



Hospital Empanelment Under Mizoram's Universal Health Care Scheme

Challenges and Implications for Financial Protection of Beneficiaries

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Abstract: The Mizoram Universal Health Care Scheme (MUHCS) aims to provide accessible, cashless healthcare to reduce the financial burden of hospitalization. This study evaluates the efficacy of MUHCS by surveying 20 patients—10 each from empanelled and non-empanelled hospitals—using a structured questionnaire and analyzing secondary data from official handbooks. SPSS was applied for data analysis and cross-tabulations. Findings reveal that patients in empanelled hospitals benefit from cashless treatment, incur lower out-of-pocket expenses, and report higher satisfaction, while non-empanelled hospital patients face greater financial hardship. Challenges include limited hospital empanelment, low awareness, slow claim processing, and insufficient collaboration between private hospitals and the government. Respondents recommend expanding public hospitals, increasing awareness, ensuring faster processing, and fostering better coordination with private hospitals. The study concludes that MUHCS has positively impacted healthcare access and financial protection, but strategic improvements are necessary to maximize its benefits and efficiency.

Index Terms - Mizoram Universal Health Care Scheme, cashless healthcare, empanelled hospitals, patient satisfaction, financial protection, health insurance, healthcare accessibility.

Introduction

The evolution of publicly funded health protection schemes in Mizoram reflects the state's ongoing efforts to strengthen financial risk protection and enhance access to quality healthcare. The journey began in April 2008 with the introduction of the Mizoram State Health Care Scheme (MSHCS), a state-led initiative aimed at providing basic financial coverage to households that were not adequately protected by central schemes. In September 2010, following the launch of the Rashtriya Swasthya Bima Yojana (RSBY) by the Central Government, Mizoram attempted to streamline and integrate RSBY with MSHCS to reduce duplication and enhance administrative efficiency.

In 2018, RSBY was discontinued nationwide and replaced by the Ayushman Bharat–Pradhan Mantri Jan Arogya Yojana (AB-PMJAY). During its first year of implementation in Mizoram, AB-PMJAY was merged with MSHCS. However, operational challenges—especially the use of separate digital portals and administrative systems—made the merger difficult, leading the state to allow MSHCS to function independently again from 2019 onward.

A major policy transition took place on 1 April 2025 with the launch of the Mizoram Universal Healthcare Scheme (MUHCS). Designed as a comprehensive and unified state health protection program, MUHCS fully replaced MSHCS and marked Mizoram’s move toward a more streamlined and inclusive universal health coverage architecture. Within this new framework, the empanelment of hospitals—determining which public and private facilities can provide services under MUHCS—has emerged as a central issue, shaping both access to care and the overall financial protection available to beneficiaries.

Overview of Mizoram Universal Healthcare Scheme

The successful rollout of a universal health coverage programme depends fundamentally on the strength of its institutional framework. In Mizoram, the Mizoram State Healthcare Society (MSHS)—already responsible for implementing AB-PMJAY—has been designated to manage the newly launched Mizoram Universal Health Care Scheme (MUHCS). To enhance administrative capacity, the Society will be further strengthened and equipped to handle the expanded mandate. At the policy level, the Government of Mizoram proposes the establishment of a Universal Health Coverage Council (UHCC), chaired by the Minister of Health and Family Welfare and comprising senior officials from relevant departments. The UHCC will serve as the apex body for policy direction, interdepartmental coordination, and oversight, with the Secretary of Health functioning as its Member Secretary and the CEO of MSHCS acting as its Convener.

MUHCS officially comes into effect on 1 April 2025, offering coverage to all bona fide residents of Mizoram. Eligibility is structured across multiple categories, including AB-PMJAY beneficiaries, state government employees, MSHS staff, provisional and muster roll employees, civil pensioners, and the general population, who will be enrolled as contributory beneficiaries. Registration will be conducted both online and offline, requiring Aadhaar for individual identification and ration cards or certified village council letters for verification of family members. MSHS will operate district and facility kiosks to ensure smooth enrolment, while government employees and provisional staff will be verified directly through existing databases such as IFMIS and PDS.

The scheme enables both online and offline enrolment pathways. Contributory beneficiaries may register digitally by uploading required documents and paying premiums through UPI or other electronic payment modes, while offline enrolment is available at sub-centres where physical forms are submitted and later uploaded to the digital system. MUHCS adopts a differentiated premium structure for contributory households, with three plan options—General, Standard, and Private—priced at ₹2,500, ₹5,000, and ₹10,000 per family per year respectively, all linked to a ₹5 lakh annual benefit but with varying room entitlements. Government employees will contribute monthly based on pay levels, while civil pensioners are divided into two categories with separate contribution rates and benefit limits. Special provisions allow pensioner households with multiple pensioners to combine or split benefits as needed.

MUHCS provides broad benefit coverage including OPD, day-care services, hospitalization, and travel reimbursement under defined conditions. Package rates, based largely on AB-PMJAY's national master but rationalised for Mizoram's context, will guide payments to empanelled hospitals. To ensure no beneficiary is denied care, the scheme includes an unspecified surgical package for procedures not listed in the scheme's package master, subject to strict criteria, mandatory pre-authorization, and medical expert review, especially for high-cost or life-saving interventions.

As a cashless scheme, MUHCS relies heavily on a digital Transaction Management System enabling real-time patient registration, pre-authorization, claim submission, and adjudication. Extended hospitalization requires periodic renewal of approvals, and stays beyond 30 days need direct permission from MSHCS. Home dialysis is the only service reimbursed rather than offered cashlessly.

Empanelment under MUHCS includes all public hospitals with inpatient facilities and private hospitals meeting predefined criteria. All hospitals empanelled under AB-PMJAY automatically qualify. Portability is a major feature: beneficiaries can access care in empanelled hospitals outside Mizoram, provided they obtain a referral from the Medical Referral Board. Non-empanelled care outside the state is also permitted on a reimbursement basis when services are unavailable within the network or in emergencies, with reimbursement capped at MUHCS package rates or CGHS rates.

To ensure successful implementation, MUHCS incorporates a strong supply-side strengthening strategy, emphasizing capacity building, improved signages, help-desks, and the upgrading of public hospitals. Vertical health programmes will be integrated into the MUHCS IT platform to streamline reporting and service delivery. Standard Operating Procedures covering beneficiary registration, claims management, anti-fraud measures, grievance redressal, private hospital categorization, service quality audits, and financial guidelines will form the backbone of the scheme's governance architecture.

Overall, MUHCS represents a significant step in Mizoram's move toward universal health coverage, anchored in a strengthened institutional mechanism, a streamlined enrolment system, comprehensive benefits, and transparent administrative processes.

Challenges in Hospital Empanelment Under MUHCS

A major challenge observed under the Mizoram Universal Healthcare Scheme (MUHCS) is the limited participation of private hospitals in the empanelment process. The Non-Government Hospital Association of Mizoram (NGHAM), which represents most private hospitals in the state, has been reluctant to join MUHCS primarily due to the government's notified treatment rates, which they perceive as too low to sustain operational costs. Additionally, there exists a notable trust deficit between private hospitals and the state government, rooted in earlier experiences such as the Government Servant Medical Reimbursement Scheme that was implemented in collaboration with ICICI Lombard, where delays and disputes reportedly created long-term dissatisfaction among private providers. As a result of these financial and institutional concerns, private hospitals have withheld participation, leading to severe shortages in empanelled facilities under MUHCS. This limited network undermines the scheme's objectives of improving access to quality care and poses significant challenges for beneficiaries who face reduced options and potential overcrowding in the few participating hospitals.

In light of the ongoing challenges in hospital empanelment under the Mizoram Universal Healthcare Scheme (MUHCS)—particularly the reluctance of private hospitals under the Non-Government Hospital Association of Mizoram (NGHAM) to participate—this study adopts a comparative, patient-level approach to understand the implications of limited empanelment. To capture differences in access, financial burden, and patient experience, the research purposively selected two categories of hospitals: MUHCS-empanelled hospitals and non-empanelled private hospitals. From each category, 10 patients were interviewed, yielding a total sample of 20 respondents. This design allows the study to assess how the shortage of empanelled hospitals affects beneficiaries' utilization patterns, out-of-pocket expenditures, and perceived quality of care, while also revealing how patients navigate the system when MUHCS coverage is unavailable in many private facilities.

Review of Literature

Ayushman Bharat and the Road to Universal Health Coverage in India — Vikash R. Keshri & Subodh Sharan Gupta (2019), in their editorial, they examine India's progress toward Universal Health Coverage (UHC) through the lens of the Ayushman Bharat programme, launched in 2018 as a major policy initiative aligned with SDG-3. They highlight the scheme's two components—PMJAY, a large publicly financed insurance programme covering nearly 40% of India's population, and Health and Wellness Centres (HWCs) aimed at strengthening primary care. While acknowledging the potential benefits of PMJAY, including cashless care up to ₹5 lakh per family and coverage of 1350 procedures, the authors argue that its impact on reducing financial hardship will be limited because outpatient care—constituting 60% of OOOPE—is excluded. They discuss significant challenges: uneven state capacity, inequitable distribution of private hospitals, weak regulation, lack of standard treatment guidelines, fiscal inadequacy, and risks of widening interstate disparities through portability. Similarly, HWCs are seen as ambitious but unrealistic given historical gaps in primary-care development and the absence of a clear implementation roadmap. The authors conclude that Ayushman Bharat may inadvertently shift resources from public to private sectors and from preventive to curative care, emphasizing the need for stronger regulation, governance capacity, and a grounded understanding of India's diverse health systems before such large-scale reforms can achieve true UHC.

In their article "*Evolution of Government-funded Health Insurance for Universal Health Coverage in India,*" Dubey, Deshpande, Krishna, and Zadey (2023) examine India's long trajectory of publicly financed health insurance schemes and their implications for universal health coverage (UHC). The authors outline how successive programmes—from ESIS (1948) and CGHS (1954) to later schemes such as UHS (2003), Aarogyasri, and Vajpayee Arogyashri—culminated in the national-level Rashtriya Swasthya Bima Yojana (RSBY) launched in 2008, which was eventually replaced by the Pradhan Mantri Jan Arogya Yojana (PMJAY) in 2018. Their review shows that while Government-Funded Health Insurance (GFHI) schemes have improved financial protection for inpatient care, the overall impact remains limited due to low utilization; for instance, only about 4 percent of eligible PMJAY beneficiaries used the scheme in 2019–20 despite high hospitalization coverage of up to 500,000 rupees per family per year. They highlight significant challenges such as high catastrophic health expenditure (CHE)—with national CHE rates around 17% and district-level variation from 0% to 70%—and the growing burden of chronic diseases whose outpatient costs are largely excluded from existing GFHI schemes. The authors argue that because outpatient expenditure constitutes a major share of out-of-pocket spending, the absence of outpatient coverage restricts the schemes' effectiveness

in reducing financial hardship. The review concludes that an integrated UHC strategy must address system fragmentation, strengthen primary care, and expand coverage beyond hospitalization to meaningfully reduce out-of-pocket expenditure and enhance health system efficiency.

In *“Lessons from Thailand: Universal Healthcare Achievements and Challenges,”* Ravikan Nonkhuntod and Suchuan Yu provide (2018) a comprehensive assessment of Thailand’s universal healthcare system through a systematic review and meta-analysis of studies published between 2001 and 2015. Drawing on 33 eligible studies from PubMed and Google Scholar, the authors evaluate outcomes related to healthcare utilization and out-of-pocket (OOP) expenditure, applying random-effects models to address high heterogeneity across studies. Their findings reveal small but statistically significant positive effects—indicating improved service utilization and modest reductions in OOP spending following the implementation of Thailand’s Universal Coverage Scheme (UCS). The paper effectively situates these results within Thailand’s historical evolution of health financing schemes and highlights both the successes of broad population coverage and persistent challenges such as benefit inequality across schemes and system fragmentation. Overall, the study offers valuable evidence for policymakers seeking to understand the real-world impact of Thailand’s move toward universal health coverage.

In their article titled *“The Impact of Common Empanelment of Hospitals on the Quality and Cost of Health Care in India,”* Asish Dash, Prof. Swarupa C. Kulkarni, and Dr. Arjita Jain (2024) examine how a unified hospital empanelment system—managed through a proposed Health Network Management Organization (HNMO)—influences healthcare quality, cost efficiency, and system governance in India. Drawing on a detailed review of primary and secondary literature from international organizations and Indian policy sources, the authors argue that common empanelment has the potential to improve standardization, transparency, and cost control by harmonizing accreditation criteria and service pricing across insurers. Their analysis highlights persistent challenges faced by HNMOs, including limited technical capacity, inconsistent protocols, weak coordination among insurers, and low trust between hospitals and regulatory bodies. Despite these constraints, the article underscores that common empanelment is integral to strengthening accountability mechanisms, reducing out-of-pocket expenditure, and improving the quality of care within India’s fragmented healthcare landscape. The authors conclude that meaningful reform will require stronger regulatory frameworks, enhanced data systems, clearer guidelines, and robust incentive structures to ensure that common empanelment delivers equitable and high-quality health services across the country.

In *“Japan’s Universal Health Coverage: Achievements, Challenges, and the Future of Social Health Insurance”* by Naoki Ikegami (2011) and colleagues, the authors present a comprehensive and insightful analysis of how Japan’s dual system of employee-based and community-based social health insurance shaped its journey toward universal health coverage. The review highlights Japan’s significant achievements—near-universal enrolment by 1961, strong cost containment through a unified fee schedule, and substantial equity ensured via cross-subsidisation and government support—while also pointing to persistent structural issues such as the fragmentation of 3500 insurance plans, uneven premium burdens, and the rising strain of an ageing population. Drawing on historical development, utilisation trends, financing mechanisms, and current policy pressures, the authors argue convincingly for the consolidation of insurance plans at the prefectural level to

sustain equity and financial stability. Overall, this article provides a rigorous and balanced assessment useful for countries considering social health insurance-based pathways to universal coverage.

In “*Evaluating the Efficacy of Cashless Health Insurance Services in India*,” Anupam Dutta and Seema S. Singha (2025) present a comprehensive examination of the rapid expansion of the health insurance sector in India and the growing prominence of cashless claim services. The authors argue that rising literacy levels, increasing health awareness, and technological improvements—alongside government initiatives such as Ayushman Bharat and 100% FDI liberalisation—have contributed to a substantial widening of the health insurance market. Their review explains how cashless services emerged as a response to consumer difficulties with reimbursement-based claims, offering immediate financial protection during hospitalisation and improving customer satisfaction. They highlight key opportunities created by cashless systems, including expanded coverage, product innovation, digitisation, and the rising demand for quality healthcare. At the same time, the authors identify persistent challenges such as claim settlement issues, high incurred claim ratios, inadequate distribution channels, documentation barriers, lack of transparency in grievance redressal, and increasing competition from foreign insurers. The study concludes that although cashless health insurance has transformed access to healthcare, the sector must address structural gaps, strengthen consumer trust, and develop innovative, customer-centric strategies to realise its potential in India’s evolving healthcare landscape fully.

Methodology

This study adopts a quantitative research design to examine the challenges of hospital empanelment under the Mizoram Universal Healthcare Scheme (MUHCS) and its implications for beneficiaries. Primary data were collected through a structured and pre-tested scheduled questionnaire, administered to 10 patients in MUHCS-empanelled hospitals and 10 patients in non-empanelled private hospitals, making a total sample of 20 respondents. This comparative approach enables an assessment of variations in service utilization, financial burden, and patient experiences across the two hospital categories. The collected primary data were coded and analysed using SPSS, applying descriptive statistics to identify patterns and differences. For secondary data, official documents were consulted, including the handbook of the Mizoram Universal Health Care Scheme (MUHCS) published by the Health & Family Welfare Department and the Mizoram State Health Care Society, along with scheme-related information available on their official website. Together, these data sources provide a robust foundation for analysing the operational challenges and outcomes associated with hospital empanelment under MUHCS.

Findings

In the analysis stage, a cross-analysis was carried out between responses from empanelled and non-empanelled hospitals to identify differences in access, service quality, financial protection, and overall patient experience. Using SPSS, the study compared key variables across the two groups, allowing for a clearer understanding of how hospital empanelment under MUHCS affects beneficiary outcomes. The cross-tabulated results are presented in the Analysis section to highlight contrasts and emerging patterns between the two hospital types.

1. Awareness of MUHCS by Type of Hospital: A cross-analysis was conducted to examine whether awareness of the Mizoram Universal Health Care Scheme (MUHCS) differed between patients

attending empanelled and non-empanelled hospitals. Out of the total 20 respondents, 17 (85%) reported having heard about MUHCS, while 3 (15%) had not. Among patients from empanelled hospitals, 9 out of 10 (90%) were aware of MUHCS, and 1 (10%) was not. In comparison, among those from non-empanelled hospitals, 8 out of 10 (80%) had heard of MUHCS, while 2 (20%) had not. Overall, awareness was high across both groups, but patients from empanelled hospitals showed slightly higher awareness (90%) than those from non-empanelled hospitals (80%). This suggests that empanelment status may slightly influence the visibility and dissemination of information regarding MUHCS.

2. **Source of Awareness and Type of Hospital:** Among the 18 respondents who had heard about MUHCS, notable differences emerge between patients from empanelled and non-empanelled hospitals. In empanelled hospitals, awareness was predominantly spread through Government Campaigns, accounting for 78% (7 out of 9) of the informed respondents. Friends/Relatives contributed to 22%, while no respondents reported learning about the scheme from Hospital Staff or Social Media. In contrast, patients from non-empanelled hospitals showed a more varied pattern. Government Campaigns remained the major source but at a lower 67% (6 out of 9). Meanwhile, Hospital Staff contributed 22%, and Social Media accounted for 11%. No respondents in this group cited Friends/Relatives as their source of information. Overall, combining both hospital types, Government Campaigns emerged as the single largest source of awareness at 72% (13 out of 18), followed by Friends/Relatives at 11%, Hospital Staff at 11%, and Social Media at 6%. This indicates that while government-led communication efforts remain central, the role of hospital staff and digital platforms varies significantly depending on hospital type.
3. **Awareness of Cashless Treatment Benefit Under MUHCS:** The analysis shows that awareness regarding the cashless treatment provision of MUHCS is identical across both empanelled and non-empanelled hospital respondents. In empanelled hospitals, 80% (8 out of 10) of patients reported being aware of the cashless benefit, while 20% were unaware. The same distribution was observed among respondents from non-empanelled hospitals, where 80% were aware and 20% were not. Overall, out of the total 20 respondents, 16 individuals (80%) indicated awareness of the cashless treatment feature, whereas 4 respondents (20%) lacked this knowledge. This suggests that general awareness of the cashless component is relatively high and does not differ based on the type of hospital the patients visit.
4. **Awareness of Out-of-Pocket Payment Requirement in Non-Empanelled Hospitals:** The findings reveal a strong overall awareness regarding the requirement to pay the full treatment cost when admitted to non-empanelled private hospitals in Mizoram. Among respondents from empanelled hospitals, awareness was universal, with 100% (10 out of 10) acknowledging that patients must pay out-of-pocket in such hospitals. In contrast, awareness among patients in non-empanelled hospitals was slightly lower, though still high: 80% (8 out of 10) were aware of this requirement, while 20% were not. Taken together, 90% (18 out of 20) of total respondents understood that MUHCS does not provide financial coverage in non-empanelled hospitals, whereas 10% lacked this awareness. This gap—

particularly within non-empanelled institutions—indicates a need for clearer communication regarding financial responsibilities under the scheme.

5. **Attention Toward MUHCS and Public Health Care Systems:** The respondents showed a mixed pattern regarding when they pay attention to MUHCS or other public health care systems. Among patients in empanelled hospitals, half of them—50% (5 out of 10)—reported that they pay attention only when they or their family members require hospitalization. The remaining 50% indicated that they actively follow such schemes even before needing them. A similar trend is observed in non-empanelled hospitals, though with slight variation. Here, 40% (4 out of 10) pay attention only when hospitalization becomes necessary, while a majority—60% (6 out of 10)—remain attentive to health policies beforehand. Overall, the results suggest that proactive awareness of public health schemes is slightly higher among patients in non-empanelled hospitals. However, in both settings, a substantial proportion of respondents only engage with health schemes at the point of personal need, indicating limited routine awareness of public health financing mechanisms.
6. **Reasons for Choosing Empanelled vs. Non-Empanelled Hospitals:** The reasons for hospital choice show a distinct difference between patients admitted to empanelled and non-empanelled facilities. Among respondents in empanelled hospitals, the decision was evenly divided: 50% (5 out of 10) chose the hospital due to convenience for diagnosis, while the remaining 50% selected it based on their financial situation—either to avoid financial burden or because their financial condition allowed it. In contrast, respondents in non-empanelled hospitals demonstrated a uniform pattern. All patients—100% (10 out of 10)—reported admitting themselves or their family members solely due to convenience for diagnosis, with 0% citing financial considerations. This indicates that, despite the higher out-of-pocket expenses required in non-empanelled hospitals under MUHCS, diagnostic convenience remains the dominant factor influencing hospital selection in these settings. Overall, 75% (15 out of 20) of respondents across both categories prioritised diagnostic convenience, while 25% (5 out of 20) considered financial circumstances. This highlights a critical challenge for MUHCS: even though empanelment offers financial protection, patients may still prefer non-empanelled hospitals if they perceive superior or more convenient diagnostic services there.
7. **Information Provided by Hospitals on MUHCS Eligibility and Benefits:** A significant disparity was observed between empanelled and non-empanelled hospitals regarding patient communication about MUHCS eligibility and benefits during admission. Among patients admitted to empanelled hospitals, 80% (8 out of 10) reported that they were informed about their eligibility or scheme benefits, while 20% stated that they received no such information. In contrast, communication in non-empanelled hospitals was notably weaker. Only 30% (3 out of 10) of respondents were informed about MUHCS-related benefits, whereas a large majority—70% (7 out of 10)—reported receiving no information at all. Overall, among all respondents, only 40% (8 out of 20) were informed about their MUHCS eligibility during admission, while 60% (12 out of 20) were not. This gap reflects a systemic challenge in disseminating scheme information, particularly in non-empanelled hospitals, where patients are at a greater risk of incurring high out-of-pocket expenses without being aware of available financial protection mechanisms.

8. Overall Quality of Services Provided by Hospitals: Patients' perception of service quality varied between empanelled and non-empanelled hospitals. Among empanelled hospital respondents, 10% (1 out of 10) rated the service as very good, 80% (8 out of 10) as good, and 10% (1 out of 10) as average. None of the respondents considered the service poor. This indicates a generally positive perception of service quality in empanelled hospitals. In non-empanelled hospitals, 50% (5 out of 10) rated the service as very good, 40% (4 out of 10) as good, and 10% (1 out of 10) as poor, with no respondents marking it as average. Although the proportion of very good ratings was higher in non-empanelled hospitals, there was also the presence of poor ratings, suggesting greater variability in service quality. Overall, across all hospitals, 30% (6 out of 20) rated services as very good, 60% (12 out of 20) as good, 5% (1 out of 20) as average, and 5% (1 out of 20) as poor. This shows that most patients perceive hospital services positively, but quality consistency may vary between empanelled and non-empanelled facilities.
9. Satisfaction with Hospital Staff's Attitude and Assistance: Patient satisfaction with hospital staff varied across empanelled and non-empanelled hospitals. In empanelled hospitals, 0% (0 out of 10) were very satisfied, 90% (9 out of 10) were satisfied, and 10% (1 out of 10) were dissatisfied. This indicates that most patients had a generally positive experience with staff, though very few rated their experience as excellent. In non-empanelled hospitals, 40% (4 out of 10) of respondents were very satisfied, 50% (5 out of 10) were satisfied, and 10% (1 out of 10) were dissatisfied. This shows a higher proportion of strong satisfaction in non-empanelled hospitals, but similar levels of dissatisfaction as empanelled hospitals. Overall, across all hospitals, 20% (4 out of 20) were very satisfied, 70% (14 out of 20) were satisfied, and 10% (2 out of 20) were dissatisfied. This suggests that while most patients were satisfied with hospital staff and assistance, there is room for improvement in creating consistently very positive patient experiences.
10. Hospital Choice Considering Costs, Services, and Facilities: When asked about their preferred hospital after considering prices, services, facilities, and family financial status, the majority of patients preferred empanelled hospitals.
- Among patients admitted to empanelled hospitals, 90% (9 out of 10) would choose an empanelled hospital again, while 10% (1 out of 10) would opt for a non-empanelled hospital.
 - Among patients admitted to non-empanelled hospitals, 100% (10 out of 10) stated they would choose an empanelled hospital if given the choice.
 - Overall, 95% (19 out of 20) of all respondents preferred empanelled hospitals over non-empanelled hospitals, while only 5% (1 out of 20) would choose a non-empanelled hospital.

This indicates a strong patient preference for empanelled hospitals under the MUHCS, likely due to cashless treatment, cost-effectiveness, and perceived quality of care, highlighting the importance of increasing empanelment and accessibility of such hospitals for patients.

11. Financial Hardship for Non-Empanelled Hospital Patients: Among patients admitted to non-empanelled hospitals under MUHCS: 80% (8 out of 10) reported that hospitalization caused financial hardship for their family. 20% (2 out of 10) reported that it partially caused financial hardship. This highlights that hospitalization in non-empanelled hospitals leads to significant out-of-pocket expenses, emphasizing the importance of cashless treatment at empanelled hospitals to reduce financial burden for patients.

12. Opinion on the Cashless System of MUHCS : Among the respondents

Empanelled Hospital Patients (10 respondents):

40% (4 patients) considered the cashless system very beneficial.

50% (5 patients) considered it beneficial.

10% (1 patient) were neutral.

Non-Empanelled Hospital Patients (10 respondents):

40% (4 patients) considered the system very beneficial.

20% (2 patients) considered it beneficial.

40% (4 patients) were neutral.

Overall (20 respondents):

40% (8 respondents) found it very beneficial.

35% (7 respondents) found it beneficial.

25% (5 respondents) were neutral.

Interpretation:

The majority of patients, especially those admitted to empanelled hospitals, perceive the cashless system positively, highlighting its convenience and financial relief. However, a notable proportion of patients in non-empanelled hospitals remain neutral, likely due to limited access or unfamiliarity with the cashless benefits.

13. Main Challenges of MUHCS (Respondents' Opinion): Based on the survey of 20 patients (multiple responses allowed, total responses = 29):

Limited Empanelment of Hospitals: 13 responses (44.8%): The most frequently reported challenge. Many private hospitals are reluctant to join MUHCS due to low government-notified rates and lack of trust from previous schemes, leading to limited access for patients.

Lack of Awareness: 12 responses (41.4%), a significant number of respondents indicated that patients often do not know about the scheme, its benefits, or the cashless treatment facility, reducing utilization.

Slow Processing of Claims: 2 responses (6.9%), a smaller proportion highlighted delays in claim processing as an issue, affecting the efficiency of service delivery.

Poor Cooperation Between Government and Private Hospitals: 2 responses (6.9%), Some respondents noted coordination issues between government authorities and private hospitals, which can limit the effectiveness of the scheme.

Overall, the survey indicates that structural issues, such as limited hospital empanelment and lack of awareness, are the primary challenges of MUHCS, while operational concerns like slow processing and poor cooperation are secondary. Addressing these challenges is crucial to improving accessibility, utilization, and patient satisfaction under the scheme.

14. Opinion on MUHCS Premium (Considering Family Financial Status and Hospital Availability): From the survey of 20 patients

Well Enough / Affordable: 15 responses (75%), the majority of respondents felt that the premium is reasonable considering the benefits, cashless treatment, and coverage provided by the scheme.

Too Costly: 4 responses (20%), a small proportion of respondents, particularly from non-empanelled hospital users, felt that the premium is high relative to their financial capacity.

Too Low: 1 response (5%), very few respondents considered the premium too low, potentially indicating a perception that the coverage may not match the cost.

Overall, most respondents perceive the MUHCS premium as reasonable, suggesting that cost is not a major barrier for enrollment for the majority. However, there is still a concern among some patients, especially those seeking care in non-empanelled hospitals, regarding affordability.

15. Responsibility of Private Hospitals for Non-Empanelment under MUHCS: The respondents were asked whether private hospitals should be blamed for not joining MUHCS and thereby increasing patients' financial burden. Out of 20 respondents:

Yes – Private hospitals are at fault: 6 responses (30%), some respondents feel that private hospitals are not prioritizing patient welfare, as their refusal to join the scheme increases out-of-pocket expenses for patients.

No – Hospitals are business institutions: 3 responses (15%), a few respondents recognize that private hospitals operate as businesses, and the cashless scheme may not be financially viable for them.

Neutral – Both sides partly responsible: 11 responses (55%), the majority of respondents take a balanced view, indicating that both the government and private hospitals share responsibility, given past issues like low notified rates and lack of trust in government schemes.

Most respondents (55%) believe that the responsibility is shared, highlighting the need for better government-private collaboration and trust-building measures to expand hospital empanelment under MUHCS. Only a minority fully blame private hospitals, reflecting a realistic understanding of the financial constraints on hospitals.

16. Suggestions for the Future of MUHCS: Respondents were asked for their suggestions on the future of MUHCS based on their experiences:

Going back to the old system (OOP/MUHSCS): 1 response (5%), very few respondents preferred reverting to the old out-of-pocket system, indicating limited support for the previous method.

Continuing the cashless system with improvements: 19 responses (95%), The overwhelming majority suggested that the cashless system should continue, but it must be enhanced according to government readiness, addressing issues like hospital empanelment, claim processing, and public awareness.

Almost all respondents favor the cashless MUHCS system over the old reimbursement method. This indicates strong public acceptance of cashless treatment, provided that the scheme is better managed and improved. This also highlights the importance of addressing existing challenges like limited empanelment and slow processing to ensure sustainability.

Expenditure and Duration of Hospital Stay Analysis

Type of Hospital	Total Expenditure Incurred in Rupees (Rs)	Average Expenditure incurred per patient in Rupees (Rs)	Duration of Hospital Stay	Average Duration of Hospital Stay	Average Expenditure of patients per day in Rupees (Rs)
Empaneled	269500	26950	105	10.5	2567
Non – Empaneled	518500	51850	80	8	6481

Source : Fieldwork, 2025

The analysis of patient expenditure and duration of hospitalization under the Mizoram Universal Health Care Scheme (MUHCS) reveals a clear distinction between empaneled and non-empaneled hospitals. The total expenditure incurred by patients in empaneled hospitals was Rs. 2,69,500, with an average of Rs. 26,950 per patient. In contrast, patients admitted to non-empaneled hospitals incurred a total expenditure of Rs. 5,18,500, with an average of Rs. 51,850 per patient. This indicates that the cost of hospitalization in non-empaneled hospitals was almost double that of empaneled hospitals, highlighting the financial benefits of utilizing cashless services under MUHCS.

When the duration of hospital stay is considered, patients in empaneled hospitals stayed for a slightly longer period, averaging 10.5 days, compared to 8 days in non-empaneled hospitals. Despite the longer stay, the average expenditure per patient per day in empaneled hospitals was Rs. 2,567, which is significantly lower than the Rs. 6,481 spent per day in non-empaneled hospitals. This difference emphasizes the cost-effectiveness of empaneled hospitals, as patients can receive treatment at a lower financial burden, even for extended hospital stays.

These findings underscore the importance of empanelment under MUHCS. While the duration of care remains comparable between the two types of hospitals, the cashless treatment rates in empaneled hospitals is lower than non-empaneled hospital that indicates for private hospitals these rate seems to be unacceptable. Non-empaneled hospitals, on the other hand, impose a higher financial strain, which can create hardship for families, especially those with limited income. Therefore, expanding the network of empaneled hospitals and encouraging patients to utilize these facilities can enhance access to affordable healthcare, ensuring that MUHCS fulfills its objective of reducing financial stress during medical emergencies.

Recommendations of Respondents

Based on the experiences and opinions of the respondents, several key recommendations emerged to improve the effectiveness of the Mizoram Universal Health Care Scheme (MUHCS). First, there is a strong consensus that private hospitals should collaborate more closely with the government to join the MUHCS network. Respondents emphasized that greater cooperation from private healthcare providers would reduce the financial burden on patients and increase accessibility to cashless treatment.

Second, the expansion of public hospitals is seen as a vital step to ensure wider coverage and availability of healthcare services. Many respondents highlighted the limited availability of empaneled hospitals as a significant challenge under MUHCS, suggesting that increasing the number and capacity of public healthcare facilities could bridge this gap.

Third, enhancing awareness about MUHCS among the general population is essential. Respondents noted that many patients remain uninformed about the benefits and procedures of the scheme, which affects its overall utilization. Effective awareness campaigns, including government outreach programs and the use of social media, could ensure that more people are informed and encouraged to use the scheme.

Finally, respondents strongly suggested faster processing of claims and administrative procedures. Delays in claim settlement and bureaucratic inefficiencies were cited as obstacles that undermine the convenience and reliability of the cashless system. Streamlining procedures and implementing technology-driven solutions for quick approvals could significantly enhance the user experience and satisfaction with MUHCS.

Overall, these recommendations highlight the need for better collaboration, expanded infrastructure, increased awareness, and improved administrative efficiency to strengthen MUHCS and make cashless healthcare more accessible and effective for the people of Mizoram.

Conclusion

The study on the Mizoram Universal Health Care Scheme (MUHCS) demonstrates that the scheme has created significant benefits for patients, particularly in empanelled hospitals, by providing cashless treatment and reducing the financial burden during hospitalization. Awareness of MUHCS is generally high, with government campaigns being the most effective source of information. Patients in empanelled hospitals show higher satisfaction with hospital services and staff assistance, while non-empanelled hospital patients experience greater out-of-pocket expenditures and occasional financial hardship.

Despite the positive impact of the scheme, challenges remain. Limited empanelment of private hospitals, primarily due to low government-notified rates and lack of trust, restricts patient access to cashless services.

Slow claim processing, lack of awareness among certain patient groups, and insufficient communication from hospitals further hinder the scheme's effectiveness.

Patients overwhelmingly support the continuation of the cashless system, emphasizing the need for expansion of hospital networks, faster claim processing, increased awareness, and better cooperation between the government and private hospitals. The preference for empanelled hospitals, coupled with reduced financial stress and higher satisfaction, highlights the critical role of cashless healthcare in improving access to quality medical services.

Overall, MUHCS has the potential to significantly enhance healthcare access in Mizoram, but its success depends on strategic improvements in hospital empanelment, public hospital expansion, administrative efficiency, and public engagement. Addressing these challenges will ensure the scheme achieves its goal of equitable and affordable healthcare for all residents.

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