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Demographic Determinants of Inpatient Complaining Behaviour

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Abstract: Demographic factors are the socioeconomic characteristics of a population expressed statistically such as age, sex, education level, income level, marital status, occupation, religion, etc. The actions resorted to by customers after a dissatisfaction episode have always been a topic of research. The broad area covered in this study is consumer satisfaction, dissatisfaction and complaining behaviour. The consumers considered are the inpatients who were dissatisfied with any service during their hospital stay. This study is an attempt to identify the type of demographics of inpatients who have the propensity to complain post dissatisfaction with the hospital services. A total of 312 inpatients who were admitted and discharged from 100+ bedded private and cooperative hospitals across nine districts belonging to northern, central and southern Kerala were surveyed. Their action after being dissatisfied was studied with a dichotomous scale and thus categorized as either complainers or non-complainers. Data pertaining to a total of eight socio-demographic variables were collected with categorical scales whereas their length of hospital stay and self assessment of medical awareness was collected with a continuous scale. The study revealed that except occupation, none of the other variables had an effect on the complaining behaviours of inpatients.
Keywords: Demographics, medical awareness, duration of hospital stay, inpatient, complainers, non-complainers

INTRODUCTION

Demographics can be defined as the specific demographic factors like age, income level, gender, religion etc. which identify and distinguish a target population or market. Merriam Webster defines demographics as the qualities like age, sex and income of a specific group of people. While doing a survey, researchers need to make decisions regarding who to approach for conducting the survey and how to breakdown the overall survey responses into meaningful categories of respondents [1]. The importance of demographic data in research studies was investigated [2] and defined as a field of study in which researchers analyze the quantifiable statistics and the common ones are gender, ethnicity, education level, disabilities, employment and socioeconomic status.

While studying a representative sample of a population, understanding the distribution of the respondents' demographic characteristics helps in identifying the extend of similarity of the sample with the population. In addition, survey with a large sample size facilitates segregation into various sub-groups. Such kind of data is highly relevant in consumer studies to explore various behavioural patterns. Grouping consumers based upon these characteristics facilitates industries to provide better service thereby ensuring customer satisfaction and subsequent profits.

The characteristics of credence-dominated services were studied [3] and found that quality of service cannot be fully evaluated even after its purchase and consumption. According to previous researches [4, 5], consumers depend upon word-of-mouth sources while searching for information regarding credence-dominant services. They do not have sufficient knowledge to evaluate the service and hence they depend on these subjective sources. As credence services are associated with higher levels of uncertainty and ambiguity, a consumer might find it difficult to make choices like switching or exiting [6].

Though extant literature has documented consumer satisfaction/dissatisfaction studies, data pertaining to consumer complaining behaviour are comparatively lesser, especially in the Indian context. Consumer action after dissatisfaction is pertinent information to the industry, particularly the service sector. Propensity to complain has been defined as 'an individual's demonstrated preference and intentions to complain as a result of an unsatisfactory purchase experience' [7]. Complaining intentions or propensities are divided into exit intention, negative word-of-mouth intention, direct voice intention (directly complaining to the provider), indirect voice intention and third party complaint intention, also called amplified voicing [8, 9].

Extant studies have substantiated the fact that dissatisfied consumers need not essentially complain [10-12]. A considerable number of dissatisfied consumers never complain, rather they exit and resort to negative word-of-mouth behaviour. It was of interest to investigate into the type of behaviour indulged in by dissatisfied patients.

Five models of complaining are cost-benefit model, personality model, learning model, resource model and restraints model [13]. The personality model is based on the personal characteristics of consumers. This model argues that complainers tend to be more self-confident and aggressive than non-complainers. Expectancy-Disconfirmation Paradigm [14] has been the most dominant model in satisfaction research as depicted in Figure 1. In this, consumers compare their pre-consumption expectations with post-consumption experience of a service, in order to form an attitude of satisfaction or dissatisfaction towards the service. Much of the extant literature on patient satisfaction does not look at a complete range of connections between expectations from various service points and level of satisfaction with each.

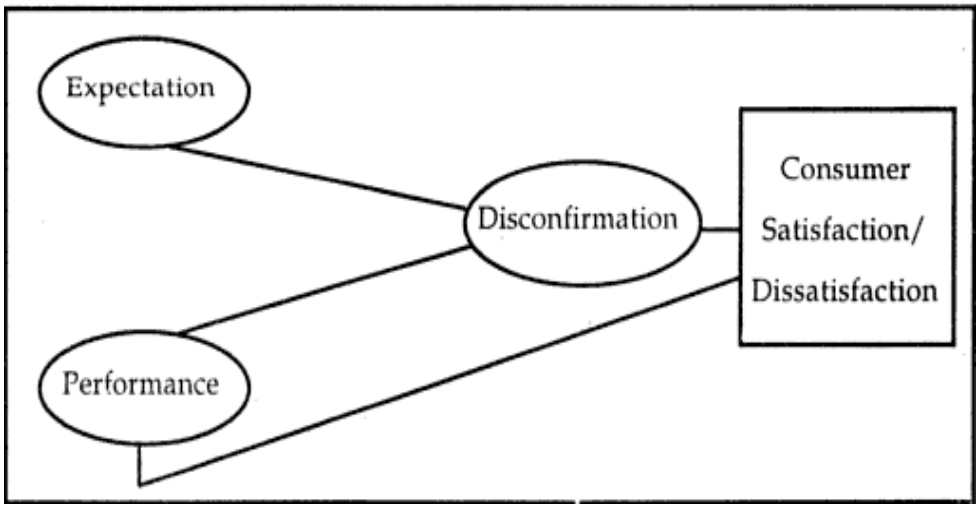

Fig-1: Disconfirmation paradigm [15]

The Expectancy-Disconfirmation Model from marketing theories as in Figure 1 [15] can be applied to hospital sector. Patient satisfaction increases with the increase in perceived fulfillment of expectations and reduces with the decrease in perceived fulfillment of expectations. Hence, if the expectation is low, satisfaction ought to be higher and vice versa.

Non-complainers are consumers who do not voice their dissatisfaction to the service provider or other third party, but may engage in other dissatisfaction responses like negative word-of-mouth or switching [16]. Many researchers have tried to explore the reasons behind complaining and non-complaining behaviors of customers. Consumer Complaining Behavior (CCB) has been found to be a complex phenomenon [17] influenced by an array of factors in the choice of a particular complaining action. Whilst consumer demographics have been studied by various authors [10, 18-21], psychographics and attitude towards complaining [22], general attitude towards business [21], product attributes [20, 23, 24] and attribution of blame [25, 26] have also been documented.

A study on complainers and non-complainers of advertising in Australia [8] found that the former had a high propensity to openly voice their complaints when dissatisfied with a purchase when compared to the latter. Complainants, according to this study, were found to be less likely to forget about the product or service and do nothing and also less likely to decide never to use the product or service again. A study on CCB in restaurants [27] classified customers into three clusters- those who were not likely to complain, those who complain to anyone / word-of-mouth complainers and the silent critics. The second category, the majority among all, was the most price-conscious and most susceptible to interpersonal influence. The last category was found to be the least price-conscious and comparatively younger group.

The reasons behind non-complaining behaviour have also been researched earlier. Research exploring the deterrents of complaining among the non-complaining inpatients established that the most frequently quoted reason for non-complaining was their anxiety of not receiving any positive outcome after complaining. In addition, credulousness of inpatients was found to be a major deterrent of inpatient complaining behaviour [28, 29]. Dual failures which resulted from double deviation scenarios in the service sector were investigated [30]. The words dual or double resulted from the customer being dissatisfied twice, one with the service and the other with the provider's response to the complaint.

The antecedents of inpatient complaining behaviour were classified as hospitality & cordiality, patient care & concern, amenities and technical competence, after performing exploratory factor analysis [31]. Based on the studies in the financial sector [32], it can be concluded that the higher the perceived customer dissatisfaction, the higher their precautions, communication with higher level managers and negative behavior to firms.

Based on the socioeconomic and demographic characteristics, researchers have tried to distinguish complainers from non-complainers. While complainers were categorized as a heterogeneous group [33], these variables were argued [13] to have no explanatory power. Also CCB was found to have a positive relationship with education and income [17]. A comparative study among people from different areas of domicile [34] found that those from urban areas had more propensity to complain than others. Whereas education and income had a positive correlation with CCB [35, 36], younger consumers were more inclined to complaining than older ones [35]. In addition, elderly consumers had more difficulty in complaining assertively and were more vulnerable in the marketplace [37].

The findings about education and income were true not only in the Western world, but also in developing countries [38]. They found that complainers in Indonesia had higher level of income and education, exhibited greater degrees of self confidence and individualistic characteristics, were willing to take risk and had positive attitude towards complaining when compared to non-complainers. Age, income and level of education were the three demographic variables that were found to have a significant relationship with CCB among Singapore customers [39].

With regard to gender, women were found to have more propensities to complain than men [40]. But, marital status and ethnic grouping were not found to have any relationship with CCB. Consumers who publicly complained were younger with better education and higher income than non-complainers [40, 41]. Gender, income and education were found not to have any effect on CCB for both complainers and non-complainers [42]. Complainants had above average education, managerial or professional status and above-average income [18]. Whereas religion [43] and marital status [44] were found to influence complaining behavior, race, employment status and family type were not strong determinants of CCB. Nevertheless, hospitals being a place frequented by people of various levels of profession, occupation, educational qualification, religion, marital status, age and places of domicile, these variables need to be explored to establish distinction, if any, between complainers and non-complainers in hospitals.

Based on the review of literature, the objective of the study was to identify the socio economic and demographic factors that influence inpatient complaining behaviour

EXPERIMENTAL SECTION

The population of the study comprised of the inpatients or their bystanders who availed various services of any private or cooperative hospital in Kerala during the 0-6 months of the data collection period and were dissatisfied with any of the services of that hospital during their stay. The sampling technique followed was probability sampling. The data collection tool was structured and self-administered questionnaire. The data was gathered from the sampled nine districts of Kerala, three each from three zones, north, central and south Kerala. The target population was identified from those admitted in private or cooperative hospitals having more than 100 beds, belonging to these three zones of Kerala. An equal representation of samples was sought from the three zones, comprising three districts each. This survey made use of the retrospective recall technique to extract reliable and genuine responses of consumers regarding actual service experiences they had encountered during their stay in the hospital. The final sample size was 312.

The behavioral response of inpatients to dissatisfaction episodes was measured with the question ‘what action did you resort to when dissatisfied during your stay’ using dichotomous scale bearing options ‘complained’ and ‘did not complain’. The respondents were asked to rate their knowledge about diagnostic and therapeutic procedures on a 3-point scale ranging from ‘not at all aware’ to ‘highly aware’. The eight socio-economic and demographic variables that were included in this study were gender, age, education, occupation, financial status, religion, marital status and nature of place of residence.

Bivariate data analyses were done by performing chi square test, a non-parametric test, in IBM SPSS 20.0.

RESULTS AND DISCUSSION

The question given to the respondents had dichotomous alternatives, namely, ‘complained’ and ‘did not complain’. The responses are tabulated below in Table 1.

Table 1: Distribution of respondents based on action resorted to when dissatisfied

Patient action	**Frequency**	**Per cent**
Complained	71	22.8
Did not Complain	240	76.9
No response	1	.3
Total	312	100.0

It is evident that more than three-fourth of the respondents (76.9 per cent) comprising 240 dissatisfied inpatients were covert complainers whereas 71 were overt complainers contributing to 22.8 per cent.

The results are in congruence with earlier studies where about two-thirds of customers do not report their dissatisfaction. Moreover, they may either take action or stay silent [51, 52].

Hypotheses pertaining to nature of patient action post dissatisfaction

The results of the hypothesis tests for each of the *eleven* variables in relation to patient action post dissatisfaction are presented below.

H_1: There is no true difference between male and female respondents in respect of the nature of action resorted to post dissatisfaction.

This hypothesis was tested with chi square. Table 2 & 3 gives the cross tabulation and chi square test results of gender and patient action.

Table 2: Gender & action (Cross tab)

Gender	Complained	Did not complain	Total
Male	23.9 %	76.1 %	100
Female	21.2 %	78.8 %	100

Table 3: Gender & action (Chi Square)

Test	Value	Df	Asymp sig. (2-sided)
Pearson Chi-Square	3.643	2	.162
N of Valid Cases	307		

The proportion of complainers and non-complainers among males (23.9 and 76.1 per cent respectively) and females (21.2 and 78.8 per cent respectively) were almost alike. It was of interest to find out whether gender of the respondents and propensity to complain were associated. The test is not significant, X^2 (2, n=307) =3.643, p=0.162. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between male and female patients in respect of the nature of action resorted to post dissatisfaction.

H_2: There is no true difference between respondents belonging to various age groups in respect of the nature of action resorted to post dissatisfaction

This hypothesis was tested using chi square. Table 4 depicts the cross tabulation of age and patient action.

Table 4: Age and Patient action (Cross tabulation)

Age (years)	Complained	Did not complain	Total
20 to 29	25.9%	74.1%	100.0%
30 to 39	25.3%	74.7%	100.0%
40 to 49	15.0%	85.0%	100.0%
50 to 59	22.7%	77.3%	100.0%
Above 60 years	17.6%	82.4%	100.0%

Whereas more than three-quarter of respondents from all age groups exhibited non-complaining behaviour, almost one-quarter of respondents belonging to the age groups of 20-29, 30-39 and 50-59 years indulged in overt complaining behaviour.

Table 5 illustrates the chi square testing to examine whether any difference exists between various age groups in respect of the nature of action resorted to by them post dissatisfaction.

Table 5: Age and patient action (Chi Square tests)

Test	Value	Df	Asymp sig. (2-sided)
Pearson Chi-Square	2.523	4	0.641
N of Valid Cases	297		

The test is not significant, X^2 (4, n=297) =2.523, p=0.641. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between respondents belonging to different age groups in respect of the nature of action resorted to post dissatisfaction.

H_3: There is no true difference between respondents belonging to different levels of education in respect of the nature of action resorted to post dissatisfaction

This hypothesis was tested using chi square. Table 6 gives the cross tabulation of education and nature of action resorted to post dissatisfaction.

Table 6: Educational level and Patient action (Cross tabulation)

Education	Complained	Did not complain	Total
Literate	16.7%	83.3%	100.0%
School up to 5th standard	30.8%	69.2%	100.0%
School from 6-9th standard	50.0%	50.0%	100.0%
SSLC/HSC	18.3%	81.7%	100.0%
Graduate	21.4%	78.6%	100.0%
Post Graduate	30.6%	69.4%	100.0%
Professional Qualification	21.2%	78.8%	100.0%

No specific pattern can be observed in respect of propensity to complain for the respondents belonging to different levels of education. While only one sixth of the 'literate' group complained, the proportion respectively for 'school up to fifth standard' and 'school from 6-9th standard' were 30.8 and 50.0 per cent respectively. The percentage of complainers among the 'graduates' and the 'professionally qualified' were nearly equal. A little less than one third of the 'post graduates' reported that they complained on being dissatisfied.

Table 7 illustrates the chi square testing to examine whether any true difference exists between respondents holding various educational qualifications in respect of the nature of action resorted to post dissatisfaction.

Table 7: Educational level and Patient action (Chi Square tests)

Test	Value	Df	Asymp sig. (2-sided)
Pearson Chi-Square	8.543	6	.201
N of Valid Cases	305		

The test is not significant; X^2 (6, n=305) =8.543, p= 0.201. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between respondents belonging to different levels of education and the nature of action resorted to post dissatisfaction.

H_4: There is no true difference between respondents belonging to various categories of occupation in respect of the nature of action resorted to post dissatisfaction

This hypothesis was tested using chi square. Table 8 gives the cross tabulation of occupation and patient action.

Table 8: Occupation and Patient action (Cross tabulation)

Occupation	Complained	Did not complain	Total
Wage labourer	13.8%	86.2%	100.0%
Self employed	30.8%	69.2%	100.0%
Service – government or private	29.3%	70.7%	100.0%
Retired	0	100.0%	100.0%
Unemployed	17.0%	83.0%	100.0%
Others	41.7%	58.3%	100.0%

The highest non-complaining propensity was observed among the 'retired' group with all of them reporting that they did not complain at all. More than three-fourth of the 'wage labourers' and 'unemployed' respondents reported to have engaged in non-complaining behaviour. However, the respondents belonging to 'others' category comprising students and house-wives as well as 'self-employed' category made the highest representation in complaining overtly (41.7 per cent and 30.8 per cent respectively).

Table 9 illustrates the chi square testing to examine whether there is any difference between respondents belonging to various classes of occupation and the nature of action resorted to post dissatisfaction.

Table 9: Occupation and Patient action (Chi Square tests)

Test	Value	Df	Asymp sig. (2-sided)
Pearson Chi-Square	14.584	5	.012
N of Valid Cases	304		

The test is statistically significant; X^2 (5, n=304) =14.584, p= 0.012. As the p value is lesser than the significance level, we have evidence to reject the hypothesis and state that there is a significant difference between respondents belonging to various classes of occupation and the nature of action resorted to post dissatisfaction.

H_5: There is no true difference between respondents belonging to various classes of financial status in respect of the nature of action resorted to post dissatisfaction

This hypothesis was tested with chi square. Table 10 gives the cross tabulation and chi square test results of financial status and patient action.

Table 10: Financial Status and Patient action (Cross tabulation)

Financial Status	Complained	Did not complain
Well-off	18.2%	81.8%
Middle class	22.9%	77.1%
Poor	30.8%	69.2%
Below Poverty Line	22.2%	77.8%

Table 11: Financial Status and Patient action (Chi square)

Test	Value	Df	Asymp sig. (2-sided)
Pearson Chi-Square	1.170	3	.760
N of Valid Cases	306		

The respondents who reported themselves as belonging to the 'well-off' class had the highest non-complaining propensity in the event of dissatisfaction with 81.8 per cent of them reporting that they have not complained. The non-complaining propensity of the middle class and the BPL category were more or less the same with a little more than three fourth of them in each case reporting as not having complained. Though only 69 per cent of those who described themselves as 'poor' did not complain, they exhibited the highest complaining propensity at 30.8 per cent.

The test is not significant; X^2 (3, n=306) =1.170, p=0.760. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between respondents belonging to various categories of financial status in respect of the nature of action resorted to post dissatisfaction.

H_6: There is no true difference between respondents belonging to different religious backgrounds in respect of the nature of action resorted to post dissatisfaction.

This hypothesis was tested using chi square. Tables 12 gives the cross tabulation and chi square test results of religion and patient action.

Table 12: Religion and Patient action (Cross tabulation)

Religion	Complained	Did not complain
Hindu	20.0%	80.0%
Muslim	28.4%	71.6%
Christian	25.0%	75.0%
Prefer not to respond	11.1%	88.9%

Table 13: Religion and Patient action (Chi square)

Test	Value	Df	Asymp sig. (2-sided)
Chi-Square	3.491	3	.322
N of Valid Cases	309		

The respondents who preferred not to disclose their religious background had the highest non-complaining propensity in the event of dissatisfaction with 88.9 per cent of them reporting that they have not complained. Among those who reported themselves as belonging to the 'Hindu' religion, 80 per cent turned out to be complainers. A little higher than one-quarter of the respondents who reported themselves as belonging to the Muslim religion (28.4 per cent) and exactly one-quarter of those belonging to the Christian religion (25 percent) were observed to exhibit complaining propensity than the rest of the respondents.

The test is not significant; X^2 (3, n=309) =3.491, p=0.322. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between respondents belonging to various religious backgrounds in respect of the nature of action resorted to post dissatisfaction.

H_7: There is no true difference between respondents belonging to various categories of marital status in respect of the nature of action resorted to post dissatisfaction

This hypothesis was tested using chi square. Table 14 gives the cross tabulation and chi square test results of marital status and patient action.

Table 14: Marital Status and Patient action (Cross tabulation)

Marital Status	Complained	Did not complain
Never Married	22.8%	77.2%
Married	25.3%	74.7%
Divorced	25.0%	75.0%
Living Separately	0%	100.0%
Prefer not to respond	5.6%	94.4%

Table 15: Marital Status and Patient action (Chi square)

Test	Value	Df	Asymp sig. (2-sided)
Chi-Square	4.509	4	.342
N of Valid Cases	309		

The non-complaining propensity was observed to be the highest among the respondents who reported to be 'living separately' with all of them stating that they did not complain at all. Greater than or equal to three-fourth of the rest of each category who reported that they were 'never married', 'married', 'divorced' and who 'preferred not to reveal' their marital status reported high non-complaining propensity with 77.2 per cent, 74.7 per cent, 75 per cent and 94 per cent respectively. The respondents who reported to belong to 'married' and 'divorced' categories exhibited almost equal complaining propensity.

The difference between these variables is not significant; X^2 (4, n=309) =4.509, p=0.342. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between respondents belonging to various categories of marital status in respect of the nature of action resorted to post dissatisfaction.

H_8: There is no true difference between respondents belonging to various places of residence in respect of the nature of action resorted to post dissatisfaction

This hypothesis was tested using chi square. Table 16 gives the cross tabulation and chi square results of nature of place of residence and patient action.

Table 16: Nature of place of stay & patient action (Cross tab)

Nature of place of stay	Complained	Did not complain
Urban	28.9%	71.1%
Semi Urban	18.6%	81.4%
Rural	22.6%	77.4%

Table 17: Nature of place of stay & patient action (Chi square)

Test	Value	Df	Asymp sig. (2-sided)
Pearson Chi-Square	3.016	2	.221
N of Valid Cases	309		

The respondents who reported to represent semi-urban areas exhibited the highest non-complaining propensity (81.4 per cent). The highest complaining propensity was observed among those from urban areas with 28.9 per cent of them reporting to have complained post dissatisfaction.

The difference between these variables is not significant; X^2 (2, n=309) =3.016, p=0.221. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between respondents belonging to various places of residence in respect of the nature of action resorted to post dissatisfaction.

H_9: There is no true difference between respondents possessing different levels of medical awareness in

respect of the nature of action resorted to post dissatisfaction

This hypothesis was tested using chi square. Table 18 gives the cross tabulation of medical awareness and patient action.

Table 18: Patient action and Medical awareness (Cross tabulation)

Patient action	Not at all aware	Somewhat aware	Highly aware
Complained	20.8%	23.1%	24.2%
Not Complained	79.2%	76.9%	75.8%
Total	100.0%	100.0%	100.0%

The non-complaining propensity among the respondents who reported their self-assessment regarding their level of medical awareness was almost equal for the three categories namely, 'not at all aware', 'somewhat aware' and 'highly aware'. It could be observed that the highest complaining propensity was among the respondents who reported to possess high awareness about diagnostic and therapeutic procedures (24.2 per cent).

Table 19 illustrates the chi square testing to examine whether any difference exists between respondents with different levels of medical awareness in respect of the nature of action resorted to post dissatisfaction.

Table 19: Patient action and Medical awareness (Chi-Square Test)

Test	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	.439	3	.932
N of Valid Cases	311		

The difference between these variables is not significant; X^2 (3, n=311) =0.439, p=0.932. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between respondents possessing different levels of awareness regarding diagnostic and therapeutic procedures in respect of the nature of action resorted to post dissatisfaction.

H_{10}: There is no true difference between respondents who have and have not undergone surgery in respect of the nature of action resorted to post dissatisfaction.

This hypothesis was tested using chi square. Table 20 gives the cross tabulation of surgery undergone and patient action.

Table 20: Surgery underwent & patient action (Cross tab)

Patient action	Undergone Surgery	No surgery Involved
Complained	25.0%	22.3%
Not Complained	75.0%	77.7%
Total	100.0%	100.0%

Table 21: Surgery underwent & patient action (Chi-Square)

Test	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.162	2	.559
N of Valid Cases	311		

The respondents who declared to have undergone surgery exhibited a higher propensity to complain with one-quarter of them reporting that they complained overtly post dissatisfaction.

There is no true difference between these variables and the test is not significant; X^2 (2, n=311) =1.162, p=0.559. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between patients who have undergone and have not undergone any kind of surgical procedures in respect of nature of action resorted to post dissatisfaction.

H_{11}: There is no true difference between patients who stayed for less than or equal to one week and those who stayed for more than one week in respect of nature of action resorted to post dissatisfaction

This hypothesis was tested using chi square. Table 22 shows the cross tabulation of length of hospital stay and patient action.

Table 22: Action and length of hospital stay (Cross tabulation)

Patient action	</= 1week	>1 week
Complained	21.2%	26.8%
Not complained	78.8%	73.2%
Total	100.0%	100.0%

The respondents whose duration of stay was stated to be more than one week reported a higher propensity to complain with 26.8 per cent of them having complained post dissatisfaction. Table 23 illustrates the chi square testing to examine whether there was any difference between respondents based on their length of hospital stay in respect of nature of action resorted to post dissatisfaction.

Table 23: Action and length of hospital stay (Chi square)

Test	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	1.771	2	.413
N of Valid Cases	311		

The test is not significant; X^2 (2, n=311) =1.771, p=0.413. As the p value is higher than the significance level, we have evidence to retain the hypothesis and state that there is no true difference between respondents who stayed for less than or equal to one week and those who stayed for more than one week in respect of nature of action resorted to post dissatisfaction.

Table 24: Consolidated results of hypotheses pertaining to patient action post dissatisfaction

Sl. No. of hypotheses	**Independent variable**	**Sig. (p value)**	**Decision**
H_1	Patient gender	0.162	Retain the hypothesis
H_2	Patient age	.641	Retain the hypothesis
H_3	Patient education	.201	Retain the hypothesis
H_4	Patient occupation	.012	**Reject hypothesis**
H_5	Patient financial status	.760	Retain the hypothesis
H_6	Patient religion	.322	Retain the hypothesis
H_7	Patient marital status	.342	Retain the hypothesis
H_8	Nature of place of stay	.221	Retain the hypothesis
H_9	Patients' medical awareness	.932	Retain the hypothesis
H_{10}	Surgery undergone	.559	Retain the hypothesis
H_{11}	Duration of hospital stay	.413	Retain the hypothesis

Dependent variable: Patient action; Test performed: Chi square

From the above table, it can be observed that there was no true difference between respondents from different socio-economic and demographic backgrounds, possessing various levels of medical awareness, being subjected to surgery and duration of hospital stay in respect of nature of action post dissatisfaction. A statistically significant difference was observed only between respondents holding different levels of occupation.

CONCLUSION

An alarming indicator to the entire industry is the fact that respondents are not ready to overtly communicate their complaints to the provider. Unlike the other service sectors like restaurants, airlines and banking where the scenario is entirely different and consumer voicing is predominant, the characteristics of the health care sector in addition to the cultural make-up of the country might prevent people from engaging in public action post dissatisfaction. Studies have marked India as a collectivistic society [45] with lower traits of individualistic culture when compared to the Western developed nations. As a major share of respondents exhibited a higher propensity of non-complaining behaviour, the results of the study are useful to the industry. In such a scenario, the provider will never get a chance to know about the dissatisfaction unless until they devise a proper enquiry mechanism. This gives a warning signal as the industry may never know the consumers' mindset as patient feedback through these private actions adopted is not directly reaching the service provider.

The results of this study conform to those of earlier studies [44] in which gender, education, and income had no significant influence on the complainers and non-complainers in the mobile telecommunication services sector. However, as far as the age and marital status of the respondents are concerned, these two variables appeared to have a significant influence on complaining behavior and hence their results are contradictory to those of the current study.Moreover, it is at variance with the findings that gender may have an influence on complaining and non-complaining

behaviors of consumers [46]. A significant positive relationship was proved between voicing behavior and age, gender, education and occupation [47]. Complainants had above average education, managerial or professional status and above-average income [18]. The results with respect to the variable 'occupation' in the current study are justified [43, 44], whereas the other variables are contradicted.

Post-operative medical conditions like nausea and vomiting, pain and other complications were found to be the reasons for dissatisfaction of surgical inpatients [48]. A study on the relation between patients' medical awareness and satisfaction [49] found that knowledge of diagnosis and disease complications was significantly associated with patient satisfaction. The relation between patient dissatisfaction and length of stay (LOS) in the hospital [50] found that whereas longer LOS patients complained about advice on illness, physicians' responsiveness, their attention to take care and their manners, shorter LOS patients were dissatisfied with laboratory and X-ray results, cleanliness of room, nurses' manners and staff coordination and cooperation.

SCOPE FOR FUTURE RESEARCH

Future research may concentrate on implementation of similar research design and methodology on different populations or different designs on the same population. A particular zone or district of Kerala with a larger sample size for an in-depth analysis of inpatient complaining behavior may be considered for bringing in better outcomes in the CCB of inpatients. Another possibility for future research could be to include personality attributes like extroversion, dogmatism and self-presentational concerns, or personal variables or situational factors like severity of illness as causal factors and study their influence on inpatients' complaining propensities. Considering other patient factors like psychographics, attitude towards complaining or other psychological variables may be a value addition to the CCB theory as far as their behavioural aspects are concerned. The study may be extended to other states and countries to explore whether CCB differs across geographies, the results of which might contribute to the extant literature. As studies have recognized the complaining behavior across cultures to be different, there also lies an opportunity to explore whether there is any difference in inpatient complaining behavior across collectivistic and individualistic cultures.

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