The role of the universal health coverage in patients' behavioral intentions
A survey study in some primary health care centers in Al-Diwaniyah city center

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Abstract

The current study aimed to shed light on the impact of the universal health coverage in enhancing the behavioral intentions of the customer for a sample of (491) patients who belong to (18) primary health centers in Al- Diwaniyah city center. The variant of the universal health coverage includes three main dimensions which are population coverage, health services coverage and financial coverage while the variant of the behavioral intentions variant involves three dimensions which are the situational loyalty, tendency to switch and re-deal intention for the second time. The study adopted questionnaire as a basic measurement tool for gathering data that was dedicated to test the study main and subsidiary hypotheses through the use of a number of statistical means, the most prominent of which are (Pearson simple correlation coefficient, simple and multiple regression analysis). The study reached a set of conclusions, the most important of which is the existence of a correlative and impact relationship of the dimensions of the universal health coverage on the dimensions of the behavioral intentions of the patients.

Key words: universal health coverage, the patients behavioral intentions .

Introduction

The quality of health care is considered as the basis for the universal health coverage, because access to health care services without quality is an empty promise to achieve the universal health coverage. In addition, the provision of high quality health care for all may seem to be an ambitious idea, yet it can be achieved in all circumstances under good leadership, perfect planning and intelligent investment. And since health care services become more competitive, these services providers as well as academic researchers are increasingly interested in exploring how patients recognize the quality before building their own satisfaction and obtaining their own behavioral intentions, and according to what was mentioned above, the current study is trying to determine the level of universal health coverage through the health care centers for their wide impact on patients' behavioral intentions. In order to achieve its objective, the study has been structured into four axes; the first axis is the scientific methodology, the second axis was dedicated to the presentation of theoretical bases for universal health coverage and behavioral intentions, the third axis is allocated for presenting the practical framework while the fourth axis concluded with the presentation of the conclusions and recommendations of the study in the light of field results.

The first part : The Research methodology

First: The Research problem

The problem of the study can be summarized as the following questions: -

1. What is the range in which health care centers offer universal health coverage for patients?
2. What is the reality of behavioral intentions of patients benefiting from primary health care centers?
3. What is the impact of spatial, health and financial coverage on patients' behavioral intentions who get benefits from primary health care centers?

Second: The Research significance

1. The health care sector is considered as an important and vital sector and therefore, the concepts of quality and marketing must be employed as well as its modern administrative ideas for improving the level of services provided.
2. This study would contribute to bridge the gap between the reality of the health sector in our beloved country and what it should be similar to the neighboring countries that had gone a long way in this field.

3. We hope that this study will benefit health care centers in Iraq and health centers in particular, in forming a reliable integrated action plan to diagnose the way of dealing with the services provided by health centers in case of epidemics and diseases, and then contribute to processing and improvement in order to plant positive intentions in its customers.

Third: The Research objectives

The goal we all strive for is to ensure that everyone has the right to access to high quality health care services.

Accordingly, the current study aims at achieving a bunch of objectives whose the most prominent ones may include:

1. To begin to establish correct foundations to achieve universal health coverage and raise the level of quality of health services provided in primary health care centers.
2. To study and evaluate customers' level of behavioral intentions towards health care centers, through which their behavior can be predicted, which is considered as a basis for any marketing process.
3. To diagnose the extent to which workers in health centers provide high quality services to the customer that reflected on his/her future behavioral intentions.

Fourth: hypothesis of Research

Figure (1) shows hypothesis of Research, which shows effect of universal health coverage on behavioral intentions of patients

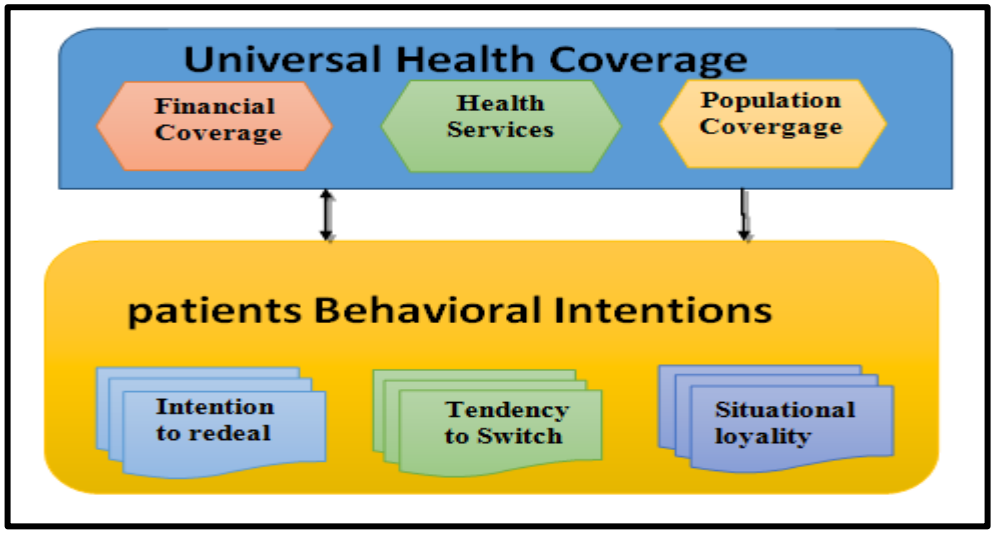

Figure (1) hypothesis of Research

Five: Research hypotheses

The first main hypothesis: There is a statistically significant linking relationship between universal health coverage in its components with behavioral intentions in its components. The following sub-hypotheses can be derived from this main hypothesis:

1. There is a statistically significant linking relationship between universal health coverage in its components with situational loyalty.
2. There is a statistically significant linking relationship between universal health coverage in its components with tendency to switch.
3. There is a statistically significant linking relationship between universal health coverage in its components with intention to re-deal for the second time.

The second main hypothesis: There is a statistically significant impact relationship between universal health coverage in its components with behavioral intentions in their components. The following sub-hypotheses can be derived from this main hypothesis:

1. There is a statistically significant impact relationship between universal health coverage in its components with situational loyalty.
2. There is a statistically significant impact relationship between universal health coverage in its components with tendency to switch.
3. There is a statistically significant impact relationship between universal health coverage in its components with intention to re-deal for the second time.

Six : Research methodology and tools

The current study follows the descriptive analytic approach in solving the problem and achieving the objectives of the study. Questionnaire was used as a main tool in this study and quinary Likert scale was used too, this scale ranges from (fully agree) for the highest and (not fully agree) for the lowest level of an answer. After extracting the study data, the Statistical Package for the Social Sciences (SPSS) was used and some statistical tools, which are (arithmetic mean, standard deviation, Cronbach's alpha and Correlation Coefficient-r value), were used too.

Seven: **Research sample**

The primary health care centers were selected in the city center of Diwaniyah as a society for the current study. The questionnaire forms were distributed in (18) health centers, (28) questionnaires for each center, (491) of them were returned back since

some of centers' managements agreed to cooperate with researchers in distributing the questionnaire forms directly among patients in health centers.

The second axis: Research theoretical side

First: Universal health coverage concept

Health care sector is one of the fastest growing sectors in the services economy and this growth is partly due to population aging, increased competitive pressure, increased consumption, modern treatments and techniques. Health care refers to health maintenance or improvement through prevention, diagnosis, treatment, recovery or disease or injury treatment and any other physical and mental disabilities among people (Dagger, etal., 2007: 123). The first who used the quality concept in the medical field was a British nurse called Falurans Nayitangil when she was supervising health care services in the hospital and was able to apply simple performance standards in her work which led to a noticeable decline in the number of deaths in that hospital (Who 2018: 2). Universal health coverage became a global health priority in the field of health as it rooted in the World Health Organization Constitution, which was adopted in 1948, and made health as one of the fundamental rights of every human being (Lucia,2013:4). The universal health coverage implies a legal framework for national governments to provide health care for all population with the obligation of the international community to support poor countries in the implementation of this right (Schwartz et al., 2007: 81). (Derkyi-Kewarteny et al., 2021: 1) defined it as one of the sustainable development goals, which ensure access to good basic health care services and access to basic and safe medicines which are effective, affordable and of reasonable quality and protected from financial risks. Depending on all what was mentioned above, it seems that universal health coverage is governmental efforts aimed at achieving preventive, therapeutic and habitational health care for individuals, family and society at appropriate prices which insure that all could get this health care. And this represents one of the sustainable development goals in today's world.

Second: Dimensions of universal health coverage

Accordance to the definition of the World Health Organization for universal health coverage, all individuals and communities need to get health services they need without financial sufferings, and these services include a full range of high quality basic health services, such as health enhancement to prevention, treatment, rehabilitation and palliative care. (Tao et al., 2019: 2).

1. **Population Coverage**: The universal health coverage means that everyone has access to high quality health services without financial difficulties. All individuals are looking to obtain high quality health care at appropriate prices. (Tichenor et al., 2017: 334).
2. **Health services coverage**: Health services include a range of procedures for prevention, treatment and health care. These services must be sufficient to meet the health needs (Mills et al., 2012: 126).
3. **Financial coverage**: The vision of the universal health coverage in 2030 is that services and high quality medicines should reach everyone in society at reasonable prices, and this will not only include enhancing financial systems, but also redeveloping the mechanism in which health care systems work (Carrin et al., 2004: 15).

Three: behavioral intentions

The goal of each organization is to meet the needs and requirements of stakeholders. Meeting the needs and requirements of stakeholders will not only guarantee the organization permanence, but will also make it prosper. The customer is supposed to be one of the most important stakeholders in any organization, without him/her, these organizations are unlikely to succeed. Marketers emphasize to research in consumer's behavior, especially behavioral intention. Knowing the customer's behavior will proceed along the way to ensure effective marketing policies towards the interest of customers, which will eventually facilitate the positive position of the customer towards organizations more specifically since the customer's behavioral intention is a strong indicator of his/her actual behavior (Maiyaki, 2011: 42). The behavioral intention of customers can be positive or unfavorable (Cuony, 2020: 1666). The positive behavioral intention often leads to connectivity with the service provider, increasing business size, and expressing positive praise for the service provider, on the contrary, unfavorable behavior intention leads to show customers' higher probability of brand switching, and planning to reduce their business size, and engage in negative oral speech, and show no desire to pay distinctive prices (Ladhari, 2009: 308) The behavioral intentions may be favorable or unfavorable depending on satisfaction, it is a precise indicator of actual behavior, customers who express positive behavioral intentions built a relationship with the organization (ZEITHAML & BITNER: 2000: 125). Therefore, (Amornkitpinyo et al, 2015: 2091) defined behavioral intention as the expected future or planned behavior to use a specific technique, this expectation is represented when the

customer may adopt a particular behavior in a specific situation. It was also defined by (Shen et al., 2020: 300) as the extent of difficulty of individuals' desire to try, and the amount of effort that is planning to pay for the behavior. The researcher defines behavioral intentions of the customer as the customer readiness to suggest the organization for others and his/her own continuous relationship with it through his/her re-dealing for more than once.

Four: Dimensions of behavioral intentions

The behavioral intentions are based on information from the same customer because he is able more than others to express his/her future behavior. Researchers emphasize that behavioral intentions are linked to the actual behaviors of customers. On the other hand, they can be a tool for predicting future behaviors of customers and customers may generate different behavioral intentions in the light of their experiences (Nawi et al., 2019: 148).

1. **Situational loyalty:** Customer loyalty illustrates customer relationship with a particular service provider and product preference or service over other alternatives, and when the customer is sincere behaviorally, he/she intends to rebuy the same brand and then maintain a relationship with a particular service provider. (Jones&Taylor,2007:147).
2. **Tendency to switch**: The behavioral intention can be recognized when organizations try to do less work with service provider in the coming period. Reputation, price, customer satisfaction and responses to service failure, service products, service quality, non-voluntary switch and customer's commitment, all have an important impact on customer's switching behavior (Vyas & Raitani, 2014: 322).
3. **Re-deal intention for the second time:** The intention to return represents the customer's desire to engage in frequent visits to the organization (Bujisic et al., 2014: 1273). The development of a high percentage of sincere consumers is the ultimate goal of marketing practitioners in order to determine those unsatisfied customers about the experience of service who seek to change the brand.

Five: The relationship between the two variables

Since health care services became more competitive, health care practitioners and academic researchers are increasingly interested in discovering the way in which patients recognize quality before building their satisfaction levels and generate their

behavioral intentions, and today, health organizations are increasingly aware of the need to concentrate on the quality of service as a measure to improve their competitive situation. Therefore, customer based determiners and service quality perceptions play an important role when choosing the health center (Arjun, 2013: 549). In recent years, there was an increasing interest in health centers' services as living levels changed and demand for better medical care increased to improve lifestyles, and improving the quality of health care services took a great deal of patients' attention, and to provide better service to patients, the quality of service became increasingly important for health centers especially with regard to patients' satisfaction and retention (Alhashem et al., 2011: 249). For example, (Meehan et al., 2002.) illustrated that understanding the of internal patients' evaluation of the quality performance of health centers services will improve the results of the current health care system and strengthen the quality of service, and therefore, the number of internal patients will increase and they will continue to visit their health centers (Arslasi et al., 2008:8). (Trumble et al.,2006:306) showed that patients are able to assess the skills of doctors and nurses when they deal with them. The ability of patients to understand and recognize the results of hospital services significantly affects the overall experiences of patient's evaluation. These results emphasize that the relationship between the patient and the doctor is significantly affected by the behavior of the interaction of service providers (doctors) and enhances patients' confidence in their doctors (Gaur et al., 2011).

The third axis: Research practical framework

First: Testing and developing the measurement tool

1. **Natural distribution test for data:**

a- Natural distribution test for independent variable of the universal health coverage.

The normality of universal health coverage distribution was assessed by adopting the (Kolmogorov-Smirnov Test), as we can note in Table (1) that the test statistics reached (0.021), while the moral level of statistics of the test (0.206) which is higher than the level (0.05) which refers that it is not moral, this indicates that all universal health coverage aspects are subject to natural distribution and it allows the use of parametric statistics in analysis and testing.

Table (1): The test of Kolmogorov-Smirnov of the independent variable explains the effectiveness of the universal health coverage

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
StrAgi	0.021	491	.206	0.621	491	0.031

a. Lilliefors Significance Correction

Source: outputs of (SPSS V.26) program

b- Natural distribution test for consolidated behavioral intent variable

The normality of universal health coverage distribution was assessed by adopting the (Kolmogorov-Smirnov Test), as we can note in Table (2) that the test statistics reached (0.034), while the moral level of statistics of the test (0.187) which is higher than the level (0.05) which refers that it is not moral, this indicates that all universal health coverage aspects are subject to natural distribution and it allows the use of parametric statistics in analysis and testing.

Table (2): The test of Kolmogorov-Smirnov of the adopted variable explains the behavioral intentions.

Tests of Normality

	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
EffOCM	0.034	491	.187	0.860	491	0.011

a. Lilliefors Significance Correction

Source: outputs of (SPSS V.26) program

2. Exploratory factor analysis

The results of the measurement of the exploratory factor analysis of the internal variables in this study are as follows:

a. The KMO test indicates that there is a relationship between the factors involved in universal health coverage variable, behavioral intentions variable, that indicates the adequacy of the sample size and that the value of the test is excellent and acceptable, in addition, the relationship among the implied factors is not linear and this what (Bartlett's) test referred to revealing that the linking matrix is not only one and that each variable represents itself.

b. The results of the table (3) showed that the test value (KMO = 0.802) for the universal health coverage, which is good according to (Kaiser, 1974) classification indicating that the size adequacy of the studied sample and the factors in variable analysis of the universal health coverage represent themselves, and that the valuable square chi-square (8441.130) supports this theory, with a degree of freedom equal to (490).

c. The results of the table (3) showed that the test value (KMO = 0.871) for the behavioral intentions variable, which is good according to (Kaiser, 1974) classification indicating that the size adequacy of the studied sample and the factors in variable analysis of the universal health coverage represent themselves, and that the valuable square chi-square (3251.933) supports this theory, with a degree of freedom equal to (490).

Table (3) the link strength among the study variable factors

KMO and Bartlett's Test			
Variables		**Health coverage**	**Behavioral intentions**
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		0.802	0.871
Bartlett's Test of Sphericity	**Approx. Chi-Square**	8441.130	3251.933
	df	490	
	Sig.	0,000	

3. Confirmatory construct validity test

In building the sample, the accuracy and objectivity of the sample must be measured in order to decide either to be accepted or rejected through a range of sample quality indicators. Table (4) below shows goodness-of-fit index that aim at measuring the strength of structural equation modeling.

Table (4) **Goodness-of-Fit** indicators

No.	General rule		General rule
A	**(Goodness-of-Fit) index**		
	1	**and x^2 Rate of Chi-square value (df) degree of freedom**	**Less than 5**
	2	**Goodness-of-fit index (GFI)**	**Higher than 0.90**
	3	**Adjusted Goodness-of-Fit Index (AGFI)**	**Higher than 0.90**
	4	**The Root Mean Square Error of Approximation (RMSEA)**	**Between 0.08 - 0.05**
B	**(Standardized Regression Weights)**		**Accepted weights are 0.30 or higher**

Source: Hair, J.F., Black, W.C., Babin, B.J., & Anderson, R.E. (2010).

"Multivariate Data Analysis" ,7th ed., Prentice Hall, Upper Saddle.

Confirmatory Factor Analysis results were as the following:

A. Confirmatory Factor Analysis of the universal health coverage variable:

The structural figure was built, it aimed at measuring the extent to which items belong to the dimensions of the universal health coverage and then extract the universal quality indicators to judge accuracy and acceptance of the sample, and therefore, the confirmatory construct schema is designed for universal health coverage items by using the statistical package of (AMOS.V.25). The results of figure (1) shows that the value of chi-square (X2) to the degree of freedom reached (3.275) and the goodness-fit index (GFI) equals to (0.936), and with an adjusted goodness-fit index AGFI of (0.928), with a root mean square error of approximation of (0.057) and therefore, the presented results showed that the sample was accepted since they met the conditions reflected in table (5), indicating the capabilities of health staff management to invest in the universal health coverage in order to

improve their capabilities of population and financial coverage, and health services in a way that it serves the interests of the center and citizens in general.

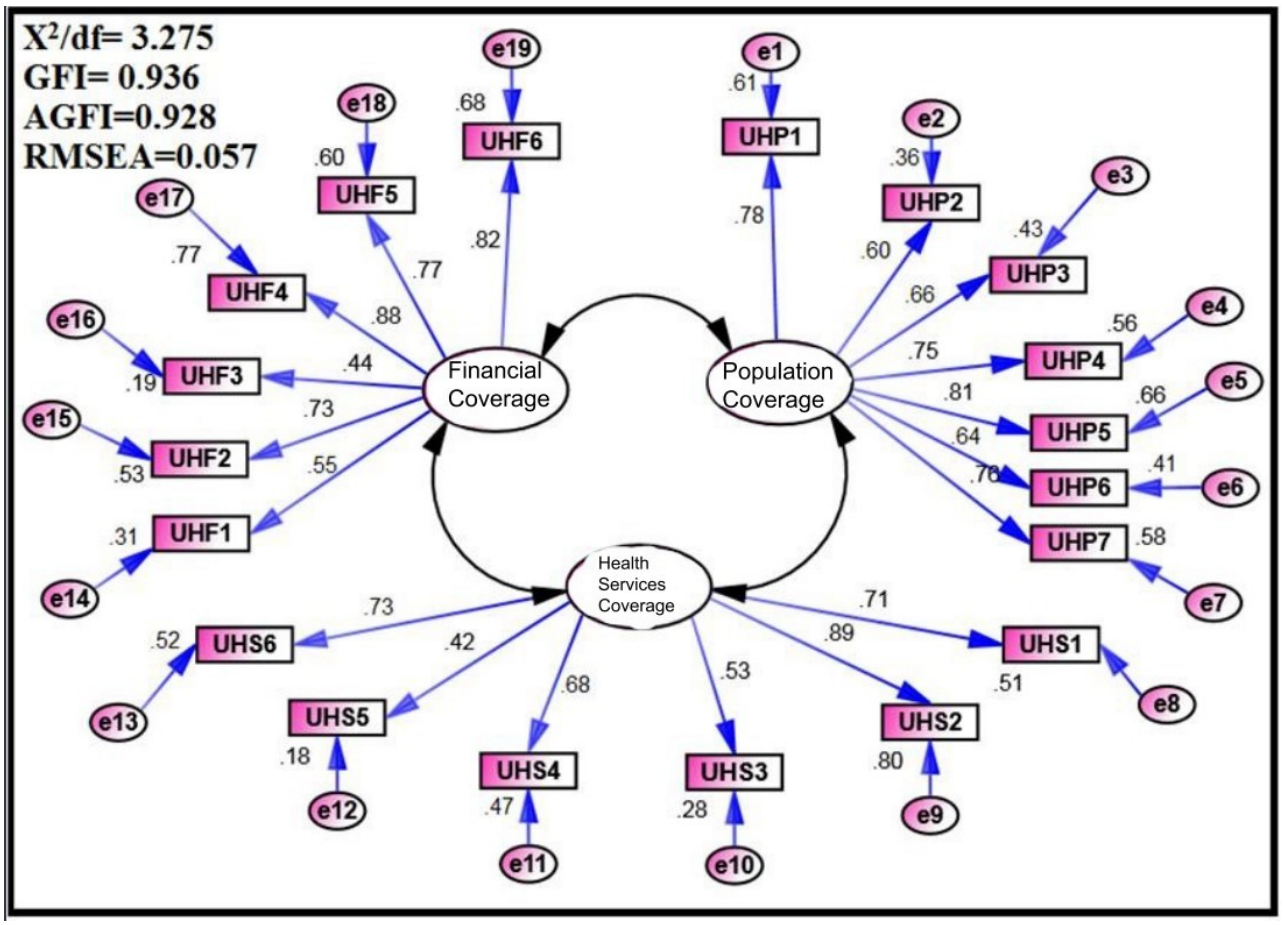

Figure (1) The structural model of the universal health coverage variable

Table (5) Confirmatory Factor Analysis units to measure the independent variable of the universal health coverage

Health Services Coverage				Population Coverage			
SRW	**Item**	**Track**	**Dimension**	**SRW**	**Item**	**Track**	Dimension
0.713	UHS1	<---	**UHS**	0.778	UHP1	<---	UHP
0.892	UHS2	<---	**UHS**	0.599	UHP2	<---	UHP
0.532	UHS3	<---	**UHS**	0.655	UHP3	<---	UHP
0.682	UHS4	<---	**UHS**	0.751	UHP4	<---	UHP
0.424	UHS5	<---	**UHS**	0.811	UHP5	<---	UHP
0.723	UHS6	<---	**UHS**	0.638	UHP6	<---	UHP
				Financial Coverage			
				0.553	UHF1	<---	UHP
				0.730	UHF2	<---	UHF
				0.441	UHF3	<---	UHF
				0.878	UHF4	<---	UHF
				0.774	UHF5	<---	UHF
				0.825	UHF6	<---	UHF
				0.760	UHP7	<---	UHF

Source: Program Output (AMOS V.23)

B. Confirmatory factor analysis of behavioral intentions variable:

The results of Figure (2) indicate that the value of chi-square is (X2) and the degree of freedom is (4.628) with a goodness-fit index of (0.917), and with an adjusted goodness-fit index AGFI of (0.905), with a root mean square error approximation RMSEA of (0.072). Therefore, the presented results shows the acceptance of the sample since they met the conditions reflected by Table (6), indicating the indicating the capabilities of health staff management to enhance the behavioral intentions order to improve their capabilities of towards the situational loyalty, tendency to switch and re-dealing for the second time in a way that it serves the interests of the center and citizens in general.

Figure (2) The structural model of behavioral intentions

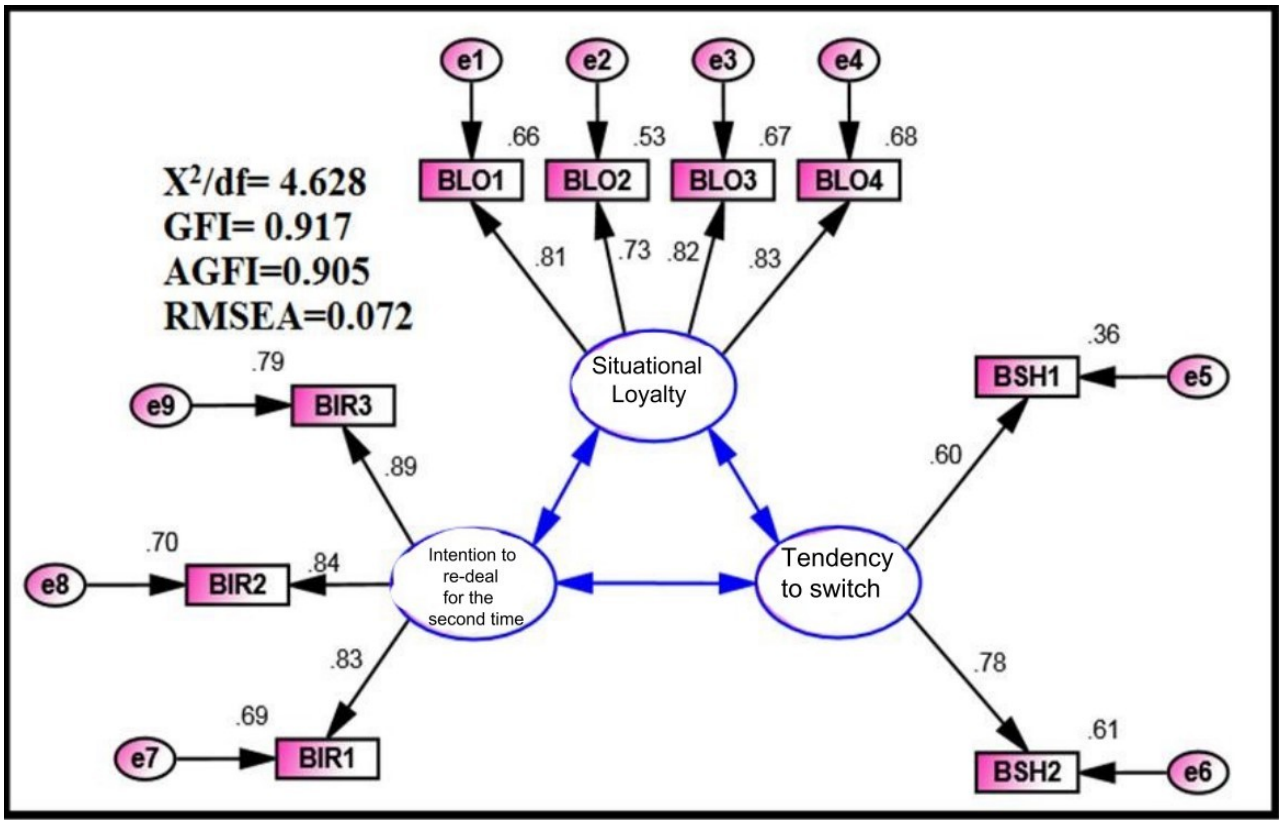

Table (6) Confirmatory Factor Analysis units for measuring behavioral intentions

Re-deal intention for the second time (BIR)				Situational Loyalty (BLO)			
SRW	**Item**	**Track**	**Dimension**	**SRW**	**Item**	**Track**	Dimension
0.828	BIR1	<---	**BIR**	0.812	BLO1	<---	BLO
0.835	BIR2	<---	**BIR**	0.727	BLO2	<---	BLO
0.887	BIR3	<---	**BIR**	0.817	BLO3	<---	BLO
				0.826	BLO4	<---	BLO
				Tendency to switch (BSH)			
				0.597	BSH1	<---	BSH
				0.783	BSH2	<---	BSH

4. Stability coefficient test for the measurement tool

In order to identify the validity of the scale and steadfastness of the questionnaire, the researcher adopted the Cronbach's Alpha test, which is considered as one of the best methods for the stability of behavioral tests. The results of the table (7) indicate that Cronbach's Alpha processes for the variables involved in the analysis reached higher than (0.75) indicating that the

measurement tool is characterized with relatively high stability, in addition, all values have ranged between (0.958-0.965), which are statistically accepted values and that indicates that the measurement tool is suitable with patients' responses towards health centers in the province.

Table (7) Cronbach's Alpha processes for variables and dimensions of the study

No.	Dimensions and variables	Cronbach's Alpha factor
1	**Population coverage**	**0.961**
	Health services coverage	**0.960**
	Financial coverage	**0.962**
	Universal health coverage	**0.959**
2	**Situational loyalty**	**0.958**
	Tendency to switch	**0.963**
	Re-deal intentions	**0.965**
	Behavioral intentions	**0.958**

Source: Prepared by the researcher depending on SPPS V.26 outputs

5. **Internal consistency test:**

The researcher adopted Pearson's correlation factor to know the moral link between those variables, dimensions and their items as these moral links indicate the strength of the adopted test.

1. **Internal consistency of dimensions and variables of universal health coverage**

   The results of table (8) indicate that the processes of internal correlations between dimensions and variables on the one hand, and items, dimensions and variables on the other hand, are higher than (0.60) and ranged between (0.606 - 0.863) and this indicates stability of the items of the universal health coverage.

Table (8) the internal consistency of dimensions of universal health coverage variables

Universal health coverage variable								
Items' connection to dimension								
			Items' connection to variable					
						Dimension's connection to variable		
								First dimension : population coverage
		0.781			0.663			UHP1
		0.863			0.633			UHP2
		0.609			0.680		**0.938**	UHP3
		0.783			0.767			UHP4
		0.670			0.730			UHP5
		0.758			0.606			UHP6
		0.692			0.782			UHP7
								Second dimension : health services coverage
	0.638			0.623				UHS1
	0.612			0.727				UHS2
	0.703			0.736			**0.903**	UHS3
	0.616			0.701				UHS4
	0.810			0.641				UHS5
	0.763			0.728				UHS6
							Third dimension : financial coverage	
0.675			0.770				**UHF1**	
0.808			0.754				**UHF2**	
0.795			0.643			**0.928**	**UHF3**	
0.847			0.748				**UHF4**	
0.749			0.642				**UHF5**	
0.843			0.703				**UHF6**	

Source: Prepared by the researcher depending on SPSS V.26 outputs

2. Internal consistency of the dimensions and items of behavioral intentions variable

The results of table (9) indicate that the processes of internal correlations between dimensions and variables on the one hand, and items, dimensions and variables on the other hand, are higher than (0.60) and ranged between (0.649 - 0.935) and this indicates stability of the items of the universal health coverage.

Table (9) the internal consistency of items and dimensions of universal health coverage variable

Behavioral intentions variable									
Items' connection to dimension									
			Items' connection to variable						
						Dimension's connection to variable			
									First dimension : Situational loyalty
		0.781			0.663				UHP1
		0.863			0.633			**0.919**	UHP2
		0.609			0.680				UHP3
		0.783			0.767				UHP4
		0.670			0.730				UHP5
		0.758			0.606				UHP6
		0.692			0.782				UHP7
									Second dimension : tendency to switch
	0.638			0.623					UHS1
	0.612			0.727					UHS2
	0.703			0.736			**0.807**		UHS3
	0.616			0.701					UHS4
	0.810			0.641					UHS5
	0.763			0.728					UHS6
									Third dimension : re-deal intention for the second time
0.675			0.770						**UHF1**
0.808			0.754						**UHF2**
0.795			0.643			**0.872**			**UHF3**
0.847			0.748						**UHF4**
0.749			0.642						**UHF5**
0.843			0.703						**UHF6**

Second: Research statistical description and analysis

1. Description and diagnosis of the universal health coverage

The results of table (10) showed that the arithmetic mean of the universal health coverage variable reached (3.85), and it is going forward to a high agreement level, and a standard deviation of (0.562) and relative importance of (77%). This shows that the health care centers are interested in population coverage aspect at an arithmetic mean of (3.9) and a standard deviation of (0.606) and a relative importance reached (78%). In addition, this indicates the necessity to pay attention to health care centers in terms of improving health services in an arithmetic mean of (3.80) and a standard deviation of (0.565) and a relative importance of (76%), indicating that the interest of health centers in treating all patients of the health center stimulates patients to deal with this particular center only.

Table (10) Arithmetic means, standard deviations and the relative importance of the dimensions the universal health coverage variable

Dimension	Arithmetic mean	Standard deviation	Response orientation	Relative importance %	Importance rank
Population coverage	3.9	0.606	High	78%	**First**
Health services coverage	3.80	0.565	High	76%	**Third**
Financial coverage	3.86	0.654	High	77%	**Second**
	3.85	**0.562**	High	**77%**	***
General average of the universal health coverage					

2. Descriptive analysis of the customer's behavioral intentions

The results of table (11) showed that the arithmetic mean of the customer's behavioral intentions reached (3.98), and it is going forward to a high agreement level, and a standard deviation of (0.668) and relative importance of (80%). This shows that the health care centers are interested in the tendency to switch aspect at an arithmetic mean of (4.11) and a standard deviation of (0.766) and a relative importance reached (82%). In addition, this indicates the necessity to pay attention to health care centers in terms of improving the intention to re-deal for the second time in an arithmetic mean of (3.88) and a standard deviation of (0.886) and a relative importance of (78%), referring to

the interest of health centers in meeting all patients' requirements and that stimulates patients to re-deal with the center.

Table (11) Arithmetic means, standard deviations, and relative importance of the dimension of the behavioral intention variable

Dimension	Arithmetic mean	Standard deviation	Response orientation	Relative importance %	Importance rank
Situational loyalty	3.95	0.667	High	79%	**Second**
Tendency to switch	4.11	0.766	High	82%	**First**
Re-deal intention for the second time	3.88	0.886	High	78%	**Third**
	3.98	**0.668**	High	**80%**	***
General average of the customer's behavioral intentions					

Third: Research hypothesis test

1. **The first main hypothesis test.**
   (There is a correlative relation of a moral indication between the universal health coverage and the behavioral intentions)
   The results of Table 12 show a statistical relationship between the universal health coverage and the customer's behavioral intentions and at (0.711) and at a moral level of (0.01) which is a strong positive correlation accordance to Cohen el., 1983: 2) which indicates that the interest of health centers in improving its coverage will be reflected positively on the improvement of the situational loyalty and reduces the possibility of the tendency to switch, and raise the intention of re-dealing for the second time. In addition, there is a linking relationship with the dimensions of customer's behavioral intentions and at (0.518) for the re-deal intentions for the second time and at (0.760) for the dimension of the situational loyalty. It means that the interest of health centers in improving the situational loyalty through social media contributes in stimulating patients to re-deal with the health center.

Table (12) The correlation matrix of the dimensions of the universal health coverage and the dimensions of the customer's behavioral intentions

Variables	Population coverage	Services coverage	Financial coverage	Universal health coverage	Situational loyalty	Tendency to switch	Re-deal for the second time intention	Behavioral Intentions
Population coverage	1							
Health services coverage	.783**	1						
Financial coverage	.815**	.738**	1					
Universal health coverage	.938**	.903**	.928**	1				
Situational loyalty	.657**	.769**	.686**	.760**	1			
Tendency to switch	.596**-	.539**-	.526**-	-.599**	.659**-	1		
Intention to re-deal for the second time	.353**	.691**	.410**	.518**	.758**	.466**	1	
Behavioral intentions	.602**	.768**	.611**	.711**	.919**	.807**	.872**	1
**. Correlation is significant at the 0.01 level (2-tailed).								
n = 491				Sig. (2-tailed) = 0.000				

Source: Prepared by the researcher depending on (Microsoft Excel, SPSS) out puts

Depending on what was mentioned above, the first main hypothesis can be accepted.

2. **The second main hypothesis test.**

   (There is an impact of a moral indication for the universal health coverage and the customer's behavioral intentions)

   The results of table (13) and illustrated in figure (3) indicate that there is an impact of the universal health coverage on the customer's behavioral intentions. The universal health coverage contributed in the explanation of (0.38) of cases that limit the capability of health care centers to pay attention to the customer's behavioral intentions and this indicates that the increasing of the universal health coverage by a single unit leads to the increasing of the customer's behavioral intentions at (0.792) and with a standard error of (0.046) and a critical value of (17.217) and at the same time, () of changes in behavioral intentions belongs to other factors not included in the model .

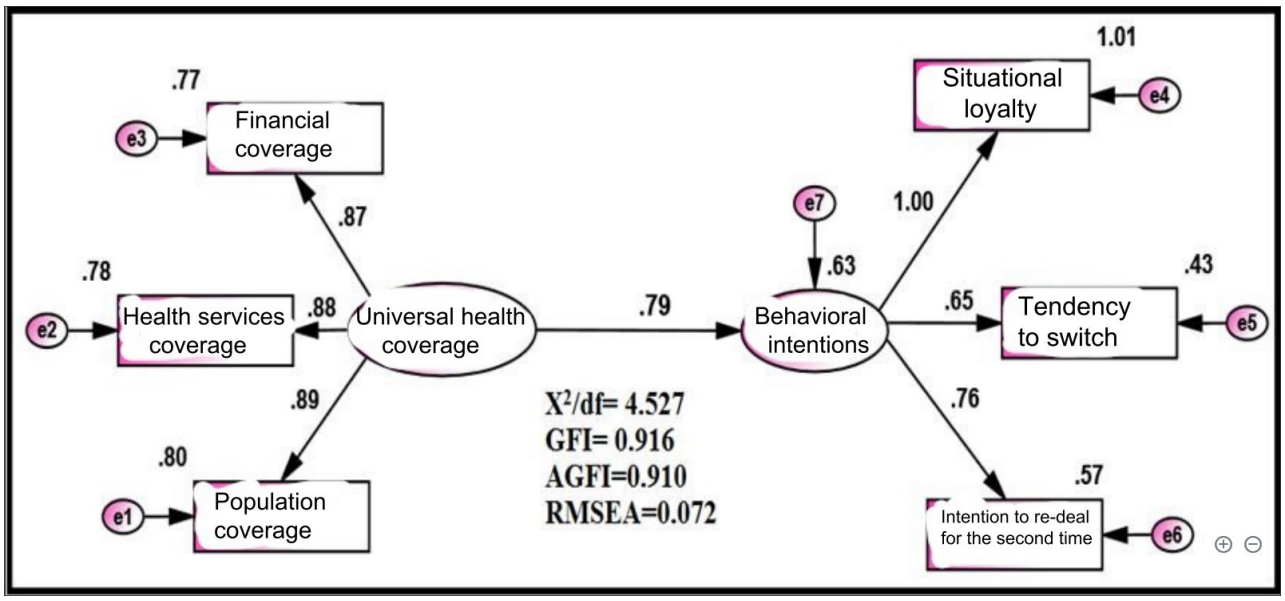

Figure (3) Contractual model for the impact of the dimensions of the universal health coverage on the customer's behavioral intentions

Table (13) Impact analysis of the universal health coverage on the customer's behavioral intentions

Regression track			SRW	Standard error	Critical rate	Determination factor R2	Possibility (P)	Kind of impact
Universal health coverage	**--->**	**Customer's behavioral intentions**	0.792	0.046	17.217	0.38	***	Moral

The fourth axis: Conclusions and recommendations

First: Conclusions

1. The study concluded that government efforts, which are meant to obtain patients to health, preventive and therapeutic services, positively affect the behavioral intentions of these patients and their loyalty and their intention to re-deal.
2. The results of the study proved that all patients have the right to take advantage of health centers and their service coverage in terms of providing services or protection from the economic consequences of using such services. All this would improve the level of patients' situational loyalty and minimize their tendencies to switch from a health center to another, and improve their intentions to repeat dealing with the health center they deal with.

3. The study highlighted results are that patients have an intention to repeat dealing with the health centers they deal with due to their confidence that these centers are doing their best especially through the recent health challenges and the government's austerity policy.
4. It was noted that patients have no desire or intention to abandon health centers they currently deal with, even if their places of residence were changed or they got any other additional services from other health centers, and therefore, the studied health centers were able to retain their current customers despite their difficulties.
5. Primary health care centers succeeded to publish and distribute guides, warning and instructional posters to educate patients about appropriate preventive and therapy procedures for some cases of transitional and contagious diseases, for example, Corona virus or bacterial diseases.

Second: Recommendations

1. Primary health care centers have to increase the level of patients' confidence in their services by paying attention to the appearance of the centers or doctors being wearing their official medical uniforms by conducting awareness and educational campaigns, and not to oblige if such campaigns are not effective.
2. The administrations of health centers have to conduct surveys from time to time to learn about the level of patients' satisfaction and acceptance of the services of these centers and the way they are treated by these centers' staff members through the centers websites or by giving the patients short questionnaires to determine the most prominent weaknesses in order to avoid them.
3. It is important for health centers to increase the loyalty level their patients by focusing attention on aspects that increase the level of positive feelings and reduce the level of negative feelings. That can achieved by enhancing psychological and emotional links with patients, in order to reach the status of integration between patients and health centers that are used to deal with.

References

1. Alhashem, A.M., Alquraini, H. and Chowdhury, R.I. (2011), "Factors influencing patientsatisfaction in primary healthcare clinics in Kuwait", International Journal of Health Care Quality Assurance, Vol. 24 No. 3, pp. 249-262.

2. Amornkitpinyo, T., & Wannapiroon, P.(2015). Causal Relationship Model of the Technology Acceptance Process of Learning Innovation in the 21 ST Century for Graduate Students. Procedia-Social and Behavioral Sciences, 174, 2090-2095.

3. Arasli, H., Ekiz, E.H. and Katircioglu, S.T. (2008), “Gearing service quality into public and private hospitals in small islands”, International Journal of Health Care Quality Assurance, Vol. 21 No. 1, pp. 8-23.

4. Arjun Murti& Aashish Deshpande & Namita Srivastava,(2013), "Patient Satisfaction and Consumer Behavioural Intentions: An Outcome of Service Quality in Health Care Services",Journal of Health Management,15(4) 549–577.

5. Bujisic, M., Hutchinson, J., & Parsa, H. G. (2014). The effects of restaurant quality attributes on customer behavioral intentions. International Journal of Contemporary Hospitality Management, pp.1273.

6. Carrin Guy et James Chris,(2004) Atteindre la couverture universelle par l'assurance maladie obligatoire : Problématiques conceptuelles-clé Durant la période detransition, Organisation Mondiale de la Santé, Genève, p.15.

7. Cuong, D. T. (2020). The effect of physical environment and perceived value on customer satisfaction and behavioral intention at the cinema in Vietnam. Test Engineering and Management, 82(1-2), 1665-1674.

8. Cohen, J., Cohen, P., West, S. G., & Aiken, L. S. (1983)," Applied Multiple Regression/Correlation Analysis for the Behavioral Sciences", 3rd Edition, Mahwah, NJ: Lawrence Erlbaum Associates.pp.2.

8. Dagger Tracey S., Jillian C. Sweeney & Lester W. Johnson (2007) "A Hierarchical Model of Health Service Quality Scale Development and Investigation of an Integrated Model" Journal of Service Research, Volume 10, No. 2, November 2007 123-142.

9. Derkyi-Kwarteng, A. N. C., Agyepong, I. A., Enyimayew, N., &Gilson, L. (2021). A narrative synthesis review of out-of-pocket payments for health services under insurance regimes: a policy implementation gap hindering universal health coverage in sub-Saharan Africa. International Journal of Health Policy and Management,pp.1.

10. Gaur, S.S., Xu, Y., Quazi, A. and Nandi, S. (2011), “Relational impact of service providers’ interaction behavior in health care”, Managing Service Quality, Vol. 21 No. 1, pp. 67-87.

11. Hair, J.F., Black, W.C., Babin, B.J., & Anderson, R.E. (2010). "Multivariate Data Analysis" ,7th ed., Prentice Hall, Upper Saddl,pp.664.

11. Jones, M.A., Suh, J.:(2007) Transaction-Specific Satisfaction And Overall Satisfaction: An Empirical Analysis. Journal Of Services Marketing 14(2),pp. 147-159.

12. Ladhari, R. (2009) b. Service quality, emotional satisfaction, and behavioural intentions: A study in the hotel industry. Managing Service Quality.Vol. 19 No. 3, pp. 308-331.

13. Lucia D'Ambruoso, (2013), Global health post-2015: the case for universal health equity, Global Health ,pp1-6.

14. Maiyaki , Audu &Mokhtar ,Sany Mohd,(2011)," Determinants of Customer Behavioural Intention in Nigerian Retail Banks* ",Interdisciplinary Journal of Research in Business Vol. 1, Issue. 10, (pp.42- 48) November.

15. Mills A, Ataguba JE, Akazili J, Borghi J, Garshong B, Makawia S, (2012). Equity in financing and use of health care in Ghana, South Africa, and Tanzania: implications for paths to universal coverage. Lancet. 2012;pp.126–133.

16. Nawi, N. M., Hashim, N. A. A. N., Shahril, Z., & Hamid, R. (2019). Airbnb Physical Environment Attributes and Customer Behavioral Intention: A Proposed Study. International Journal of Academic Research in Business and Social Sciences, 9(8), pp.144-151.

17. Schwartz J, Evans RG, Greenberg S. (2007),Evolution of health provision in Pre-SARS China: the changing nature of disease prevention. China Review ;7:pp.81–104.

18. Cui, W., Shen, H., Yan, Y. Q., & Shi-zheng, H. (2020). The Impact of E-service quality in P2P accommodations on Customer Behavior Intention: Evidence from Chinese Customers. Revista Argentina de Clínica Psicológica, 29(5),pp. 30

19. Tao, W., Zeng, Z., Dang, H., Lu, B., Chuong, L., Yue, D., & Kominski, G. F. (2020). Towards universal health coverage: lessons from 10 years of healthcare reform in China. BMJ global health, 5(3), pp.1.

20. Tichenor, M., & Sridhar, D. (2017). Universal health coverage, health systems strengthening, and the World Bank. Bmj,pp.334.

21. Trumble, S.C., O'Brien, M.L., O'Brien, M. and Hartwig, B. (2006), "Communication skills training for doctors increase patients' satisfaction", Clinical Governance: An International Journal,Vol. 11 No. 4, pp. 299-307.

22. Vyas, V., & Raitani, S. (2014). Drivers of customers' switching behavior in Indian banking industry. International Journal of Bank Marketing, 32(4), 321 – 342.

23. World Health Organization. (2018). Delivering quality health services: a global imperative for universal health coverage. World Health Organization,PP.2

23. Zeithaml, V. A., & Bitner, M. J. (2000). Services Marketing, 2/e, Tata McGraw-Hill Publishing Company Limited. New Delhi, pp.125