What is the customer’s knowledge of ‘The Consumer Protection Code 2012’ and do they have a clear understanding of their current health insurance policy.
Dissertation submitted in part fulfillment of the requirement of the degree of Masters in Business Administration at Dublin Business School and Liverpool John Moores University.

III DECLARATION

I declare that no part of this work referred to in this dissertation has been submitted in support of an application for another degree or qualification of these or other university or institute of learning.

Further, all the work in this dissertation is entirely my own, unless referenced in the text as specific source and included in the bibliography.

Signed: Cathy Cribben-Pearse

Dated: 16th August 2013
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Abstract

Gaps exist between what customers expect and understand from their health insurance policy and what the Consumer Protection Code 2012 legislation requires them to understand. The following dissertation review seeks to identify: the main problem(s) preventing customers from clearly understanding their health insurance policy, to provide a closer inspection of other factors in the insurance market from a consumer’s perspective, to develop a review of consumer’s attitudes to health insurance, to establishing whether the consumer protection code is widely recognised, to determining whether the consumer knows how/where to complain to if they are unhappy with their health insurance policy, to identify the key trends amongst consumers and forthcoming trends.

Following the anonymous and confidential completion of 153 questionnaires, the research has proven that typically consumers do not have a clear understanding of their health insurance policy. The overall factor for having a health insurance was due to fear of the public system, supported by the fact they can afford to have the policy. The perceived value of healthcare, despite the impact on personal finances, appears to be the most common theme in identifying why the consumer has health insurance. However in the current prolonged period of austerity where, as identified by the research, households have had to make large financial savings there are growing numbers of people cancelling their health insurance policy because it is no longer affordable. Despite the reduction in consumers disposable income, the overall consensus is health insurance is a priority and policies would only be canceled as the result of considerable financial changes with a person’s circumstances.

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1.1 Introduction

In the Republic of Ireland (Ireland), the public health system has a symbiotic affiliation with private health insurance not seen elsewhere in other European countries. The population of Ireland are entitled to free care in a public hospital provided by the state; however despite this approximately 46.3% (end of June 2012) of the population currently pay for private health insurance (Dept of health and children 2012) insurance in Ireland has grown into a profitable market place where the insured avail of ‘private’ healthcare, much of which is delivered in public hospitals – for example, both public and private patients can be treated in acute public hospitals by the same consultant (Wren 2006) There is universal, although not necessarily free at the point of use, entitlement to a public bed in a public hospital (Wren 2006). This usage is controlled through a quota, set at 20% nationally by the Department of Health and Children (2012), on the number of beds designated for private patients in public hospitals (Wren 2006). Legislation restricts accommodation of a private patient in a public bed to emergency cases when a private bed is unavailable (Wren 2006). Similar rules apply to a public patient in a private bed.

Concerns have arisen that providers may sidestep these restrictions on private practice in acute public hospitals, diverting resources from public to private patients. This apparent penchant for private practice has been facilitated, on the demand side, by recent substantial growth in private health insurance subscriptions. On the supply side, there are financial incentives for providers favouring the treatment of private patients. Consultants are rewarded on a fee-for-service basis for private care, but receive a salary for public practice. Public hospitals, meanwhile, receive ‘an additional income stream’ for every private patient in a private bed in the form of a fixed daily payment (equivalent to approximately half of the actual treatment cost, which effectively subsidises private care in public hospitals, placing private hospitals at a competitive disadvantage. These factors have resulted in a two-tier system in Ireland, which is proving problematic from both efficiency and an equity perspective.
The following two topics ‘Irish Health service and Health Insurance’ and ‘Regulation of Health Insurance in Ireland’ highlight the heritage and development of health insurance in Ireland, which is the foundation on which the problems of health insurance in Ireland have risen.

1.2 Irish Health service and Health Insurance

In the late 1950s a monopoly state-backed, not-for-profit health insurer ‘the Voluntary Health Insurance Board’ (VHI) was started to provide for the upper 15% of the income division, who did not (then) have the privilege of using public hospitals from the state. Ireland’s public and private health care system has been described as a symbiotic relationship (Barrington 1987), with state-backed insurer offering income tax relief on premiums paid (Nolan and Wiley, 2002).

The lack of a welfare base in the Ireland lead to immense influence of hierarchical powers, both the Catholic Church and the medical profession, ensuring that private healthcare continues to be a powerful factor of health services in Ireland (Barrington, 1987; Geary, 2004). The healthcare system was designed to ensure that the whole population had access to hospital care, whilst fulfilling the demands of medical consultants at their private practices. Individuals in an advantageous fiscal position were encouraged to take out insurance cover, with the cost of hospital care covered by the state for the remainder of the population. Private patients receiving care in public hospitals resulted in the insurance company reimbursing the hospital (Wren 2006). However, public hospitals only claimed for the ‘hotel’ facilities relating to being in a private room. Additionally a large number of consultants are contracted to treat public patients in public hospitals on a salaried basis, whilst preserving their right to treat private patients on a fee-for-service basis (Cantillon, 2001). This two-tiered system, offering different conditions to differing socio-economic groups, is outlined by Cantillon, (2001) as a twofold arrangement providing both public and private healthcare, side by side.

In Ireland the leading non-life insurance market is the health insurance market. In 2009,
Premium incomes from health insurance providers totalled €1.85bn, compared to income of €1.3bn in motor insurance, the second largest non-life insurance market. In 2010, revenue from premiums in the health insurance market rose to €1.95bn. This market has grown year-on-year until the customer base reached 2.3 million people (51.7% of the population) in 2008 (Department of Health and Children 2008). Due to the ensuing global economic downturn, these numbers fell slightly in the subsequent two years to just under 2.23 million people (49.8% of the population) in 2010. The belief is that in recessional times, with unemployment increasing, policy holders will have lost their jobs (which may include a healthcare policy) or policies have lapsed due to growing financial constraints. Why consumers are buying health insurance needs to be better understood, Wren (2006) infers that policy holders benefit from increased privileges and timelier care as a result of an insurance policy (The health insurance authority Annual Report 2010). This may explain a readiness to pay, the customer fearing that without insurance they are left vulnerable to the public system. Concerns over long waiting lists, poorer standards or less personalised care may contribute to the population’s underlying opinion of inadequate public hospital infrastructure in Ireland (O’Connor, 2007). It is therefore reasonable to suggest that the population’s perception of healthcare commodification has had a significant influence on the growth in insurance policies sold.

1.3 Regulation of Health Insurance in Ireland

The Irish health service has conventionally been confronted with inequalities in Irish society (Barrington, 1987; Nolan, 2001) therefore a regulatory environment acts as an imperative component in governing institutions in relation to financial services (Hughes 1994). A significant social concern is healthcare inequalities, which are intertwined with numerous components connected to social and economic inclusion (Barry, 2005). The Irish insurance market engages numerous stakeholders such as customers, underwriters (the insurance companies & government), financial regulators and ombudsman which has resulted in an intricate system, particularly in terms of regulation.

In 1992, the EU passed the Third Non-Life Insurance Directive, allowing health insurance
companies from any EU Member State to provide health insurance in Ireland. As a result, health insurers in Ireland were regulated differently, for example Vhi Healthcare was made exempt from prudential regulation (but obtained approval from the Minister for Health and Children in certain aspects of its business). As a result Vhi Healthcare is not subject to any solvency requirements. Laya Ireland is a subsidiary of BUPA Insurance Ltd, a UK company, which means the underwriting is subject to UK solvency requirements. VIVAS Health is the only health insurance company in Ireland regulated by the Financial Regulator that set solvency requirements.

1.4 Justification of the research

The research is justified as there is limited research looking at how the Consumer Protection code of 2012 supports the venerable customer. The research indicates that health insurance companies are unaware of their customers understanding of their health insurance policies. The aim of the research is to add to the existing pool of research that analyses how health insurance providers view, support and protect their customers. In the current economic climate health insurance providers should have a good understanding of their customer, gauging their satisfaction in order to maintain growth, demand and overall contentment with their policy (Kotler et al, 2008).

When reviewing the literature, the researcher identified areas where health insurance providers need to improve and gain knowledge on how they can enhance customer satisfaction, customer loyalty and overall consumer protection (Parasuraman et al, 1988, Seth et al 2005). Consequently the researcher will make recommendations as to how to minimise or eliminate malfunctioning aspects of the service in order to protect the vulnerable customer. These recommendations could prevent customer dissatisfaction, service quality failure and ultimately business failure (Kotler et al 1977).

There have been recent changes in the Irish consumer protection law, which has been implemented to protect the consumer; therefore assessing the consumers’ knowledge of this law is imperative to the research.
The Health Insurance Authority (HIA) was established in 2001 to monitor health insurance legislation and the associated regulations. The HIA’s power to enforce regulations is very limited and does not have the explicit function of protecting customers compared to other sector regulators, such as the Financial Regulator. For example, if the HIA believes the information provided by a health insurer to consumers is misleading, it only has the power to de-register the health insurer.

In recent years there has been further regulation in Ireland which has established a single financial service regulator made up of the Central Bank. This system has many distinctive issues in terms of regulating all types of financial services (Pellegrina and Masciandaro 2008), however in order to guarantee a reliable level of safeguarding for consumers the Central Bank has drawn up the ‘Consumer Protection Code’, which commenced in August 2006, which was subsequently revised and an Addendum issued in May 2008. The Consumer Protection Code was again amended and the updated legislation came into effective from 1 January 2012 (Appendix 2). The conditions of this Code are compulsory for all ‘regulated entities’, which must at all times comply when providing financial services. The Code relates to the ‘regulated activities’ of ‘regulated entities’ working in the State, including: insurance undertakings and insurance intermediaries.

The 2012 Consumer Protection Code introduced a new requirement in relation to the vulnerable consumer, outlining the identification of a vulnerable consumer as follows; Identification of a consumer’s vulnerability will require the exercise of judgement and common sense and should be based on a consumer’s ability to make a particular decision at a point in time. The code considers that identification of a vulnerability should be an inherent part of the knowing the consumer process, during which regulated entities should consider whether there is any evidence of consumer vulnerability, as outlined in categories 1, 2 and 3 below.

1.4.1 Categories of Vulnerable Consumers

1 Their ability to make decisions but their particular life stage or circumstances should be taken into account when assessing suitability for example; age, poor credit history, low
income, serious illness, newly bereaved, etc.

2 The customer’s ability to make decisions but require reasonable accommodation in doing so; hearing-impaired, vision-impaired, English not first language, poor literacy.

3 The consumers limited capacity to make decisions; temporary/permanent mental illness or intellectual disability.

Consumers that fall into Category One should have their circumstances taken into account by regulated entities as part of the revised ‘Knowing the Consumer and Suitability’ requirements.

The regulated entities must provide those identified as ‘vulnerable consumers’ with such reasonable arrangements or assistance that may be necessary to facilitate their dealings with that regulated entity.

The following review seeks to identify:

- The main problem(s) preventing customers from clearly understanding their health insurance policy
- A closer inspection of other factors in the insurance market from a consumer’s perspective (i.e. motivations for changing to an alternative health insurance company or changing policies)
- A review of consumer’s attitudes to health insurance (comprising of motivations for purchasing or ending their health insurance)
- Establishing whether the consumer protection code is widely recognised
- Determining whether the consumer knows how/where to complain to if they are Unhappy with their health insurance policy
- The identification of key trends amongst consumers and forthcoming trends.

This research will be of benefit to those buying health insurance and may also be of benefit to health insurance companies to improve the provision of knowledge to their customers. Other beneficiaries are hospitals and care providers in supporting vulnerable customers.
during a time of ill health. Through identification of the reasons why the consumer doesn’t understand their insurance policy, all bodies involved can seek to improve training and support for both staff and the consumer.

In January 2012 the ‘Consumer Protection Code 2012’ was introduced as a key priority for the Central Bank to strengthen the consumer protection framework. A range of significant points were addressed in areas of concern to ensure that consumers are adequately protected in their dealings with financial entities. These enhancements include additional protections for vulnerable consumers, therefore the following literature review will address some of the possible vulnerabilities associated with healthcare in Ireland.

The Literature Review will critically review three main areas; Irish health service and the health insurance industry, the ethics of commodification and the regulation of health insurance in Ireland. The research will also investigate the implementation and success of the new legislation from the Central Bank ‘The Consumer Protection Code 2012’ in relation to the provision of health insurance to the ‘vulnerable customer’.

1.5 The background to the research problem

Whilst healthcare has become an extremely high-profile and politically sensitive topic, health insurance has only recently become part of the debate. There has been political debate regarding “insurance for all”, either via social insurance or subsidised private insurance, which is a new concept addressed by the current Minister for Health James Rielly. The slogan “everyone should be a private patient” illustrates that having 50% of the population with insurance alters the context of such an argument. It will arguably be difficult to move forward when “insurance for all” means very different things to those advocating it and clarity about who would gain and who would lose out has not yet been addressed. Consumer culture is fundamentally linked to an ethos of difference, which is a dividing force in society (Baudrillard, 1998). In the current economy, where people are making difficult decisions on how to spend their limited income, one area many consumers will be addressing is health insurance affordability and value for money.
Having worked in healthcare for many years the researcher has observed that a significant number of patients do not understand their insurance policy. Therefore it is evident that customers are buying health insurance products/policies without a clear understanding of what level of cover they have purchased. This can be a distressing situation for the customer/patient during a time of vulnerability, which raises many ethical questions such as; how has the customer purchased a product without having a clear understanding of the cover provided? Are these uninformed purchasing decisions due to the buyer’s lack of prior research or are the insurance companies neglecting to provide a clear outline of the level of protection they are providing on an individual level?

The research problem wants to examine and identify if there is a lack of consumer knowledge surrounding health insurance, the fundamental reasons why consumers initially buy health insurance and the influencing factors why the consumer may discontinue their health insurance policy.

1.6 Background to the Hypothesis

This research is attempting to understand and explain why consumers purchase health insurance in a country with a first world public healthcare (O Connor 2007) system during a period of economic austerity. The researcher is interested in using current research and knowledge of consumer buying influences to investigate why people are buying health insurance.

The researcher will examine the literature looking at consumer behaviour in purchasing, why they remain loyal to a product or service and what are the main influences surrounding consumer behaviour. The body of research which exists on the similar constructs i.e. ‘consumer buying’ was important in providing the foundation on which to build the current study.
1.6.1 Hypothesis

To establish why consumers buy health insurance the hypothesis is:

1. Consumers are buying health insurance out of fear of poor standards of public health care and is that it is necessary to have health insurance as a priority in seeking out adequate healthcare.

2. The customer does not have a clear understanding of the health insurance policy they have purchased.

1.7 Research Aims and Objectives

The purpose of this research sets out to assess what influences consumers in their purchasing decision, and subsequent up-keep, of their health insurance policy. It will also determine whether the new legalisation ‘The Consumer Protection Code 2012’ is protecting and supporting the customer in understanding their health insurance policy and what are the main reasons people choose to purchase health insurance?

1.7.1 The objectives of this research are to:

1. To assess consumers attitudes towards health insurance, comprising of motivations for purchasing and ending health insurance policies
2. To identify the main problem(s) preventing the customer from clearly understanding their health insurance policy
3. To provide an insight into components of the insurance market from a consumer perspective; i.e. looking at motivations for changing to an alternative health insurance company
4. To gauge whether the consumer is aware of the Consumer Protection code 2012
5. To ascertain whether the consumer understands how/where to complain if they are unhappy with the service and support provided by their health insurer
6. To identify key trends amongst consumers and insight into forthcoming trends
1.8 Research Scope

The scope of the research is to meet the outline objectives through conducting qualitative and quantitative research, testing the hypothesis and to identify areas for improvement. The research will focus on a selected private hospital based in Co. Dublin. For confidentiality reasons the identity of the hospital will remain anonymous and is only referring to as ‘the hospital’.

1.9 Suitability of the research

As a qualified nurse the author has both a professional and personal interest in the subject of health insurance. The author was granted permission to have access to the hospital staff to participate in the research, maintaining confidentiality at all times.

1.10 Recipient of the research

The study will be submitted as part of the part-time MBA programme at the Dublin Business School in association with Liverpool John Moore University, who are the primary recipient of this study.

1.11 Approach to the research

The research question, the objectives and the hypotheses were continuously developed during the research process, supported by undertaking a secondary data collection through the review of relevant literature. The researcher also carried out primary quantitative data collection by conducting interviews and administering an impartial and anonymous questionnaire. The findings are represented in Chapter 4, utilising in graphs and diagrams to provide explanations of the findings.
1.12 Organisation of the Dissertation

This dissertation comprises of six chapters, of which the content is outlined below:

Chapter 1 - The Introduction Chapter

This will provide a preliminary understanding to Irish health care and the prevalence of health insurance, health insurances role in Irish health care and the history of health insurance law. This chapter will identify the hypothesis that firstly consumers are buying health insurance out of fear of poor standards of public health care and is that it is necessary to have health insurance as a priority in seeking out adequate healthcare. Secondly, the customer does not have a clear understanding of the health insurance policy they have purchased. The purpose of this research is identified setting out to assess what influences consumers in their purchasing decision, and subsequent up-keep, of their health insurance policy. This chapter will also give an overall view of the new legalisation ‘The Consumer Protection Code 2012’ and its role in protecting and supporting the customer in understanding their health insurance policy and what are the main reasons people choose to purchase health insurance.

Chapter 2 - The Literature Review

This chapter will explore a range of research material available on the study of health insurance in Ireland. The review will address; consumer behaviour, consumer needs and wants, pricing and positioning, switching, consumer retention and loyalty, brand preference and product attribute, consumer economic issues and the ethics of commodification. This literature review will set the scene for the background of the research and add validity of studying consumers buying health insurance.

Chapter 3 - The Methodology and Methods

This chapter will address the methods of research used and justify their appropriateness.
The researcher clearly defines the research approach and justification. The census method was chosen and demonstrated through the use of in-depth interviews and the administration of questionnaires. Survey Monkey, and IT system was used to analysis the data and to graph the findings. The processes of achieving the data are clearly outlined throughout this chapter.

Chapter 4 - Data Findings and Analysis

This chapter will address the findings of the research undertaken by the researcher. The aim of this chapter is to establish relationships and trends within gathered data from the semi-structured interviews and the questionnaires. The researcher aims to address each objective separately using the findings from the interviews, the questionnaires and the support from relevant research undertaken. This chapter will analyse the research objectives, which in turn will lead to answering the hypothesis.

Chapter 5 – The Conclusions and Recommendations

This chapter will address the conclusions and recommendations as per the findings which are that, consumers are buying health insurance out of fear of poor standards of public health care and is that it is necessary to have health insurance as a priority in seeking out adequate healthcare, and the customer does not have a clear understanding of the health insurance policy they have purchased. Following the gathering of quantitative and qualitative data the researcher proved that the hypothesis was right. According to the research findings it can be seen that the consumer is influenced by fear, fear of a poor public health service and fear of if they become ill the most effective way to obtain healthcare is by having a health insurance policy. The data also identified the customers lack of understanding relating to their health insurance policy, many had received bill for which they thought their health insurance had covered, proving a lack of understanding. Many had little knowledge on switching policies or insurance providers, again highlighting a lack of understanding of health insurance in general.
Chapter 6 – Self-reflective Learning

This is the chapter whereby an examination of the learning, which has occurred throughout the dissertation process, is discussed. The undertaking of the MBA was a challenge for the researcher and the particular experiences of this process is addressed by reflecting on many areas of learning including; Skills Learning Styles, Personal Development Planning, Research Organisation, Influences of own learning styles on research, Critical Experience and learning, Application of Learning and Lifelong learning. The researcher has gained not only new academic ability from doing the MBA but also personal strength by facing up to challenges and goals, even when times were tough and the challenges were deemed as to great. This chapter allows the researcher to reflect on the overall experience of personal and professional growth.
Chapter 2

2.0 The Literature Review

2.1 Introduction

This Literature Review will seek to provide contributions to current knowledge; a foundation for further research, providing direction to the relationship between consumers’ buying criteria and their health insurance policy. The Literature Review endeavours to address the main research objectives, as outlined in the Methodology; identify the main issues(s) preventing customers from clearly understanding their health insurance policy, a review of consumer’s attitudes to health insurance (comprising of motivations for purchasing or ending their health insurance), an insight into the health insurance market from a consumer’s perspective with an emphasis on the motivations for changing to an alternative health insurance company (switching), identifying if the consumer protection code is widely recognised, determining whether the consumer knows how to/where to complain if they are unhappy with their health insurance policy and finally the identification of key trends amongst consumers and forthcoming trends.

In January 2012 the ‘Consumer Protection Code 2012’ was introduced as a key priority for the Central Bank to strengthen the consumer protection framework, incorporating additional protection for vulnerable consumers. The following literature review will address some of the possible vulnerabilities associated with healthcare in Ireland. The study of consumer buying behaviour is therefore of utmost importance for many reasons, which will be examined in greater detail throughout this chapter. It is important to recognise that consumer behaviour can influence the economic health of a nation (Blackwell et al., 2006).

The Literature Review will critically review the key concepts of; consumer behaviour, consumer needs and wants, pricing and positioning, consumer economic issues, branding preferences and product attributes, consumer retention and loyalty, switching and the ethics of commodification, all of which are in keeping with the key objectives of the research.
2.2 Consumer Behaviour

Consumer behaviour encompasses more than just how people buy goods and services, it also refers to the process in which people obtain, consume and dispose of goods and services (Blackwell et al, 2001). The purchasing of health insurance is a process based on consumer behaviour. These processes are driven by decisions around which policy to buy, which insurer to buy it from and the type of the policy cover required. It is therefore vital to understanding the set of decisions (what, why, when, how much and how often) the consumer makes that influences their purchasing behaviour (Hoyer et al 2004). The rationale as to why consumers buy certain products is often rooted in their minds; as a consequence consumers are not always aware of what affects their purchases. “Ninety-five percent of the thought, emotion, and learning [that drive our purchases] occur in the unconscious mind that is without our awareness” (Armstrong et al. 2005). Therefore how a consumer acts is significantly influenced by his or her insight of the situation; how an individual acts and reacts is based more on their perceptions and less on the basis of objective reality (Kelley, 1950).

There are many purchasing decisions made by consumers when buying health insurance, after evaluating the offers available to them. Schiffman and Kanuk (2000), describes consumer behaviour as how consumers make their purchasing decisions with the use of the available resources such as time, money and effort. It is also recognised that consumer behaviour is influenced by personal characteristics such as the consumer’s age, occupation, economic situation, lifestyle, personality and self-concept (Kotler 2001). All people as individuals have a unique personality of different characteristics, such as self-confidence, dominance, sociability, autonomy, defensiveness, adaptability, and aggressiveness and an individual’s demand for products shifts depending on occupation, financial situation and their stage in life (Blackwell et al. 2001). Armstrong et al. (2005) supports this argument suggesting that a person’s lifestyle affects his/her activities, their interests and opinions also affect their choice for products.

When customers commence consuming or using the products purchased it is then
customers appraise the products bought, giving rise to levels of satisfaction; when consumer’s expectations are greater than the suspected performance and vice versa (Blackwell et al., 2006). Rayport and Jaworski, (2001) identify this stage as crucial because customers may make repeat purchases provided they are content with the aforementioned stages. Therefore if products are not up to the standard of customer expectations, then discontentment will result, often in the form of unfavourable reviews particularly on the internet.

The internet has had a revolutionary influence on consumer behaviour, allowing comprehensive product research and instant purchasing of products available to them online. Rayport and Jaworski (2003) concur that the power of the internet on the consumer purchasing decision has changed significantly. Uusitalo (2001) suggests this new medium, which allows non-shop purchasing, as replacing the regular catalogue and TV shopping and its expansion has been rapid.

Another factor affecting consumer behaviour is social grouping, which is composed of small groups, social roles and status. Every person plays multiple roles in their daily life; professional role, family or social role, and each of these roles have a certain effect on consumer buying behaviour. Each role has a particular status in society and consumer behaviour is considerably depended on this status factor, choosing products which can enhance their standing.

Some of social groupings have a direct influence on a person, i.e. membership groups, groups that a person can belong to (Kotler et al. 2005), and reference groups which “serve as direct (face-to-face) or indirect points of comparison or reference in forming a person’s attitudes or beliefs” (Armstrong et al. 2005). The influence from groups tends to be higher when purchasing an expensive, luxurious ‘status symbol’ product which will be seen by friends and acquaintances (Kotler et al, 2001). The industry has considerable interest in ‘family’ buying behaviour. It is one of the most important consumer segments of society and it targeted extensively.
2.3 Consumer Needs and Wants

There is a ‘need recognition’ which occurs when an individual is aware of a difference between their perception and the actual satisfaction level (Solomon et al., 2006). People regularly identify things they need or want, and block the view of unneeded or unfavourable stimuli (Hornik, 1980). The explanation of stimuli is highly subjective and is centred on what the consumer expects to see in light of previous experience, its motives and interests at the time of perception. The distortion of an objective interpretation is mainly due to the physical appearance, the first impression and stereotypes (Kelley, 1950).

Maslow (1971) theorised that, there is a hierarchy of human needs, which he identified as; physiological needs, safety needs, belongingness needs, esteem needs and self-actualisation needs. His theory reviews how humans seek to progress through the stages of the hierarchy and, as needs are satisfied at one stage, they move to the next level to prevail. However Abubakar et al (2001) suggests that satisfaction is a post-purchase appraisal, where customers are influenced by their overall experience. As far as the consumer decision process, consumers need to go through many steps before reaching their final decisions. These steps include need recognition, search for information, pre-purchase, evaluation, purchase, consumption, post-consumption evaluation and divestment (Blackwell et al., 2006).

The buying process is initiated when people recognise their unsatisfied need (Levy and Weitz, 1992). There are two kinds of needs; explicitly functional needs and psychological needs. Functional needs are related to the performance of the product whereas psychological needs are intrinsically obtained when customers feel contented with shopping or owning a product which they long for. Nonetheless perception of product performance on the salient attributes is more important than actual performance (Mason & Bequette, 1998).
2.4 Pricing and Positioning

Price is typically the most valuable metric used by consumers to appraise a product. Price can at times be a gauge of quality; with a higher price indicating higher quality (Mowen & Minor, 1998). Porter (1985) argues that companies can create value by providing lower price, or unique offers, to the customers to exercise their competitive advantages over others. Consumers distinguish that a higher price can be attributed to the higher cost of quality control, a task that is often achieved by spending significantly more on advertising.

Many consumers are extremely price sensitive (elastic demand), whereby a high price may swing consumers towards more cost effective competitor brands (Mowen & Minor, 1998). Therefore price can have a positive or negative influence on customers. When a product is a “high-price relative to competing brands, it is likely to receive more brand-building media advertising to support its higher-price position; on the other hand, when a product has a lower relative price, it is more likely to receive a greater allocation to sales promotions” (Low and Mohn, 2000, p393).

Another view to consider is that the overuse of sales promotions may decrease a consumer’s price expectations, a risky outcome for high-priced brands (Low and Mohn 2000). It should also be recognised there are other variables impacting on the consumers choice including price, location, convenience (McIlroy and Barnett 2000). Moore and Carpenter et al (2006) propose that a consumer can differentiate price in both a positive and negative way, both influencing their buying behaviour. When price is seen as a positive indicator, it indicates quality or status and in its negative role price is perceived as poor quality or as a loss leader. In both roles opinion of price operates as market indication that assist the consumer in their decision making process within increasingly complex market situations.

Consumer price behaviour is affected by different degrees of purchasing involvement. Stamer and Diller (2006) recognises that there are circumstances where probability and importance of losses are high, consumers will recognise high purchase investment and
adjust their spending behaviour to lessen the risk and at the same time the price behaviour will provide guidance relating to price ambiguity or quality uncertainty, depending on the significance the consumer puts on the price or quality attributes to the product or service. Sirohi et al (1998) suggests that the most successful way to increase a customer’s intention to purchase or a customer’s willingness is to improve the perception of value in the eyes of the customer.

2.5 Switching

There are evaluations that consumers use to compare different products and brands to make purchasing decisions, which may encourage them to switch to a new product or brand. Consumers pay particular attention to the attributes which are most relevant to their needs (Kolter et al., 2005). In a diverse and mature marketplace, consumers will always have the choice and opportunity to alter their shopping behaviour; this often results in customers switching between brands. Negligible consumer switching costs places enormous pressure on retailers to secure customers. Extensive choice results in limited levels of product differentiation, thereby pushing larger retailers into competitive pricing policies. Price wars are becoming more frequent, intensified by the increasing customer awareness on product costs through the use of internet price comparison sites and product advertising. The basic dependency gives rise to aggressive competition (Datamonitor 2009). Whilst some companies operate in other industries that can absorb the temporary impact of declining sales, or high supply prices, for many retail lies at the heart of business.

In light of competitive shifts in the health insurance industry, it is crucial for insurance providers to gain a better understanding of the insurance customer. If consumers are using price as a driver for their purchasing decisions it is crucial that providers align their pricing strategy with the overall direction of the firm. A pricing strategy should be consistent with existing functional strategies that communicate the retailer’s overall value to the customer; promotional strategy, brand strategy and merchandising strategy (Moore and Carpenter 2006). A wide range of factors are identified as being the drivers of future change in a consumer’s needs, demands, expectations and as a result reasons to switch (Jones et al
Attributes like quantity, size, quality and price are commonly used to judge a brand by customers. Any changes in these attributes can affect consumer decisions towards switching brand or product loyalty (Blackwell et al., 2006).

2.6 Consumer Retention and Loyalty

Customer loyalty could be expressed as a customer’s commitment to do business with a particular organisation, purchasing their goods or services repeatedly and recommending the services or products to friends and associates (Mollroy and Barnett 2000). Satisfaction is a necessary, but not exclusive, condition of the loyalty established when a consumer makes a commitment to a brand. The main benefits of customer loyalty to an organisation are lower sensitivity to pricing levels, reduced expenditure on attracting new customers and improved organisational profitability (Rowely 2005). A loyalty programme can be defined as a “marketing strategy based on offering an incentive with an aim of securing customer loyalty to a retailer” (Gomez et al 2006). The thoroughness of the programme varies for different customers, depending on a number of variables such as personality, social class, income, size of purchase, past experiences, prior brand perceptions (Moorthy et al., 1997), as well as customer satisfaction.

Mowen and Minor (1998) suggested that industry leaders must understand the attributes that their customers expect in a product and how positively or negatively these attributes were values, to help develop and promote a successful product. Health insurance companies need to be knowledgeable of the key product attributes perceived to be the most important by each individual consumer group, in order to build and maintain market share (Warrington & Shim, 2000). A consumer’s attitude always has a perception of various physical and social objects including products, brands, models, stores and people. Consumers also have attitudes towards imaginary objects such as concepts and ideas (Peter et al, 1999), beside their experience of past actions and future behaviour. In this way consumers behave to choose the final product which best meet their needs and expectations, influencing their decisions to stay loyal or not.

Loyalty to brands is currently low, with media advertising becoming generally ineffective,
increasingly being replaced by word-of-mouth recommendations by friends, family (Jones et al 2008) or product reviews available online. It is widely recognised that consumers learn about products to purchase from friends, family members, through advertisements and from their own experience. Therefore the degree of consumer effort in searching for information is affected by physiological factors namely; motivation, perception, learning, and beliefs & attitudes (Armstrong et al 2005).

Increased customer retention has two main significant effects on retailing. Firstly it can lead to a gradual increase in a company’s customer base, which is vital in the era of low sales growth. Secondly, the profits earned from each individual retained customer grow the longer the customer stays loyal to the firm (Sirohi et al 1998). Capizzi and Ferguson (2005) state that ‘loyalty marketing’ is a mature discipline that has come full circle; it is now poised to enter a period of renewed growth and creativity. As a result loyalty marketeers face the challenge of reinvigorating the market with new strategies and tactics, backed by an innovative and creative marketing campaign.

Consumers typically have their preferences, purchasing products from a specific retailer, and hence the remaining retailers are selected using the rule of ‘survival of the fittest’. On a larger scale, consumers’ buying decisions provide an indication as to which industry will survive, which companies will succeed and which products will excel in the market place. Shopping is viewed by many as an enjoyable recreational experience, for others it is purely a necessity to be accomplished in the shortest possible time. Consideration needs to be given to the fact that the motivation of a consumer reflects the need for the actual product or service, necessity is ultimately the decisive factor when consumers choose a product or service.

Through an understanding of the reasons for consumers buying the products and their buying habits, health insurance companies can utilise such information to devise corresponding marketing strategies in response to the consumer’s needs (Blackwell et al 2006). For instance, tailor-made products can be produced to enhance customer value and thus facilitate repeat purchase, despite price sensitivity in the market (Gabbott and Hogg 1998). Moreover, present consumer behaviour studies regard consumers as important
determinants of organisational success and it is found that the most successful organisations are customer-centric (Blackwell et al 2006).

2.7 Brand Preference and Product Attribute

Consumers gather information from their environment, using their learning processes to create a framework which guides them in their buying behaviour (Blackwell 2001). The most effective component of this information gathering is a product’s evaluation in terms its general ‘favourableness’. Purchasing attitudes are a predisposition towards specific identifiable brands, products or companies that cause consumer to remember and respond favourably or unfavourably towards them (Assael, 1992). Each consumer determines which attributes are most relevant, and therefore important, to them. Different consumer groups place different importance on different attributes (Warrington & Shim, 2000). Romariuk & Sharp (2003) suggested there are two objectives of brand building, short-term and long-term. In the short term, health insurance companies need to identify specific attributes to be communicated to the consumers, based on which message gives the best results - the key aim is to develop likeable advertising. In the long-term, health insurance companies should strive to build up a ‘bank’ of consumer perception about the brand to make it the one most often thought of during the buying process, making it difficult for competitors to have access to the minds of consumers (Romariuk & Sharp, 2003).

Advertising brand messages are interpreted differently among different genders (Maldonando et al 2003; Putrevu, 2001), and earlier studies have demonstrated that females were more likely to engage in embellishment than men (Maldonado et al 2003), rather than purely information lead advertising. Biehal et al (1992) argue that, whether a consumer likes or dislikes an advertisement does not necessarily result in brand approval or rejection. Even when customers like an advertisement they see/hear, it does not inevitably indicate that they will buy the brand advertised. Regardless of the content, advertising for brand leaders is more lucrative due to the recognition and persuasiveness of the brand (Putrevu 2001). Two individuals may be subject to the same advertising stimuli, under equivalent conditions, but recognise, organise and interpret the advert’s message in
completely different ways. Hogg et al (2003) established that when women were asked to recollect advertising messages, they paid more attention to the characters in an advertisement. This may be justified by the fact that females have a superior ability to consider and process large amounts of secondary information.

Women are ‘comprehensive processors’, trying to gather all available information about the product. Alreck et al (1999) proposed six strategies in building brand; Association - arguing that the product or brand is linked to need through repeated messages. He identifies Mood Associations as, brands should be associated with good feelings through slogans, songs etc, subconscious Motivation as the use of symbols to excite consumers’ subconscious motives, while behaviour Modification is that consumers are conditioned to buy the brand by controlling cues and reward schemes, then cognitive Processing is the penetrating perceptual and cognitive barriers to create favourable attitudes towards the brand or product and model Emulation is the portraying of idealised lifestyles for consumers to desire and imitate.

Vasquez et al (2001) suggested that consumer assessment of a product can be broken down into evaluation related to product (tangible or physical attributes) and brand name (intangible attributes, or images added to the product due to its brand names). Product attributes are characteristic that an object may or may not have and includes both intrinsic and extrinsic features (Mowen & Minor, 1998). People seek products that have attributes that will solve their problems and fulfils their needs (Mowen & Minor, 1998). Understanding why consumers choose a product based upon its attributes is vital to health insurance companies in order to understand why consumers have preferences for certain brands over others (Gwin et al 2003). Mason and Bequette (1998) argue that perceptions on product performance, based on prominent attributes, are more imperative in manipulating the consumer purchasing behaviour than definite product attribute performances. Myers (2003) agrees that brand value is more influenced by attribute knowledge rather than consumer preference.

The brand name is a crucially important attribute of any product. Brands have both functional (product-related) and symbolic dimensions (Vazquez et al 2001), the product-
related benefits are that consumers evaluate product performance based on its capabilities, usage effectiveness, value for money and reliability. Symbolically, the purchase and consumption of products is increasing regarded by consumers as an indirect way of communication to improve their self-image and deliver certain impressions to other people in their environment (Vazquez et al 2001), rather than the direct benefits the product has personally. As such, brand name benefits are perceived by consumers as highly interrelated to the product-based benefits. Big brand means a better image and a better product (Vazquez et al, 2001), however, as mention earlier, Mason and Bequette (1998) suggested that perceived product performance is more important than actual attribute performance.

Similarly, Myers (2003) concluded that brand equity might be influenced by attribute knowledge more than consumer preference. This may be due to consumer bias and prejudice, Consumer’s product evaluations are inevitably influenced by memory. However customer bias can be reduced by providing current information, experience and knowledge to replace a historical predisposition or assumption (Mason and Bequette, 1998). It’s not surprising that the brands which consumers believe offer superior value are the those brands which are preferred and chosen often (Myers, 2003). Brands with higher equity resulted in greater preferences and subsequently a higher market share. There is no evidence that certain attributes are more related to customer loyalty than others (Romariuk & Sharp, 2003). It was, found though, that the more attributes (non-negative) associated with a brand, the more loyal the customer (Romariuk & Sharp, 2003).

2.8 Consumer Economic Issues

Ireland’s poor economic conditions in recent years has led to reduced levels of personal income, which consequently has brought an overall tightening in spending; this is something we hear about on a daily basis in the media. Events and forces in the consumers’ environment, such as change in the economy, technology, politics, and culture will affect their buying incentives, all effective in changing consumer knowledge, attitude and behaviour (Evans, Moutinho & Van Raaij, 1996). Increasing numbers of people have taken
pay cuts or are losing their jobs and there is less disposable income to spend. Retail margins remain low and competition is demanding for manufacturers and service suppliers, evidence of this is the introduction of more health insurance companies in recent times, such as GLOW and LAYLA. In response to aggressive competition, companies selling goods and services are diversifying their product line, in order to compete and offer more value for money (Carpenter and Moore 2006). Consumers are increasingly torn between value for money and meeting their individual needs in the process. In a recessionary period, characterised by increasing retailer power, it has become more likely for brand manufacturers to compete through cutting advertising spending and increase price promotions (De Chernatony et al, 1991). During difficult economic times, brand investment is ‘eroded’ as is the ‘added values that distinguished between brands’ which in turn empowers consumers to shift the allegiance to the equivalent store brand and allowing the retailer to compete with national brands on a physical and psychological level (De Chernatony et al, 1991).

As economic prospects worsen in Ireland we see the growth of new health insurance companies wanting to take a share of the market. However the Irish economy remains in recession, unemployment in at an all-time high. The severe down-turn, which does not appear to be improving at present, will have an impact on how consumers spend their money. Health insurance providers need to re-assess the needs of their customers.

2.9 The Ethics of Commodification

Commodification is the alteration of ideas, goods or other entities not necessarily viewed as goods, into an article of trade. Nolan and Wiley (2002) describe it as a conversion of a service or an object into a creation that can be bought and sold for profit.

Wren’s (2003) portrayal of a two-tier system is evident in the commodification of Ireland’s healthcare, describing it as a unique failure in providing care when needed by all citizens. Many critics argue that commodification may create a threat to essential social values (Nolan and Wiley, 2002), particularly in the current recessional times when expenditure cutting is paramount (Cerny, 2008; Plehwe et al, 2007). Unequal access to treatment, based
on private or public status, regularly presents itself in the dialogue surrounding the two-tier health system. It is arguable that customers are put in a vulnerable position, fearing the potential negative impact on their long-term health if they do not invest in an insurance policy. There is much anecdotal evidence in the media highlighting public hospital waiting times, suggesting it is foremost in people’s minds for those with and without insurance. Essentially the belief is that timely hospital care, without undue waiting, from a medical consultant of their choice is only possible if with investment in insurance cover. Therefore this perception of timely, high quality private care is the main driver driving demand for health insurance.

Marx widely criticised commodification, with the most extreme case of commodification being slavery, where humans become the commodity. It can be argued that the privatisation of healthcare, being only available to those who can afford it, is essentially buying and selling a person’s health. Baudrillard (1998) identified the body as the premium consumer object, becoming a unit of salvation in consumer societies. According to the consumer character, ‘needs’ often compel for a display of value for money and a reassurance of correct decision-making (Bauman, 2000). Arguably, the motivation to pay for healthcare is entrenched in a belief that the individual shrewdly prepares for their own destiny, through consumer choices as opposed to state generosity (Bauman, 2000). It is also becoming more apparent that health services are no longer allocated according to necessity but rather for fiscal profit.

Rising numbers of private hospitals have inspired debate surrounding the existence of health markets in Ireland (O’Connor 2007). Private hospitals tend to focus on profitable niches within healthcare and typically avoid providing basic care and emergency services to patients (Wiley, 2007). Private hospitals also avoid the costly and risky essential health services that are provided by public hospitals. O’Connor (2007) describes private hospitals as over specialised, fragmented and de-personalised. They are in a position to ‘cherry pick’ profitable and low-risk treatments and, as a consequence, private patients are forced into the public system for critical and emergency care (O’Loughlin 2002). Private hospitals are built on low cost, profit making foundations, therefore putting pressure on areas such as quality, staffing numbers and up-keep in the face of profiteering priorities.
The transfer of social services, from a state run capacity to private markets, represents an amendment of social rights and entitlements (Baudrillard, 1989). A profit enticement may obscure ethical thoughts in goodwill of the patient being treated (Baudrillard, 1989). The presence of profit incentives within medical practice conjures up many ethical questions and uncertainties for the consumer, due to their status as outsiders (O Connor 2007).

Healthcare’s change from a ‘right’ to becoming a commodity, to be profited from, raises contentious questions regarding a patient’s access to treatment and the quality of the treatments offered. As a result of this shift in public opinion, and the healthcare market, it is essential that regulation supports consumers when choosing the appropriate healthcare option. Due to the number of healthcare options, levels of cover and multiple providers, choosing a healthcare option is extremely complex and often confusing for the customer. Clear legislation is required to ensure policy guidelines that support customers, particularly those most in need of healthcare; the ill, elderly and vulnerable.

2.10 Conclusion

Based on my literature review, there appears to be a gap in the research that explicitly considers the issue of the vulnerability of the customer when buying health insurance. There is a relatively small body of work which has addressed the issue indirectly, through discussion of the inequalities of health care and the rationale in why customers feel the need to buy health insurance. The research fails to give explicit attention to issues of the customers understanding of the policies they are buying, such as what the policies cover them for and whether they are covered in a private or public hospital. This indicates the need for further research to ascertain the customers understanding of what they know about health insurance cover, raising awareness of the underlying structural causes of inequality and injustice.
CHAPTER 3

3.0 Research Methods & Methodology

3.1 Introduction

In this chapter, the research enquiry is declared and built upon. The research design, implementation and analysis required to test ‘the knowledge of the customer when purchasing their health insurance policy’, in an unbiased manner is outlined. Individual differences exist between research methods and research methodologies (Denscombe, 2002). ‘Methods’ refer to techniques and procedures used to obtain and analyse data (Bryman et al, 2011, Saunders et al, 2009), while methodology refers to the theory of how the research ought to be undertaken (Saunders et al, 2009). However there are arguably different meanings of methodology as Fisher (2004) states; it is a study which raises all types of philosophical questions for the researcher to know and check the validity of their knowledge. Whereas Riley et al (2005) argue that there are always trade-offs and compromises in choosing a research method.

This chapter examines the methods and methodologies for collecting data by peeling the layers of the “Research Onion” (Figure 8) (Saunders et al, 2009), especially; identifying the research problem, choosing the objectives of the study, developing the research question, reviewing the related literature, choosing the research methodology and methods which will be worthwhile when answering the research question. The chapter will set out to describe the data collection instrument, namely interviews and a questionnaire, the advantages and disadvantages of both, followed by a justification for selecting this particular approach from among possible alternatives. Details of the approach used and conditions under which the various stages of investigations were carried out, development of initial contacts, pilot survey, and design of main research instrument (questionnaire) will be addressed.
The sampling method used will also be discussed and the limitations of the study design will be examined. Finally the ethical issues relating to the research are to be addressed and a summary of the chapter presented and the research methodologies used are discussed. The research design can be described as an outline of the research, with an aim of addressing approximately four main problems: what questions should be studied, what data is applicable, what data to gather and how to analyse the data to seek out results (Yin, 1994).

![The Research Onion](image)

Figure 8: The Research Onion: Source Saunders et al (2009)

### 3.2 The Research Philosophy

The philosophical level of a research method communicates its assumptions, establishing the most universal features of the world, encompassing such aspects as the mind, reality, truth, reason, matter, nature of knowledge, and proof of that knowledge (Hughes, 1994). The research philosophy is a phrase linking the expansion of knowledge and the nature of that knowledge (Saunders et al, 2009), and is separated into three views; Ontology is the view of the nature of reality or being, Epistemology is the view regarding what constitutes acceptable knowledge, and Axiology is the view of the role of values in research (Saunders et al, 2009).
3.2.1 Epistemology

The epistemology research view is divided into four philosophies; positivism, realism, interpretivism and pragmatism (Saunders et al, 2009). Epistemology (what is accepted to be true) compared to doxology (what is believed to be true) addresses the many philosophies of research. The motivation of this research is to focus on the development of transforming things ‘believed to be true’ into things ‘known to be true’ (Galliers, 1991). Saunders et al (2009) argue that in the majority of cases of research a combination of positivism and interpretivism is used.

3.2.2 Positivism

Positivism is a structured approach and helps to test the theory (Saunders, et al, 2011). Positivists trust that reality is stable and functional; it can be explained from an objective point of view, without interfering with the phenomena being studied (Levin, 1988). "Positivism has a long and rich historical tradition. It is so embedded in our society that knowledge claims not grounded in positivist thought are simply dismissed as a scientific and therefore invalid" (Hirschheim, 1985, p.33).

It is therefore reasonable to propose that predictions can be made based on observations of how customers buy and use their health insurance policy. Quantified and generalised interpretations will be made when collecting the data, which will be analysed statistically (Saunders, et al, 2011), as it is a quantitative research approach (Denscombe, 2002) and deductive in nature (Saunders, et al, 2011).

3.2.3 Interpretivism

Interpretivism argues the need to recognise the differences between humans in their role as social actors (Sunders et al, 2009). It is entirely a qualitative approach (Denscombe, 2002). This perspective is appropriate when under taking business and management research (Saunders et al, 2009).
3.2.4  Realism

The Realism philosophy shapes and tests hypotheses addressing patterns of relationships between selected data and hypotheses, and are treated as potential explanations as opposed to fixed laws (Fisher, 2004). Realism employs a scientific system for creating knowledge (Sunders et al; 2009). It is additionally divided into Critical Realism and Direct Realism (Sunders et al; 2009).

3.3 Research Philosophy Choice

The author will concentrate on a ‘Pragmatist’ approach, this approach aids to collect and interpret data (Saunders et al, 2009). The justification for this selection is that it is regard as the philosophical companion for the mixed methods approach (Denscombe, 2002), as it imparts a set of assumptions about knowledge and enquiry that are created on the mixed methods approach (Saunders et al, 2009). Riley et al (2005) argues that the only variant between positivism and interpretivism is based on a universal desire to understand behaviour, whereas both methods make different assumptions of the world of phenomena. It is therefore possible to work within both positivism and interpretivism positions, and refer to it as pragmatism (Saunders et al 2009).

3.4 Research approach

There are two research approaches existing in research; inductive and deductive (Saunders et al 2009). The classification of the research approach in terms of whether it is deductive or inductive is essential (Crotty, 1998). Differentiating between these two-research designs is important to this study.
3.4.1 Deductive

The deductive approach allows for the testing of a theoretical proposal by employing a strategy intentionally designed for the function of its testing (Saunders et al, 2009). There are six stages to this approach; theory, hypothesis, data collection, findings, hypothesis confirmed or rejected and revision of theory (Bryman et al (2011). The researcher will go on to apply a deductive approach to this research study as this approach allows for the use of more than one method of data collection.

3.4.2 Inductive

The inductive approach allows for the development of a theory as a result of observation of empirical data (Saunders et al, 2009).

3.5 The Research question

What is the customer’s knowledge of ‘The Consumer Protection Code 2012’ and do they have a clear understanding of their current health insurance policy.

3.6 The Research objectives

1. Assess consumer attitudes towards health insurance, comprising of motivations for purchasing and ending health insurance policies
2. Identify the main problem(s) preventing the customer from clearly understanding their health insurance policy
3. Provide an insight into components of the insurance market from a consumer perspective; looking at motivations for changing to an alternative health insurance company
4. Gauge whether the consumer protection code is widely recognised
5. Ascertain whether the consumer understands how/where to complain if they are unhappy with the service and support provided by their health insurer
6. Identify key trends among consumers and insight into forthcoming trends

3.7 Hypotheses

There are two different hypotheses defined by Saunders et al. (2009); a testable proposition stating that there is a significant difference or relationship between two or more variables, or a testable proposition about the relationship between two or more events or concepts.

3.7.1 The hypotheses for this research

Gaps exist between what customers expect and understand from their health insurance policy and what the Consumer Protection Code 2012 says they should understand.

3.8 Research Strategy

The strategy is a broad plan of how the author will answer the research question (Saunders et al., 2009), or a general course on how to accomplish the business research (Bryman et al., 2011).

The researcher will use two methods of data collection: qualitative and quantitative, through the administration of questionnaires and by conducting in-depth interviews.

For the purpose of this research the author will use the survey strategy, a common strategy in business research (Saunders et al., 2009). The researcher divided the strategy into: selecting the sample, preparing the interview questions, designing the questionnaires, organising where to conduct the interviews and when, contacting the mail recipients via email with the questionnaire, selecting a date to follow up on questionnaires and when to send a reminder email. Finally the author decided on a date to have all questionnaires returned in order to start processing and evaluating the findings. The researcher used the survey strategy as it uses a systematic method of collecting defined information from individual respondents (Brannick et al., 1997) while highlighting the investigation of tangible
things (Denscombe, 2002). This method allows for a large amount of data from a sizable population to be collected (Saunders et al, 2009).

3.9 Research Choice

This researcher will use a deductive research design. The following paragraphs will go on to explain how the researcher set out to achieve this through exploration and data collecting: the semi-structured interviews and questionnaires used endeavor to address the research question. Selecting this method allows the researcher to either use the single data collection technique, with corresponding analysis procedures (mono method), or use more than one data collection technique and analysis procedure to answer the research question (multiple methods) (Saunders et al, 2009).

3.9.1 Qualitative & Quantitative

The researcher will use quantitative research to focus on capacity and to examine the fundamental relationships between variables. The researcher aims to use quantitative research to address the hypothesis, primary explanations and generalisations (Ritchie and Lewis, 2003).

Qualitative and quantitative research strategies are suited to different types of research questions but they also complement each other well (Rossman et al 1991). The author will use both qualitative and quantitative research methods, as these designs are varied and are seen to enhance the scope of research, at the same time as compensating for the limitations of either approach alone. The researcher aims to allow for a deeper appreciation of the influences, beliefs and experiences of the customers in buying and using their health insurance policy. Secondary data was collected through reading and critically reviewing previous research, reports, records and books related to consumer behavior and health insurance.
3.9.2 Mixed Method

The researcher’s rationale in choosing a mixed method is to allow for more accurate findings, through using different methods throughout the investigation, by giving a chance to verify the findings from one method against the findings from another method, while checking for bias in the research methods.

The researcher has carried out a mixed method approach combining quantitative and qualitative data techniques and analysis procedures. The quantitative method focuses on customer behavior and perception of their health insurance policy and the health insurance provider by administering an internet mediated questionnaire via ‘Survey Monkey’, while and the qualitative method focuses on a small group of employees by administering in-depth interviews. Saunders et al (2009), agrees that the advantage of a mixed method approach is that different methods can be used for different purposes in a study. While Tashakkori et al (2003) agrees that multiple methods are constructive simply if they offer enhanced opportunities to answer the research question, permitting an improved evaluation where the findings can be trusted and conclusions are made from them.

3.10 Time Horizons

The Time horizon for this research is cross-sectional, a ‘snapshot’ in time of the employees identified in the hospital. A cross-sectional study utilises the survey strategy (Easterby-Smith et al, 2008, Robson, 2002). The interviews took place on the 2nd of July 2012. The questionnaires were sent out ten days later with a deadline to complete the questionnaire of seven days (the 19th of July).

A longitudinal study was not chosen as it would have taken a longer and due to the time constraints of this study this approach was not realistic.
3.11 Population and Sampling Methods

The survey population is gained by census or sample (Saunders et al 2009). A census collects data from all potential situation or group in a population, where as a sample is a subgroup or an element of a bigger population (Saunders et al, 2009).

3.11.1 Research Population

The fundamentals of the population are a Dublin Private Hospital, the sampling units are a group of employees within the organisation (including all disciplines such as doctors, nurses, IT, stores staff and catering staff – those staff who have email accounts), but the key factor is they have to have a health insurance policy.

3.11.2 Sampling Frame

The target population is based on employees that are on the internal email system, whom are covered by a health insurance policy at the time the research was undertaken in July 2012.

3.12 Census

The researcher, to collect data from a group of the population, uses a census.

The criteria for the census size were based on; all employees who are on the internal email system during the summer of 2012. All employees wishing to undertake the questionnaire must be covered by a health insurance policy, however as a small organisation not all employees have access to email. There are approximately 500 people on the internal mailing system.

A minimum of 135 responses would have to return a completed questionnaire to guarantee validity of the data gathered (Saunders et al, 2009). The researcher aims to receive a
response rate of 70 %, as a 100% response rate is unlikely (Saunders et al; 2009), as the timeframe coincided with the summer holiday period and not all employees will hold a health insurance policy.

3.13 Data Collection Method

Primary and secondary data was collected by means of quantitative and qualitative methods.

3.13.1 Secondary Data Collection

The researcher gathered secondary data by evaluating written material largely acquired from reading books, journals and articles. Secondary data is the fostered analysis of existing data (Riley et al 2005).

3.13.2 Primary Qualitative Data Collection

The researcher conducted in-depth interviews to gather primary data with 4 employees at their place of work. An interview is a deliberate discussion involving two or more people this can be accomplished by structured, semi-structured or unstructured questioning, providing the researcher with the data required by using open-ended questions for exploratory the research (Denscombe 2003, Saunders et al 2009). The researcher chose in-depth interviews to uncover underlying motivation, feelings, beliefs and attitudes towards having a health insurance policy.

When planning the interviews the author was aware of the disadvantages associated with in-depth interviewing which include; they lack structure, allowing the results to be exposed to the interviewer’s influence, the completeness and quality of the results will depend on the interviewer’s skills, analysing and interpretation of the results can be difficult; and additional observations are required to be added to the analyses (Malhorta 2010).
3.14 Qualitative In-Depth Interview Administration

The researcher recognised the interviewer’s role as critical in achieving the in-depth interview, therefore the researcher set out to a clear plan to achieve the interviews. Four senior members of the hospital staff were chosen to be interviewed. They were randomly chosen from the IT database of emails. This non-probability sampling method was used as a convenience sampling procedure, involving the selection of cases on the basis that they are easiest to obtain (Saunders et al 2009). They were contacted by email outlining the details of the research, including reassurance of confidentiality, and asked if they wished to participate. All four employees agreed to be interviewed. They were told the interview was expected to last approximately thirty minutes and that all information shared would remain confidential.

The venue was a room within the hospital, which was booked in advance. It was a comfortable room with a sofa and chairs and there was a large ‘do not disturb’ sign on the door, away from the work place in order to avoid distractions, to ensure the respondent was comfortable and relaxed with the air conditioning on. The interviewer provided a glass of water for each respondent and he/she was made aware that if they needed to take a break at any time they could. The researcher encouraged the respondent, by ensuring all questions were explained clearly and the development of answers were encouraged by not accepting single word answers. It is important that questions and probe questions follow the interest and logic of the respondent, allowing encouragement and motivation of the respondents to respond in a suitable manner supporting the interviewer to be more relaxed and effective (Malhorta, 2010).

3.15 Qualitative In-Depth Interview Design

The researcher designed unstructured open-ended questions, also known as free-response or free-answer questions (Malhotra, 2010). The intention is to allow the respondent to answer in their own words, encouraging the respondent to provide an extensive answer,
while allowing the respondents to express opinions without the bias associated with closed-ended questions (Saunders et al, 2009, Malhotra, 2010).

3.16 Primary Quantitative Data Collection

It is widely accepted that the use of interviews are an effective way of collecting data however it is agreed they are not strong enough on their own (Saunders et al 2009), therefore the researcher has used a qualitative method of research which is easier to organise and to analyse the findings. To achieve this, the researcher used the survey method, which is the most common method of primary data collection (Saunders et al, 2009), to achieve this the researcher administered a questionnaire. Malhotra (2010) argues there are three main objectives in the design of a questionnaire; it must highlight the information required into a set of specific questions; is must encourage, uplift and motivate the respondent to cooperate, become involved and to complete the interview; and it should minimise response error.

The researcher administered the questionnaire online using an IT software programme called ‘Survey Monkey’, this allowed for the easy distribution of the questionnaire to a large sample group. The questionnaire was developed to research the opinions of the employees at the Dublin Private Hospital. The link to the questionnaires on Survey Monkey was emailed to all hospital staff (those who have email accounts, not all staff in the hospital have an email account, which is approximately 500 people) with a detailed explanation of the purpose of the questionnaire, how to fill it in, how many sections there are, how many question there are, a specific date by which to complete and reassurance that all data will remain confidential.

There are some disadvantages to this method as the researcher may not receive the preferential information from the respondents, the closed response questions may prevent a completely correct answer and wording the questions may prove difficult (Saunders et al 2009).
3.17 Questionnaire Analysis

There were a total of 500 questionnaires sent out via the email system to the employees. The email addresses were obtained from the in-house database, which stores all Mail Users email addresses.

The total response rate was 153
The total number of questionnaires sent 500

The researcher was satisfied with the total number of responses but was aware the low response rate may be due to the holiday period and many staff members were on holiday. Also in order to participate the employees had to have health insurance in order to participate. As less than half of the Irish population has health insurance it can be assumed that there were a substantial number of employees that did not have health insurance.

3.18 Quantitative Questionnaire Design

It is imperative that the researcher reviews the literature diligently, prior to designing the questionnaire, while recording the stages necessary to ensure a question is both valid and reliable (Saunders et al 2009).

The researcher designed the questionnaire as structured closed questions. The questions provide optional answers where the respondents are directed to select an answer, using a mixture of type and rating questions (Saunders et al, 2009). The rationale in choosing structured questions over unstructured questions was to shape the element of a census and the intricacy of recording, charting, and analysing respondent’s answers. By using structured questions the researcher hoped to reduce prejudice, making it more probable for the researcher to achieve collaboration from the respondents (Malhotra, 2010) since structured questions are earlier and quicker to answer (Saunders et al, 2009).

A scaling devise was used to document responses. The selected scale is based on the ‘Likert scale’ (Saunders at al, 2009) and Dichotomous scale (Malhotra, 2010). It works by allowing
respondents to indicate how strongly they agree with the statement and forcing the respondents to articulate a view since a “no opinion” option is not given (Malhotra, 2010). This scale was easy to create and administer and easy for the respondents to understand. The disadvantage to this scale is; it takes longer to complete compared to other rating scales, as respondents have to read all options as opposed to a short phrase (Malhotra, 2010).

3.19 Data Analysis

The data gathered by the researcher was turned into quantifiable information by using diagrams and statistics in order to establish relationships and trends. The Survey Monkey software was used to quantify the data, however the challenge was not just collecting the data, but constructing a vision from that data (Saunders et al, 2009).

3.19.1 Qualitative Data Analysis

The researcher worked with a deductive based research approach and embarked on primary qualitative data gathering by administering four non-standardised, in-depth interviews.

The Qualitative Data Analysis processes was separated by the researcher into: Summarising (shortening) and Categorisation (classifying and structuring) either on their own or collectively (Saunders et al, 2009). The researcher has chosen this controlled method that were formalised using a description. The researcher choose this option as narration pursues a formation that might not happen in any order, it identifies what the story is about, what occurred, the consequences that took place, the consequence of these actions, and the concluding effect (Saunders et al, 2009). This approach allowed the researcher to thematically analysis themes in transcripts, identifying the occurrence of certain incidents, words or phrases. The researcher’s motivation was to embark on a thematic analysis, which is a universal approach to qualitative data analysis (Saunders et al 2009, Bryman et al, 2011). The interviews provided valuable information in the exploration of employee perception of
their health insurance policy. The researcher has outlined the key findings of the interviews comparing each individual’s answers in Appendix 1.

3.19.2 Quantitative Data Analysis

The researcher focuses on deductive based research and has carried out primary quantitative data collection using questionnaires. The questionnaire was devised from structured closed questions using a mix of category and rating questions. Quantitative data results in numerical and standardised data where the analyses are demonstrated through the use of diagrams and statistics (Saunders et al 2009).


Data analysis was achieved by the use of Survey Monkey: the data was automatically gathered from the employee’s responses which automatically uploaded to survey monkey when they answered the questionnaire. The researcher applied tables and charts to represent the data through a survey monkey application, and then went on to explain the data results and their relationships.

3.20 Ethical Considerations

The research questionnaire is designed to not compromise the participants in anyway; it will not do harm or result in any other disadvantage (Saunders et al, 2010). The researcher will protect the details of the hospital and the employees will be kept confidential. The names and demographics of all participants will also be kept anonymous, participants can withdraw at any time in the process, data will not be used for other purpose and all information collected will be shredded at the end of the research.
The in-depth interview participants and the questionnaire participants were given clear information allowing for informed consent (Saundar et al, 2009), while being made aware of the fact that they were the subjects of the research (Saunders et al, 2009).

3.21 Reliability of the Research

Reliability is the degree to which the measures used, have no errors and present dependable results (Zinkmund 2000). Scandura et al (2000) states that the main hazards to the reliability of research are: the subject of error; the subject of basis, observer error and observer bias. Robson (2002) argues that the danger of errors in the data gathered may be due to the participant’s mood and concerns.

3.22 Validity of the Research

The validity of the research measures how genuine the findings are. The key threats to validity are: the heart of the research appears to cause intimidation to a respondent, a sizeable percentage of participates drop out of the research, any changes inside “the Company”, and any doubt of the importance of the questioning. At the time of the research there were no validity issues threatening the heart of the research.

3.23 Limitations to the research

1. The study is cross sectional and therefore will not recognise the changes in customer perception over time
2. The possibility of being biased in relation to the convenience sampling
3. The timeframe limitations of the research
4. The possibility of a low response rate
5. The researcher has no previous experience in conducting such extensive research
Chapter 4

4.0 Data Analysis and Findings

4.1 Introduction

The aim of this chapter is to establish relationships and trends within the gathered data from the semi-structured interviews and the questionnaires. The researcher aims to address each objective separately using the finding from the interviews, the questionnaires and support from relevant research. This chapter intends to analysis the research objectives, which in turn will lead to answering the hypothesis. The greatest challenge for the researcher is not only retrieving the data, but also building a prophecy from the data gathered (Dibbs et al, 2001).

4.2 Quantitative Data Analysis

The author has undertaken the primary quantitative data collection by administering structured Internet mediated questionnaires. 153 people provided completed questionnaires, which were designed in order to explore customer understanding and perception of their health insurance provider. The researcher outlines the results from the questionnaires in Appendix 2.

There have been many consistent patterns emerging from in-depth interviews and the questionnaires in relation to customers’ view of health insurance, of customer knowledge of their insurance product and customers’ knowledge of the Consumer Protection Code.

4.3 Findings versus Objectives

4.3.1 Objective 1) Assess consumer attitudes towards health insurance, comprising of motivations for purchasing and ending health insurance policies
The research found that the main reasons given for choosing health insurance is due to ‘poor access to public health care’, followed by the ‘cost of medical treatment is expensive’, then the consumer is ‘influenced by poor standards of public health care’, followed by ‘they can afford it’ and next of importance was health insurance was a priority as ‘my friends/family advised have it’ (figure 1). O Connor (2007) argues that the two-tier healthcare system in Ireland exists on the back of fear that there are poor standard in the public system and, if one can afford health insurance, it is advisable.

Figure 1.

The findings of the research identified the main reason given for why they may cancel their policy is if they can no longer afford the policy or have lost their job, indicating that finances are a significant reason for purchasing a health insurance policy (figure 2). The literature supports these findings arguing that many consumers are extremely price sensitive, whereby a high price may swing consumers towards more cost effect choices or prioritising of need for certain brands (Mowen & Minor, 1998). The researcher identified price as having a positive or negative influence on customers, interestingly 28% of respondents said that any price hikes, even over €450 per year, would not influence them to cancel their
health insurance policy, indicating the important that health insurance has in their lives. Over all ‘cost’ seems to be the main motivation influencing customers on whether to hold on to their health insurance policy as even considerable price hikes would not influence them to cancel their policies.

Figure 2.

The research findings identified that customer attitudes towards their health insurance provider varied. The researcher identified that 16% of the 87% customers who had made a claim on their health insurance policy either as an in-patient or an out-patient, were overall dissatisfied with how their health insurance claim was processed (figure 3). Therefore it is expected that consumer reaction is significantly influenced by his or her insight of the situation; how an individual acts and reacts is based more on their perceptions and less on the basis of objective reality (Kelley, 1950).
This is supported by the researcher’s findings as; 14% of respondents had received a bill from their insurance company, despite their understanding that their policy would have covered all expenses (figure 4).
There were 40% of respondents who either didn’t know or thought that there was a waiting period when switching to a new insurer when in fact there is no waiting period when switching. When determining this information 47% of respondents then stated that they would switch providers. However taking all of these findings into consideration 68% of respondents said they were satisfied overall with the level of information given to them by their insurance provider relating to their policy. The research suggests that consumers’ motivation to buy certain products is often rooted in the consumers mind; as a consequence consumers are not always aware of what affects their purchases, “ninety-five percent of the thought, emotion, and learning [that drive our purchases] occur in the unconscious mind that is without our awareness” (Armstrong et al. 2005).
4.3.2 Objective 2) Identify the main problem(s) preventing the customer from clearly understanding their health insurance policy.

The findings of the research identified 77% of respondents are self-funding their health insurance policy (figure 5); they are a well-educated group with 49% having a postgraduate course. It can therefore be suggested that this sample of people are a knowledgeable, intelligent group and therefore should have a good understanding of their health insurance policy. Blackwell (2001) agrees, suggesting that consumers gather information from their environment, using their learning processes to create a framework, which guides them in their buying behaviour. Also it can be argued that being self-funded they have made certain choices to select the insurance policy suitable for them.

Figure 5.

The literature suggests that the most effective component of information gathering is a product’s evaluation in terms its general ‘favourableness’, causing the consumer to
remember and respond favourably or unfavourably towards them (Assael, 1992). Different consumer groups place different importance on different attributes (Warrington & Shim, 2000). With 73% of the population having had health insurance for over six years, 40% of which have health insurance for over 21 years (figure 6), the researcher agrees that health insurance is certainly a ‘favourable’ purchase for this group. It can also be assumed that this group of people are experts in the area of holding an insurance policy and therefore must have a high level of knowledge and understanding in choosing the most favorable policy and provider of health insurance.

Figure 6

Consumers pay particular attention to the attributes which are most relevant to their needs (Kolter et al., 2005). A wide range of factors are identified as being the drivers of future change in a consumer’s needs, demands and expectations (Jones et al 2007), such as quantity, size, quality and price, which are commonly used to measure the value of the product/service (Rowely 2005). The researcher therefore suggests that any changes in these attributes can affect the consumers understanding of the product or service being offered.
4.3.3 Objective 3) Provide an insight into components of the insurance market from a consumer perspective, looking at motivations for changing to an alternative health insurance company.

The researcher found that 31% of respondents had not considered switching health insurance providers, with 60% of respondents (figure 7) saying they have never switched health insurer providers. Of those who have switched insurance providers, 24% have only switched once, 8% have switched twice, 2% have switched three times and 1% have switched four times. Kolter et al., (2005) argues that consumers pay particular attention to the attributes which are most relevant to their needs when making a purchase decision. In a diverse and mature marketplace, consumers will always have the choice and opportunity to alter their shopping behaviour; this often results in customers switching between brands or choosing not to change at all (Kolter et al., 2005). Therefore the research findings suggest that the respondents have matched their needs to their health insurance policy well.

Figure 7
However the attributes like quantity, size, quality and price are commonly used to judge a brand by customers (Jones et al 2007), any changes in these attributes can affect consumer decisions towards switching brand or product loyalty (Blackwell et al., 2006). The researcher identified the two main reasons given for switching was the ‘new provider was cheaper’ and the ‘new insurer offered more services/procedures for less money’. Satisfaction is a necessary but not an exclusive condition of the loyalty established when a consumer makes a commitment to a brand. The motivation for change differs from customer to customers, depending on a number of variables such as personality, social class, income, size of purchase, past experiences, prior brand perceptions (Moorthy et al., 1997), as well as customer satisfaction. The majority of respondents in this research say they haven’t changed as they are satisfied overall with their current provider and there are no comparable cost saving to be made by switching.

The researcher identified 71% of respondents felt it would be easy to change health insurance providers and they would predominately compare plans using the internet and calling the insurance companies for advice (Figure 8). Those who have compared plans indicated that they were best informed through the use of the Internet. Consumers awareness on product costs through the use of internet price comparison sites and product advertising are becoming more common (Moore and Carpenter 2006). Loyalty to brands is currently low, with media advertising becoming generally ineffective, increasingly being replaced by word-of-mouth recommendations by friends, family (Jones et al 2008) or product reviews available online (Armstrong et al 2005). Therefore the degree of consumer effort in searching for information is affected by physiological factors namely; motivation, perception, learning, and beliefs & attitudes (Armstrong et al 2005).
4.3.4 Objective 4) Gauge whether the consumer protection code 2012 is widely recognised by the consumer

The research identified that 79% of respondents had not heard of the Consumer Protection Code 2012, while 7% were fully aware of the Irish Health Insurance Authority and its functions. However considering the conditions of the protection code are compulsory when providing health insurance it is interesting that 79% of respondents had not heard of this code (figure 9).
Figure 9.

Healthcare has changed from a right to becoming a commodity to be profited from, raising contentious questions regarding a patient’s access to treatment and the quality of the treatments offered. As a result it is essential that regulation supports consumers when choosing the appropriate healthcare option (Department of Health and Children 2001). Clearly legislation is not being promoted amongst the health insurance consumer market, which is a requirement to ensure policy guidelines support customers, particularly those most in need of healthcare; the ill, elderly and vulnerable (O Connor 2008).

4.3.5 Objective 5) Ascertaining whether the consumer understands how/where to complain if they are unhappy with the service and support provided by their health insurer.

The researcher identified 18% of respondents have made a complaint to their health insurer with 44% of these overall dissatisfied with how this complaint was handled (Figure 10).
Yet when asked if you had a problem with the health insurance company who would you complain to, 48% of respondents would complain to the insurance company itself. It is arguable that this puts customers in a vulnerable position, fearing the potential negative impact on their long-term health if they do not invest in an insurance policy. Wren’s (2003) portrayal of a two-tier system is evident in the commodification of Ireland’s healthcare, describing it as a unique failure in providing care when needed by all citizens. Many critics argue that this commodification may create a threat to essential social values (Nolan and Wiley, 2002), particularly in the current recessional times when expenditure cutting is paramount (Cerny, 2008; Plehwe et al, 2007).

4.3.6 Objective 6) Identify key trends among consumers and insight into forthcoming trends.

The current economic climate has detrimentally affected 58% of the respondents, with their household taking a pay cut in the past year. There are many purchasing decisions made when buying health insurance, after evaluating the offers available to them. Price is the
main trend identified in the research and is typically the most valuable metric used by consumers to appraise a product (Mowen & Minor, 1998). Porter (1985) argues that companies can create value by providing lower price, or unique offers, to the customers to exercise their competitive advantages over others. 29% of respondents say ‘no increase would encourage me to lapse; I would continue regardless’ indicating the high value they place on having a health insurance policy. 22% of respondents say ‘all increases’ would result in them cancelling their policy (figure 11); this indicates the value ‘price’ plays for the consumer holding a health insurance policy.

4.4 Conclusion

The aim of this research dissertation was to assess the consumers’ knowledge of their health insurance policy and ascertain the reasons why the consumer chose to have health insurance, including any reasons why they may cancel their cover subsequently. The
research has proven that typically consumers do not have a clear understanding of their health insurance policy. The overall factor for having a health insurance was due to fear of the public system, supported by the fact they can afford to have the policy. As a result of these findings, the objectives set out by the researcher were achieved.

The perceived value of healthcare, despite the impact on personal finances, appears to be the most common theme in identifying why the consumer has health insurance. However in the current prolonged period of austerity where, as identified by the research, households have had to make large financial savings there are growing numbers of people cancelling their health insurance policy because it is no longer affordable. Despite the reduction in consumers disposable income, the overall consensus is health insurance is a priority and policies would only be canceled as the result of considerable financial changes with a person’s circumstances.
Chapter 5

5.0 Conclusions and recommendations

Meeting the objectives and supporting or refuting the research hypotheses has answered the research question, as outlined in this chapter.

The research concentrated on the consumer behavior in buying or cancelling their health insurance policy. The researcher believed it is important from a social, ethical and marketing point of view to recognise the factors influencing the consumer in making choices relating to the health insurance.

5.1 Hypothesis answered:

1. Consumers are buying health insurance out of fear of poor standards of public healthcare and the perceived necessity to have health insurance as a priority to seeking out adequate healthcare.

2. The customer does not have a clear understanding of the health insurance policy they have purchased.

Collection of quantitative and qualitative data has proved that this hypotheses was correct. According to the research findings it can be seen that the consumer is influenced by fear, fear of a poor public health service and fear that if they become ill the most effective way to obtain healthcare is by having a health insurance policy.

The data collated also identified the customers’ lack of understanding relating to their health insurance policy. Many respondents had received bills which they thought their health insurance would cover, demonstrating a clear lack of understanding of the policy they had purchased. Many had little knowledge on switching policies or insurance providers,
again highlighting a lack of understanding of health insurance in general.

5.2 Research question

What is the customer's knowledge of ‘The Consumer Protection Code 2012’ and do they have a clear understanding of their current health insurance policy.

The research question has been answered throughout the project but in summary, the research findings highlight the lack of consumer knowledge relating to the ‘Consumer Protection Code 2012’ which is in place to protect the consumer, the health insurance customer. Considering the evidence suggesting that the consumer does not have a clear understanding of their health insurance policy, there is certainly a requirement for the greater consumer education in order to support them to understand the details of their policy.

5.3 Limitations of the research

The research has been successful in assessing the views, motivations and influences of the customer, who at the time of the research, held an insurance policy. However it is important to identify the limitations of the research.

They survey was administered during the summer holidays and there were many ‘out of office’ replies which negatively affected the response rate. The researcher believes that the response rate could have been higher if it were not a holiday period, or if the length of time to reply was extended to a longer period of time.

The research only studied the consumers who held a health insurance policy. The organisation comprises of people who have health insurance and those who do not, therefore if these consumers were asked to identify themselves a cleared understanding of the general population would be more apparent. Also if information was measured from
those without health insurance the researcher would have a better understanding of the
low response rate to the questionnaire.

It could also be said that a sample taken from the healthcare industry would be more likely
to have a health insurance policy and that therefore these finds were no indicative of the
society in generals. However to counter this point, it could also be suggested that if the
findings show healthcare professionals do not understand the coverage provided by their
policy, then society's vulnerable would have little chance in understanding the policy small
print.

5.4 Research Summary

The researcher concludes that consistent results and findings emerged from the in-depth
interviews and the questionnaires. The results indicated that consumers were overall
satisfied with their health insurance policies however there is evidence they don’t have a
clear understanding of their terms & conditions policy coverage. Therefore health insurance
providers need to develop strategies to ensure that consumers understand the product they
have purchased from them. The author will outline the areas for improvement in the
following recommendation section.

5.5 Recommendations

5.5.1 Recommendations for healthcare providers (hospitals, clinic, private healthcare
providers of all types) and insurance providers

Healthcare providers and health insurance providers should have a clear customer focus,
motivated to have a detailed understanding of customer needs, implement effective quality
measurement tools, incorporate feedback and employ a customer care system (Barry et al,
1988 & Seth et al, 2005), in order to ensure the customer feels supported when using their
health insurance policy. This commitment will involve full dedication from top management
to set high standards and communicate these to standards to employees (Kotler, 1991),
who in turn can support the consumer to understand their health insurance policy when attending a health care provider for treatment.

In order to ascertain the perceptions, needs and experiences of the customers the healthcare providers should embark on marketing surveys, with the information collected from the survey applied within the organisation to maintain quality (Berry et al, 1988), when support the customer.

The researcher has identified that consumer understanding is important, as it can influence the customers’ perceptions of having a health insurance policy. Consumers are not always aware of the steps taken by healthcare providers to ensure clear understanding of the service and the cost of the service provided. Therefore it is imperative that healthcare providers inform consumers of special efforts being made to ensure quality and understanding of the service, which may not be immediately evident to the customers (Parasuraman et al, 1985).

Health insurance providers are expected to solve a problem as quickly as possible with the customer (Berry et al, 1988) and to inform their customers about the procedure when a problem arises. Staff must support the consumer to check coverage of their health insurance policy before treatments, to ensure costs are covered. These principles necessitate not only adequate staffing but the correct kind of staff to strive for customer understanding rather than purely sales commission (Berry et al, 1988). Health insurance providers therefore, as per legislation, must ensure that consumers are well informed and educated to choose the correct policy which meets their requirements and they have a clear understanding of the claims/complaints procedures.

5.5.2 Recommendations for the Consumer

In order to achieve satisfactory service quality, health insurance providers need to learn about their customers’ requirements (Johne et al, 1998). The consumer should develop a relationship with their health insurance provider, contacting them with specific questions before and after using their policy. Providers must communicate the best policy for their
specific needs and budget, discussing switching options and mostly allowing for ease of
collection and overall relationship building to support their overall needs.
Communication is the key in order for the consumer to ensure their needs are met.
Furthermore, the consumer needs to communicate any problems that occur in order to
resolve these problems at the foremost opportunity (Berry et al, 1988).

The researcher found that consumers were most comfortable researching their health
insurance using the internet; however the data reports a high number of consumers did not
have a clear understanding of their health insurance policy. Therefore the researcher
suggests the consumer needs to develop a better relationship with their health insurance
provider. The consumer also needs to know what legislative support there is in place to
support them in making choices, switching and complaining. Taking ownership of their
health and their policy is essential in order to ensure transparency is achieved.

5.6 Recommendations for Future Research

It is widely accepted that customer expectations and perceptions are subject to continuous
change. Therefore the research findings can only be applied to a specific period of time, a
predefined market and current economic circumstances (Naik et al, 2010). The researcher
therefore recognises that the same study could be repeated periodically to compare the
influences affecting the consumers then compare it to the findings of this research study to
identify the factors influencing the consumer in health insurance choices over a sustained
period.

The results of the questionnaires were limited to employees/consumers who had a health
insurance policy at the time the research was undertaken. It would be beneficial for future
research to extend the sample group, to include consumers who have had health insurance
policies in the past and cancelled them. This data would capture information looking at the
factors that influenced these consumers into cancelling their policy. They would provide
facts based on their motivations compared to the current research findings which overall
suggest that there would have to be major changes in their lifestyle before they would consider cancelling their health insurance policy.

The primary research findings suggest that a majority of the health insurance customers are satisfied with the service provided by their health insurance provider, this leads to repeat business. However, the author undertook research in a hospital; this may have resulted in bias responses from the participants due to their overall understanding of healthcare (Malhotra, 2010). This may have somewhat decreased the validity of the study, therefore a longitudinal study may possibly overcome or eradicate these limitations (Saunders, 2009).

5.7 Conclusion

Proficient services are characterised by experiences taking place between the health insurance provider and the consumer (Johne et al, 1998). In order for the health insurance provider to accomplish adequate levels of quality, an overall venture is necessary (Gabbott et al, 1998), with particular emphases being placed on learning about their customer needs, developing communication pathways and ensuring customers have a clear understanding of the policy they have been sold (Johne et al, 1998). The health insurance companies should implement new marketing strategies and identify failure points in order to enhance the service they provide to an effective service to their customers.
Chapter 6

6.0 Reflections on Skills

6.1 Introduction

This chapter intends to provide an insight into the learning and skills developed during the course of researching and subsequently writing the dissertation. As a result the fundamental experiences that created the pathway of the research and analysis followed by a narrative of the learning achieved from the event. The theoretical concepts associated with learning styles, the affiliation between my personal learning style, the approach to the dissertation and how this has affected the conclusion is also discussed. Additionally an account of how the skills and learning gained from this journey can be applied in my career going forward.

6.2 Learning Styles

Cameron (2007) states that learning has evolved from being a process of just absorbing theories and concepts to a process of being able to ‘construct meaning’. The author cites Kolb, Rubin and Macintyre’s (1984) learning framework in which it is suggested that learning by making sense of experiences is a circular process that involves undergoing an experience followed by reflecting and forming concepts based on the experience. The next step is to experiment with these concepts to create another experience and repeating they cycle. This cycle is reflected in the diagram below.
This process of continuously analysing experiences and developing new concepts and learning from them is particularly applicable in the study course such as the post-graduate MBA. Such course of study is a rigorous and expects participants to apply theories to develop practical solutions in real life situations (using case studies etc). This encourages the use of experiences gained while working in organisations and the development or application of concepts based on learning from those experiences.

We were given many models to use to assess this theoretical type. Based on Kolb’s ‘Learning Cycle’, Honey and Mumford (1989, cited in Cameron, 2007) identify four different learning styles dependent on the specific stage of Kolb’s learning process that each individual prefers over the other stage.

My learning style is that of an activist learner. Knowing my learning type from early on in the course was of great benefit as I was aware of my strengths and weaknesses and therefore I ensured that I listened to others in the group without making hasty decisions, which may result in conflict. According to Mitchell (1998), conflict is structured into three parts consisting of attitudes, behavior and situations that relate and produce conflicts between individuals. Understanding my learning style supported me in maturing further during the course, previously I would have been keen to get my point across first, now I sit back and

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wait, approaching an argument with a more calm and posed response. The biggest challenge for the team leader is figuring out how to balance conflict, once achieved a leader can be more effective (Brockmann, 1996).

Through the course I sometimes felt aggrieved at times when receiving low grades for group work compared to the impressive grades of my individual work. These situations lead to unnecessary time wasted on reflecting on how we could have done better. Now at the end of the MBA I realise that it is important to do things to a high standard but not to become preoccupied with prior work, rather to concentrate on improving in the next project. I have learnt that a grade does not necessarily indicate complete success; it is an indicator of success. This learning process is something I think will certainly benefit me in my personal and professional life.

6.3 Personal Development Planning

The personal development portfolio is used as a method of highlighting skills and knowledge gained over a period of time, which can be used to enhance the development of future success.

“Change is the end result of all true learning”, Leo Buscaglia.

Having a personal development plan is no longer regarded as being in the right place at the right time, or about gaining a paper qualification. These are very significant but valuable personal developments, which require the acquirement and refining of certain skills, which are not examined in the usual formal way. These are the skills, which help to stand out from the crowd. By expressing ourselves we can proactively direct our vigor in the right direction and strive to progress things appropriately to our needs and the situation. The personal development plan helped me to accomplish while making a plan to improve my learning skills, communication skills, and presentation skills during the competition of the MBA.
6.4 Research Organisation

Having previously written a dissertation I was under no illusion the task involved. This time it was a little more overwhelming due to the commitment of working full time and studying, this required a great deal of organisational skill and ability. Before commencing the literature search I undertook the planning, which helped me in the defining the parameters of research. I had a clear idea of the subject area I was interested in and I had a good understanding of what my question may be, however I needed further research evidence before I could finalise my question. Once I had a plan in place the task of identifying, sorting, coding and organising articles began, identifying topics and key common points between the articles. Bell (1999) supports this method of planning identifying the importance of grouping the research articles in relation to how it contributes to your research question. Following this intense period the research question was fixed upon and eventually refined.

The process of undertaking the research was self-structured, I had a plan for every day or every weekend or every period of time taken off work. I had a GANT chart which clearly depicted the stages of the research and the time frame in which each stage had to be completed. This plan helped not only give me structure; it helped me have goals that were achievable within the allotted time frame. I discussed these timeframes with my supervisor who assured me that the goals and timeframes were achievable as defined. Working full time was something I initially worried about, I was concerned that I wound not have enough time to achieve the task in hand, however I took holiday occasionally to utilise time effectively in the library in particular, especially as the library closes early during the summer months.

6.5 Influences of own learning styles on research

My learning style is that of an activist learner, discovered when I completed the self-administered learning style questionnaire as part of the research skills analysis module of
the MBA. This meant the advantages and disadvantages of these individual styles had a great influence on my approach to this dissertation.

The advantages of having an activists approach to certain aspects of research meant that research into relevant literary resources was undertaken with great attention to the structure and detail as I like to be involved in new experiences and I am enthusiastic about these new ideas. When setting out to complete the research as an activist I enjoyed identifying problems and opportunities and been thrown in the deep end with a difficult tasks in order to complete the task in hand.

The disadvantage of being an activist is that I am unlikely to prepare for the learning experience or review the learning afterwards. This became apparent as I spent a considerably larger amount of time than usually required spent exploring different approaches to reviewing particular topics. True to type I do enjoy doing things impulsively, tending to act first and consider the implications afterwards. I was not driven or motivated by the amount of reading entailed and there were times when I sought short cuts, reading only the introduction and the conclusion of some articles, for example.

The dissertation presented me with a challenge by having a specific time period for completion and by having specific requirements in terms of its structure, presentation, etc. A time limitation meant that the activist did not want to spend too much time analysing various aspects elaborately. In complying with the structure requirements of the dissertation, the activists own logical structure had to be modified into a document that would meet the requirements of this research.

However by successfully completing this dissertation, I have been able to overcome these activist’s limitations, resulting in the development of important skills in the process. This has helped overcome prominent disadvantages of having a preferred learning style and the tendency to rely on these styles, knowingly or unknowingly, while working on the dissertation. These skills and their usefulness are discussed in detail in the next few sections.
6.6 Critical Experience and learning

Cameron (1999) argues that learning has evolved from being a process of just absorbing theories and concepts to a process of being able to ‘construct meaning’. The main lesson I have learnt is that the MBA and writing the dissertation is only the beginning of my learning. It has opened the door to areas in business and research which before I had never been exposed to. I have learnt that in order to continue to improve I will need to pursue further areas of study.

In the course of completing this dissertation I have had a few critical experiences, which resulted in new learning. The dissertation seemed to be a daunting task; especially with the experience of completing a dissertation in the past I know the road ahead was a long and at times – a dark one. Although there was research in the area of healthcare and health insurance I had some difficulty in narrowing the topic down to suit a masters level dissertation. Research of relevant literature and previous research topic, with the support of work colleagues and peers, I eventually narrowed the topic down to an area suitable for research.

I have also learnt to challenge my fears, my first few weeks of commencing the research project I was full of self-doubt. I did not think I had the time or ability to achieve the research project what we originally viewed as limited time, however with commitment, drive, enthusiasm and passion I have managed to achieve the research project successfully.

I have also learnt there is always room for improvement and not reaching perfection is not something to be ashamed of. I have learnt to be proud of all achievements but always continue to do my best.

Learning was also developed in the area of managerial research, especially in concepts related to research methodology, the different methods of collecting qualitative and quantitative data and their various attributes and data coding and analysis. This was my first experience of collecting primary data, in previous research dissertation I wrote a literature
review and then a research proposal. The skills gained in writing a questionnaire and analysing the findings will be invaluable in my career going forward.

6.7 Application of Learning

When I graduated from university I started as a junior member of the healthcare team in a busy London hospital. I quickly found my feet and developed the skills and knowledge necessary to gain promotion. Over the following ten years I have continued to study and support my development through further learning. This type of learning is described by Houle (1980) as 'education that occurs as a direct participation in the events of life' in this situation learning while on the job. Learning was shared and questioning of one another was encouraged to allow every member to participate in the job (Tuckman & Jensen 1977), my confidence in my abilities as a leader and a professional grew, however I always had an underlying uncertainty, which eventually lead me down the path of an MBA.

During the course of the MBA and the research dissertation I have been exposed to many areas which I have learnt from and will be applicable going forward in my career. I have been exposed to Six Sigma, a quality management tool, which is an area I hope to explore in more detail at a later date. Throughout the learning process I have grown in confidence not only as a professional but as a professional with new skills which will support my career to new heights. Having gained further knowledge in project management and healthcare while undertaking the research project I am confident I have grown in ability. Utilising these newfound abilities professionally, I managed the setting up of a new private clinic for a hospital in Dublin, which is running successfully to date. I also intend to continue to explore new areas of study in order to continue with my personal and professional development, a task I look upon fondly.

6.8 Life-long learning

Life is a learning experience and I now understand that learning is a life-long process. Every day bring new challenges but with these challenges brings new learning experiences. All of
the skills I have acquired are vital for anyone pursing a career in management. I do have previous experience of people management, however the skills I have gained from the MBA will certainly further my ability in managing confidently.

6.9 Conclusion
I have learnt to never be afraid of a daunting challenge, which I know will support me the rest of my career. I know that I can succeed at anything I put my mind to as long as I continue to be driven, passionate and interested. Undertaking the MBA has been both a personal challenge and a professional challenge. There were days when I questioned who I was and where was I going professionally, however through this great learning experience I learnt to stay strong and fight every battle individually. Take one day at a time and great things can be achieved and concurred. The last year has taught me most of all to stay strong and the rest will follow.
Chapter 7

7.0 Reference list


30. Department of Health and Children (2012), HIA Report to the Minister for Health on an evaluation and analysis of returns for 1 July 2011 to 30 June 2012 including advice


Appendix 1

Interview Findings - question and consolidated answers

Q1 how do you perceive the service given to you by your health insurance company?
One of the four described the service as ‘poor’ while the other three were satisfied overall with the service that their insurance company provided them with.

Q2 do you have a clear understanding of your health insurance policy?
One out of the four interviewed said they did not have a clear understanding of their insurance policy and described it as “confusing”. Whereas the remaining three felt that they had a clear understanding of the policy they held.

Q3 have you ever changed health insurance providers?
Two had changed providers in the past while two have never seen the need to change.

Q4 have you ever needed to make a complaint, if so who did you complain to?
None have ever had to make a complaint, however two said if they needed to they would probably complain to the health insurance provider as they wouldn’t know who else to complain to. Whereas one said he would complain to the financial regulator whilst the fourth thought he would complain to the healthcare provider as he felt they should have a clear understanding of policies before treating a patient.

Q5 Have you heard of the Consumer Protection Code 2012 and do you know what it means?
Three had never heard of the Consumer Protection Code, one had heard of it but was sure what it was or what it was used for.

Q6 what could the health insurance company do to increase your loyalty?
All four felt that cost was the main factor and if it were reduced it would entice them to remain loyal. Two felt that for the current price they should have increased cover. And one
felt that the excess premiums should be decreased.

**Q7 how could your health insurance provider improve their overall service to you?**

1. Remove automated telephone system as they’d prefer to talk to a human
2. Overall happy with the provider but would like more specialised centres closer to home
3. Provide a clearer breakdown of the plan provided and the different schemes
4. Provide a free yearly medical
Appendix 2

Questionnaire Findings

How old are you?

38% of the respondents were aged 26-35 years old, 30% were aged 36-45 years of age, 23% of respondents were 46-55 years of age, 6% were 56-65 years of age and 3% were over 65 years of age.
Who pays for your health insurance?

119 respondents were self-funded, 17 respondents had their insurance paid by their partner, 10 respondents had their insurance paid for by their employer while 7 respondents had their insurance paid by their partner’s employer.
Please tick the most recent/most relevant educational level.

49% of respondents had postgraduate education, 34% had third level education while 17% had leaving certificate level education.
How often do you pay for your health insurance policy?

119 respondents paid monthly, 19 respondents paid annually, 6 respondents didn’t know, 5 respondents ticked other and 4 respondents paid quarterly.
How many years have you been covered by a ‘Health insurance’ policy?

40% of respondents have been covered by a health insurance policy for over 21 years, 18% have been covered for 2-5 years, 12% have been covered for 6-10 years, 11% have been covered for 11-15 years, 10% have been covered for 16-20 years, 6% don’t know how long they have been covered and 3% have been covered up to one year.
How many children aged under 18yrs old, are covered by this policy?

99 respondents don’t have any children on their policy, 20 respondents have 2 children on their policy, 17 respondents have one child on their policy, 12 respondents have 3 children on their policy, 3 respondents said ‘other’ and 2 respondents said they have four children on their policy.
How many adults, over 18 years old, including yourself, are covered by this policy?

78 respondents have themselves only on the policy, 51 respondents have 2 adults on their policy, 14 respondents have 3 adults on their policy 5 respondents have 4 adults on their policy, 3 respondents ticked ‘other’ while 2 respondents say they have 5 adults on their policy.
Please rate the following points in order of importance to you. Justifying the most important reasons for why you have a health insurance policy. 1 being the most important to 10 being the least important. Moving from left to right in order of important.

Most important reason for why the respondents have health insurance was 7.0/10 ‘my employer pays for my insurance policy’, 6.8/10 say ‘I am included on my partners policy’ is why they have health insurance, 6.5/10 say ‘my partner/spouse include me on their policy’, 6.4/10 rate was for responses who see health insurance important as they are ‘planning to have children’, 5.9/10 rate ‘I have children’ as they reason for having health insurance, 5.8/10 rate all other responses, 5.7/10 have health insurance as ‘my friends/family advised having it’, 4.5/10 rate ‘they can afford it’, 4.3/10 are influence by poor standards of public health care, 4.2/10 say the ‘cost of medical treatment is expensive’, 4.0/10 say ‘poor access to public health care’ is why they have a health insurance policy.
What would be the main reasons you would cancel your health insurance?

88 respondents say they would cancel if they can’t afford it, 51 respondents say they would cancel if they lost their job, 28 respondents say ‘if health insurance was no longer value for money’ they would cancel their policy, 23 respondents haven’t thought about it, 18 respondents would take all responses into consideration, 10 would cancel their policy if they were satisfied with the public health care system, 5 respondents felt that ‘too much uncertainty in the health insurance market’ would influence them to cancel their insurance policy, whereas 4 respondents felt if they ‘were no longer covered by their partners health insurance policy’ they would cancel their policy, 2 respondents felt that they would cancel their insurance if they no longer agreed with private health insurance while a further 2 responses felt that they would not have health insurance if it was not covered by their work place.
If your annual premium rose by the following (Euro), would you discontinue, your cover?

44 respondents state that ‘no increase would encourage me to lapse, I would continue regardless’, 34 respondents say ‘all increases’ would result in them cancelling their policy, 18 responses say there would need to be an increase of €450 for them to discontinue their policy, 14 responses say the increase would need to be €200, 10 respondents state an increase of €150 would cause them to discontinue, 9 respondents would be influenced by an increase of €100, 8 respondents would be influenced by an increase of 250E, 7 would be influenced by €300, 4 respondents would be influenced by a €50 increase, 3 respondents would be influenced by an increase of €400 while 2 respondents would be influenced by an increase of €350.
Have you ever made a claim on your policy, for treatment in a hospital, either as a day patient (outpatient appointment) or as an overnight stay in a hospital?

73 respondents had made a claim as a day patient, 61 respondents had used their health insurance for an overnight stay while 32 respondents have not used their health insurance cover for treatments.
Please rate how satisfied or dissatisfied you were with the approach in which your health insurer processed your claim/s?

64 respondents were very satisfied, 25 respondents were fairly satisfied, 24 respondents say they don’t know, 19 respondents were very dissatisfied, 16 respondents were neither satisfied nor dissatisfied while 5 respondents were fairly dissatisfied.
Have you ever received a bill for a test/procedure from your health insurance company, however your understanding was; your insurance policy covered the specific test/procedure?

71% of respondents answered ‘no’, 15% have not used their health insurance for a test/procedure and 14% answer ‘yes’, stating they had received an unexpected bill.
Have you attended a hospital/clinic/doctor for treatment and were informed you were not covered for the procedure or test, when your understanding was that your insurance policy covered the specific test/procedure?

73% of respondents answer ‘no’, where 14% of respondents answer ‘yes’ stating they had received an unexpected bill for a hospital/clinic/doctor where their understanding was their insurance policy covered them for the procedure in question, 13% had not attended a hospital/clinic/doctor.
Overall how satisfied were you with the level of information your health insurer gave you in terms of your policy?

72 of all respondents were fairly satisfied, 33 respondents were very satisfied, 23 respondents were neither satisfied nor dissatisfied, 13 respondents were fairly dissatisfied, 7 respondents said they didn’t know and 5 were very dissatisfied.
Has your health insurer ever changed or updated your policy without your consent?

65% of respondents say no, 21% of respondents didn’t know if they policy had been changed without their consent while 14% said yes their insurance policy had been changed without their consent.
Has your health insurer informed you of a change in your ‘plan’, but reassured you it was comparable with the previous plan?

46% of respondents answer ‘yes’, their health insurer had informed them of a change in their plan, but reassured it was comparable with the previous plan. 45% of respondents deny this as the case, whilst 9% don’t know.
How satisfied or dissatisfied are you overall with your current health insurance provider?

98 respondents say they are satisfied, 47 respondents are neither satisfied nor dissatisfied while 8 respondents say they were dissatisfied.
If your health insurer did change you to a ‘comparable plan’ – have you later used the plan and then become aware you were not covered as expected (for a procedure/test)?

91 of respondents say ‘no’ where 30 of respondents say ‘I have never had a plan change’, 24 of respondents didn’t know and 8 of respondents say they have later used their plans and become aware they were not covered as expected.
If you have ever made a complaint to your health insurer, how satisfied or dissatisfied are you overall with how they handled your complaint.

62 respondents didn’t know, 9 respondents were neither satisfied or dissatisfied, 5 respondents were very satisfied, 5 were fairly satisfied, 4 were fairly dissatisfied and 4 were very dissatisfied.
If you were to have a problem with your private health insurance, who would you seek advice or help from?

82 respondents say they would contact ‘the private health insurance company’, 41 of respondents say they would contact the ‘health insurance authority’, 27 say the ‘financial services ombudsman’, 11 respondents don’t know who to contact, 5 indicate ‘other’ 4 respondents say they would contact ‘the financial regulator’ and 1 response would contact the government ‘Department of Health and Children’.
Have you heard of the ‘Consumer Protection Code 2012’?

121 of respondents have not heard of the code, 11 respondents say they have and 11 respondents are ‘not sure’.
Have you ever considered switching from your current health insurance provider to another?

68% of respondents say yes they would consider switching from their current health insurance provider. 31% of respondents say ‘no’ they wouldn’t switch while 1% of respondents ‘don’t know’.
Have you ever switched from one health insurer to another health insurer?

60% of respondents have never switched health insurer, 38% of respondents have switched while 2% don’t know.
How many times have you switched Private Health Insurer?

83 of respondents have never switched, 36 of respondents have switched once, 12 have switched twice, 3 respondents have switched 3 times, where 2 have switched 4 times.
If you have switched, why did you decide to change insurers? Please tick the appropriate answer.

77 of respondents ‘have never changed insurer’, 32 respondents say ‘new insurer was cheaper’, 13 respondents say ‘new insurer offered more services/procedures for less money’, 11 respondents said a ‘change of employer’ caused them to change, 9 respondents said ‘new insurer offered more services/products, 9 respondents say ‘other’ factors influenced their switch, 4 respondents switched due to ‘recommendations from others’, where 4 other respondents say ‘the new insurer offered a higher level of information and consumer advice, while 4 other respondents say they ‘wanted to support the competition’, and finally 3 respondents say they were ‘dissatisfied by the service offered by the previous insurer.'
Are there any particular reasons preventing you from switching to a new insurer? Please tick the main reason preventing you from switching.

46 respondents ‘are satisfied with current insurer’, 28 of respondents say ‘there are no comparable cost savings’, 27 respondents say ‘it’s too difficult to compare plan’, 27 other respondents say ‘all response’ are relevant, 24 respondents say ‘concerned that new coverage would not be the same/better’, 15 of respondents say ‘I’m not considering it’, 13 respondents say they ‘are concerned about waiting periods’, 12 respondents say ‘the level of cover is not any better’, 8 respondents say they have ‘just joined their current policy’ while 6 respondents say ‘there is a lack of information on how to switch’ and 6 respondents say their ‘employer is responsible for their policy’ hence they don’t switch.
What are the main reasons that would encourage you to switch from your current health insurance provider to another provider?

92 of the respondents say ‘if there we significant cost savings to be made’, 81 respondents says if the level of cover was better, 38 respondents say ‘if premiums of my current insurer increased significantly’, 29 respondents say ‘if the range of products were better’, 23 respondents say ‘if comparisons between plans of different insurers were easier’, 21 respondents say ‘if there were no waiting periods’, 10 respondents say ‘ if they know more about it’ they may switch, 8 respondents say ‘nothing/would never switch insurer and 3 respondents say there are ‘other’ reasons that would encourage them to switch.
How easy or difficult do you think it would be to switch from your current Private Health Insurance provider to another insurer? Please tick the most relevant to you.

62 respondents say it would be ‘fairly easy’ to switch insurer, 35 respondents think it would be ‘very easy’, 13 respondents thing it would be ‘neither easy nor difficult’, 11 respondents thing it would be ‘fairly difficult’, 10 respondents ‘don’t know’ how difficult it would be and 5 respondents feel it would be ‘very difficult to switch to another health insurance provider.'
If you were to compare plans how would you do this?

88 respondents said they would ‘use the internet’, 60 respondents said they would ‘call the insurance companies to discuss their plans’, 24 respondents said they would ‘discuss it with family/friends’, and 17 respondents said they would use ‘other’ when comparing plans.
How much savings, in Euro, would you need to encourage you to switch to a new insurance company, onto a comparable plan?

31 respondents say a saving of ‘€201-300 per year’ would encourage them to switch, where 31 of respondents say ‘€101-200 per year’ would encourage them to switch, 21 respondents would switch if they had savings of ‘€50-100’ per year, 20 respondents would need savings of ‘€301-400’ per year, 18 respondents would need savings of over ‘€500’ and 10 respondents would need ‘€401-500’ in order for them to make a switch to a new insurance company.
If you have compared plans, please rate the following in terms of how informative they were? 1 being very informative and 3 being least informative.

1.6 using the internet
1.8 calling the insurance company to discuss their plans
2.6 discussing with family/friends
3.4 other
If you wanted to switch to a new insurance company, and you had finished the essential waiting period with your current insurer, do you think you would be required to serve a further waiting period with the new insurer, before being covered?

66 respondents say 'no'
40 respondents say 'yes'
25 respondents say they 'don’t know'
In Ireland currently, you do not need to serve a further waiting period, when you have finished the essential waiting period with your current insurer. Knowing this is it more possible that you would switch from your current insurance company to a new insurance company?

62 respondents say ‘yes’
44 respondents say ‘no’
27 respondents say they ‘don’t know’
Many people have been affected by the current economic downturns in Ireland, could you tell me which if any of the following have affected you or someone in your household in the past year.

94 respondents say their ‘household has taken a pay cut in the past year’, 23 respondents have had ‘household has lost benefits such as pensions and healthcare in the last year’, 22 respondents have had ‘none of these’, 17 respondents say their ‘household has lost a job’ and 8 respondents have had ‘hours reduced at work’.
Please read the following statements and identify the one that best describes your awareness of Ireland’s Health Insurance Authority?

50 respondents say they ‘have heard of the Health Insurance Authority, but I’m not sure what they do’, 48 respondents said they ‘have some awareness of the Health Insurance Authority and its functions’, 23 respondents said they ‘have never heard of the Health Insurance Authority’ and 9 of the respondents say they were ‘fully aware of the Health Insurance Authority and its functions’.