary the focus by investigating actual behaviour and its influence on importance of evaluative criteria. For example, consumers could be asked to recall their behaviour the last time they actually selected a hospital and the criteria they actually used to make the selection. Since attitudes do not always correlate with behaviour (Widing, Sheth, Pulendran, Mittal, & Newman 2003) this type of research may highlight differences between criteria deemed important (attitudes) and those actually used (behaviour) when selecting a hospital. Changes in evaluative criteria are possible as shown by Smith Gooding (1995) who found that time makes a difference to the type of evaluative criteria being used. Also, decision heuristics should be investigated in relation to these evaluative behaviours since the rating and ranking of criteria could change depending on the type of heuristic used.

Three limitations were apparent in this current research. The first limitation is that the internet as an information source was not considered. Next, internal information sources were omitted for it was beyond the scope of this research. Finally, only some of the questions from the locus of health control scale were included in this questionnaire. These three areas should be included in further research to provide a more comprehensive picture.

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## **Appendix**

### **Locus of health control scale**

- I have a lot of confidence in my ability to cure myself once I get sick.
- Taking care of yourself has little or no relation to whether you get sick.
- In the long run, people who take care of themselves stay health and get well quickly.
- There is little one can do to prevent themselves from getting sick.
- Doctors can rarely do very much for people who are sick.
- Recovery from illness requires good medical care more than anything else.
- Most sick people are helped a great deal when they go to a doctor.
- Seeing a doctor for regular checkups is a key factor in staying healthy.
- I only do what my doctor tells me to do.
- Doctors can almost always help their patients feel better.
- Good health is largely a matter of good fortune.
- Some kinds of illnesses are so bad that nothing can be done about them.

**Table 1**  
**Demographic profile of survey respondents**

<b>Demographics</b>	<b>Frequency</b>	<b>Percentage</b>
<b>Sex</b>		
Male	73	24.2
Female	229	75.8
<i>Total</i>	<i>302</i>	<i>100</i>
<b>Age</b>		
Under 18	1	.3
18-24 years	7	2.3
25-34 years	51	16.7
35-44 years	63	20.7
45-54 years	65	21.3
55-64 years	53	17.4
65 years and over	65	21.3
<i>Total</i>	<i>305</i>	<i>100</i>
<b>Education level</b>		
Still at school/still studying	5	1.7
Secondary education	159	53.9
Post secondary education	64	21.7
Tertiary education	67	22.7
<i>Total</i>	<i>295</i>	<i>100.0</i>
<b>Number of children</b>		
None	172	57.5
1-2	86	28.8
3-4	38	12.7
5 or more	3	1
<i>Total</i>	<i>299</i>	<i>100</i>
<b>Household income before tax</b>		
Negative/nil income	11	4.4
Up to \$15,599	32	13
\$15,600 - \$31,199	72	29.1
\$31,200 - \$45,599	31	12.6
\$46,600 - \$77,999	66	26.7
\$78,000 or more	35	14.2
<i>Total</i>	<i>247</i>	<i>100</i>
<b>Health insurance</b>		
Has insurance	259	84.6
Does not have insurance	47	15.4
<i>Total</i>	<i>309</i>	<i>100</i>

**Source: Research results**

**Table 2**  
**Levels of belief of control over one's health outcomes as measured by the locus of health control scale**

Attitude score	No of respondents	Percentage (%) of respondents
Internal (score > median = 16)	178	62.0
External (score =< median = 16)	109	38.0
Total	287	100.0

Source: Research results

(Table 3 here)

**Table 3 Importance levels placed by internals and externals on information sources**

	Sig	High score (Internals)		Low score (Externals)	
		Mean	SD	Mean	SD
Doctor's recommendation of hospital	Sig	4.59	.665	4.48	.700
Word of mouth communication - family		4.31	.843	4.22	.928
Word of mouth communication - friends		4.29	.774	4.21	.832
Observations of health facility	Sig*	4.19	.814	4.11	.820
Hospital promotional literature	Sig*	3.94	.995	3.63	1.012
Phone call to service provider	Sig	3.89	1.068	3.61	.961
Newspaper editorial/news stories		3.84	1.098	3.59	1.116
Local council providing information	Sig*	3.83	1.039	3.59	.993
Hospital newsletters	Sig*	3.70	1.058	3.21	.953
Health professional speaking	Sig*	3.53	1.066	3.36	.993
Employee providing health care	Sig	3.44	1.159	3.23	1.073
Newspaper advertisement		3.34	1.244	3.32	1.125
Radio news stories		3.29	1.178	3.20	.995
Radio advertisement	Sig	3.01	1.134	2.75	.973

Note: Sig: significant at alpha = .05; Sig\*: significant at alpha = .01

Source: Research results

**Table 4**

**Significant differences in importance levels of sources for internals and externals**

Sources	Sources grouped by importance levels for both internals and externals
Doctor's recommendation of hospital	Most important

Word of mouth communication - family	Second most important group
Word of mouth communication - friends	
Observations made	
Hospital promotional literature	Third most important group
Phone call	
Newspaper editorial/news stories	
Local council providing information	
Hospital newsletters	Fourth most important group
Health professional speaking	
Employee providing health care	
Newspaper advertisement	
Radio news stories	
Radio advertisement	

**Note:** Significant at alpha = .05

**Source:** Research results

**Table 5**

**Significant difference placed by internals and externals on evaluative criteria**

Criteria	Internals			Externals			Sig
	Rank	Mean	SD	Rank	Mean	SD	
Confidence in doctor(s), and staff at hospital	1	4.94	.267	1	4.93	.258	
Health professionals explain	2	4.92	.273	3	4.86	.398	

treatment							
I have the opportunity to ask questions	3	4.89	.314	2	4.87	.342	
Level of communication	4	4.86	.380	4	4.85	.406	
Quality of emergency care	5	4.91	.303	5	4.75	.475	Sig
The hospital and my room are clean	6	4.81	.450	8	4.69	.536	
Availability of after hours care	7	4.82	.384	11	4.57	.611	Sig*
Quality of health care services	8	4.80	.444	7	4.71	.544	Sig
Staff treat me in a pleasant manner	8	4.80	.412	6	4.74	.547	
Availability of specialist doctors	9	4.77	.450	10	4.59	.592	Sig
Availability of pathology services	9	4.77	.474		4.41	.690	Sig*
Hospital staff respond in a timely manner	10	4.76	.443	9	4.65	.533	
Availability of acute care services	11	4.74	.558	14	4.44	.731	Sig*
Reputation of hospital in the community	12	4.71	.558	12	4.50	.614	Sig
The cost of treatment	13	4.66	.555	13	4.45	.732	Sig
I am able to sleep in a peaceful and quiet environ.	14	4.63	.647	11	4.53	.656	
Admission and discharge handled professionally	15	4.61	.567	14	4.44	.814	
Catering staff	17	4.55	.650	16	4.27	.771	Sig
Variety of health care services	17	4.53	.624	15	4.42	.731	Sig
Geographical location of hospital	18	4.51	.781	15	4.42	.717	
Availability of physiotherapy services	19	4.43	.785	17	4.11	.740	Sig*
Availability of private rooms	20	4.26	.861	18	3.95	1.077	
Availability of woman's health nurse	21	4.16	.847	19	3.67	.957	Sig*
Whether it's a private hospital	22	3.89	1.120	21	3.51	.983	Sig
Availability of hearing aid specialist	23	3.80	.964	22	3.35	.940	Sig*
Availability of maternity services	24	3.78	1.148	20	3.55	1.097	
Whether it's a public hospital	25	3.64	1.202	23	3.30	1.003	

**Note:** Sig: significant at alpha = .05; Sig\*: significant at alpha = .01

**Source: Research results**