

The role of the Catholic Church in the healthcare-seeking behaviour: A qualitative enquiry from Karnataka, India

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Abstract: By supporting socio-economic determinants of health, easing access to care, and advancing moral principles that direct patient-centred practice, religious communities have long been essential partners in health systems. Particularly in areas without institutional health infrastructure, faith-based organisations frequently mobilise resources, provide culturally sensitive care, and reach out to marginalised communities. The Catholic Church in the southern region of South India, with a focus on various parts of Urban Karnataka, has made full use of Sunday Mass services as a strategic opportunity to organise enrollment drives and camps for state-specific social health insurance schemes. This study aims to understand and explore the role of the Catholic Church across various parts of Karnataka, India, in relation to enrolment behaviour under the Ayushman Bharat Arogya Karnataka Scheme. This study qualitatively enquires from fellow believers on the role the church plays in their healthcare-seeking behaviour. It was observed that households enrolled in the AB-Ark scheme without encountering operational challenges at the ground level, such as delays or procedural ambiguity, due to the support of the churches. It was observed that through such interventions, healthcare is uplifted, and, along with it, the Catholic Church-led hospitals extend their reach beyond their Christian community; everyone benefits, thus creating an overall climate of well-being. The concept of health cannot be studied in isolation.

Keywords: social health Insurance, Catholic church, religions, enrollment behaviour

Introduction

Religious institutions and faith-based organisations often serve as critical intermediaries in the dissemination and utilisation of social welfare programs. Many religious institutions have extensive networks of congregations, charitable organisations, and community groups that

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serve disadvantaged populations and are essential for building trust and shaping social norms around seeking help. By drawing on moral discourses, collective identity, and social capital, religious actors can reduce information disparities, overcome access barriers such as transportation, documentation, and literacy, and offer specialised support that aligns with the cultural and spiritual environment. The literature reports that, since Independence, Catholic Institutions in India have fulfilled their role in social upbringing by educating the underprivileged (Toppo 2007). Furthermore, the role of Catholic Missionaries cannot be overstated in providing care facilities to the fishing community in Tamil Nadu. Compassion towards the lower tier of the population has been evident throughout history, as evidenced by the Portuguese Jesuits' construction of their centres and shelters (Dhanalakshmi 1997). As a country always struggling with its population as a construct, protecting children from socio-economic warfare has been significantly challenging for most households; thus, religious support from the church in lending them a better quality of life and protecting them from immoral activities has been actively provided by the Catholic church (Prasad Phillips 2015).

By supporting socioeconomic determinants of health, easing access to care, and advancing moral principles that direct patient-centred practice, religious communities have long been essential partners in health systems. Particularly in areas with no institutional health infrastructure, faith-based organizations frequently mobilize resources, provide culturally sensitive care, and reach out to marginalized communities. Through dependable community leadership, their networks may promote preventative behaviours, lower the stigma associated with sickness, and improve health literacy. Partnerships between religious organizations and public health officials have improved vaccination rates, maternal and child health outcomes, and emergency response capabilities in numerous low- and middle-income nations, highlighting the critical role that faith communities play in promoting holistic health.

The Catholic Church in the southern region of South India, with a focus on various parts of Urban Karnataka, has made full use of Sunday Mass services as a strategic opportunity to organise enrollment drives and camps for state-specific social health insurance schemes. This information was gathered through members of various Catholic churches across Bangalore as part of a study on the Ayushman Bharat Arogya Karnataka Scheme (AB-Ark). AB-Ark is the state-governed

public health insurance coverage provided to the economically weaker sections. Participants are provided with a coverage of 5 lakh rupees (\$5512) annually on a family floater basis for hospitalisation needs.

By aligning enrollment activities with the rhythms of Sunday worship, churches create a natural, community-centred flow that reduces barriers to engagement and invites parishioners and potential members to learn more in a familiar, reverent setting. It emphasises hospitality, clearly communicates about church programs, and provides practical assistance by explaining enrollment steps, including form submissions, catechetical information, and membership expectations.

This inclusive posture further acknowledges the region's social and cultural realities, where religious identity often intersects with daily life and neighbourhood networks. Consequently, inviting non-Catholics to participate in enrollment drives and camps helps the church nurture dialogue, mutual understanding, a sense of welcome, and clear information about the steps to affiliate or become meaningfully engaged in parish life. In this way, the post-Mass outreach functions not only as an administrative mechanism for enrollment but as a bridge-building exercise, strengthening local spiritual communities, fostering informed participation, and improving fellowship among diverse members of the neighbourhood.

Theoretical underpinning

Emile Durkheim's theory of religious functionalism serves as the primary structural backbone of this study. His idea of religion as above and beyond the spiritual and the sacred has been a significant ideology in sociology. He explained that, through symbolic interactionism and the creation of totems, society generates in-groups. He believed that religion accounts for social cohesion, better interpersonal relationships, morals, and overall societal well-being. He pointed out that religions create a sense of meaning and purpose in life and are associated with better psychological well-being. According to his philosophy, religion motivates and creates an environment to drive positive social change (Pressbooks 2016). This theoretical standpoint contributes to this study by viewing religion as a platform for creating better opportunities and access for people to achieve a higher quality of life.

Max Weber's philosophy of religion and social action holds that religion serves as a cultural norm and is the core driving force of society, with its ties to ethics. His ideology was criticised for its over-reliance on certain religions, its narrow focus on subgroups, and its

emphasis on capitalism. Weber's work has been channelled into understanding the major religions and how they have shaped the economic and trade stances of the countries in which they are practised over the years. Societal development, social order, and religion are interconnected forms (Bhadauria 2012).

These two theories have been considered a theoretical backdrop for this study because societal well-being, through stable health and healthcare access, contributes to population well-being and a strong workforce. Religions serve as cultural groupings that encourage devotees or members of churches to participate and contribute to society's upliftment.

Existing literature

By demonstrating that religious participation in morality-based social services is influenced by both opportunity structures (which determine the degree of involvement) and moral doctrines (which determine the type of engagement), the paper contributes to the body of research on faith-based welfare. By demonstrating how Protestant religious organisations frequently align with state goals while Catholic religious organisations frequently display incongruent, unconnected engagement, particularly in abortion and sex-work policy, it connects welfare-state research with religion and morality policy. In a secular welfare regime, this offers a nuanced, within-country comparative perspective on how doctrinal differences translate into implementation strategies (Mettang and Euchner 2023). To achieve long-term poverty reduction in Igbo communities, this study examines how state and Catholic Church welfare programs can work together or separately, evaluating opportunities for integration, gaps, and synergies. microfinance programs run by the Catholic Church that give women and young people small loans to launch or grow small businesses, encouraging independence and lowering reliance on aid. addresses a significant aspect of poverty related to health costs and access by focusing on Church-run clinics and hospitals that offer free or low-cost medical care, immunisations, and health education (Nwafenna and Ayika 2025). Abraham et al. 2024 argue that when its values, principles, and practices are applied to promote social welfare, economic growth, and environmental stewardship, religion can be a powerful force for sustainable development in Nigeria. It also examines the ways in which religious values can both support and undermine sustainability, highlights the critical role that religious

organisations play in development initiatives, and suggests inclusive, dialogue-rich strategies, as well as further research, to maximise the potential of religion while resolving conflicts and implementation issues. A theoretical review of Islamic social welfare is presented in this study, with an emphasis on the contribution of Islamic generosity and zakat to family resilience. By focusing on fair wealth distribution, poverty relief, and social justice through a well-organised zakat system, Islam provides a middle ground between capitalism and socialism. Zakat can be administered by the government or specialised organisations, although people are encouraged to give priority to their immediate family while allocating their income to the larger community. To illustrate zakat's capacity to address poverty, unemployment, debt, disasters, and income inequality within an Islamic framework, the study examines historical and contemporary perspectives on zakat, its goals, nisab criteria, and the relationship between zakat, charity (sadaqah), and infaq (Kakar et al. 2022).

Aim of the study

To understand and explore the role of the Catholic Church across various parts of Karnataka, India, in relation to enrolment behaviour under the Ayushman Bharat Arogya Karnataka Scheme. This study qualitatively enquires from fellow believers on the role the church plays in their healthcare-seeking behaviour. India has had a slow rate of health insurance coverage across all populations, which has improved over the years through the implementation of Universal Health Coverage and social health insurance schemes, such as Ayushman Bharat (Kavita Bajeli-Datt 2025). This observation is supported by the finding that health insurance enrollments are significantly influenced by social and cultural norms that shape their trust and belief systems (Deb & Urfat Anjem Mir 2023). Hence, this study aims to investigate the role of the church in improving enrollment ratios and healthcare opportunities in Karnataka, South India.

Methodology

Research Paradigm

The researcher has adopted a constructivist research philosophy to initiate this study. As established and curated by Creswell and Creswell (2023), this research paradigm emphasises multiple interpretations of data through the lens of both respondents and

researchers. This philosophy prioritises the participants' setting, their perspective on the topic, and the researcher's reflexivity. As researchers, understanding the nuances of participants across multiple social settings, regional groupings, and socio-economic dynamics, guided by the philosophy of social constructivism, will yield valuable, in-depth results. This study employs a phenomenological approach to conduct this qualitative research.

Research design

Elaborating further, this study has followed a qualitative research design. As proposed by Lim (2024), qualitative studies extend beyond methodologies to encompass a deep motivation to delve into participants' lives and experiences in their social settings. The researcher has adopted this approach to gain a deeper understanding of the reasons behind individuals' behaviours towards a social health insurance scheme. These further answer the 'why' element of this study. As stated by Pyo et al. (2023), qualitative research is relevant for policymakers to break down socio-psychological issues and understand human perceptions.

Research approach

This study employs a phenomenological approach to conduct this qualitative research. This design was adopted because this study aims to explore individuals' perceptual stances and understanding of a social health scheme. Furthermore, Edmund Husserl, the founder of phenomenology, understood that this approach considers humans beyond their scientific being and also their perceptual being (Damsgaard 2020). Janne Damsgaard writes deeply about the importance and relevance of incorporating phenomenology and hermeneutics among healthcare professionals to understand and map the subtle acts of individuals, and to comprehend the interhuman dynamics for a better quality of life.

Study population

This study aims to explore the factors that influence enrollment and the claims experiences of individuals participating in the Ayushman Bharat Arogya Karnataka Scheme. Therefore, for this research, the population is the group of households that hold a valid Ration Card or Food Card of Karnataka and fall under the economic classification of Below Poverty Line (BPL) or are defined as the 'Eligible Household' under the National Food Security Act, 2013 (Government of Karnataka

2025). As this scheme is released for both BPL and APL populations, the researcher wishes to clarify that the objectives of this study are limited to the BPL population only.

Sampling and data collection

To extract the most appropriate sample from the above-mentioned population, the researcher has combined two sampling techniques: Purposive (Campbell et al. 2020) and Snowball (Parker et al. 2025). As this study required households enrolled in and participating in a social health insurance scheme, the researcher observed that it is essential to identify families through contacts or routes based on trust and long-standing relationships. These interviews collect information on their vulnerabilities, previous hospital admissions, social status, and health outcomes. The researcher wanted to approach households that would be comfortable and willing to respond without feeling judged or offended, and who would be willing to be interviewed without any financial compensation.

Sampling size

Establishing an optimal sample size remains a challenging aspect of qualitative enquiry (Bouncken et al. 2025). The researcher has attempted to achieve a sample size in accordance with Creswell and Poth's (2016) recommendations. They have suggested a range of 5 to 25 interviews for a phenomenological study. To further clarify the sample sizes for qualitative enquiry, this study has also referred to the work of Wutich et al. (2024), which suggests that studies employing reflexive thematic analysis do not require a minimum sample size. The saturation is based on the researcher's capacity for data collection and the availability of resources, aligning with the study's objectives. This study has followed the PRICE model of data and theme saturation, proposed by Naeem et al. (2024), as it has been analysed using Reflexive Thematic Analysis (RTA).

Ethical consideration

The Ethical clearance for this study was obtained from CHRIST (Deemed to be) University's Research Conduct and Ethics Committee on 26 August 2024. The form was verified and approved by the RCEC. The Informed consent form was created in accordance with the WHO template for qualitative studies (Research Ethics and Review Committee (ERC), 2025).

Informed consent

Informed consent was obtained from all the participants. The informed consent form clarified that participants could withdraw from the study at any time. The informed consent stipulated that none of the data would be shared externally or used in a way that would compromise participants' security. The consent form was provided to the participants before the interview recording began, translated into their preferred language, and read aloud to non-English-speaking participants.

Findings

During the interviews, it was observed that Households have enrolled in the AB-Ark scheme without encountering operational challenges at the ground level, such as delays or procedural ambiguity. Therefore, these excerpts explain the pattern of how individuals got enrolled through the church enrollment drives at various parts of Bangalore.

LSP says that, "He had announced in the church the parish priest during mass.... He announced after all the mass in the church. That this Ayushman card is to be made for hospital admission, it will be useful.... They will come on so and so date on Sunday after mass. It was really good because everyone can get free on Sunday after their job.... So he announced two weeks before so all of us had gone with the ration card and Aadhar Card, me, my son, and my mummy. We took her in the auto. Father also asked us to inform other people, not just church people, to come. I informed my neighbours, but they feel it's only for Christian people and make faces at that time. ... But I informed cause God should keep all people well right, not just us. We made the card for all in the house and we got it after few days."

This interview excerpt above explains how families trust the faith they follow and how disseminating information across various mass times in a large parish will lead to a significantly higher participation rate in the scheme. The belief system of offering care to all individuals directly reflects from the preachings and the faith they follow.

AST recalls that "They had announced in the church for my mummy, she stays with my brother, they had announced about Health card But we didn't know about it or what is it for nothing we knew. My mummy was not going for it to make. They said only 50 rupees or something we have to pay they will give the card. Then my neighbours and other members of the church forced my mummy to make it and took her to the church one sunday. By the Lord's grace that time we

made it and kept the card... because when my brother had his third surgery at St. Johns hospital last year ... they said if you have Ayushman we can claim it under that and no need to pay whole amount... the staff who knew us asked us to bring it and use it. Thankfully by the approval we got the authorization for his surgery and that happened, only few medicines we had to pay something extra.”

This interview had been significantly important in this study as the family had been pushed to a catastrophic health expenditure in the past due to multiple ailments affecting the brother of the participant. This scheme's coverage had saved them from a total of five lakh rupees during the entire hospitalisation duration.

MML said that, “That Infant Jesus Church you know.... We were asked to go there... its near only. We went there stood in line long back time... and then got the card there. The church people had told us to go there with the Ration card ... or will come and get the card ... we had the health card then that time... My son has a hearing problem ... one ear is slightly deaf ... like mine ... I had tried to use the Health card at hospital but it was not used they said, because no admitted only daily check-up. They told us if he needs surgery later this health card we can use here”. The participant's son had recurring hearing disability and hence wished to be treated at a nearby hospital, but as there was no hospitalization involved in the treatment, they could not derive the benefit of it at that point in time, but are aware of the actual scheme modality.

Beyond the participants who informed about their enrollment status through the church, others mentioned the referrals they have received from the church or the monetary support extended during a health crisis. The following excerpts will explain this further.

“Before my husband passed away, he was there in the hospital, but all of them were full ... Because corona was high, peak time, but uncle was in a serious condition”, they told me. I called our church father, and he said, “Don't worry, I will arrange a bed in St. John's hospital. I will call the nun there and ask. Just because of that, he got bed and then was admitted in the ICU after his pneumonia they helped a lot at that time” says PAL.

“His new kidney after transplant stopped working after five years now, then there was so much problem, we had spend 15 lakhs before to get the new kidney but no use. Now monthly five dialysis we have to do for my husband, each time some 35000 Rs. so it was so difficult so,

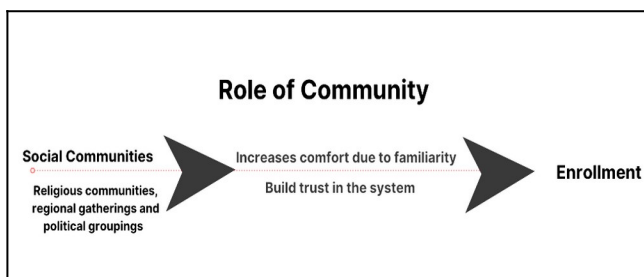
from church father gave one letter to give one dialysis free every month” explains ASM.

In both the excerpts mentioned above, the breadwinning members of the family had been severely hit by terminal illness or either deceased later died. Under both circumstances, it was understood that the church’s support had been pivotal in their lives. During the last leg of the interviews, it became apparent to us that the scheme had been upgraded for senior citizens over 70 years of age, and this was communicated at the churches (Kurian 2025). The following excerpt shall explain this, “During mass yesterday at the time of announcement, they said that Ayushman is now available for old people ... above 70, and that they will help people to register into it from the church itself if we want to enrol or help us through WhatsApp ... It was really good to know because I did not have insurance for my father.”

Discussion

Faith and religion play significant roles in the lives of individuals regarding health and healing. The primary philosophy that guides people towards their healthcare-seeking patterns stems from vulnerabilities and acting on them. Otherwise, accept and believe in the concept of religious fatalism. According to this study's findings, it can be stated that religions and the messages conveyed through those belief systems build trust or distrust in the relevant matter. To support, Organisational trust acts as a strong force in designing healthcare-seeking behaviours (Schoorman et al. 2007). The intervention of priests or clergy is often considered to lead the devotees into a better future and better life choices. Thus, most suggestions or support received from religious organisations, in this case the Catholic Church, often build trust, foster a sense of acceptance, and reduce hesitation.

The effect of religious community on enrollment behaviour (Note: Compiled by the author)



Conclusion

It was observed that through such interventions, healthcare is uplifted, and, along with it, the Catholic Church-led hospitals extend their reach beyond their Christian community; everyone benefits, thus creating an overall climate of well-being. The concept of health cannot be studied in isolation. The roles of faith and culture cannot be undermined in the daily discourse of a functioning society.

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