

An Empirical Study on the Role of Cashless Health Insurance in Influencing Treatment-Seeking Behaviour toward Private Healthcare Institutions

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Abstract

Healthcare financing and access patterns have changed dramatically in India as a result of the growth of the cashless health insurance programs. The paper is an empirical research on how cashless health insurance has affected the treatment seeking behaviour in relation to the private healthcare institutions. Quantitative, descriptive research design was used and the respondents were asked to fill in a structured questionnaire consisting of 200 respondents with the help of a five-point Likert scale. The mean score analysis, descriptive statistics, and analysis of cross-tabulation were used to check the association between insurance status and hospital preference. It is observed that 76.7 percent of insured respondents had more preference to private hospitals as opposed to 37.5 percent of non-insured patients, and this behavioural change is significant. The average scores of resource variables (greater than 3.70) confirm that decrease of the financial burden, perceived quality of service, and accessibility of facilities are principal determinants that affect the utilization of the privatized hospitals. The paper concludes by noting that cashless insurance empanelment has been proven to greatly channel the patient flow in favor of the private health care provider in case, however, long term regulatory controls are necessary to make sure of financial security and quality of services. The findings offer insights that are policy-relevant towards the improvement of designing and implementing of public-funded health insurance schemes.

Keywords: Cashless Health Insurance, Treatment-Seeking Behaviour, Private Healthcare Institutions, Hospital Preference, Financial Protection, Empanelment, Healthcare Utilization.

Introduction

Programmes of publicly-funded and commercial health-insurance funded by cashless, point-of-service, treatment have been actively encouraged to increase ease of access to inpatient treatment, as well as to decrease immediate out-of-pocket (OOP) payments. In India, the mission-coded and mostly-aligned-to public and private hospitals, large purchaser-provider packages, such as the Ayushman Bharat-PMJAY, are used to provide fixed bundles of care, which form financial and operational incentives capable of modifying how patients decide to



seek care (Prinja et al., 2017). Although some of the evaluations have found that hospital utilisation growth with insurance expansion, the implications to the location of patient care (private or public hospitals) and financial protection is uncertain: empanelment can boost nominal access, but does not consistently lead to reduced OOP spending, particularly when claim volume is concentrated in a limited number of private providers or when reimbursement and benefit design result in residual patient payments (Prinja et al., 2017; Garg et al., 2019; Joseph et al., 2021). This paper empirically investigates the research question of whether the concept of cashless empanelment and its supposed positive trend of increasing treatments seeking by changing the provider to a private healthcare institution is connected by some mechanism (density of empaneling, perceived quality, reimbursement practices, and uncovered charges).

Literature review

Multi-site appraisals and systematic reviews indicate that publicly financed health insurance (PFHI) usually positively affects hospital utilisation and creates irregular financial-protection returns (Prinja et al., 2017; Prinja et al., 2019). Review by Prinja et al. confirmed the positive and consistent increases in service usage but weak evidence or uneven findings on decreases in OOP and catastrophic expenditure, which means that increased utilisation does not necessarily lead to better financial protection of households.

Some empirical research in India records that the contribution of private providers would be significant in cashless schemes. Administrative and field evaluations of national and state PFHI programmes show that the portion of claims and claim value to empanelled private facilities can be huge, which may result in higher utilisation by the insured to the private sector (Joseph et al., 2021; Garg et al., 2019). In regions of high concentration of private empanelment, residential surveys give higher odds of the insured patient selecting a private hospital-in some cases with small reductions in net OOP itself in violation of informal charges or uncovered services or greater ancillary costs (Garg et al., 2019; Joseph et al., 2021).

Provider behaviour studies and empanelment studies shed light on supply-side. The research at the facility level suggests that private hospitals move to cashless networks to boost the number of patients and market share but encounter operational blockages of delayed payments and hard tariffs and the administrative burden that can induce negative reactions



towards cashless benefits (service restriction, informal payment, selective empanelment) to patients (Dave et al., 2021; Vellakkal, 2013). The quasi-experimental and claim record studies provide evidence that insurance may change provider incentives to have both demand and supplier induced effects (changes in length of stay, rigor of services) that are difficult to predict directly regarding patient movement to the private facilities.

Qualitative work and household-level focus on patient perceptions that direct the choice of hospitals. Insured patients are often encouraged to switch to a private hospital when they have reduced financial barriers in the face of perceived quality, reduced wait times, and reputation; however, distrust of empanelment processes, fear of cost-skimming, or previously negative experiences with private empanelled providers can counter such a switch (Reshmi et al., 2021; Singh, 2022). The socio-economic heterogeneity will be important: richer and urban households will more readily afford insurance and access the private care, but the impoverished may still be prevented (due to awareness, transport, co-payments) even with the cashless plans (Yadav, 2021; Harish et al., 2020).

More recent empirical research asks the question of whether cashless empanelment can realistically enhance financial protection in case of care shifting to the private providers. A number of studies conducted at the state level and based on household expenditure data indicate that PFHI was lowering OOP in certain situations, but in other scenarios the residual payments and catastrophic expenditure in the private sector stayed at significant levels due to PFHI (Kumar et al., 2023; Sriram et al., 2022). These inconclusive findings provide evidence that empanelment in and of itself is a necessary and yet inadequate prerequisite to equitable and cost protecting redirection of care to the private hospitals.

Collectively, the literature helps to develop three proximate conclusions that are applicable to the given study: (1) cashless insurance leads to the greater formal hospital utilisation but does not ensure the lessening of OOP; (2) the presence of the private hospitals occupying a significant part of the empanelment capacity and claims means they are key players in ensuring the provision of the insurance-led change in care-seeking; and (3) the overall impact on hospital choice and financial protection of patients is to be achieved by the combination of the empanelment density, tariff and reimbursement practices, The empirical gap is a stringent pathway-based quantification of the effects of cashless empanelment, based on turns toward

treatment in favor of private hospitals, and consider these mediating elements-gap that is desired to be bridged in this paper.

Objective:

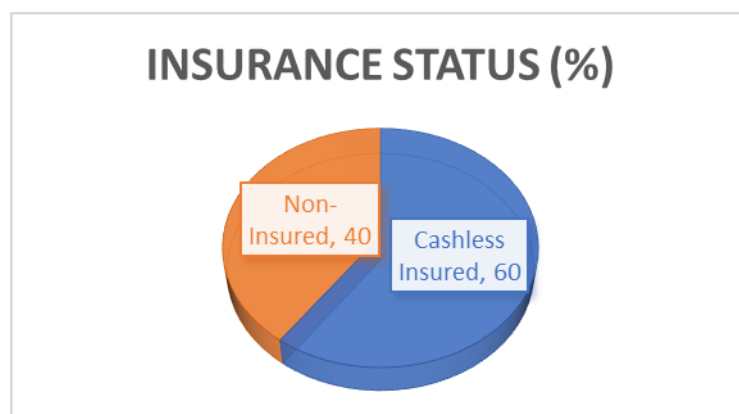
This study aims at conducting an empirical study of the role of cashless health insurance in modifying the treatment-seeking behaviour of patients to the private healthcare institutions as well as the impact that insurance empanelment has on hospital choice and service usage pattern and the financial burden of the insured beneficiaries sought of private healthcare facilities against uninsured individuals.

Methodology

The research design used in this study is descriptive and analytical research design to study the issue of cashless health insurance and its impact on the treatment-seeking behaviour in relation to the institutions of the healthcare privatisation. The structured questionnaire will be used as a primary data selection tool to enable the collection of primary data to be done concerning the insured and non-insured patients who have received inpatient services. The sample size of 200 respondents will be obtained through stratified random sampling to obtain the necessary representation in terms of insurance status and type of hospital, whereas secondary data will be gathered by consulting published reports and journal articles to facilitate analysis.

Data Analysis

The current research is founded on the primary data that was gathered among 200 respondents (cashless insured as well as non-insured patients who used inpatient services).





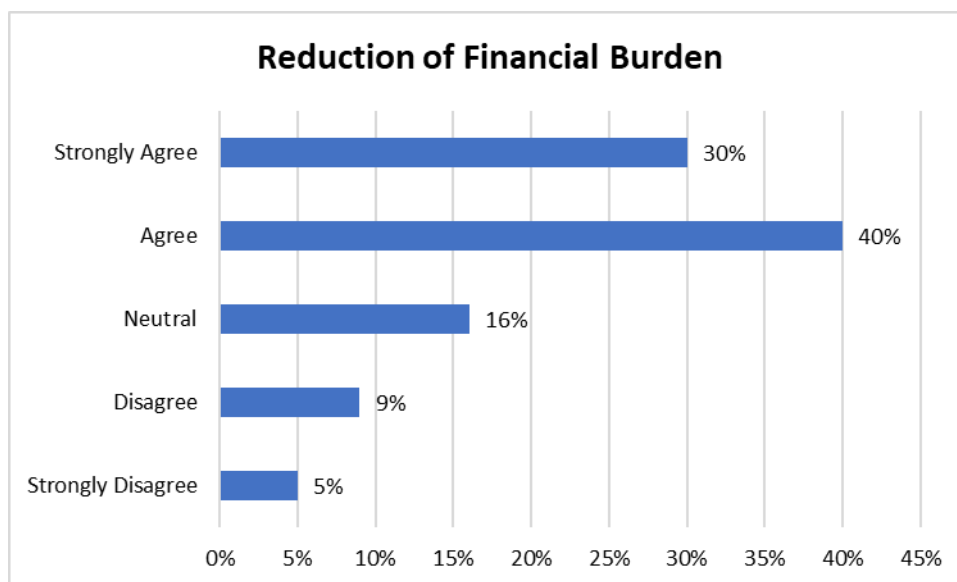
Sixty percent of the 200 respondents were insured by cashless health insurance schemes, and 40 percent were not insured. As a comparative means of analysing treatment seeking behaviour, the distribution is balanced.

Table 1 Cross Tabulation of Insurance Status and Hospital Preference

Insurance Status	Private Hospital	Public Hospital	Total
Cashless Insured	92 (76.7%)	28 (23.3%)	120
Non-Insured	30 (37.5%)	50 (62.5%)	80
Total	122 (61.0%)	78 (39.0%)	200

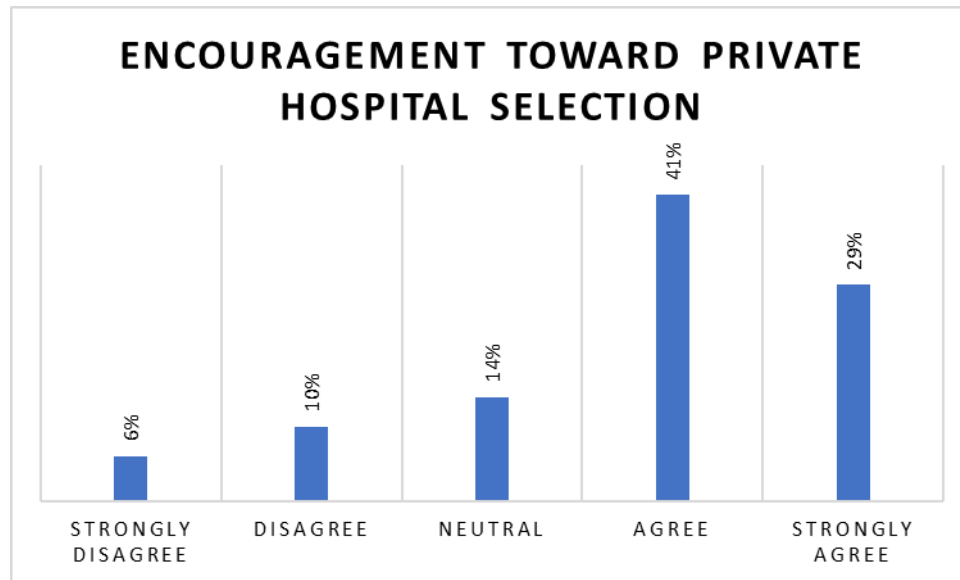
There was a significant preference among insured respondents with private hospitals 76.7% of the total respondents compared with a non-insured which was only 37.5%. On the other hand, 62.5 percent of uninsured respondents liked the public hospitals. The results have a high likelihood that cashless health insurance plays a significantly significant role in causing patients to opt to be treated in privately owned health institutions.

The perception of the respondents towards financial relief, hospital preference, and perceived quality were measured on a five-point Likert scale.

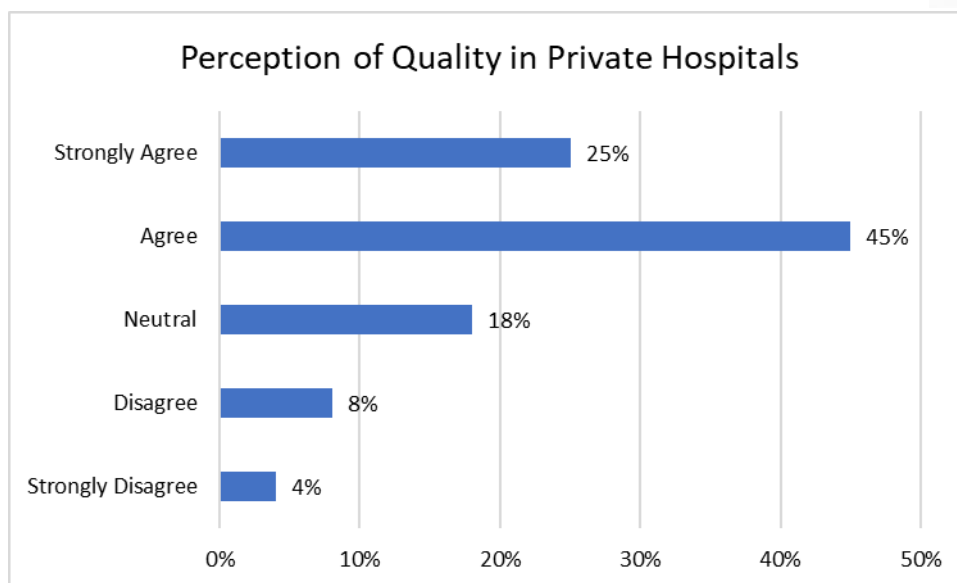


Above Figure shows that a big majority of the respondents believe that cashless health insurance can help to diminish the financial cost incurred in hospitalization. Nearly 70% of the respondents agreed (40 percent), or strongly agreed (30 percent) with the statement, and

only 14 percent disagreed with it. The average score obtained is 3.81 (out of 5 points), which is a high positive perception. This observation implies that the cashless tool is able to reduce both direct out-of-pocket spending and financial pressure immediately after the treatment and, therefore, acts as the important enabling element of healthcare decision-making.



Above figure indicates that 70 percent of the respondents said they agreed or strongly agreed that cashless health insurance will make them prefer to seek treatment in the private hospitals. Only one out of five (16 percent) people expressed opposing the idea, and 14 percent were neutral. The average score of 3.77 shows that there is a great agreement between respondents. This illustrates that the presence of cashless facilities has a significant impact on the preferences of hospitals as it reduces the barriers to entry into private healthcare facilities thus helping to facilitate a behavioral change in the system between the public and the private providers.



As shown above in Figure, 70% of the respondents affirmed or strongly affirmed that the services offered by private hospitals are better than other services. The perception of superior quality happens to be a solid determining factor of hospital choice when the mean of its scores is 3.79. The percentage of people who did not support the statement is 12 and 18 per cent found themselves in agreement. The results display that, in addition to financial incentives, perceived level of care is a very important complement to the critical role in determining the behavior of insured patients in seeking treatment in the privately owned healthcare facilities.

The empirical results indicate a high correlation between the coverage of cashless health insurance and the preference of the privatized healthcare organizations. Utilization of the private hospitals among insured respondents was very high as compared to other non-insured people. Likert scale study establishes that financial relief, perceived quality, and ease of access are the leading factors that bring this behavioural change. The findings support the thesis that the cashless empanelment systems are the central factor affecting the choices to seek treatment.

Conclusion

The study results clearly state the fact that cashless health insurance is key in determining the treatment seeking behaviour to the private healthcare institutions. The ratio of insured respondents who indicated preference of private hospitals over non-insured persons was significantly higher which implies that a quantifiable change could be attributed to the



elimination of the immediate monetary barriers. Likert scale analysis further proves that the decrease in financial load, simple admissions and perceived high quality of private hospitals are all the forces that lead to this behavioural change. The average scores with more than 3.5 in the crucial variables indicate a very favorable impression of cashless insurance systems. Nevertheless, even though insurance increases the availability of the private healthcare provision, the remaining costs and quality disparities identify that financial health insurance can be expected to be in some measure uneven. On the whole, the research concludes that cashless empanelment is a conclusive point in patient flows reorientation to the private healthcare providers.

Recommendations

Going by the findings, it is advised that policy makers enhance regulation on empanelled private hospitals to make sure that there is actual cashless treatment without any disguised or informal costs. They should have standardized bundles of treatments and timely reimbursement systems to avoid cost increase and denial of services. Sensitization should also be carried out to enhance the knowledge of insurance schemes beneficiaries on coverage limits and entitlements. Additionally, the services should ensure benchmarking of quality of pancreatic hospitals in an attempt to accredit them in order to uphold the standards of services. The future of multipanelment in underserved regions will enhance fair access and less overreliance on individual facilities. Finally, institutionalized constant monitoring and impact assessment systems are also necessary to make sure that cashless insurance schemes can be used not only to get a higher number of people insured but also protect their financial needs significantly.

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