

UNDERSTANDING THE PERCEPTION OF WORKING PROFESSIONALS TOWARDS MEDICAL CARDS – THE CASE OF SODEXHO

Dr. Subrata Chattopadhyay

Associate Professor and Head-Corporate Relations
Future Institute of Engineering and Management.

Introduction:

In Indian corporate health care utilisation depends on many factors that relate both to the health care system and to the characteristics of individual patients. In a time of social and economic transition, characterised by increased life expectancy, population ageing, changing expectations and the re-structuring of health services, it is crucial to disentangle the complex patterns and drivers of health service utilisation. This will help us understand the future demand for health care services, and better assess the potential impact of an ageing population. In line with previous work, this research highlights the differential utilisation rates between medical card holders and non-medical card holders (Nolan and Nolan 2004; Nolan 2007; Nolan and Nolan 2008; Nolan and Smith 2012) indicating that the price faced by users is a strong determinant of health care utilisation. However, different patterns arise in the case of community and social care services with age being a major driver of utilisation.

Research Objectives:

- To measure the customer perception about the sodexo medical card through the concept card.
- Upon based on which they will introduce their medical card in the market.
- To get the brief idea about the medical reimbursement process given by the various companies to its employees.
- To know the various parameters upon based on which the organizations give medical benefits to its employees.
- To get an overall idea about the medical insurance market scenario in eastern part of the country.

Literature Review:

SODEXO AFFILIATE NETWORK:

- Pan India coverage
- 60%to80% network penetration across all categories
- Web based Affiliate outlet Locator on Sodexo website
- Downloadable mobile App-Affiliate Outlet Locator
- Cardholder can suggest Affiliates to be incorporated into the Sodexo network

CARD PROGRAM FEATURES FOR EMPLOYEES:

E-mail/SMS Alerts

- *Purchase Transactions*
- *Card Hotlisted*
- *Card Expiry*
- *Any other activity*

DEDICATED CUSTOMER SERVICE:

IVR Support

- *Balance Enquiry*
- *Change PIN*
- *Card Hotlisting & Replacement*
- *Lock &Unlock Cards*

Web Based Access

- *View card account details*
- *Update cardholders/Dependent Details*
- *View/Print Transaction History*
- *Download/Print & submitted to the Employee*

WHY SODEXO MEDICAL CARD?

Limit for Medical Reimbursement will be defined on the primary card issued to the employee

- ✓ *Add-on cards will derive spends based on available limit on the primary card*
- ✓ *All expenses linked to the primary card*

✓ *All expenses incurred by primary and add-on cards can be viewed remotely using a web portal*

✓ *Primary cardholders will received transaction alerts via SMS/Email*

No more hassles of collecting and storing medical bills until reimbursement time

✓ *Card draws funds for a pool of funds maintained by your employer-Hence you need not pay first and then get reimbursed*

✓ *Dependent members (in a different city)need not scan or courier medical bills*

✓ *Just download and print statements*

Sodexo will ensure strategic tie ups with leading hospitals/clinics, diagnostic centers, path Labs, etc. and work out

✓ *Discounts/offers on preventive health checkup packages*

✓ *Discounts by Hospitals on defined services*

✓ *Access to various deals that are offered to users of other Sodexo Products-Value Deals, Promotional offers,etc*

Consumer usage and buying of any product largely depend upon their perception about the product. Perception develops through how effectively product has been marketed. These days' firms are putting their best efforts in marketing in order to get customer attention and positive impression on customer's mind (DICKENSON 1994),consumer perception is also identified by the color, shape, and taste of the product (weinsblit ,1999).

Perception is how human recognize and interpret stimuli (SITTER, 2008). Consumers' perception of quality is measured an essential determinant of product choice (Zenithal, 1988) in other words perception is the first impression that individual draw and on the basis of it select, and interpret information to form a meaningful picture of the world (MUNNUKKA, 2008). That's why it is believed that consumer perception influence customer level of satisfaction and so their buying and usage decisions.

Aaker (2000) assess that brand awareness plays a vital role in consumer perception especially when their buying pattern is not defined. Branded items gives the feeling of familiarity especially in low involvement products for example soaps and other day to day usage items, media and advertisement are effective tools for awareness.

Nandagopal and Chinnaiyan (2003) conclude that the mode of purchase of product also effecting buying pattern and so perception of consumer.

PHYSICAL FEATURES OF PRODUCT AFFECTING PERCEPTION:

The most important factors which effect consumer Perceptions are:

- Accessibility
- Availability
- Quality
- Durability
- Regular supply of product
- Mode of payment.

Zeithaml (1991) pointed out that perceived value is very subjective and distinct and it is different from one customer to another. After consolidating four consumers' expressions of value, she defined perceived value as a customer's overall assessment of the utility of a product based on the perception of what is received and what is given. Subsequently, when he/she is faced with any problem with regards to the product, he/she might consider that customer service is the most important factor that will affect his/her Satisfaction/dissatisfaction.

In service marketing, the value concept appears quite frequently, but any clear definition cannot be found until we turn to the literature on pricing. Monroe (1991) defined customer -perceived value as the ratio between perceived benefits and perceived sacrifice. The perceived sacrifice was not solely referred to the purchase price but also includes all other possible costs that the customer might face in the purchasing process.

Thus, perceived value is the results or benefits customers receive in relation to total costs (which include the price paid plus other costs associated with the purchase). In simple terms, value is the difference between perceived benefits and costs. However, what constitutes value appears to be highly personal, idiosyncratic, and may vary widely from one customer to another (Holbrook, 1994; Zenithal, 1988). Research evidence suggests that customer who perceive that they received value for money are more satisfied than customer who do not perceive they received "value for money" (Zeithaml, 1991).

RESEARCH METHODOLOGY

Research process is a series of systematic steps that are followed to solve a business problem. It is the framework of the entire plan-of-action.

Data collection instrument:-

The instrument that was chosen by me to conduct the market survey was that of structured questionnaire & face-to-face interview. A list of questionnaire was prepared which could give relevant information when answered by respondents. Random sampling sample are drawn randomly.

- **Data collection place:** All Over Kolkata and it surrounding places.

- **Sample Size:** 100 samples have been taken.
- **Statistical tools used:**
 - Chi-Square test

 - Histogram

 - Normal Distribution

 - Factor Analysis

 - Scree Plot

Research findings:

SECTORWISE PERCEPTION:

Sector		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	IT_ITES	25	25.0	25.0	25.0
	BFSI	13	13.0	13.0	38.0
	TELECOM	15	15.0	15.0	53.0
	MEDIA	8	8.0	8.0	61.0
	PSU	15	15.0	15.0	76.0
	MANUFACTURING	12	12.0	12.0	88.0
	HOTEL_HOSPITALITY	12	12.0	12.0	100.0
	Total	100	100.0	100.0	

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
Sector	100	3.59	2.123	1	7

Chi Square Tests:

H0: There is no significant association between sector of work and demand for health cards

H1: There is significant association between sector of work and demand for health cards

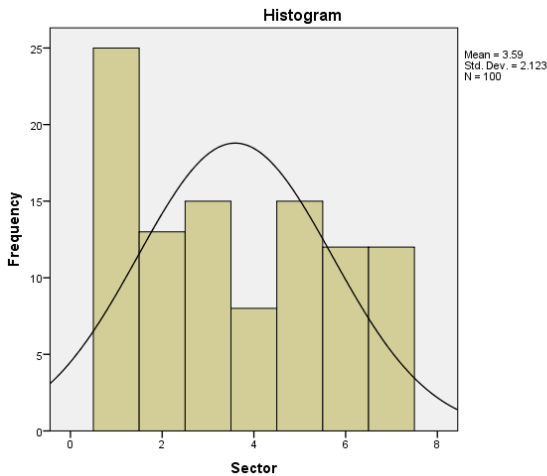
Sector

	Observed N	Expected N	Residual
IT_ITES	25	14.3	10.7
BFSI	13	14.3	-1.3
TELECOM	15	14.3	.7
MEDIA	8	14.3	-6.3
PSU	15	14.3	.7
MANUFACTURING	12	14.3	-2.3
HOTEL_HOSPITALITY	12	14.3	-2.3
Total	100		

Test Statistics

	Sector
Chi-Square	11.720 ^a
df	6
Asymp. Sig.	.049

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 14.3.



Explanation: At 95% confidence the value of the degree of significance is 0.049 which is less than 0.05. Hence the null hypothesis that there is no significant association between sector of work and demand for health cards is rejected and the alternate hypothesis that there is significant association between sector of work and demand for health cards is accepted signifying that there is an association between sector of work and preference for health cards. The negative bias of the normal curve also shows that the null hypothesis is rejected and alternate hypothesis is accepted

APPLYWISE PERCEPTION

Way to apply

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid THROUGH ONLINE	28	28.0	28.0	28.0
THROUGH CONVENTIONAL WAY	72	72.0	72.0	100.0
Total	100	100.0	100.0	

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
Way to apply	100	1.72	.451	1	2

H0: There is no significant difference in the mode of application for health cards

H1: There is a significant difference in the mode of application for health cards

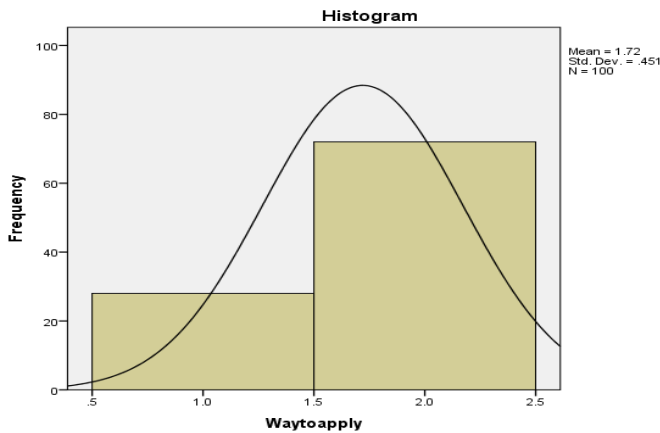
Way to apply

	Observed N	Expected N	Residual
THROUGH ONLINE	28	50.0	-22.0
THROUGH CONVENTIONAL WAY	72	50.0	22.0
Total	100		

Test Statistics

	Way to apply
Chi-Square	19.360 ^a
df	1
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 50.0.



Explanation: At 95% confidence the value of the degree of significance is 0.000 which is less than 0.05. Hence the null hypothesis that there is no significant association between way to apply and demand for health cards is rejected and the alternate hypothesis that there is significant association between way to apply and demand for health cards is accepted signifying that there is an association between way to apply and preference for health cards. The negative bias of the normal curve also shows that the null hypothesis is rejected and alternate hypothesis is accepted

FREQUENCYWISE PERCEPTION:

Frequency

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	MONTHLY	1	1.0	1.0
	QUARTERLY	34	34.0	35.0
	HALFYEARLY	18	18.0	53.0
	ANNUALLY	47	47.0	100.0
	Total	100	100.0	100.0

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
Frequency	100	3.11	.920	1	4

H0: There is no significance difference between frequency of usage and preference for health cards
H1: There is significance difference between frequency of usage and preference for health cards

Frequency

	Observed N	Expected N	Residual
MONTHLY	1	25.0	-24.0
QUARTERLY	34	25.0	9.0
HALFYEARLY	18	25.0	-7.0
ANNUALLY	47	25.0	22.0
Total	100		

TIME CONSUMPTION WISE PERCEPTION:

How long time takes

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid 15 DAYS	47	47.0	47.0	47.0
1 MONTH	46	46.0	46.0	93.0
1_2 MONTH	6	6.0	6.0	99.0
4	1	1.0	1.0	100.0
Total	100	100.0	100.0	

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
How long time takes	100	1.61	.650	1	4

H0: There is no significant difference between reimbursement time take and usage of the medical cards.
H1: There is significant difference between reimbursement time take and usage of the medical cards.

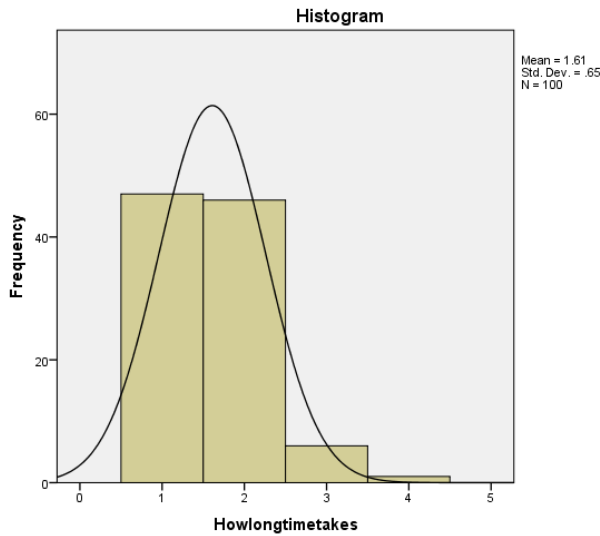
How long time takes

	Observed N	Expected N	Residual
15 DAYS	47	25.0	22.0
1 MONTH	46	25.0	21.0
1_2 MONTH	6	25.0	-19.0
4	1	25.0	-24.0
Total	100		

Test Statistics

	How long time takes
Chi-Square	74.480 ^a
df	3
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 25.0.



Explanation: At 95% confidence the value of the degree of significance is 0.000 which is less than 0.05. Hence the null hypothesis that there is no significant association between how long time take and demand for health cards is rejected and the alternate hypothesis that there is no significant association between how long time take and demand for health cards is accepted signifying that there is an association between how long time takes and preference for health cards. The negative bias of the normal curve also shows that the null hypothesis is rejected and alternate hypothesis is accepted.

PROCESSING TIME WISE PERCEPTION:

Processing time of reimbursement

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	EASY	28	28.0	28.0
	SOMEWHAT EASY	34	34.0	62.0
	HARD	27	27.0	89.0
	VERY HARD	11	11.0	100.0
	Total	100	100.0	100.0

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
Processing time of reimbursement	100	3.21	.977	2	5

H0: there is no significant difference between processing time of reimbursement and use of medical cards

H1: there is significant difference between processing time of reimbursement and use of medical cards.

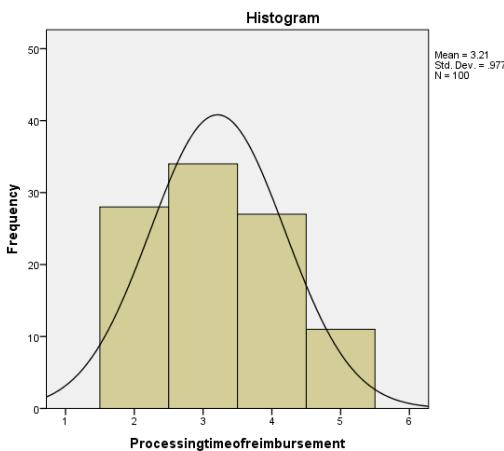
Processing time of reimbursement

	Observed N	Expected N	Residual
EASY	28	25.0	3.0
SOMEWHAT EASY	34	25.0	9.0
HARD	27	25.0	2.0
VERY HARD	11	25.0	-14.0
Total	100		

Test Statistics

	Processing time of reimbursement
Chi-Square	11.600 ^a
df	3
Asymp. Sig.	.009

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 25.0.



Explanation: At 95% confidence the value of the degree of significance is 0.009 which is less than 0.05. Hence the null hypothesis that there is no significant association between **processing time of reimbursement** and demand for health cards is rejected and the alternate hypothesis that

there is no significant association between **Processing time of reimbursement** and demand for health cards is accepted signifying that there is an association between **processing time of reimbursement** and preference for health cards. The negative bias of the normal curve also shows that the null hypothesis is rejected and alternate hypothesis is accepted

THE WHOLE CLAIM PROCESS WISE PERCEPTION:

The whole claim process

	Frequency	Percent	Valid Percent	Cumulative Percent
EASY	16	16.0	16.0	16.0
SOMEWHAT EASY	39	39.0	39.0	55.0
HARD	39	39.0	39.0	94.0
VERY HARD	6	6.0	6.0	100.0
Total	100	100.0	100.0	

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
The whole claim process	100	3.35	.821	2	5

H0: there is no significance difference between the whole claim process and the use of medical card
H1: there is significance difference between the whole claim process and the use of medical card

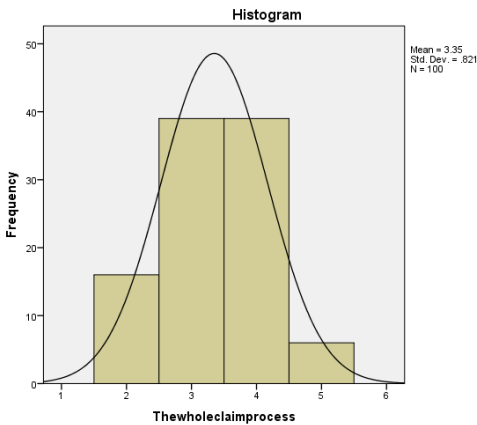
The whole claim process

	Observed N	Expected N	Residual
EASY	16	25.0	-9.0
SOMEWHAT EASY	39	25.0	14.0
HARD	39	25.0	14.0
VERY HARD	6	25.0	-19.0
Total	100		

Test Statistics

	The whole claim process
Chi-Square	33.360 ^a
df	3
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 25.0.



Explanation: At 95% confidence the value of the degree of significance is 0.000 which is less than 0.05. Hence the null hypothesis that there is no significant association between **The whole claim process** and demand for health cards is rejected and the alternate hypothesis that there is no significant association between **The whole claim process** and demand for health cards is accepted signifying that there is an association between **The whole claim process** and preference for health cards. The negative bias of the normal curve also shows that the null hypothesis is rejected and alternate hypothesis is accepted

OVERALL LIKEABILITY OF THE CONCEPT:

Overall likeability

	Frequency	Percent	Valid Percent	Cumulative Percent
DISLIKE	55	55.0	55.0	55.0
SOMEWHAT LIKE	40	40.0	40.0	95.0
LIKE	4	4.0	4.0	99.0
9	1	1.0	1.0	100.0
Total	100	100.0	100.0	

Descriptive Statistics

	N	Mean	Std. Deviation	Minimum	Maximum
Over all likeability	100	2.55	.869	2	9

H0: there is no significant difference between overall likeability and use of the medical cards
 H1: there is significant difference between overall likeability and use of the medical cards

Over all likeability

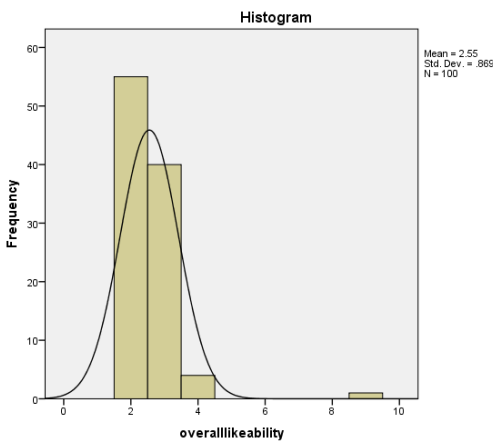
	Observed N	Expected N	Residual
DISLIKE	55	25.0	30.0

SOMEWHAT LIKE	40	25.0	15.0
LIKE	4	25.0	-21.0
9	1	25.0	-24.0
Total	100		

Test Statistics

	Over all likeability
Chi-Square	85.680 ^a
df	3
Asymp. Sig.	.000

a. 0 cells (.0%) have expected frequencies less than 5. The minimum expected cell frequency is 25.0.



Explanation: At 95% confidence the value of the degree of significance is 0.000 which is less than 0.05. Hence the null hypothesis that there is no significant association between **overall likeability** and demand for health cards is rejected and the alternate hypothesis that there is no significant association between **overall like ability** and demand for health cards is accepted signifying that there is an association between **overall likeability** and preference for health cards. The negative bias of the normal curve also shows that the null hypothesis is rejected and alternate hypothesis is accepted

KMO and Bartlett's Test

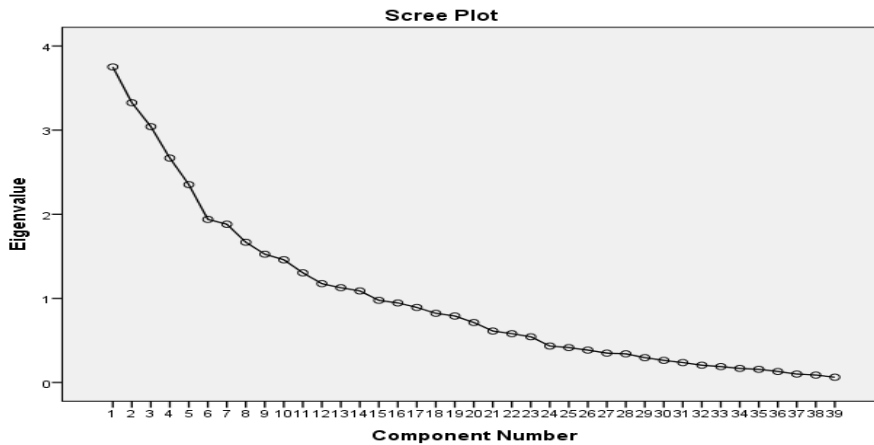
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.842
Approx. Chi-Square		1608.459
Bartlett's Test of Sphericity	df	741
Sig.		.000

Communalities

	Initial	Extraction
Sector	1.000	.777
Gender	1.000	.587
Income Strength	1.000	.677

EmployeeStrenght	1.000	.774
Regularity	1.000	.756
Issues	1.000	.731
Frequency	1.000	.715
Documents	1.000	.864
Waytoapply	1.000	.907
Howlongtimetakes	1.000	.788
Storing bills	1.000	.710
Originalcopiesofbills	1.000	.712
gettingthebillsamprescriptions	1.000	.793
submissionoffadedbills	1.000	.642
Timeconsumedinapplication	1.000	.652
Processingtimeofreimbursement	1.000	.724
Frequencyofclaims	1.000	.736
Moneybeinglockedtillreceive	1.000	.689
authenticationofbills	1.000	.688
Gettingduplicatebills	1.000	.708
Thewholeclaimprocess	1.000	.605
Noneedtopayfirstandclaimlater	1.000	.469
Noneedtosubmitbills	1.000	.622
Noneedtocouriorthebills	1.000	.785
Limitforprimaryandaddoncards	1.000	.777
DiscountsOffers	1.000	.808
Discountsinsodexoaffiliatedhospitals	1.000	.752
Promooffers	1.000	.811
smsalerts	1.000	.777
EmailAlerts	1.000	.743
WebbasedampMobiebasedoutet	1.000	.702
Onlineaccesstoviewtransactionhistor	1.000	.761
y		
Multiplecustomersupportchannels	1.000	.789
Pintoensurecardsecurity	1.000	.779
overalllikeability	1.000	.677
RelevanceofConcept	1.000	.772
uniuenessofconcept	1.000	.610
Acceptancepossibility	1.000	.680
Acceptancepossibilityfordependants	1.000	.753

Extraction Method: Principal Component Analysis.



Total Variance Explained

Component	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	3.751	9.619	9.619	3.751	9.619	9.619
2	3.326	8.527	18.146	3.326	8.527	18.146
3	3.042	7.799	25.945	3.042	7.799	25.945
4	2.668	6.840	32.785	2.668	6.840	32.785
5	2.353	6.033	38.818	2.353	6.033	38.818
6	1.939	4.972	43.790	1.939	4.972	43.790
7	1.881	4.824	48.614	1.881	4.824	48.614
8	1.667	4.275	52.889	1.667	4.275	52.889
9	1.525	3.910	56.799	1.525	3.910	56.799

A Monthly Double-Blind Peer Reviewed Refereed Open Access International e-Journal - Included in the International Serial Directories.

International Research Journal of Management and Commerce (IRJMC)

Website: www.aarf.asia, Email: editoraarf@gmail.com, editor@aarf.asia

10	1.459	3.741	60.539	1.459	3.741	60.539
11	1.304	3.343	63.883	1.304	3.343	63.883
12	1.175	3.013	66.896	1.175	3.013	66.896
13	1.127	2.890	69.785	1.127	2.890	69.785
14	1.088	2.790	72.576	1.088	2.790	72.576
15	.977	2.504	75.080			
16	.945	2.424	77.504			
17	.892	2.288	79.792			
18	.823	2.109	81.901			
19	.790	2.027	83.928			
20	.713	1.828	85.757			
21	.612	1.569	87.325			
22	.581	1.489	88.814			
23	.543	1.393	90.207			
24	.433	1.111	91.319			
25	.415	1.064	92.383			
26	.385	.987	93.369			
27	.349	.895	94.264			
28	.341	.875	95.139			
29	.295	.757	95.896			
30	.263	.674	96.570			
31	.236	.606	97.176			
32	.206	.528	97.704			
33	.189	.486	98.190			
34	.167	.429	98.618			
35	.157	.402	99.020			
36	.131	.335	99.355			
37	.100	.257	99.612			
38	.089	.227	99.839			
39	.063	.161	100.000			

Extraction Method: Principal Component Analysis.

Conclusions:

Medical cards in India despite being a relatively a new phenomenon is almost certainly to be a major source of earnings in years to come. India's healthcare industry is already growing at 30 per cent annually. This gives patients confidence in the healthcare offered by India generally as they are already used to the expertise and professionalism of Indian medical staff. Nevertheless, with the business growing, so is competition too. As more and more patients from nations with high medical costs look for medical care options, India has competition from countries like Thailand, Singapore and other Asian countries. All these countries have good hospitals, attractive climates, and are established tourist destinations too (Todd, 2005). Sodexo has thus made a sincere commitment to these coordinated moves allows each stakeholder to focus on his own competencies and may even alleviate the level of competition – allowing for better long run revenues throughout the entire sector.

References:

- Andersen, R. M. (1995). “Revisiting the behavioral model and access to medical care: does it matter?” *Journal of Health and Social Behavior*: 1-10.
- Barrett A, B. H., Cronin H, Hickey A, Kamiya Y, Kenny RA, Layte R, Maty S, McGee H, Morgan K, Mosca I, Normand C, O’Regan C, O’ Sullivan V, Savva G, Sofroniou N, Timonen V,

Whelan B. (2011) Fifty plus in Ireland 2011: First results from The Irish Longitudinal Study on Ageing (TILDA). Dublin: Trinity College Dublin.

Behan, J., Condon, N., Milicevic, I., Shally, C. (2009). A quantitative tool for workforce planning in healthcare: example simulations, FÁS, Skills and Labour Market Research Unit. HIA (2007). Competition in the Irish Private Health Insurance Market.

http://www.hia.ie/assets/files/publications/competition_report/Competition-Report 2007.pdf
HSE, D. (2009).

Demico, F.J. and Cetron, M. (2006). Club medic. Asia Pacific Biotech News,10 (10), 527-531.

English, V., Mussell, R., Sheather, J. and Sommerville, A. (2006). Medical Tourism. Journal of Medical Ethics, 32(4), 248-248.

Eggertson, L. (2006). Wait-list weary Canadians seek treatment abroad. CMAJ: Canadian Medical Association Journal, 174(9), 1247-1247.

Frechtling, D.C. (1997). Current research on health and tourism issues and future directions. In Tourism and Health: Risks, Research, and Responses, Clift, S. and Grabowski, P. eds. London: Pinter.

Goodrich, J.N. and Goodrich, G.E. (1990). Health Care Tourism. In Managing Tourism, Medlik, S., ed. New York: Butterworth Heinman. Henderson1, J.C. (2003). Healthcare tourism in South East Asia. Tourism Review International, 7(3/4), 111-121.

“Medical card/GP visit card national assessment guidelines.” Inouye SK, Zhang Y, Jones RN, Shi P, Cupples LA, Calderon HN, Marcantonio ER. Risk factors for hospitalization among community-dwelling primary care older patients: development and validation of a predictive model. Med Care. 2008 Jul;46(7):726-31.

Kelly, A. & Teljeur, C. (2004) A new national deprivation index for health and health services research. Dublin, SAHRU McGrail K, Green B, Barer ML, Evans RG, Hertzman C, Normand C.

(2000). “Age, costs of acute and long-term care and proximity to death: evidence for 1987-88 and 1994- 95 in British Columbia.” Age and Ageing 29(3): 249-253. Nolan, A. (2007). “A

dynamic analysis of GP visiting in Ireland: 1995–2001.” Health Economics 16(2): 129-143.

Nolan, A. and B. Nolan (2004). “A panel data analysis of the utilisation of GP services in Ireland: 1995-2001.” ESRI Working Paper No. 13

Nolan, A. and B. Nolan (2008). “Eligibility for free GP care, “need” and GP visiting in Ireland.” The European Journal of Health Economics 9(2): 157-163.

“A microeconomic analysis of Canadian health care utilisation.” Health Economics 15(3): 219-239. Wiley, M. M. (2005). “The Irish health system: developments in strategy, structure, funding and delivery since 1980.” Health Economics 14(S1): S169-S186