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PUBLIC OR PRIVATE? AN ANALYSIS OF THE HEALTHCARE FACILITY CHOICE IN INDIA

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ABSTRACT

India's healthcare system is increasingly dominated by private providers, raising the question of what drives this reliance and how different factors interact. Existing research points to quality gaps, accessibility issues, and socioeconomic inequalities, but much of it has lacked nationally representative evidence. Using microdata from the National Sample Survey (NSS) 75th Round, 2017–18, alongside secondary literature, this study examines household patterns of public versus private healthcare use. Weighted analysis reveals consistent trends: concerns about quality, doctor availability, and trust push patients toward private providers, while public facilities serve poorer households disproportionately. Private hospital preference rises with income, education, age, and is higher among women and upper-caste groups. Financing patterns show around 80% of households depend on income or savings, rural families more often borrow, and insurance coverage remains low (14.1% rural, 19.1% urban). Out-of-pocket spending still accounts for nearly half of national health expenditure. These findings highlight the urgent need for policies that rebuild confidence in public care while reducing financial vulnerability.

Keywords: Healthcare choices, healthcare utilization, Insurance coverage, Out-of-pocket expenditure, trust.

1. INTRODUCTION

India, home to over 1.4 billion people, faces a massive challenge in ensuring accessible and adequate healthcare for all its citizens. Recognising the importance of health, the Indian government has implemented a wide range of schemes, subsidies, and policies aimed at providing affordable or even free medical treatment. Flagship programmes such as Ayushman Bharat, Pradhan Mantri Jan Arogya Yojana (PM-JAY), Janani Suraksha Yojana (JSY), Rashtriya

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Swasthya Bima Yojana (RSBY), and the National Health Mission (NHM) are aimed at strengthening public health infrastructure and reducing the financial burden on low-income households (National Health Authority, n.d.; National Health Mission, n.d.; Government of India, n.d.; NHRC/NHA, n.d.).

The question arises: Why do so many Indians opt for private healthcare even when public alternatives are available almost free of cost? Is it simply about better facilities, or are deeper economic and systemic factors at play? This paper aims to answer these questions through data-driven analysis and research. This study explores the multidimensional factors behind this preference - from perceptions of quality and trust to access barriers and hidden costs in public health services.

Understanding this dynamic is crucial for a wide array of stakeholders. For the Government, such insights can help target healthcare insurance more appropriately, reinvest in public healthcare infrastructure to restore trust in government hospitals and lead to more effective public-private partnerships to bridge the disparity faced by millions. For health insurance companies, the findings could be used to implement price discrimination in healthcare premiums based on demand and urgency. For private healthcare providers, this study offers a deep dive into consumer behaviour, which can help pricing, service delivery, and patient engagement.

Today, over 65% of Indians continue to turn to private healthcare providers, even when it places a significant financial burden on their households, according to the National Sample Survey (NSS) 75th round (2017–18) (Ministry of Statistics & Programme Implementation [MOSPI], 2019). India has one of the highest rates of Out-of-Pocket Expenditure (OOPE) globally, with over 40.6% of total health expenditure borne directly by households creating financial vulnerability (National Health Accounts / NHSRC, 2019–20). In 2024-25, the Union Government's allocation to health amounted to approximately Rs.87,657 crores, which stakeholders interpret as representing a low share of total government expenditure and GDP relative to global norms (Government of India, Ministry of Finance, 2023; PRS Legislative Research, 2023).This funding gap limits the ability of public facilities to provide consistent quality services and contributes to overcrowding, long wait times, and staff shortages (Chokshi et al., 2016; MOSPI, 2019).

At the heart of this issue lies a simple truth: when people fall sick, they deserve timely, affordable, and high-quality care - regardless of how much they can pay. The choice between public and private healthcare is not just about cost - it is about trust, access, and survival. Understanding the reasons behind these choices is the first step toward designing a more equitable and effective healthcare system in India.

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2. BACKGROUND

The government has built an extensive network of hospitals and clinics intended to serve everyone; meanwhile, a sprawling private sector has emerged and is widely relied upon for care (Ministry of Statistics & Programme Implementation [MOSPI], 2019; Barik & Desai, 2014). National survey evidence shows the mixed results of that dual system: NSS 75th-round key indicators report that roughly 30% of persons seeking treatment used government hospitals in 2017–18, with a larger share turning to private providers (MOSPI, 2019). LASI-based analyses and other surveys echo the strength of private provision for certain groups: for example, analyses of older adults report private outpatient use at around 63–64% and public outpatient use around 22–23% (Rahaman et al., 2022; Arokiasamy et al., 2022).

Empirical work also documents low trust in public facilities in some settings: a recent mixed-methods study in Bihar reports high levels of low trust in the public healthcare system and a notably smaller share preferring public providers in that state (Kumar et al., 2025). Broadly, national and regional studies observe that the public system is often outpaced by reliance on the private sector, even though private providers vary in quality (MOSPI, 2019; Patenaude, Rao, & Peters, 2021).

Socio-economic status and related demographic variables matter for provider choice. Studies of older populations and national analyses show that higher income, greater education, and higher caste are associated with greater use of private hospitals, whereas lower socioeconomic status is linked with relatively greater reliance on public facilities (Chatterjee et al., 2019; Ranjan & Muraleedharan, 2020; Patenaude et al., 2021). Concentration-index analyses using NSS data further indicate that public clinics serve poorer groups disproportionately in states with stronger public systems (Ranjan & Muraleedharan, 2020; Patenaude et al., 2021).

Inter-state variation is important. Studies of successful state models describe how durable public investment and management can change utilisation patterns: the Tamil Nadu “model” is widely cited for strengthening rural public provisioning and supply chains (Parthasarathi & Sinha, 2016), while recent analyses of Kerala document a comparatively high share of outpatient visits to government facilities, reflecting sustained public commitment in that state (Adithyan, Ranjan, Muraleedharan, & Sundararaman, 2024; MOSPI, 2019).

Several reviews and empirical studies converge on the idea that the choice between public and private care is multidimensional. Cost is important, but perceived quality, trust, convenience, and accessibility also shape decisions (Barik & Desai, 2014; MOSPI, 2019; Patenaude et al., 2021; Rahaman et al., 2022). Finally, policy and scholarly assessments emphasize improving

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infrastructure, service quality, and patient experience in the public sector as central levers for rebuilding trust and expanding effective access (Ranjan & Muraleedharan, 2020; MOSPI, 2019).

3. DATA

For our analysis we use data from the 75th Round of the National Sample Survey (NSS), conducted in India during July 2017–June 2018. The NSS75 Schedule 25.0 (Household Social Consumption: Health) is a national household survey administered under the Ministry of Statistics & Programme Implementation and is documented in the NSS Key Indicators report and the NSS microdata catalogue (MOSPI, 2019; NSSO, 2019).

The survey covered a stratified, multi-stage sample designed to be nationally and state representative. The 75th round sampled 113,823 households comprising 555,115 persons (Rural: 325,883; Urban: 229,232) drawn from 8,077 rural villages and 6,181 urban wards/blocks; these sample counts and their two-stage selection are described in the official NSS documentation and in secondary summaries of the round (MOSPI, 2019; Ranjan & Muraleedharan, 2020).

Schedule 25.0 collects detailed health information at the household and person level. The questionnaire includes modules for demographic and household characteristics, morbidity and treatment seeking, hospitalization (365-day recall), outpatient/illness episodes (15-day recall), maternity and child health (including institutional delivery and immunization items), and particulars about expenditures and financing of care (MOSPI, 2019; NSSO, 2019). The NSS documentation and microdata codebook lay out the block structure and variable definitions (for example, hospitalization items use a 365-day reference period while outpatient spells use a 15-day window), which we follow when constructing analytic variables. (MOSPI, 2019; NSSO, 2019).

Provider type is recorded in the schedule and distinguishes government/public hospitals and clinics, private hospitals and doctors, NGO/charitable facilities, and other or informal providers. Expenditure items are collected at the episode level and include reported amounts for fees, medicines, diagnostics, and transport, enabling linkage of provider choice to out-of-pocket spending (MOSPI, 2019; NSSO, 2019).

The NSS 75th-round microdata are released with sampling weights and documentation describing the stratified sample design and estimation procedures; accordingly, all estimates in our analysis use the provided unit weights and account for the survey design so that results are representative of the Indian population (MOSPI, 2019; NSSO, 2019).

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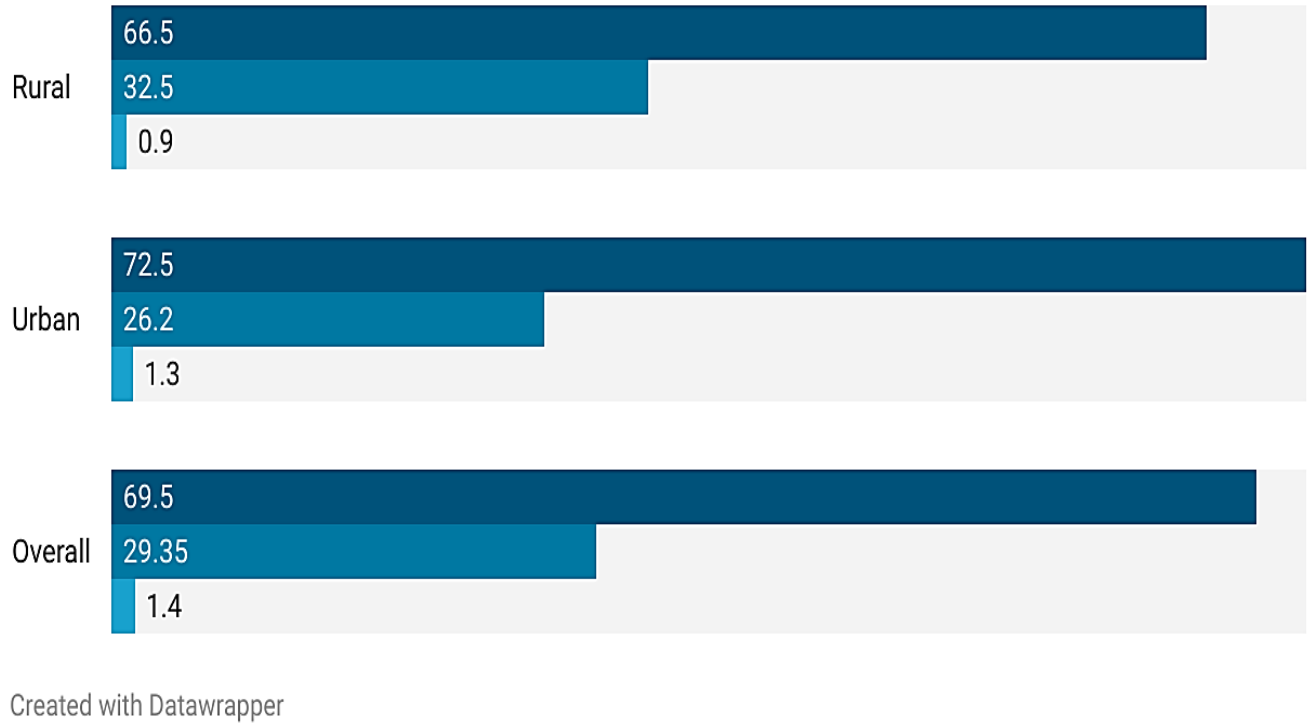
4. ANALYSIS

Fig 1. Percentage (%) of treated ailments in Private, Public or NGO-Run hospitals



Source: Authors' calculations from unit-level data of the NSSO health survey 2017-18

Figure 1 reveals a clear preference for private hospitals over public, particularly in urban areas, where reliance on private healthcare is the highest. The preference of private healthcare over public is up by 46.3 percentage points, emphasising its dominant role in service delivery. This disparity may be explained by the perception that private institutions provide better amenities and infrastructure as inferred in a study done by Owusu-Frimpong et al (2010). In rural areas, although private facilities are chosen more often than public ones, the reliance on private healthcare is lower by 6 percentage points compared to urban populations. These findings align with earlier research by Rout et al. (2019), which reported low utilisation of public facilities for healthcare services. This may be observed due to the low density of private hospitals in rural areas than urban ones as the findings of a study by Patil et al. (2002) The observed pattern highlights the importance of examining the factors that shape the choice between private and public healthcare in India.

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Table 1. Correlations between individual characteristics and the preference for private healthcare

Factor	Correlation Coefficient
Age	0.12
No. of Years of Schooling	0.07
Monthly Consumption Expenditure	0.05
Female	0.046
Upper Caste	0.04

Source: Authors' calculations from unit-level data of the NSSO health survey 2017-18

All coefficients indicate a positive correlation with each of these factors, suggesting that an increase in age, no. of years of schooling and income is associated with a greater likelihood of choosing private healthcare. It also displays that females and upper caste individuals are more inclined towards private healthcare. Among these, age shows the strongest correlation (0.12) highlighting that as a person grows older, they prefer private healthcare over public. Research done by Hargreaveshave et al. (2015) demonstrates that this may be because older people have greater overall satisfaction, lesser cost barriers and more experience than young adults. Although the values are modest, the consistent positive value in each of the coefficients highlights the influence of socioeconomic and demographic factors on healthcare preferences.

Table 2. Percentage (%) of Indians covered by any scheme for health expenditure support

	Rural	Urban
Covered	14.1	19.1
Uncovered	85.9	80.9

Source: Authors' calculations from unit-level data of the NSSO health survey 2017-18

Clearly observed in mini-table 2, only 14.1% of rural residents and 19.1% of urban residents report coverage (the complements are 85.9% and 80.9%, respectively). Coverage is extremely low overall, with urban areas only modestly better off. This helps explain why out-of-pocket spending remains so large despite flagship schemes (as seen in Sheet 5). There's no odd numerical anomaly here, just a worrying pattern: insurance penetration is thin, so households still rely on savings and borrowing when sick. These figures come from the NSS 75th round key indicators and sit alongside national health-accounts evidence on high OOPE. (MOSPI, 2019; National Health Systems Resource Centre, 2023).

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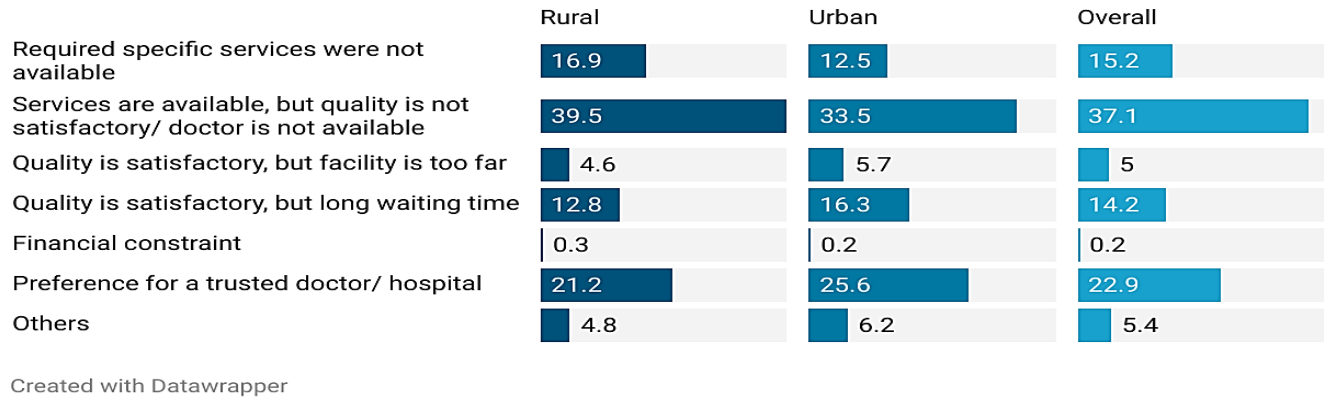
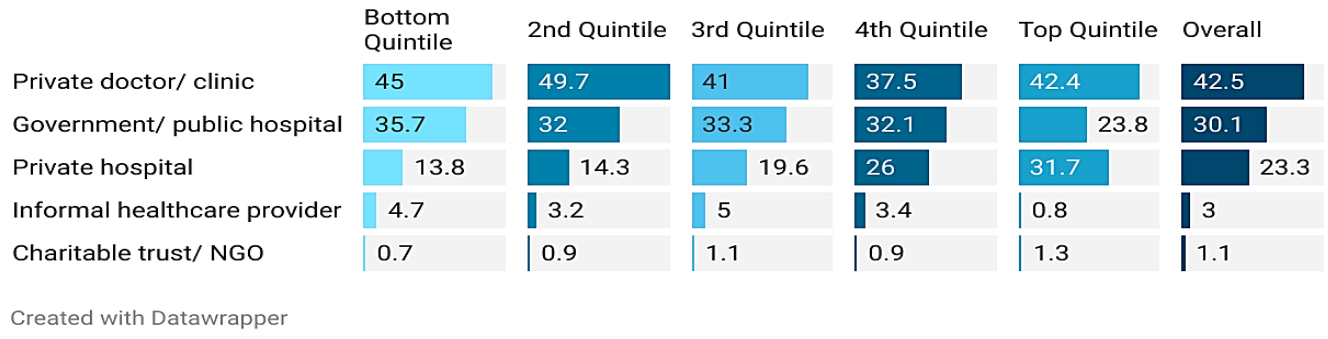
Fig 2. Reasons for not availing government/ public hospitals (in %)



Source: Anand, I., & Thampi, A. (2020, May 4). Less than a third of Indians go to public hospitals for treatment. LiveMint.

As seen in Ishan Anand and Anjana Thampi's analysis (Anand & Thampi, 2020), Figure 2 provides a clear headline: perceived poor quality or absent doctors is the dominant reason (≈39.5% rural, 33.5% urban), followed by a preference for a trusted doctor/hospital (≈21–26%), while distance and outright financial constraint are comparatively minor. A small but telling anomaly is the very low share citing "financial constraint." This doesn't mean cost isn't important, but that people more often explain non-use in terms of quality and trust, a pattern seen in NSS analyses and studies of forgone care. The takeaway: rebuilding reliable, respectful, and well-staffed public services will likely do more to pull patients back than only expanding infrastructure (MOSPI, 2019; Barik & Desai, 2014; Patenaude, Rao, & Peters, 2021).

Fig 3. Treated cases by type of service provider and class* (in %)



Source: Anand, I., & Thampi, A. (2020, May 4). Less than a third of Indians go to public hospitals for treatment. LiveMint.

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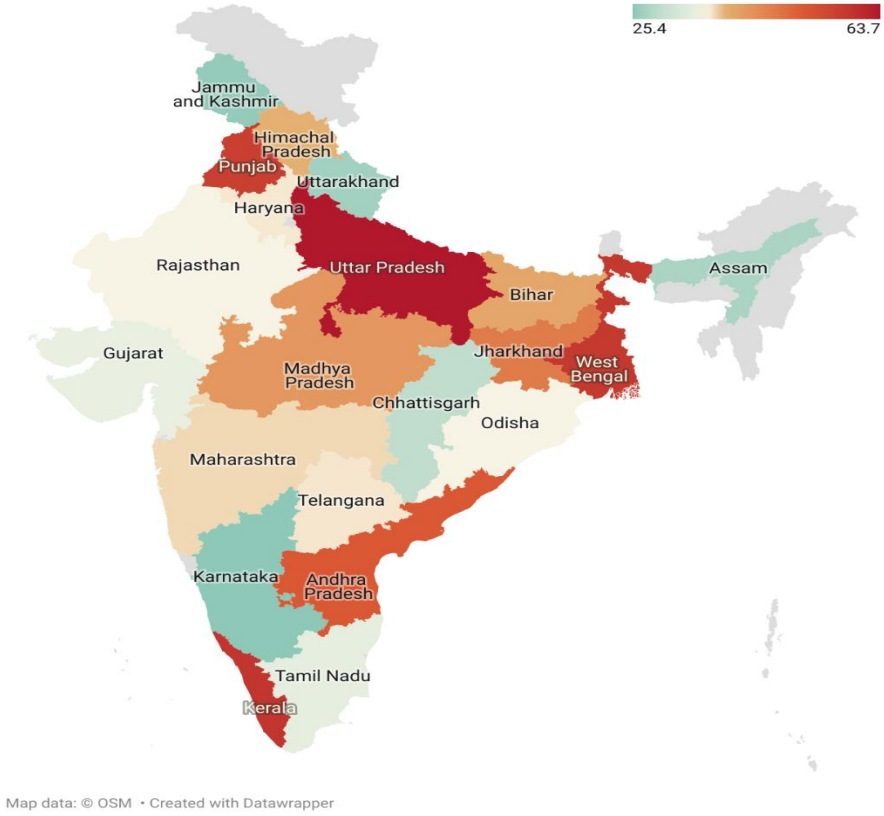
In the analysis recorded by Ishan Anand and Anjana Thampi (Anand & Thampi, 2020), Figure 3 clearly shows that private doctors/clinics dominate at every income level (≈37–50%), government/public hospitals matter relatively more for the poorest (35.7% in the bottom quintile vs 23.8% in the top), while private hospitals climb sharply with income class (from 13.8% bottom to 31.7% top), indicating that wealth buys access to higher-end inpatient care. A small but interesting point is that informal providers still account for a non-trivial share among lower–middle groups (peaking in the 3rd quintile at 5%) while they're nearly absent in the top quintile. This likely reflects local supply, trust and affordability dynamics rather than any single behavioral quirk. Overall, the pattern matches national NSS findings of pervasive private-sector reliance and a pro-rich tilt in private hospital use. It also underlines that financial and non-financial barriers together shape unequal healthcare choices (MOSPI, 2019; Barik & Desai, 2014; Patenaude, Rao, & Peters, 2021).

Fig 4. Out-of-Pocket expenditure as a percentage (%) of State Total Health Expenditure



Note: Grey areas indicate union territories which are not part of the study.

Source: National Health Accounts (NHA) Estimates for India

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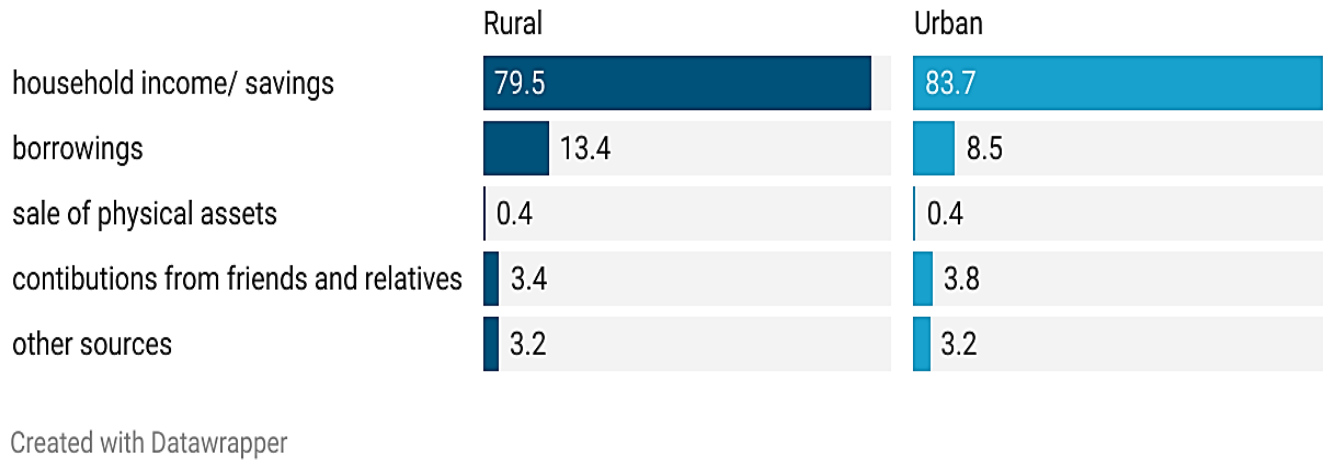
The choropleth map in Figure 4 illustrates that Uttar Pradesh records the highest share of out-of-pocket health expenditure at 63.7%, while states like Punjab, West Bengal, and Kerala also display relatively high proportions compared to the rest of the country. According to a study by Shailender Kumar Hooda (2017), such elevated levels of OOPE have serious repercussions for household well-being, often pushing vulnerable sections of society into extreme poverty. In contrast, Karnataka reports the lowest OOPE at just 25.4%. This can be attributed to the state's healthcare initiatives, such as the Yeshasvini Cooperative Farmers Health Scheme, which have improved the affordability and accessibility of medical services. This goes to show how effective state-level policies and schemes can significantly enhance access to basic healthcare and improve overall quality of life.

Fig 5. Sources of finance for funding medical expenditure (in %)



Source: Authors' calculations from unit-level data of the NSSO health survey 2017-18

Clearly depicted in the Figure 5, most families pay from their own income or savings (≈80% rural, ≈84% urban), borrowing is the next-most common strategy (higher in rural areas: 13.4% vs 8.5% urban), while sale of assets, help from relatives, and other sources are relatively small. A subtle but important point must be noted here that the very high reliance on income/savings and the larger rural reliance on borrowing signals weak insurance coverage and persistent vulnerability to medical shocks (as seen in Sheet 2), even if dramatic asset sales are uncommon. That pattern mirrors national NSS findings and broader NHA evidence about heavy out-of-pocket financing. Policy-wise, this argues for strengthening prepayment mechanisms and affordable credit/insurance in rural areas rather than assuming households can self-finance care (MOSPI, 2019; National Health Systems Resource Centre, 2023; Barik & Desai, 2014).

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5. POLICY RECOMMENDATIONS

The choice between private and public healthcare in India is shaped not only by cost but also by factors such as perceived quality, accessibility, waiting time, and trust in institutions. Given the strong preference for private healthcare - with nearly two-thirds of nationwide ailments being treated in private facilities - government policies must strike a balance between making private services affordable and improving the strength of the public system.

Affordability and Financial Protection- Expanding subsidisation and insurance schemes allows citizens to access private hospitals without heavy financial strain. For instance, Ayushman Bharat – PM-JAY provides coverage of up to ₹5 lakh per family per year for over 12 crore poor and vulnerable households, while state schemes such as Karnataka's Yeshasvini and Tamil Nadu's CMCHIS extend protection to millions more. Increasing the number of empanelled private hospitals, ensuring efficient implementation, and allocating greater public funds can reduce the reliance on Out-of-Pocket Expenditure (OOPE), which still accounts for nearly 48% of total health spending in India (World Bank, 2020). At the same time, scaling up Jan Aushadhi Kendras and generic drug supply chains can lower the cost of medicines, a major driver of OOPE.

Quality of Care- One of the major reasons people prefer private facilities is the perception of better quality and shorter waiting times. To address this, the government could implement stricter accreditation systems for public hospitals, invest in modern equipment, and provide continuous training for healthcare staff. This would narrow the quality gap between public and private providers.

Accessibility and Infrastructure- Many households choose private care simply because public facilities are too far or overcrowded. Expanding Primary Health Centres (PHCs), Community Health Centres, and district hospitals in underserved regions can improve accessibility. Additionally, scaling up telemedicine platforms like *e-Sanjeevani* would provide rural populations with specialist consultations without the need to travel.

Trust and Transparency- Low trust in public institutions is another driver of private healthcare preference. Policies that establish grievance redressal systems, improve transparency in hospital functioning, and regulate private hospital pricing practices can restore confidence in the system. Standardised treatment costs and clear billing guidelines in private hospitals would further reduce exploitation.

Awareness- Finally, awareness campaigns are essential to inform citizens about the free and subsidised services already available in public hospitals and insurance schemes. Community

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participation in local health committees can also foster trust and accountability at the grassroots level.

By subsidising private access through insurance schemes and simultaneously improving the capacity and quality of public hospitals, policymakers can create a hybrid framework that guarantees equity, affordability, and reliability in healthcare delivery.

6. LIMITATIONS

While this paper sheds light on the major factors influencing the choice between public and private healthcare in India, its scope also opens avenues for further study. Since the analysis is primarily descriptive, future research could apply regression or other econometric techniques to quantify the relative importance of different determinants. Similarly, the reliance on secondary data suggests scope for primary surveys and interviews that can capture real-time patient perspectives and behavioral motivations.

Moreover, healthcare in India is highly state-specific, and disaggregated studies could provide deeper insights into regional variations. Finally, examining the impact of expanding health insurance schemes and patient perceptions of quality could complement the findings presented here and provide a more holistic understanding of healthcare decision-making in India.

7. CONCLUSION

The analysis across our charts reveals clear highlights: Indians overwhelmingly prefer private healthcare in both rural and urban areas—about forty percentage points more than public hospitals—driven by perceived quality, doctor availability and trust. Most households finance care from income or savings (~80%), with rural families borrowing more; insurance coverage is low (rural 14.1%, urban 19.1%). Preference for private providers rises with age, income, education and is higher among women and upper-caste groups. State-level out-of-pocket spending still makes up a large share of health budgets. Policy must prioritise improving public service quality, expanding prepayment mechanisms, and restoring patient trust urgently and equitably.

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