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Post Graduate Diploma in Health and Hospital Management

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A dissertation

On

Customer Satisfaction in Mass Health Insurance Policy-A case of Rashtriya Shwashtya Bima Yojana-Haryana

For

Partial fulfillment

Of

Post-Graduate Diploma in Health and Hospital Management

By

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7th May 2010

Certificate

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TO WHOM IT MAY CONCERN

This is to certify that Mr.Neeraj Sharma has successfully completed his 3 months internship in our organization from February 1, 2010 to April 30, 2010. During this intern he has worked on Topic - Customer Satisfaction in Mass health Insurance policy – A case study of Rashtriya Shwashtya Bima Yojana-Haryana as Customer Service Manager in Rashtriya Shwashtya Bima Yojana under the guidance of me and my team at Ambala, ICICI LOMBARD & has been performed at good level.

We wish him good luck for his future assignments

Parveen Sethi

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CERTIFICATE OF APPROVAL

The following dissertation titled "**Customer Satisfaction in Mass health Insurance Policy –A case study of Rashtriya Shwashtya Bima Yojana-Haryana**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory to warrant its acceptance as a prerequisite for the award of **Post- Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

Dissertation Examination Committee for evaluation of dissertation

APPROVAL OF DAC

This is to certify that **Mr. Neeraj Sharma**, a participant of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He is submitting this dissertation titled "**Customer Satisfaction in Mass health Insurance Policy –A case study of Rashtriya Shwashtya Bima Yojana-Haryana"** in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management**.

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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IIHMR, New Delhi	**ICICI LOMBARD, Ambala**

ABSTRACT

Introduction-Wherever there is uncertainty there is risk. The risk can't be averted. It involves multiple losses. And so, risk is uncertainty of financial losses. We do not have any command on uncertainties. The insurance is a co- operative device to spread the loss. Further, it is also a social device to accumulate funds to meet uncertain losses. The main function of **insurance** is to provide protection against the possible chances of generating losses. It eliminates worries and miseries of losses at destruction of property and death. It also provides capital to the society as the accumulated funds are invested in the productive heads.

Objective:- The main objective of this Primary data based study is to find out the level of customer satisfaction in Mass health insurance policy(Rashtriya shwashtya bima yojana-Haryana). In India and whole world increasing the Marketing Strategy day by day, cause the different Unethical Issue of human being and create the cause of different new risks for human lives, so there is need of check the level of Customer satisfaction, especially in mass health insurance policy.

Key Words: - Insurance, RSBY, Customer satisfaction.

Method: - The present Primary data based study is conducting in different districts in Haryana, level of satisfaction regarding Rashtriya Shwashtya Bima Yojana. Ethical Issue was assessed during survey. The sample size of this study is 200(Approx.) and based on random sampling.

Findings: - The scale and nature of the benefits of customer in this mass health insurance policy is more (More then 95%). The Findings (Parameter based on questionnaire) given below-

i. The Customer is more satisfied from this Mass health Insurance policy.

ii. The good quality of food services by empanelled hospital in this mass health insurance policy.

iii. The waiting times are less.

iv. The transportation facility provided by empanelled hospitals in this policy is better.

v. The facility of treatments in this policy is better.

So, we can say that, the level of satisfaction in this Mass health insurance policy is more.

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I deem it a sacred duty to thank all those who helped us in the completion of this project. It is an esteemed pleasure to present this project, and we whole heartedly thank each and every one who helped us in this task.

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ABBREVIATIONS

RSBY-Rashtriya shwashtya Bima Yojana

ESI-Employee State Insurance

FKO-Field Key officer

DKMA-District key Management authority

CGHS-Central Government health schemes

WHO-World Health Organization

HMO-Health management organizations

DKM-District key manager

CSM-Customer Service Manager

HTE -Hospital Transaction Enablers

MOLE- Ministry of Labor and Employment

HMO-Health Management Organization

FKM-Field Key Manager

FINO-Financial Information Networking Operation

ILO-International Labour Organization

CBHI-Community Based Health Insurance

GDP-Gross Domestic Products

BPL-Below Poverty Line

APL-above Poverty Line

NGO-Non Governmental Organization

IRDA- Insurance Regulatory and Development Authority

INTERSHIP REPORT

ICICI Bank (BSE: ICICI) (formerly **Industrial Credit and Investment Corporation of India**) is India's largest private sector bank by market capitalization and second largest overall in terms of assets. Total assets of Rs. 3,562.28 billion (US$ 77 billion) at December 31, 2009 and profit after tax Rs. 30.19 billion (US$ 648.8 million) for the nine months ended December 31, 2009. The Bank also has a network of 1,700+ branches (as on 31 March, 2010) and about 4,721 ATMs in India and presence in 18 countries, as well as some 24 million customers (at the end of July 2007). ICICI Bank offers a wide range of banking products and financial services to corporate and retail customers through a variety of delivery channels and specialized subsidiaries and affiliates in the areas of investment banking, life and non-life insurance, venture capital and asset management. (These data are dynamic.) ICICI Bank is also the largest issuer of credit cards in India. ICICI Bank has got its equity shares listed on the stock exchanges at Kolkata and Vadodara, Mumbai and the National Stock Exchange of India Limited, and its ADRs on the New York Stock Exchange (NYSE). The Bank is expanding in overseas markets and has the largest international balance sheet among Indian banks. ICICI Bank now has wholly-owned subsidiaries, branches and representatives offices in 18 countries, including an offshore unit in Mumbai. This includes wholly owned subsidiaries in Canada, Russia and the UK (the subsidiary through which the HiSAVE savings brand is operated), offshore banking units in Bahrain and Singapore, an advisory branch in Dubai, branches in Belgium, Hong Kong and Sri Lanka, and representative offices in Bangladesh, China, Malaysia, Indonesia, South Africa, Thailand, the United Arab Emirates and USA. Overseas, the Bank is targeting the NRI (Non-Resident Indian) population in particular.

ICICI reported a 1.15% rise in net profit to Rs. 1,014.21 crore on a 1.29% increase in total income to Rs. 9,712.31 crore in Q2 September 2008 over Q2 September 2007. The bank's current and savings account (CASA) ratio increased to 30% in 2008 from 25% in 2007.

History of ICICI

- 1955: The Industrial Credit and Investment Corporation of India Limited (ICICI) was incorporated at the initiative of World Bank, the Government of India and representatives of

Indian industry, with the objective of creating a development financial institution for providing medium-term and long-term project financing to Indian businesses.

- 1994: ICICI established Banking Corporation as a banking subsidiary. Formerly Industrial Credit and Investment Corporation of India. Later, ICICI Banking Corporation was renamed as 'ICICI Bank Limited'. ICICI founded a separate legal entity, ICICI Bank, to undertake normal banking operations - taking deposits, credit cards, car loans etc.
- 2001: ICICI acquired Bank of Madura (est. 1943). Bank of Madura was a Chettiar bank, and had acquired Chettinad Mercantile Bank (est. 1933) and Illanji Bank (established 1904) in the 1960s.
- 2002: The Boards of Directors of ICICI and ICICI Bank approved the reverse merger of ICICI, ICICI Personal Financial Services Limited and ICICI Capital Services Limited, into ICICI Bank. After receiving all necessary regulatory approvals, ICICI integrated the group's financing and banking operations, both wholesale and retail, into a single entity. At the same time, ICICI started its international expansion by opening representative offices in New York and London. In India, ICICI Bank bought the Shimla and Darjeeling branches that Standard Chartered Bank had inherited when it acquired Grindlays Bank.
- 2003: ICICI opened subsidiaries in Canada and the United Kingdom (UK), and in the UK it established an alliance with Lloyds TSB. It also opened an Offshore Banking Unit (OBU) in Singapore and representative offices in Dubai and Shanghai.
- 2004: ICICI opened a representative office in Bangladesh to tap the extensive trade between that country, India and South Africa.
- 2005: ICICI acquired Investitsionno-Kreditny Bank (IKB), a Russia bank with about US$4mn in assets, head office in Balabanovo in the Kaluga region, and with a branch in Moscow. ICICI renamed the bank ICICI Bank Eurasia. Also, ICICI established a branch in Dubai International Financial Centre and in Hong Kong.
- 2006: ICICI Bank UK opened a branch in Antwerp, in Belgium. ICICI opened representative offices in Bangkok, Jakarta, and Kuala Lumpur.
- 2007: ICICI amalgamated **Sangli Bank**, which was headquartered in Sangli, in Maharashtra State, and which had 158 branches in Maharashtra and another 31 in Karnataka State. Sangli Bank had been founded in 1916 and was particularly strong in rural areas. With respect to the

international sphere, ICICI also received permission from the government of Qatar to open a branch in Doha. Also, ICICI Bank Eurasia opened a second branch, this time in St. Petersburg.

- 2008: The US Federal Reserve permitted ICICI to convert its representative office in New York into a branch. ICICI also established a branch in Frankfurt.
- 2009: ICICI made huge changes in its organization like elimination of loss making department and restreching outsourced staff or renegotiate their charges in consequent to the recession. In addition to this, ICICI adopted a massive approach aims for cost control and cost cutting. In consequent of it, compensation to staff was not increased and no bonus declared for 2008-09.

ICICI Lombard General Insurance Company Limited is a 74:26 joint venture between ICICI Bank Limited , India's second largest bank with $79 billion in assets and Fairfax Financial Holdings Limited, a Canada based $26 billion diversified financial services company engaged in general insurance, reinsurance, insurance claims management and investment management.

ICICI Lombard is the largest private sector general insurance company in India with a Gross Written Premium (GWP) of Rs. 3345 million for the year ended March 31, 2008

ICICI Lombard General Insurance has been conferred the 'Customer and Brand Loyalty award in the 'Insurance Sector - Non-Life' at the 2nd Loyalty awards, 2009. It was awarded the ‘General Insurance Company of the Year’ at the 11th Asia Insurance Industry Awards. The company also won the 'NDTV Profit Business Leadership Award 2007' and was adjudged as the most Customer Responsive Company in the Insurance category at the Economic Times Avaya Global Connect Customer Responsiveness Award 2006. It has the Gold Shield for "Excellence in Financial Reporting" by the ICAI (Institute of Chartered Accountants of India) for the year ended March 31, 2006

The company has been assigned a domestic rating of iAAA by ICRA (an associate of Moody’s Investors Service) for highest claim paying ability and a fundamentally strong position

The company presently has 5697 employees in 395 branches. In the financial year ended March 31, 2009, the company issued over 4 million policies across India and serviced over 33 lakh claims. The company has a claim disposal ratio of 97% (percentage of claims settled against claims reported) as on March 31, 2008.

Management:- **Board Members**

- Chanda Kochhar, Chairperson
- R. Athappan, Director
- Sandeep Bakhshi, Director
- B.V. Bhargava, Director
- Dileep Choksi, Director
- James Dowd, Director
- N.S. Kannan, Director
- S. Mukherji, Director
- Chandran Ratnaswami, Director
- M.K. Sharma, Director
- H.N. Sinor, Director
- Bhargav Dasgupta, Managing Director & CEO

Channels:- Channel is the term used for the various approaches a company uses to tap its customers. ICICI Lombard uses a multi channel approach to sales, service and other allied activities. The channels used by ICICI Lombard can be broadly stated as under:

Retail-The Retail channel consists of sales executives, sales officers, brokers and agents.

Online-ICICI Lombard has developed a web-based system to meet all the pre and post-policy transaction. One can get quotes, buy, renew and track their policies online through the website.

Bancassurance-Bancassurance is the distribution of insurance products through a bank's network. ICICI Lombard has a tie-up with various banks. With a team of product managers, sales managers and sales executives, the company has been using this channel to sell, cross-sell and up sell its products.

Buying Insurance Online-ICICI Lombard was among the first companies to make their insurance products available online in India. ICICI Lombard has web-based systems to meet all pre and post-policy transactional needs of its customers. One can compare plans, get quotes, buy, renew and keep a track of their insurance policies online.

Telecalling-ICICI Lombard was the first general insurance company in India to start telesales operations due to its inherent profitability. However in recent times, public outburst against pushy and intrusive telecalling in general has led to a reduction in cold calling and the introduction of 'do-not-call' (opt-out) lists similar to the US 'Do Not Call Registry'. ICICI Lombard too has the Do Not Call option and respects the privacy of their customers

Customer satisfaction, a business term, is a measure of how products and services supplied by a company meet or surpass customer expectation. It is seen as a key performance indicator within business and is part of the four of a Balanced Scorecard.

In a competitive marketplace where businesses compete for customers, customer satisfaction is seen as a key differentiator and increasingly has become a key element of business strategy.

There is a substantial body of empirical literature that establishes the benefits of customer satisfaction for firms.

Measuring customer satisfaction:- Organizations need to retain existing customers while targeting non-customers;. Measuring customer satisfaction provides an indication of how successful the organization is at providing products and/or services to the marketplace.

Customer satisfaction is an abstract concept and the actual manifestation of the state of satisfaction will vary from person to person and product/service to product/service. The state of satisfaction depends on a number of both psychological and physical variables which correlate with satisfaction behaviors such as return and recommend rate. The level of satisfaction can also vary depending on other factors the customer, such as other products against which the customer can compare the organization's products.

Improving Customer Satisfaction: - Published standards exist to help organizations develop their current levels of customer satisfaction. The International Customer Service Institute (TICSI) has released The International Customer Service Standard (TICSS). TICSS enables organizations to focus their attention on delivering excellence in the management of customer service, whilst at the same time providing recognition of success through a 3rd Party registration scheme. TICSS focuses an organization’s attention on delivering increased customer satisfaction by helping the organization through a Service Quality Model.

TICSS Service Quality Model uses the 5 P's - Policy, Processes, People, Premises, Product/Services, as well as performance measurement. The implementation of a customer service standard should lead to higher levels of customer satisfaction, which in turn influences customer retention and customer loyalty.

Customer Service Manager-One of the key roles of the Customer Service Manager is to motivate his or her staff & customers. To ensure customer service employees deliver positive customer interactions they must be motivated to do so. Demotivated, unhappy team members will not be at their best when dealing with customers and may result in a negative experience for the customers.

Although it may be a difficult task to motivate an individual person, it is possible for the Customer Service Manager to create an environment where motivation can flourish.

One of the most respected theories of motivation was created by the eminent psychologist, Abraham Maslow. Maslow's theory was called "The Hierarchy of Needs". Simply put, Maslow believed that every one of us is trying to fulfill our own needs, and is motivated to do so in a hierarchical order.

As a Customer Service manager in Rashtriya Shwashtya Bima Yojana, Haryana I am taking care of different activities like Enrollments, Claim management, Liaisioning with Government officers and others ground related issues.

INTRODUCTION

Universally, the quality of health services is ensured either through legislation, or through health financing / health insurance mechanisms or a combination of the two. In India, however, health is a State subject and, as such, there is no nationally applicable legislation to regulate and monitor the quality of service delivery in the private and public healthcare sectors Health insurance can be defined in very narrow sense where individual or group purchases in advance health coverage by paying a fee called "premium". But it can be also defined broadly by including all financing arrangements where consumers can avoid or reduce their expenditures at time of use of services. The health insurance existing in India covers a very wide spectrum of arrangements and hence the latter- broader interpretation of health Insurance is more appropriate. The main function of **insurance** is to provide protection against the possible chances of generating losses. It eliminates worries and miseries of losses at destruction of property and death. It also provides capital to the society as the accumulated funds are invested in the productive heads. The product of insurance benefits the industry, the business, an individual and a group of persons.

Health Insurance- Social security for medical emergencies is not new to the indian ethos. It is a common practice for villagers to take a 'piruvu' (a collection) to support a household with a sick patient. However, health insurance, as we know it today, was introduced only in 1912 when the first Insurance Act was passed (Devadasan 2004). The current version of the Insurance Act was introduced in 1938. Since then there was little change till 1972 when the insurance industry was nationalized and 107 private insurance companies were brought under the umbrella of the General Insurance Corporation (GIC). Private and foreign entrepreneurs were allowed to enter the market with the enactment of the Insurance Regulatory and Development Act (IRDA) in 1999. The penetration of health insurance in India has been low. It is estimated that only about 3% to 5% of Indians are covered under any form of health insurance. In terms of the market share, the size of the commercial insurance is barely 1% of the total health spending in the country. The Indian health insurance scenario is a mix of mandatory social health insurance (SHI), voluntary private health insurance and community-based health insurance (CBHI). Health insurance is thus really a minor player in the health ecosystem. Government or state-based systems include Central Government Health Scheme (CGHS) and Employees State Insurance Scheme (ESIS). It is estimated that employer managed systems cover about

20-30 million of population. There are many employers who reimburse costs of medical expenses of the employees with or without contribution from the employee. It is estimated that about 20 million employees may be covered by such reimbursement arrangements. There are several government and private employers such as Railway and Armed forces and public sector enterprises that run their own health services for employees and families. It is estimated that about 30 million employees may be covered under such employer managed health services (Ellis et al. 1996).

Over the last 50 years India has achieved a lot in terms of health improvement. But still India is way behind many fast developing countries such as China, Vietnam and Sri Lanka in health indicators (Satia et al 1999). In case of government funded health care system, the quality and access of services has always remained major concern. A very rapidly growing private health market has developed in India. This private sector bridges most of the gaps between what government offers and what people need. However, with proliferation of various health care technologies and general price rise, the cost of care has also become very expensive and unaffordable to large segment of population. The government and people have started exploring various health financing options to manage problems arising out of growing set of complexities of private sector growth, increasing cost of care and changing epidemiological pattern of diseases.

Health Insurance Scheme- Health insurance in a narrow sense would be 'an individual or group Purchasing health care coverage in advance by paying a fee called *premium*.' In its broader sense, it would be any arrangement that helps to defer, delay, reduce or altogether avoid payment for health care incurred by individuals and households. Given the appropriateness of this definition in the Indian context, this is the definition, we would adopt. The health insurance market in India is very limited covering about 10% of the total population. The existing schemes can be categorized as:

(1) Voluntary health insurance schemes or private-for-profit schemes;

(2) Employer-based schemes;

(3) Insurance offered by NGOs / community based health insurance, and

(4) Mandatory health insurance schemes or government run schemes (namely ESIS, CGHS).

Usually the insurance contract provides for the payment of an amount on the date of maturity or at specified dates at periodic intervals or at unfortunate death if it occurs earlier. So, there is a price to be paid for this benefit. Among other things, the contract also provides for the payment of premiums by the assured.

Voluntary health insurance schemes or private-for-profit schemes

In private insurance, buyers are willing to pay premium to an insurance company that pools people with similar risks and insures them for health expenses. The key distinction is that the premiums are set at a level, which provides a profit to third party and provider institutions. Premiums are based on an assessment of the risk status of the consumer (or of the group of employees) and the level of benefits provided, rather than as a proportion of the consumer's income.

Employer-based schemes

Employers in both the public and private sector offers employer-based insurance schemes through their own employer-managed facilities by way of lump sum payments, reimbursement of employee's health expenditure for outpatient care and hospitalization, fixed medical allowance, monthly or annual irrespective of actual expenses, or covering them under the group health insurance policy. The railways, defence and security forces, plantations

Employer-based schemes

Employers in both the public and private sector offers employer-based insurance schemes through their own employer-managed facilities by way of lump sum payments, reimbursement of employee's health expenditure for outpatient care and hospitalization, fixed medical allowance, monthly or annual irrespective of actual expenses, or covering them under the group health insurance policy. The railways, defence and security forces, plantations.

Insurance offered by NGOs / community-based health insurance

Community-based funds refer to schemes where members prepay a set amount each year for specified services. The premia are usually flat rate (not income-related) and therefore not progressive. Making profit is not the purpose of these funds, but rather improving access to services. Often there is a problem with adverse selection because of a large number of high-risk members, since premiums are not based on assessment of individual risk status. Exemptions may be adopted as a means of assisting the poor, but this will also have adverse effect on the ability of the insurance fund to meet the cost of benefits.

Social Insurance or mandatory health insurance schemes or government run schemes (namely the ESIS, CGHS)

Social insurance is an earmarked fund set up by government with explicit benefits in return for payment. It is usually compulsory for certain groups in the population and the premiums are determined by income (and hence ability to pay) rather than related to health risk. The benefit packages are

Standardized and contributions are earmarked for spending on health services the government-run schemes include the Central Government Health Scheme (CGHS) and the Employees State Insurance Scheme (ESIS).

Micro-Health Insurance- Micro insurance is a form of health, life or property insurance, which offers limited protection at a low contribution (hence "micro"). It is aimed at poor sections of the population and designed to help them cover themselves collectively against risks (hence "insurance"). Normally, micro insurance schemes are linked to associations (besides non-governmental organizations for instance trade unions, religious congregations and hospitals), who's main area of work puts them in direct contact with the target groups. They may, but must not necessarily, act as the insurance provider: in many cases, they have transferred the risks of the insurance business to a professional insurer.

Customer satisfaction is defined as the measurement of how a company's products or services meet or surpass its customer's expectations. It is also a measure of how the customer perceives the way the company's representatives dealt with his or her needs.

Customer satisfaction plays a major role in determining the likelihood of an organization's success and profitability over the long term. It is an important way for a business to develop customer loyalty that in turn builds repeat business through customer retention. Generally speaking, there are three different levels of customer satisfaction: Dissatisfied customers who are seeking another supplier; satisfied customers who will buy from the company in the future and loyal customers who will remain so despite competitive offers.

Unless a business organization develops a base of satisfied customers, it will be difficult if not impossible to remain viable in its marketplace. Moreover, any business not focused on satisfying its customers will be at the mercy of competitors who will eventually satisfy that person's needs and desires. Taking prompt action to resolve a customer's problems can make 85% of them repeat customers. It costs on the average six times as much to find a new customer as it does to keep an existing one happy. This underscores the importance of customer satisfaction.

Yet, nearly 80 per cent of Indian population is without life insurance cover while health insurance and non-life insurance continues to be below international standards. And this part of the population is also subject to weak social security and pension systems with hardly any old age income security. This itself is an indicator that growth potential for the insurance sector is immense.

For people living below poverty line, an illness not only represents a permanent threat to their income earning capacity, in many cases it could result in the family falling into a debt trap. When the need to

get the treatment arises for poor families they often ignore it because of lack of resources, fearing wage loss, or wait till the last moment when it's too late. Even if they do decide to get the desired health care it consumes their savings, forces them to sell their assets and property or cut other important spending like children's education. Alternatively they have to take on huge debts. Ignoring the treatment may lead to unnecessary suffering and death while selling property or taking debts may end a family's hope of ever escaping poverty.

Yet more than three-fourths of India's insurable population has no life insurance or pension cover. Health insurance of any kind is negligible and other forms of non-life insurance are much below international standards.\

A healthy labour force is fuel for GDP of a country. In other words, health of both the financial and labour markets are positively correlated. In a country like India where 86 per cent of the total labour force exists in unorganized sector and contributes around 50 per cent to the national GDP (NCEUS Report,2008), health of labour force becomes a vital area of investment for private and public sector stakeholders. This becomes even more interesting when just around 2 per cent of the total population of India is covered by health insurance (Chandraseker Hemalatha, 2009) and public spending on healthcare is just 0.9 percent of the GDP. In this context, it is in the larger interest of the economy to invest in the labour health and well being.

These tragic outcomes can be avoided through a health insurance which shares the risk of a major health shock across many households by pooling them together. A well designed and implemented health insurance may both increase access to healthcare and may even improve its quality over time.

Insurance is a federal subject in India. There are two legislations that govern the sector- The Insurance Act- 1938 and the IRDA Act- 1999. The insurance sector in India has come a full circle from being an open competitive market to nationalization and back to a liberalized market again. Tracing the developments in the Indian insurance sector reveals the 360 degree turn witnessed over a period of almost two centuries.

The health care demand is rising in India now days. It is estimated that only 10 per cent of health insurance market has been tapped till today. Still there is a scope of rise up to 35 per cent in near future.

A critical review of the existing and earlier health insurance schemes was done with the objective of learning from their good practices as well as seeks lessons from the mistakes. After taking all this into

account and also reviewing other successful models of health insurance in the world in similar settings, Rashtriya Swasthya Bima Yojna was designed.

Insurance is an Rs.400 billion business in India, and together with banking Services add about 7% to India's GDP. Gross premium collection is about 2% of GDP and has been growing by 15-20% per annum. India also has the highest number of life insurance policies in force in the world, and total investible funds with the LIC are almost 8% of GDP.

In the past Government have tried to provide a health insurance cover to selected beneficiaries either at the State level or National level. However, most of these schemes were not able to achieve their intended objectives. Often there were issues with either the design and/ or implementation of these schemes.

Keeping this background in mind, Government of India decided to design a health insurance scheme which not only avoids the pitfalls of the earlier schemes but goes a step beyond and provides a world class model. A critical review of the existing and earlier health insurance schemes was done with the objective of learning from their good practices as well as seeks lessons from the mistakes. After taking all this into account and also reviewing other successful models of health insurance in the world in similar settings, Rashtriya Swasthya Bima Yojna was designed.

RSBY has been launched by *Ministry of Labour and Employment, Government of India* to provide health insurance coverage for Below Poverty Line (BPL) families. The objective of RSBY is to provide protection to BPL households from financial liabilities arising out of health shocks that involve hospitalization. Beneficiaries under RSBY are entitled to hospitalization coverage up to Rs. 30,000/- for most of the diseases that require hospitalization. Government has even fixed the package rates for the hospitals for a large number of interventions. Pre-existing conditions are covered from day one and there is no age limit. Coverage extends to five members of the family which includes the head of household, spouse and up to three dependents. Beneficiaries need to pay only Rs. 30/- as registration fee while Central and State Government pays the premium to the insurer selected by the State Government on the basis of a competitive bidding.

The RASHTRIYA SWASTHYA BIMA YOJANA (Started in 1st April 2008 by Prime-minister Dr.Manmohan Singh) a Government of India scheme for providing Health Insurance to BPL Citizens of India is in the process of being implemented by different States across India. The Ministry of Labour department, GoI the governing agency for the scheme intends to provide specifications for the software so as to have interoperable software PAN India. The objective of this document is to highlight the

requirement specification for automating the Card Issuance workflow of the requirements of Ministry of Labour & Employment (MoLE) for the RSBY project.

Haryana has become the first state in the country to achieve the distinction of extending health insurance cover to all the 12.97 lakh below-poverty-line (BPL) families under the Rashhtriya Swasthya Bima Yojana (RSBY).

RSBY Scheme aims for providing health insurance to BPL families and unorganized sector workers of Weaker section of the society and involves issuance of cards in villages and remote locations of the country. The scheme involves providing benefits to BPL Families in Private and Government Hospitals Empanelled by various insurance companies across the country and which are going to be significant in Number over a period of time. Also it is very important that the smart card transaction software installed in Hospitals is running smoothly so that cashless benefit can be provided to beneficiary which is the key to success of the scheme.

The scheme is designed to cover all districts in a phased manner, starting with FY 2008-09. Towards the end of March, 2009, the scheme was already in place in 104 districts of 17 States. The coverage is set to expand to cover all States in FY 2009- 10.

The Government of India, in cooperation with the participating state governments, is closely monitoring the ground realities of the scheme since start of its implementation and it will continue for the next few years. Adjustments are being made as the experience is unfolding, always with the same objective in mind to provide poor households with insurance against the costs associated with major illness.

Literature review-

The Government of India launched the Difference policy for Poor and middle class family ,but in Present scenario ,most of the Scheme has been going to path of failure ,the reason behind is that the Minimal level of Customers satisfaction or we can say that ,the access of health care is unable to reach the people ,who have the need most.

1)-J.D. Power and Associates conducts the research (different Regions In world), publicly announces the results, and then offers analysis based on consumer feedback to product and service providers to help them improve their businesses & Satisfaction with Health Plans & Services provided to Customers.

The study finds that the majority of health plan & Services members rate their insurer lowest for the communications and information that are provided to help them understand their plan. Only 45 percent of members reported they fully understand how to use their health insurance coverage and member services. Enhancing member understanding with critical plan details—such as prescription coverage, co-pays, how to locate physicians and how to appeal coverage denials—can lead to higher satisfaction For Insurers. Nearly 50 Percent of Members Say They Don't Fully Understand the Details of Their Health Insurance Plan & Services.

2) - Assessment of after-sales service behaviors of Ethiopia Telecom customers- The primary purpose of this paper is to assess and review fixed-line telecom customers' perception of the quality of after-sales services provided by Ethiopian Telecom. The paper was conducted on telecom customers who are in Addis Ababa using self-administered questionnaires sent to a sample of 450 respondents. In addition to this, interviews were conducted with managers and selected employees to provide supporting data. The data were processed, analyzed and interpreted using Statistical Package for the Social Sciences. The results show some degree of customer dissatisfaction, but not to the extent expected. Dissatisfied customers point at lack of clarities of bills and delays in making decisions on complaints as some of the main reasons for their dissatisfactions other reasons include telephone interruptions during rainy seasons, old cables and networks, and damaged and stolen cables, which combined, increase the frequency of faults and interruptions. Nearly 40 percent of respondents have negative assessments of the role of employees in delivering good quality after-sales service.

Hypothesis-

Any of the study or Survey of customer satisfaction never be complete without assuming the hypothesis, some hypothesis is mentioned below

Hypothesis 1- The level of customer's satisfaction may be affected by Quality of food provided by Hospitals during the treatment.

Hypothesis 2:- The most of customers expect less waiting time during the admission on hospitals**.**

Hypothesis 3:- The patients are most satisfied from private hospitals, because they are providing better facility for patients.

Objective of the Study: - The main objective of this Primary data based study is to find out the level of customer satisfaction in Mass health insurance policy (Rashtriya shwashtya bima yojana-Haryana). In India and whole world increasing the Marketing Strategy day by day, cause the different Unethical Issue of human being and create the cause of different new risks for human lives, so there is need of check the level of Customer satisfaction, especially in mass health insurance policy.

Need of Study: - In present time, the government of India & Private organization launching different scheme for poor and for peoples who have the need most like Weavers & Artisans policy, Krishi vikash yojana, Gramin Rojgar yojana, Laxmi yojana & Rashtriya Shwashtya Bima Yojana.

But the most of schemes is going to the path of failure due to minimal level of customer's satisfaction, so ,In this primary data based survey conducted on different districts & place of Haryana for the measuring the level of satisfactions of customers in one Governments mass health insurance scheme Rashtriya Shwashtya Bima Yojana, Haryana.

Research Methodology

On the basis literature review the RSBY scheme is not the first attempt to provide health insurance to low income workers by the Government in India.

The general methodology of study will be based on primary data collected from survey. The survey will involve responses from more than 200 Patients/Customers .A questionnaire will be filled from persons who are already enrolled under RSBY and availed services at least once or two times during the tenure of policy. The data will be analyzed by using SPSS and Microsoft Excel.

This primary data based study is done in Different district of Haryana & questionnaire was filled by Patients/Customers on behalf of existing medical facilities & services provided by the hospitals of Haryana & Support of Government.

Research Design: - The whole study based on questionnaire

Sample size: - The size of sample drawn for study is 200.

Tools: - The tools used in this study are SPSS & excel sheet based.

ANALYSIS

1) -Sex of respondent

	Male	Female	Total N
% response by Interviewee	54.0	46.0	200

Table No.-1

-In this survey 54% of male and 46% Female responded participated in this survey, means awareness is more in male respondent in compare with female.

2) – District

How much you are satisfied with this Policy? * Zonal classification Crosstabulation

			Zonal classification					
			North	South	East	West	Central	Total
How much you are satisfied with this Policy?	"Fully Satisfied"	Count	59	28	14	72	21	194
		% within Zonal classification	98.3%	96.6%	93.3%	97.3%	95.5%	97.0%
	"Partially satisfied"	Count	0	1	0	2	1	4
		% within Zonal classification	.0%	3.4%	.0%	2.7%	4.5%	2.0%
	"No satisfied"	Count	1	0	1	0	0	2
		% within Zonal classification	1.7%	.0%	6.7%	.0%	.0%	1.0%
Total		Count	60	29	15	74	22	200
		% within Zonal classification	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Table No.-2

-Table showing that in this survey the participation of responded from different district of Haryana means the most respondent participated & satisfied from West & North zone.

3) - Which hospital was first visited for the treatment of the patient?

		Frequency	Percent
	Government Hosp,	14	7.0
	Private Hosp.	186	93.0
	Total N=	200	100.0

Table No.-3

-In this survey the only 07% responded visited government hospital first time & rest visited private hospitals, because they think, private hospital will provide better facility for them.

4)-What was the disease for which hospitalization/treatment was sought?

		Frequency	Percent
	"Respiratory related disease"	66	33.0
	"Ophthalmology related disease"	16	8.0
	"Gynecology related disease"	28	14.0
	"Orthopedic related disease"	12	6.0
	"Heart disease"	31	15.5
	"Intestinal disease"	23	11.5
	"General disease"	5	2.5
	"Other disease"	19	9.5
	Total N=	200	100.0

Table No.-3

-This table is showing the most of the respondent in that district has visited for respiratory & gynecological diseases. Most of the BPL persons are using various forms of Tobacco like Smoke & Smokeless, due to this behavior they are suffering from respiratory and gynecological diseases.

5) - Did the hospital provide treatment?

	Frequency	Percent
"Yes" TOTAL N=	200	100.0

Table No.-5

-This table showing that all empanelled hospitals in this mass health insurance policy are providing the treatments for BPL card holders.

6) - Why this particular hospital was chosen for treatment?

	Frequency	Percent
"Only near from home"	1	.5
"Near by village and good facility"	11	5.5
"Well attended and better treatment"	184	92.0
"No response"	4	2.0
Total N=	200	100.0

Table No.-6

-This table is showing that, most of the respondents have chosen hospitals for treatments due to well attendant and better treatment. This explains that now a day patients want quality treatments, whether they have to go far from home.

7)- How far hospital? Or transport?

	Frequency	Percent
"10-15 KM"	68	34.0
"15-20 KM"	102	51.0
">20 KM"	30	15.0
Total N=	200	100.0

Table No.-7

8)- For how many days patient was admitted?

	Frequency	Percent
1 day	113	56.5
2 days	49	24.5
3 days	38	19.0
Total N=	200	100.0

Table No.-8

-This table is showing that most of the respondent have admitted only for1 day, this may stands many reasons like they want to go back for earning.

9)-How did the patient go to the hospital?

	Frequency	Percent
"Hospital Cab"	71	35.5
"Road wage bus"	111	55.5
"Hired vehicle"	18	9.0
Total N=	200	100.0

Table No.-09

-This table is showing that most of the respondent preferred road wage bus because the availability of road wage bus is more than hospital cab or private vehicle.

10)- How many members enrolled?

	Frequency	Percent
"only 1"	93	46.5
"2 members"	70	35.0
"3 members"	14	7.0
"4 members"	18	9.0
"5 members"	5	2.5
Total N=	200	100.0

Table No.-10

This table is showing that most BPL card holder having 1 or 2 member enrolled in this policy, that shows lack of awareness regarding number of person could be enrolled.

11) - What was the estimated cost to reach the hospital?

	Frequency	Percent
"Rs.50-100"	73	36.5
"Rs.100-150"	127	63.5
Total N=	200	100.0

Table No.-11

This table is showing that the most of the empanelled hospitals in this policy are near from village of the respondent.

12)- Did the hospital reimburse the cost of transport?

	Frequency	Percent
"Yes"	200	100.0

Table No.-12

This table is showing all empanelled hospitals reimbursed the cost of transport by 2 ways either provide hospital cab for patient or provided by cash.

13) - How much was the reimbursement?

	Frequency	Percent
Rs. 100 TOTAL N=	200	100.0

Table No.-13

14) - Was there a RSBY help desk at the hospital?

	Frequency	Percent
"Yes" TOTAL N=	200	100.0

Table No.-14

This table is showing all empanelled hospitals having help desk. It shows proper management of the hospitals and patients are receiving well attention.

15) - **Was it a separate desk for RSBY or part of the other desk like reception?**

	Frequency	Percent
"Yes"	131	65.5
"I don't know"	36	18.0
"No response"	33	16.5
Total N=	200	100.0

Table No.-15

This table is showing that most of the respondents know that hospital having separate desk for RSBY but some of the respondents doesn't know or they did not notice about RSBY help desk.

16) - Were all necessary equipments available at the help desk?

	Frequency	Percent
"Yes"	144	72.0
"I don't know"	40	20.0
"No response"	16	8.0
Total N=	200	100.0

Table No.-16

This table is showing the most of the respondents found availability of all necessary equipments like POS machine etc which are important for identification of patients.

17)-How did the beneficiary find out about the RSBY help desk?

	Frequency	Percent
"Near to indoor gate"	194	97.0
"I don't know"	6	3.0
Total N=	200	100.0

Table No.-17

- This table is showing that all empanelled hospitals in this policy having the better and proper management of help desk for first counter of patients.

18) - How long did the patient have to wait before he/she was attended by the staff?

	Frequency	Percent
"5-10 mints"	114	57.0
"10-15 mints"	81	40.5
"15-20 mints"	4	2.0
">20 mints"	1	.5
Total N=	200	100.0

Table No.-18

- This table is showing that the most of the respondent found, the waiting time in all empanelled hospitals in this mass health insurance policy is range between 5-15 minutes.

19) - Was the bed made available as soon as the patient was advised admission?

	Frequency	Percent
"Yes"	200	100.0
TOTAL N=		

Table No.-19

- This table is showing that most of the respondent found the full availability of the bad during the hospitalization or we can say that the arrangement of bad in all empanelled hospitals is better , that show better management of the hospitals.

20) - Was a wheelchair/ stretcher available?

	Frequency	Percent
"Yes"	200	100.0
TOTAL N=		

Table No.-20

- This table is showing that the availability of wheel chairs is almost all time ,this things the better management of all empanelled hospitals.

21) - After admission how long did the nursing staff take to come?

	Frequency	Percent
"5-10 mints"	92	46.0
"10-15 mints"	102	51.0
"15-20 mints"	3	1.5
">20 mints"	3	1.5
Total N=	200	100.0

Table No.-21

- This table is showing that the waiting time for attention of new admission in all empanelled hospitals by all staff like nursing staff is range between 10-20 minutes.

22) - Were the family asked to pay by themselves if the tests were done outside?

	Frequency	Percent
"No" TOTAL N=	200	100.0

Table No.-22

- This table is showing that the level of awareness is about treatment and diagnostic services provided by the hospitals.

23) - After how long did the Doctor on duty come and check the patient?

	Frequency	Percent
"5-10 mints"	92	46.0
"10-15 mints"	102	51.0
"15-20 mints"	4	2.0
">20 mints"	2	1.0
Total N=	200	100.0

Table No.-23

- This table is showing that most of the respondent found that the waiting time for doctors in range between 10-20 minutes.

24) - Were the family asked to pay if the medicines were brought from outside?

	Frequency	Percent
"No" TOTAL N=	200	100.0

Table No.-24

- This table is showing that awareness among policy and services.

25)- Was the patient provided with food during stay at the hospital?

	Frequency	Percent
"Yes"	200	100.0
TOTAL N=		

Table No.-25

- This table is showing that availability of food during the treatments of hospitals is almost full ,that things indicates the better services by hospitals.

26) - What was the quality of food?

	Frequency	Percent
Excellent	158	79.0
Good	38	19.0
Edible	3	1.5
worst	1	.5
Total N=	200	100.0

Table No.-26

- This table is showing that quality of food during is excellent in all empanelled hospitals in this policy. This things indicates the better quality services provided by the hospitals.

27)-On discharge was discharge summary provided to the family?

	Frequency	Percent
"Yes"	200	100.0
TOTAL N=		

Table No.-27

- This table is showing that the better services provided by the hospitals.

28)-Was the fingerprint verification done at the time of discharge?

	Frequency	Percent
"Yes"	196	98.0
"Don't know"	4	2.0
Total N=	200	100.0

Table No.-28

- This table is showing that the awareness about policy and services.

29) - **Did you get the card back on the day of discharge?**

	Frequency	Percent
"Yes"	200	100.0
TOTAL N=		

Table No.-29

- This table is showing the better facility and services provided by the hospital as timely.

30) - Were you told about the amount of money left in the card at the time of discharge?

	Frequency	Percent
"Yes"	200	100.0
TOTAL N=		

Table No.-30

- This table is showing that the awareness about policy is most of the respondent is found more.

31)-Do you know about 5 day post hospitalization expenses coverage in RSBY?

	Frequency	Percent
"Yes"	198	99.0
88	2	1.0
Total N=	200	100.0

Table No.-31

- This table is showing that the better services provided by the hospitals and better awareness and management.

32) - Was the patient prescribed any medicines after the discharge?

	Frequency	Percent
"Yes"	1	.5
"No"	199	99.5
Total N=	200	100.0

Table No.-32

- This table is showing that better services provided by the hospitals.

33) - Age of the patient?

	Frequency	Percent
5-14 year	13	6.5
15-24 year	36	18.0
25-34 year	36	18.0
35-44 year	25	12.5
45-54 year	22	11.0
55-64 year	46	23.0
65-74 year	21	10.5
85-94 year	1	.5
Total N=	200	100.0

Table No.-34

- This table is showing that the most of the respondent treated from empanelled hospitals is range between 55-65yr that show , the disease package are more beneficiary for all persons who have the treatment most.

34) -**How much you are satisfied with this Policy?**

		Frequency	Percent
	"fully satisfied"	194	97.0
	"Partially satisfied"	4	2.0
	"No satisfied"	2	1.0
	Total N=	200	100.0

Table No.-34

- This table is showing that more than 95% of respondents are satisfied by this policy, due to better facilities and services provided by the empanelled hospitals in this mass health insurance policy & some of the respondents are partially satisfied due to quality of food and not provided services on the time.

Result & Findings

Along with many other companies out there today is largely based around the relationship of a business with its customers. Without one, we cannot have the other. ICICI Lombard is one of the customer service experts or gurus out there that does his best job to improve that relationship between Hospitals and its Patients. Think of him as a Customer Service manager for customer relations. We all know customer satisfaction is essential to the survival of Rashtriya Swasthya Bima Yojna. How do we find out whether our customers are satisfied? The best way to find out whether your customers are satisfied is to ask them.

So, after SPSS & Excel sheet analysis, we can say, the Satisfaction level of this Rashtriya Shwashtya Bima Yojana is more then 95 %(+~97%).

Figures

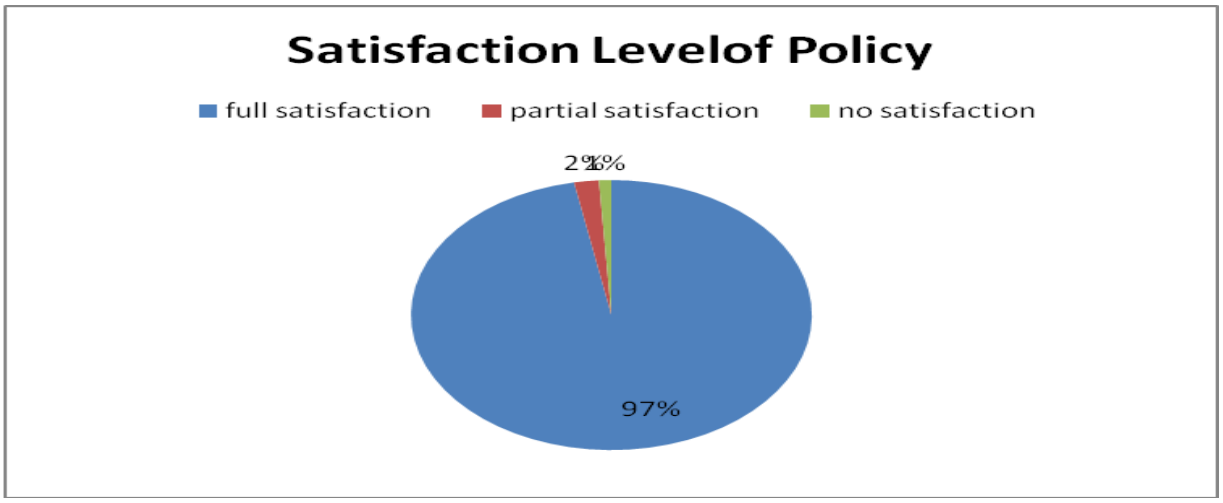


FIG.No.-01

-This Graph showing that ,overall satisfaction of this mass health Insurance policy(Rashtriya shwashtya Bima Yojana) is more then 95%(97%), due to less waiting time ,good quality of foods ,totally cashless hospitalization facility for BPL family & good transportation facility Provided by the empanelled hospitals under this policy.

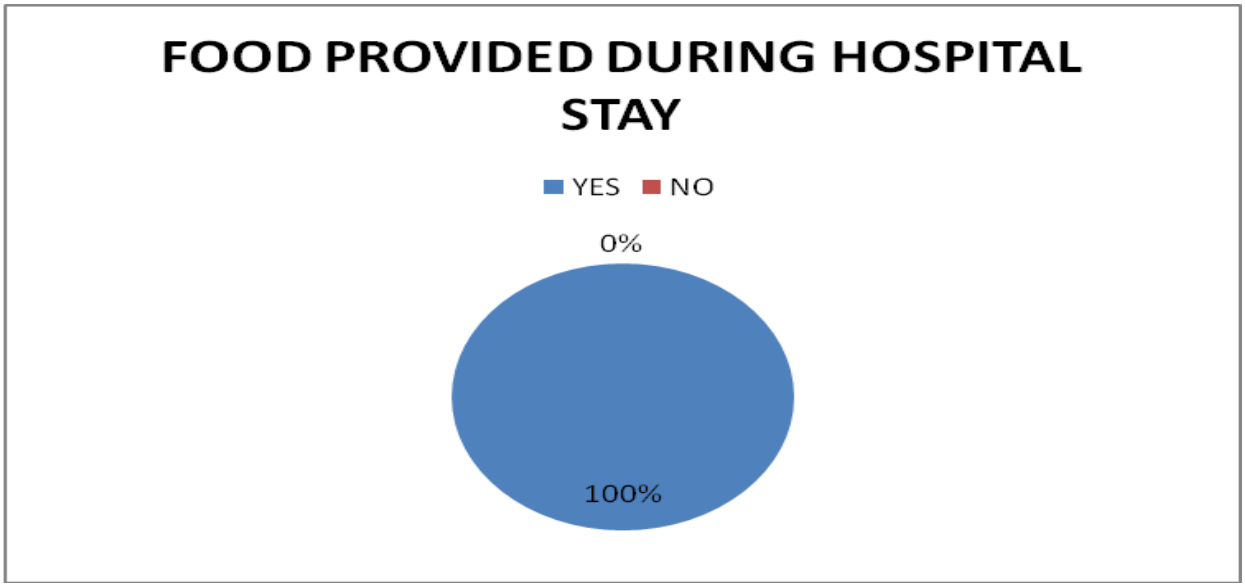


FIG No.02

-This graph showing that, hospitals empanelled under this mass health insurance policy (RSBY) provide food during stay. Evenly some patents told us, hospitals provide the food for his family also.

So, satisfaction level is more in this policy.

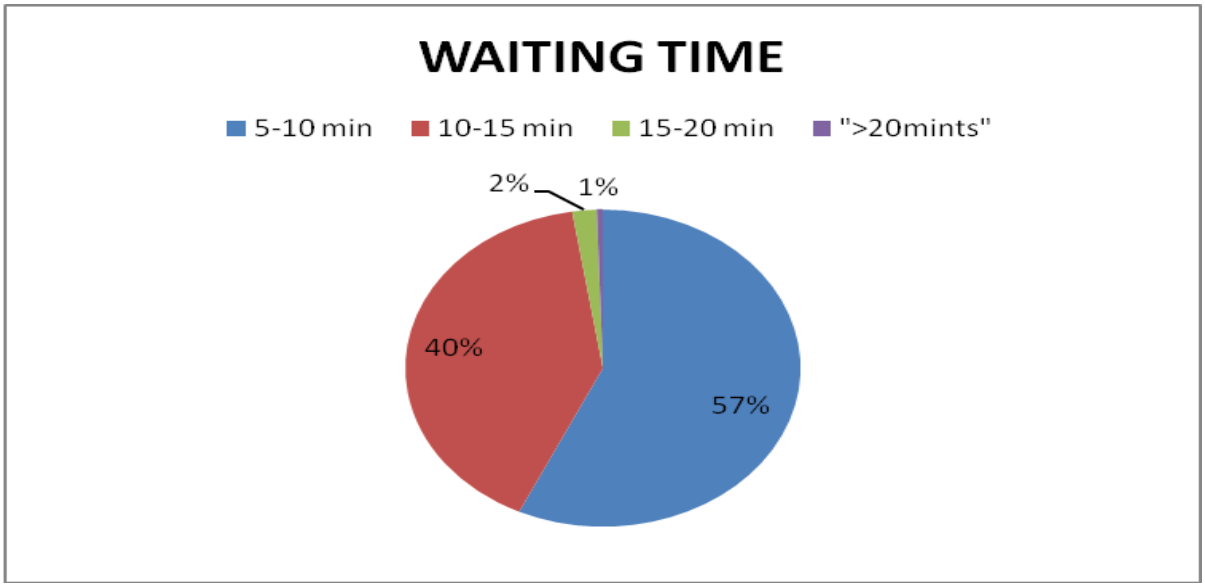


FIG-03

-This graph is showing that 57% of Respondent said that average waiting time is in range between 5-15 min & rest said that the average waiting time is 15-20 min, because waiting time is an important factor which determines the satisfaction level.

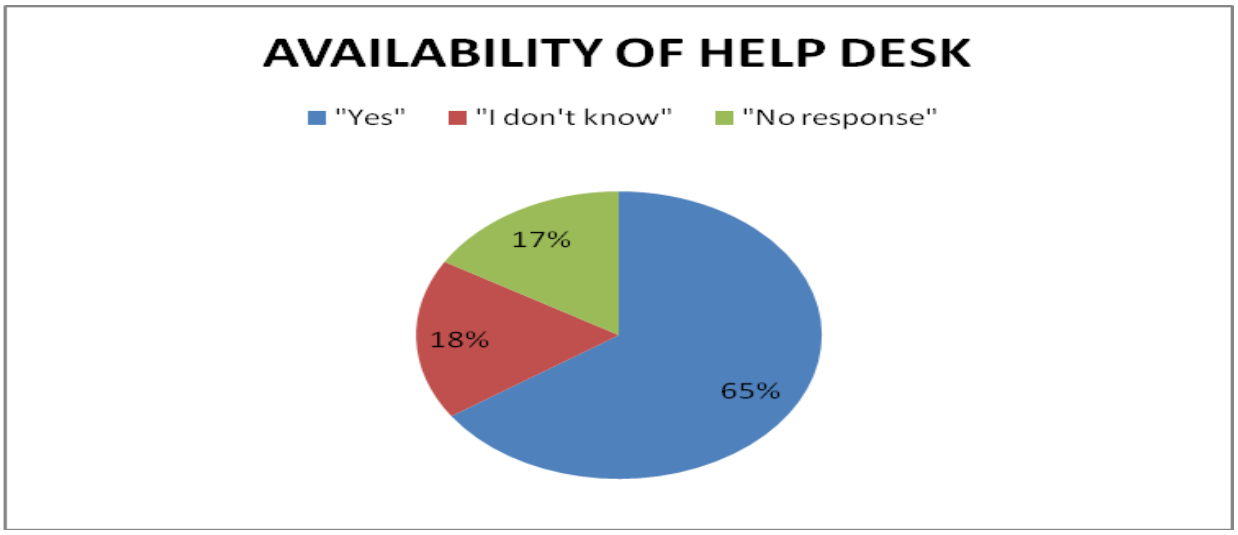
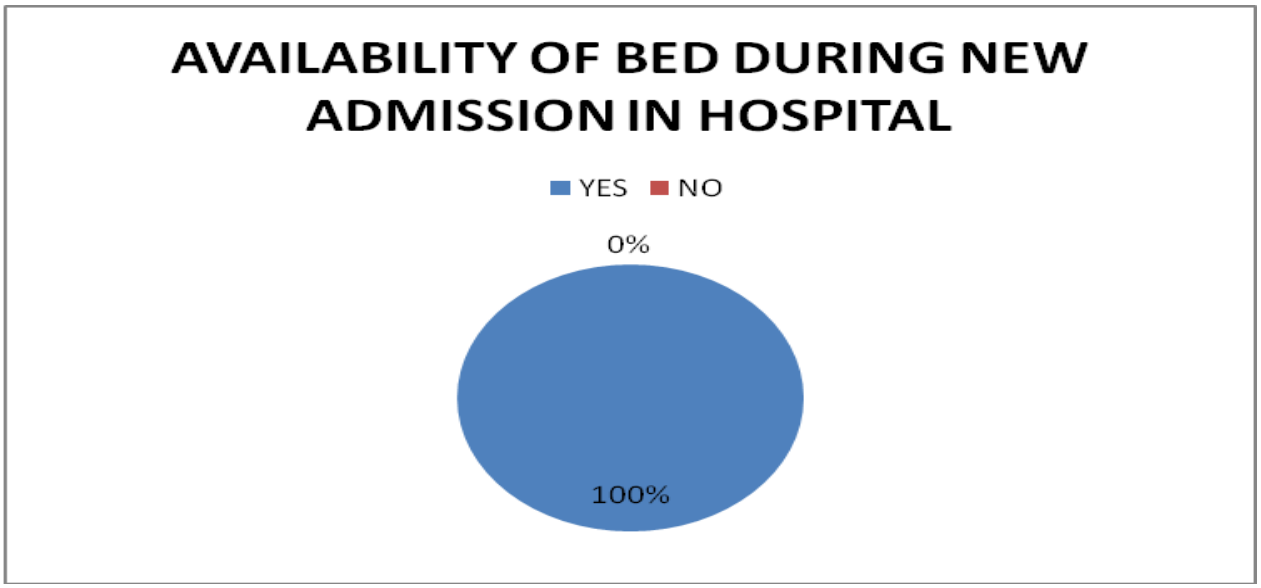


FIG.No-4

-This graph is showing that, more than 65% of customers said that the availability of Help Desk facility is RSBY empanelled hospitals in Haryana.



-This graph showing that the availability of the bad during the admission of patents in hospitals is 100%, that things affect the satisfaction level of this mass health insurance policy (RSBY).

FIG.No-5

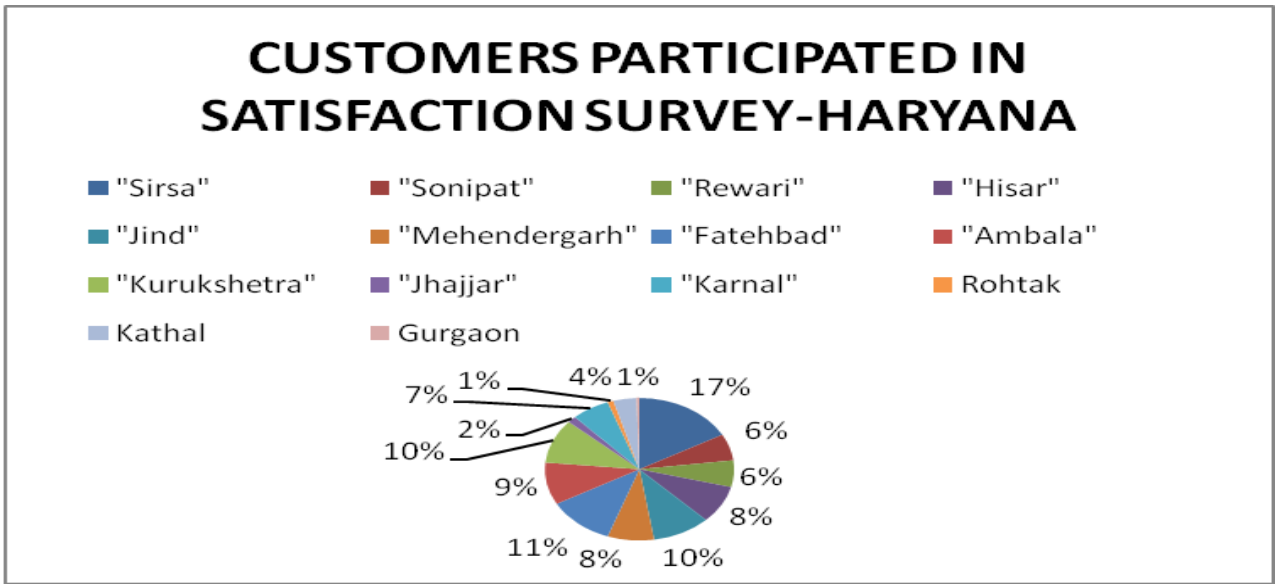


FIG. No-6

-This figures showing that how much percentage of peoples participated in satisfaction survey in different districts of Haryana.

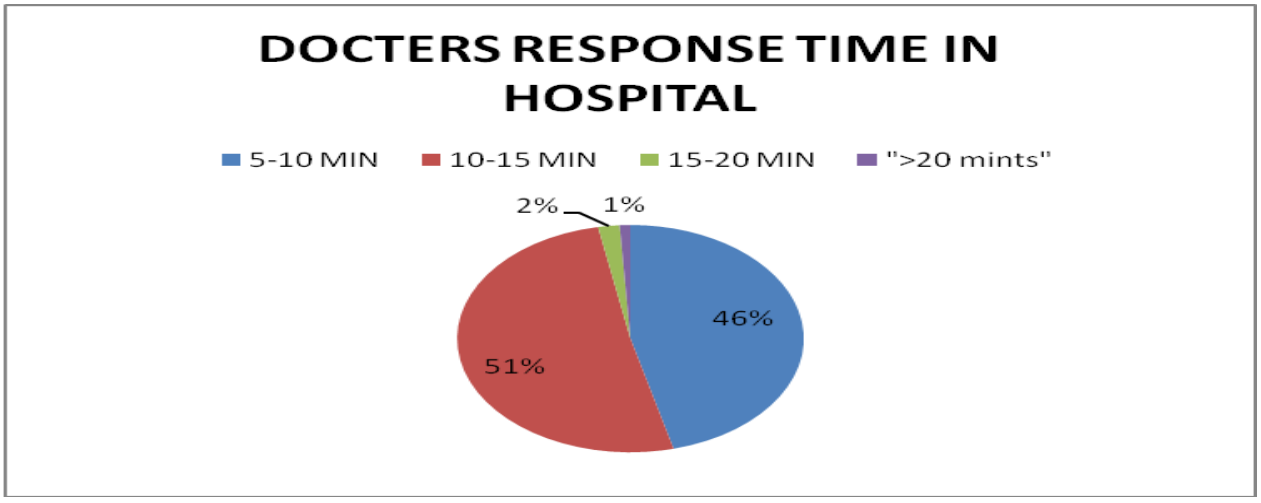


FIG. No-7

-This figure showing that the more than 50% of respondent said that doctors available for treatment in empanelled hospitals under RSBY within 10-15 min & rest said that doctors available for treatment within 5-10 min.

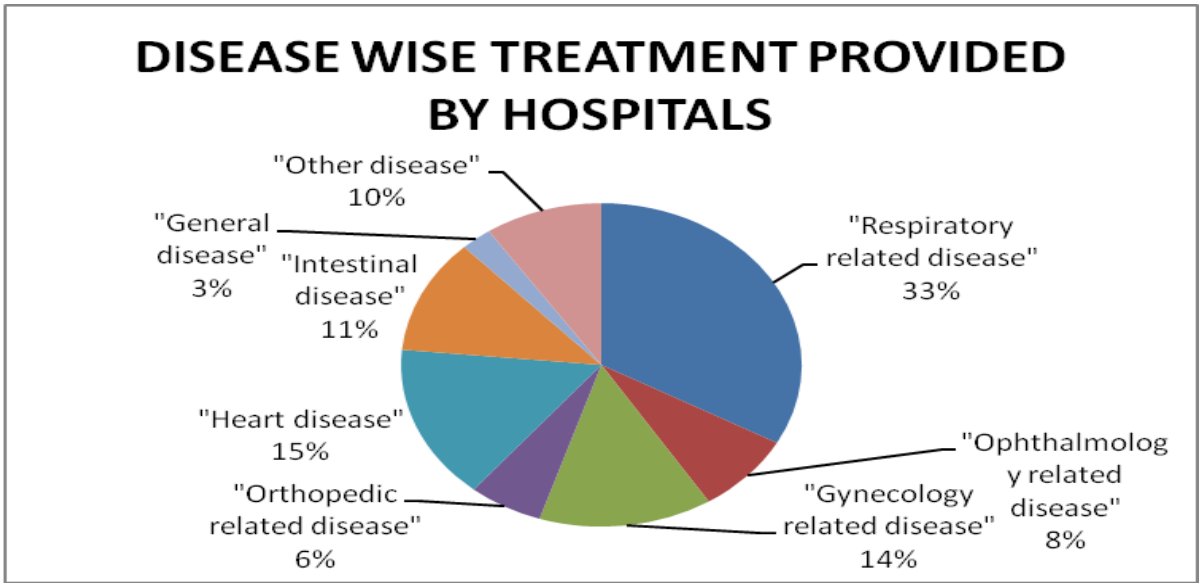


FIG.No.-08

-This figure showing that the treatments wise distribution of different diseases, most of respondent told us for treatment of different respiratory diseases.

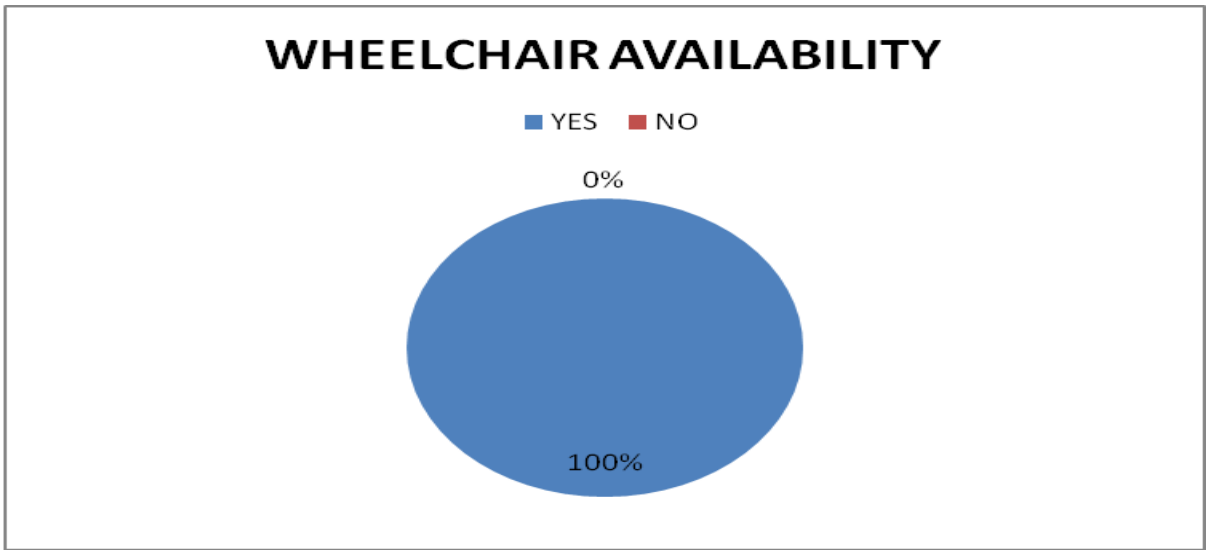


FIG.No.-09

-This figures describes that the availability of wheelchairs (for emergency patents) is available is 100% of all empanelled hospitals under this mass health insurance policy (RSBY).

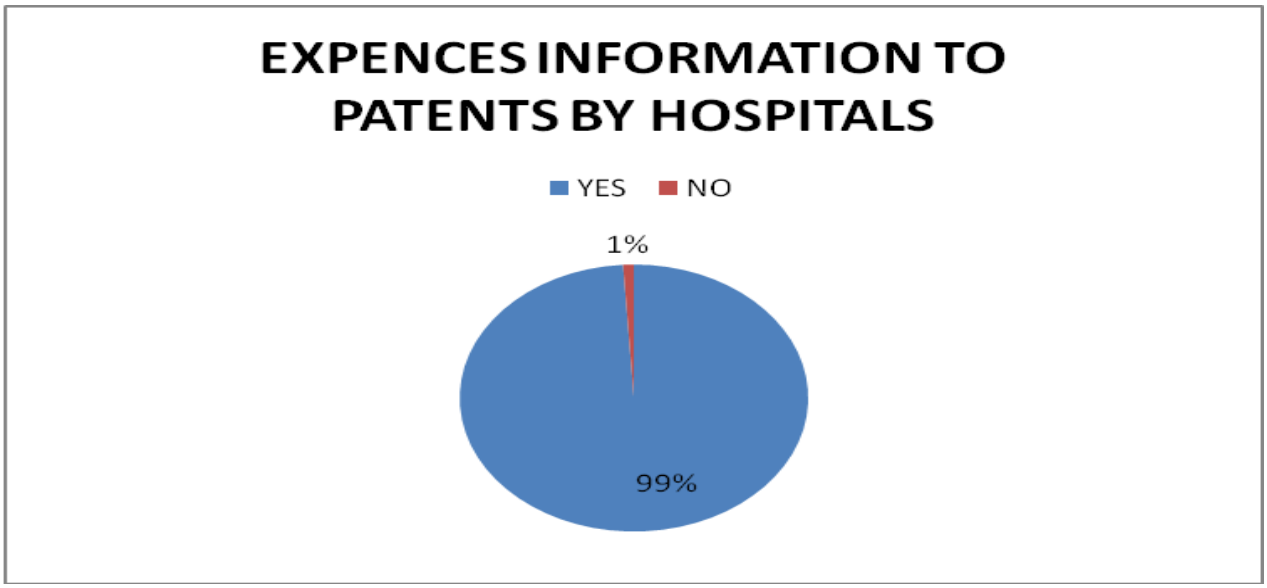


FIG.No.-10

-This figures showing that the expenses information to patents by all hospitals under this mass health insurance policy is more than 95%.

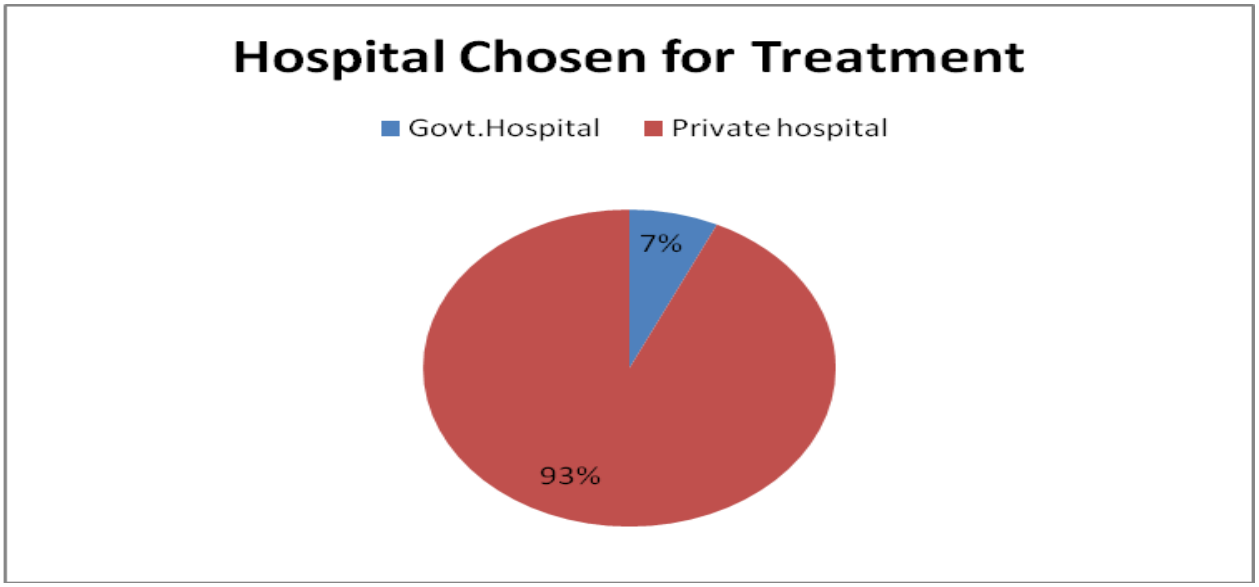


Fig.No.-11

So, finally we can say these are some finding regarding satisfaction of this policy given below-

1- Food quality serving in all empanelled hospitals under this policy is better and specially in private hospitals in Haryana.

2- Waiting time is very less in all empanelled hospitals in Haryana.

3- Availability of wheelchairs is 100% in all empanelled hospitals in Haryana.

4- Availability of bad during the patents admission in hospitals is more than 97%, which affect the satisfaction level.

5- Availability of Help desk in proper place in all empanelled hospitals in Haryana is more than 98%.

CONCLUSIONS & RECOMMENDATIONS

The RSBY scheme is not the first attempt to provide health insurance to low income workers by the Government in India. The RSBY scheme, however, differs from these schemes in several important ways.

Empowering the beneficiary – RSBY provides the participating BPL household with freedom of choice between public and private hospitals and makes him a potential client worth attracting on account of the significant revenues that hospitals stand to earn through the scheme.

Business Model for all Stakeholders – The scheme has been designed as a business model for a social sector scheme with incentives built for each stakeholder. This business model design is conducive both in terms of expansion of the scheme as well as for its long run sustainability.

Insurers – The insurer is paid premium for each household enrolled for RSBY. Therefore, the insurer has the motivation to enroll as many households as possible from the BPL list. This will result in better coverage of targeted beneficiaries.

Hospitals – A hospital has the incentive to provide treatment to large number of beneficiaries as it is paid per beneficiary treated. Even public hospitals have the incentive to treat beneficiaries under RSBY as the money from the insurer will flow directly to the concerned public hospital which they can use for their own purposes. Insurers, in contrast, will monitor participating hospitals in order to prevent unnecessary procedures or fraud resulting in excessive claims.

Intermediaries – The inclusion of intermediaries such as NGOs and MFIs which have a greater stake in assisting BPL households. The intermediaries will be paid for the services they render in reaching out to the beneficiaries.

Government – By paying only a maximum sum up to Rs. 750/- per family per year, the Government is able to provide access to quality health care to the below poverty line population. It will also lead to a healthy competition between public and private providers which in turn will improve the functioning of the public health care providers.

Information Technology (IT) Intensive – For the first time IT applications are being used for social sector scheme on such a large scale. Every beneficiary family is issued a biometric enabled smart card containing their fingerprints and photographs. All the hospitals empanelled under RSBY are IT enabled and connected to the server at the district level. This will ensure a smooth data flow regarding service utilization periodically.

Safe and foolproof – The use of biometric enabled smart card and a key management system makes this scheme safe and foolproof. The key management system of RSBY ensures that the card reaches the correct beneficiary and there remains accountability in terms of issuance of the smart card and its usage. The biometric enabled smart card ensures that only the real beneficiary can use the smart card.

Portability – The key feature of RSBY is that a beneficiary who has been enrolled in a particular district will be able to use his/ her smart card in any RSBY empanelled hospital across India. This makes the scheme truly unique and beneficial to the poor families that migrate from one place to the other. Cards can also be split for migrant workers to carry a share of the coverage with them separately.

Cash less and Paperless transactions – A beneficiary of RSBY gets cashless benefit in any of the empanelled hospitals. He/ she only needs to carry his/ her smart card and provide verification through his/ her finger print. For participating providers it is a paperless scheme as they do not need to send all the papers related to treatment to the insurer. They send online claims to the insurer and get paid electronically.

Robust Monitoring and Evaluation – RSBY is evolving a robust monitoring and evaluation system. An elaborate backend data management system is being put in place which can track any transaction across India and provide periodic analytical reports. The basic information gathered by government and reported publicly should allow for mid-course improvements in the scheme.

It may also contribute to competition during subsequent tender processes with the insurers by disseminating the data and reports.

Self-reports of customer satisfaction invariably possess distributions that are negatively skewed and exhibit a positivity bias. Examination of the customer satisfaction literature and empirical investigations reveal that measurements of customer satisfaction exhibit tendencies of confounding and methodological contamination and appear to reflect numerous artifacts. Implications and suggestions for research and practice are discussed.

Without question, customer satisfaction is one of the most widely studied and embraced constructs in marketing. Over the past two decades more than 15,000 academic and trade articles have been published on the topic. As the cornerstone of the marketing concept, customer satisfaction has been embraced by practitioners and academics alike as the highest-order goal of a company. Firms espouse their commitment to satisfying customers in their advertisements, public relations releases, and mission statements.

Customer satisfaction appears to most typically be measured through surveys (McNeal and Lamb 1979). Surveys provide formal feedback to a firm and send a positive signal to customers that the firm is interested in them. Their popularity derives from their directness, ease of administration and interpretation, clarity of purpose, and face validity. Although unobtrusive, indirect measures of customer satisfaction (e.g., sales, profits, complaints) are also utilized, they are typically viewed as complementary to direct survey measures. Ratings of customer satisfaction derived from surveys are used to evaluate the performance of company employees (including being incorporated in merit and compensation reviews), enhance sales management and training programs, obtain insights into competitors, and, if favorable, are included in company advertising (Bertrand 1989a, 1989b; Smith 1989).

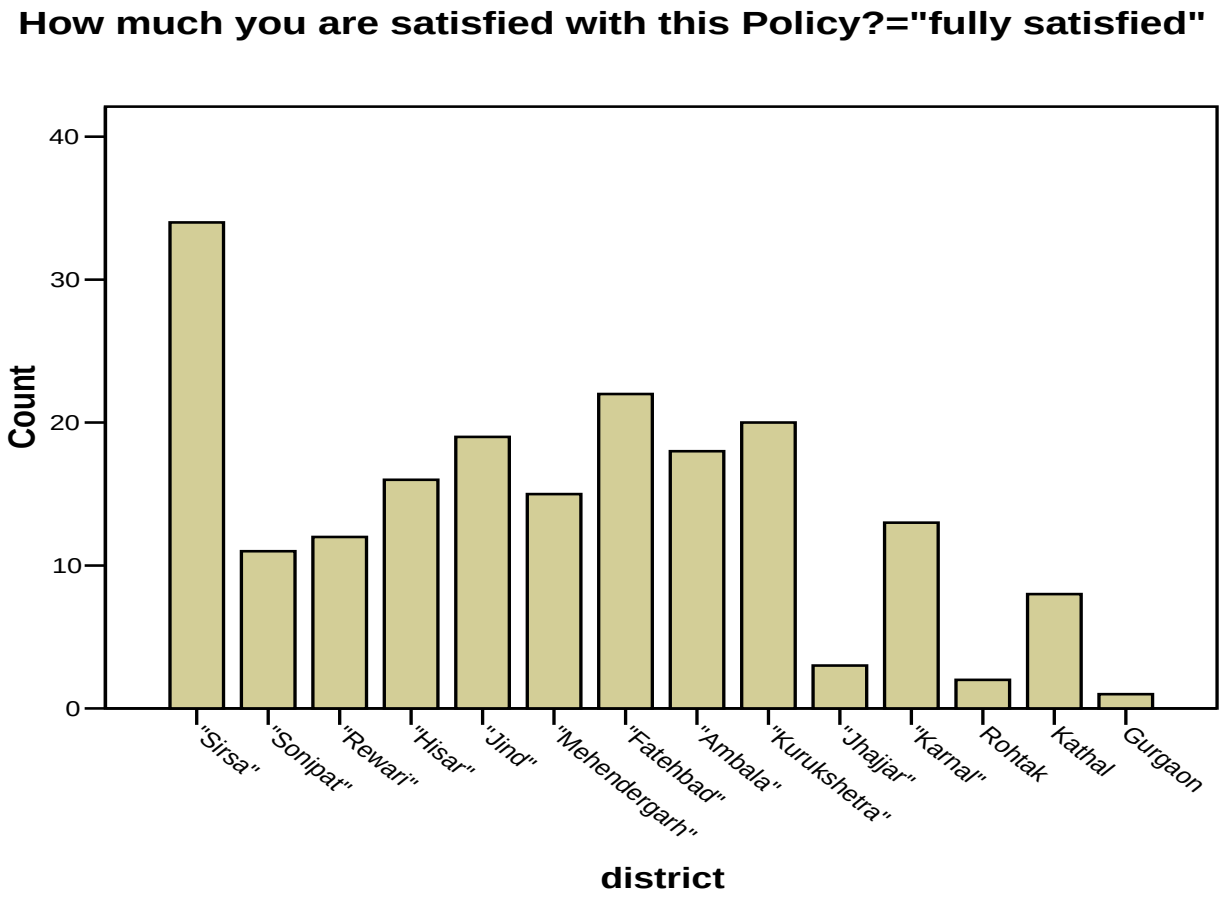


Fig.No.-11

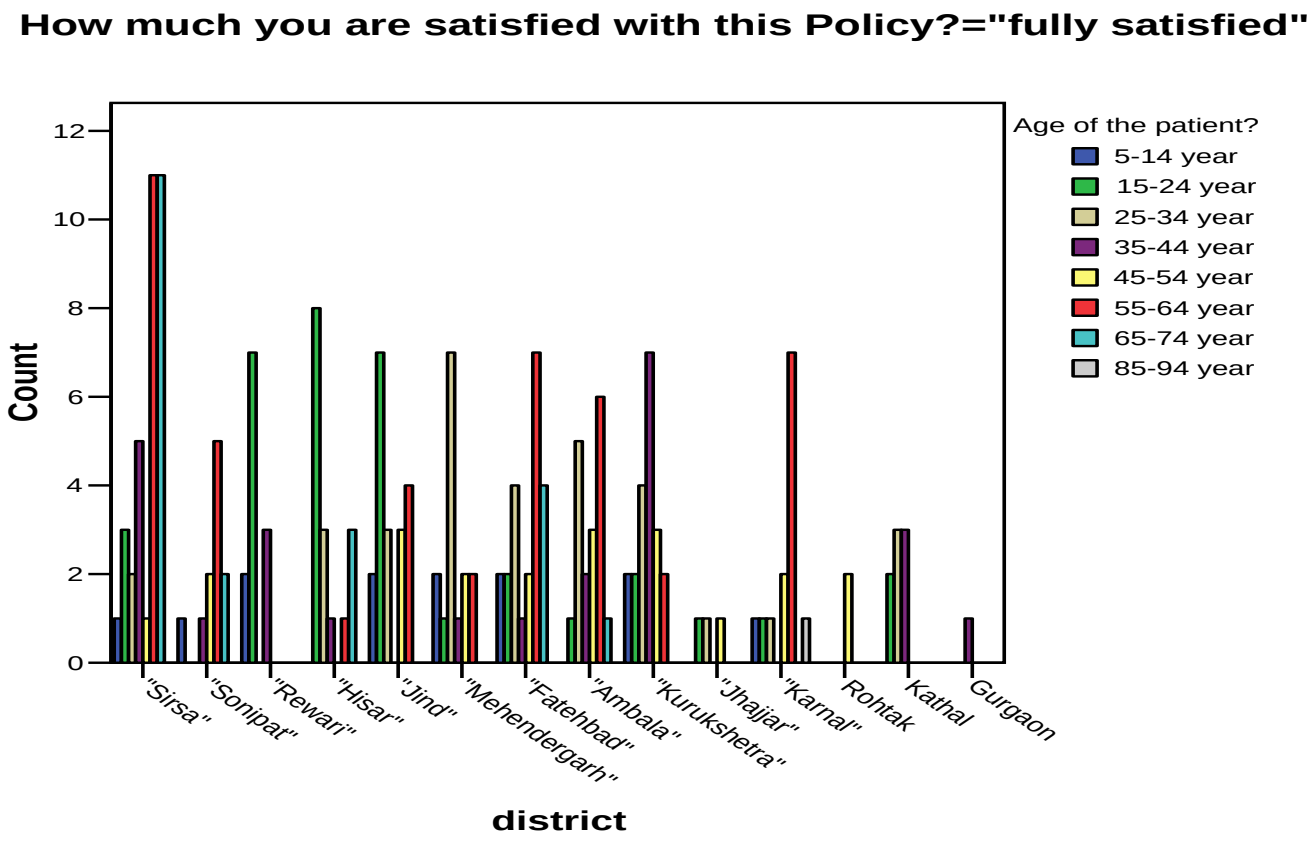
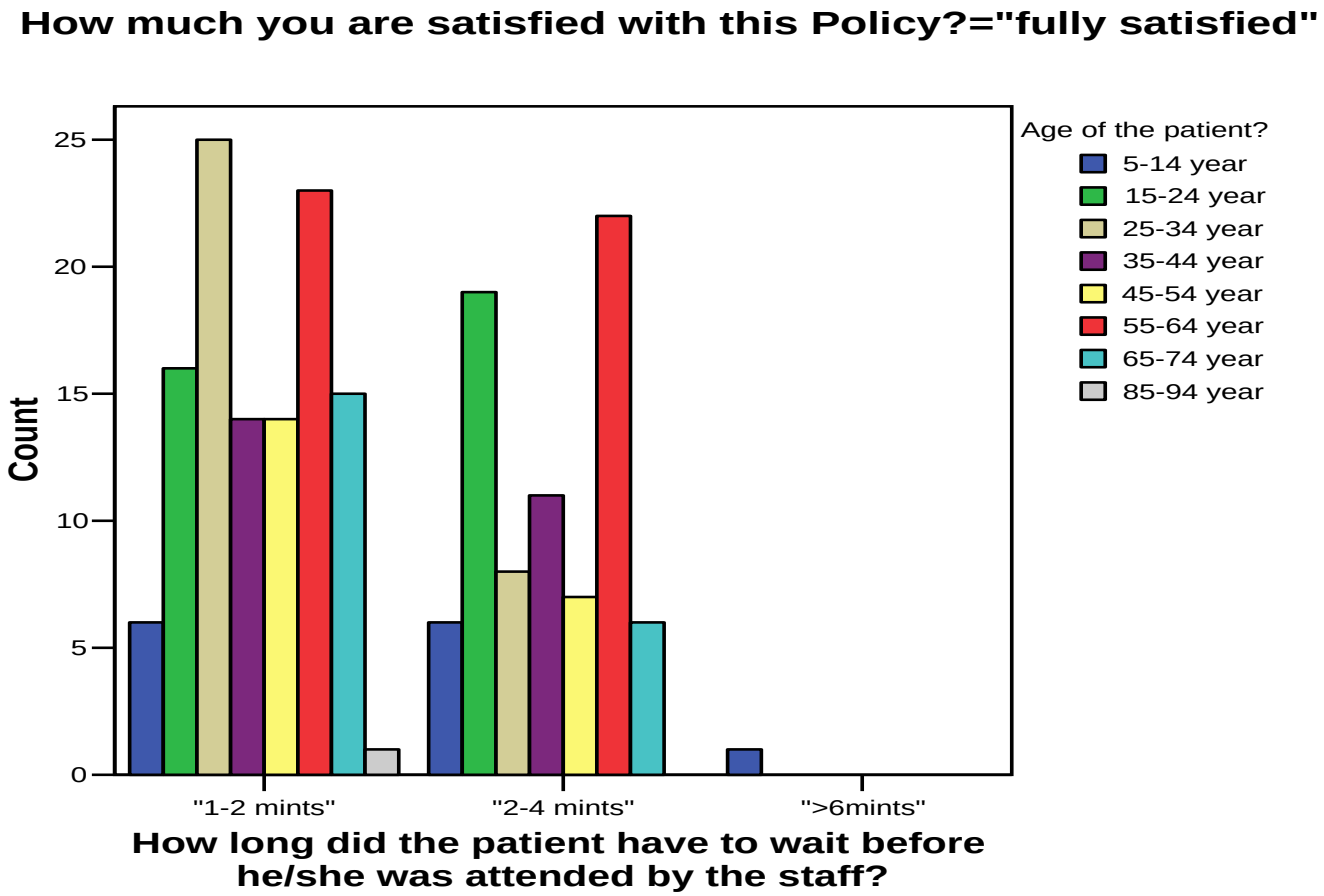


Fig.No.-12

-These given above bar chart are showing the level of satisfaction in different district of Haryana as per age group criteria.

So ,we can say the most number of respondent from District Sirsa ,where the level of satisfaction of this mass health insurance policy (Rashtriaya shwashtya Bima yojana) is more (as per questionnaire) and the most satisfactory group is between from 35 -50 yr.

Currently waiting time is the prime factor for the deciding the benchmark of services. In Haryana respondent said that the waiting time in all empanelled hospitals in Rashtriya shwashtya Bima Yojana (RSBY) is (average



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Research Hypothesis is that if preventive and promotive health services are covered in the insurance scheme, more and more people will like to go for these services leading to better health of general population. Another hypothesis is that people would like to pay more for Smart card (health insurance), if this scheme also covers OPD, preventive and diagnostic services.

An electronic list of eligible BPL households is provided to the insurer using a pre-specified data format. An enrollment schedule for each village, along with dates, is prepared by the insurance company with the help of the district level officials. As per the schedule, the BPL list is posted in each village at enrollment station and prominent places prior to the enrollment and the date and location of

the enrolment in the village is publicized in advance. Mobile enrollment stations are set up at local centers (e.g., public schools) at each village. These stations are equipped by the insurer with the hardware required to collect biometric information (fingerprints) and photographs of the members of the household covered and a printer to print smart cards with a photo. The smart card, along with an information pamphlet describing the scheme and the list of hospitals, is provided on the spot once the beneficiary has paid the 30 rupee fee. The process normally takes less than ten minutes. The cards are handed over in a plastic cover.

The Proper Customer Satisfaction Approach

Sam Walton, the founder of Wal-Mart, the biggest chain of its kind in the world is credited with establishing an excellent set of guidelines for customer satisfaction:

- A customer is the most vital person in any business organization
- A customer isn't dependent upon us, we're dependent upon him
- A customer doesn't interrupt our work, he is the reason for it
- A customer does us a favour by coming in. We aren't doing him a favor by waiting on him.
- A customer is an essential part of our business, not an outsider
- A customer is not just money in our cash register. He is a person with feelings that deserve to be treated with respect.
- A customer is a person who comes to us with his needs and wants. Our job is to fill them.
- A customer deserves the most courteous attention we can provide. He is the lifeblood of this and every other business. He pays your salary. Without him, we would have to close our doors. Don't ever forget it!

The aim of a quality improvement process is to enable the provision and coordination of health services which are:

- Equitable: health care is accessible, affordable and timely, and is provided to all who need it regardless of gender, ethnicity or socioeconomic status

- Patient-centered: health care will be responsive to and respectful of the patient's values and choices to promote patient satisfaction at every health care encounter.
- Safe: health care ensures that the patients and staff do not suffer undue harm from the treatment itself and from the manner it was given.
- Effective: any form of treatment or patient care will be based on guidelines that follow current scientific evidence.
- Integrated: services are organized to provide continuity over time (for instance within one hospital) and between providers (for example, referral to and from secondary care)
- Efficient: waste is avoided and resources are used appropriately to ensure optimum benefits for patients and the population.

Limitations of Rashtriya shwashtya Bima Yojana policy:-The limitations of this policy are given below-

1) - OPD not cover: - OPD is not covered in RSBY. Therefore, medicines and tests which are not related or do not lead to hospitalization need to be paid by the beneficiary, Because most of the diseases comes in the category for out patents departments & this facility is not covered in this policy.

2) So we can say RSBY does not cover OPD expenses, or expenses in hospitals which do not lead to hospitalization.

3) - Only 5 members as per floater basis is only covered in this scheme.

4) Food only for the person who is hospitalized is covered in the package rate.

5) Coverage amount of Rs. 30,000 is on a floater basis. Therefore, the total amount will remain Rs. 30,000 even if the family consists of only one. So we can say the amount of coverage is not more than Rs 30,000.

6) Activation of cards after one month means for the districts where smart cards have been issued in the first phase (Tendered in 2008) benefits will start accruing from the 1st of the month after the month in which the first set of cards was issued in a district. For the cards which are distributed after 1st April 2009, the policy will commence from the next month from which the 1st smart card is issued in the district. For all the subsequent issued smart cards, the policy start date will remain the same as in case of first smart card issued.

7) In BPL Smart card, rashan card number & Parent name is not, so many cases the identification of BPL card holder is tough.

8) Coverage of limited numbers of diseases.

Recommendations: - After completed & analyzing the survey finally I have some recommendation, which is given below-

1) The Out patents treatments (OPD) should be cover in this schemes.

2) Expenses of disease, which need not hospitalization, should be covered in this mass health insurance policy.

3) Activation of BPL Smart should be within 1 week after the enrollments.

4) The amount of coverage should be more.

5) The awareness regarding this policy should be more.

6) Formation of a "Health Committee" by MoLE.

7) Formulation of "Empanelment cum grading criteria".

8) A network hospital having achieved NABH accreditation and/or ISO Certification will automatically qualify to receive a bonus for the highest grade in the scheme.

9) Review and finalize the criteria for grading the quality levels in network hospitals.

10) Prepare / formulate the scheme for empanelment of (independent) assessors, including training curricula, identification of the institutions for imparting the training.

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Appendices

Study of Customer Satisfaction in Mass Health Insurance Policy-Rashtriya Shwashthya Bima Yojana- Post-hospitalization Survey

Namaskar

This survey is being conducted by me just to assess the experience of yours in Mass Health Insurance Policy-Rashtriya Shwasthya Bima Yojana. This survey would help us to understand the issues and the experiences that individuals are going through. We would appreciate your participation in this survey. The information collected would be kept confidential, analyzed and use for academic purposes. It is Voluntary and takes only 5 minutes. You have the right not to answer any question, and to stop the interview at any Time. I would be happy to share the results with you.

Signature of Investigator_____ Date…….Month….. Year…….

1. Name of the patient:_____
2. Age: _____ years 3. Gender: M ☐ / F ☐
4. State_____ 5. District: _____
6. Block: _____ 7. Village: _____
8. Marital status: Married ☐ Unmarried ☐
   Widow or Widower ☐ Divorced ☐
9. Patient UHID No.: _____
10. Number of members enrolled: _____
11. Card Holder Name: _____
12. Relationship of patient with card holder: _____
13. What was the disease category for which hospitalization/treatment was sought?

    Respiratory ☐ Orthopedic ☐ Heart disease ☐
    Gynecology ☐ Intestinal ☐ Ophthalmology ☐
    General disease ☐ Other disease: (Please mention) _____

14. Which hospital was first visited for the treatment of the patient?

Private ☐ Government ☐ Semi govt. ☐ Don't know ☐

15. Did the hospital provide satisfactory treatment?

Yes ☐ No ☐ don't know ☐ No response/ can't say ☐

16. Why this particular hospital was chosen for treatment?

Well attended only ☐ well attended and better treatment ☐

Only near from Home ☐ nearby village and good facility ☐

Don't know ☐ No response ☐

17. For how many days patient was admitted? _____days

18. How far hospital? Or transport? _____Km

19. How did the patient go to the hospital?

Bus provided by hospital ☐ Road wage bus ☐

Hired or self arranged vehicle ☐

Any other (Please mention) _____

20. What was the estimated cost to reach the hospital? _____rupees

21. Did the hospital reimburse the cost of transport?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

22. How much was the reimbursement? _____Rupees

23. Was there a RSBY help desk at the hospital?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

24. Were all necessary equipments available at the help desk?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

25. How did the beneficiary find out about the RSBY help desk?

Near to indoor ☐ Far from indoor ☐

Don't know ☐ No response ☐

26. How long did the patient have to wait before he/she was attended by the staff?

_____Minutes

27. Was the bed made available as soon as the patient was advised admission?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

28. Was there wheelchair/ stretcher available?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

29. After admission how long did the nursing staff take to come? _____Minutes

30. After how long did the Doctor on duty come and check the patient? _____Minutes

31. Were the family asked to pay by themselves if the tests were done outside?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

32. Were the family asked to pay if the medicines were brought from outside?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

33. Was the patient provided with food during stay at the hospital?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

34. What was the quality of food?

Excellent ☐ Good ☐ Average ☐ Only edible ☐

Any other comment (Please mention) _____

35. On discharge was discharge summary provided to the family?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

36. Was the fingerprint verification done at the time of discharge?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

37. Did you get the card back on the day of discharge?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

38. Were you told about the amount of money left in the card at the time of discharge?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

39. Do you know about 5 day post hospitalization expenses coverage in RSBY?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

40. Was the patient prescribed any medicines after the discharge?

Yes ☐ No ☐ Don't know ☐ No response/ Can't say ☐

41. For how many days the medicines needed to be taken after discharge? _____Days

42. Are you happy and satisfied with this Policy?

Fully satisfied ☐ Partially satisfied ☐ No satisfied ☐

Any other comment (Please mention) _____

Thank you



Process outflow:-

