THE EFFECT OF SERVICE QUALITY AND SERVICE CONVENIENCE ON PERCEIVED VALUE SATISFACTION AND CUSTOMER PATRONAGE: A HEALTH INSURANCE PERSPECTIVE

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in

Management

By

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DECLARATION

I hereby declare that the thesis entitled "*The effect of service quality and service convenience on perceived value, satisfaction and customer patronage: A health insurance perspective"* submitted to Lovely professional university, Jalandhar on 18/11/2022, for award of the degree of Doctor of Philosophy, is the original and independent work carried out by me under the supervision of Dr. Avinash Rana. This thesis has not been previously formed the basis for the award of any Degree, Diploma, Fellowship, or other similar titles.

(Atanu Bhattacharyya)

CERTIFICATE

TO WHOM IT MAY CONCERN

I certify that Mr. Atanu Bhattacharyya has prepared his thesis entitled **"***The effect of service quality and service convenience on perceived value, satisfaction and customer patronage: A health insurance perspective***"** for the award of a Ph.D. degree under my guidance. He has carried out the work at Mittal School of Business, Lovely Professional University.

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ABSTRACT

This study aims to summarize all the available knowledge about customer patronage in the healthcare sector in general and health insurance and extend the knowledge so that all the stakeholders in the healthcare landscape such as hospitals, insurers, third party administrators, device manufacturers, etc., can come together to create a holistic engagement ecosystem. Such an engagement ecosystem can be a revolution, as it will change the way businesses are conducted and how stakeholders interact with one another. With the advent of technology in healthcare, researchers and practitioners are curious to know how health insurance companies should tweak their strategies to reduce the overall cost of healthcare.

Based on previous literature, significant dimensions of customer patronage in the health insurance sector were selected for this study. The study listed five service quality dimensions (tangibles, responsiveness, reliability, assurance, and empathy) and five service convenience dimensions (access, decision, transaction, benefit, and post benefit). These variables were examined and checked for validity as well as reliability via the measurement model.

The structural equation modelling technique was used to observe the relationship between service quality dimensions and service convenience dimensions with perceived value leading to satisfaction and finally customer patronage. The relationship between perceived value and satisfaction was found significant. The relationship between satisfaction and customer patronage was found significant as well.

The effect of four moderators, which has an indirect bearing on customer patronage, was also studied.

Finally, based on the findings, limitations, and implications for theory and practices are devised.

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Dated: 18-11-2022 (Atanu Bhattacharyya)

PREFACE

The intended motive of this exercise is to find out the interplay between several factors in the health insurance sector in India. The objectives were to identify various dimensions which can ultimately lead to, the customer being the advocate of the policy and spreading positive word of mouth. To examine this relationship, a conceptual framework was proposed. In Chapter 1 background of the health insurance sector, the history of entry into the private sector, and a broad overview are described. Chapter 2 provides the backdrop of the topic, literature review on various variables, etc. The relationship between various variables as explored by earlier researchers is deliberated in this chapter. In Chapter 3, research design of the study is discussed. Research procedure, Research instrument, sample frame is deliberated and then content validity, reliability of pilot study data was also covered in this chapter. In chapter 4 data analysis was explained systematically. The demographic profiles of respondents, the relationship between various constructs have been examined. The impact of variables and hypotheses testing were also explained in the segment. The outcome of the data interpretation is conducted with the help of statistical tools and techniques. The relationship between variables was also analyzed as well as discussed. In the last chapter 5, conclusions, suggestions, and findings of the study were discussed. In this chapter scope of future research was also discussed.

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Sr no	LIST OF ABBREVIATION	Abbreviation
1	Non- Government Organization	NGO
2	Rashtriya Swasthya Bima Yojana	RSBY
3	Out of pocket	OOP
4	Insurance Regulatory and Development Authority of India	IRDAI
5	Below Poverty Line	BPL
6	Central Government Health Scheme	CGHS
7	Non-communicable disease	NCD
8	World Health Organization	WHO
9	Vice President	VP
10	Earnest & Young	EY
11	Financial Year	FY
12	Service Quality	SQ
13	Service Convenience	SC
14	Perceived Value	PVAL
15	Customer Patronage Decision	CPD
16	Satisfaction	SAT
17	Composite Reliability	CR
18	Word of Mouth	WOM
19	Technology Acceptance Model	TAM
20	Self Service Technology	SST
21	Structural Equation Modelling	SEM
22	Partial Least Square	PLS
23	Average Variance Extracted	AVE
24	Goodness of Fit	GOF
25	Behavioural Intention	BI
26	Exploratory Factor Analysis	EFA
27	Confirmatory Factor Analysis	CFA
28	Standard Deviation	SD
29	Variation Inflation Factor	VIF
30	low- and middle-income countries	LMIC

CHAPTER 1: INTRODUCTION

1.1 Overview

In the backdrop of major climate changes and potential disasters looming large in many countries across the world, the health and health system is undergoing rapid changes (Bloom & Wolcott, 2013). COVID pandemic has pushed the world to rethink its globalization strategy, bringing resilience into the supply chain. However, the negative affect of global growth like the aging population, expeditious increase in non-communicable diseases coupled with environmental changes cannot be brushed aside under the carpet anymore. In the health ecosystem, the relationship between non-governmental organizations (NGOs), concerned governments, for-profit actors, and citizen groups is undergoing changes. Even though rapid improvement in technology is ushering in the health care system, many countries are still left behind in achieving equitable and affordable health outcomes for all citizens. The world has witnessed the emergence of the pluralistic health system to take care of the health need of the bulging population due to shortage of resources, insufficient infrastructure, and weak governance.

This chapter describes the following

- Background of study
- Characteristics of health insurance
- Present health insurance scenario in India
- Research problem
- Scope of research
- Significance of research
- Structure of thesis

1.2 Background of the study

The Indian Government is committed to United Nation to achieve Universal Health for all citizens by 2030. As things stand today the target appears to be utopian and idealistic. The government has launched several schemes from time to time like RSBY, Ayushman Bharat, etc based on different models to include the poorest of poor in the scheme, but the result so far appears to be a case of too little too late. Kumar (2017, p. 37) stated that hitherto, in India, health insurance has been made largely available for catastrophic illnesses – addressing secondary and/or tertiary care. However, nearly two-thirds of out-of-pocket (OOP) expenses are drug expenses which currently are not addressed by any healthcare financing model. For a country like India, an improvement on the Human Development Index ranking (current rank - 135) will be possible only with a robust health care financing model delivering services in a cost-efficient manner. It has been estimated that a good 2- 3 percent of the total population ends up in poverty due to OOP. Expenditure on drugs (75 percent of total OOP) continues to remain the largest component of the OOP for both inpatient and outpatient care. It has also been estimated that this percentage is the same in both rural and urban areas (Garg et al., 2008). By way of bringing the missing piece, the pharma industry, into the primary health care financing, through an effective pharmaceutical financing strategy, one should be able to address OOP to a large extent.

The aging population, growth of non-communicable diseases, innovation encompassing digital footprint, upward surfing, internet-of-things, netiquette, growth of artificial intelligence and new generation mind-set driven by the exposure to multiple sources of information are dynamically changing frontiers of health care (Margan, 2017 p.16). The basic premise under which the insurance sector operates is predominantly meant to tackle financial issues after the onset of medical issues. This very approach is undergoing a shift towards associating and cooperating with affected persons in staving off health-related threats and life constancy. Across the different health stages, which the common man usually goes through i.e. wellness, prevention,

diagnosis, therapy, and control, health insurers so far have kept their focus only towards therapy.

1.3 Characteristics of health insurance

The health care expenditure of the individuals being distributed by pooling their premium payments is the basic principle of this concept (Venugopal, 2017, p.39). So, under Health insurance, the premium is collected from the individuals like life insurance, and the health expenses are pooled together. While the State and the Central Governments provide some health coverage to their employees and pensioners, they also run a few schemes for the sake of the poor and the downtrodden including the BPL families. The following are those schemes: Employees' State Insurance Scheme,·Central Government Health Scheme- CGHS, Rashtriya Swasthya Bima Yojana- RSBY, National Rural Health Mission, Ayushman Bharat.

There are three parties involved under the health cover- the insured, insurer, and the health care provider. The insured thinks that he/she can undergo all the medical tests- whether required or not as there is the insurance to reimburse the cost. This is anti-selection. The insurer suspects every person who comes for the health insurance thinking that there is every possibility of him/her falling sick. So only the healthy, young people are preferred for insurance, which is called 'cherry picking' or 'cream skimming'. Both these ideas are wrong. There should be a balance as health insurance is again pooling resources and sharing of expenses, which is like any insurance.

Health insurance coverage in India starts and ends with in-patient only and indemnity types are being sold the most, whereas more than 75 percent of the healthcare expenditure is spent as out-of-pocket by the customers. Margan (2017), resonating the growing global concern about NCD, states that close to 50 percent of the inpatient admissions in India, is due to lifestyle or NCD. The share of NCD is expected to increase to over 75 percent of the overall disease burden by the year 2030. World Health Organization (WHO) has predicted that India is losing a big portion of its GDP due to premature mortality and morbidity from NCD.

As pointed out by (Nawani, 2017), even though improvement in health insurance coverage is indeed the right step, we should not consider health insurance as having the end in itself. The motive of health insurance is twofold; to enhance the quality of health care and eliminate or at least lighten the economic burden caused by medical expenses. Even though India has achieved some advancement in improving health care, especially visible in rural India with an increase in institutional birth rate, however, it failed to create a similar impact in mitigating financial distress. He substantiated his statement by saying that if one considers the out-of-pocket expenses and finds its contribution to overall health care expenses; the same has marginally fallen from 68 percent to 62 percent in the last ten years. In real terms, households are depending more on their savings to find health care. While the consumers are facing financial hardship, health insurance companies are also not in pink of their health. Even though they have grown in premium and customer base, the claim ratio has worsened from 94 percent in 2010 to 101 percent in 2015.

Despite the functional limitations of the Indian healthcare insurance sector and the inability of service providers to undertake or adopt a holistic purview, the recent development in consumer retention and satisfaction through engagement has gained popularity (Margan, 2017). The engagement model is putting equally significant emphasis on wellness and prevention as well. In the long run, the stakeholders will be better off if the engagement model is introduced. The government is saved from a funding crisis and the challenge of handling health catastrophes. Insurers can play a pivotal role in achieving this goal as they stand at the intersection of all activities by other healthcare actors. Insurers have access to authentic data of patients which can be exploited by healthcare actors to sensitize the insured towards wellness. Insurers are in a position to involve the insured which shall portray a profound knowledge of their health-related and experience needs.

It is also obvious that the finest method to reduce expenses (of the insurer) is to do away with the requirement of admission to the hospital altogether. These efforts may

also bring advantages like improved profitability through increased customer loyalty and reduced administrative costs.

Healthcare is an unusually challenging industry. The insured are all different individuals, having different ailments and illnesses. They may come from a diverse demographic background with separate psycho and techno graphics settings. Detected and projected behaviour may be different. Therefore, insurers should concentrate not only on consumers' life cycles but also on fitness and sickness cycles. This demonstrates that the reinforcing infrastructure, communication, and variables to demarcate are more complex. AT Kearney (2011) mentioned that insurers control three key levers that can steer those health-improving, cost-lowering behaviours; a) furnish suitable messaging b) Make it easy to do the right things c) offer additional incentives.

The health insurance industry is witnessing a major upheaval in its fundamental approach and trying to realign its business model to stay relevant. On one side they are under pressure to combat increasing medical cost inflation and on another side the digital revolution is opening a new vista for them to collaborate with other players in the eco system. Customers, who are already experiencing improved service from many service sector operators like banks etc, are now expecting something more from insurance companies. Insurance companies are also willing to make a difference in the life of consumers provided they are ensured of a renewal of policy whenever it is due. They are ready to influence the life of the insured by offering additional services like doctors on call, 24 X 7 telemedicine service, medical guidance, etc., and trying to learn the ropes of marketing to ensure repurchase by clients. Now there is a visible shift in the approach which focuses on association and cooperation with consumers in risk stoppage and continuation of life, rather than financial reimbursement after the event. (Margan, 2017).

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A unique challenge for health insurance companies is to strategically align their business with the future of health care. They need to adopt a coherent strategy looking ahead into the business of reducing and influencing risk. To stay ahead, health

insurers are required to revamp their business models in elementary ways: to understand the psychology of consumers and risks, use technologies and information in revised ways.

IRDAI (Insurance Regulatory and Development Authority of India), the regulatory body has been proactive and established on the experience encountered, scrutinized the advice of specialists on Health Insurance and reactions obtained from all people concerned. IRDAI arrived at the conclusion that the Health Insurance regulatory framework, needs to have a relook for the following reasons.

- To intensify the extent of creation of new product
- To encourage policyholders to maintain healthy behaviour by way of reward
- To simplify the entire compliance procedure of product introduction
- To ease and smoothen the process of inclusion of fitness and preventive traits as part of Health Insurance Policies.

Accordingly, the people concerned reconceived the foundation of existing rules which resulted in notification by IRDAI on 18 th July 2016 and directions on "Standardization and Product filing in Health Insurance on 29th July 2016". These IRDAI (Health Insurance) Regulations, 2016 along with the Guidelines, inter alia, conveyed the following areas:

- Authorization to float Pilot Products for a period not exceeding five years- it was envisaged that the industry may leverage on this specific facilitation to enhance the Health Insurance penetration.
- Wellness and Preventive Features- certain health insurance products now encourage policyholders to maintain a healthy lifestyle by following a regular exercise regimen and rewarding such behaviour. It is expected that such wellness and preventive features would help in not only reducing the incidence of lifestyle-related diseases but also keep the claim costs in control, which may, in turn, make health insurance more affordable

- Assistance to propose ‘Group Products under Use and File Procedure**”-** It is envisaged that this facilitation enables the industry to bring in new group health insurance products with speed and agility to suit the dynamic needs of different groups.
- Norms to protect the interests of policyholders-Some products are now designed to cover persons with existing chronic conditions such as Diabetes, Asthma, Hypertension, etc. which also provide coverage for managing such conditions through prescribed protocols.
- Enhancing the scope of Health Insurance- Ayush treatment, Health plus life combo product.
- Claim administration and mitigation of frauds

EY (2015) recommended five strategies to negotiate across a rattled insurance environment:

- **Consumer-orientation**
  - Influence how your patient behaves offers a substantial chance to suppress expenses.
  - To what extent do you know your customers?
- **Go digital**
  - Improve effectiveness and influence behaviour by intelligent analysis of data through mobile.
  - How much you have grasped the fast-changing virtual world?
- **Partner**
  - Collaboration and cooperation are considered key to solving complex challenges. Impossible to achieve it alone.
  - Do you collaborate with trailblazers and reformers?
- **Use correct benchmarks**
  - The correct barometer and criteria are vital for gauging business model innovation.
  - Do you keep yourself abreast about days to come?
- **Be proactive**

- Agility and adaptability are the key in this disruptive world.
- Are you chasing time or time is chasing you?

The report suggests that the basic value premise that is likely to be offered should be like the following lines: "Sign up with us and we will partner with you to keep you healthy for the rest of your life — or as long as you choose to stay with us. You'll get the latest apps and technologies to help you manage your health — your diet, activity, biometrics, sleep, and more. Over time, you can expect that your premiums will increase more slowly than they would if you had signed up with another insurer — and you'll even earn additional rewards for proactively managing your health."

To ensure customer patronage and repurchase intention, companies need to devise new strategies. One player in the USA, Oscar health allocates a "Concierge Team" to its members who comprise of three health counselors and a trained nurse who takes care of coordination of clinical care as well as traditional customer service questions. Paul Gazely, Vice President, Oscar's customer care division during a conversation with "*Phoenix Business Journal*" in 2017 commented that the concierge model of Oscar "helps to build a relationship and build trust with our members with their health care needs. He added that the model also contributes to Oscar's understanding of the requirements of members considering the entire health history of members (see appendices).

The new offer from the insurance industry could be made conditional. EY (2015), in their report titled "Future of health Insurance" opines that the benefit to be accrued to the consumer may take the pattern of a "carrot" (discount if conditions are met) and/or if conditions are not met then maybe a stick (e.g., a contract spanning more than a year with inbuilt penalty clause), depending on directives and limitations in different markets. Since the success of the model warrants that these consumers would be healthier than the underlying population, it may lead to a slower-than-average rate of increase in premium for them: this may act as extra motivation for consumers to continue with the program with a long-term perspective. However, one pre-condition

for rolling out this model is to bring together partners having complementary skills and assets under one roof. The constituents of this group may include

1. The Insurer 2. Provider network 3. Patient Organization 4. Data consolidator 5. Technology provider 6. Government 7. Device and app manufacturer 8. Gym or fitness centres/supermarket chains

1.4 Current health insurance scenario in India

The total health insurance premium collected by all health and general insurance companies in 2019-20 is Rs 50758 crore. There is a jump of 13 % over the previous year. Even though public sector companies are constantly losing market share, still they contribute to 49 % of market volume during 19-20 (down from 52 % in 18-19). The loss of public sector market share has been grabbed gleefully by stand-alone health insurers (an increase of market share by 24 %). Private sector general insurers maintained their market share of 24 % in 2018-19 and 2019-20.

Table 1.1: Trends in Health Insurance Premium in last 5 years

Sectors	**2015-16**		**2016-17**		**2017-18**		**2018-19**		**2019-20**	
	Rs Crores	**%**	**Rs Crores**	**%**	**Rs Crores**	**%**	**Rs Crores**	**%**	**Rs Crores**	**%**
Public sector general insurers (4 companies in total)	15591	64	19227	63	21509	58	23536	53	24631	49
Private sector general insurers (18 companies in total)	4911	20	5632	19	7689	21	10655	23	12391	24
Standalone health insurers (6 companies in total)	3946	16	5532	18	7831	21	10681	24	13735	27
Industry Total	24448		30391		37029		44872		50758	
Annual Growth rate in %	21.7		24.3		21.8		21.2		13.0	

Source- IRDA annual report

Health Insurance Business of General and Health Insurers': Class of Business-wise: If we categorize health insurance business, major categories will comprise of

Group Health Insurance, Health Insurance sponsored by Government, and Individual Health Insurance. If we consider the amount of premium collected, Group Business would emerge at the top with 51 percent share, the second rank would come from individual business (38 percent) and then Government Business (11 percent). The business generated by health insurance companies through a collection of premiums has grown tremendously considering the last five-year period.

The share of health insurance premiums collected from 5 states namely Maharashtra, Karnataka Delhi, Tamil Nadu, and Gujarat add up to as high as 64 percent of total health insurance premium (without Travel Insurance and Personal Accident Business). The balance 36 percent comes from other states as shown below. The lion's share of health insurance premium among these five states is from the state of Maharashtra which alone contributed Rs 14,781 crore (29 percent).

Table 1.2: Sector wise Health Insurance Business in India

SECTORS	**18-19**	**19-20**	**18-19**	**19-20**	**18-19**	**19-20**
	No of policy issued (in lacs)		***No of lives covered (in lacs)***		***Gross premium (in crores)***	
Govt sponsored schemes including RSBY	0.003	0.002	3571	3619	5672	4920
premium growth	-3%	-5%	-1%	1%	42%	-13%
share	0.001	0.001	75.65	72.58	12.640	9.690
Group business (other than Govt Business)	10.9	7.61	728.54	935.17	21676	25881
premium growth	68.68	-30.2	-18.55	28.36	22.08	19.4
share	5.27%	4%	15.43%	19%	48.31%	51%
Individual	195.91	171.72	420.64	432.25	17524.00	19957
premium growth	39.11	-12.35	26.41	2.76	14.61	13.88
share	94.73%	96%	8.91%	9%	39.05%	39%
Industry Total	206.82	179.33	4720.00	4987	44872.00	50758
premium growth	40.41	-13.29	-2.06	5.65	21.18	13.12
share	100.00	100	100.00	100	100.00	100

Source- IRDA annual reports

Industry expert (Nawani, 2017) mentioned that individual health insurance has increasingly become important in the health insurance landscape of the country. From

35% of the overall market in FY 11, it now comprises 44% and has relatively healthy claims ratios of 81%. However, most of this business comes from traditional indemnity-based products. Given the ability to assess risk and modulate service delivery, individual health insurance needs to be at the cutting edge of the health insurance ecosystem of India. As highlighted earlier, the disease pattern of India is shifting increasingly to non-communicable diseases, which require a much higher level of diagnostics, disease management systems, etc. This opens new horizons of growth for the industry, to add products other than indemnity-based insurance to its bucket. Another area of growth could come from the longer life spans and assisted living market. New developments in wearable and connected devices are making staying in touch with customers easy and less intrusive at the same time.

1.5 Research problem

Disruptive trends in health insurance

EY (2015) talks about six trends disrupting health insurance. They are

- The chronic disease crisis (non-communicable disease, aging population)
- The move to outcome and value (incentives aligning with health outcomes)
- M –health technologies (proliferation of M health technologies)
- The big data revolution (quantum increase in variety, volume, velocity in information)
- Customer centricity in insurance (empowered with more transparent information)
- Pressures on underwriting (declining investment income, increase in regulatory constraints)

With the current health insurance scenario and the above disruptive factors affecting the industry, the health insurance sector is on a crossroad. While the low penetration of health insurance in India is alluring, the lack and apathy of general people about this business is a stumbling block that they need to surmount. Government can extend a supporting hand to the industry only when they are convinced that changes in

lifestyle as proposed by the insurance industry can lead ultimately to lesser pressure on budgetary allocation in the health sector.

As a renewal of the policy, customer re-purchase inclination and positive word of mouth is what the insurance industry is aiming for, the problem lies in realizing the underlying factors ensuring them. Other than the usual common factors like service quality and service convenience, are there any other factors that moderate the relationship constructs? Whether factors like trust, inertia, and word of mouth, which have been researched for their role in various service industries, are also having influencing role to play or not, is also part of this study.

The present research also aims to discover if the type of organization (public sector or the private sector) has any effect on the response of consumers.

1.6 Scope of the study

The research is based on the health insurance space in India. Three states Maharashtra, Tamilnadu, and Karnataka have the maximum share in health insurance premium, which may be due to their level of awareness, size, and other demographic factors. The study was carried out based on data collected in online mode; the respondents were from Maharashtra and Delhi. Respondents are mostly educated and have basic knowledge about different aspects of health insurance. However, as responses were sought from people who have taken any individual/family-floater etc. (no corporate or group policy) health insurance policy in the recent past, the scope is limited to that extent.

1.7 Significance of study

The entire health eco system if used collaboratively by assembling data from all the constituents, also from the mobile-health gadgets which are utilized by patients, can generate a futuristic databank with upgraded wisdom and wavelength that have no place in today's health systems. This is a game-changer as it not only portrays an exhaustive list of customers' genetic background, behavioural traits, genetic data,

diagnostic outcomes, medication, and more but also since it is based on real-time flow of data, information and not just on a routine test carried out in the centre.

However, the success of this model for insurance service providers would sustain only when most of their existing customers remain committed to them and renew their patronage whenever the health coverage policy is due for renewal.

1.8 Structure of thesis

This write-up is split into five major chapters. These chapters are shown below:

- Chapter 1: Overview
- Chapter 2: Literature Review
- Chapter 3: Research Methodology
- Chapter 4: Results, Interpretations, and Discussion
- Chapter 5: Conclusions, Suggestions, and Limitations

Chapter 1- Overview

In the first chapter of the study, basic information regarding the topic has been given in detail. The background of the study, an overview of health insurance, health insurance coverage position of India has been given. The research problem, significance, and scope of the study have also been discussed.

Chapter 2- Review of Literature

The literature review is an important component of the research which gives a strong base to achieve the research. A literature review not only helps to find out the objectives and background but also helps to find out the research gaps for the study. In this chapter, previous studies have been discussed which are relevant. All the literature has been collected from various journal articles, books, official reports, and other sources. Previous studies have been based on consumers' satisfaction with health insurance, their various dimensions like service quality,

service convenience. Various studies related to the customer's patronage decision, the impact of trust, word of mouth have also been discussed in this part. This chapter offers a background of constructs that are outlined in the study.

Chapter 3- Research Methodology

In this chapter mainly a road map has been discussed for research. The methods for preparation and for conducting this research have been explained in this part of the thesis. It includes the hypotheses, objectives, research design, and methodology of the study. Apart from this, the statistical methods, reliability, as well as validity of the scales, have been mentioned in this chapter. The survey approach, population, sampling, content validity, pilot testing results have also been included in this chapter.

Chapter 4: Results, Interpretations, and Discussion

The tools and techniques which are mentioned in chapter 3 have been evaluated in this chapter for the results. Data analysis has always come out as a difficult task for any research. In the present study, SEM techniques have been used for the evaluation of data that are collected from policy holders. The results, interpretations, and discussions have been founded on data analysis. The results of statistical analysis, the interpretations of hypotheses have been discussed in this part.

Chapter 5: Conclusions, Suggestions, and Limitations

With the help of results, managerial implications, limitations, and suggestions, this chapter has been compiled. Apart from these, the chapter has suggested the future scope of study and assumptions. At the end, references of all the statements, studies and reports have been given.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

Any research cannot be completed without the help of literature which includes previous studies and other related work. The literature review helps to pin down the gaps in the research, frame the research hypothesis, and helps to avoid duplication in work. With the help of this, researchers can decide their way to research. This chapter of the study explains previous studies in brief and serves as a base for the present study.

The review of literature has been grouped into the following sections of this chapter:

- Service Quality (SQ)
- Service Convenience (SC)
- Relationship of SQ & SC with Perceived value
- Perceived value & Satisfaction
- Satisfaction & Customer Patronage
- Repurchase intention and intention to recommend
- Trust/Inertia/Word of mouth
- Summary

2.2.1 Service quality

Parasuraman et al. (1985), (1988), (1991 a, b) conducted several studies which led to "SERVQUAL the most popular and widely used service quality model. Originally, the model was based on ten features of service quality viz communication, credibility, security, competence, understanding consumer, access, tangibility, reliability, responsiveness, and courtesy". These 10 dimensions forms the basic building block of service quality. In 1988 they have developed the scale of SERVQUAL, where they have taken 3 original constructs and two combined dimensions and finally came out with five dimension and their definitions shown as under:

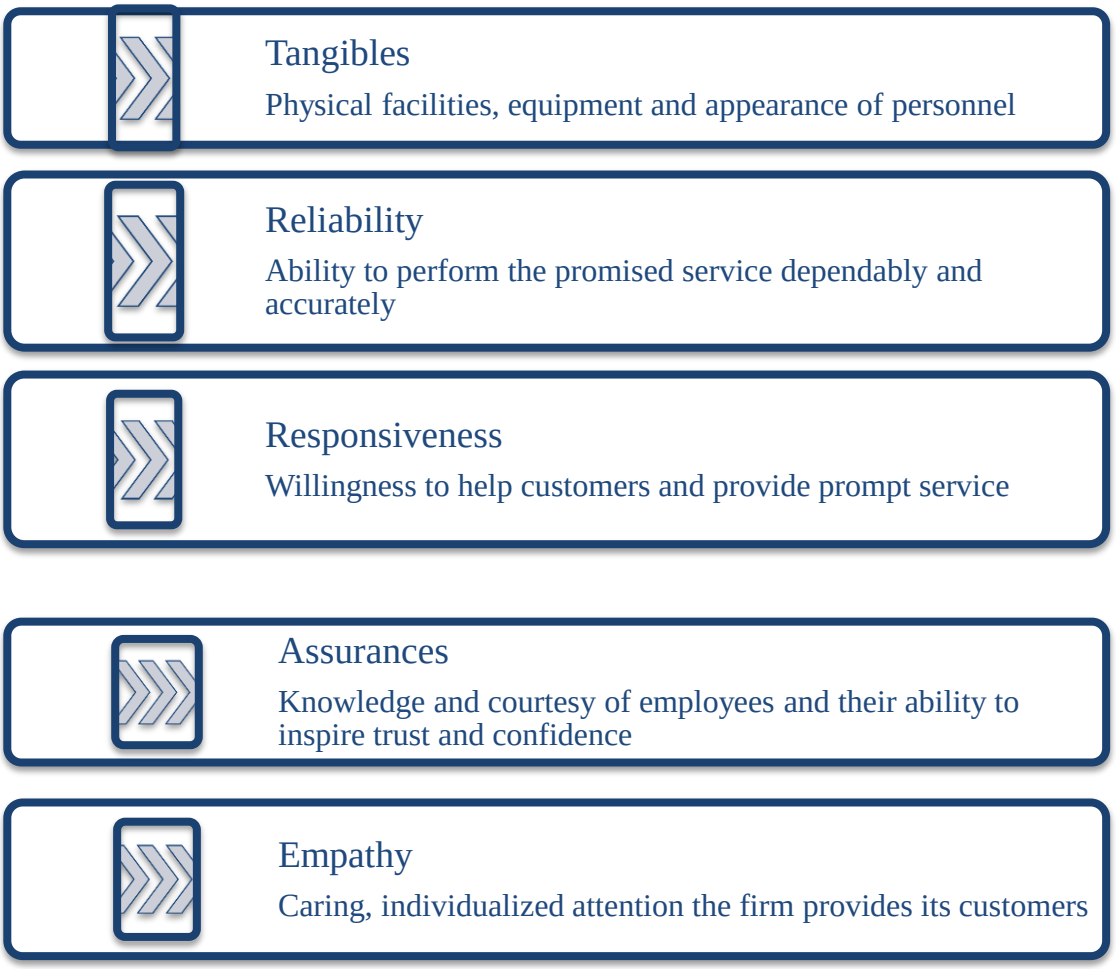


Fig. 2.1 Dimensions of Service Quality

The last two items capture all the balance items of the original 10-point scale except the item access, which did not remain distinct after two stages of purification by researchers.

How do we develop our assumptions and belief for a service? They are formed by word of mouth from other people, from other customers, from the referrals, and matching with the service provider qualification and capabilities, etc., and experience with the same service provider. These are the usual drivers that create the service expectation. Subsequently, the service perception is generated after the service consumption and if the perception is superior to expectations; that means, the service has created a much better feeling with the consumer than their expectation before the service, then it is quality serendipity. That means, it is a delightful surprise for the customer, if it is equal, it just meets the expectation, then it is an even keel situation. So, it is satisfactory, but just customer satisfaction is not enough, because if somebody else, a competitor can provide the same level, then you will lose out in competition eventually? So, even though, you may have a customer who is apparently satisfied, it does not necessarily mean a repeat customer and of course, it is the unacceptable service level when the service provider provides a service but the perception after the consumption is less than the original expectation.

The SERVQUAL model extensively studies the correlation between the two preconceived notions of consumers about service quality. The first is ‘‘customer expectation’’, which captures the customer’s presumption or anticipation of what the quality of service should be and the other is ‘‘customer perception’’, which is the consumer’s comprehension of the nature of the service quality (Zeithaml et al., 1990, 2013). A third notion namely, ‘‘perceived service quality’’, is developed owing to the gap between the two previous notions.

2.2.2 Service convenience

Conceptualization

Seiders et al. (2007) conceptualized explicitly and implicitly the various concepts of service convenience. He has proposed them to be a second-order, formative construct and has broken them down into five first-order dimensions. They proposed that customers' time and effort costs are the two principal facets. For example, the substructure of convenience assimilates optimization of time, which would also provide flexibility, polychromatic time use, passion, situation, ease of negotiation, and task distribution. Berry et al. (2002) proposed that conceptually, it is advantageous, if service convenience is understood in terms of the customer pursuit required to acquire or use service, because appraisal of convenience becomes primary during major stages of the service experience. As per researchers, five dimensions identified for service convenience, are formative in nature, because at first, all of them not necessarily should co-vary with one another. Secondly, variation in any one of them will affect the construct. And this would happen irrespective of any other variable changing or not. Thirdly removing any of these five dimensions would alter the basic construct itself. In addition, the nomological network of five dimensions may differ as they are measured at different phases of the service consumption process, and dimensions need not have the same after-effects and antecedents.

Service convenience can be described as "consumers' time and effort perceptions related to buying or using a service" (Berry et al., 2002). As a result, when retailers begin to offer ways for easier shopping, they are saving their clients' valuable time or exertion in the service encounter process and in this way, increment the estimation of their market offer (Colwell et al., 2008). Undoubtedly, with the advancement of the Internet, innovation and technology are significantly responsible for imparting convenience to patients. For instance, e-health services are now being offered by numerous medical care firms, and the emergence of "patient portals" assists consumers to obtain or retrieve their medical records via electronic means. Credence-based services, such as healthcare services, that cannot be utilized after its consumption are more complex in nature due to several factors including, (i) a significant level of data deviation between the purchaser (patient) and dealer (medical care supplier), (ii) an increased level of customer engagement along with an elevated

level of emotional susceptibility, and (iii) customers' look for medical care administrations as a way to accomplish greater well-being (Dobele & Lindgreen, 2011).

2.2.3 Perceived value

While studying perceived value, (Cengiz & Kirkbir, 2007) has observed that despite the growing attention bestowed on perceived value, it has no comprehensible and universally accepted definition. Several researchers have tried (McDougall & Levesque, 2000; Zeithaml, 1988) to describe that as psychological price, utility perceived by the consumer, perceived merits when compared with sacrifice, worth, and quality (Woodruff, 1997). This wide variability between researchers hinders unison with the definition. It also varies with the type of product and services and individual characteristics of consumers (Zeithaml, 1988).

Thaler (1985), and other early researchers described value mainly about price. Thaler believed that consumers compare between structures of prices they perceive through advertisement, through reference price from advertisement, and also from internal sources. Monroe (1990) used the concept of the weighted sum of acquisition and transaction value. The gap between maximum price and actual selling price is considered as acquisition value and the gap between actual price and reference price can be construed as transaction value.

The "give versus get" model of (Zeithaml, 1998) is the most common model for value. She conceptualized perceived value as consumers' overall assessment about the utility of the product or service which is focused on what is received and what is given. The comparison between products or service's "get and give" components shape the perceived value as she mentioned. Another common approach is well known; the value for money concept of (Kean, 1985, Cravens et al., 1988; Monroe, 1990), which is based on the ratio or trade-off between price and quality. Researchers thought that these two components have separate and differential effects on perceived value for money.

Zeithaml (1998), also understood that for some price-conscious consumers, low price is an indication of the value and for others, it depends on the balance between price and quality. So, weightage of different components of perceived value changes with the consumer's thought process. Bolton & Drew (1991) mentions that it is too simplistic to perceive value as a trade-off between price and quality. Other researchers suggested marketers should provide extra or worthier value with respect to product quality or additional features or after-sales service. They went on to suggest that existing constructs of only price and quality are too narrow and need to be expanded to make them relevant under different circumstances. Woodruff (1997) has a strong view that "customer value is a customer's perceived preference for and evaluation of that product attributes, and consequences arising from use, that facilitate (or block) achieving the customer's goals and purposes in use situations".

Customer value is also seen as an addition to the constructs of quality. Inclusion of cost beyond customer value as a part of the benefit makes the attainment of expectation more broad-based. The concept of (Gale, 1994) on this was most popular, as he identifies customer value as a combination of perceived benefit and costs. Moreover, the cost can be either material cost consisting of money or non-material cost like time, financial cost, etc.

Rust & Oliver (1994) has rephrased the concept and stated that value is an amalgamation of what is sacrificed and what is received. That may also include preference in a situation when different alternatives are available, and we want both of them (Lamont, 1955). Zeithmal (1988) proposed a model for customer value, wherein she stressed significant detachment in combination with perceived quality, along with inherent, extraneous, and price attributes as drivers of perceived value. By inherent attributes, she referred to physical constituents of a product or high detachment or attitude level such as service quality Extraneous attributes can be related to products or services, but they are not part of them directly and they are probable to deviate over time. According to (Zeithaml,1988), advertising, price, and brand can term as extrinsic cues to quality and ultimately value. Additionally, when the consumer is less

aware of intrinsic attributes, extrinsic cues can be used to replace intrinsic attributes (Bitner, 1990).

The concept surrounding the value and new understanding of the same is the backbone of relationship marketing. As a result, in academic research (Parasuraman & Grewal, 2000) and in marketing management field (Bolton et al., 2000), value is closely linked with customer loyalty. Moreover, value is also inevitably connected with significant consumer behaviour constructs such as quality and satisfaction. Researchers like (Bolton & Drew, 1991; Iacobucci & Ostrom, 1995; Baker & Crompton, 2000; Brady et al., 2001), while attempting to go deep into the difference between satisfaction and quality, often, leaned into the value concept. Perceived value is perceived to come from the core heart of the service assessment activity of the consumer (Cronin & Taylor, 1992; Bolton & Drew, 1991). According to (Cronin et al., 2000), three waves of conceptual research in service marketing were recognized and they are service quality, consumer satisfaction, and perceived value.

The logical features of decision-making include inherent aspects, which mean that an object or experience should be valued for its own sake. Hirschman & Holbrook (1982) advocated for an empirical perspective that considers the symbolic, hedonic, and aesthetic aspects of the consumption process. They went on to add that utilitarian criteria are the most assessed aspect i.e how well a product or service satisfies the need of the consumer or perform its proper function. The utilitarian and hedonic components are also acknowledged by other researchers (Batra & Ahtola, 1990) and they have referred to them as “thinking and feeling dimension”

Grewal et al. (1998), have bifurcated perceived value into two constituents-transaction and acquisition value. They defined the former as the positive contribution a consumer generates when the product or service is acquired. The second part i.e perceived transaction value is defined as more of a psychological satisfaction what you get with a good deal. The number of statements used by them to figure out perceived acquisition is three and for the perceived transaction it is nine.

Woodruff (1997) thought that at a different stage of purchasing, the customer may perceive value differently. He developed a value hierarchy model wherein he conceptualized desired value (what the consumer desires to have) and received value (when they experience the product or service). De Ruyter et al. (1997), Woodruff (1997), Sanchez et al. (2006), and Sweeney & Soutar (2001) suggested that perceived value should be viewed as a multidimensional construct. They visualized the angle of the emotional and social aspects of consumers depicted in their purchasing behaviour. They tried to embed this dimension with the functional dimension which is concerned with the rational and economic valuations of individuals. This dimension also includes the quality of product or service or both. The emotional aspect is related to feeling and the social dimension is connected to the social impact of the purchase.

Multidimensionality is expressed as a combination of cognitive and affective aspects. Sheth et al. (1991) extended the same concept to five dimensions of value (social, epistemic, functional, conditional, and emotional). There, the functional dimension is expressed as the perceived utility of the attributes and emotional value as feelings, or the affective states developed during consumption. How an individual can connect with his social environment and the resulting appropriateness or usefulness can be termed as social value. The product or service is expected to arouse interest, should surprise them, satiate their quest for knowledge and this is the epistemic value. Sheth et al. (1991) refers conditional value as specific circumstantial or conjectural factors.

Almost following the similar thought, De Ruyter et al. (1997) deliberated on an exhaustive approach to the value which considers a coherent reaction (value for money) and emotional ingredient. All these authors describe perceived value as a combination of three elements viz. emotional, logical, and functional. The perceptual evaluation during the service encounter helps to measure the emotional dimension. The experiential features during the service occurrence reflect the functional dimensions and logical dimensions can be explained by the value for money concept

i.e., whether the service is worth the price being paid for. These three dimensions cover the entire gamut of service performance.

A new measurement scale PERVAL is proposed by (Sweeney & Soutar, 2001) wherein they discarded the five earlier proposed parameters of perceived value and dropped epistemic and conditional dimensions. The three-pointer scale developed by them consists of functional value, social value, and emotional value. According to their perception, quality consists of the estimated outcome of the product or service, and perceived quality and price should have a close connection with the value for money concept. They also talked about a new dimension versatility which depicts the resilience and feasibility of the product. Emotional and social attributes are intangibles that influence the association. Sanchez et al. (2006), created GLOVAL scale as a tool to compute the perceived value of 24 items post-purchase. He has sub-divided the features of perceived value into functional and affective. While functional part consists of the functional value of installations, contact executives, service purchased, and price. The contact personnel functional value represents professionalism and that of service purchased represents quality. The affective dimension talks about social value and emotional value.

The multipronged approach to perceived value is a broader concept under which the overall opinions on consumer behaviour exist. If we talk about convenience and welfare, that makes it predominantly reasoned and logical. This is in contrast with the multidimensional approach which not only considers reasoned and logical side but also intuitive systems.

The table below presents the researchers' names who have proposed the multifaceted approach and it also shows the suggested features of the construct. The common platform for all of them is the two fundamental dimensions of perceived value: affective and functional. The quality of a product or service is a part of a functional parameter that is logical and has an economic valuation. On the other hand, if we need to capture the feelings or emotions, we consider the sentimental dimension.

Table 2.1: Multidimensional Approach to Perceived value

Shethetal (1991) Epistemic value Emotional value Social value Functional value Conditional value	**Grönroos (1997)** Cognitive Emotional(psychological) **Mattson (1991)** Cognitive Affective
Sa´nchez et al. (2006) Functional value price Functional value of the service purchased (quality) Functional value of the establishment (installations), Functional value of the contact personnel (professionalism), Social value Emotional value	**DeRuyter, Wetzels, Lemmink, and Mattson (1997)** Functional value (price/value for money) Functional value (versatility) Functional value (performance/quality) Emotional dimension or intrinsic value Functional dimension or extrinsic value **Sweeney, Soutar, and Johnson (1999)** Social value (acceptability) Emotional value Logical dimension
Groth (1995) Cognitive/ perceived utility Psychological External Internal	**Sweeney and Soutar (2001)** Emotional dimension Functional dimension (economic and quality) Social dimension

Table 2.2: Literature Linking Quality, Value, and Satisfaction to Various Service Encounter Outcomes

Source	**Relevant constructs**	**Link(s) to outcomes**	**Empirically tested?**
Parasuraman, Zeithaml, and Berry (1991)	BI, SQ	SQ	Yes
Parasuraman, Berry, and Zeithaml	BI, SQ	SQ	Yes

(1988)			
Anderson and Sullivan (1993)	SAT, BI, SQ	SAT, SQ	Yes
Boulding et al. (1993)	BI, SQ	SQ	Yes
Taylor and Baker (1994)	BI, SQ, SAT,	SQ	Yes
Cronin and Taylor (1992)	SQ, SAT, BI	SAT	Yes
Anderson and Fornell (1994)	SQ, SAT	SAT	No
Zeithaml, Berry, and Parasuraman (1996)	BI, SQ	SQ	Yes
Taylor (1997)	SQ, SAT, BI	SAT, SQ	Yes
Athanassopoulos (2000)	SAC, SQ, SAT, BI	SQ	Yes
Fornell et al. (1996)	SQ, SAT, SV, BI	SAT	Yes
Chenet, Tynan, and Money (1999)	SQ, SAT, SV, BI	SAT	No
Garbarino and Johnson (1999)	BI, SAT	SAT	Yes
Bolton (1998)	BI, SAT	SAT	Yes
Gotlieb, Grewal, and Brown (1994)	SQ, SAT, BI	SAT	Yes
Ostrom and Iacobucci (1995)	SAC, SQ, SAT, VAL, BI	SAT	Yes
Patterson and Spreng (1997)	SAT, SV, BI	SAT	Yes
Hallowell (1996)	BI, SAT	SAT	Yes
Andreassen (1998)	SAT, SQ, SV, BI	SAT	Yes
Oliver (1999)	BI, SAT	SAT	No
Bolton and Lemon (1999)	BI, SAT	SAT	Yes
Bernhardt, Donthu, and Kennett (2000)	BI, SAT	SAT	Yes
Ennew and Binks (1999)	SAT, SQ, SV, BI	SAT, SV	Yes
Zeithaml (1988)	BI, SAC, SQ, SV,	SV	No
Bolton and Drew (1991)	SAT, SQ, SV, BI	SV	No
Gale (1994)	SQ, SV, BI	SV	No
Chang and Wildt (1994)	SQ, SAC, SV, BI	SV	Yes
Hartline and Jones (1996)	SQ, SV, BI	SV	Yes
Wakefield and Barnes (1996	SQ, SV, BI	SV	Yes
Cronin et al. (1997)	SAC, SQ, VAL, BI	SV	Yes
Sirohi, McLaughlin, and Wittink (1998)	SAC, SQ, SV, BI	SV	Yes
Sweeney, Soutar, and Johnson (1999)	SAC, SQ, SV, BI	SV	Yes

According to (Zeithaml, 1988), the researcher has proven that consumers who believe that they got "value for money" are better satisfied than consumers who do not see "value for money" while doing the transaction for a product or service. The difference between an assessment of what is received and what is given will dictate the perceived value as per this theory. Many papers on service marketing have deliberated on the relationship between satisfaction and future intention with perceived value. While (Anderson et al., 1994) argued that value creates a straightforward impact on consumers as to how satisfied they are with their suppliers.

McDougall & Levesque (2000), in their research, proposed that customer satisfaction is directly affected by perceived value which, in turn, leads to future intentions. They went on to argue that managers involved in the service industry should be very careful about the exact role of perceived value impacting their industry. If satisfaction directly comes from perceived value, then it is not sufficient to deliver the core service quality and relational service quality. Additionally, customer must perceive that they got their "money's worth". So, by incorporating perceived value in their decision, managers can make their endeavour to satisfy customers more effective.

2.2.4 Satisfaction

Jones & Sasser (1995) mentions that attaining consumer satisfaction is the foremost objective of most service industries. Subsequently, this leads to customer retention and customer advocacy which in turn will lead to increased profit, positive word of mouth, and expenses incurred on marketing (Reichheld, 1996). In general, companies resort to measuring the consumer satisfaction level of his last service encounter by using Likert type scales (Peterson & Wilson, 1992).

An avid reader of literature on customer satisfaction has noticed that considerable debate has taken place among researchers that whether customer satisfaction is an attitude embedded into an individual or it is short-lived, transitory, an outcome limited to consumption, or it is linked with the evaluation process (Yi, 1990). Interestingly Cronin & Taylor (1992) and Parsuraman et al. (1985) argued whether satisfaction

leads to service quality, or it is the other way round (Bitner, 1990; Bolton & Drew, 1991). Even though the connection between customer satisfaction and future intention is established (Bearden & Teel, 1983; Oliver, 1980), the determinants of future intention and their relationship with perceived value and service quality were still under investigation (Bolton & Drew, 1991). Obviously, for persons responsible for service delivery, it is essential to know what drives consumer satisfaction. How the constituents are linked with each other and how they relate to future intention. All these will put him in a better position to judge a decision. They would be better off in allocating resources to that part of service delivery that matters most to the customers as far as the creation of satisfaction goes.

Customer satisfaction is a layered and complex process. Perception of the customer, their experience or satisfaction with the service acts is directly impacted by their judgment of service events, and that in turn, affects their satisfaction level with the overall service encounter (Woodside et al., 1989).

2.2.5 Inertia

Theoretically, Inertia is the resistance of any physical object to any change in its velocity. It refers to resistance to change. Hu et al. (2016), studied the relationship between patient satisfaction, relationship inertia, and loyalty. They have also inspected whether the barriers in switching will moderate the path relationship in the patient satisfaction model. Their results show that satisfaction and relationship inertia will have a positive impact on patient loyalty. While studying inertia stages and patients' behaviour, Goncalves & Feliciano (2020), integrated the concept of inertia into a healthcare context to understand how to repeat visitors act and make revisit decisions.

Inertia is described as a type of emotion emanated in a non-conscious state, uni-dimensional in nature demanding "passive service patronage without true loyalty" (Huang & Yu 1999). Status quo bias theory tries to define it as a cognitive bias where the incumbent would prefer to remain with the existing set-up. They would prefer that

everything stays as they are now. Many people fear changes. Many perceive a change as a loss or detriment. This tendency can have an influence on human behaviour, a powerful effect on the decision they make (Samuelson & Zeckhauser, 1988). According to Samuelson & Zeckhauser (1988), it comes naturally to the consumer to remain inactive as this is a corollary of his thought process in terms of switching costs, the price for remaining with existing, and risks connected with alternatives.

Grey et al. (2017), while studying the interaction between inertia and switching behaviour, commented that inertia will dampen the likelihood of changing the service provider. But there is no certainty that inertia will affect the behaviour to switch between service providers. Greenfield (2005), and Polites & Karahanna (2012) conceptualized inertia as a combination of cognitive inertia and affective inertia. When the consumer, despite being aware that his current standing may not be the right option to choose, still sticks to that, he portrays cognitive inertia. On the other hand, many a time one has to stick to the status quo because the other alternatives are hard to gather. This state is called affective inertia. Handle (2013) investigated adverse selection and inertia in the health insurance market in the USA. Researchers tried to find how inertia is one source of choice inadequacy and how it interacts with adverse selection, in the US health care system.

The apathy towards any change is attributed to customer inertia (Bawa, 1990; Meidan, 1996; Panther & Farquhar, 2004; White & Yanamandram, 2004). When the customer is undergoing inertia syndrome, they show reluctance to spend time to understand the offers of other companies, even if they are lucrative or beneficial to them. Inertia has a direct influence or a moderating role that impacts customer patronage and subsequent decisions (Ghose & Lowengart, 2013; Oliver, 1997).

2.2.6 Word of mouth

Word of mouth (WOM) has been defined by various researchers from many different perspectives. With much recent technological advancement in process of delivery of messages, word of mouth has attained different frames and colours. But the basic structure of effectiveness of WOM communication still suggests that it depends on the

nature of the relationship between sender and receiver, the strength of content, the ambiance of delivery, and a host of other factors. Sweeney et al. (2008), Murray, (1991) defined WOM as a mode of informal communication. Repo (1999) and other studies have interestingly pointed out that for repurchase decisions, WOM is increasingly becoming the primary deciding criteria and marketers are struggling to ensure a positive WOM about their product and service. Word of mouth has also become very important for consumers to express their satisfaction or dissatisfaction about any product or service which they have experienced. Research also suggests that positive feedback has lesser chances to be shared compared to negative feedback. Consumers normally find ways to vent out their negative feedback in some form or other.

2.2.7 Trust

Trust is viewed as an inseparable part of any successful transaction. Marketing literature lets us believe that when one partner has confidence in the integrity and reliability of other partners, we conceptualize that as trust (Morgan & Hunt, 1994; Ranaweera & Phrabu, 2003). While describing trust in the technology acceptance model (TAM), (Friedman et al., 2000; Wang et al., 2003) stressed that, it has a strong & direct bearing on the willingness of the individual to divulge personal information and money online while indulging in the online transaction. Morgan & Hunt (1994) believed that to generate trust as a part of an economic long-term relationship, firms often travel beyond satisfaction. Bejou et al. (1998) however, pointed out another dimension of trust which says that it is not easy to develop. But he went on to maintain that once trust is developed, it wields substantial effect in building and maintaining the relationship.

Al-Ekam et al. (2012), likewise characterizes trust with a comparable significance and concurred that trust factor cannot happen in a short time and completely relies on the correlation between two entities. Another view referenced that consumer trust is the conviction that an individual will discover what they want in their trade associates. Trust must be considered as an impetus in different exchanges amongst service providers and purchasers to accomplish customer satisfaction (Kassim & Ismail, 2009).

2.2.8 Customer patronage

Re-purchase intention and intention to recommend

Cronin & Taylor (1992), Parasuraman et al. (1988), Udo et al. (2010), Hafeez & Muhammad (2012), believed that marketers are no longer satisfied with a satisfied customer unless that does not translate into repeat purchase intention. So, they are leaving no stones unturned until they are holding back the customers, ensuring their cent percent loyalty. This would be used as a competitive edge. Now researchers have also identified scale to measure purchase intention as "conceivable to purchase, proposed to purchase and contemplate purchasing". They further added a new dimension as; "impulse purchasing, halfway arranged purchasing and completely arranged purchasing".

The link between customer satisfaction and loyalty is also well established. The impression gained by the customer when he is satisfied with a purchase is positive and that leads to repurchase (Mittal & Kamakura, 2001). They are also ready to accept little higher prices provided it is not exorbitant (Homburg et al., 2005; Homburg et al., 2005). Homburg et al. (2005), Lam et al. (2004), and Mittal & Kamakura (2001) suggested that the relationship between customer satisfaction and the subsequent manifestation in loyalty may be non-linear. The angle of return to scale in the relationship between satisfactions and repurchase intention was researched by Heskett et al. (1994) and they found it increasing or in other words, once customer satisfaction crosses a certain milestone, the repurchase intention increases rapidly.

Ngobo (1999), has added a new dimension of the delighted customer which according to him is the next step of satisfaction. In case the customer is delighted, the return in purchase intention would be increasing. Oliver et al. (1997), has added in the same argument by saying that tremendously satisfied customer or delighted customer is more like to be loyal than those who are merely satisfied. The same argument also holds good for word of mouth and readiness to pay premium prices. So, there is an increasing return to scale between the outcome of attitudinal loyalty and customer satisfaction.

Repurchase intention can be termed as the readiness of the customer to continue the relationship with the product/brand /service provider by purchasing/utilizing next time whenever decided to procure. Julander & Soderlund (2003), suggested a three-point scale to describe repurchase intention. They suggested that positive switching barrier, negative switching barrier, and satisfaction are the three variables affecting repurchase intention.

Researchers have stood by the obvious revelation that satisfaction and repurchase intention are directly linked (Ahmad et al., 2010; Bolton & Lemon, 1999; Patterson & Spreng, 1997; Selnes, 1998). Even though the major outcome of customer satisfaction is repurchased intention, it has some other ramifications also (Mittal & Lassar, 1998; Sharma & Patterson, 2000). While studying customer behaviour in the service industry, Henkel et al. (2006) suggested that satisfied customer has a high future repurchase intention. Even though customer behaviour is a subjective outcome, still purchase intention in the future can be termed as an index to predict the same. In other words, Fishbein & Ajzen (1975) opines that purchase intention will manifest itself in the future in the form of repeat purchase of the same product or avail service from the same service provider (Dodds et al., 1991; Schiffman & Kanuk, 2004). By an interesting observation, Fishbein & Ajzen (1975), argued that purchase intention also acts as a mediator and influences the relationship between consumer's attitude and their actual purchase behaviour.

The measurement suggested for purchase intentions are "possible to buy, intended to buy and consider buying". It was further rephrased and referred to them as "unplanned buying, partially planned to buy and fully planned buying". Kandampully, (1998), and Zeithaml et al. (1996) argued that firms will make utmost effort to extend superior service to retain customers and influence their repurchase. Szymanski & Henard (2001), has categorically mentioned that service quality can be termed as a prerequisite for consumer satisfaction. Initially, consumer loyalty and brand loyalty were almost the same. In addition, numerous prior investigations that thoroughly studied brand loyalty for tangible goods, served as the groundwork for a notion of

customer loyalty that now reaches out to service organizations, that commonly comes up with less tangible products (Gremler & Brown, 1996).

Customer loyalty is a building block that is constructed by incorporating performative and behavioural factors into a single integrated structure. Palmatier et al. (2006) perceive customer loyalty as an amalgamated result of goals, dispositions, and indicators of the service provider's performance. The concept of loyalty in service delivery in the development of marketing strategies is not recent or unheard of (Wong et al., 2012). In addition, the function of managers in the service industry is to develop strategies to increase the standard of loyalty of their customers that lead to strong service growth and promote self-sufficiency and longevity of the business (Chen & Cheng, 2012; Keiningham & Aksoy, 2012).

Researchers also claim that customer loyalty strongly helps a company to bring in revenue and gradually reduce the costs using which companies bring in new customers or hold on to the old ones, i.e, costs of customer acquisition and retention are significantly lowered (Auka, 2012; Rapp et al., 2012; Reichheld, 1993; Reichheld & Sasser, 1990). Hence, Krumay & Brandtweiner (2010), Mokhtar & Maiyaki (2011), and Wong et al. (2012), explained customer loyalty as the extent to which a customer manifests repeat purchasing patterns with regards to the same service provider, maintains a biased temperament towards the provider, and strongly prefers this provider as and when a need for this service is in question. Customer loyalty is calculated by the extent to which a customer is willing to praise and speak positively about their respective service providers to their peers and acquaintances (Alok & Srivastava, 2013; Arasli et al., 2005; Elmayar, 2011; LeBlanc & Nguyen, 2001)

A survey of customer perceptions about the quality of services of life insurance firms in New Delhi by Singh et al. (2014) revealed four distinct factors connected to the quality of health insurance service. These factors are Tangible factors, Responsiveness and Assurance factors, Empathy factors, and Convenience factors. These factors corroborate 71 percent of the overall variance.

2.2.9 Health insurance & health care sector

Health insurance sector

By a comprehensive and intrusive study on health insurance customers (Abu-Salim et al., 2017) summarizes as follows:

- Customers' presumptions regarding the quality of service and their understanding of the total cost that is essential for the service will largely decide how they view the service quality.
- How the customers view the service quality (which is largely governed by their presumptions and their understanding of the total cost required for the service) will significantly decide the extent to which the customers are satisfied with the service provided.
- The level of satisfaction (which is again, governed by the customers' presumptions, understanding of the total cost, and their individual experience of the service) will in turn determine whether the customers will continue with their present service providers or not.

Rahman et al. (2014), in their study showed that customers consider the following factors when selecting a specific healthcare insurance policy: i.e. performance of the firm and their prominence in the business environment. Customers' interpretation of the company's potential to satisfy its consumers directly influences the decision of customers to continue with the service. Customers also sometimes link their association with the health insurance service with their respective religion, which in turn impacts their satisfaction level. This study further suggests that the customers' decision to be a frequent client to the firm is substantially decided by the fundamental elements of service quality (reliability, tangibility, assurance, empathy, and responsiveness); customers' interpretation of the firm's policies and agendas to satisfy their customers such as in terms of religion; and the firm's reputation and prominence in the corporate environment. Hence, healthcare insurance providers must develop better approaches to interact with their clients, for instance, by sharing details of their

medical care. The knowledge level of service providers and their proposition regarding advertisement should be at par with the expectations of the customers.

Rahman et al. (2018) also states that health insurance service providers must comprehend the fact that focusing only on the quality of service is inadequate; what is preferable is to keep the customers exceptionally satisfied. Furthermore, an increasing customer satisfaction level lends itself to the patronage behaviour of satisfied customers. This also allows health insurance service providers to save their marketing cost since satisfied customers creates a great deal of marketing power.

Customers' perceived service value is greatly linked with and affected by Functional Quality (FQ), Technical Quality (TQ), and Firms Image (FI) (Abdelfattah et al., 2015). Moreover, customers' perceived value and customers' loyalty are two elements of service quality that are extensively interwoven. The indirect outcome of perceived value is far greater than the outcome of the correlation between technical quality and customer loyalty. Thus, in the case of a specific service provider where perceived value plays a significant mediating role, customer loyalty is substantially affected by the technical quality of the service. Whereas, when perceived value plays a minimized mediating role, customer loyalty is substantially affected by the company's image.

Health care sector

Chaniotakis & Lymperopoulos (2009) thought that any service comprises components borrowed from technical quality and functional quality. In medical services, technical quality is the quality of the clinical supervision provided, which is essentially the result of the care provided to the clients. Whereas functional quality is the way the clinical supervision is provided, that is the whole process of care provided to the clients. It is presumed that the more fulfilled and satisfied the new mothers are with the maternity service; the more pleased and inclined they are towards indulging in affirmative word-of-mouth marketing. Empathy happens to be a significant element out of all the other dimensions in the service quality model because:

- It directly influences word-of-mouth marketing.

- Other than reliability, it largely impacts all the dimensions in the service quality model.

According to Padma et al. (2009), the following (Fig. 2.2) are the aspects of service quality in medical services.

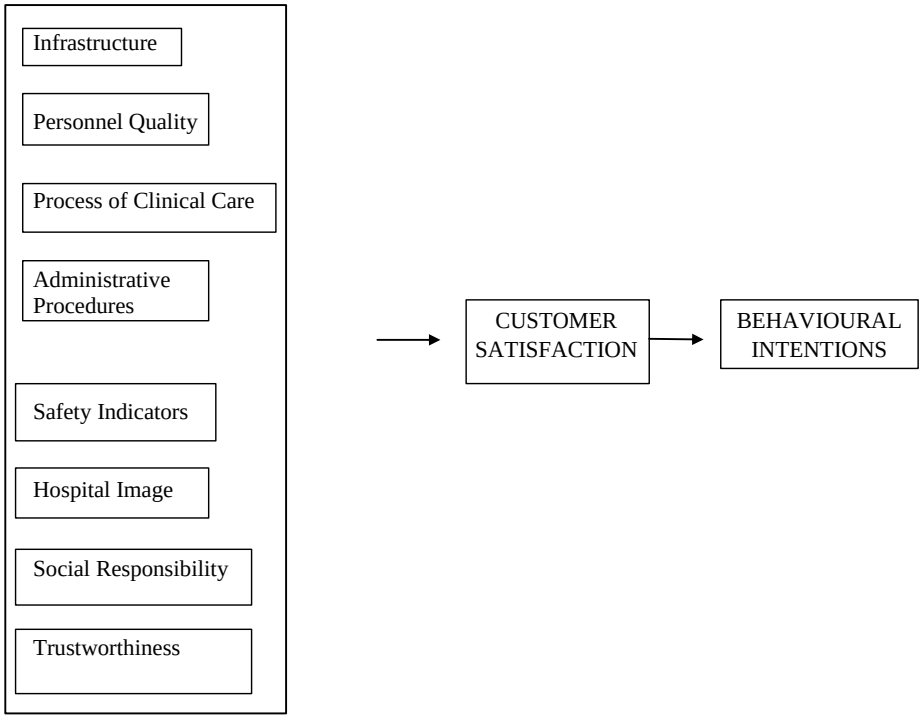


Fig 2.2 Service Quality Dimension

In a study in an Indian hospital Kondasani & Panda (2014), used in their model the following items as constructs of perceived service quality: tangible setting of the service, honesty and dependability, well-behaved and courteous staff, correspondence, accountability, security, and the trust and loyalty of consumers. The study concluded that the two elements: dependability and security are not delivering considerably towards the loyalty of the consumers. This suggests that medical service providers are not competent enough to offer these factors in their respective services.

If we take the study conducted in Malaysia into consideration, we can observe that the inhabitants there have significantly low presumptions and expectations regarding private health care services (Sohail, 2003). This may be because most Malaysians

depend on services in government hospitals where the expense for clinical administrations is a lot lower due to huge subsidies. Nevertheless, the value of the private sector should not be misjudged since the income from private emergency clinics is near 50% of the medical services industry's absolute income.

Health insurance sector-

A study on consumer discernments regarding health insurance was conducted in Ranny Taluk and its primary intention was to comprehend the level of information available and its sources to the consumers about health insurance, to recognize the variables that impact consumers in their choice of health insurance and choice of specific health insurance company, to understand the degree of satisfaction of the consumers (Jacob, 2018). Based on a very limited sample of 50 respondents her study concludes that a significant purpose behind picking a specific health insurance organization is convenient access to associated hospitals 24 percent, along with a quick claim process with very few procedures and name and notoriety of the insurance agency, just 14 percent respondents select an insurance agency based on an inclusive coverage offered by them.

Health care sector

Tuzovic & Kupelweiser (2016), was one of the first researchers to study service convenience in the health care sector through an in-depth recorded telephonic interview method. The study uncovered that health care service convenience comprises of seven unique measurements: decision, access, planning, enlistment and registration, transaction, care conveyance, post consultation convenience. Moreover, usefulness, usability, and safe and agreeable factors of self-service technology (SST) are significant side elements that affect its overall use, and eventually on the patients' encounters with the registration and transaction processes.

Higgins et al. (2014), in a literature review paper concludes that a preference-related process utility exists, which is not dependent on health outcomes. Issues like social value judgments warrant consideration, and perspective may need to be modified to show the correct utility of interference, particularly when the external, process-related

advantages are likely to be considerably greater than any displaced ones connected with health. The focal point should not be on encouraging process usefulness on top of all other decision-making factors but on developing a poised perspective of the overall cost and utilities associated with interference.

Tse & Wilton (1988) believed satisfaction to be the difference between a consumer's former assumptions regarding quality and the genuine perceived quality. Discrepancies between customers' perception regarding the quality of the service and their former assumptions decide their degree of satisfaction or dissatisfaction, which thus decides consumer loyalty (Rust & Oliver, 2000; Che´ron & Nornart, 2010).

Consumer satisfaction is imperative to the marketer since it, for the most part, is thought to be a critical factor in convincing customers to display patronage behaviour, manifest affirmative word-of-mouth tendencies, and exhibit customer loyalty (Bearden & Teel, 1983)

Health Insurance sector

The study in the health insurance sector in Hong Kong by (Wong et al., 2014) shows that customers, who are satisfied, very often portray brand preference toward insurers offering satisfactory services. A substantial shift in brand preference was noticed, with a standardized regression weight of 0.476 and significance ($p = 0.000$), as validated by the level of customer satisfaction. Prior studies suggested significant relations between customer brand preference and customer loyalty. However, this study uncovered that, in Hong Kong's healthcare insurance industry, brand preference appears to be an imperative precursor of consumer loyalty.

Results from a consumer experience survey across industry conducted by McKinsey's (2015), showed that the possibility of consumers renewing their health insurance policy gradually escalated with their satisfaction level. The prospect of customers reporting their policy renewal was five times more present in customers satisfied with the service than customers who were not. The possibility of customers staying with the same insurer, while changing between segments, gradually escalates with the satisfaction level, as backed by evidence.

McKinsey's (2015), report based on research, establishes that ample opportunity still exists for insurance companies to enhance customer satisfaction/ engagement and the report also emphasizes the importance of understanding the journey customers imbibe as they study, finalize, and utilize health insurance. The report also suggests that the consumer's interaction with the payer starts with sign–up and joins, followed by selecting a provider, receiving care, etc ending with the renewal of coverage. There are seven key steps and insurers need to understand customers' motivation at each of these touchpoints.

Tse and Wilton (1988, p. 204) believed, satisfaction to be the difference between consumers' former assumptions regarding quality and their perceived quality. This difference is also responsible for deciding a consumer's satisfaction or dissatisfaction level, which thus decides their patronage behaviour concerning the service. (Koenig-Lewis & Palmer 2014). Usually, consumers' decision to become a patron is largely governed by their satisfaction level and their experience with the services provided (Butt & De Run 2010).

Althabaiti et al. (2019), in their concluding remark in their literature review section on a similar subject mentioned that Well-developed healthcare systems provide an opportunity for the development of effective insurance programs that help economically disadvantaged individuals pay their medical bills. Insurance remittances also play a significant role in enhancing the overall quality of care by settling other health-related costs. In cases where insurance companies are proficient to meet obligations, patient satisfaction is improved, and customer dissatisfaction is highly likely in cases where the healthcare insurance plans do not deliver on their promises.

While studying consumer satisfaction in Cooperative health insurance (CHI) in Saudi Arabia, (Alharbi, 2017) postulated four characteristics of CHI, namely Availability, Accessibility, Acceptability, and Quality (AAAQ). The outcomes of the research revealed that, when evaluated exclusively, the independent variables depicting the service characteristics of Cooperative health insurance, largely lend themselves to the dependent variable, the satisfaction of domestic and international employees with the Cooperative health insurance program. An imperative healthcare consumption

determinant in both the private and public sectors is the customers' convenient access, as suggested by the constructive correlations between the factors of accessibility and customer satisfaction. The elements of satisfaction and acceptability also develop a constructive correlation between themselves. The most distinctly depicted variable was that of quality. The R^2 value (0.34) of the quality dimension is principally connected to the satisfaction level of the customer. This suggested the existence of a significant and unwavering correlation between the perceptions of customer service quality and customer satisfaction with the services provided.

A study was conducted by Kumar & Sabrin (2020), in Tiruchirappalli city of India to analyse the satisfaction of customers towards the health insurance policies. The satisfaction was measured in detail with five aspects, i.e., customer service, quality of product, the performance of employees, procedure for the claim, and infrastructure facilities. The suggestions given in the study says

- The high-income respondents are not highly satisfied with the performance of the agents and other staff of the insurance companies. They may expect recognition for their status. Hence, it is suggested that the companies should change their strategy of approach with high-income group respondents.
- Only high insurance premium paying customers are satisfied with the customer services, infrastructure, and overall satisfaction. The insurance companies should improve their services to satisfy all customers irrespective of the size of the policy.

It is essential to hold the current client instead of pulling in another client in the health insurance industry since the cost of presentation in continuing with the same client will be significantly less (Rubala & Selvachandra, 2020). Their investigation centres on the loyalty level of health insurance policyholders in Nagappattinam District and concludes that there is a significant connection between the ages, of the policyholders with the standard of health benefits in health insurance.

The level of satisfaction in medical coverage policyholders relies considerably on the kind of policy along with the kind of insurance agency (Vijay & Krishnaveni, 2018) Customers acquiring health insurance policies from private agencies tend to be more satisfied with the policies than those acquiring the same from public agencies. With regards to the kind of policies too, there appears to be a substantial amount of influence on the level of satisfaction of customers. Family floater policies and individual policies are not as favoured as compared to group policyholders, with regards to the level of satisfaction in customers.

Health care sector

Kitapci et al. (2014), believed that in the health protection industry, prior studies on customer satisfaction have discovered a connection between satisfaction and service quality. For instance, Anbori et al. (2010) concludes that the two dimensions of service quality, that is empathy and assurance, which mostly exhibit word-of-mouth marketing, had a considerable amount of impact on determining the patient's behavioural intention of becoming a patron or a repeat customer. Customer loyalty appears to have sub-facets of its own, that is, WOM and RI. Between these two dimensions, RI is an apparent personal goal or preference of the customer that determines their wish on continuing the relationship with a service provider and approaching the same one as and when the need for that service occurs.

Fascinating research on health care revealed the following three stances Firstly, it deals with customer loyalty to a medical care association utilizing the information from the entirety of the respondents. Secondly, the information was examined based on sex, while lastly, it dealt with the age of the participants. The study inferred that if the relationship between service providers and customers is adequate, then the loyalty exhibited by both male and female customers will also be significantly higher (Astuti & Nagase, 2014). Hence, researchers strongly suggest the existence of a constructive relationship between relationship marketing and loyalty. Still, customer satisfaction does not necessarily mediate the correlation between relationship marketing and loyalty. Customers can exhibit loyalty despite being dissatisfied with the service due

to relationship marketing. Hence, relationship marketing can often have poor consequences and can have no substantial effect on the loyalty of customers.

A study in UAE reveals that contact employees (Aburayya et al., 2020) mainly the registration staff and receptionist with the level of customer orientation positively influence parents' view of the clinic's quality of service and eventually result in customer loyalty and satisfaction. This study directs management to train frontline employees and reward exemplary performances based on feedback from consumers.

Ali et al. (2010), when examining medical care loyalty in Yemen postulates that the socio-demographic characteristics, other than the sex of the participants, do not play a significant role with regards to the loyalty of customers. A significant proportion of participants (34.2 %) revealed a substandard perception of the overall quality of the service. The desire to revisit the same service provider largely depends on the cost enhancement strategies, assurance, reliability, and empathy of the private hospitals.

Astuti & Nagase (2014) resolved that patients are disappointed with the services because of a reduced amount of palatable treatment as contrasted with their prior assumptions with the service. The study further reveals that the prospect of customers changing their service providers has an enormous impact on customer loyalty.

Mohamed & Azizan (2015), developed constructs of perceived service quality while investigating patients in a Malaysian hospital: "Infrastructure, Interaction, Administrative procedure, medical care, and nursing care." The study strongly backs the belief that perceived service quality, customer satisfaction, and adherence to social ethics are all imperative elements in medical care quality.

Amongst the two cognitive elements of the multi-attribute attitude model, that is service quality and value, service quality appears to be a more imperative causal factor for customer satisfaction, over value. Outcomes dictate that both service quality and value have a substantial effect on behavioural intention whereas; value assessment was impacted by perceived service quality.

The two most imperative elements of medical care service are assurance and responsiveness (Lim et al., 2000). The outcomes of their research in Singapore, when

considered altogether, suggest a significant message from customers to the service providers in the healthcare industry be sympathetic, be cordial, be considerate, treat patients with utmost decorum and regard, and above all, disclose to patients the details about their ailment properly.

Wang (2011) opined that dissatisfied customers often exaggerate their experience to gain sympathy or recognition from receivers of messages. Ennew et al. (2000) showed through research that positive word of mouth from satisfied customers improves further purchase and it is used as a highly effective advertising tool by marketers. Mazzarol et al. (2007), mentioned that advertisement using genuine word of mouth is nine times more effective than traditional advertising. However, the good news is that dissatisfied customers are not always bad news for the company. Many marketers look forward to getting some feedback from dis-satisfied customers as they know that if they can proactively solve the reason of dissatisfaction, these customers are most likely to be a loyal customer of the company for life long. In most cases, it does not involve a great expenditure to provide the solution, just some attention to ensure deliverables is sufficient.

Rather than the features of the product or the service, customers have become the most sought-after assets for companies to achieve their desired level of success (Solnet & Kandampully, 2008). Because customers manifest the word-of-mouth tendencies, whether on social media or in real life, whether appreciative or comments of dissatisfaction, are scrutinized by other potential customers (Khare et al., 2011). Hence, a company must centre their focus around building customer relationships with trust and engagement (Eisingerich et al., 2014) With regards to the possibilities of service, loyalty can be procured while, with regards to the possibilities of a product, loyalty can be bought (Edvardsson et al.,2000). A WOM provider may be urged by character attributes, congeniality, and a craving for assisting others (Lau & Ng, 2001).

Health Insurance Sector

As revealed by research on the Greek medical coverage industry by (Tsoukatos & Rand, 2006) consumers do not permit the tangible facets of service in estimating their satisfaction level. Thus, they fundamentally focus on enhancing their human resources factor than the tangible element of their services. Another fascinating discovery is that emotional loyalty is a precursor of behavioural loyalty and, behavioural loyalty is not impacted by customer satisfaction. Subsequently, insurers must enhance their sales procedure in acquiring the inclination of customers towards indulging in positive WOM as opposed to focusing simply on direct sales.

Health care sector

A robust relationship is postulated by Ferguson & Paulin (2010) between positive WOM tendencies and the congeniality of surgery patients in Toronto backed by both their character attributes and individual ethics. Patients exhibiting affability and outwardness have a larger prospect of indulging in positive word of mouth.

Health insurance sector

Rahman et al. (2014), uncovered that the reputation and notoriety of the firm act as mediating factors between trust and the willingness of the customer to become a patron. This study additionally infers that the function of trust in between the quality of service and the willingness of the customer to become a patron is not completely interceded. At the same time, the connection between trust and the willingness of the customer to become a repeat purchaser isn't significant.

Fattah et al. (2016) examined the impact of service quality and trust on the customer's decision to become a repeat purchaser in the Malaysia health insurance sector and their study discovered that to confront the cutthroat and ambitious domain of the corporate world, service providers in the health insurance agency must improve their quality of service by propagating the notoriety and reputation of the firm to procure the trust of the consumer so that they can increase the desire of the consumers of becoming a repeat purchaser (Haque et al., 2012).

Health care sector

A major factor for customer dissatisfaction with medical care in China is the absence of trust (Shan et al., 2016). Trust procured from patients is an imperative indicator of the satisfaction level in patients, and it is formed by the patient's interpretation of the service provided, manifesting compassionate communication and a more proficiently constructed health insurance that offers a more secure monetary aid.

A more skilful service execution is an essential element for ensuring the trust and loyalty of customers (Huang & Liu, 2010). Observations suggest that consumer satisfaction has a constructive and salient impact on the trust of the customers (Kantsperger & Kunz, 2010; Chung & Shin, 2010). Similarly, consumer satisfaction has the same desired impact on the loyalty of the consumers (Dagger & O'Brien, 2010; Sheng & Liu, 2010).

An investigation by (Ramli & Sjahruddin, 2015) on medical care patients in the city of Makassar demonstrates that the patient had acquired the desired and necessary services that might expand their level of satisfaction, yet it is not meeting their ideal level. A more thorough investigation revealed that the patients are most content with the overall treatment of their ailment, followed by, the doctors' recommendations regarding medicines, the test results, and lastly, details provided by the doctor regarding the patient's ailment.

Health Insurance Sector

Some of the roadblocks studied in the health insurance sector are adverse selection, poor health plan choice by consumers. A collection of research summarized that decision of a consumer is highly influenced by context and can systematically be different from what is taken in a frictionless environment. (Handel, 2013) noted that in the alternative context inertia may not be a direct cost but has a close relationship with adverse selection.

Health care

The findings of the work by Goncalves et al. (2020) say that inertia is a significant antecedent of loyalty, and it also claims that inertia has a stronger effect on healthcare than other services. The reason lies in the inherent nature of health care. The health

care service is not comparable with any other product or service as it involves life and death. Medical science has always maintained that mental health is equally important if not more than physical health which ultimately determines a patient's survival. So, unless the consumer had a negative experience from an earlier company, inertia plays a significant role in deciding to choose the next move.

Health insurance sector

Research by (McKinsey's, 2015) puts forward numerous benefits of improving the customer experience and member engagement, which eventually enhances the firm's financial status. The benefits can be reduced attrition rates, reduced administrative onus and consequently, increased cost savings, reduced medical expenses while improving results, evading disruptions by other providers. A better approach towards customer engagement brings forth a more enhanced financial status of the firm. Health insurance providers must study the patterns that govern how their customers purchase and utilize the health insurance provided by them so that they can assist their customers in healthcare in a more thorough manner.

Health care sector

Cengiz & Kirkbir (2007), suggested that perceived value is a multifaceted concept that comprises eight facets namely, the functional value which has its subdivisions including, instalment, quality of the service, cost and code of conduct, emotional value with its subdivisions including originality, regulations, and pleasure indulgence and social value. Consumer attachment is considered as having perceptive, psychological, and behavioural aspects (Wong & Merrilees, 2015). Van et al. (2010), defined consumer attachment as the clients' physiological articulation in the context of the brand or the firm, more than the process of procurement, coming out of inspirational drivers. It contains a huge combination of conducts entailing word-of-mouth (WOM), suggestions active counselling and guidance, blogging etc.

After examining the function of all the facets of perception of service merit in the increment of consumer attachment and allegiance in medical assisted living centres in Egypt, Mohsen et al. (2018) believed first, there is no imperative correlation between

instalment, cost, code of conduct, quality of the service as features of the operative perceived value features, and consumer attachment. Moreover, originality as an emotional perceived value feature has no major connection with consumer attachment. However, dominance as psychological perceived value features have a major connection with customer engagement. Meanwhile, social value has a major connection with consumer attachment. Finally, it is found that consumer attachment and brand loyalty are majorly connected. In mediation analysis, the results show that only control has a major indirect attachment on loyalty through consumer attachment. Also, consumer attachment partially incites the correlation between Control and Customer loyalty by percent.

2.3 Research gap

A close look into the existing research that has taken place covering the health insurance domain reveals the following gaps

- The concept of service convenience construct as per the SERVCON scale is very rarely studied in the health insurance domain. As the industry is going very fast, convenience would gain more weightage progressively in people's minds.
- The concept of post benefit may have a broader meaning in consumers' minds because of many innovative offers being made by insurance companies off late. The original SERVCON scale (developed in 2007) defined post benefit as re-establishing subsequent contact with the firm. However, we conceptualize that as some offers and discounts thrown in by companies once you stick to them.
- Even after an extensive search, we could not find papers where factors like trust and word of mouth (WOM) are studied as moderators on the relationship between satisfaction and customer patronage in the health insurance domain. Even inertia as a moderator in the health insurance sector convoluted with reputation and service performance of the insurance firm also is first published in a paper in 2021.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

This chapter deliberates on research methodology which many considers as the heart of the research. The link between the research gaps obviating from the laborious literature study and the outcome of the study is made through a carefully crafted research methodology. This research can be considered as a cross-sectional study that majorly applied convenience sampling technique. Researchers explored to determine the constructs and sub-constructs of customers' re-purchase intention of healthcare insurance products under the perspective of service quality and service convenience. Existing knowledge on these topics is probed and different models used in previous research were investigated. Service quality is already a frequently researched construct and other than health insurance, it is researched also in a variety of service industries like telecom, health care, airlines, etc. Service convenience is probed in the fitness industry, health care, and many others.

Using scientific methods and qualitative/quantitative techniques, this part of the research tries to obtain a relationship among the variables used. Starting from sample selection, data collection, data interpretation is discussed in this chapter. Primarily questionnaires were set, taking help from existing literature and help from industry experts, and used as a research instrument to collect data from respondents. This chapter is subdivided into the following sections:

- Objectives of the Research
- Development of Research Hypothesis
- Conceptual Framework
- Research Design and Methodology
- Summary

3.2 Objective of the research

- To determine the effect of determinants of service quality and service convenience on perceived value in the health insurance sector.
- To determine the effect of perceived value on customer satisfaction in the health insurance sector
- To determine the moderating role of trust, inertia word of mouth, and type of organisation issuing the policy on customer patronage in the health insurance sector
- To determine the role of perceived value and customer satisfaction on customer patronage in the health insurance sector.

3.3 Development of research hypotheses

The term perceived value relates to the perception of the consumer in terms of value. The word value relates to whatever merit or desirability of a product or service's the customer perceives, especially in comparison to a competitor's product. The concept of customer value was first propagated by (Zeithaml, 1988). He defined customer value as "the consumer's overall assessment of the effectiveness of the product based on perceptions of what is received and what is given.". Extensive research carried out by (Zeithaml et al., 1990) revealed the obvious connection between service quality and perceived value. Zeithaml (2013) and other researchers, while studying the relationship between service quality and perceived value, have shown that if marketer pushes customer expectation too high, the buyer is likely to be disheartened after encountering the service, but at the same time, if the expectations are set too low, there may not be any buyers of that service. So, it works as a double-edged sword.

Different researchers have studied the measurement of service quality under different industry scenarios (Dauda et.al. 2016; Jun and Cai, 2010; Yang & Jun, 2008; Haenlein et al., 2007). Many researchers have also worked on various models about the constructs of service quality (Parasuraman et al., 1988; Cronin and Taylor, 1994). Thereafter (Hossain et al. 2015) noticed that service quality is context-oriented and

different industries provide different service quality to their clients hence the constructs may vary across industries. Even though SERVQUAL developed by Parsuramn et al. (1988) is the most well-known construct of service quality, different researchers have modified the scale and made them more relevant to the specific industry, *viz.* WebQual (Loiacono et al., 2002), GovQual (Batini et al., 2009), CouQual (Valaei et al., 2016), e-GovQual (Papadomichelaki et al., 2012). The term service quality is also explained as a measure of superiority in the sense that how the consumer finds the service superior compared to other similar services available. (Babakus et al., 2004). Service quality in the health insurance and health care sector is also studied by earlier researchers (Rahman et al., 2017; Rahman et al., 2014; Rubala & Selvachandra, 2020). In most of these research, SRVQUAL model is used to validate their results.

So based on the above research, the following hypothesis has been developed.

Hypothesis (H1*):* Determinants of Service Quality (SQ) significantly affect Perceived Value (PVAL) in the context of health insurance products.

Service convenience can be associated with the advantage a consumer is getting in terms of time and effort while experiencing a service, leading to value addition in the process. (Colwell et al., 2008). Researchers have studied the relationship between service convenience and perceived quality on perceived value, satisfaction, and client loyalty in many sectors. Garcia-Fernandez. et al. (2018) evaluated positive relationship among the above variables in the low-cost fitness sector. In general, we perceive the quality of a product or service as a benefit, but value means much more. Value has a more global characterization, which means a comparison between sacrifices and benefits. Moreno et al. (2016) studied spectators in a sporting event and found a straightforward and positive relationship between quality and value. For example, (Keaveney, 1995) demonstrated that for online service client's convenience had a big influence over perceived value. Other researchers who have replicated similar studies and examined similar relationships in examinations of students participating in educational trips (Gallarza & Gil, 2006), restaurant-goers (Chang et

al., 2010); service clients (Martín et al., 2008), persons who frequent shopping centres (Lloyd et al., 2014); hotel clients (Martín-Ruíz et al.,2012). In extrapolating these findings to the health insurance context, we hypothesized hypothesis 2.

Hypothesis (H2): Determinants of Service Convenience (SC) significantly affect Perceived Value (PVAL) in the context of health insurance products

The relationship between service quality leading to customer satisfaction and its direct relationship with customer patronage is well documented by (Rahman et al., 2014). Researchers from the last 3 decades showed considerable insights into all constituents of customer patronage. Cronin Jr et al. (2000) has assessed the effect of perceived value, service quality, and satisfaction on the behavioral intention of consumers in service encounters. According to his study, when all these variables are taken collectively and cohesively, service value, service quality, and satisfaction may be considered as directly related to behavioral intentions. His study also went on to note that indirect effects of quality and value significantly strengthen their effect on behavioral intention.

Based on the above views concerning the relationship between customer patronage and perceived value, we propose the following hypothesis

Hypothesis (H3): Perceived Value (PVAL) significantly affects customer patronage decision (CPD) in the context of health insurance products.

Perceived value as enumerated above is also an influencer for satisfaction. Because of its potential influence on consumer satisfaction, it has been the subject of much attention in the literature (Bitner and Hubbert, 1994; Cardozo, 1965; Oliver, 1980, Olshavsky & Miller, 1972). Satisfaction as a construct has evolved the interest of marketers and researchers for the last 3-4 decades and is being studied extensively under various contexts. Satisfaction is a combination of emotional reactions and evaluative feelings. The first objective of any marketer to boost the sale of a product

or service is the creation of satisfied customers. Moreover, it is also established that satisfaction has a strong influence on behavioural intentions and customer retention. A consumer will be satisfied when the possession of any good or service will create a positive vibe or feeling in him (Anderson & Fornell, 1994; Anderson & Sullivan, 1993; Bolton & Drew, 1994; Cronin & Taylor, 1992; Fornell, 1992; Oliver, 1980; Oliver & Swan, 1989, Rust & Oliver, 1994).

Based on the above views concerning the relationship between satisfaction and perceived value, we propose the following hypothesis.

Hypothesis (H4): Perceived value (PVAL) significantly affects Satisfaction in the context of health insurance products

Based on the basic notion that the satisfaction of the consumer is a necessary but not a sufficient condition for future intention (Bolton & Drew, 1991) proposed that consumer's assessment of service value influences purchase intention and behaviour. However (Hurley & Estelami, 1998) had the opinion that satisfaction and service quality are distinct constructs and there exists a seminal connection. The perception of service quality influence emotions of satisfaction and this, in turn, affect future purchase behaviour.

The service in healthcare is altered and shaped constantly by physicians, nurses, and other professionals. Several major acts are identified in a hospital care encounter such as admission, nurse-patient encounter, physician-patient encounter, housekeeping, food service, technical service, and discharge. A halo effect of association occurs among hospital services on quality and customer satisfaction evaluation of specific service acts; for example, the level of satisfaction in consumers with the quality of food service is related empathetically to the level of satisfaction in consumers with regards to the quality of nursing care.

Marketers have always maintained that the process of customer satisfaction should lead to customer patronage and once customers attain the level of customer advocacy,

the company can sit back and only strive to retain that level. Even though this is easier said than done, the company can reduce some of its traditional marketing expenses once this level is achieved. Continuance intention is a yardstick that an individual will perform a specified behaviour repeatedly**.** Studies are done concerning different purchasing behaviour including the use of the mobile app and the likelihood of the continuation of similar behaviour in future

Based on the above views concerning the relationship between satisfaction and Customer patronage, we propose the following hypothesis.

Hypothesis (H5): Satisfaction significantly affects Customer Patronage Decision (CPD) in the context of health insurance products.

Continuance Intention

Continuance intention also can be referred to as the level of strength of one's desire to perform a specified behaviour**.** Limayem, et al. (2007) defined continuance intention as post-adoption behaviour. So, this can give a fair idea or prediction of future intention to repurchase. So, any factors which directly or indirectly affect the behaviour are a matter of study. De & Markus (2009) narrates that factors are not always cognition or logical and mainly they are based on emotional traits of a human. There is a strong connection between attitude and patronage, mainly where adoption of technology is involved. Wu & Wang (2005) found a strong reciprocal connection between satisfaction and continuance intention. Chen, (2008) also found a similar relationship where self-service technology usage is involved. In the case of the use of self-service technology mentioned in a study of inline retail shops that satisfaction was directly related to the continuation of consumer patronage in the future.

Lien (2012) studied a similar relationship for online shopping in Taiwan and corroborated the same strength. Hedman & Henningsson (2015), and Dahlberg, et al. (2015) also stressed in their research while someone is making a mobile payment, lot many stakeholders are involved in the whole dynamics. Therefore, a complex set of

constructs comes into play which determines the propensity of the consumer to continue to use that mobile app. Eramus et al. (2015) found that persuasion knowledge is one precondition of continuation and is strongly related to satisfaction. In summary, both satisfaction and continuance intention are complementary to each other, having a strong reciprocal relationship. In other words, continuance intention can be viewed as a measure of satisfaction of the customer.

Loyalty

Loyalty can be defined as the commitment of the consumer towards the brand or company. Studies revealed that in online shopping unless the consumer trusts the vendor, he or she is unlikely to divulge personal information and will be sceptical to accept any offers from them however genuine that may be. So, companies whose sale depends on sending personalized messages to prospective buyers, first need to develop trust. So, the loyalty developed from trust propels consumers to buy from the same vendor repeatedly and frequently. This helps in creating long-term sustainable relationships and positive word of mouth (Reichheld & Schefter 2000) defined loyalty as an outcome when the consumer generates dependability with a product or service, creating goodwill in the process, which culminates in re-purchase intention.

Cyr et al. (2006) found that in the field of online financial transaction loyalty is the most important construct for continuous intention behaviour. Holland & Baker (200l) while studying e-business marketing, observed that consumers display attitudinal preference and behavioural propensity when they develop brand site loyalty, such as frequent visits of, positive reinforcement of, and appreciative attitude toward the website. Amoroso & Ogawa (2013) while studying online retailers stressed that loyalty was important to enhance satisfaction and repeated use inclination for online consumers.

Inertia

Amoroso & Ogawa (2013) suggested in their paper that loyalty or repeat customer patronage and resultant satisfaction are heavily influenced by inertia. Consumers do consciously weigh all negative and positive factors in their calculation of switching

cost, which may be procedural and psychological (Samuelson & Zeckhauser, 1988; Blut et al., 2015). Many a decision involving inertia may not evolve through a logical process, but as a resistance to change, just let the things be as they are unless something warrants a change.

Payment made towards any medical check-up in India is considered a waste of money and not an investment by most Indian people. We can compare this mentality as a preference for breakdown maintenance in industry rather than periodic maintenance. The government of India is also not helping in changing this perception by the dearth of proper medical facilities in small cities and towns. These factors have resulted in a sense of inertia in minds of people towards medical insurance or issues related to that. Psychologists have therefore termed inertia because of a social-cultural and economic condition that needs to be studied.

Trust

Yuen (2007) defines trust as eagerness or keenness to depend on somebody. Al-Ekam et al. (2012), also define trust with similar meaning and agreed that trust factor cannot be generated instantly, it must develop through a period and that depends on so many factors. The major factor is the nature of the relationship between the parties involved. However, Chaudhuri & Holbrook (2002), argue that consumers develop eagerness when the brand of product or service they are using performs to their satisfaction. Delgado-Ballester & Munuera-Alemán (2001), very rightly pointed out in their research the determinants of trust creation. They said service quality is the factor that has a long-lasting effect on the consumer while generating trust. Research very clearly shows that for services like a credit card, industrial laundry, industrial distribution, auto servicing, how year upon year the lifetime value of the customer increases almost exponentially. So, it is just not an incremental benefit that you get from a long-term relationship with the customer, but you get multiple-multi tear benefits.

Word of mouth (WOM)

The effect of interpersonal communication was always regarded as valuable by researchers of consumer behaviour and social psychology. This interpersonal communication when recognized by companies as a major tool for repurchase intention was made known as word of mouth (Vazquez-Casielles et al., 2009). Major multinational companies like Cadbury, Nestle, Unilever, Proctor & Gamble have accepted that word of mouth is a highly credible, persuasive, and effective channel of communication. Nowadays there are specialized companies' expert in building WOM communication as a part of integrated marketing communication.

Researchers claim that a customer's decision to choose a product and a service provider is largely governed by word-of-mouth. Apart from empathy and assurance, the other dimensions of service quality do not have a notable impact on the level of satisfaction. Moreover, word-of-mouth is a huge incentive for customers for repeat purchasing.

Type of company offering the policy

After independence when the government decided to start an insurance company, the life insurance sector and general insurance sector were not open for the private sector. However, with the opening of the economy and the effect of liberalization, first life insurance and then general insurance sector was made open for the private sector through incorporation on **Insurance Regulatory and Development Authority (**IRDA) in 1999. The general insurance sector mainly comprises motor vehicles insurance, Property insurance and health insurance. The major market share of Indian health insurance was held by public sector companies till 5 years back, but private companies have gained a lot of market share in the last few years by offering innovative products and currently, both the public sector and private sector are enjoying almost equal market share.

Since the type of company i.e. public sector or private sector may have an influence on our research outcome we propose to study the moderating effect of the same on the relationship between satisfaction and customer patronage decision regarding health insurance products.

In view of the above discussion, we propose to study the moderating role of trust, inertia, word of mouth, and type of insurance company issuing the policy on the relationship between satisfaction and customer patronage decision.

Hypothesis (H6): Trust, inertia, word of mouth, and organization type significantly moderate the relationship between satisfaction and customer patronage decision in the context of health insurance products.

3.4 Conceptual framework

Based on various literature surveys and related articles, attempts are made to conceptualize a theoretical framework. In 2020, several studies are done in the health insurance space. Studies were done on policy holder's perception and satisfaction. The influence of personal and socioeconomic variables on health insurance is researched. Even though service quality is highly researched in health insurance, service convenience is seldom researched. However, it was felt that with the opening of the health insurance sector to the private sector from early 2000, market growth and entry of new players and intense competition is inevitable. Now consumers will be more demanding, along with service quality, providing convenience also will be of extreme importance.

To have a comprehensive view of the customer patronage in health insurance, we tried to have a robust model which shall also study the indirect effect of trust, inertia, and word of mouth on customer patronage. The fourth moderator "type of organization" was later added in the model as it was felt that the perception of respondents may vary depending upon the insurance policy of which type of organization they are using.

The following figure shows the model depicting the constructs and sub-constructs and their proposed relationship used in this research.

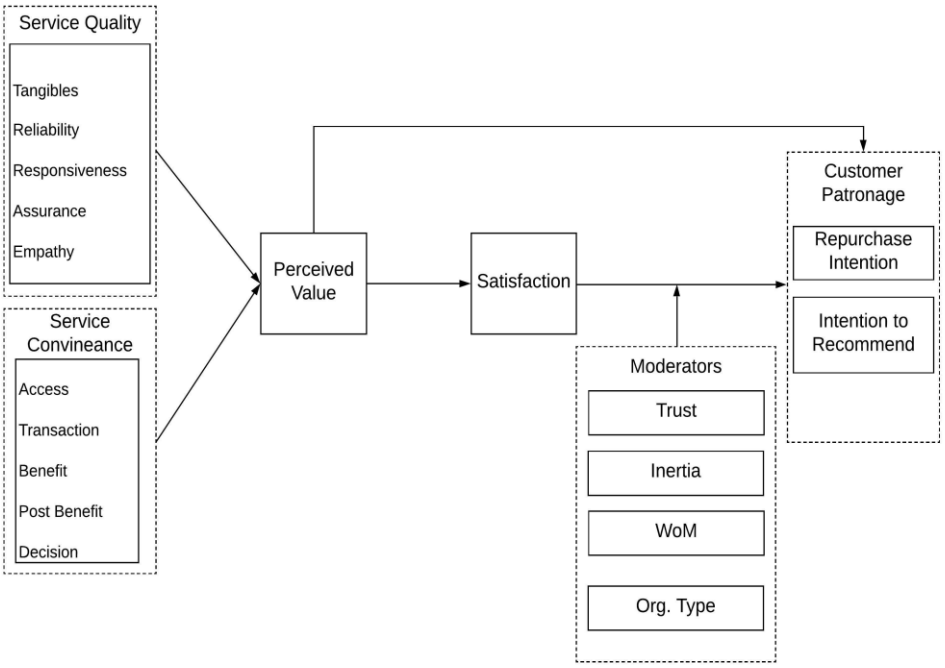


Fig 3.1 Conceptual Framework

3.5 Research design

This section would provide the framework or design on which the whole research is based. It defines the type of information to be collected, origin or source of data, collection process, method of analysis, etc. It also set out the relevance of the study and ensures that the procedure used is feasible and economical.

3.5.1 Study population

The population of the study consists of health insurance policyholders who have experienced renewing the policy at least once in the recent past.

3.5.2 Sample size selection

Due to the large Indian population and quantitative nature of the study, a sample survey technique was used. Health insurance penetration in India is low and mainly

city based. There is wide scope for health insurance companies to expand to tier 2 and tier 3 cities, before going further to rural India. The following table gives the contribution of Indian states in health insurance premiums in 2017-18

Table 3.1 Share of health insurance premium

2017-18		
Share of top 5 states in health insurance premium		
State	**Total premium of Health Insurance**	
	Amount	**All India share**
Maharashtra	11812	32
Tamilnadu	4669	12
Karnataka	3654	10
Delhi	2971	8
Gujrat	2133	6
Rest of India	11789	32
Total	37028	100

Source: IRDA annual report

As seen from the above table, Maharashtra is the undisputed leader, way ahead of other states, which can be attributed to their status as India's financial capital. Moreover, most of the private entities and some public sector companies are having their head office in Mumbai. Tamilnadu and Karnataka are close in their premium numbers, whereas Delhi being a small state has quite a substantial figure. Our bunch of respondents is mostly from Maharashtra (mainly based out of Mumbai) and Delhi, which comprise around 40 percent of our health premium collection points.

The survey was conducted by sending a direct questionnaire to respondents and first-hand information was collected. For the selection of respondents, convenience sampling was done. Overall, 530 responses were collected and then after rejecting some data for inadequacy etc., data of 500 respondents were used. The sample size is more than adequate based upon other similar studies and as per the standard formula used at a 95 % confidence level.

3.5.3 Research instrument

The primary data was collected through a structured questionnaire. The familiar method of sample survey with responses based on 7 points Likert scale is used.

3.5.4 Development of research instrument

The instrument was developed after a thorough study of existing literature and taking care of recent development in the insurance ecosystem. The questionnaire consisted of 80 items in total, which is further subdivided into the following broad sections

Service Quality: Twenty-three (23) items were developed from SERVQUAL, which was modified to fit the health insurance industry. The items are divided further into tangibles (5 items) reliability (4 items), responsiveness (5 items), assurance (4 items), and empathy (5 items). The items were adapted from works of various researchers (Rahman et al., 2014; Rahman et al., 2017). Service convenience: Twenty-five (25) items were developed from SERVCON which comprises access (5 items), transaction (5 items), benefit (5 items), post benefit (5 items), and decision (5 items). (Seiders et al., 2007) conceptualized explicitly and implicitly the various concepts of service convenience. He has proposed them to be a second-order, formative construct and has broken them down into five first-order dimensions. The items were adapted from works of previous research (Garcia-Fernandez et al., 2018)

Table 3.2: Statement selected from literature to measure service quality and service convenience

Tangibles	I find the insurance company uses modern technology in infrastructure and communication
	Physical facilities of the insurance company are visually appealing to me
	I find the employees and agents neat and professional appearances
	I hind the insurance company and people associated are having modern equipment
	I find the physical facility of the insurance company is in keeping with the type of service provided

Responsiveness	Employees and agents was never being too busy to respond to my requests
	I find the company settling my queries with no unnecessary delays
	Employees and agents giving me personal attention
	Whenever I faced problem my health insurance company was sympathetic and re assuring
	The employees of my health insurance company don't always have to be willing to help
Assurance	All relevant information like deductible at the time of reimbursement is disclosed to me
	I believe the company maintains data accuracy in all transactions
	I find the employees of the companies are experts in subject matter
	The maximum cap applicable at reimbursement is well explained to me at the time of purchasing
Empathy	The insurance company always had my best interest at heart
	Employees and agents being consistently courteous to me
	The employees and agents of the company were always willing to help me
	I always find the employees of my health insurance firm as polite
	It is unrealistic to expect the employees of my health insurance company to always keep my best interest at heart
	2) Service Convenience
Decision (time and effort cost associated with purchase decision/non-monetary cost)	The insurance company made it easy for me to find suitable health insurance policy.
	It was easy to get the information I needed , to decide which insurance company to approach.
	I spent minimal time finding the information to choose a insurance company
	The time it took to arrive at a decision was not too long
	I was easily able to determine prior to purchasing whether the insurer can offer what I am looking for
Access	It was easy for me to contact this service provider.
	It did not take me much time to reach this insurance company
	I can easily figure out the location /website of this company.
	I was quickly able to connect with the insurer's sales representative.
	The insurer offered convenient hours to interact

Transaction convenience	This insurance company allowed me diversified methods of payment
	The method of payment provided by this company is convenient
	I was able to complete my purchase quickly in this company
	I did not have to make much effort to make the payment
	The insurer made it easy for me to conclude the payment transaction
Benefit (experiencing the core benefit of the offering)	I could easily obtain benefits from the services provided in this company
	I found that the services in this company were easy to use
	The speed of providing services in this company met my requirements
	It is easy to get policy clarity from the insurer
	The policy was delivered to me at the appropriate time by the insurer
Post benefit (re-establishing subsequent contract with the firm)	When I had a problem, company resolved my problem quickly
	The company extended reward to me based on my performance through the policy.
	The company enabled me to arrange renewal of policy with minimal effort
	I feel the company has a good channel to handle complaints and recommendations
	It takes little effort to arrange for follow-up service

Perceived value (5 items) & Satisfaction (5 items) are adapted into the questionnaire after analysing various research papers (Garcia-Fernandez et al., 2018; Wu et al., 2016). The moderator section considers three subparts consisting of trust (5 items), inertia (5 items), and word of mouth (4 items). The items were adapted from works of various researchers (Rahman et al., 2014; Amoroso et al., 2018)

The dimension of customer patronage is considered as a combination of repurchase intention (5 items) and intention to recommend (4 items). The items were adapted from works of various researchers (Rahman et al., 2014; Garcia- Fernandez et al., 2016; Vazquez-Casielles et al., 2009)

7-point Likert scale is used where 1 denotes very strongly disagree and 7 denotes very strongly agree. Statements were asked to respondents (for example one sample statement in tangible construct was – "I find the insurance company uses modern

technology in infrastructure and communication". Respondents had to pick up one option from 1 to 7.

- **General Information:** Items related to the demographic information of respondents were considered in this part. These items were related to age, gender, income level, type of organization, etc. Data about type of organization type was collected given respondents two options to choose from *viz*. Public sector and Private sector

3.5.5 Content validity & pilot testing

The next step of content validity was required to check the face validity of the instrument, which means whether items of each construct are relevant, meaningful, and appropriate (Connel et al., 2018). To do these the questionnaire was presented to three academicians and two industry experts to ensure that possibly, responses will give us correct direction in this research.

Table 3.3: List of Experts Consulted for Content Validity

Name	Experience	Designation and address	Industry
Dr. V P Gangwar	20	Faculty, MSOB, LPU	Academics
Dr. Puja Kansara	10	Faculty, MSOB, LPU	Academics
Dr. Vishal Soodan	10	Faculty, MSOB, LPU	Academics
Mrs Indrani	25	Sr Mgr, OIC Ltd	Insurance
Mr Anil Verma	27	Director, Howden Brokers	Insurance

In the assurance construct, two items were added as per the advice of industry experts. Opinions of academic experts were used mainly to fine-tune words in some items, presentation of the matter, etc. After doing all these changes, the final instrument for the study was framed. After finalizing items of the different scales, the next step was Pilot Testing. It was done after collecting 150 responses, more than 10% of the respondents of the study (Bajpai, 2011; Connell et al., 2018).

3.5.6 Reliability test

Table 3.4 Construct reliability and validity

Construct	Cronbach's Alpha	rho_A	Composite Reliability	Average Variance Extracted (AVE)
Access	0.787	0.817	0.851	0.534
Assurance	0.746	0.925	0.816	0.530
Benefit	0.803	0.818	0.863	0.558
Decision	0.846	0.880	0.888	0.615
Empathy	0.851	0.855	0.894	0.627
intention to recommend	0.938	0.939	0.955	0.843
perceived value	0.949	0.950	0.961	0.832
post benefit	0.815	0.846	0.869	0.572
repurchase intention	0.962	0.962	0.970	0.868
Responsiveness	0.828	0.817	0.872	0.576
Satisfaction	0.944	0.944	0.957	0.817
Tangible	0.840	0.852	0.885	0.607
tran conv	0.840	0.933	0.881	0.597

Reliability is a measure of the consistency of results. Reliability is about how consistent the respondent is when he/she is answering the questions. Cronbach alpha is an indicator of reliability widely accepted in research and a value of alpha more than 0.7 is considered reliable. The other standard measures of reliability and validity composite reliability (CR) and AVE are also checked. The value of CR for all the variables is more than 0.7 and the Average Variance Extracted (AVE) more than 0.5. The other conditions, that CR>AVE, is also found to be followed in our data.

3.6 Missing data treatment

In a survey covering 500 respondents, there is always a chance that some respondent is not able to fill up all the required answers and kept certain part as partially answered or blank. Even though the structure of the questionnaire was made in a way where most of the options were marked as mandatory to answer before one can go to the next section, still in today's fast-moving world, there is always a chance of some missing or incomplete data. However, as we used convenience sampling and data was collected during the COVID period where people were mostly at home, the occurrence of missing data was not too daunting. We have collected 530 responses

and after removing some responses due to incomplete or improper data, we have finalized 500 responses for further treatment**.**

3.7 Outlier examination

Outliers are unique values that are very distinct from other observations. It leads to non-normality of data and creates inaccuracy in the outcomes (Hair et al., 2006). Outliers appear if the value of the specific observation is excessively far as compared to other observations of the dataset. Once it is identified, it can be deleted from the data set and the measurement model can be re-run using the newly cleaned dataset. After the deletion of a few extreme outliers, it might improve the multivariate normality and the process could be repeated.

There are four main reasons behind the outliers (Tabachnick & Fidell, 2007). These reasons are:

- The incorrect entry of data.
- Incorrect specification of codes for missing values
- Entry for those observations which one is not a part of the observation.
- Variables in the population that have extremes values than a normal distribution.

Table 3.5: Multivariate Outliers with Mahalanobis distance

MAH_1	Probability	MAH_1	Probability	MAH_1	Probability
69.29206	0.50	56.72467	0.87	59.85770	0.80
65.57020	0.63	83.90719	0.12	63.83535	0.68
67.53945	0.56	75.49013	0.31	69.84838	0.48
62.49042	0.73	75.68067	0.30	68.52945	0.53
77.26666	0.26	67.29711	0.57	65.00390	0.65
65.72392	0.62	53.54991	0.93	67.94261	0.55
67.25670	0.57	54.31021	0.92	70.15651	0.47
65.79649	0.62	74.56360	0.33	65.13672	0.64
69.86596	0.48	84.93661	0.11	70.74459	0.45
58.95993	0.82	74.55109	0.33	70.34752	0.47
60.61496	0.78	79.30922	0.21	69.01998	0.51
75.76610	0.30	66.13814	0.61	64.59539	0.66
66.30338	0.60	75.48998	0.31	71.83829	0.42

MAH_1	Probability	MAH_1	Probability	MAH_1	Probability
73.64156	0.36	74.39695	0.34	71.46038	0.43
75.55619	0.30	65.30042	0.64	70.24297	0.47
66.02461	0.61	71.84034	0.42	73.57819	0.36
68.60469	0.52	67.87302	0.55	84.77150	0.11
71.16391	0.44	59.30841	0.82	80.81510	0.18
58.37246	0.84	64.51167	0.66	89.91779	0.05
64.34177	0.67	54.60471	0.91	63.73240	0.69
67.39097	0.57	72.70226	0.39	73.87116	0.35
63.69817	0.69	72.87229	0.38	73.35301	0.37
66.04714	0.61	65.62257	0.63	75.44560	0.31
53.30502	0.93	66.21697	0.61	67.78389	0.55
74.34036	0.34	82.68147	0.14	69.55296	0.49
60.33920	0.79	77.92304	0.24	79.47817	0.21
56.91989	0.87	67.56832	0.56	65.77587	0.62
75.28423	0.31	60.49689	0.78	75.03999	0.32
63.42747	0.70	75.14701	0.32	60.58661	0.78
60.22695	0.79	73.73490	0.36	82.75765	0.14
70.92482	0.45	71.02936	0.44	71.37492	0.43
73.45371	0.37	75.51877	0.30	70.96682	0.45
50.62629	0.96	82.63902	0.14	65.85262	0.62
62.50191	0.73	76.14426	0.29	90.49081	0.05
67.63711	0.56	66.95567	0.58	75.31348	0.31
65.79242	0.62	93.07214	0.03	62.89801	0.71
68.65214	0.52	67.46353	0.56	59.55634	0.81
59.68856	0.81	69.34338	0.50	88.12274	0.07
71.27262	0.44	55.15731	0.90	74.36167	0.34
61.25122	0.76	68.34283	0.53	70.50288	0.46
81.00152	0.17	64.56822	0.66	56.38699	0.88
55.19526	0.90	76.41763	0.28	74.53708	0.33
71.35776	0.43	67.22283	0.57	81.13822	0.17
76.80764	0.27	63.30025	0.70	75.90985	0.29
79.01543	0.22	89.72881	0.06	65.44846	0.63
69.80298	0.48	69.58501	0.49	68.40176	0.53
66.26303	0.60	60.98655	0.77	68.40796	0.53
49.21163	0.97	69.60628	0.49	60.82098	0.78
77.09756	0.26	79.52852	0.20	71.40056	0.43
70.63393	0.46	81.71906	0.16	60.69074	0.78

Leys et al. (2013) and Fidell & Tabachnick (2003), mentioned in their study that in this process multivariate outliers were observed through Mahalanobis D2 measure which is a multidimensional form of z-score. Any probability lower than 0.001, is considered as an outlier. In our table above, there is no such value and hence outlier examination criteria through Mahalanobis distance are satisfied.

3.8 Normality test

Normality of data is the first and most important condition for data analysis in multivariate analysis. To access the normality of variables in the study the skewness and kurtosis were checked. The descriptive statistics for variables under study are given in Table 3.6. The variables showed negative and positive skewness and in the case of kurtosis the distribution is light tails, and, in most cases, it is platykurtic distribution. (Cameron, 2007) suggested the values of kurtosis and skewness should between +2 and -2. Otherwise, the greater values indicate non normality of data. Table 3.6 showed skewness and kurtosis. No value of any variable in the table is crossing the threshold limit. Thus, data is not presenting any extreme case of non-normality.

Table 3.6: Skewness and Kurtosis

Construct	Kurtosis	Skewness	Number of Observations Used
access	-0.708	-0.026	150.000
assurance	-0.830	0.048	150.000
benefit	-0.951	-0.025	150.000
decision	-0.937	-0.028	150.000
empathy	-0.890	-0.080	150.000
intention to recommend	-1.151	-0.010	150.000
perceived value	-1.158	0.091	150.000
post benefit	-1.177	0.014	150.000
repurchase intention	-1.216	0.056	150.000
responsiveness	-0.905	-0.116	150.000
satisfaction	-1.065	0.093	150.000
tangible	-0.677	0.305	150.000
tran conv	-0.958	-0.131	150.000

3.9 Homoscedasticity

Homoscedasticity describes a position where the sequence of random variables appears to have the same constant finite variance. It is a situation where the relationship among the variables (dependent & independent) is the same across all

values (Tabachnick & Fidell, 2007). As per Fidell & Tabachnick (2003), it is a prerequisite in multiple regressions to have data with the assumption of equal variance. If the data is not homoscedastic, it is known to be heteroscedastic. In multivariate analysis, heteroscedastic data can create compound problems (Jr & Black William C., 2006). In the independent variable, higher error at some level can lead to heteroscedasticity (Fidell & Tabachnick, 2003). To check the homoscedasticity Levene‘s test is one of the most suitable method. Fidell & Tabachnick (2003) also suggested applying Levene's test for homogeneity of variances. In the present study, the pilot study sample size was 150 which show that this test can be considered for analysis as Leven’s test can be used for a large sample (Field, 2006). Hence, for observing the homoscedasticity of the present study Levene’s test has been used through SPSS software using intention to recommend as dependent and gender as the factor. After the analysis, most of the values were found above the value of 0.05 which suggests that the variance was equal in most of the variables. This indicates that in the current study homogeneity of variance is not violated.

Table 3.7: Test of Homogeneity of Variance

		Levene Statistic	df1	df2	Sig.
intr1	Based on Mean	.000	1	148	.992
	Based on Median	.000	1	148	.994
	Based on Median and with adjusted df	.000	1	147.571	.994
	Based on trimmed mean	.000	1	148	.990
intr2	Based on Mean	.574	1	148	.450
	Based on Median	.597	1	148	.441
	Based on Median and with adjusted df	.597	1	147.998	.441
	Based on trimmed mean	.571	1	148	.451
intr3	Based on Mean	.009	1	148	.923
	Based on Median	.006	1	148	.940
	Based on Median and with adjusted df	.006	1	147.999	.940
	Based on trimmed mean	.010	1	148	.921
intr4	Based on Mean	.000	1	148	1.000
	Based on Median	.004	1	148	.950
	Based on Median and with adjusted df	.004	1	147.921	.950
	Based on trimmed mean	.000	1	148	.995

3.10 Multicollinearity

Pallant (2007), finds out in his study that when there are lower tolerance and higher VIF values, it shows the existence of multicollinearity. According to (Hair Jr, Hult, Ringle, & Sarstedt, 2016) the variance inflation factor (VIF) determines the intensity of the collinearity among the indicators and the acceptable value of VIF must be lower than 5. In the present research, VIF has been calculated by taking all variables and applying regression analysis. As shown in table 3.8, the results showed that for all variables the values of VIF were less than 5. Therefore, there was no issue of multicollinearity.

Table 3.8: Multicollinearity Assessment of constructs through VIF values

Multicollinearity VIF values			
acc1	1.606	pval1	4.162
acc2	1.492	pval2	3.506
acc3	1.449	pval3	3.933
acc4	1.430	pval4	3.271
acc5	1.484	pval5	4.896
assu1	1.417	rel1	1.680
assu2	1.372	rel2	1.971
assu3	1.348	rel3	2.394
assu4	1.596	rel4	1.990
ben1	1.847	rep1	4.891
ben2	1.507	rep2	4.986
ben3	1.702	rep3	4.997
ben4	1.447	rep4	4.733
ben5	1.385	rep5	4.947
deci1	1.775	res1	2.118
deci2	1.813	res2	2.276
deci3	2.104	res3	1.875
deci4	1.466	res4	1.441
deci5	2.002	res5	1.393
emp1	2.168	sat1	3.671
emp2	1.747	sat2	3.563
emp3	1.885	sat3	3.352
emp4	1.773	sat4	3.975
emp5	1.605	sat5	3.454

Multicollinearity VIF values contd…			
intr1	4.820	tan1	2.020
intr2	3.782	tan2	1.639
intr3	3.176	tan3	2.206
intr4	3.741	tan4	1.755
pben1	1.656	tan5	1.762
pben2	1.557	tcon1	1.651
pben3	1.568	tcon2	2.058
pben4	1.583	tcon3	1.976
pben5	1.860	tcon4	1.570
		tcon5	1.841

After verifying the data through pilot testing as described above the next step was the collection of the entire data and carrying forward further analysis. Factor analysis and partial least square structural equation modelling were (PLS-SEM) used. As all the constructs are tested and well researched earlier by various researchers' exploratory factor analysis (EFA) was not required and hence not carried out. So next step was structural equation modelling which is a combination of factor analysis and regression. Confirmatory factor analysis (CFA) was performed to ascertain whether the scale used to measure the construct demands any modification and ascertain the proposed model is an adequate fit to the data set. Once the CFA confirms the veracity of theoretical assumptions, researchers applied hypothesis testing by applying Structural Equation Modelling (SEM).

Researchers have decided to use PLS-SEM using Smart PLS software. The reason for using PLS-SEM is manifold. One of the main reasons is the better statistical power of this tool over other tools. The assumptions required for the co-variance-based tool for example AMOS like multivariate normality and linearity are not required in smart PLS. This software also can work in a small sample size, even though in our case that was not a limitation. The latest versions of smart PLS also provide enough indicators to measure the goodness of fit.

3.11 Summary

This chapter is devoted to portraying the basic purpose of this study and to discussing the various research hypotheses, overall design, and methodology. We also discussed the survey perspective, frame of the sample, design of research questionnaire, data analysis approach, and technique. This chapter also discusses the entire process of choosing respondents, the process of collection of data. The gathered data were coded then analysed by using structural equation modelling. Based on the partial least square algorithm, smart PLS software is used for analysis.

CHAPTER 4: DATA ANALYSES AND DISCUSSION

4.1 Introduction

This chapter deliberates on the results of all objectives and then a discussion on the implication of the results. Primary data was collected through an online survey and results are then interpreted with the help of a literature review. Data was initially collected in a google form from respondents and then data is coded and transferred into an excel/csv file. For further analysis purposes, structural equation modeling (SEM) is used. SEM is a combination of measurement models followed by a structural model. In the measurement model confirmatory factor analysis (CFA) is done and in the structural model, the path analysis/regression is carried out.

4.2 Response rate and respondent's profile

The demographic details of the respondents have been collected through the questionnaire. The demographic details of all respondents who have participated in the survey are explained in this section. The details are based on age, gender, annual income, and the type of insurance company they are associated with. The personal details of the respondents shown through different graphs are as follows:

Table 4.1: Gender wise analysis of respondents

Gender wise analysis of respondents		
Gender	**No of respondents**	**%**
Male	378	75.6
Female	122	24.4
Total	500	100

Fig. 4.1 shows that out of 500 respondents there are only 122 (around 24 %) female respondents and the rest of 76 percent of respondents are male.

Table 4.2: Age wise analysis of respondents

Age group	No of respondents	Percentage
Below 35	32	6.4
35-45	118	23.6
46-55	261	52.2
56-65	67	13.4
> than 65	22	4.4
Total	500	100

Source: Survey Based

Table 4.2 reveal that most of the respondents fall under 46-55 years i.e., 52 percent. It has been found that there are 24 percent of respondents between the age group of 35-45 years. There are 13.6 percent of respondents between the age group of 56-65 years. Only 6.4 percent of respondents are of the age group below 35 years, whereas a mere 4.4 percent of respondents belong to above 65 years. It has been observed that the maximum number of respondents is of the older generation, a fair observation has been done because the respondents understand the question being asked by researchers.

Table4.3: Income wise analysis of respondents

Income range	No of respondents	Percentage
< than 5 lacs	89	17.80%
5- 10 lacs	145	29%
10-15 lacs	136	27.20%
15-25 lacs	92	18.40%
> than 25 lacs	38	7.60%
Total	500	100%

Source: Survey Based

As can be seen in above table, 56 percent of respondents fall in the income range of 5-15 lacs.

Table 4.4: Type of Organization wise distribution of Policies

Type of organization wise analysis	
Type of Organisation	**Number of respondents**
Private sector	250
Public sector	250

As shown in the above table, our respondents are equally distributed between their choice of taking insurance policy of private sector and public sector.

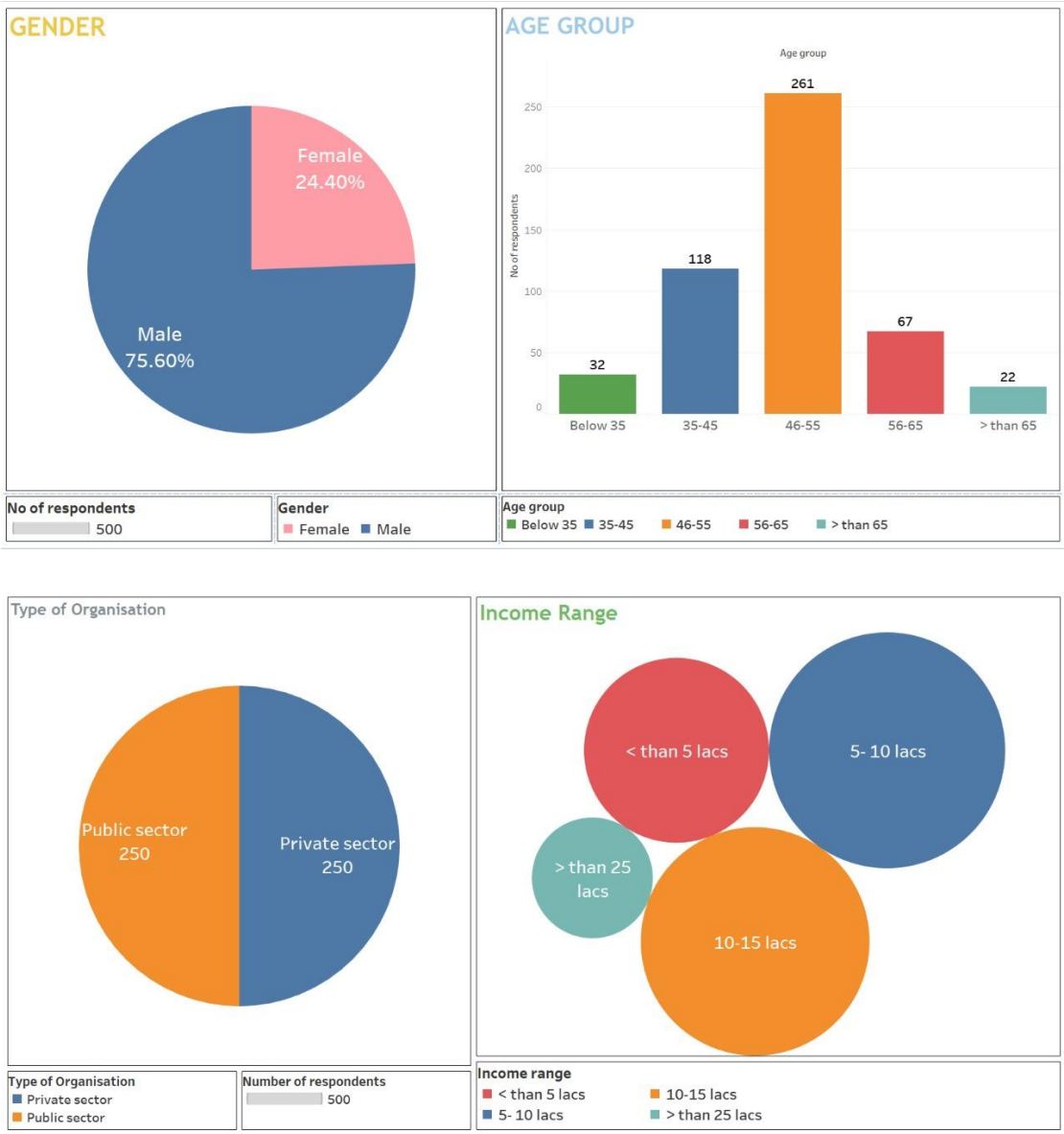


Fig: 3.3 Dashboard of demographic variables

4.3 Structure equation modelling (SEM)

In the present study for evaluating the data, SEM technique has been used. Both experimental and non-experimental data can be studied using SEM. The huge popularity of SEM across discipline can be attributed to its flexibility and generality

(Dash & Paul, 2021). This method essentially develops a complex model which is then connected with the data collected for the purpose of validation. The terminology used for the outcome of this process is called model-data fit. In general SEM demands a minimum sample size of 200. Variety of technique used for estimation, spread type of observed variable and complexity of model determines the model size. Measurement model followed by path analysis forms the base of SEM. However multilevel models and growth models are also considered in SEM

The integrated model developed through SEM represents observed variables and latent variables. The steps in the process of SEM can be enumerated as

- Individual construct
- Preparing for CFA
- Running CFA
- Structural Modelling
- Findings

Smart PLS-SEM was developed by (Ringle, Wende & Will 2005). The PLS-SEM is a non-parametric analysis technique. In the behavioral research field, PLS-SEM provides much value for causal inquiry (Lowry & Gaskin, 2014). The assumptions in PLS-SEM show leniency regarding sample size, measurement scales, and residual distributions (Monecke & Leisch, 2012).

Before 2010, most research papers were using covariance-based SEM (CB-SEM) for social science research. However, for the last ten years, the trend has shifted towards using partial least square based SEM (PLS-SEM) in many social science disciplines like marketing management (Hair et al., 2012b), operations management (Peng & Lai, 2012), human resource management (Ringle et al., 2020), management information systems (Ringle et al., 2012). The reason behind the increase in popularity is its ability to estimate complex models with many constructs, structural paths, and indicator variables without any restriction on data (Hair et al., 2019). The striking feature of PLS-SEM is structurally it remains a model to provide a causal

explanation, but the software also produces predictions based on statistical techniques (Wold, 1982; Sarstedt et al., 2017a). The balance between prediction and explanation is much more robust in the case of PLS-SEM. It has been found that the average variance extracted (AVE) and composite reliability from PLS-SEM is more, indicating better construct reliability and validity. Moreover, people with limited knowledge of statistical tools can use this software, but at the same time, an advanced tool like R can also execute this technique. CB-SEM, normally carried out by software packages such as LISREL or AMOS, is based on the covariance matrix of the data and evaluates the model variables taking into consideration only common variance. In contrast, PLS-SEM is cited as variance-based, as it takes into consideration the total variance and utilizes the same to evaluate variables (Hair et al., 2017b).

Based on the above advantages of smart PLS, Partial Least Square (PLS) based software Smart PLS 3.3.5 has been used in this research. Two models have been used for assessing the data and these are Measurement Model and Structural Model.

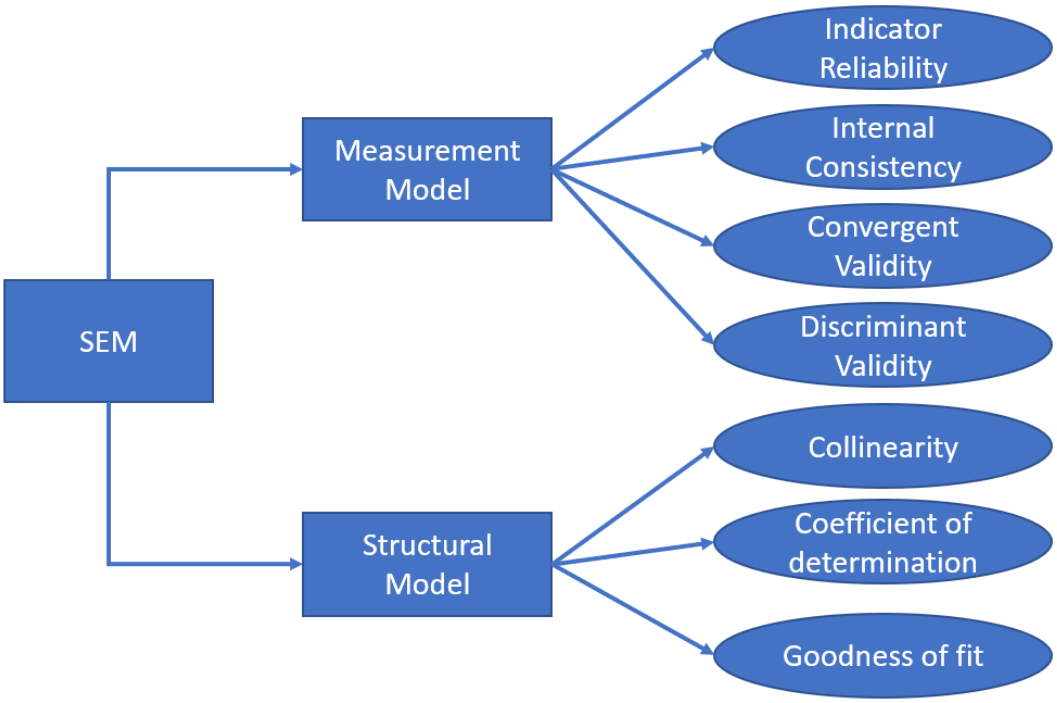


Fig. 4.1: Structural Equation Modelling

Normality of Data

The PLS-SEM is a non-parametric technique of estimation. The normality of data is not a necessary condition in the case of PLS-SEM application. The information should be collected from the continuous and multivariate normal population and the researcher can use the estimation technique as per the kurtosis and skewness of data (Kumar, 2015). The descriptive statistics for variables under study are given in Table 4.5. The variable tcon4 represents the highest mean value of 4.09 with a standard deviation (SD) of 1.983, while ben3 represents the lowest mean value of 3.95 with a standard deviation of 2.003. Cameron (2007) suggested the values of kurtosis and skewness should between +2 and -2. Otherwise, the greater values indicate non normality of data. Table 4.5 showed standard deviation, skewness, and kurtosis. No value of any variable in the table is crossing the threshold limit. This data is not presenting any extreme case of non-normality.

Table 4.5: Descriptive Statistics

	Mean	**Median**	**Standard Deviation**	**Kurtosis**	**Skewness**
acc1	4.014	4.000	2.012	-1.264	-0.007
acc2	3.978	4.000	2.010	-1.269	0.021
acc3	3.998	4.000	2.012	-1.264	0.003
acc4	4.006	4.000	2.013	-1.266	0.002
acc5	4.012	4.000	2.011	-1.265	-0.002
assu1	4.012	4.000	2.012	-1.263	-0.005
assu2	4.012	4.000	2.012	-1.263	-0.005
assu3	4.012	4.000	2.012	-1.263	-0.005
assu4	4.012	4.000	2.012	-1.263	-0.005
ben1	3.956	4.000	1.988	-1.239	0.029
ben2	4.020	4.000	1.995	-1.249	-0.003
ben3	3.950	4.000	2.003	-1.254	0.049
ben4	4.012	4.000	2.001	-1.252	0.000
ben5	4.006	4.000	2.011	-1.267	0.007
deci1	4.012	4.000	2.012	-1.263	-0.005
deci2	4.012	4.000	2.012	-1.263	-0.005
deci3	4.012	4.000	2.012	-1.263	-0.005
deci4	4.012	4.000	2.012	-1.263	-0.005
deci5	4.012	4.000	2.012	-1.263	-0.005

Table 4.5 continued……

	Mean	Median	Standard Deviation	Kurtosis	Skewness
emp1	4.084	4.000	2.006	-1.249	-0.055
emp2	4.018	4.000	1.987	-1.242	0.013
emp3	4.046	4.000	1.999	-1.242	-0.018
emp4	4.030	4.000	1.982	-1.234	0.000
emp5	4.032	4.000	1.974	-1.232	0.013
intr1	4.012	4.000	2.012	-1.263	-0.005
intr2	4.012	4.000	2.012	-1.263	-0.005
intr3	4.012	4.000	2.012	-1.263	-0.005
intr4	4.012	4.000	2.012	-1.263	-0.005
pben1	4.012	4.000	2.012	-1.263	-0.005
pben2	4.012	4.000	2.012	-1.263	-0.005
pben3	4.012	4.000	2.012	-1.263	-0.005
pben4	4.012	4.000	2.012	-1.263	-0.005
pben5	4.012	4.000	2.012	-1.263	-0.005
pval1	4.042	4.000	1.991	-1.253	0.001
pval2	4.052	4.000	1.989	-1.249	-0.008
pval3	4.042	4.000	1.993	-1.247	-0.005
pval4	4.048	4.000	1.990	-1.251	-0.004
pval5	4.042	4.000	1.996	-1.253	-0.008
rel1	4.012	4.000	2.012	-1.263	-0.005
rel2	4.012	4.000	2.012	-1.263	-0.005
rel3	4.012	4.000	2.012	-1.263	-0.005
rel4	4.012	4.000	2.012	-1.263	-0.005
rep1	4.012	4.000	2.012	-1.263	-0.005
rep2	4.012	4.000	2.012	-1.263	-0.005
rep3	4.012	4.000	2.012	-1.263	-0.005
rep4	4.012	4.000	2.012	-1.263	-0.005
rep5	4.012	4.000	2.012	-1.263	-0.005
res1	4.064	4.000	1.983	-1.233	-0.033
res2	4.044	4.000	1.976	-1.239	-0.011
res3	4.022	4.000	1.970	-1.210	-0.009
res4	3.994	4.000	1.983	-1.226	0.015
res5	4.010	4.000	2.011	-1.261	-0.002
sat1	4.012	4.000	2.012	-1.263	-0.005
sat2	4.012	4.000	2.012	-1.263	-0.005
sat3	4.012	4.000	2.012	-1.263	-0.005
sat4	4.012	4.000	2.012	-1.263	-0.005
sat5	4.012	4.000	2.012	-1.263	-0.005
tan1	4.064	4.000	2.000	-1.246	-0.037
tan2	4.008	4.000	2.012	-1.263	0.001
tan3	4.004	4.000	2.014	-1.269	-0.014
tan4	4.004	4.000	2.006	-1.246	-0.006
tan5	4.048	4.000	2.005	-1.247	-0.036

Table 4.5 continued……

	Mean	Median	Standard Deviation	Kurtosis	Skewness
tcon1	4.012	4.000	2.012	-1.263	-0.005
tcon2	4.016	4.000	1.991	-1.239	-0.004
tcon3	4.024	4.000	1.980	-1.222	-0.013
tcon4	4.090	4.000	1.983	-1.217	-0.074
tcon5	3.998	4.000	1.994	-1.254	0.003

4.3.1 Measurement model

Chin & Newsted (1999) point out that with the help of the measurement model the correlation between latent variables and indicator variables has been defined easily. The most essential metrics of the measurement model have been found as the ‘ındicator reliability, internal consistency reliability, convergent validity & discriminant validity”.

4.3.1.1 Indicator reliability

An accurate validity, as well as reliability of various constructs, is an essential step in the survey method, reliability ensures the scale’s consistency and accuracy that eliminates the possibility of biases. (McDaniel & Gates 2006) find out that there have been many ways of checking the reliability like test-retest, Cronbach‘s coefficient, and split-half. In table 4.6 indicator reliability has been considered. (Hair Jr et al., 2021) revealed in their study that relationships between variables and their indicators need to be estimated for reflective measurement models. All the values of indicators are above 0.7 which is the required value. Their composite reliability and Average Variance Extracted (AVE) have been found appropriate so these measures are considered further for analysis.

Table 4.6: Indicator Reliability

Construct	Indicator	Reliability/Outer Loading	Construct	Indicator	Reliability/Outer Loading
Access	acc1	0.746	Assurance	assu1	0.776
	acc2	0.701		assu2	0.716
	acc3	0.750		assu3	0.722
	acc4	0.773		assu4	0.751
	acc5	0.737			
Benefit	ben1	0.790	Reliability	rel1	0.792
	ben2	0.738		rel2	0.811
	ben3	0.715		rel3	0.843
	ben4	0.731		rel4	0.865
	ben5	0.718	Re Purchase Intention	rep1	0.936
Decision	deci1	0.772		rep2	0.923
	deci2	0.780		rep3	0.925
	deci3	0.857		rep4	0.929
	deci4	0.709		rep5	0.921
	deci5	0.771	Responsivenes s	res1	0.797
Empathy	emp1	0.774		res2	0.721
	emp2	0.708		res3	0.723
	emp3	0.708		res4	0.733
	emp4	0.712		res5	0.706
	emp5	0.735	Satisfaction	sat1	0.922
Intention to recommend	intr1	0.923		sat2	0.904
	intr2	0.910		sat3	0.897
	intr3	0.913		sat4	0.912
	intr4	0.923		sat5	0.910
Post Benefit	pben1	0.790	Tangibles	tan1	0.715
	pben2	0.718		tan2	0.707
	pben3	0.715		tan3	0.818
	pben4	0.736		tan4	0.732
	pben5	0.768		tan5	0.763
Perceived value	pval1	0.927	Transaction Convenience	tcon1	0.764
	pval2	0.903		tcon2	0.774
	pval3	0.910		tcon3	0.726
	pval4	0.894		tcon4	0.731
	pval5	0.922		tcon5	0.736

Source: Author's Calculations

4.3.1.2 Internal consistency reliability

Osman et al. (2012), revealed that it is necessary to assess the reliability along with the validity of all the variables for further study and analysis. Internal consistency is one of the ways to check the reliability and it will be calculated based on output from the analysis. In the present study, internal consistency has been measured with the help of Composite Reliability & Cronbach's alpha. (Hair Jr et al., 2016) mentioned in their study that Cronbach's alpha is the major criterion for measuring the internal consistency because it shows the estimate of the internal reliability. Tabachnick & Fidell, (2007) mentioned in their study that in various research Cronbach's alpha is the most suitable and well-implemented way to check the reliability of the output. On the other hand, (Hair et al., 2016) mentioned in their study that to make research more technically appropriate it is better to apply composite reliability for checking the internal consistency.

Therefore, Composite reliability is also measured to estimate internal consistency. Fornell & Larcker (1981), mentioned that to accomplish internal consistency the CR value must be equal to or greater than 0.70. Similarly, for Cronbach's alpha, the value must be equal to or higher than the threshold value of 0.7 (Cronbach, 1951). In table 4.7 the internal consistency of the constructs has been measured with both Composite reliability and Cronbach's Alpha. It has been found from results that the values of both for all the constructs are above 0.7 which means that there are no issues of internal consistency and reliability.

Table 4.7: Internal Consistency Reliability

Construct	Cronbach's Alpha	rho_A	Composite Reliability
Access	0.796	0.802	0.859
Assurance	0.728	0.734	0.830
Benefit	0.792	0.797	0.857
Decision	0.838	0.852	0.885
Empathy	0.778	0.780	0.849
Intention to Recommend	0.937	0.937	0.955
Perceived Value	0.949	0.949	0.961

Post Benefit	0.803	0.815	0.862
Reliability	0.847	0.850	0.897
Repurchase Intention	0.959	0.959	0.968
Responsiveness	0.791	0.796	0.856
Satisfaction	0.947	0.948	0.960
Tangibles	0.805	0.820	0.864
Transaction	0.802	0.804	0.863

Source: Author's Calculations

4.3.1.3 Convergent validity

Convergent validity helps to know how much two measures of equal concepts are correlated (Abbasi, 2011). (Hair Jr et al., 2016) revealed that it is considered to check the level of correlation between the measures of the same constructs by using different indicators. The reliability, as well as validity, must be considered in the reflective measurement model. (Yahaya & Onukwube, 2019) find out that it is the third stage of the measurement model and testing the measures is one of the most important steps for getting appropriate results of the analysis. Convergent validity is the extent to which a variable connects positively with other variables of a similar construct. It is evaluated by extracted AVE and to calculate this, each indicator's loading must be squared, and the mean value is calculated. If AVE is 0.50 or higher, then it is considered as a construct that describes more than fifty percent variance of its indicators. Hence, to gain the value of AVE above 0.5 some of the items from different constructs have been deleted. These items are as follows:

Table 4.8: Deleted items from different constructs

S.No	Items deleted from Service Quality Construct
1	When my health insurance company promises to do something by a certain time, they usually do that
	Items deleted from Service convenience construct
2	I feel safe in doing transactions with my insurance company
	Items deleted from Inertia Construct
3	My intentions are to continue with the current health insurance company rather than using alternate means

Table 4.9 shows the AVE value for the constructs has been above 0.5, so the convergent validity is verified.

Table 4.9: Convergent validity

Construct	Average Variance Extracted (AVE)
Access	0.550
Assurance	0.550
Benefit	0.546
Decision	0.608
Empathy	0.530
Intention to Recommendation	0.841
Perceived Value	0.830
Post Benefit	0.557
Reliability	0.686
Repurchase Intention	0.859
Responsiveness	0.543
Satisfaction	0.826
Tangibles	0.560
Transaction	0.557

4.3.1.4 Discriminant validity

Hair Jr et al. (2016) found that the degree to which one construct is different from another construct is known as Discriminant validity. It can also be defined as the 'degree to which two measures designed to measure similar but conceptually different construct are related". Awang (2015) indicates that the constructs of the measurement model must be free from redundant items and the identified item must be deleted

before running the measurement model. It is requiredthat a construct must be unique, and its items are not representing any other construct. So, to check the dissimilarity between different constructs the discriminant validity has been executed. In table 4.10 it is shown

Table 4.10: Discriminant Validity through Fornell-Larcker criterion

	Access	Assurance	Benefit	Decision	Empathy	Intention to Recommendation	Perceived Value	Post Benefit	Reliability	Repurchase Intention	Responsiveness	Satisfaction	Tangibles	Transaction
Access	**0.742**													
Assurance	0.003	**0.742**												
Benefit	-0.020	0.016	**0.739**											
Decision	-0.024	-0.021	-0.008	**0.779**										
Empathy	-0.018	0.021	0.008	-0.005	**0.728**									
Intention to Recommendation	0.196	0.228	0.262	0.135	0.234	**0.917**								
Perceived Value	0.229	0.237	0.282	0.149	0.257	0.818	**0.911**							
Post Benefit	-0.008	-0.012	-0.011	0.017	-0.001	0.134	0.159	**0.746**						
Reliability	0.021	0.021	-0.025	-0.004	-0.011	0.269	0.269	0.014	**0.828**					
Repurchase Intention	0.199	0.248	0.267	0.144	0.262	0.783	0.841	0.129	0.232	**0.927**				
Responsiveness	-0.008	-0.011	-0.023	0.015	0.010	0.223	0.236	0.000	-0.015	0.238	**0.737**			
Satisfaction	0.202	0.247	0.275	0.129	0.257	0.765	0.823	0.131	0.238	0.793	0.243	**0.909**		
Tangibles	0.011	-0.001	0.031	-0.027	-0.009	0.155	0.154	0.016	0.021	0.157	-0.003	0.156	**0.748**	
Transaction	0.009	-0.015	0.028	0.028	0.003	0.269	0.323	-0.004	0.003	0.297	-0.001	0.277	0.012	**0.746**

The square roots of AVE are all the diagonal values (in bold) whereas other values are the correlation between the respective constructs. When the diagonal values are higher than the values of its row and column then the discriminant validity for all constructs is achieved. Referring to Table 4.10, it has been found out that the discriminant validity is achieved.

Table 4.11: Heterotrait-Monotrait (HTMT) ratio of the correlations

	Access	Assurance	Benefit	Decision	Empathy	Intention to Recommendation	Perceived Value	Post Benefit	Reliability	Repurchase Intention	Responsiveness	Satisfaction	Tangibles
Access													
Assurance	0.036												
Benefit	0.040	0.037											
Decision	0.043	0.033	0.032										
Empathy	0.048	0.049	0.038	0.029									
Intention to Recommendation	0.225	0.274	0.304	0.151	0.273								
Perceived Value	0.261	0.283	0.322	0.166	0.298	0.867							
Post Benefit	0.031	0.044	0.038	0.039	0.049	0.154	0.178						
Reliability	0.031	0.033	0.041	0.015	0.037	0.302	0.299	0.033					
Repurchase Intention	0.226	0.295	0.304	0.159	0.302	0.826	0.882	0.144	0.257				
Responsiveness	0.029	0.042	0.043	0.042	0.035	0.254	0.267	0.040	0.044	0.268			
Satisfaction	0.231	0.296	0.316	0.143	0.298	0.812	0.868	0.148	0.265	0.832	0.277		
Tangibles	0.035	0.033	0.054	0.052	0.047	0.175	0.171	0.035	0.037	0.173	0.041	0.175	
Transaction	0.035	0.032	0.040	0.039	0.046	0.308	0.368	0.029	0.034	0.336	0.047	0.316	0.039

HTMT

The HTMT compares the mean value of correlations of items spread over constructs with the geometric mean of the average correlations for the items spreading over the same construct. As per data from previous research if HTMT is low, the discriminant validity problem will not arise. Henseler et al. (2015) opines that for structural models HTMT threshold value is 0. 90. All our values as shown in table 4.11 are much lower than the maximum permissible value.

Cross loading

Vinzi et al. (2010) find out that discriminant validity can be assessed from cross-loading also. To accomplish the "discriminant validity", the loadings of one construct must be higher than other constructs' loading. Referred to table 4.12, it has been found that the loading of each construct is higher on its measures ascompared to other constructs which means the discriminant validity is achieved.

Table 4.12: Discriminant validity through Cross Loadings

	Acc	Assu	Ben	Deci	Emp	Intr	Pval	Pben	Rel	Rep	Res	Sat	Tan	Tcon
acc1	**0.746**	0.019	-0.020	-0.021	0.007	0.133	0.160	-0.022	-0.008	0.139	-0.014	0.146	-0.006	-0.016
acc2	**0.701**	-0.004	-0.025	-0.044	-0.023	0.133	0.144	0.000	0.008	0.114	0.004	0.128	-0.016	0.007
acc3	**0.750**	-0.016	-0.006	-0.001	-0.005	0.143	0.184	-0.015	0.009	0.158	0.005	0.155	0.021	0.010
acc4	**0.773**	0.016	-0.008	-0.010	-0.033	0.163	0.194	-0.004	0.039	0.162	-0.006	0.163	0.029	0.025
acc5	**0.737**	-0.005	-0.019	-0.019	-0.011	0.151	0.160	0.012	0.025	0.160	-0.017	0.154	0.004	0.002
assu1	0.021	**0.776**	-0.006	-0.014	0.042	0.193	0.201	0.020	0.025	0.209	-0.002	0.196	-0.009	-0.010
assu2	0.016	**0.716**	0.014	0.004	0.009	0.172	0.159	-0.002	-0.003	0.179	0.005	0.168	0.006	-0.008
assu3	-0.031	**0.722**	0.014	-0.036	-0.014	0.151	0.161	-0.028	0.008	0.175	0.003	0.190	-0.001	-0.021
assu4	-0.002	**0.751**	0.027	-0.017	0.020	0.157	0.176	-0.029	0.029	0.170	-0.039	0.177	0.003	-0.006
ben1	-0.035	0.005	**0.790**	0.011	0.030	0.211	0.231	-0.014	0.005	0.224	-0.029	0.238	0.019	0.032
ben2	0.010	0.025	**0.738**	0.007	0.005	0.180	0.226	0.002	-0.042	0.207	-0.011	0.204	0.024	0.034
ben3	-0.023	0.005	**0.715**	-0.011	-0.012	0.188	0.174	-0.045	-0.030	0.171	-0.009	0.197	0.054	0.018
ben4	-0.022	0.008	**0.731**	-0.033	-0.016	0.188	0.192	-0.006	-0.026	0.195	-0.018	0.177	0.000	0.008
ben5	-0.006	0.013	**0.718**	-0.009	0.013	0.201	0.209	0.013	-0.003	0.184	-0.017	0.193	0.023	0.009

deci1	0.005	-0.026	-0.004	**0.772**	-0.006	0.100	0.120	0.007	-0.007	0.096	0.026	0.078	-0.001	0.030
deci2	-0.022	-0.015	0.000	**0.780**	-0.008	0.109	0.103	0.001	-0.011	0.117	0.010	0.105	-0.017	0.039
deci3	-0.028	-0.007	0.004	**0.857**	0.004	0.122	0.143	0.018	-0.009	0.136	0.003	0.130	-0.033	0.005
deci4	-0.018	-0.019	-0.011	**0.709**	-0.008	0.088	0.100	-0.009	0.015	0.102	0.005	0.085	-0.020	0.013
deci5	-0.031	-0.017	-0.025	**0.771**	-0.007	0.103	0.109	0.046	-0.001	0.105	0.015	0.097	-0.030	0.026
emp1	0.005	0.034	-0.002	-0.009	**0.774**	0.175	0.203	-0.022	0.017	0.211	0.015	0.200	-0.021	-0.010
emp2	-0.024	0.034	-0.011	0.008	**0.708**	0.158	0.170	0.001	-0.044	0.158	0.007	0.147	-0.016	0.014
emp3	0.016	-0.012	-0.009	-0.024	**0.708**	0.159	0.181	0.028	-0.004	0.194	0.000	0.199	0.019	-0.004
emp4	-0.028	0.005	0.030	-0.001	**0.712**	0.171	0.188	0.022	0.001	0.187	0.009	0.190	-0.003	0.009
emp5	-0.036	0.016	0.018	0.007	**0.735**	0.186	0.191	-0.028	-0.015	0.200	0.003	0.195	-0.010	0.005
intr1	0.179	0.200	0.254	0.118	0.213	**0.923**	0.760	0.122	0.231	0.726	0.193	0.703	0.143	0.247
intr2	0.149	0.197	0.235	0.130	0.217	**0.910**	0.726	0.138	0.247	0.697	0.199	0.681	0.141	0.246
intr3	0.210	0.213	0.222	0.130	0.220	**0.913**	0.751	0.111	0.257	0.718	0.222	0.707	0.133	0.243
intr4	0.179	0.223	0.249	0.116	0.208	**0.923**	0.762	0.122	0.253	0.732	0.202	0.716	0.150	0.251
pben1	-0.015	0.005	-0.002	0.006	-0.014	0.109	0.141	**0.790**	-0.011	0.108	0.007	0.109	0.012	0.003
pben2	0.003	-0.008	-0.014	0.024	0.016	0.092	0.102	**0.718**	0.034	0.087	-0.038	0.074	0.030	-0.005
pben3	-0.004	-0.017	0.000	-0.009	0.029	0.096	0.094	**0.715**	-0.010	0.071	-0.008	0.084	0.023	0.010
pben4	-0.023	0.003	0.006	-0.003	-0.006	0.101	0.108	**0.736**	0.021	0.097	0.016	0.103	-0.011	0.004
pben5	0.007	-0.027	-0.028	0.039	-0.015	0.101	0.136	**0.768**	0.020	0.110	0.016	0.113	0.008	-0.020
pval1	0.220	0.223	0.255	0.137	0.250	0.757	**0.927**	0.156	0.241	0.789	0.223	0.773	0.133	0.306
pval2	0.215	0.212	0.254	0.127	0.224	0.734	**0.903**	0.128	0.238	0.752	0.205	0.743	0.135	0.290
pval3	0.203	0.201	0.250	0.144	0.234	0.746	**0.910**	0.158	0.245	0.769	0.227	0.746	0.144	0.298
pval4	0.198	0.231	0.263	0.131	0.213	0.729	**0.894**	0.133	0.239	0.748	0.208	0.736	0.153	0.278
pval5	0.206	0.212	0.263	0.141	0.249	0.760	**0.922**	0.149	0.261	0.773	0.213	0.750	0.138	0.300
rel1	0.019	0.019	-0.026	-0.012	-0.016	0.205	0.231	0.018	**0.792**	0.192	0.017	0.198	0.012	-0.001
rel2	0.012	0.024	-0.008	-0.003	-0.023	0.213	0.201	-0.002	**0.811**	0.185	0.001	0.182	0.006	-0.004
rel3	0.021	0.020	-0.025	-0.004	-0.009	0.234	0.219	0.010	**0.843**	0.185	-0.037	0.193	0.007	-0.005
rel4	0.018	0.008	-0.023	0.004	0.010	0.239	0.236	0.017	**0.865**	0.204	-0.029	0.213	0.042	0.016
rep1	0.175	0.237	0.256	0.131	0.259	0.729	0.778	0.109	0.220	**0.936**	0.227	0.747	0.141	0.271
rep2	0.180	0.226	0.242	0.123	0.224	0.722	0.771	0.121	0.211	**0.923**	0.220	0.720	0.148	0.270
rep3	0.182	0.233	0.254	0.144	0.240	0.721	0.784	0.115	0.213	**0.925**	0.234	0.745	0.138	0.265
rep4	0.196	0.230	0.239	0.128	0.244	0.737	0.796	0.144	0.215	**0.929**	0.213	0.737	0.153	0.274
rep5	0.190	0.222	0.247	0.139	0.247	0.721	0.768	0.109	0.215	**0.921**	0.208	0.727	0.145	0.294
res1	-0.009	-0.005	-0.048	0.028	0.013	0.167	0.187	-0.004	0.000	0.168	**0.797**	0.188	0.001	0.009
res2	0.003	-0.014	-0.013	-0.013	-0.008	0.132	0.131	-0.024	-0.039	0.136	**0.721**	0.153	-0.040	-0.013

res3	-0.019	-0.011	0.004	0.009	-0.002	0.149	0.150	-0.011	-0.033	0.160	**0.723**	0.167	0.011	-0.019
res4	-0.012	0.000	-0.009	0.037	0.006	0.179	0.193	0.003	0.008	0.196	**0.733**	0.182	0.002	-0.002
res5	0.008	-0.014	-0.014	-0.015	0.020	0.181	0.192	0.028	-0.004	0.201	**0.706**	0.195	0.006	0.013
sat1	0.190	0.241	0.252	0.124	0.244	0.719	0.764	0.104	0.221	0.730	0.229	**0.922**	0.143	0.256
sat2	0.178	0.219	0.255	0.121	0.232	0.694	0.742	0.126	0.219	0.714	0.218	**0.904**	0.151	0.230
sat3	0.174	0.203	0.261	0.098	0.237	0.667	0.732	0.118	0.219	0.703	0.210	**0.897**	0.139	0.254
sat4	0.185	0.235	0.249	0.106	0.228	0.709	0.752	0.121	0.196	0.726	0.221	**0.912**	0.141	0.255
sat5	0.191	0.223	0.233	0.134	0.225	0.689	0.749	0.128	0.224	0.731	0.226	**0.910**	0.137	0.263
tan1	0.017	-0.005	0.005	-0.043	-0.016	0.082	0.077	-0.007	0.006	0.077	-0.028	0.086	**0.715**	-0.036
tan2	-0.004	0.009	0.031	0.021	0.024	0.116	0.111	0.008	0.027	0.115	-0.019	0.112	**0.707**	0.013
tan3	0.006	-0.009	0.005	-0.011	-0.009	0.127	0.141	0.033	0.012	0.141	-0.002	0.141	**0.818**	0.022
tan4	0.011	0.010	0.028	-0.038	-0.045	0.116	0.104	0.015	0.035	0.113	0.028	0.118	**0.732**	0.004
tan5	0.014	-0.007	0.046	-0.037	0.007	0.127	0.127	0.002	0.000	0.124	0.003	0.116	**0.763**	0.022
tcon1	0.015	-0.028	0.029	0.027	0.006	0.218	0.261	-0.001	-0.002	0.245	0.006	0.213	0.010	**0.764**
tcon2	-0.010	-0.012	0.015	0.009	0.038	0.219	0.250	0.004	-0.003	0.234	-0.028	0.225	0.005	**0.774**
tcon3	0.018	-0.014	0.022	0.049	0.021	0.200	0.238	-0.002	0.046	0.229	0.006	0.196	0.008	**0.726**
tcon4	0.019	0.004	0.012	0.012	-0.033	0.192	0.245	0.006	-0.019	0.218	0.038	0.220	0.009	**0.731**
tcon5	-0.013	-0.006	0.027	0.006	-0.025	0.168	0.206	-0.024	-0.013	0.173	-0.032	0.173	0.012	**0.736**

Source: Author's Calculations

4.3.2 Structural model

When the validity and reliability of the measurement model have been proven, the next step is to assess the outcomes of the linear relationship. This relationship appears among the independent and dependent variables (Chin, 1998). In fig 4.2 structural models is shown and the path coefficients along with their t-values have been shown in table 4.18. The t-values have been provided by the bootstrapping procedure. All the hypotheses of the study have been tested and the results are given below.

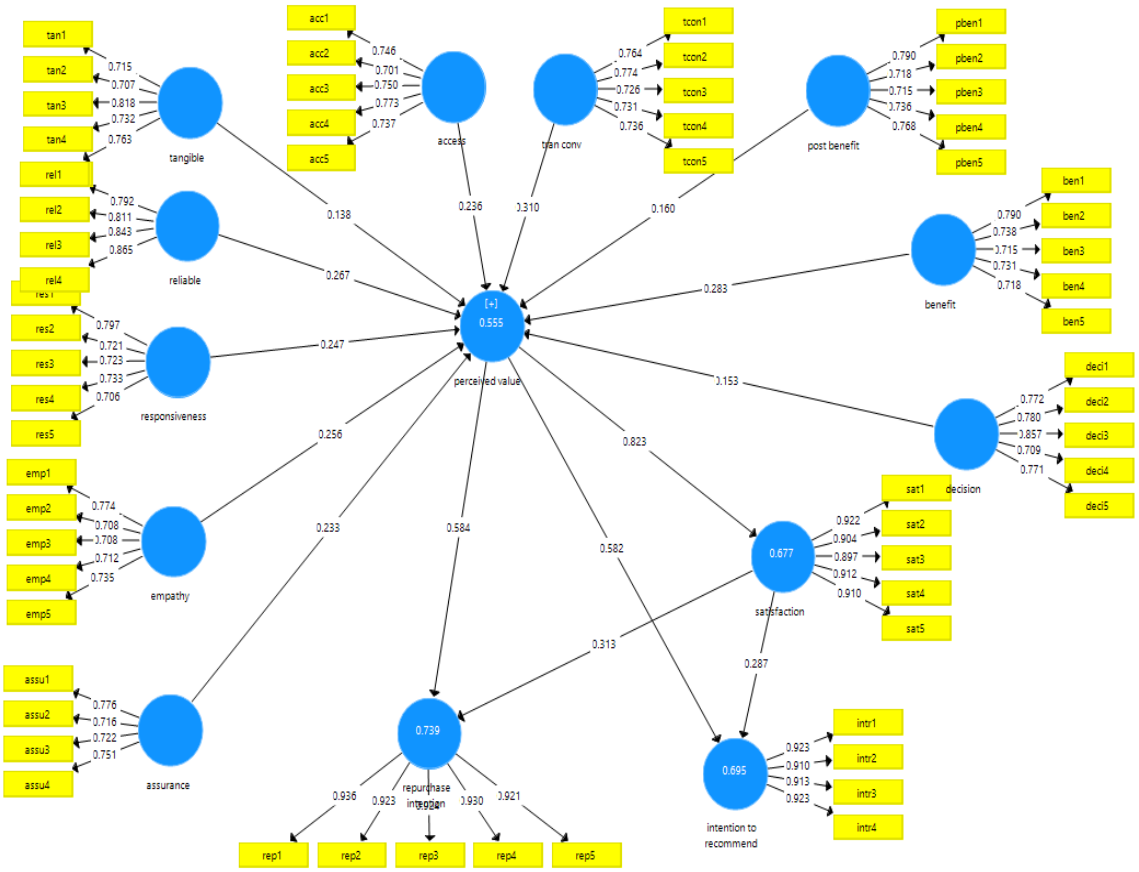


Figure 4.2:
Structural Model

Source: Author's Calculations

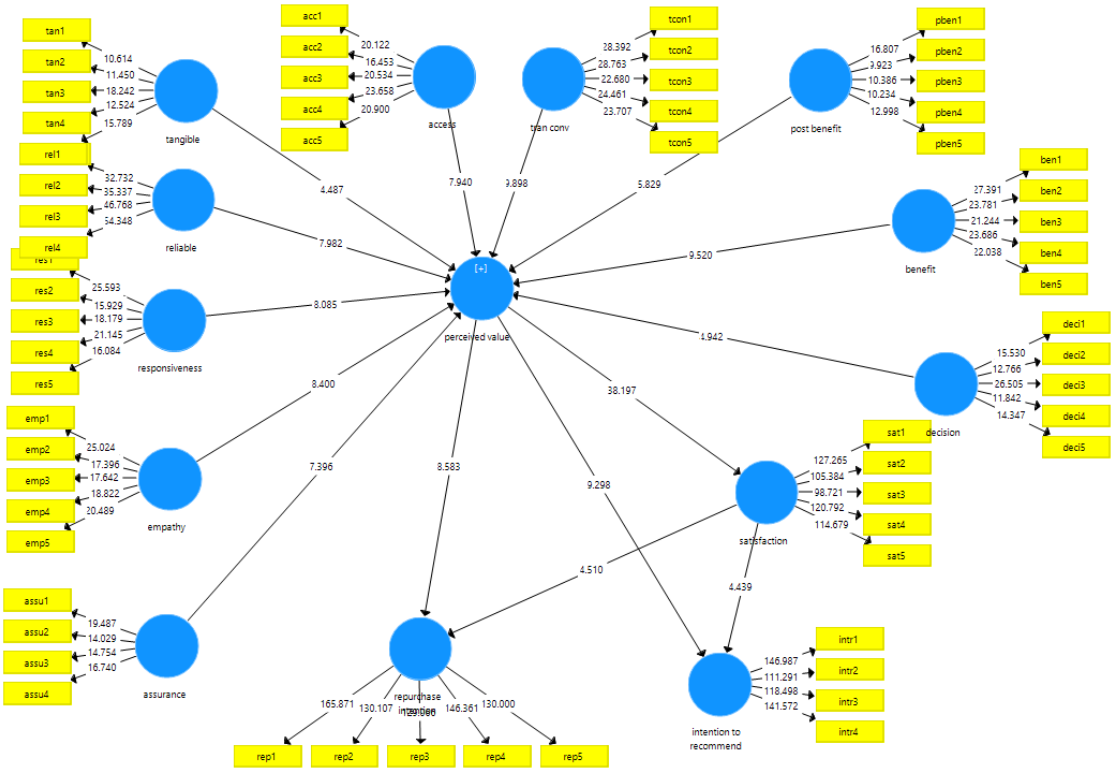


Figure 4.3: Structural Model (Bootstrapping)

The first step in going through the structural model is checking multicollinearity.

Table 4.13: Multicollinearity Assessment of constructs through VIF values

Construct	Items	VIF	Construct	Items	VIF
Access	acc1	1.544	**Perceived value**	pval1	4.552
	acc2	1.439		pval2	3.567
	acc3	1.478		pval3	3.840
	acc4	1.536		pval4	3.308
	acc5	1.511		pval5	4.296
Assurance	assu1	1.380	**Reliability**	rel1	1.623
	assu2	1.343		rel2	1.896
	assu3	1.357		rel3	2.055
	assu4	1.392		rel4	2.198
Benefit	ben1	1.648	**Re-purchase intention**	rep1	4.989
	ben2	1.436		rep2	4.416
	ben3	1.503		rep3	4.469
	ben4	1.495		rep4	4.746
	ben5	1.411		rep5	4.315
Decision	deci1	1.646	**Responsibility**	res1	1.778
	deci2	1.791		res2	1.626
	deci3	2.107		res3	1.520
	deci4	1.486		res4	1.397
	deci5	1.702		res5	1.323
Empathy	emp1	1.582	**Satisfaction**	sat1	4.234
	emp2	1.432		sat2	3.586
	emp3	1.400		sat3	3.392
	emp4	1.389		sat4	3.842
	emp5	1.466		sat5	3.781
Intention to recommend	intr1	3.850	**Tangibles**	tan1	1.596
	intr2	3.418		tan2	1.402
	intr3	3.450		tan3	1.761
	intr4	3.834		tan4	1.524
Post Benefit	pben1	1.581		tan5	1.534
	pben2	1.496	**Transaction**	tcon1	1.547
	pben3	1.518		tcon2	1.633
	pben4	1.525		tcon3	1.468
	pben5	1.510		tcon4	1.484
				tcon5	1.581

After verifying the normality of data, the next step is to find out the coefficient of determination (R^2), predictive relevance (q^2), and estimation of path coefficient (β). The accepted values for the coefficient of determination (R^2), predictive relevance (q^2), and estimation of path coefficient (β) are discussed in table 4.14

Table 4.14: Accepted value criterion

Criterion	Explanation	Acceptable value
R^2 (Coefficient of determination)	The R^2 value gives the share of variance explained in a dependent construct (Yahaya, 2019).	Value is between 0 to 1. Value near to 0 is weak and near to 1 is strong (Chin, 1998)
Path estimation(β)	It is the path coefficient. It measures manifold correlation coefficients between dependent and independent variables	Value of t=2.58 p<0.01,t=1.96 p<0.05 and t=1.64 p<0.10, t=2.326 p<0.01 (Jr & Black William C.,2006).
Q^2 Predictive relevance	It is indicator model of predictive relevance (Fidell & Tabachnick, 2003)	A value of 0.02 is weak, 0.15 is medium and 0.35 is having a large impact (Chin, 1998).
GOF	A test to measure how effective a sample data fit with a distribution from a population (Jr & Black William C., 2006).	Near to 1 is a better value (Chin, 1998).

4.3.2.1 Path estimation (β)

Each path relationship that is hypothesized in the given framework is defined with the assistance of a regression coefficient. In a regression coefficient, the t-value concludes the importance of the regression coefficient and is generated by the PLS bootstrapping process. It has been shown in the table that all path relations are significant. It has been found that the relation of perceived value is significant with all measures of service value like tangibles, responsiveness, reliability, assurance, and empathy. Relation of perceived value is also found to be significant with all measures of service convenience like access, transaction, benefit post benefit, and decision. Another dimension of customer patronage i.e., satisfaction has been found to have significant relation with perceived value.

4.3.2.2 Coefficient of determination (R^2)

Yahaya & Onukwube, (2019) and Chin, (1998) mentioned in their study that, the coefficient of determination measures the percentage of the variation in the dependent variables which is described by the independent variables. In the current study, the

inner path model has the following values 0.585 for intention to recommend, 0.546 for perceived value, 0.628 for re-purchase intention, 0.676 for satisfaction. Henseler et al. (2017) and Hair et al. (2016) mentioned that an R^2 value of 0.67, 0.33, and 0.19 expresses strong, moderate, and weak relations. It has been found from table 4.12 that satisfaction has the highest variance, the R^2 value is 0.676 or 67.60% followed by the re-purchase intention with R^2=0.628 or 62.8% and intention to recommend with R^2=0.585 or 58.5%.

Table 4.15: Coefficient of Determination (R2)

Construct	Cronbach's Alpha	C.R	AVE	R Square	Q square
Access	0.796	0.859	0.550		0.124
Assurance	0.728	0.830	0.550		0.122
Benefit	0.792	0.857	0.546		0.179
Decision	0.838	0.885	0.608		0.053
Empathy	0.778	0.849	0.530		0.147
Intention to Recommendation	0.937	0.955	0.841	0.585	
Perceived Value	0.949	0.961	0.830	0.546	2.096
Post Benefit	0.803	0.862	0.557		0.057
Reliability	0.847	0.897	0.686		0.160
Repurchase Intention	0.959	0.968	0.859	0.628	
Responsiveness	0.791	0.856	0.543		0.137
Satisfaction	0.947	0.960	0.826	0.676	1.695
Tangibles	0.805	0.864	0.560		0.043
Transaction	0.802	0.863	0.557		0.215
Average				**0.609**	**0.419**
Goodness of fit (GOF)				**0.505076**	

Source: Author's Calculations

4.3.2.3: Predictive relevance (q^2)

Predictive relevance means the calculation accurately predicts the information purposes of markers in the intelligent estimation model of the endogenous construct. It is assessed to check the predictive relevance of the framework. It is conducted by the blindfolding procedure of Smart PLS. Fornell & Cha (1994) found that themodel is considered to have predictive relevance if the value of q^2 is larger thanzero.

Chin (1998) suggested that a value of 0.02 is weak, 0.15 is medium and 0.35 is having a large impact. In table 4.16, the values of predictive relevance are shown.

Table 4.16: Predictive Relevance

Construct cross-validated redundancy	
	Q^2 (=1-SSE/SSO)
Intention to recommend	0.489
Perceived value	0.452
Repurchase intention	0.537
Satisfaction	0.555

Source: Author's Calculations

4.3.2.4 GOODNESS OF FIT INDEX (GoF)

After evaluating the path estimation, R^2, Q^2, the next analysis to conduct is to assess the model for the GOF. Tenenhaus et al. (2005) recommended a geometric mean of average of R^2 and average communality for estimating GOF. The goodness of fit value must be between 0 to 1 and as values increases it indicates a better fit (Tenenhaus et al., 2005). Table 4.15 shows the value of the GOF. The findings show the value of GoF is 0.505 which is accepted at a strong level. Hence, the modelis strongly fit for the evaluation.

Table 4.17: **Model Fit**

Model Fit Summary		
	Saturated Model	**Estimated Model**
SRMR	0.029	0.045
d_ULS	1.953	4.592
d_G	0.576	0.740
Chi-Square	1693.768	2023.340
NFI	0.911	0.893

SRMR should be < 0.1 and NFI should be > than 0.9

4.4 Path analysis & hypotheses testing in PLS-SEM

Table 4.18 Path Analysis for Hypotheses Testing

Hypotheses	Path	β	Mean	StDV	T	*p*
H1: Determinants of Service quality (SQ) significantly affect Perceived Value (PVAL) in the context of health insurance products	tangible -> perceived value	0.138	0.140	0.032	4.328	0.000
	reliable -> perceived value	0.267	0.263	0.032	8.234	0.000
	responsiveness -> perceived value	0.247	0.248	0.032	7.803	0.000
	assurance -> perceived value	0.233	0.232	0.033	7.100	0.000
	empathy -> perceived value	0.256	0.256	0.031	8.258	0.000
H2: Determinants of Service Convenience (SC) significantly affect Perceived Value (PVAL) in the context of health insurance products	access -> perceived value	0.236	0.235	0.032	7.461	0.000
	tran conv -> perceived value	0.310	0.307	0.032	9.629	0.000
	benefit -> perceived value	0.283	0.280	0.029	9.634	0.000
	post benefit -> perceived value	0.160	0.160	0.027	5.848	0.000
	decision -> perceived value	0.153	0.155	0.031	4.929	0.000
H3: Perceived Value (PVAL) significantly affects customer patronage decision (CPD) in the context of health insurance products	perceived value -> intention to recommend	0.582	0.588	0.063	9.298	0.000
	perceived value -> repurchase intention	0.584	0.591	0.068	8.583	0.000
H4: Perceived value (PVAL) significantly affects satisfaction in the context of health insurance products	perceived value -> satisfaction	0.823	0.823	0.020	41.311	0.000
H5: **S**atisfaction significantly affects customer patronage decision (CPD) in the context of health insurance products	satisfaction -> intention to recommend	0.765	0.766	0.020	38.990	0.000
	satisfaction -> repurchase intention	0.793	0.795	0.018	43.412	0.000

H1: There is a significant positive relationship between Service Quality and Perceived Value

Hypothesis H1 predicts a significant relationship between determinants of Service Quality and Perceived Value. In our research service quality construct is represented by five items and the above table shows the data of our analysis against each item. As suggested by the empirical data of Path Coefficients (β), T statistics, and P values, we fail to reject the hypothesis.

H2: There is a significant positive relationship between Service Convenience and Perceived Value

Hypothesis H2 predicts a significant relationship between determinants of Service Convenience and Perceived value. In our research service convenience construct is represented by five items and the above table shows the data of our analysis against each item. As suggested by the empirical data of Path Coefficients (β), T statistics, and P values, we fail to reject the hypothesis

H3: There is a significant positive relationship between perceived value (PVAL) and customer patronage decision (CPD) in regard to the health insurance products

Hypothesis H3 predicts a significant relationship between Perceived value and Customer Patronage. As suggested by the empirical data of Path Coefficients (β), T statistics, and P values, we fail to reject the hypothesis

H4: There is a significant positive relationship between satisfaction and Perceived Value

Hypothesis H4 predicts a significant relationship between Satisfaction and Perceived Value. As suggested by the empirical data of Path Coefficients (β), T statistics, and P values, we fail to reject the hypothesis.

H5: There is a significant positive relationship between satisfaction and Customer Patronage

Hypothesis H5 predicts a significant relationship between Satisfaction and customer patronage. As suggested by the empirical data of Path Coefficients (β), T statistics, and P values, we fail to reject the hypothesis.

4.5 Moderation analysis

Hypothesis (H6): Trust, inertia, word of mouth, and type of organization significantly moderate the relationship between satisfaction and customer patronage decision in the context of health insurance products.

The researcher has studied moderating effect of the above four factors and the results are as follows

Word of mouth (WOM)

The moderating effect of word of mouth has come significant as shown in the table.

Table 4.19: Path coefficients showing moderating effect results for WOM

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
SAT_WOM_ITR -> intention to recommend	0.055	0.054	0.016	3.547	**0.000**
SAT_WOM_REP -> repurchase intention	0.050	0.049	0.015	3.325	**0.000**
WOM -> intention to recommend	0.849	0.847	0.034	24.881	**0.000**
WOM -> repurchase intention	0.764	0.760	0.036	21.471	**0.000**

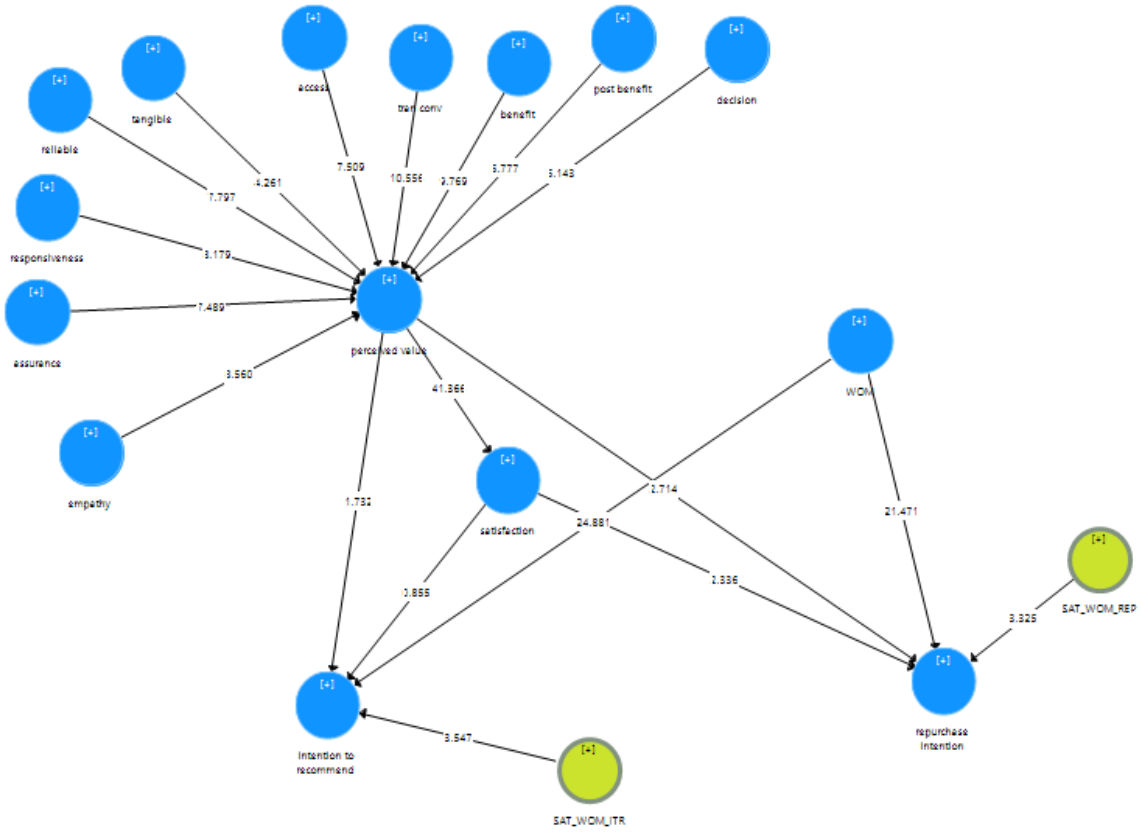


Fig 4.4: Structural model showing moderation of WOM

Trust

The moderating effect of trust has shown a mixed result. In the case of the relationship between satisfaction and intention to recommend, the moderating effect has come significant. But in the case of the relationship between satisfaction and repurchase intention, the moderating effect has come non-significant.

Table 4.20: Path coefficients showing moderating effect results for trust

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
Sat*Trust-Intr -> intention to recommend	0.045	0.046	0.022	2.056	**0.040**
Sat*trust-RPi -> repurchase intention	0.036	0.037	0.019	1.843	**0.066**

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
Trust -> intention to recommend	0.062	0.059	0.026	2.415	**0.016**
Trust -> repurchase intention	0.058	0.055	0.023	2.500	**0.013**

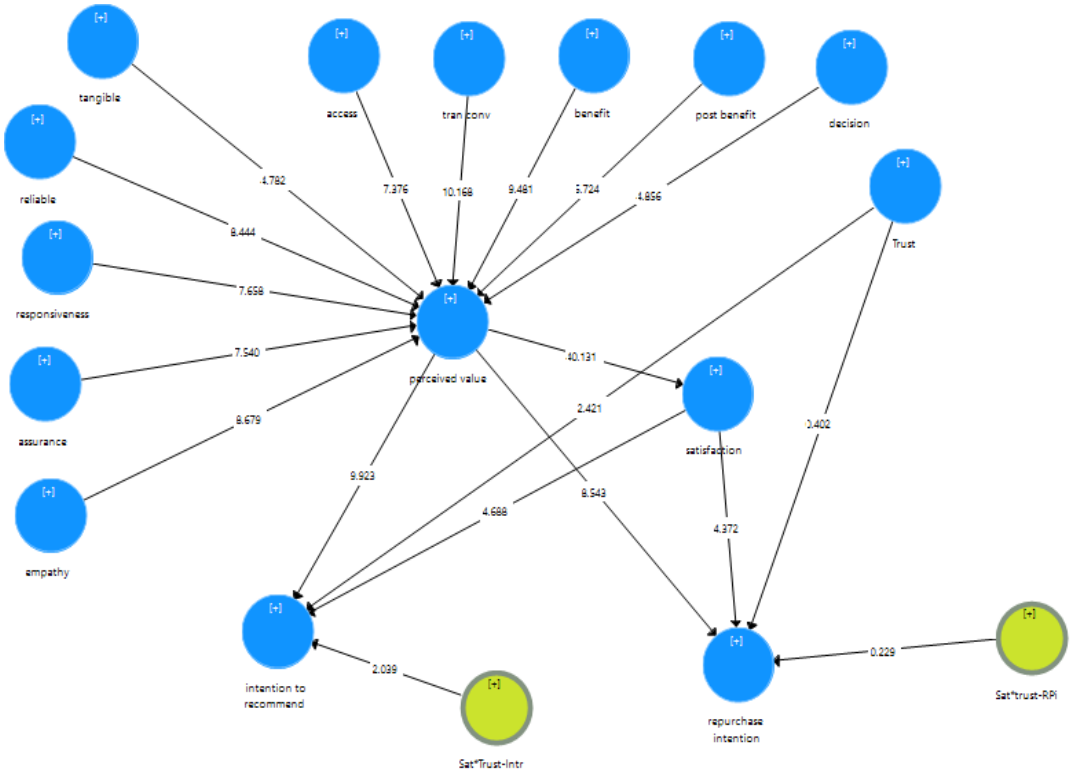


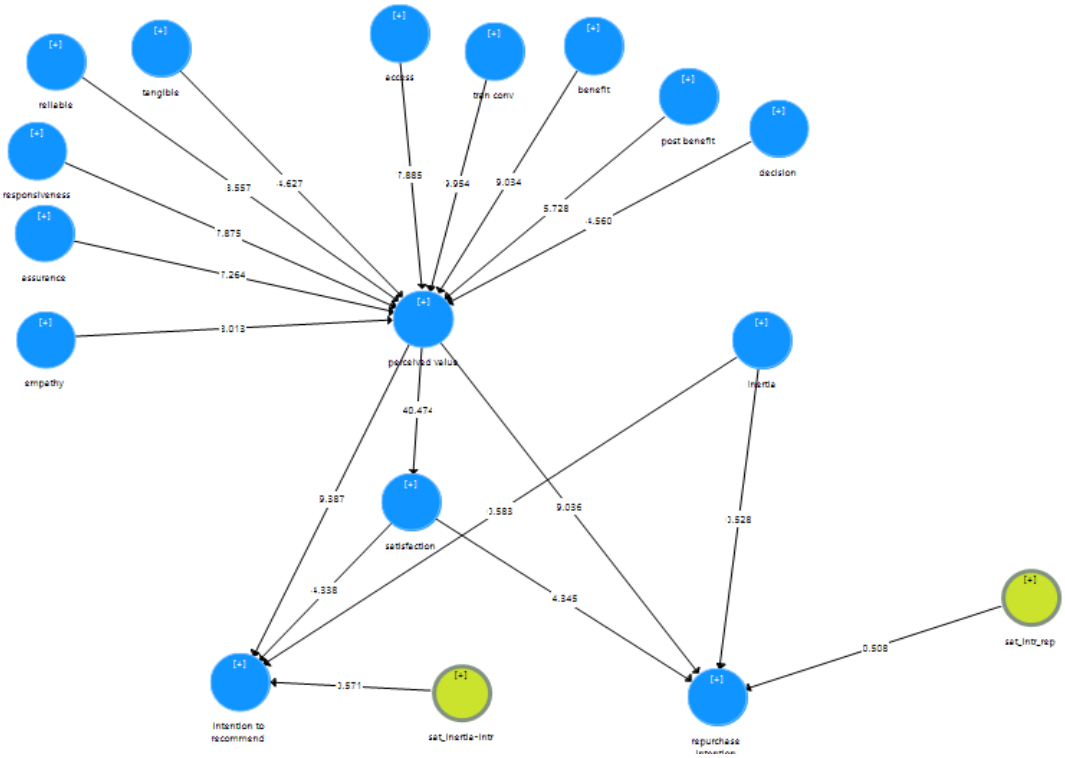
Fig 4.5: Structural model showing moderation of Trust

Inertia

The moderating effect of inertia has shown a different result. The moderating effect on both count i.e on the relationship between satisfaction and intention to recommend and with repurchase intention has come non-significant

Table 4.21: Path coefficients showing moderating effect results for inertia

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
sat_inertia-intr -> intention to recommend	0.013	0.015	0.023	0.571	**0.284**
sat_intr_rep -> repurchase intention	0.012	0.013	0.024	0.508	**0.306**
Inertia -> intention to recommend	-0.017	-0.017	0.029	0.583	**0.280**
Inertia -> repurchase intention	-0.016	-0.016	0.030	0.528	**0.299**



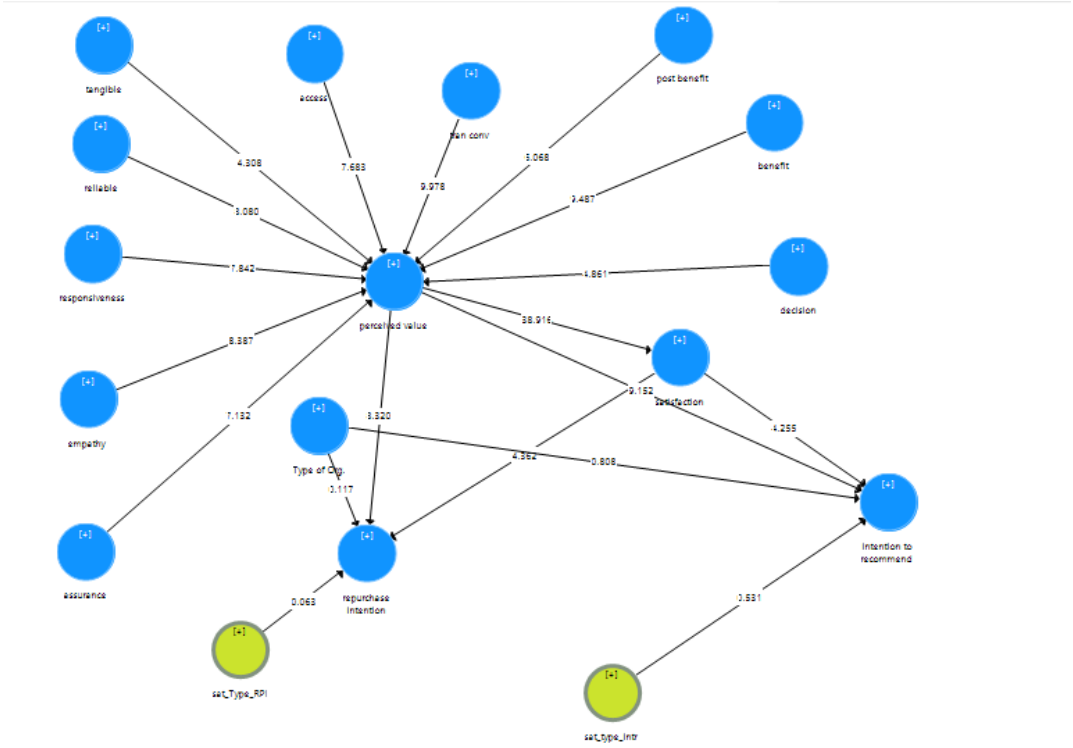
. Fig 4.6: Structural model showing moderation of Inertia

Type of organization

The moderating effect of the type of organization i.e the company issuing the insurance policy (Public sector or Private sector) has come as non-significant.

Table 4.22: Path coefficients showing moderating effect results for the type of organization

	Original Sample (O)	Sample Mean (M)	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
sat_Type_RPI -> repurchase intention	0.002	0.003	0.026	0.063	0.950
sat_type_intr -> intention to recommend	0.014	0.014	0.025	0.531	0.596
Type of Org. -> intention to recommend	-0.021	-0.021	0.026	0.808	0.420
Type of Org. -> repurchase intention	0.003	0.000	0.023	0.117	0.907



. **Fig 4.7: Structural model showing moderation of Type of Organization**

4.5.1 Slope analysis

Further to better understand the interaction pattern between the satisfaction and customer patronage, interaction plot is formed using (Aiken et al., 1991) standard practice of estimating slopes one standard deviation below and above the mean of moderating variable.

4.5.1.1 Slope analysis of WOM moderation

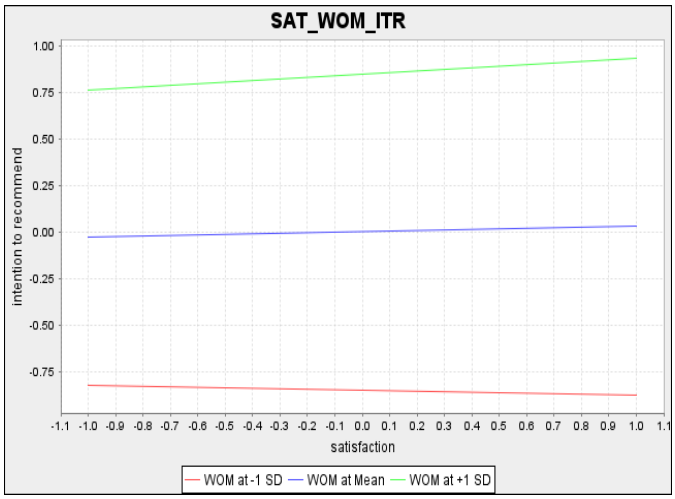


Fig 4.8: Slope analysis of WOM moderation between Satisfaction and Intention to recommend at different standard deviation

The figure (4.8) shows that at high WOM score respondents, with the increase of satisfaction of consumers, their intention to recommend goes up at a rate higher than for consumers with medium or low WOM scores. For medium WOM score consumers, the relationship between satisfaction and intention to recommend is almost flat. For low WOM score consumers also there is a slight negative slope.

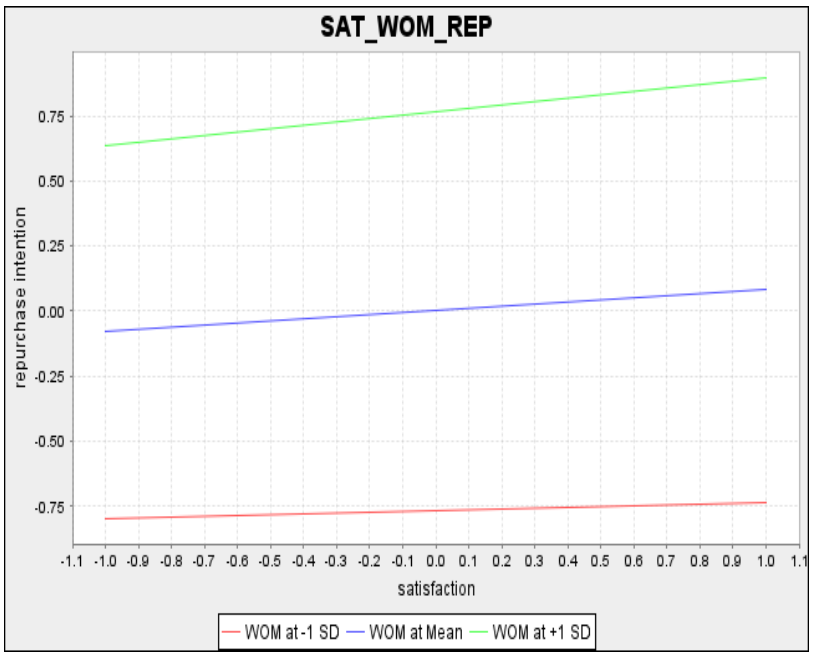


Fig 4.9: Slope analysis of WOM moderation between Satisfaction and Repurchase Intention at different standard deviation

Figure (4.9) shows three almost parallel lines. That means that for consumers with high, medium, or low WOM scores there is hardly any difference in their moderating effect on the relationship between satisfactions and repurchase intention**.**

4.5.1.2 Slope analysis of trust moderation

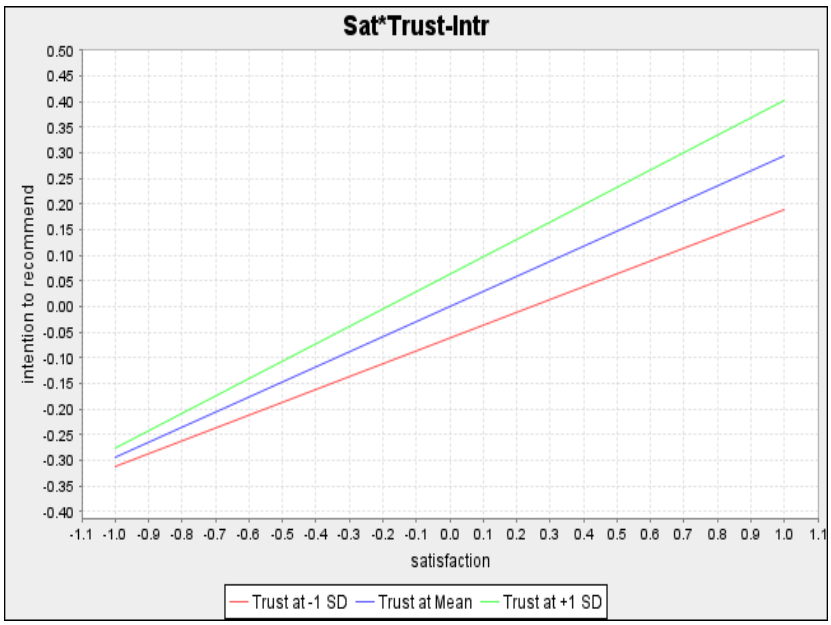


Fig 4.10: Slope analysis of Trust moderation between Satisfaction and Intention to recommend at different standard deviation

The figure (4.10) shows that at a higher satisfaction level, for high trust consumers, the effect of an increase in satisfaction on intention to recommend is more compared with consumers of medium or low trust**.**

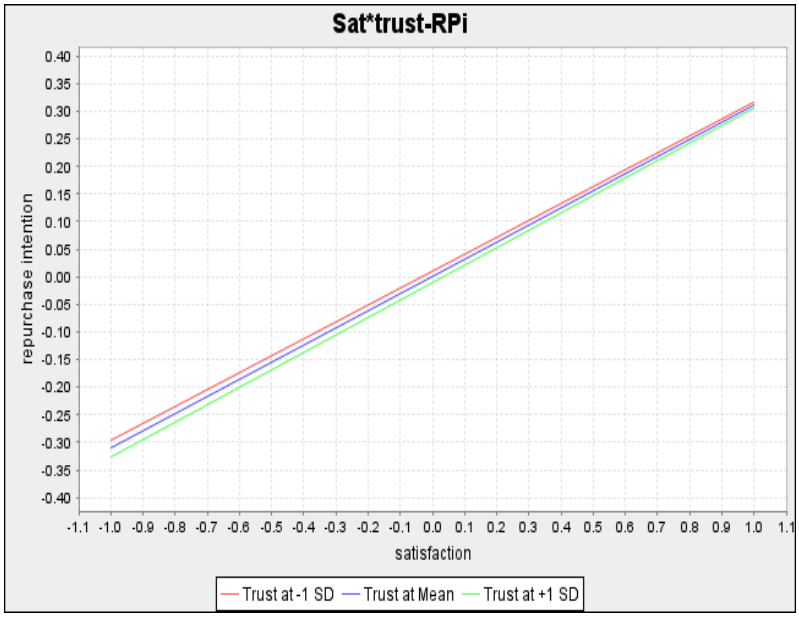


Fig 4.11: Slope analysis of Trust moderation between Satisfaction and Repurchase Intention at different standard deviation

Figure (4.11) shows that there is hardly any difference between the groups in their moderating effect on the relationship between satisfaction and repurchase intention.

4.5.1.3 Slope analysis of inertia moderation

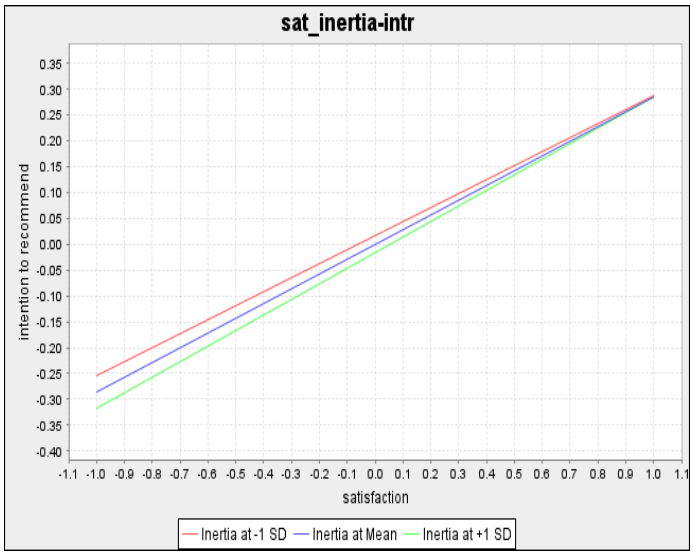


Fig 4.12: Slope analysis of Inertia moderation between Satisfaction and Intention to recommend at different standard deviation

Fig 4.12 shows a very minor difference between the groups in their moderating effect on the relationship between satisfaction and intention to recommend.

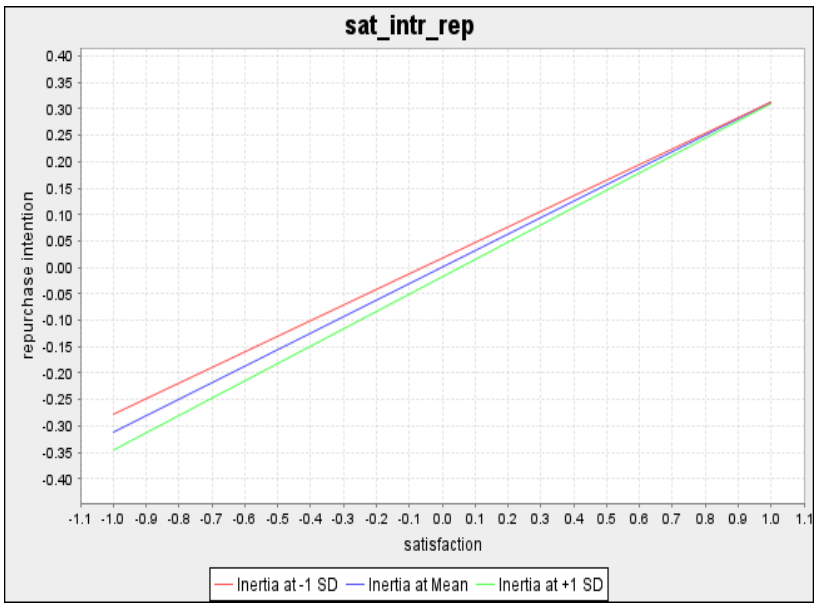


Fig 4.13: Slope analysis of Inertia moderation between Satisfaction and Repurchase Intention at different standard deviation

Figure (4.13) shows that there is hardly any difference between the groups in their moderating effect on the relationship between satisfaction and repurchase intention

4.6 Cluster & multi-group analysis of moderating variable

Cluster analysis is done to separate the respondents into two groups based on their responses. This process transforms the continuous variable into a categorical variable. Then Multi-group analysis in PLS-SEM was undertaken to ascertain whether the difference between moderation of high and low construct dimensions is significant or not.

4.6.1 Cluster & MGA: WoM

Cluster analysis using SPSS for the respondents with regard to their responses of WOM items was done and the analysis suggests the formation of two groups, designated as high WOM (260) and low WOM (240) respondents.

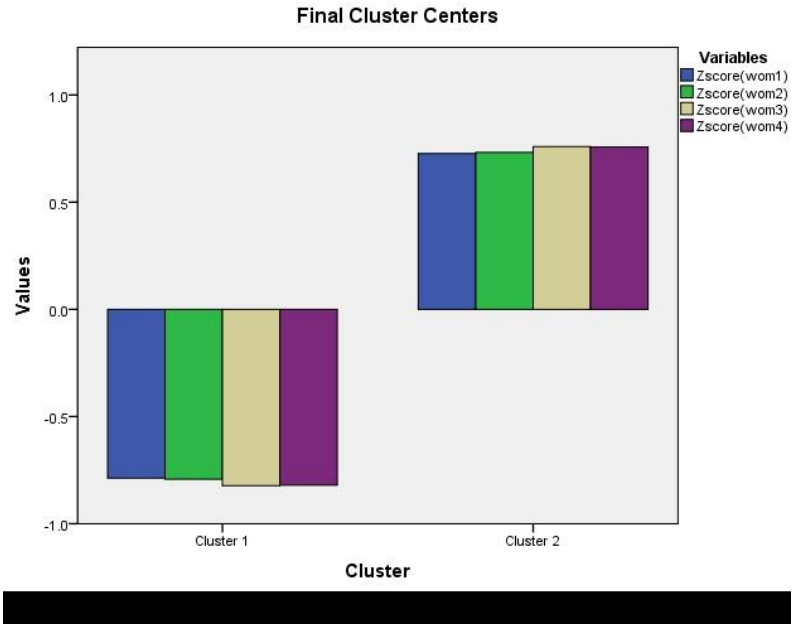


Fig 4.14: Cluster analysis of WOM response

Once two different clusters are formed, the next task was to verify whether there is any significant difference between their moderating effects. To carry out this analysis, multi-group analysis was done, and the results are as shown below

Table 4.23: Multi-Group Analysis of WOM responses.

	Path Coefficients-diff (HIGH WOM - LOW WOM)	p-Value original 1-tailed (HIGH WOM vs LOW WOM)	p-Value new (HIGH WOM vs LOW WOM)
SAT_WOM_ITR -> intention to recommend	0.134	0.017	**0.017**
SAT_WOM_REP -> repurchase intention	0.048	0.225	0.225
WOM -> intention to recommend	-0.034	0.659	0.341
WOM -> repurchase intention	-0.079	0.830	0.170

As seen in table 4.23, the multi-group analysis shows that the difference in path coefficient for the moderation effect of WOM on the relationship between satisfaction and intention to recommend between high WOM and low WOM responses is

significant. However similar response in the case of repurchase intention is not significant.

4.6.2 Cluster & MGA: Trust

Cluster analysis using SPSS for the respondents about their responses of trust items were done and the analysis suggest the formation of two groups, designated as high trust (248) and low trust (252) respondents.

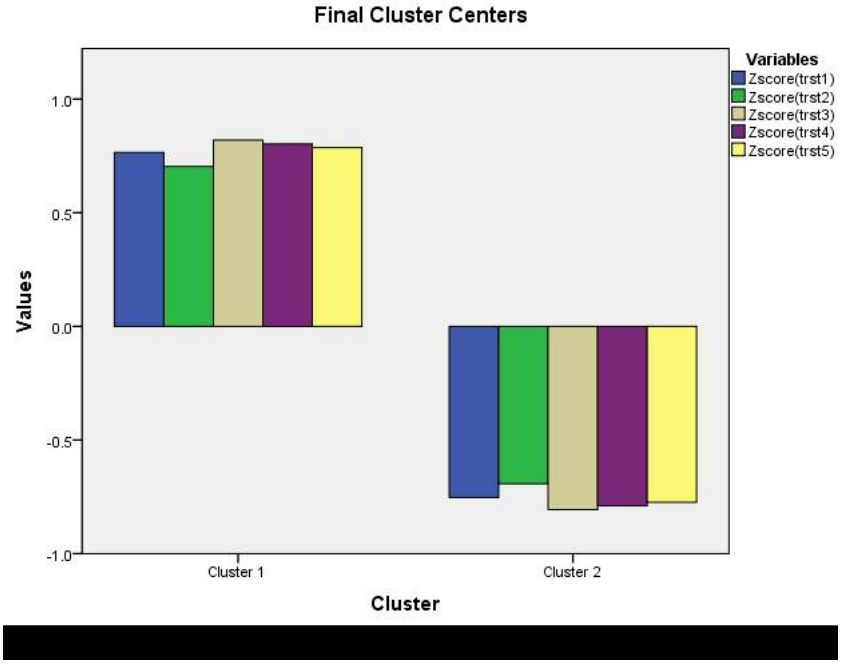


Fig 4.15: Cluster analysis of trust responses

To verify whether there is any significant difference between their moderating effects, a multi-group analysis was done, and the results are as shown below

Table 4.24: Multi-Group Analysis of trust responses

	Path Coefficients-diff (HIGH TRUSTQCL_0(0.0) – LOW TRUSTQCL_0(1.0))	p-Val original 1-tailed (HIGH TRUSTQCL_0(0.0) vs LOW TRUSTQCL_0(1.0))	p-Value new (HIGH TRUSTQCL_0(0.0) vs LOW TRUSTQCL_0(1.0))
Sat*Trust-Intr -> intention to recommend	0.005	0.465	0.930
Sat*trust-Rpi -> repurchase intention	0.030	0.256	0.513
Trust -> intention to recommend	-0.054	0.801	0.399
Trust -> repurchase intention	-0.049	0.783	0.434

As seen in table 4.24, the multi-group analysis shows that the difference in path coefficient for the moderation effect of trust on the relationship between satisfaction and intention to recommend and repurchase intention between high trust and low trust responses is not significant.

4.6.3 Cluster & MGA: Inertia

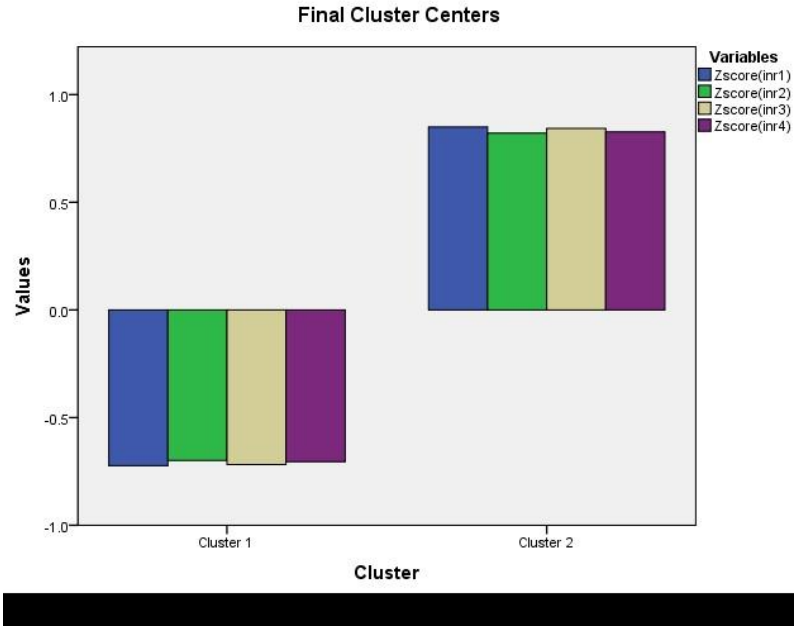


Fig 4.16: Cluster analysis of inertia responses

To verify whether there is any significant difference between their moderating effects, multi-group analysis was done, and the results are as shown below

Table 4.25: Multi-Group Analysis of inertia responses

	Path Coefficients-diff (HIGH INERTIAQCL_0(1.0) - LOW INERTIAQCL_0(0.0))	p-Value original 1-tailed (HIGH INERTIAQCL_0(1.0) vs LOW INERTIAQCL_0(0.0))	p-Value new (HIGH INERTIAQCL_0(1.0) vs LOW INERTIAQCL_0(0.0))
sat_inertia-intr -> intention to recommend	0.008	0.434	0.434
sat_intr_rep -> repurchase intention	-0.097	0.871	0.129
Inertia -> intention to recommend	-0.032	0.680	0.320
Inertia -> repurchase intention	0.096	0.092	0.092

As seen in table 4.25, the multi-group analysis shows that the difference in path coefficient for the moderation effect of inertia on the relationship between satisfaction and intention to recommend and repurchase intention between high inertia and low inertia responses is not significant.

4.7 Discussion of results

4.7.1 Introduction

This section of the chapter discusses the results obtained as per the hypotheses framed. The hypotheses have been framed for the four objectives of the study.

Crosby & Stephens (1987) suggested that insurance as a service business develops on trust. By nature, the business is complex, evaluation is abstract. The benefit to be accrued to consumers is futuristic and therefore hard to ascertain.

4.7.2 Discussion of hypotheses results

Hypothesis (H1): There is a significant positive relationship between Service quality

(SQ) and Perceived Value (PVAL) in regard to the health insurance products

Service quality is the most frequently researched construct in the social science paradigm and has been studied in almost every possible field. The SERVQUAL scale is also the most favourite among researchers; however, there are other variations too. We stated before that research in the Indian health insurance sector is few and far between. With the opening of this sector to private players and allowing higher FD by successive governments, a lot of activity and interest are visible and hence the number of research has also increased from 2019 onwards. Moreover, the current pandemic has reoriented peoples' minds towards health care and health insurance. This research has further strengthened the notion that service quality continues to have a strong effect on perceived value leading to satisfaction in the health insurance sector.

Hypothesis (H2): There is a significant positive relationship between service convenience (SC) and perceived value (PVAL) in regard to the health insurance products

Whenever there is growth in any sector, service quality stops being the only criteria that can guarantee customer satisfaction. Whenever customers are having ample choices to choose from, service convenience, which reduces the effort and time to obtain the service, starts becoming important. Even though service convenience is not a very frequently researched construct in the health insurance sector, our result which confirms its strong relationship with perceived value leading to satisfaction validates the finding of earlier researchers (Cooil et al., 2007; Homburg et al., 2005).

According to path coefficient data transaction convenience (β =0.310, t statistics- 9.629, p value < 0.001) is the most important to the customers followed by benefit (β =0.283, t statistics- 9.634, p value < 0.001). This can be attributed to the reasoning that while purchasing a policy, out of all the constructs of service convenience, transaction is first required to acquire the policy and once that is assured, next most important consideration is the accrued benefit. Against this backdrop, our study assists service providers to prioritize resources in order to generate maximum output. Resource limitation is a constant issue that acts as a constraint and hence optimum use of the same is always welcome. For some customers, reducing their effort and time

may go a long way to enhance their satisfaction. These customers can even be identified from their sociodemographic and psychographic characteristics.

Hypothesis (H3): There is a significant positive relationship between perceived value (PVAL) and customer patronage decision (CPD) in regard to health insurance products.

Perceived value, a frequently researched construct is believed to have multiple effects. While it obviously is an antecedent of customer satisfaction, it also has a direct effect on customer patronage. Consumer decision-making relative to their purchases of service products is a complex and comprehensive process. A manager cannot afford to have the straight jacket thought process that perceived value will lead only to satisfaction. The indirect effect of perceived value on behavioural intention cannot be ignored. Our data shows strong (β =0.582, t statistics- 9.298, p value < 0.001 for intention to recommend and β =0.584, t statistics- 8.583, p value < 0.001 for repurchase intention.)

Hypothesis (H4): There is a significant positive relationship between perceived value (PVAL) and satisfaction (S) in regard to the health insurance products

Perceived value has always been a favourite construct for social science researchers because, at the end of the day, whatever game they play with service quality and service convenience, how the customer perceives it is of utmost importance. Is it creating any value in the mind of the customer? Or there is a service gap? The trade-off or balancing act which a manager must perform in terms of enhancing service quality but at the same time controlling spiralling associated cost rise. In a competitive environment, a manager must compromise somewhere to remain in the fray. They cannot forget the rational economic behaviour tendency of the public. Managers, who tend to ignore the balancing act between quality and price, do so at their peril. Appropriate resource allocation is the key. As an example, "core service quality should typically be the primary focus of the firm (getting it right the first time), followed by the perceived value (ensuring that customers get their money's worth)". The way the service is delivered, what is known as relational value is to be

given due importance. Finally, the implication for the practicing managers can be elaborated as a guideline to doing trade-offs between quality and price. The prudence lies in the perfect balance between the two, a combination of these two creates the perception of value, and the same is directly linked with satisfaction.

The importance of "getting it right the first time" cannot be overemphasized. Practicing managers should be clear in their mind about the basic promise they made and deliver that to customers. The promise generates the expectation in the minds of consumers which is also referred to as perception.

Hypothesis (H5): There is a significant positive relationship between satisfaction (S) and customer patronage decision (CPD) in regard to health insurance products. We have been emphasizing from the very beginning of our research report that satisfaction is not our final goal. It is a steppingstone to generate advocacy from customers. A customer may be satisfied, but it does not guarantee repeat business from him. In the Indian context, as our health insurance penetration is abysmally low, many service providers initially focus on developing new customers by offering them generic products and services. With our huge population and the increased awareness among people about health-related issues during the current pandemic, these companies may generate modest business and survive. But as the market matures, it will attract more and more service providers with innovative products. That time the concept of customer patronage will come in handy.

Hypothesis (H6): Trust, inertia, word of mouth, and organization type significantly moderates the relationship between satisfaction and customer patronage decision in regard to the health insurance products

The summary of results obtained through different statistical techniques is shown below

Table 4.26: Summary of moderation results

Moderating variable	Dependent variable	Moderating effect	Theory back up in health insurance	Multi-Group Analysis
Word of mouth	Re-purchase intention	**Significant**	NIL	Diff between high/low group non-significant
	Intention to recommend	**Significant**	NIL	**Diff between high/low group significant**
Trust	Re-purchase intention	non-significant	NIL	Diff between high/low group non-significant
	Intention to recommend	**Significant**	NIL	Diff between high/low group non-significant
Inertia	Re-purchase intention	non-significant	No Moderation during positive effect	Diff between high/low group non-significant
	Intention to recommend	non-significant	Moderation during negative effect	Diff between high/low group non-significant

The moderating effect of the above four variables shows very interesting results. Even the different result obtained for repurchase intention from the intention to recommend in case of moderation of trust is a new revelation.

In the case of word of mouth, the moderating effect has been significant in both sub-constructs of the customer patronage domain. However, the result of multi-group analysis (MGA) shows that the difference in opinion between high WOM and low WOM responses is significant for intention to recommend. This result might have come, as a respondent who already has received WOM from many people (high WOM group) may tend to recommend the same company to his known circle much more than people of low WOM group. However, for repurchase intention, the difference between the two groups is not significant.

The role of Word of mouth as a moderator is researched in the health care sector (Chaniotakis & Lymperopoulos, 2009). It was found to have a moderating effect on the selection of health care services in China. Zhang & Lee (2015) explained the

moderating role of attitude towards risk, self-esteem, and word of mouth in medical tourism. Antecedents of positive word of mouth intention were also studied by (Ferguson et al., 2010) and their article opines that WOM primarily relied on different sets of experiences generated from service experience but also to the peculiar nature of the individual consumer.

For trust as moderating variable, the result shows an insignificant role for repurchase intention, but a significant role in intention to recommend. As the MGA is also non-significant, there is no deviation in result due to opinion difference between customers with high or low trust. The reason may be attributed to as trust works as an antecedent for satisfaction or we can conclude that once respondent is satisfied, trust does not moderate the relationship with the repurchase intention. We do not have any study available in the literature of the health insurance field which can give contrary evidence. Rahman et al. (2014) tried to study the mediating role of trust in between service quality and customer patronage decisions in Malaysia.

We have a recent study (Kautish et al., 2021) where researchers have found some moderating role of inertia when the customer is already having a negative effect in his mind about the service provider. But in our study when we have not taken any precondition for moderating the role of inertia, the result did not show any significance. As the MGA is also non-significant, there is no deviation in result due to opinion difference between customers with high or low inertia.

Kautish et al. (2021), in their recent paper mentioned that as per their knowledge goes, their paper is the first paper finding the moderating role of inertia in the health insurance field convoluted with other parameters. At the outset, they have stated that any service creates two types of effects in the minds of customers, the positive effect, and the negative effect. This kind of effect influences customer retention and switching behaviour. Their study has ultimately found a moderating effect of inertia on the relation between negative affect and customer retention. However, their similar hypothesis of studying the moderating effect of inertia on the relation between positive affect and customer retention is rejected. They found through the test of

invariance that both low and high inertia significantly moderate relation between negative affect and customer retention.

For the type of organization, our result shows that type of organization does not yet moderate the relationship under study. The possible reason for this may be consumers so far have not developed any preference about the type of company as far as health insurance is concerned. As long as the terms of the policy (mainly the premium) are favourable to them, whether it is private or public sector does not matter. Maybe the presence of IRDA as regulating body has generated the confidence that type of organization does not have much relevance. Once the market matures in the future, this variable will also have an effect.

CHAPTER 5: FINDINGS AND CONCLUSION

5.1 Overview

The present thesis has been divided into five major chapters. In Chapter 1 introduction part is discussed in detail. Thereafter, the literature review has been explored in chapter 2 of the study. With the help of this literature, a conceptual framework has been framed along with the research methodology for further research. Apart from this for achieving the objectives of the study, a suitable research design and hypothesis have been discussed in chapter 3. Further, the data analysis which is based on statistical techniques has been discussed in chapter 4. The discussion part related to the results of the analysis has also been discussed in detail along with the results of previous studies. Chapter 5 has been comprised of the conclusion, findings & implications, suggestions, and the limitations of the present study. The future scope of the study has also been discussed.

This chapter is divided into the following sections:

- Conclusions in context with objectives of the study
- Findings & Implications
- Suggestions
- Limitations & Future scope of the study
- Summary

5.2 Conclusion in context with objectives of the study

Based on the literature review of research papers available on health insurance and health care, we created a model to showcase the relationship between different service parameters leading to customer patronage. In our effort to add some more factors which are not yet studied in the health insurance sector, we decided to build on word of mouth, trust, and inertia as moderating variables. During the research, it was felt that since private insurance companies are gaining market share, maybe the type of

organization also may have a say on the relationships leading to patronage, and hence it was also added. Four objectives have been framed in the present study and all of them are primary data based. For primary data, the responses have been collected from the respondents spread mainly from Maharashtra and Delhi.

It took time to collect data from respondents in the sense that on one side people were mostly at home during the lockdown and some of them had more spare time. But on the other side due to the overall gloomy health situation across the country, a lot of follow-up efforts were necessary to push them to fill up the survey. Later to the compilation of the data, analysis was undertaken with the help of statistical tools and techniques which are mentioned in chapter 4 of the study. The conclusion of framed objectives is as below:

5.2.1 Effect of SQ and SC on perceived value

To determine the effect of determinants of Service Quality and Service Convenience on perceived value in the health insurance sector.

The result of this objective has been achieved with the help of a literature review and output of a survey conducted. The results suggest that there is an effect of both service quality and service convenience determinants on perceived value in the health insurance sector.

Conclusion in the context of the effect of Service Quality on perceived value in the health insurance sector.

The research further confirms that service quality constructs of SERVQUAL is highly relevant in the health insurance context and marketer should endeavor to ascertain all facets of service quality like tangibles, responsiveness. Agents and marketing executives should deliver the policy creating empathy and reliability in the minds of the customer. On one side they should portray professional behavior and maintain a modern-looking office, and on the other side connect with the customer at

the emotional level. Lack of transparency is one factor possibly displayed by many insurance agents/officials and our survey confirms through the factor assurance that respondents consider this factor as contributing factor to their journey towards satisfaction. As stated earlier anything related to health is close to our heart and respondents may take decisions based on emotions. This is where the role of agents and officials comes in and it is their responsibility to alleviate fears in the minds of consumers about complications about going for a policy. With regard to tangibles, Indian consumers are now exposed to modern and sophisticated standards set in the industry. Information on all possible channels of communications and their regular updates are nowadays considered the bare minimum. Gone are the days when insurance officials used to respond as per their convenience, as now for the consumer the alternative is just a phone call away.

Conclusion in the context of the effect of Service Convenience on perceived value in the health insurance sector

Though service quality is the most frequently researched construct in heal insurance and health care, with the advent of digitalization and more and more superior service convenience provided by other services like banking, transport, etc, the importance of service convenience in the health insurance sector has also increased and being researched. Mathur et al. (2016) while discussing the role of service convenience in health insurance, also discussed the role of personal factors and organizational factors in creating satisfaction and patronage.

However, in our model, the item post benefit is a new concept that all marketers should take note of and prepare themselves. In the original SERVCON scale, post benefit was limited to connecting with the service provider post transaction i.e the service recovery process. However, with growth in the market, companies cannot guarantee customer satisfaction unless it creates a wholesome value affecting the lifestyle of policyholders. This requires the creation of an eco-system (it was discussed in detail in our introduction in chapter 1) with other health service providers like medical shops, diagnostic centers, gymnasiums, etc. However, the pivotal role in creating this eco-system is to be taken by the insurance company only.

Other convenience factors like access, transaction, benefit, and decision factor are also significant. The word benefit can have a different connotation to a different customer. Other than the premium amount to be paid, the list of panel hospitals, their location, the important clauses, dos, and don'ts, all must be explained to a policyholder. With the explosion in social media, the word access has now broadened and now it is 24 x 7. Contrary to earlier days, the consumer is not ready to wait for an indefinite period to take a decision now. Information should be available to him at the click of a button and decisions are made in a jiffy.

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5.2.2 Effect of PVAL on customer patronage

Too often service quality is considered as the key ingredient to generate customer satisfaction. However, the importance of perceived value brings the focus into perception in the minds of the customer. McDougall & Levesque (2000), while explaining three factors- core service quality, relational service quality, and perceived value, argued that none of these factors impacted loyalty directly, but done so through satisfaction. However, as per our model for the health insurance sector, perceived value can also affect customer patronage directly and through satisfaction.

Our findings on perceived value stress the importance of perceived value as a strategic objective in the health insurance sector. We have already stressed the fact that the health insurance sector is credence-based. The significant indirect effect shows that models of consumer evaluation based on a single variable or direct effect are likely to produce an incomplete assessment. This further strengthens our argument that the consumer decision process in the case of buying a service product is a complex and comprehensive process.

5.2.3 Effect of PVAL on customer satisfaction

Perceived value and its role in creating satisfaction is a well-researched area and our result which shows a strong connection between the two, only corroborates the other findings (Anderson et al., 1994; Zeithaml, 1988; McDougall & Levesque, 2000). In the health insurance sector also the importance of perceived value is discussed at

length in creating satisfaction. Abdelfattah et al. (2015) and Han, (2018) have discussed the role of perceived value as part of the ongoing effort to increase satisfaction with health insurance by patients, especially those who have a chronic disease.

5.2.4 Role of customer satisfaction in customer patronage

The health insurance sector is evolving at a rapid speed with the new entry of multinational companies in this field offering a variety of options to Indian consumers to choose from. Private sectors players are wooing existing customers at the time of renewal offering options like hassle-free portability with no financial or coverage loss. They are also able to add many first-time customers to their fold with the help of aggressive marketing and facilitated by the fact that health insurance has very low penetration in India. The retention of existing customers is crucial for any health insurance policy renewal, especially in the Indian market (Meesala & Paul 2018).

So, companies have to ensure highly satisfied customers or customers who are delighted with the level of product and service provided. However, this is easier said than done due to a lack of trust between insurance companies and the public.

5.2.5 Effect of moderating factors

Any form of inertia is not good for the consumer as well as for the health insurance company (White & Yanamandram, 2004). Inertia can exist in different forms and levels. It may exist as consumers know that there is hardly any difference in the product and service offered by competitors or can exist simply because of individual lethargy. Companies need to dig deep into their past behaviour so that they can predict possible switching and complaining behaviour. The research by (Kautish 2021) has concluded that the marketing strategy of the insurance company cannot depend on customer inertia in long run. He went on to add that if the company has customers who prefer to opt for competing, other service providers are likely to generate negative word of mouth, less ability to cross-sell, resistance towards newer products, etc. However, our research finding that inertia has no significant moderating effect possibly hints that in the health insurance space, trust and word of mouth are

more significant. In other words, if a consumer has a positive word of mouth and has developed trust towards some service provider, inertia will not stop the consumer from take the right decision. This can give a clear-cut direction to practicing managers that if you can create positive word of mouth and trust towards your product, the inertia of consumers will not come on the way.

Our research finding that word of mouth has a moderating role in health insurance can make the companies think to generate positive word of mouth. Now worldwide marketers have agreed on the tremendous potential of word of mouth in influencing behaviour. So, health insurance companies also need to devise their strategy accordingly. Storytelling is a common form of word-of-mouth communication. As an academic discipline, it refers both to a set of objects of study and a method by which they are studied.

However, there is a limitation and underlying danger in the role of word of mouth. If it is in the form of a recommendation the effect is positive and the marketer would love that. On the contrary, any complaint by a customer can spread negative WOM about a product or service and it can create havoc in making or destroying a brand. The irony is, there is no guarantee that a satisfied customer will make positive WOM, but a dissatisfied customer is more likely to propagate negative WOM and even magnify the bad experience. Ennew et al. (2000) opines that when potential customers are exposed to positive WOM, there is the chance of an increase in purchase or repurchase. Moreover, those customers who themselves are offering positive WOM, are more likely to stay as loyal customers (Gremler & Brown 1996). According to Mazzarol et al. (2007), WOM is nine times more effective than traditional advertising.

Even our finding that, for creation of intention to recommend in consumer's mind, trust plays a moderating role, may lead to some changes in the way companies present their policies. They can change starting from the language of the policy, marketing pitch, and approach to the customer, and even offering flexibility in policy depending on the emerging situation can go a long way in creating trust. In the case of repurchase intention, our finding that moderating role of trust is not significant may be giving us an indication that trust in the case of health insurance plays a role

different from other service products. It can be a direct antecedent of repurchase intention in the health insurance space.

The authorities who can make a difference after taking an insight from this research work, are private and public sector companies guided by Insurance Regulatory Authority of India (IRDA). The cajoling role of IRDA officials to bring other players of the ecosystem in the loop is likely to be crucial in this model. There would be initial resistance from unorganised players like medical shops, gymnasiums, diagnostics centres. Unless they are very sure of their increased clientele, they would like to share a burden of the reduced premium of health insurance policies. Even companies can assure them a handholding by ensuring a minimum guaranteed return in first 1-2 years till the model is understood and well settled.

5.3 Findings and implications

Health insurance is a complex product cum service due to its nature of business. While taking the policy, the customer is mostly not aware of even the major terms of the policy either because of the complex nature of terms and conditions written or general apathy generated from the notion that now they are ok, and they may not need to use it during the tenure of the policy which is normally one year.

However, country requires action from health insurance companies in two areas. The first is to reduce their marketing cost in terms of agent's commission etc. which can be achieved by ensuring repeat purchase of customers and strong advocacy. The second requirement which is the most important is to reduce overall expenses on health care and to reduce the out-of-pocket expenditure of insured customers by providing them with tailor-made policies at an affordable rate. As explained in chapter 1 that encouraging consumers to have a healthy lifestyle and connecting it with the benefit to be accrued out of the policy may go a long way in achieving the ultimate target of proving affordable health care to Indian citizen

The extent to which a health insurance company could think of customer service a few years ago was limited to improving the claim settlement process. However, the

two factors which are forcing them to rethink are commoditization and disintermediation. The ubiquity of social media and e-commerce is enabling consumers to demand a lot more transparency and access to care and understanding their needs.

The result of one study on financial catastrophe reveals that each year more than 150 million suffer from this situation by spending 40 % on health expenses except food. The poor offtake of health insurance in many LMICs (low and middle-income countries) is mainly due to a lack of literacy or education in the context of health insurance.

Many implications have been originated from the results of the study. These implications are for researchers, businesses, and officials. The research highlights the relation between service quality and service convenience with perceived value in the health insurance sector and how they lead to customer satisfaction and finally customer patronage. The marketing literature strongly suggests that creating a satisfied customer is not enough, companies have to generate advocacy from satisfied customers. So, repurchase from a satisfied customer is not enough, but they also need to take an active part in promoting the company's product or service.

The implications can be structured and highlighted as follows

- **Researcher**- The positive relationship between SQ, SC with perceived value, satisfaction and customer patronage which normally hold good for other services also holds good for health insurance sector**.** Four moderators studied in our research shows different types of results and need to be investigated further.
- **Business**- Diagnostics/Medical/Fitness centers can tie-up with insurance company to make a win-win eco system
- **Policy makers**-

Insurance company- officials can give due importance to service convenience and finds ways to generate positive word of mouth.

There should be closer and more frequent interaction between insured and insurance companies. The current trend of possible interaction only at the time of renewal of policy is not going to work in the future.

IRDA- IRDA must be proactive in their approach and may offer more leg room to companies to tinker with policy terms and conditions as long as they remain within the larger ambit of achieving universal health. They need to push companies to innovate benefits for consumers connecting other players in the proposed eco-system to create a win-win proposition.

As trust moderates' intention to recommend, officials to work out plan to improve trust- improving transparency in policy terms my help

As the Indian population is not so health-conscious and has a reservation in buying a health insurance policy, only a competitive premium amount can satisfy the highly price-sensitive consumers

5.4 Suggestions

Based on the findings and observations of the researcher, the following suggestions are offered:

- There should be closer and more frequent interaction between insured and insurance companies. The current trend of possible interaction only at the time of renewal of policy is not going to work in the future.
- The major policy terms and conditions must be written in a bullet point format on a single page and explained to the insurer in detail. The current format of policy is not at all comprehensible by the ordinary insurer.
- Any external change, which can influence health like the current pandemic situation should be discussed with the insurer in detail. It should be made clear

to them whether their current policy covers the new disease or not and what steps they should take.

- As the Indian population is not so health-conscious and has a reservation in buying a health insurance policy, only a competitive premium amount can satisfy the highly price-sensitive consumers.
- Insurance companies need to appreciate that they are part of a larger ecosystem. Claim reimbursement is only a part of their objective. Inclusion of other players like medicine shops, gymnasiums, diagnostic centres all are to be brought under one umbrella to make a real difference
- IRDA must be proactive in their approach and may offer more leg room to companies to tinker with policy terms and conditions as long as they remain within the larger ambit of achieving universal health.

5.5 Limitations and future scope

5.5.1 Limitations

There is hardly any study without limitations and these limitations create research gaps and a need to fulfill these gaps. Several limitations create an interruption to reaching out objectives of the study. Some limitations are as below:

Health insurance is a complex issue as it is linked not only with health care but other supporting services. Even the personal elements of the consumer also have a bearing on the repurchase intention. It appears that a lot of external factors also affect consumers, other than the factors included in our research, due to which the moderating effect of trust and inertia was found not significant.

Even though we have collected data on demographic factors like age, income, and gender, whether these factors have any impact on the outcome of our research is not explored.

Moreover, with the growth of penetration in health insurance and the entry of newer companies, differentiated policy terms are being offered. Our consideration of health policy without much differentiation in their types may be considered as a limitation.

The current COVID pandemic has added another dimension. As most of the responses were taken during the pandemic, we cannot say now whether our research may have a different outcome without this pandemic. Maybe a longitudinal study in the future can throw some different angle.

While considering word of mouth, we have not differentiated between the positive word of mouth and negative word of mouth. Future studies can try to amend this limitation.

With the growth of industry, there would be a newer and newer benefit to the customer through the generation of eco-system discussed in earlier chapters. Future researchers may find a revised scope in the context of the construct of benefit and post-benefit.

Paucity of research in Indian context is limited in their scope. Moreover, the concept of post benefit with the help of eco-system is new and evolving and not much research is not available in public domain.

The correlation among the moderators and how that affects the relationship leading to customer patronage can also be considered as a limitation.

5.5.2 Future scope of research

Researchers are excited about the future scope of similar studies. Future researchers can explore different innovative offerings by companies within the proposed ecosystem. They may structure their model with many new constructs like diagnostic and wellness centers, gymnasiums, and medical shops. Their research can find newer avenues to reduce overall expenditure on health by consumers, which can go a long way in helping the successive government with their limited health budget. In the future new moderators or mediators can also be studied. The relationship between the moderators says for example whether trust affects inertia or word of mouth etc and how in combination they affect the customer patronage may also be explored.

BIBLIOGRAPHY

ATKearney Inc (2011) Health Insurance: The customer engagement imperative https://www.atkearney.de/documents/20152/434495/health_insurers-the_customer_engagaement_imperative.pdf/55423c9f-4330-a51c-fb70-23e3ce6fbd2f

Abbasi, M. S. (2011). Culture, demography and individuals' technology acceptance behaviour: A PLS based structural evaluation of an extended model of technology acceptance in South-Asian country context (*Doctoral dissertation, Brunel University Brunel Business School PhD Theses*).

Abdelfattah, F. A., Rahman, M. S., & Osman, M. (2015). Assessing the antecedents of customer loyalty on healthcare insurance products: Service quality; perceived value embedded model. *Journal of Industrial Engineering and Management, 8*(5), 1639-1660.

Aburayya, A., Marzouqi, A., Alawadhi, D., Abdouli, F., & Taryam, M. (2020). An empirical investigation of the effect of employees' customer orientation on customer loyalty through the mediating role of customer satisfaction and service quality. *Management Science Letters*, *10*(10), 2147-2158.

Abu-Salim, T., Onyia, O. P., Harrison, T., & Lindsay, V. (2017). Effects of perceived cost, service quality, and customer satisfaction on health insurance service continuance. *Journal of Financial Services Marketing*, *22*(4), 173-186.

Ahmad, Z., Ahmed, I., Nawaz, M. M., Usman, A., Shaukat, M. Z., & Ahmad, N. (2010). Impact of service quality of short messaging service on customers retention; An empirical study of cellular companies of Pakistan. *International Journal of Business and Management*, *5*(6), 154.

Aiken, L, Toothaker, L., & West, S. (1991). Multiple Regressions: Testing and Interpreting Interactions. *The Journal of the Operational Research Society*, 45(1), 119.

Ali, A., Sirajoon, N. G., Hematram, Y., Aqil, M. D., & Su, T. (2010). Patient satisfaction and loyalty to the private hospitals in Sana'a Yemen. *International Journal for Quality in Health Care, 22*(4).

Al-Ekam, J. M. E., Mat, N. K. N., Salleh, S. M., Baharom, N., Teh, T. R. T., Noh, N. A., & Hussain, N. E. (2012). The influence of trust, advertising, family on intention and actual purchase of local brand in Yemen. *American Journal of Economics*, *2*(4), 64-68.

Alharbi, M. F., & Qassim, K. S. A. (2017). An empirical analysis of customer satisfaction with cooperative health insurance in Saudi Arabia: The role of customer knowledge, service characteristics, and national culture. *International Journal of Health Science and Research*, *7*(11), 234-246.

Alok, K.R., & Srivastava, M. (2013). The antecedents of customer loyalty: An empirical investigation in life Insurance context. *Journal of Competitiveness*, 5(2), 139-163.

Althabaiti, K., Alzahrani, S., Alotaibi, R., & Alahmari, W. (2019). The relationship between health insurance companies and patient satisfaction with quality of care. *International Journal of Multidisciplinary and Current research, 7,* 111-113

Amoroso, D. L., Ackaradejruangsri, P., & Lim, R. A. (2018). The Impact of Inertia as Mediator and Antecedent on Consumer Loyalty and Continuance Intention. In I. Management Association (Ed.), *Mobile Commerce: Concepts, Methodologies, Tools, and Applications* (pp. 960-981). IGI Global.

Amoroso, D. L., & Ogawa, M. (2013). Comparing mobile and internet adoption factors of loyalty and satisfaction with online shopping consumers. *International Journal of E-Business Research (IJEBR)*, *9*(2), 24-45.

Anbori, A., Ghani, S.N., Yadav, H. Daher, A.M. & Su, T.T. (2010). Patient satisfaction and loyalty to the private hospitals in Sana'a, Yemen. *International Journal for Quality in Health Care, 22*(4), 310-315.

Anderson, E. W., Fornell, C., & Lehmann, D. R. (1994). Customer satisfaction, market share, and profitability: Findings from Sweden. *Journal of Marketing*, *58*(3), 53-66.

Anderson, E. W., & Sullivan, M. W. (1993). The antecedents and consequences of customer satisfaction for firms. *Marketing Science*, *12*(2), 125-143.

Arasli, H., Katircioglu, S.T., & Mehtap-Smadi, S. (2005). A comparison of service quality in the banking industry: Some evidence from Turkish and Greek-speaking areas in Cyprus. *International Journal of Bank Marketing*, 23(7), 508-526.

Astuti, H. J., & Nagase, K. (2014). Patient loyalty to healthcare organizations: Relationship marketing and satisfaction. *International Journal of Management and Marketing Research*, *7*(2), 39-56.

Auka, D. (2012). Service quality, satisfaction, perceived value and loyalty among customers in commercial banking in Nakuru Municipality, Kenya. *African Journal of Marketing Management*, 4(5), 185-203.

Awang, Z. (2015). SEM made simple: A gentle approach to learning Structural Equation Modeling. MPWS Rich Publication.

Babakus, E., Bienstock, C. C., & Van Scotter, J. R. (2004). Linking perceived quality and customer satisfaction to store traffic and revenue growth. *Decision Sciences*, *35*(4), 713-737.

Bajpai, N. (2011). Business research methods. Pearson Education.

Baker, D. A., & Crompton, J. L. (2000). Quality, satisfaction and behavioural intentions. *Annals of Tourism Research*, *27*(3), 785-804.

Batini, C., Viscusi, G., & Cherubini, D. (2009). GovQual: A quality driven methodology for E-Government project planning. *Government Information Quarterly*, *26*(1), 106-117.

Batra, R., & Ahtola, O. T. (1991). Measuring the hedonic and utilitarian sources of consumer attitudes. *Marketing Letters*, *2*(2), 159-170.

Bawa, K. (1990). Modelling inertia and variety seeking tendencies in brand choice behaviour. *Marketing Science*, *9*(3), 263-278.

Bearden, W. O., & Teel, J. E. (1983). Selected determinants of consumer satisfaction and complaint reports. *Journal of Marketing Research*, *20*(1), 21-28.

Bejou, D., Ennew, C. T., & Palmer, A. (1998). Trust, ethics and relationship satisfaction. *International Journal of Bank Marketing*, *16*(4), 170–175.

Berry, L. L., Seiders, K., & Grewal, D. (2002). Understanding service convenience. *Journal of Marketing*, *66*(3), 1–17.

Bloom, G., & Wolcott, S. (2013). Building institutions for health and health systems in contexts of rapid change. *Social Science & Medicine*, *96*, 216-222.

Blut, M., Chowdhry, N., Mittal, V., & Brock, C. (2015). E-service quality: A meta-analytic review. *Journal of Retailing*, *91*(4), 679-700.

Bitner, M. J. (1990). Evaluating service encounters: the effects of physical surroundings and employee responses. *Journal of Marketing*, *54*(2), 69-82.

Bitner, M. J., & Hubbert, A. R. (1994). Encounter satisfaction versus overall satisfaction versus quality. *Service quality: New directions in theory and practice*, *34*(2), 72-94.

Bolton, R. N., & Drew, J. H. (1991). A multistage model of customers' assessments of service quality and value. *Journal of Consumer Research*, *17*(4), 375-384.

Bolton, R. N., & Drew, J. H. (1994). Linking customer satisfaction to service operations and outcomes. *Service Quality: New Directions in Theory and Practice*, *3*(2), 173-200.

Bolton, R. N., & Lemon, K. N. (1999). A dynamic model of customers' usage of services: Usage as an antecedent and consequence of satisfaction. *Journal of Marketing Research*, *36*(2), 171-186.

Bolton, R. N., Kannan, P. K., & Bramlett, M. D. (2000). Implications of loyalty program membership and service experiences for customer retention and value. *Journal of the Academy of Marketing Science, 28*(1), 95-108.

Brady, M. K., Robertson, C. J., & Cronin, J. J. (2001). Managing behavioural intentions in diverse cultural environments: An investigation of service quality, service value, and satisfaction for American and Ecuadorian fast-food customers. *Journal of International Management*, *7*(2), 129-149.

Butt, M.M., & Run, E.C. (2010). Private healthcare quality: applying a SERVQUAL model", *International Journal of Health Care Quality Assurance*, 23(7), 658-673.

Cameron, A. (2007). Kurtosis. In M. Lewis -Beck, A. Bryman, & T. Liao (Eds.), *Encyclopedia of Social Science Research Methods*. Retrieved from: https://books.google.co.in/books?

Cardozo, R. N. (1965). An experimental study of customer effort, expectation, and satisfaction. *Journal of Marketing Research*, *2*(3), 244-249.

Cengiz, E., & Kirkbir, F. (2007). Customer perceived value: the development of a multiple item scale in hospitals. *Problems and Perspectives in Management*, (5, Iss. 3 (contin.)), 252-268.

Chang, K., Chen, M., Hsu, C., & Kuo, N. (2010). The effect of service convenience on post-purchasing behaviours. Industrial Management & Data Systems, 110(9), 1420–1443.

Chaniotakis, I. E., & Lymperopoulos, C. (2009). Service quality effect on satisfaction and word of mouth in the health care industry. *Managing Service Quality: An International Journal*. 19(2), 229-242.

Chaudhuri, A., & Holbrook, M. B. (2002). Product-class effects on brand commitment and brand outcomes: The role of brand trust and brand affect. *Journal of Brand Management*, *10*(1), 33-58.

Chen, L. D. (2008). A model of consumer acceptance of mobile payment. *International Journal of Mobile Communications*, *6*(1), 32-52.

Chen, C.-F., & Cheng, L.-T. (2012). A study on mobile phone service loyalty in Taiwan. *Total Quality Management & Business Excellence*, 23(7-8), 807-819.

Chéron, E., & Nornart, S. (2010). The effect of culture and gender on perceived service quality: An exploratory comparison of Japanese and Thai consumers. *Journal of Asia-Pacific Business, 11*(1), 28-49.

Chin, W. W. (1998). The partial least squares approach to structural equation modelling. *Modern Methods for Business Research*, 295(2), 295-336.

Chin, W. W., & Newsted, P. R. (1999). Structural equation modelling analysis with small samples using partial least squares. *Statistical Strategies for Small Sample Research*, *1*(1), 307-341.

Chung, K. H., & Shin, J. I. (2010). The antecedents and consequents of relationship quality in internet shopping. *Asia Pacific Journal of Marketing and Logistics*. *22*(4), 473-491.

Cooil, B., Keiningham, T. L., Aksoy, L., & Hsu, M. (2007). A longitudinal analysis of customer satisfaction and share of wallet: Investigating the moderating effect of customer characteristics. *Journal of Marketing*, *71*(1), 67-83.

Colwell, S. R., Aung, M., Kanetkar, V., & Holden, A. L. (2008). Toward a measure of service convenience: multiple- item scale development and empirical test. *Journal of Services Marketing*. *22*(2), 160-169.

Connell, J., Carlton, J., Grundy, A., Taylor Buck, E., Keetharuth, A. D., Ricketts, T., & Brazier, J. (2018). The importance of content and face validity in instrument development: lessons learnt from service users when developing the Recovering Quality of Life measure (ReQoL). *Quality of Life Research*, *27*(7), 1893-1902.

Cravens, D. W., Holland, C. W., Lamb Jr, C. W., & Moncrief III, W. C. (1988). Marketing's role in product and service quality. *Industrial Marketing Management*, *17*(4), 285-304.

Cronbach, L. J. (1951). Co-efficient alpha and the internal structure of tests. *Psychometrika*, *16*(3), 297-334.

Cronin, J.J., Brady, M.K., & Hult, G.T.M. (2000). Assessing the effects of quality, value, and customer satisfaction on consumer behavioral intentions in service environments. *Journal of Retailing*, *76*(2), 193-218.

Cronin, J.J., & Taylor., S.A. (1992). Measuring service quality: A re-examination and extension. *The Journal of Marketing*, *56*(3), 55-68.

Cronin Jr, J. J., & Taylor, S. A. (1994). SERVPERF versus SERVQUAL: reconciling performance-based and perceptions-minus-expectations measurement of service quality. *Journal of Marketing*, *58*(1), 125-131.

Crosby, L. A., & Stephens, N. (1987). Effects of relationship marketing on satisfaction, retention, and prices in the life insurance industry. *Journal of Marketing Research*, *24*(4), 404-411.

Cyr, D., Head, M., & Ivanov, A. (2006). Design aesthetics leading to m-loyalty in mobile commerce. *Information & Management*, *43*(8), 950-963.

Dagger, T. S., & O'Brien, T. K. (2010). Does experience matter? Differences in relationship benefits, satisfaction, trust, commitment and loyalty for novice and experienced service users. *European Journal of Marketing*. *44*(9/10), 1528-1552.

Dahlberg, T., Guo, J., & Ondrus, J. (2015). A critical review of mobile payment research. *Electronic Commerce Research and Applications*, *14*(5), 265-284.

Dash, G., & Paul, J. (2021). CB-SEM vs PLS-SEM methods for research in social sciences and technology forecasting. *Technological Forecasting and Social Change*, *173*, 121092.

Dauda, S. Y., & Lee, J. (2016). Quality of service and customer satisfaction: a conjoint analysis for the Nigerian bank customers. *International Journal of Bank Marketing*. *34*(6), 841-867.

De Guinea, A. O., & Markus, M. L. (2009). Why break the habit of a lifetime? Rethinking the roles of intention, habit, and emotion in continuing information technology use. *MIS quarterly*, 433-444.

De Ruyter, K., Wetzels, M., Lemmink, J., & Mattson, J. (1997). The dynamics of the service delivery process: a value-based approach. *International Journal of Research in Marketing*, *14*(3), 231-243.

Dobele, A., & Lindgreen, A. (2011). Exploring the nature of value in the word-of-mouth referral equation for health care. *Journal of Marketing Management*, *27*(3-4), 269-290.

Delgado-Ballester, E., Munuera-Aleman, J. L., & Yague-Guillen, M. J. (2003). Development and validation of a brand trust scale. *International journal of market research*, *45*(1), 35-54.

Dodds, W. B., Monroe, K. B., & Grewal, D. (1991). Effects of price, brand, and store information on buyers' product evaluations. *Journal of Marketing Research*, *28*(3), 307-319.

Edvardsson, B., Johnson, M. D., Gustafsson, A., & Strandvik, T. (2000). The effects of satisfaction and loyalty on profits and growth: products versus services. *Total Quality Management*, *11*(7), 917-927.

Eisingerich, A. B., Auh, S., & Merlo, O. (2014). Acta non verba? The role of customer participation and word of mouth in the relationship between service firms' customer satisfaction and sales performance. *Journal of Service Research*, *17*(1), 40-53.

Elmayar, A. (2011). Assessing the perceived service quality levels in the libyan private and public banking sectors: A customer perspective. The University of Northumbria at Newcastle upon Tyne.

Ennew, C. T., Banerjee, A. K., & Li, D. (2000). Managing word of mouth communication: empirical evidence from India. *International Journal of Bank Marketing*. *18*(2), 475-83.

Eramus, A., Donoghue, S., & Fletcher, L. (2015). Proposing Persuasion Knowledge as the Antecedent of Consumers' Self-Confidence during a Complex Purchase Decision. *Journal of Marketing Management*, *3*(2), 27-38.

EY, (2015), The future of health insurance, a road map through change https://eysweeney.com.au/Documents/EYHealthReimagined2016.pdf

Fattah, F.A.M.A., Rahman., M.S., Mohamad,M. (2016). Assessing the antecedents of customer Loyalty on Health Care Insurance Products; service quality, perceived value embedded model. *Journal of Industrial Engineering & Management*. 8(5), 1639-1660.

Ferguson, R. J., Paulin, M., & Bergeron, J. (2010). Customer sociability and the total service experience: antecedents of positive word- of- mouth intentions. *Journal of Service Management*. 21(1), 25-44.

Fidell, L. S., & Tabachnick, B. G. (2003). Preparatory data analysis. *Handbook of Psychology: Research Methods in Psychology*, *2*, 115-141.

Field, A. (2013). Discovering statistics using IBM SPSS statistics. Sage.

Fornell, C. (1992). A national customer satisfaction barometer: The Swedish experience. *Journal of Marketing*, *56*(1), 6-21.

Fornell, C., & Cha, J. (1994). Partial least squares. *Advanced Methods of Marketing*. *Blackwell*, 52-78.

Fishbein, M., & Ajzen, I. (1977). Belief, attitude, intention, and behaviour: An introduction to theory and research. *Philosophy and Rhetoric*, *10*(2).

Fornell, C., & Larcker, D. F. (1981). Evaluating structural equation models with unobservable variables and measurement error. *Journal of Marketing Research*, *18*(1), 39-50.

Friedman, B., Khan Jr, P. H., & Howe, D. C. (2000). Trust online. *Communications of the ACM*, *43*(12), 34-40.

Gale, B., Gale, B. T., & Wood, R. C. (1994). Managing customer value*:* Creating quality and service that customers can see. Simon and Schuster.

Gallarza, M. G., & Gil, I. (2006). Development of a multidimensional scale to measure the perceived value of a service experience. *Spanish Journal of Marketing Research*, *10*(2), 25-59.

García-Fernández, J., Gálvez-Ruíz, P., Fernández-Gavira, J., Vélez-Colón, L., Pitts, B., & Bernal-García, A. (2018). The effects of service convenience and perceived quality on perceived value, satisfaction and loyalty in low-cost fitness centers. *Sport Management Review*, *21*(3), 250-262.

Garg, P., Nagpal, J., Khairnar, P., & Seneviratne, S. L. (2008). Economic burden of dengue infections in India. *Transactions of the Royal Society of Tropical Medicine and Hygiene*, *102*(6), 570-577.

Gefen, D., Straub, D., & Boudreau, M. C. (2000). Structural equation modelling and regression: Guidelines for research practice. *Communications of the Association for Information Systems*, *4*(1), 7.

Ghose, S., & Lowengart, O. (2013). Consumer choice and preference for brand categories. *Journal of Marketing Analytics, 1*(1), 3-17.

Gonçalves, F. M., Cândido, C. J., & Feliciano, I. M. P. L. (2020). Inertia, group conformity and customer loyalty in healthcare in the information age. *Journal of Service Theory and Practice*. 30(3), 307-330.

Gray, D. M., D'Alessandro, S., Johnson, L. W., & Carter, L. (2017). Inertia in services: causes and consequences for switching. *Journal of Services Marketing*. 31(6), 485-498.

Greenfield, H. I. (2005). Consumer inertia: A missing link?. *American Journal of Economics and Sociology*, *64*(4), 1085-1089.

Gremler, D. D., & Brown, S. W. (1996). Service loyalty: its nature, importance, and implications. *Advancing service quality: A global perspective*, *5*(1), 171-181.

Grewal, D., Monroe, K. B., & Krishnan, R. (1998). The effects of price-comparison advertising on buyers' perceptions of acquisition value, transaction value, and behavioural intentions. *Journal of Marketing*, *62*(2), 46-59.

Haenlein, M., Kaplan, A. M., & Beeser, A. J. (2007). A model to determine customer lifetime value in a retail banking context. *European Management Journal*, *25*(3), 221-234.

Hafeez, S., & Muhammad, B. (2012). The Impact of Service Quality, Customer Satisfaction and Loyalty Programs on Customer's Loyalty: Evidence from Banking Sector of Pakistan. *International Journal of Business and Social Science*, *3*(16).

Hair, J. F., Black, W. C., Babin, B. J., Anderson, R. E., & Tatham, R. (2006). Multivariate data analysis . 6th ed. Uppersaddle River. Prentice Hall.

Hair Jr, J. F., Sarstedt, M., Matthews, L. M., & Ringle, C. M. (2016). Identifying and treating unobserved heterogeneity with FIMIX-PLS: part I–method. *European Business Review*. 28(1), 63-76.

Hair Jr, J. F., Hult, G. T. M., Ringle, C. M., & Sarstedt, M. (2021). A primer on partial least squares structural equation modelling *(PLS-SEM)*. Sage publications.

Hair Jr, J. F., Matthews, L. M., Matthews, R. L., & Sarstedt, M. (2017). PLS-SEM or CB-SEM: updated guidelines on which method to use. *International Journal of Multivariate Data Analysis*, *1*(2), 107-123.

Hair, J. F., Risher, J. J., Sarstedt, M., & Ringle, C. M. (2019). When to use and how to report the results of PLS-SEM. *European Business Review*. 31(1), 2-24.

Haque, A., Sarwar, A. A. M., Yasmin, F., & Anwar, A. (2012). The impact of customer perceived service quality on customer satisfaction for private health centre in Malaysia: a structural equation modelling approach. *Information Management and Business Review*, *4*(5), 257.

Handel, B. R. (2013). Adverse selection and inertia in health insurance markets: When nudging hurts. *American Economic Review*, *103*(7), 2643-82.

Han, J. (2018). Perceived value of health insurance and enrolment decision among low-income population. *Innovations in Pharmacy*, *9*(2), 1.

Hedman, J., & Henningsson, S. (2015). The new normal: Market cooperation in the mobile payments ecosystem. *Electronic Commerce Research and Applications*, *14*(5), 305-318.

Henkel, D., Houchaime, N., Locatelli, N., Singh, S., Zeithaml, V. A., & Bittner, M. J. (2006). The impact of emerging WLANs on incumbent cellular service providers in the U.S. M.J. Services marketing. McGraw-Hill.

Henseler, J., Ringle, C. M., & Sarstedt, M. (2015). A new criterion for assessing discriminant validity in variance-based structural equation modelling. *Journal of the Academy of Marketing Science*, *43*(1), 115-135.

Heskett, J. L., Jones, T. O., Loveman, G. W., Sasser, W. E., & Schlesinger, L. A. (1994). Putting the service-profit chain to work. *Harvard Business Review*, *72*(2), 164-174.

Higgins, A., Barnett, J., Meads, C., Singh, J., & Longworth, L. (2014). Does convenience matter in health care delivery? A systematic review of convenience-based aspects of process utility. *Value in Health*, *17*(8), 877-887.

Hirschman, E. C., & Holbrook, M. B. (1982). Hedonic consumption: emerging concepts, methods and propositions. *Journal of Marketing*, *46*(3), 92-101.

Holland, J., & Baker, S. M. (2001). Customer participation in creating site brand loyalty. *Journal of Interactive Marketing*, *15*(4), 34-45.

Homburg, C., Koschate, N., & Hoyer, W. D. (2005). Do satisfied customers really pay more? A study of the relationship between customer satisfaction and willingness to pay. *Journal of Marketing*, *69*(2), 84-96.

Homburg, C. Hoyer, W. D., & Koschate, N. (2005). Customers' reactions to price increases: do customer satisfaction and perceived motive fairness matter?. *Journal of the Academy of Marketing Science*, *33*(1), 36-49.

Hossain, M. A., Dwivedi, Y. K., & Naseem, S. B. (2015). Developing and validating a hierarchical model of service quality of retail banks. *Total Quality Management & Business Excellence*, *26*(5-6), 534-549.

Huang, E., & Liu, C. C. (2010). A study on trust building and its derived value in C2C e-commerce. *Journal of Global Business Management*, *6*(1), 1.

Huang, M. H., & Yu, S. (1999). Are consumers inherently or situationally brand loyal?—A set intercorrelation account for conscious brand loyalty and nonconscious inertia. *Psychology & Marketing*, *16*(6), 523-544.

Hurley, R. F., & Estelami, H. (1998). Alternative indexes for monitoring customer perceptions of service quality: A comparative evaluation in a retail context. *Journal of the academy of Marketing Science*, *26*(3), 209-221.

Hu, H. Y., Chang, H. C., & Cheng, C. C. (2016). Exploration on the relationship between patient satisfaction, relationship inertia and loyalty-switching barriers as the moderator. *Journal of Accounting, Finance & Management Strategy*, *11*(1). 53-82.

Iacobucci, D., Ostrom, A., & Grayson, K. (1995). Distinguishing service quality and customer satisfaction: the voice of the consumer. *Journal of Consumer Psychology*, *4*(3), 277-303.

Jacob, A. (2018). A study on customer perception towards health insurance in Ranny Thaluk. *International Journal for Advance Research and Development*, *3*(12), 41-48.

Jones, T. O., & Sasser, W. E. (1995). Why satisfied customers defect. *Harvard Business Review*, *73*(6), 88.

Julander, C. R., & Söderlund, M. (2003). Effects of switching barriers on satisfaction, repurchase intentions and attitudinal loyalty. *SSE/EFI Working paper series in Business Administration*, *1*, 1-21.

Jun, M., & Cai, S. (2010). Examining the relationships between internal service quality and its dimensions, and internal customer satisfaction. *Total Quality Management*, *21*(2), 205-223.

Kandampully, J. (1998). Service quality to service loyalty: A relationship which goes beyond customer services. *Total Quality Management*, *9*(6), 431-443.

Kantsperger, R., & Kunz, W. H. (2010). Consumer trust in service companies: a multiple mediating analysis. *Managing Service Quality: An International Journal*. 20(1), 4-25.

Kassim, N. M., & Ismail, S. (2009). Investigating the complex drivers of loyalty in e- commerce settings. *Measuring Business Excellence*. 13(1), 56-71.

Kautish, P., Khare, A., & Sharma, R. (2021). Health insurance policy renewal: an exploration of reputation, performance, and affect to understand customer inertia. *Journal of Marketing Analytics*, 1-18. https://doi.org/10.1057/s41270-021-00134-7

Kean, R. C. (1985). Perceived Importance of Selected Skills to a. Group of Discount Store Buyers. *Clothing and Textiles Research Journal*, *4*(1), 31-37.

Keaveney, S. M. (1995). Customer switching behaviour in service industries: An exploratory study. *Journal of Marketing*, *59*(2), 71-82.

Keiningham, T., & Aksoy, L. (2012). Linking customer loyalty to growth. *MIT Sloan Management Review*, 49(4), 51-57.

Khare, A., Labrecque, L. I., & Asare, A. K. (2011). The assimilative and contrastive effects of word-of-mouth volume: An experimental examination of online consumer ratings. *Journal of Retailing*, *87*(1), 111-126.

Kitapci, O., Akdogan, C., & Dortyol, İ. T. (2014). The impact of service quality dimensions on patient satisfaction, repurchase intentions and word-of-mouth communication in the public healthcare industry. *Procedia-Social and Behavioural Sciences*, *148*, 161-169.

Koenig-Lewis, N., & Palmer, A. (2014). The effects of anticipatory emotions on service satisfaction and behavioral intention. *Journal of Services Marketing*. 28(6), 437-451.

Kondasani, R. K. R., & Panda, R. K. (2015). Customer perceived service quality, satisfaction and loyalty in Indian private healthcare. *International Journal of Health Care Quality Assurance*. 28(5), 452-467.

Krumay, B., & Brandtweiner, R. (2010). Are Customer Service Offerings Influencing E-Loyalty? A Graphical Chain Model Approach in the Austrian Mobile Phone Service Provider Industry. *In BLED 2010 Proceedings*. Paper 17.

Kumar, R. (2015). Exploring Digital India's transformative plans. Retrieved from www.weforum.org: https://www.weforum.org/agenda/2015/04/exploring-digital-indias-transformative-plans/

Kumar, K.V., & Sabrin N. (2020). A Study on Customers' Satisfaction towards Health Insurance in Trichirapalli City. *Our Heritage,* 68(1), 3762-3767.

Kumar, S.N.A (2017), Assuring *Affordable Primary Health Care in a Digital Era*, IRDAI Volume XV, No 1, https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo3143&flag=1

Lam, S. Y., Shankar, V., Erramilli, M. K., & Murthy, B. (2004). Customer value, satisfaction, loyalty, and switching costs: an illustration from a business-to-business service context. *Journal of the Academy of Marketing Science*, *32*(3), 293-311.

Lamont, W. D. (1955). The value judgment. *The Philosophical Review*. 66(2), 255-258

Lau, G. T., & Ng, S. (2001). Individual and situational factors influencing negative word- of- mouth behaviour. *Canadian Journal of Administrative Sciences/Revue Canadienne des Sciences de l'Administration*, *18*(3), 163-178.

LeBlanc, G., & Nguyen, N. (2001). An exploratory study on the cues that signal value to members in retail co-operatives. *International Journal of Retail & Distribution Management*, 29(1), 49-59

Leys, C., Ley, C., Klein, O., Bernard, P., & Licata, L. (2013). Detecting outliers: Do not use standard deviation around the mean, use absolute deviation around the median. *Journal of Experimental Social Psychology*, *49*(4), 764-766.

Lien, C. Y. (2012). Establishing a consumption experience scale model for Taiwanese fine foods culture. *African Journal of Business Management*, *6*(10), 3715-3724.

Lim, P. C., & Tang, N. K. (2000). A study of patients' expectations and satisfaction in Singapore hospitals. *International Journal of Health Care Quality Assurance*. 13(7), 290-299.

Limayem, M., Hirt, S. G., & Cheung, C. M. (2007). How habit limits the predictive power of intention: The case of information systems continuance. *MIS quarterly*, 705-737.

Lloyd, A. E., Chan, R. Y., Yip, L. S., & Chan, A. (2014). Time buying and time saving: effects on service convenience and the shopping experience at the mall. *Journal of Services Marketing*. 28(1), 36-49.

Loiacono, E. T., Watson, R. T., & Goodhue, D. L. (2002). WebQual: A measure of website quality. *Marketing Theory and Applications*, *13*(3), 432-438.

Lowry, P. B., & Gaskin, J. (2014). Partial least squares (PLS) structural equation modeling (SEM) for building and testing behavioural causal theory: When to choose it and how to use it. *IEEE transactions on professional communication*, *57*(2), 123-146.

Margan, S.K., (2017), *Re-inventing customer engagement in health insurance*, IRDAI Volume XV, No 1, https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo3143&flag=1

Martín-Ruiz, D., Barroso-Castro, C., & Rosa-Díaz, I. M. (2012). Creating customer value through service experiences: an empirical study in the hotel industry. *Tourism and Hospitality Management*, *18*(1), 37-53.

Martín- Ruiz, D., & Rondán- Cataluña, F. J. (2008). The nature and consequences of price unfairness in services: A comparison to tangible goods. *International Journal of Service Industry Management*. 19(3), 325-352.

Mathur, T., Das, G., & Paul, U. K. (2016). Convenience, Satisfaction, and Post-Purchase Behavior in India's Health Insurance Market. *Journal of Global Marketing*, *29*(4), 218-232.

Mazzarol, T., Sweeney, J. C., & Soutar, G. N. (2007). Conceptualizing word- of-mouth activity, triggers and conditions: an exploratory study. *European Journal of Marketing*. 14(11/12), 1475-1494.

McDougall, G. H., & Levesque, T. (2000). Customer satisfaction with services: putting perceived value into the equation. *Journal of Services Marketing*. 14(5), 392-410.

McDaniel, C., & Gates, R. (2006). The Marketing Research Industry and Research Ethics, Ed.

McKinsey Global Insurance pools (2017) seventh edition-Global Insurance Industry Insights- An in-depth perspective

https://www.mckinsey.com/~/media/mckinsey/industries/financial%20services/our%20insights/global%20insurance%20insights%20an%20overview%20of%20recent%20trends%20in%20life%20p%20and%20c%20and%20health/global-insurance-industry-insights-an-in-depth-perspective-may-2018.ashx

McKinsey & Company, (2015) Healthcare system and service practice, Great customer
https://healthcare.mckinsey.com/wp-content/uploads/2020/02/Great_customer_experience.pdf

Meesala, A., & Paul, J. (2018). Service quality, consumer satisfaction and loyalty in hospitals: Thinking for the future. *Journal of Retailing and Consumer Services*, *40*, 261-269.

Meidan, A. (1996). Customer Behaviour and Market Segmentation. In *Marketing Financial Services* (pp. 23-49). Palgrave,

Mittal, V., & Kamakura, W. A. (2001). Satisfaction, repurchase intent, and repurchase behaviour: Investigating the moderating effect of customer characteristics. *Journal of Marketing Research*, *38*(1), 131-142.

Mital, B., & Lassar, M. (1998). Why do customers switch? The dynamics of satisfaction versus loyalty. *Journal of Service Marketing*, *12*(3), 177-194.

Mohamed, B., & Azizan, N. A. (2015). Perceived service quality's effect on patient satisfaction and behavioural compliance. *International Journal of Health Care Quality Assurance*. 28(3), 300-314.

Mohsen, Y., Hussein, H. M., & Mahrous, A. A. (2018). Perceived service value, customer engagement and brand loyalty in health care centres in Egypt. *Marketing & Management of Innovation.* 3, 85-108.

Mokhtar, S., & Maiyaki, A. (2011). The Relationship Between Service Quality and Satisfaction on Customer Loyalty in Malaysian Mobile Communication Industry. *European Union Journal*, 2(3), 32-38.

Monecke, A., & Leisch, F. (2012). semPLS: structural equation modelling using partial least squares. *Journal of Statistical Software*, *48*(1), 1-32.

Monroe, K., & Pricing, M. P. D. E. (1990). *A Guide to Strategic Pricing*, McGraw-Hill

Morgan, R. M., & Hunt, S. D. (1994). The commitment-trust theory of relationship marketing. *Journal of marketing*, *58*(3), 20-38.

Moreno, F. C., Prado-Gascó, V., Hervás, J. C., Núñez-Pomar, J., & Sanz, V. A. (2016). Predicting future intentions of basketball spectators using SEM and fsQCA. *Journal of Business Research*, *69*(4), 1396-1400.

Murray, K. B. (1991). A test of services marketing theory: consumer information acquisition activities. *Journal of marketing*, *55*(1), 10-25.

Nawani, P (2017), *Health Insurance architecture in India: Challenges ahead*, IRDAI Volume XV, No 1, https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo3143&flag=1

Ngobo, P. V. (1999). Decreasing returns in customer loyalty: Does it really matter to delight the customers? *ACR North American Advances*. 26, 469-476.

Oliver, R. L., & Swan, J. E. (1989). Consumer perceptions of interpersonal equity and satisfaction in transactions: a field survey approach. *Journal of Marketing*, *53*(2), 21-35.

Oliver, R. L. (1980). A cognitive model of the antecedents and consequences of satisfaction decisions. *Journal of Marketing Research*, *17*(4), 460-469.

Oliver, C. (1997). Sustainable competitive advantage: combining institutional and resource- based views. *Strategic Management Journal*, *18*(9), 697-713.

Oliver, R. L., Rust, R. T., & Varki, S. (1997). Customer delight: foundations, findings, and managerial insight. *Journal of Retailing*, *73*(3), 311-336.

Olshavsky, R. W., & Miller, J. A. (1972). Consumer expectations, product performance, and perceived product quality. *Journal of Marketing Research*, *9*(1), 19-21.

Osman, A., Wong, J. L., Bagge, C. L., Freedenthal, S., Gutierrez, P. M., & Lozano, G. (2012). The depression anxiety stress Scales—21 (DASS- 21): further examination of dimensions, scale reliability, and correlates. *Journal of Clinical Psychology*, *68*(12), 1322-1338.

Padma, P., C. Rajendran, and L.P. Sai. 2009. A conceptual framework of service quality in healthcare: Perspectives of Indian patients and their attendants. *Benchmarking: An International Journal* 16 (2): 157–191.

Palmatier, R.W., Dant, R.P., Grewal, D., & Evans, K.R. (2006). Factors Influencing the Effectiveness of Relationship Marketing: A Meta-Analysis. *Journal of Marketing*, 70(4), 136-153.

Pallant, J. (2011). Survival manual. *A step by step guide to data analysis using IBM SPSS. Routledge*. Taylor & Francis. https://doi.org/10.4324/9781003117452

Panther, T., & Farquhar, J. D. (2004). Consumer responses to dissatisfaction with financial service providers: An exploration of why some stay while others switch. *Journal of Financial Services Marketing*, *8*(4), 343-353.

Papadomichelaki, X., & Mentzas, G. (2012). e-GovQual: A multiple-item scale for assessing e-government service quality. *Government Information Quarterly*, *29*(1), 98-109.

Parasuraman, A., & Grewal, D. (2000). The impact of technology on the quality-value-loyalty chain: a research agenda. *Journal of the Academy of Marketing Science*, *28*(1), 168-174.

Parasuraman, A., Zeithaml, V., & Berry, L. (1985). A conceptual model of service quality and its implications for future research. *The Journal of Marketing*, 49(2), 41-50.

Parasuraman, A., Zeithaml, V.A., & Berry, L.L. (1988). SERVQUAL: A Multiple-Item Scale for Measuring Consumer Perceptions of Service Quality. *Journal of Retailing*, 64(1), 12-40.

Parasuraman, A., L.L. Berry, and V.A. Zeithaml. 1991a. Understanding customer expectations of service. *Sloan Management Review* 32 (3): 39–48.

Parasuraman, A., L.L. Berry, and V.A. Zeithaml. 1991b. Perceived service quality as a customer-based performance measure: An empirical examination of organizational

barriers using an extended service quality model. *Human Resource Management* 30 (3): 335–364.

Patterson, P. G., & Spreng, R. A. (1997). Modelling the relationship between perceived value, satisfaction and repurchase intentions in a business- to- business, services context: an empirical examination. *International Journal of service Industry management*. 8(5), 414-434.

Peng, D. X., & Lai, F. (2012). Using partial least squares in operations management research: A practical guideline and summary of past research. *Journal of Operations management*, *30*(6), 467-480.

Peterson, R. A., & Wilson, W. R. (1992). Measuring customer satisfaction: fact and artifact. *Journal of the Academy of Marketing Science*, *20*(1), 61-71.

Polites, G. L., & Karahanna, E. (2012). Shackled to the status quo: The inhibiting effects of incumbent system habit, switching costs, and inertia on new system acceptance. *MIS quarterly*, 21-42.

Rahman, M., AbdelFattah, F., & Mohamad, O. (2014). Service Quality and Customers' Patronage Decision of Healthcare Insurance Products: In-Depth Interview Approach. *Hrmars.com*, 4(7), 526-544.

Rahman, M. S., Mohamad, O., & Fattah, F. A. M. A. (2014, November). Impact of Service Quality and Trust on Customer Patronage Decision: Testing the Moderating effects of Corporate Image. In *2014 Asia Conference on Economics & Business Research (ACEB 2014) CONFERENCE PROCEEDINGS* (p. 49).

Rahman, M. S., Mohamad, O., Abdelfattah, F. A., & Aziz, N. (2014). Factors Determining Customers' Repurchase Intention Healthcare Insurance Products in Malaysia. Proceedings of the Australian Academy of Business & Social Science Conference 2014.

Rahman, M. S., Fattah, F. A. M. A., Zaman, M., & Hassan, H. (2018). Customer's patronage decision toward health insurance products: mediation and multi-group moderation analysis. *Asia Pacific Journal of Marketing and Logistics*. 30(1), 62-83.

Ramli, A. H., & Sjahruddin, H. (2015). Building patient loyalty in healthcare services. *International Review of Management and Business Research*, *4*(2), 391.

Ranaweera, C., & Prabhu, J. (2003). On the relative importance of customer satisfaction and trust as determinants of customer retention and positive word of mouth. *Journal of Targeting, Measurement and Analysis for marketing*, *12*(1), 82-90.

Rapp, A., Beitelspacher, L.S., Schillewaert, N., & Baker, T.L. (2012). The differing effects of technology on inside vs. outside sales forces to facilitate enhanced customer orientation and interfunctional coordination. *Journal of Business Research*, 65(7), 929-936.

Reichheld, F.F. (1993). Loyalty-Based Management. *Harvard Business Review*, 71(2), 64-73.

Reichheld, F. F. (1996). Learning from customer defections. *Harvard Business Review*, *74*(2), 56-67.

Reichheld, F.F., & Sasser, W. (1990). Zero defections: Quality comes to services. *Harvard Business Review*, 68(5), 105-111.

Reichheld, F. F., & Schefter, P. (2000). E-loyalty: Your secret weapon on the web. *Harvard Business Review*, *78*(4), 105-113.

Repo, K. L. (1999). Word-of-mouth communication in the hospitality industry. *Swedish School of Economics and Business Administration Research Reports*.

Ringle, C. M., Wende, S., & Will, A. (2005). SmartPLS 2.0 (beta).

Ringle, C. M., Sarstedt, M., & Straub, D. W. (2012). Editor's comments: a critical look at the use of PLS-SEM in" MIS Quarterly". *MIS quarterly*, iii-xiv.

Ringle, C. M., Sarstedt, M., Mitchell, R., & Gudergan, S. P. (2020). Partial least squares structural equation modelling in HRM research. *The International Journal of Human Resource Management*, *31*(12), 1617-1643.

Rubala, S., & Selvachandra, M. (2020). A study on policy holders' perception and satisfaction towards health insurance policy holders, *Our Heritage*, 68(1)

Rust, R. T., & Oliver, R. W. (1994). Video dial tone: The new world of services marketing. *Journal of Services Marketing*. 8(3), 5-16.

Rust, R. T., & Oliver, R. L. (2000). Should we delight the customer? *Journal of the Academy of Marketing Science*, *28*(1), 86-94.

Samuelson, W., & Zeckhauser, R. (1988). Status quo bias in decision making. *Journal of Risk and Uncertainty*, *1*(1), 7-59.

Sanchez, J., Callarisa, L., Rodriguez, R. M., & Moliner, M. A. (2006). Perceived value of the purchase of a tourism product. *Tourism Management*, *27*(3), 394-409.

Sarstedt, M., Ringle, C. M., & Hair, J. F. (2017). Partial least squares structural equation modeling. *Handbook of Market Research*, *26*(1), 1-40.

Schiffman, L. G., & Kanuk, L. L. (2004). Consumer Behaviour 8th edition Published by Prentice Hall. *Upper Saddle River*, *NJ*, 35-43.

Seiders, K., Voss, G. B., Godfrey, A. L., & Grewal, D. (2007). SERVCON: development and validation of a multidimensional service convenience scale. *Journal of the Academy of Marketing Science*, *35*(1), 144-156.

Selnes, F. (1998). Antecedents and consequences of trust and satisfaction in buyer-seller relationships. *European Journal of Marketing*. 32(3/4), 305-322.

- Shan, L., Li, Y., Ding, D., Wu, Q., Liu, C., Jiao, M., Hao, Y., Han, Y., Gao, L., Hao, j., Wang, L., Xu, W., & Ren, J. (2016). Patient satisfaction with hospital inpatient care: effects of trust, medical insurance and perceived quality of care. doi: 10.1371/journal.pone.0164366

Sharma, N., & Patterson, P. G. (2000). Switching costs, alternative attractiveness and experience as moderators of relationship commitment in professional, consumer services. *International Journal of Service Industry Management*. 11(5), 470-490.

Sheng, T., & Liu, C. (2010). An empirical study on the effect of e- service quality on online customer satisfaction and loyalty. *Nankai Business Review International*. 1(3), 273-283.

Sheth, J. N., Newman, B. I., & Gross, B. L. (1991). Why we buy what we buy: A theory of consumption values. *Journal of Business Research*, *22*(2), 159-170.

Singh, S., & Chaudhary, N. J. S. M. K. (2014). A study of customer perception towards service quality of life Insurance companies in Delhi NCR Region. *Global Journal of Management and Business Research*. 14(7),

Sohail, M. S. (2003). Service quality in hospitals: more favourable than you might think. *Managing Service Quality: An International Journal*. 13(3), 197-206.

Solnet, D., & Kandampully, J. (2008). How some service firms have become part of "service excellence" folklore: An exploratory study. *Managing Service Quality: An International Journal*. 18(2), 179-193.

Sweeney, J. C., & Soutar, G. N. (2001). Consumer perceived value: The development of a multiple item scale. *Journal of Retailing*, *77*(2), 203-220.

Sweeney, J. C., Soutar, G. N., & Mazzarol, T. (2008). Factors influencing word of mouth effectiveness: receiver perspectives. *European Journal of Marketing*. 42(3/4), 344-364.

Szymanski, D. M. M-Henard, DH (2001): Customer Satisfaction: A Meta-Analysis of the Empirical Evidence. *Journal of the Academy of Marketing Science*, *29*(16).

https://doi.org/10.1177/0092070301291002

Tabachnick, B. G., & Fidell, L. S. (2007). Using multivariate statistics, 5th edn Boston. *MA: Allyn and Bacon.*

Tenenhaus, M., Vinzi, V. E., Chatelin, Y. M., & Lauro, C. (2005). PLS path modeling. *Computational Statistics & Data Analysis*, *48*(1), 159-205.

Thaler, R. (1985). Mental accounting and consumer choice. *Marketing Science*, *4*(3), 199-214.

Tse, D. K., & Wilton, P. C. (1988). Models of consumer satisfaction formation: An extension. *Journal of Marketing Research*, *25*(2), 204-212.

Tsoukatos, E., & Rand, G. K. (2006). Path analysis of perceived service quality, satisfaction and loyalty in Greek insurance. *Managing Service Quality: An International Journal*. 16(5), 501-519.

Tuzovic, S., & Kuppelwieser, V. (2016). Developing a framework of service convenience in health care: An exploratory study for a primary care provider. *Health Marketing Quarterly*, *33*(2), 127-148.

Udo, G. J., Bagchi, K. K., & Kirs, P. J. (2010). An assessment of customers' e-service quality perception, satisfaction and intention. *International Journal of Information Management*, *30*(6), 481-492.

Valaei, N., Rezaei, S., & Shahijan, M. K. (2016). CouQual: assessing overall service quality in courier service industry and the moderating impact of age, gender and ethnicity. *International Journal of Management Concepts and Philosophy*, *9*(2), 144-169.

Van Doorn, J., Lemon, K. N., Mittal, V., Nass, S., Pick, D., Pirner, P., & Verhoef, P. C. (2010). Customer engagement behaviour: Theoretical foundations and research directions. *Journal of Service Research*, *13*(3), 253-266.

Vázquez- Casielles, R., Suárez- Álvarez, L., & Del Río- Lanza, A. B. (2009). Customer satisfaction and switching barriers: Effects on repurchase intentions, positive recommendations, and price tolerance 1. *Journal of Applied Social Psychology*, *39*(10), 2275-2302.

Venugopal, R (2017), *Understanding Health Insurance*, IRDAI Volume XV, No 1, https://www.irdai.gov.in/ADMINCMS/cms/frmGeneral_Layout.aspx?page=PageNo3143&flag=1

Vijay, A., & Krishnaveni, V. (2018). The role of awareness on the level of satisfaction among health insurance policy-holders with special reference to Ernakulam district, Kerala. *Indian J Public Health Res Dev*, *9*(12), 15-20.

Vinzi, V. E., Chin, W. W., Henseler, J., & Wang, H. (2010). *Handbook of partial least squares* (Vol. 201, No. 0). Berlin: Springer.

Wang, X. (2011). The effect of inconsistent word- of- mouth during the service encounter. *Journal of Services Marketing*. 25(4), 252-259.

Wang, Y. S., Wang, Y. M., Lin, H. H., & Tang, T. I. (2003). Determinants of user acceptance of Internet banking: an empirical study. *International Journal of service Industry Management*. 14(5), 501-519.

White, L., & Yanamandram, V. (2004). Why customers stay: reasons and consequences of inertia in financial services. *Managing Service Quality: An International Journal*. 14(2/3), 183-194.

Wold, H. (1982). Models for knowledge. In *The making of statisticians* (pp. 189-212). Springer, New York,

Wong, R., Tong, C., & Wong, A. (2012). Examine the Effects of Customer Satisfaction on Customer Loyalty: An Empirical Study in the Healthcare Insurance Industry in Hong Kong. *British Journal of Economics, Management & Trade*, 4(3), 372-399.

Wong, H. Y., & Merrilees, B. (2015). An empirical study of the antecedents and consequences of brand engagement. *Marketing Intelligence & Planning*. 33(4), 575-591.

Woodside, A. G., Frey, L. L., & Daly, R. T. (1989). Linking Service Quality, Customer Satisfaction, And Behaviour. *Marketing Health Services*, *9*(4), 5.

Woodruff, R. B. (1997). Customer value: the next source for competitive advantage. *Journal of the Academy of Marketing Science*, *25*(2), 139-153.

Wu, H. C., Li, T., & Li, M. Y. (2016). A study of behavioral intentions, patient satisfaction, perceived value, patient trust and experiential quality for medical tourists. *Journal of Quality Assurance in Hospitality & Tourism*, *17*(2), 114-150.

Wu, J. H., & Wang, S. C. (2005). What drives mobile commerce? An empirical evaluation of the revised technology acceptance model. *Information & Management*, *42*(5), 719-729.

Yahaya, M. L., Murtala, Z. A., & Onukwube, H. N. (2019). Partial least squares (PLS-SEM): A note for beginners. *International Journal of Environmental Studies and Safety Research*, *4*(4), 1-30.

Yahaya, M. (2019). Partial Least Square Structural Equation Modelling (PLS-SEM): A Note For Beginners. *Retrieved November 6*, 2020.

Yang, Z., & Jun, M. (2008). Consumer perception of e-service quality: From internet purchaser and non-purchaser perspectives. *Journal of Business Strategies*, *25*(2), 59.

Yuen, Y. H. (2007, June). Overview of knowledge management in the public sector. In *7th Global Forum on Reinventing Government: Building Trust in Government* (pp. 1-16). Vienna: United Nations.

Zeithaml, V.A., A. Parasuraman, and L.L. Berry. 1990. Delivering quality service: Balancing customer perceptions and expectations, 1–232. The Free Press.

Zeithaml Valarie, A., & Bitner, M. J. (1996). Services marketing. International Editions. The McGraw-Hill .

Zeithaml, V. A. (1988). Consumer perceptions of price, quality, and value: a means-end model and synthesis of evidence. *Journal of Marketing*, *52*(3), 2-22.

Zeithaml, V. A. (2013). Services marketing: Integrating customer focus across the firm. McGraw-Hill.

Zhang, J., & Lee, H. Y. (2015). Factors influencing Chinese customers' selection of health care service countries: Focusing on word-of-mouth moderating effects. *Journal of Distribution Science*, *13*(12), 41-52.

Appendix-1

OSCAR HEALTH

Oscar offers all members free 24/7 telemedicine visits through their Doctor on Call service as a part of their membership, which are available both through the Oscar Android or iOS app or the Oscar web app.

Oscar assigns each of its members to a "Concierge Team" which is made up of a team of three care guides and a registered nurse that handle both traditional customer service questions as well as coordination of clinical care. In an interview with the *Phoenix Business Journal* in 2017, Oscar's VP of Customer Care Paul Gazely said that Oscar's concierge model "helps to build a relationship and build trust with our members with their health care needs," and that the model helps Oscar familiarize itself "with the member's needs by looking at the entire member's health history.

In addition, Oscar offers its members Amazon gift cards as a part of a rewards program for step tracking.

Oscar offers direct appointment scheduling with a selection of its provider partners and (as of 2017) providers an application and tools to serve Oscar members, including a Clinical Dashboard that pulls Oscar members' medical histories into a single platform According to *WIRED* they built predictive models using purchased Medicare data and Oscar's own claims data to better optimize their patient and doctor provider network based on location, provider specialties

Humana

About 7,000 employees with Humana Inc. now have the opportunity to take part in a rewards program being offered under a partnership between the Louisville health insurer and Virgin Life Care.

The program, which was launched in Louisville Wednesday, is being offered to Humana customers in Louisville and two other markets. Virgin Life Care administers and underwrites the program.

The program, called HealthMiles, is Virgin's take on the popular airline miles and points programs offered by numerous U.S. companies. But instead of basing the accrual of points on customer spending, the program lets participants earn credits by improving their health.

Using HealthZone kiosks provided by Virgin, Humana employees will measure blood pressure, weight, body fat and body mass index and track improvements and exercise.

The kiosks will be in Humana's two corporate gyms and at Louisville Athletic Club's two Louis�ville facilities, according to Jim Turner, Humana's media relations manager for Kentucky and Tennessee.

Based on improvements in those measurements and a record of efforts to reach their personal goals, employees will earn credits that can be converted into "Life Care Cash."

Those rewards may be used to purchase products and services from about 50 retailers, including Target Corp., The Home Depot Inc. and Blockbuster Inc., according to Joan Kelly, a spokeswoman for Virgin.

She added that the company eventually might also allow rewards to be redeemed for products sold by Virgin Group Ltd., the British media and entertainment company founded by Sir Richard Branson that owns Virgin Life Care. Its other holdings include Virgin Atlantic Airways Ltd., Virgin Mobile USA LLC and Virgin Records America Inc.

"We didn't want this to look like we were just doing it to get customers," she said. Instead, she said, the program is designed to encourage people to exercise and be healthy.

"We want to make sure the work force is fit and healthy, and that lowers health care costs overall," Kelly said.

Appendix 2

The following set of questions relate to your feelings about your health insurance company. For each statement show the extent to which you agree or disagree with the statement. Do this by picking one of the 5 numbers next to each statement. If you strongly disagree with the statement about your insurance company, please circle in 1 and if you strongly agree, please circle 5. You may circle any of the numbers in the middle to show how strong your feelings are. There are no right and wrong answers and all we are interested in is a number that best shows your perception about your health insurance company.

		VDA	*SD*	*MDA*	*N*	*MA*	*SA*	
	1)Service Quality							
Tangibles	I find the insurance company uses modern technology in infrastructure and communication	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Physical facilities of the insurance company are visually appealing to me	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The printed and visual material like brochures were appealing to me	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I hind the insurance company and people associated are having modern equipment	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	I find the physical facility of the insurance company is in keeping with the type of service provided	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Reliability	The insurance company has given me the service right at the first time	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Employees and agent were able to understand my need	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The insurance company was informing me exactly when the services will be performed	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I find my health insurance company dependable							
Responsiveness	Employees and agents were never being too busy to respond to my requests	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I find the company settling my queries with no unnecessary delays	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Employees and agents giving me personal attention	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Whenever I faced problem my health insurance company was sympathetic and reassuring	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The employees of my health insurance company don't always have to be willing to help	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Assurance	All relevant information like deductible at the time of	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	reimbursement is disclosed to me							
	I believe the company maintains data accuracy in all transactions	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I find the employees of the companies are experts in subject matter	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The maximum cap applicable at reimbursement is well explained to me at the time of purchasing	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Empathy	The insurance company always had my best interest at heart	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Employees and agents being consistently courteous to me	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The employees and agents of the company were always willing to help me	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I always find the employees of my health insurance firm as polite	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	It is unrealistic to expect the employees of my health insurance company to always keep my best interest at heart	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	2) Service Convenience							
Decision (time and effort cost associated with purchase decision/non-monetary cost)	The insurance company made it easy for me to find suitable health insurance policy.	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	It was easy to get the information I needed, to decide which insurance company to approach.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I spent minimal time finding the information to choose an insurance company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The time it took to arrive at a decision was not too long	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I was easily able to determine prior to purchasing whether the insurer can offer what I am looking for	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Access	It was easy for me to contact this service provider.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	It did not take me much time to reach this insurance company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I can easily figure out the location /website of this company.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I was quickly able to connect with the insurer's sales representative.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The insurer offered convenient hours to interact	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Transaction convenience	This insurance company allowed me diversified methods of payment	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The method of payment	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	provided by this company is convenient							
	I was able to complete my purchase quickly in this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I did not have to make much effort to make the payment	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The insurer made it easy for me to conclude the payment transaction	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Benefit (experiencing the core benefit of the offering)	I could easily obtain benefits from the services provided in this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I found that the services in this company were easy to use	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The speed of providing services in this company met my requirements	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	It is easy to get policy clarity from the insurer	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The policy was delivered to me at the appropriate time by the insurer	**1**	**2**	**3**	**4**	**5**	**6**	**7**
Post benefit (re-establishing subsequent contract with the firm)	When I had a problem, company resolved my problem quickly	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The company extended reward to me based on my performance through the policy.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	The company enabled me to arrange renewal of policy with	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	minimal effort							
	I feel the company has a good channel to handle complaints and recommendations	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	It takes little effort to arrange for follow-up service	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	3) Perceived Value							
	The policies and services of this company have a great value for me	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I think the policy and services of this company deserve what they cost	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Compared to the cost/fees for this service I feel this offers value for the money	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Compared to the time away from leisure that this service requires, this is worthwhile for me	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I find in general the value of the policy and the services provided by this company is high	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	4)Satisfaction							
	I am satisfied with the policy terms of this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I am happy with the services of this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	I am pleased to have taken the decision to take a policy of this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	My decision to be a policy holder of this company was not a mistake	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	My choice to use the current health care insurance was a wise one	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	5)Trust							
	I believe in the employee of my current healthcare insurance company as professional workers	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I'm confident in the fulfilment of every promise raised by my current healthcare insurance company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I'm confident in the services provided by my current healthcare insurance company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I think my current healthcare insurance company is trustworthy	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I trust my current health insurance company on anything I ask of them	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	6)Inertia							

	Unless I am very dissatisfied with the service of insurance company, changing to a new company would be troublesome	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	For me the cost in time, money and effort to change to an alternative company is high.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I will find it difficult to stop using this health insurance company policy	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Once I start using a health insurance company, I usually continue.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	My intentions are to continue with the current health insurance company rather than using alternate means	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	7)Word of mouth							
	Before buying insurance policy I seek advice from people not connected to the firm.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I would choose a insurance policy only after receiving verbal recommendation from known people	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Negative verbal feedback from known people stops me from buying insurance policy	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Without receiving at least some positive	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	feedback I normally do not choose any insurance policy							
	8) Intention to recommend (ITR)							
	I will make positive comments to a friend about the policies and services of this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	If you ask me, I will recommend this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I shall encourage my friends and relatives to utilise service of this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Whenever I get the opportunity I tell my friends and relatives how satisfied I am with this firm's service	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	Re purchase intention (RPI)							
	I will continue to participate in the policies and services of this company.	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I will sign up for this company if I unsubscribe	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I intend to purchase at least the same health care insurance policy over the next 12 months	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	If I have to upgrade my policy or add new member, I shall approach this company	**1**	**2**	**3**	**4**	**5**	**6**	**7**
	I intend to contribute at least the same amount to health care over next 12	**1**	**2**	**3**	**4**	**5**	**6**	**7**

	months							

Publication details

Type of Paper (Journal Paper/Conference proceeding/Book Chapter)	Name of the Journal/Conference/Book	Journal indexing (Scopus/UGC/ Web of Science)	Title of the Paper	Published Date
Journal Paper	Sodh Sanchar Bulletin	UGC	Upcoming Revolution in Health Care Eco System	26-12-2020
Journal Paper	Empirical Economical Letters	C category in ABDC Journal list	Study of correlation between numbers of COVID-19 cases with Stock Exchange indices of India	Jul-20