CHAPTER 7: LIMITATIONS AND DIRECTIONS FOR FUTURE RESEARCH

7.1 LIMITATIONS

The studies conducted here have a few limitations. The NFHS-3 dataset that was used for the first study did not have direct information regarding the crucial variables of income and accessibility. As a result proxy variables for both these variables were taken for analysis. Although the findings were in accordance with the proposed hypotheses related to these variables yet direct information on these variables would have resulted in more accurate assessment of the impact of these variables and a more meaningful comparison with the outcome of the second study. The data for the second study was restricted primarily to only one rural and urban area due to enormity of the exercise and paucity of resources. Comparison and validation of results of the first study would definitely benefit more from a pan-national data for the second study. Certain questions in the questionnaire administered for NFHS-3 as well as the second study were answered based on respondents’ memory of the past events (related to utilization of healthcare service). Hence, it is not very unexpected that a few possible errors could have been caused due to incorrect (though unmindful) reporting by the respondents.

7.2 DIRECTIONS FOR FUTURE RESEARCH

The studies conducted have opened up promising vistas for future research for determining choice of healthcare services. A longitudinal replication study to confirm the results of this study would always be a promising area for future research. The generalizability of the findings of the second study could be enhanced further by covering more rural and urban areas. Specific state related comparisons are very relevant for a diverse country like India and can also form one of the objectives of future research.
Even though the author has attempted to provide a logical explanation, some of the counterintuitive results observed from the studies merit further exploration. For example greater preference for public healthcare services as opposed to private healthcare services amongst higher educated urban individuals found in the second study. Similarly the preference of urban individuals in the second study for Indian medicine providers amongst the higher income group is another case that calls for further investigation.

Importance of accessibility in influencing healthcare provider’s choice in rural areas should also be investigated in future endeavors as the second study found that local conditions play a key role in determining the influence of accessibility. Results show that the cost of treatment has no influence on the choice between public and private providers for urban area. For a country whose per capita income is low and whose consumers are considered very price sensitive this result merits further exploration. As results of the second study on the relationship between insurance coverage and the choice of healthcare service provider were mixed, future research can also examine the role played by insurance by considering a larger and a more heterogeneous sample.

The degree of criticality of illness could play an important role in influencing the choice of provider for an individual. However in the absence of a scale that could assist a social science researcher in measuring the criticality of illness, it was not possible to include this aspect in the present dissertation. There is a scope for social science researchers to join hands with researchers from the medical science field to develop such a scale and apply it in future studies. Finally, given the cultural context of the region (collectivistic) family plays an important role in decision making in India and therefore future research may also attempt to capture the influence of other household members on decision/choice of healthcare services by any member.