

DETERMINANTS OF PATIENT CHOICE IN DENTAL SERVICES: THE ROLE OF REPUTATION AND PERCEIVED RISK

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ABSTRACT

Patients increasingly act as informed consumers when selecting dental providers, yet the mechanisms shaping their choice remain underexplored in emerging markets. This study examines how clinic reputation, price perception, and perceived risk influence patients' choice intention, with patient trust as a mediating mechanism. Drawing on trust theory and perceived-risk theory, the model treats clinic reputation, price perception, and perceived risk (pain, cost, and safety concerns) as antecedents of patient trust, which in turn drives choice intention. Using a cross-sectional survey design, data modelled on the Vietnamese private-dental context were analysed for a sample of 340 patients by partial least squares structural equation modelling (PLS-SEM). In this study, clinic reputation ($\beta = 0.41$) and price perception ($\beta = 0.24$) positively affected patient trust, perceived risk negatively affected trust ($\beta = -0.29$), and patient trust positively affected choice intention ($\beta = 0.58$); trust mediated the antecedent–choice relationships. The model accounted for an estimated 47% of the variance in choice intention. All numerical values are simulated for demonstration and must not be interpreted as empirical findings. The study extends trust- and risk-based models to dental-service choice and offers managerial implications for patient-centered clinic strategy.

Key words: Patient choice, Clinic reputation, Perceived risk, Patient trust, Dental services, PLS-SEM.

Introduction

The market for dental services has become increasingly competitive, particularly in fast-growing urban economies where private clinics multiply and patients exercise wide choice. In this environment, patients behave less like passive recipients of care and more like informed consumers who weigh reputation, price, and risk before committing to a provider [1-4]. Understanding what drives this choice is therefore both theoretically interesting and practically important for clinics seeking to attract and retain patients.

In Vietnam specifically, private dentistry has expanded rapidly over the past decade, driven by rising incomes, growing demand for cosmetic and restorative procedures, and limited public-sector capacity in this area. Most dental care is paid out of pocket, which makes patients highly sensitive to price and acutely aware of the financial risk attached to their choice. At the same time, reliable, standardised information about clinical quality is scarce, so patients lean heavily on reputational cues and on the trust they place in a particular clinic. These conditions make the Vietnamese private-dental market an informative setting in which to study how reputation, price, and risk combine to shape choice.

The nature of dental care uniquely amplifies the significance of trust and perceived risk. Because these services possess high credence qualities, patients frequently struggle to assess technical proficiency even post-treatment while facing inherent anxieties regarding potential discomfort,

financial unpredictability, and safety standards [5-7]. Amidst such ambiguity, individuals utilize visible indicators, such as a practice's standing and price equity, to cultivate trust, which effectively mitigates the perceived hazards associated with provider selection [8-10]. Consequently, trust functions as a critical mediating variable, bridging the gap between these evaluative signals and the final decision-making process. This dynamic underscores why building patient confidence remains essential for navigating the complexities of modern dental service acquisition.

While healthcare service quality and patient satisfaction are well-documented, limited research explores how reputation, price perception, and perceived risk collectively influence dental-service selection through trust. This deficiency is particularly notable in emerging markets like Vietnam, where private dentistry is burgeoning amidst high out-of-pocket expenditures [9, 11-13]. Such theoretical gaps carry significant implications: by failing to model trust as a primary mediator, clinics may mistakenly treat these variables as independent operational levers. Consequently, practitioners miss opportunities to integrate these elements into a cohesive, strategic framework designed to effectively cultivate patient trust and secure long-term service loyalty.

The objective of this study is to test how clinic reputation, price perception, and perceived risk shape patients' choice intention in dental services and whether patient trust mediates these relationships. Drawing on an integrative model of trust [8, 14] and perceived-risk theory [5, 15], we

specify clinic reputation, price perception, and perceived risk as antecedents of patient trust, which in turn drives choice intention. The study contributes a parsimonious, testable model of dental-service choice, a reusable measurement protocol, and a transparent reporting template that distinguishes methodological scaffolding from empirical claims.

Conceptual framework and hypotheses

The framework rests on two complementary theoretical foundations. The integrative model of trust holds that trust—a willingness to be vulnerable based on positive expectations—is built on perceptions of the trustee's ability, benevolence, and integrity, and that trust translates into risk-taking behaviour in a relationship [8]. Perceived-risk theory holds that consumers anticipate potential losses across multiple facets and that these anticipated losses inhibit favourable evaluations and behaviour [5]. Read together, the two theories imply a chain in which evaluative cues about a clinic shape patients' trust, which in turn governs their willingness to choose the clinic despite the inherent risks of dental treatment. Within this chain, clinic reputation and price perception are positive trust-building cues, perceived risk is a trust-eroding force, and patient trust is the proximal determinant of choice intention.

Clinic reputation

Clinic reputation is the aggregate perception of a clinic's competence, reliability, and standing among patients and the wider community [16]. As a credible external signal of quality, reputation is especially influential in credence-heavy services where direct quality assessment is difficult; it reassures prospective patients that the clinic has consistently delivered acceptable care [17]. A strong reputation, thereby, fosters trust by signalling competence and integrity before any personal experience occurs [1, 18, 19]. Reputation is therefore expected to enhance patient trust.

H1. Clinic reputation positively affects patient trust.

Price perception

Price perception refers to patients' subjective evaluation of a clinic's prices, including their perceived fairness and reasonableness relative to the benefits expected [20, 21]. In out-of-pocket dental markets, price is a salient and sensitive cue. Perceptions of fair, transparent pricing can build trust by signalling that the clinic is not exploiting patients' limited ability to judge technical quality, whereas opaque or seemingly excessive pricing erodes it [22-24]. Fair price perception is therefore expected to strengthen patient trust.

H2. Favourable price perception positively affects patient trust.

Perceived risk

Perceived risk is the patient's expectation of potential negative outcomes associated with choosing a dental

provider, spanning performance risk (fear of pain or poor results), financial risk (uncertain or escalating cost), and safety/psychological risk (concerns about hygiene, complications, or distress) [5, 25, 26]. Perceived-risk theory holds that such anticipated losses inhibit favourable evaluations and behaviours. In healthcare, higher perceived risk undermines trust by amplifying the sense of vulnerability and the salience of what could go wrong [11, 27, 28]. Perceived risk is therefore expected to reduce patient trust.

H3. Perceived risk negatively affects patient trust.

In dentistry, three distinct dimensions of risk significantly influence patient perceptions and often function via separate mechanisms. Performance risk is notably pronounced, as dental interventions are physically intrusive and carry visible clinical outcomes, leading to concerns regarding pain or treatment failure. Financial risk remains prevalent, driven by the ambiguity of potential costs and the common adjustment of treatment plans, particularly within out-of-pocket systems. Furthermore, safety and psychological risks involve apprehensions regarding sanitation, cross-contamination, and general dental anxiety. Given that trust necessitates an acceptance of vulnerability, heightened risk perceptions in any of these areas inevitably erode patient confidence. Consequently, dental practices that proactively address these concerns through effective pain management, clear financial transparency, and rigorous hygiene standards are better positioned to foster the essential climate of trust required for patients to confidently seek care and commit to treatment.

Patient trust and choice intention

Trust is the willingness of a party to be vulnerable to the actions of another based on positive expectations of that party's conduct [8]. In healthcare, patient trust reduces the perceived vulnerability inherent in seeking care and is consistently linked to favourable behavioural intentions, including provider choice, revisit and recommendation [1, 29-31]. When patients trust a clinic, the uncertainty surrounding treatment quality and outcomes feels manageable, lowering the psychological barriers to choosing that provider. Accordingly, patient trust is expected to be the proximal driver of choice intention and the construct through which more distal cues exert their influence.

H4. Patient trust positively affects choice intention.

The mediating role of trust

Collectively, this framework illustrates how patient trust serves as the vital conduit through which reputation, price perceptions, and risk assessments influence selection intentions. While strong reputation and equitable pricing bolster trust, perceived risk serves to erode it; subsequently, trust determines the patient's final clinic choice. This mediating structure suggests that each antecedent indirectly

impacts choice intention, with the presence and significance of direct paths determining whether the mediation is partial or full [32, 33].

H5. Patient trust mediates the effects of clinic reputation, price perception and perceived risk on choice intention.



Figure 1. Proposed research model.

Materials and Methods

Sample and data collection

A cross-sectional, questionnaire-based survey design was adopted to test the hypothesised model. The target population comprised adult patients who had used or were actively choosing dental services at private clinics. For this report, a sample of 340 patients was specified, which satisfies common PLS-SEM rules of thumb concerning the ratio of observations to structural paths and provides adequate power to detect small-to-medium effects [33, 34]. In an actual deployment, a combination of on-site and online administration across multiple clinics would improve representativeness, and screening would confirm recent service use or active choice. **(Table 1)** presents the profile of the simulated sample; all values are placeholders calibrated to plausible patterns among urban Vietnamese dental patients.

Table 1. Sample characteristics (n = 340)

Demographics	f	%
Gender: Female	194	57.1
Gender: Male	146	42.9
Age 18–29	112	32.9
Age 30–45	146	42.9
Age > 45	82	24.1
Experience: First-time chooser	98	28.8
Experience: Returning patient	242	71.2
Service: Preventive/check-up	156	45.9
Service: Restorative/cosmetic	184	54.1

Note. f = Frequency, % = Percentage. All values simulated.

Measurement scales

All constructs were measured reflectively using multi-item scales adapted from prior validated studies and rated on a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). Clinic reputation was measured with items reflecting

The conceptual model is shown in **(Figure 1)**.

perceived competence, reliability and standing [16, 17]. Price perception was measured with items capturing the perceived fairness and reasonableness of fees [6, 28]. Perceived risk was measured with items spanning performance (pain, outcomes), financial (cost) and safety facets [5, 25, 35]. Patient trust was measured with items reflecting confidence in the clinic's competence and benevolence [8, 19]. Choice intention was measured with items on the intention to select and to recommend the clinic [1, 36, 37]. **(Table 2)** summarises the constructs and source instruments. All instruments would require translation and cultural adaptation into Vietnamese through forward-back translation and expert review, followed by a pilot test of clarity and reliability.

Table 2. Constructs and source instruments

Construct	Indicative content	Items	Source
Clinic Reputation	Competence, reliability, standing	4	[16]
Price Perception	Fairness, reasonableness of fees	4	[20]
Perceived Risk	Pain, cost, safety facets	5	[5]
Patient Trust	Competence & benevolence trust	4	[8]
Choice Intention	Selection & recommendation intent	4	[1]

Data analysis

Partial least squares structural equation modelling (PLS-SEM) was selected because it is well suited to prediction-orientated research, models with mediating chains, and data that may depart from multivariate normality [33, 38]. Analysis follows the standard two-stage procedure. The measurement model is assessed for indicator reliability, internal consistency (Cronbach's alpha and composite reliability), convergent validity (average variance extracted,

AVE) [39, 40], and discriminant validity via the heterotrait-monotrait ratio (HTMT) [41]. The structural model is then evaluated through path coefficients and bootstrapped significance, the coefficient of determination (R^2), effect sizes (f^2), and predictive relevance (Q^2). Mediation is tested by examining the significance of indirect effects, with the direct effect distinguishing partial from full mediation. The structural relationships are defined as follows:

$$TRUST = \beta_1 \cdot REP + \beta_2 \cdot PRICE + \beta_3 \cdot RISK + \zeta_1 \quad (1)$$

$$CHOICE = \beta_4 \cdot TRUST + \zeta_2 \quad (2)$$

$$\text{Indirect effect } (X \rightarrow CHOICE) = \beta(X \rightarrow TRUST) \times \beta_4 \quad (3)$$

Significance would be assessed via bootstrapping with at least 5,000 subsamples using bias-corrected confidence intervals; an indirect effect whose interval excludes zero is taken as evidence of mediation. Because the data are single-source and self-reported, common-method bias should be evaluated through procedural remedies and a full collinearity assessment, with variance inflation factors below recommended thresholds. In an actual study, informed consent would be obtained, participation kept anonymous and voluntary, and ethics-committee approval secured and reported; because only simulated data are used here, no human participants were involved.

Results and Discussion

Descriptive statistics indicated that the constructs were rated moderately to highly, with no problematic skewness in the simulated data. The measurement-model results (**Table 3**) show satisfactory reliability and validity: composite reliability values range from 0.85 to 0.90, exceeding the 0.70 threshold, and AVE values exceed 0.50 for every construct, supporting convergent validity [33, 40, 42].

Table 3. Measurement model (reliability and validity)

Construct	Loadings	α	CR	AVE
Clinic Reputation	0.74–0.85	0.83	0.88	0.64
Price Perception	0.72–0.83	0.82	0.88	0.64
Perceived Risk	0.70–0.82	0.84	0.89	0.62
Patient Trust	0.76–0.86	0.85	0.90	0.69
Choice Intention	0.75–0.84	0.81	0.87	0.63

Note. α = Cronbach's alpha; CR = composite reliability; AVE = average variance extracted. All values simulated.

Discriminant validity was examined using the HTMT criterion (**Table 4**); all ratios fall below the 0.85 threshold, indicating that the constructs are empirically distinct [41, 43].

Table 4. Discriminant validity (HTMT ratios)

Construct	REP	PRICE	RISK	TRUST	CHOICE
REP	—				
PRICE	0.54	—			
RISK	0.48	0.45	—		
TRUST	0.62	0.57	0.52	—	
CHOICE	0.55	0.51	0.49	0.64	—

Note. All HTMT values < 0.85 (simulated), supporting discriminant validity.

The structural-model results and hypothesis tests are reported in (**Table 5**). In this worked example, reputation and price perception positively affect trust, perceived risk negatively affects trust, and trust strongly drives choice intention; the indirect (mediated) effects are significant, supporting the trust-mediation logic.

Table 5. Structural model results and hypothesis tests

H	Path	β	t	p	Result
H1	Reputation → Trust	0.41	6.92	<0.001	Supported
H2	Price Perception → Trust	0.24	3.85	<0.001	Supported
H3	Perceived Risk → Trust	−0.29	4.55	<0.001	Supported
H4	Trust → Choice Intention	0.58	10.42	<0.001	Supported
H5a	Reputation → Trust → Choice	0.24	5.30	<0.001	Mediation
H5b	Price → Trust → Choice	0.14	3.40	0.001	Mediation
H5c	Risk → Trust → Choice	−0.17	4.02	<0.001	Mediation

Note. Bootstrapping with 5,000 subsamples assumed. $R^2(\text{Trust}) = 0.43$; $R^2(\text{Choice}) = 0.47$; $Q^2(\text{Choice}) = 0.31$.

In this research model, the constructs together explain an estimated 47% of the variance in choice intention ($R^2 = 0.47$) and 43% of patient trust, with positive predictive relevance for choice ($Q^2 = 0.31$). Among the antecedents, clinic reputation exerts the strongest effect on trust ($\beta = 0.41$), followed by perceived risk ($\beta = -0.29$) and price perception ($\beta = 0.24$). Trust, in turn, is a powerful driver of choice intention ($\beta = 0.58$), and the significant indirect paths indicate that reputation, price perception and perceived risk reach choice intention substantially through trust. These patterns are consistent with the theoretical claim that, in credence-heavy dental services, evaluative cues shape choice by first shaping trust [1, 8, 9].

Interpreted against established benchmarks, these effects would be substantively meaningful. An R^2 of 0.47 for the focal outcome sits within the moderate-to-substantial range typical of behavioural healthcare research, and the positive Q^2 indicates out-of-sample predictive relevance rather than mere in-sample fit [33, 44]. The prominence of reputation echoes evidence that reputational and provider-credibility

cues are decisive when patients cannot directly assess quality [2, 17, 45], while the negative effect of perceived risk aligns with perceived-risk theory and recent healthcare findings that risk concerns suppress trust and favourable intentions [25, 28]. The role of price perception is consistent with work showing that fair, transparent pricing supports trust in out-of-pocket health markets [22, 23, 46].

Compared with prior work, the model's contribution is to integrate reputation, price and risk within a single trust-mediated framework specific to dental-service choice. Studies that examine these cues in isolation may overstate or understate their importance by ignoring the common mechanism through which they operate. By foregrounding trust, the framework clarifies why improving any single cue—reputation, pricing transparency, or risk reduction—may be insufficient unless it ultimately raises patient trust. This is particularly relevant in emerging markets such as Vietnam, where private dental demand is growing and patients rely heavily on trust signals amid limited regulation of quality information [9, 11].

The framework carries concrete managerial implications. Because reputation is the strongest trust antecedent in the worked model, clinics should invest deliberately in reputation-building—cultivating positive patient reviews; showcasing clinician credentials and accreditations; and managing online ratings, which increasingly function as mediated trust signals [17, 47]. Because price perception matters, clinics should prioritise transparent, itemised and predictable pricing, communicating costs up front to signal fairness rather than risking the erosion of trust through unexpected charges. Because perceived risk suppresses trust, clinics should make risk-reduction visible: effective pain management, clearly communicated hygiene and safety protocols, and honest discussion of expected outcomes and contingencies. Crucially, the trust-mediation logic implies that these levers work by converging on a single outcome—patient trust—so a coordinated strategy that strengthens reputation, fairness and safety simultaneously is likely to be more effective than piecemeal improvements. These implications are offered as hypotheses for practice that the eventual empirical study can test.

Conclusion

Several limitations frame this template. Most importantly, all results are simulated; the manuscript demonstrates how the study would be structured, measured and reported but provides no empirical evidence, and genuine data collection across multiple dental clinics is the essential next step. The proposed cross-sectional design cannot establish causal ordering, so longitudinal or experimental designs would more convincingly test the temporal logic of the reputation/price/risk–trust–choice chain. Reliance on single-source, self-reported measures invites common-method concerns that should be addressed procedurally and statistically. The single-country focus limits

generalisability; multi-country or multi-clinic studies could examine whether the mediation holds across cultural and health-system contexts and could test moderators such as treatment type, prior experience, health literacy and insurance status. Future work might also disaggregate the three risk facets to compare their relative effects on trust and incorporate constructs such as perceived value, satisfaction and word-of-mouth to enrich the nomological network around choice.

This research introduces a methodological and conceptual framework to explore how dental clinic reputation, perceived cost, and risk influence patient selection, with patient trust functioning as a critical mediator. By synthesising perceived-risk theory and an integrative trust model, this study proposes five hypotheses and demonstrates their testing via PLS-SEM using simulated data tailored to the Vietnamese dental landscape. The analysis reveals that while reputation and equitable pricing foster trust, perceived risk diminishes it; subsequently, trust acts as a primary catalyst for choice intention, mediating the impacts of these three variables. These findings highlight that within the credence-intensive dental sector, patient decision-making is fundamentally rooted in trust, positioning trust-building as a paramount strategic objective. Notably, the reported quantitative results are strictly illustrative rather than empirical evidence. Practically, clinics should prioritise credible reputation management, transparent pricing, and robust risk-mitigation strategies, such as rigorous hygiene and clear communication. Future scholarly efforts should validate this model empirically using objective indicators across diverse international markets and varying healthcare provider categories.

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