WHITE BLACK LEGAL LAW JOURNAL

ISSN: 2581-8503

Peer - Reviewed & Refereed Journal

The Law Journal strives to provide a platform for discussion of International as well as National Developments in the Field of Law.

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WHITE BLACK LEGAL is an open access, peer-reviewed and refereed journal providededicated to express views on topical legal issues, thereby generating a cross current of ideas on emerging matters. This platform shall also ignite the initiative and desire of young law students to contribute in the field of law. The erudite response of legal luminaries shall be solicited to enable readers to explore challenges that lie before law makers, lawyers and the society at large, in the event of the ever changing social, economic and technological scenario.

With this thought, we hereby present to you

A STUDY ON PRIVATE HEALTH CARE SYSTEM IN INDIA

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Abstract:

This research examines what is known about the behavior of the private health sector in India and how the government should intervene in the private sector. The analysis is based on an extensive review of the literature in India and in six of its major states. Focusing on contracting and regulation, the literature points out that the government has limited capacity to regulate private health providers and to monitor con- tracts. We present several examples in which government collaboration with the private sector has been shown to work or has the potential to work well: cooperating in disease surveillance reporting, contracting for environ- mental activities in cities, contracting for nonclinical services in large hospitals, collaborating on disseminating public health information,sharing resources for managing drug supplies, and establishing patient referral This chapter examines what is known about the behavior of the private health sector in India and how the government should intervene in the private sector. The analysis is based on an extensive review of the literature in India and in six of its major states. Focusing on contracting and regulation, the literature points out that the government has limited capacity to regulate private health providers and to monitor con- tracts. The government needs to pursue these types of collaboration because the private sector is already playing a dominant role in curative health care and because the government has an obligation to ensure health services are safe, high quality, and accountable to the public. The government must find ways to increase that access to health services and financial protection for the poor.The sample size is 206.

Keywords: Government, Private Sector, Hospitals, Public Health, Healthcare Services.

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Introduction:

In the past, India’s private hospitals had to put in strenuous efforts to sustain their growth and achieve recognition in the healthcare market. However, the scenario has changed a lot today, and that is primarily owing to the healthcare reform initiatives and growing privatization of industries.The Indian healthcare industry has successfully leveraged the technological developments and adapted itself to the diverse social and economic fabric of the country. Currently, there is a radical consolidation in the industry, with the private healthcare sector dominating more than 80% of the entire market. Most of the metro hospitals in India today offer state-of-the-art infrastructure, world- class medical facilities, and efficient healthcare services. In that regard, the private healthcare sector is already being considered as a vibrant force in the Indian healthcare industry.The healthcare sector today comprises, collectively of hospitals, diagnostics, pharmaceuticals, telemedicine, health insurance, medical devices, and equipment, as well as other goods and services related to medical care. The rising demand for healthcare services in the global market has generated immense opportunities for the private players in the sector, and as a result, has turned out to be a potential investment for large corporations.In the Indian scenario, the private healthcare sector has emerged as a vibrant force, gaining national and international reputation. Owing to the high-end technologies, superior devices, and trustworthy surgical procedures, the private healthcare sector is gaining higher preference by Indians for their health related needs,further contributing to the growth of the private sector.High Quality Healthcare,The increased use of technology has allowed healthcare services to reach millions with improved operational efficiency. The private healthcare providers are consistently adopting new and advanced technologies to offer better quality healthcare services to the consumers. Particularly, telemedicine has increased the accessibility of healthcare services in rural areas by creating a network of quality health service providers. Overall, the innovative business models and competitive environment has paved the way for providing quality services in a cost- effective manner.Rising Income and Healthcare Expenditure,Today, owing to the rising income levels, more and more consumers willingly demand access to quality healthcare facilities. Moreover, easy access to medical insurance has further contributed positively to the affordability of healthcare and related services. In addition, the current demographics of the increasing aging population is also a major contributing factor for higher healthcare expenditure and growth of the private healthcare sector in India.Public Awareness of Health,The current healthcare sector is seeing a shift from communicable diseases to lifestyle diseases. Today’s urbanization and problems associated with modern living have replaced traditional health problems with lifestyle diseases, which has further increased the demand for specialized healthcare services. This has heightened

the current generation's awareness towards personal health and hygiene, as well as precautionary treatments. As a result, all of these have led to improved diagnostics treatments, resulting in increased hospitalization.Governmental Factors,In the past decades, the government has significantly contributed to the growth of the private sector. To add to the fact, the Indian Government had subsidized private sector organizations by providing low rates for hospital establishments and giving exemptions from taxes and duties for imported medical equipment and drugs.The private sector is not only India's most unregulated sector but also its most potent untapped sector. Although inequitable, expensive, over-indulgent in clinical procedures and without quality standards or public disclosure of practices, the private sector is perceived to be easily accessible, better managed and more efficient than its public counterpart. It is assumed that collaboration with the private sector in the form of Public/Private Partnership would improve equity, efficiency, accountability, quality and accessibility of the entire health system. Advocates argue that the public and private sectors can potentially gain from one another in the form of resources, technology, knowledge and skills,management practices, cost efficiency and even a make-over of their respective images.The size of the private sector can be illustrated in terms of the num- ber of beds, the number of private clinics with and without inpatient facilities, the size of the workforce, the private sector's market share (number of inpatients and outpatients), and the assets that it owns. It is also useful to know its rural-urban distribution. One crucial aspect of the private sector is the number of indigenous medical practitioners it includes, and more effort must be made to estimate their number. In India, with its dominant private health sector and relatively weak government oversight, there is a need to develop self-regulatory systems that involve the stakeholders and that are less threatening to providers than government regulation. Self-regulation is gaining acceptance, as revealed in the study conducted in Mumbai. One of the foremost steps for any intervention or involvement would be to develop an appropriate information base on the private health sec- tor. Many governments are handicapped by a lack of information on this dominant sector. The medical system is failing its own people. Yet the government of India has stated: "To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment."2 Medical tourism to India is expected to become a billion dollar business by 20127 and is starting to change the financing and regulation of certain private hospitals by encouraging private health insurance and international accreditation.The private health sector in India has made some impressive strides but has done so at the cost of the public sector. To regulate it may be, however, just another opportunity for bureaucratic delays and corruption. A better solution might be to impose greater social accountability on private providers, making a

certain proportion of private services available to the poor.The first priority must be to increase public expenditure on health care. The government's common minimum programme promises an increase in the spending on health care from 0.9% to 2-3% of GDP in five years with a health insurance scheme for poor families.In the past two years, although expenditure on health has increased in absolute terms, the proportion of GDP it represents has declined.In India, each year tuberculosis kills half a million people and diarrhoeal diseases more than 600 000. It is time for the government to pay more attention to improving the health of Indians rather than to enticing foreigners from affluent countries with offers of low cost operations and convalescent visits to the Taj Mahal.Information on private providers could be linked with registration and licensing mechanisms.**The main aim of this research is to know about the comparison between the private healthcare and public health system.**

Objectives:

- To know about the awareness of health care among all sections of the Indian people.
- To find the awareness among functionaries involved in Health and Hospital Management.
- To analyze the research in the field of Health and Hospital Management. in order to Know about the efficiency of Health Care delivery Systems.
- To know about the development of high quality hospital services and community health care.

Review of Literature:

(Purohit 2019),This book addresses major aspects of inequity, such as access, financing, financial risk protection, gender, service delivery and utilization, in the healthcare sector in India, Further, it discusses various measures for defining inequity in each of these aspects, and employs different indices for each dimension of inequity, which include financing, utilization, region, health outcomes, caste and class, and gender. The book covers both theoretical and empirical issues, examining fifteen major Indian States, as well as selected case studies at the district level.

(Samuel et al. 2021),This study reflects the Vaccine hesitancy is of considerable concern as it threatens the great potential of a vaccine against COVID-19. Community health workers (CHWs) bridge the gap between the community and the health care system. Their intention to get vaccinated will not only affect them but will also affect the community's perception of the vaccine. This study aims to understand the intention to get vaccinated against COVID-19 among

community health care workers in India and its determinants.**(Roy 2021)**,Indian Union Budget 2021-22: While healthcare is one of the most important pillars of nation-building, traditionally India has not invested sufficient resources on the health of its citizens. Despite the significant TB burden and sporadic outbreaks of other infectious diseases including chickenpox, our public health infrastructure has been largely deficient, and COVID-19 pandemic had ascertained this further.**(Kumar, n.d.)** This study shows that the Private hospitals in India are least monitored by the government, which leads to violation of the roles and responsibility they have to offer for the community. Indeed, it is a more serious issue in a country like India where people are forced below poverty line (BPL) after every hospitalization.**(Diwate 2021)**, This study shows that India's healthcare delivery system is categorised into two major components public and private. The government, i.e. public healthcare system, comprises limited secondary and tertiary care institutions in key cities and focuses on providing basic healthcare facilities in the form of primary healthcare centres (PHCs) in rural areas.**(Mudur 2003)**,This study examines the Indian government has announced fiscal incentives to boost private investment in health care, promote India as an inexpensive health destination for foreign patients, and expand health insurance coverage. The federal budget for 2003-4, unveiled last week, has a package of measures for health that includes tax benefits to financial institutions that provide loans to hospitals with more than 100 beds. Private investments have fuelled the growth of corporate hospitals in several Indian cities in recent years, and the new incentives are expected to encourage private hospitals.**(Sarabanda 2019)**, This study examines that the private health sector in India has made some impressive strides but has done so at the cost of the public sector. To regulate it may be, however, just another opportunity for bureaucratic delays and corruption. A better solution might be to impose greater social accountability on private providers, making a certain proportion of private services available to the poor.**(Saha, Reshmi, and Sabu 2012)**,This study examines that social audit of private hospital services in India. In the present era when information is considered a right of people, people are becoming more assertive about their rights to be informed. This is making every organisation, including governments of all countries, to be more accountable and socially responsible.**(Nandraj 2015)**,The National Health Accounts is a global tool that provides a snapshot of the flow of funds in a country's health system by financing sources, providers of healthcare and healthcare functions. This article comments on some of the major advances and gaps in the latest NHA estimation methodology and in the presentation of results.**(Khan and C. 2020)**,In India, Out-of-pocket expenses account for about 62.6% of total health expenditure - one of the highest in the world. Lack of health insurance coverage and inadequate coverage are important reasons for high out-of-pocket health expenditures. There are many Public Health

Insurance Programs offered by the Government that cover the cost of hospitalization for the people below poverty line (BPL), but their coverage is still not complete. The objective of this research is to examine the effect of Public Health Insurance Programs for the Poor on hospitalizations and inpatient Out-of-Pocket costs.**(Sharma and Parihar 2016)**,This article is written with an intention to bring cognizance to challenges and issues faced by a 21st-century nurse for getting the desired professional status in India. Authors also dispensed strategies that could be beneficial in restructuring and upliftment of nursing as a respectable job.**(Rout, Sahu, and Mahapatra 2021)**,This study examines the government initiatives aimed at improving public healthcare services, private-sector has been a dominant player in most of the Indian states. Limited evidence is available on the factors that influence the choice of using public or private health services, which assume significance in the present context, when the government is willing to purchase care from the private providers.**(Yadav et al. 2022)**, This study examines the healthcare infrastructure of a country determines the health-seeking behaviour of the population. In developing countries such as India, there is a great disparity in the distribution of healthcare institutions across urban and rural areas with disadvantages for people living in rural areas.**(Thazha et al. 2022)**, This study shows that India's healthcare industry comprises hospitals, medical devices and equipment, health insurance, clinical trials, telemedicine and medical tourism. These market segments are expected to diversify as an ageing population with a growing middle class increasingly favours preventative healthcare. Moreover, the rising proportion of lifestyle diseases caused by high cholesterol, high blood pressure, obesity, poor diet and alcohol consumption in urban areas is boosting demand for specialised care services.**(Garg et al. 2022)**, This study shows that COVID-19 pandemic has caused widespread illness and a significant proportion of the infected required hospitalisation for treatment. People in developing countries like India were vulnerable to high hospitalisation costs. Despite its crucial importance, few primary studies are available on this aspect of the pandemic.**(Morgareidge 2015)**, This study reflects that India is a land full of opportunities for players in the medical devices industry. The country has also become one of the leading destinations for high-end diagnostic services with tremendous capital investment for advanced diagnostic facilities, thus catering to a greater proportion of population. Besides, Indian medical service consumers have become more conscious towards their healthcare upkeep**(Gupta and Basu 2014)**, This study shows the Health policy formulations in India have witnessed a shift from a reactive approach to a more proactive approach over the last decade. It is therefore important to understand the effectiveness of recent national health policies (such as the National Rural Health Mission and the National Urban Health Mission) in addressing the varied needs of the heterogeneous population of India.**(Baru 1998)**,This chapter examines what is known about the

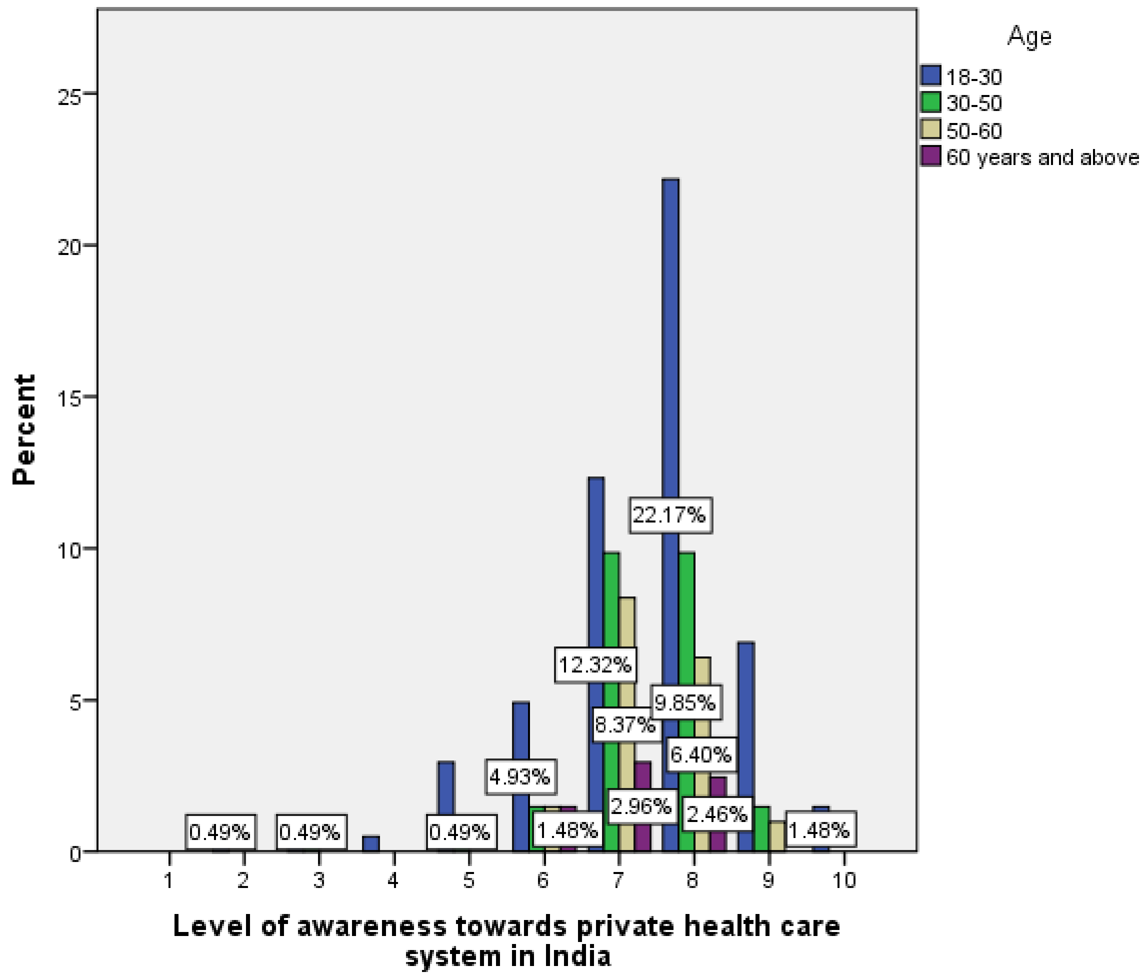
behavior of the private health sector in India and how the government should intervene in the private sector. The analysis is based on an extensive review of the literature in India and in six of its major states.**(Narmadha and Varalakshmi 2022)**,This study examines Healthcare delivery is moving outside the four walls of the traditional health system. Health care providers have realized that products or services alone, no matter how strong they are technically, will not be enough in future.**(Pandya, Khanal, and Upadhyaya 2022),**The mental health initiatives at the workplace are growing in numbers over the past few years. Public and private sectors continue to explore avenues to navigate and adapt initiatives to promote employee's mental wellbeing. However, such initiatives in the Indian context are not thoroughly studied. The attempt to review existing literature on workplace mental health interventions was in the Indian context.

Methodology:

The researcher obtained the primary source of data by conducting an empirical study on seeking responses from the general public based on a questionnaire and also relied on secondary sources of data such as books, journals, e-sources, articles and newspapers. The research method followed here is empirical research. A total of 206 samples have been taken out of which is taken through Random sampling methods. Collection of data through actual survey decreased the limitations of the researcher to collect data from the field.Since the data is collected on offline splatform the original opinion of the respondent is found out.The sample frames taken by the researcher are various students and their parents especially belonging to the urban parts of Chennai. The independent variables are age, gender and occupation. The statistical tool used by the researcher is graphical representation.The essence of the survey method can be explained as “questioning individuals on a topic or topics and then describing their responses”. Random sampling method was used for the purpose of this study. There are totally 200 samples collected for this study.

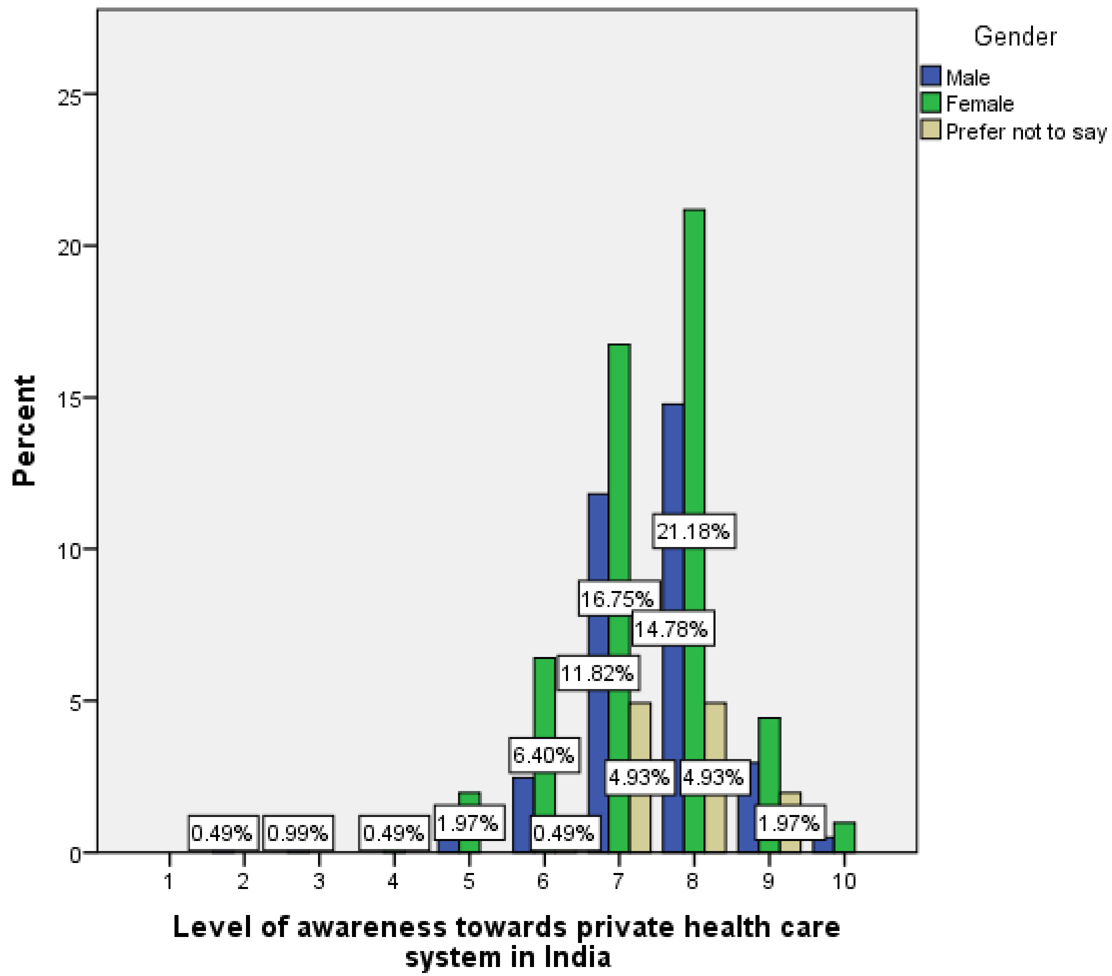
Analysis:

Figure-1



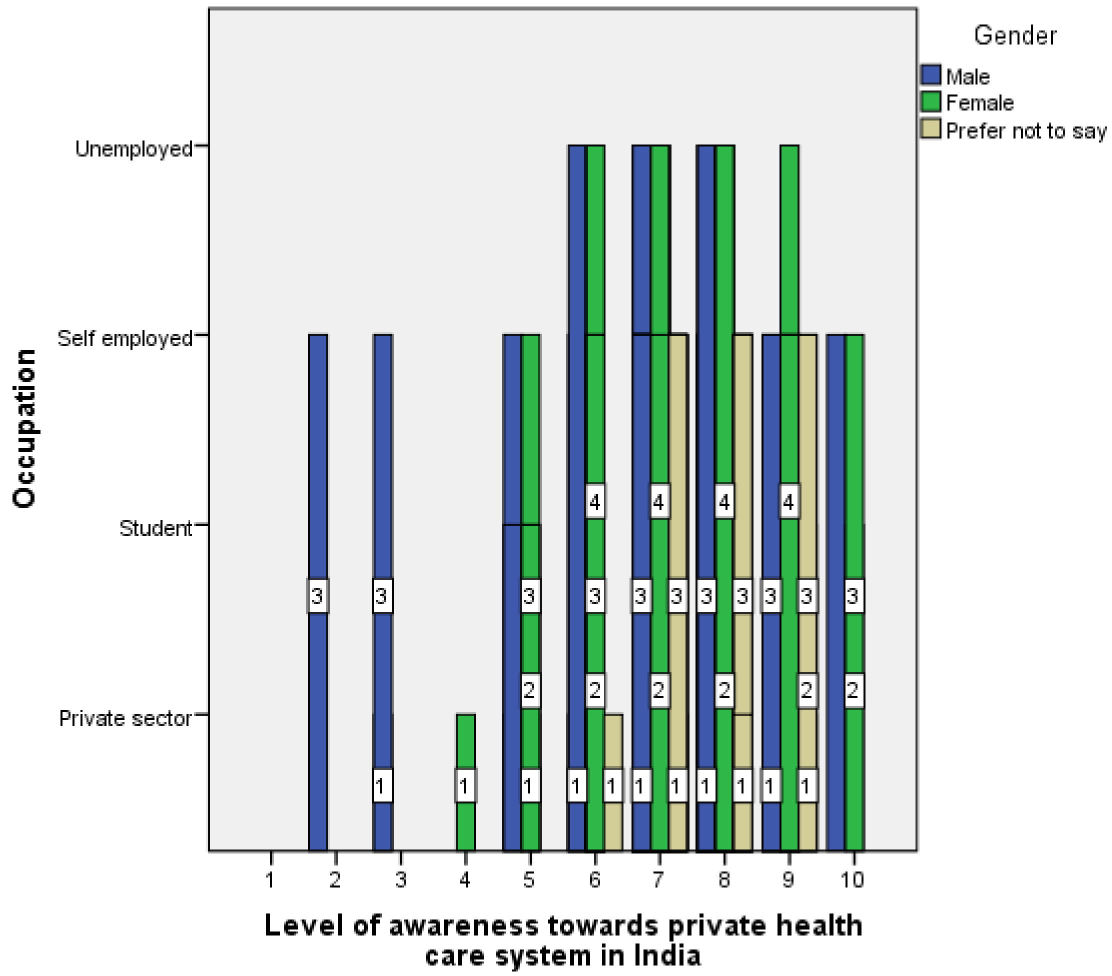
Legend: The figure-1 represents the correlation between age and dependent variable according to the age group 18-30 have agreed to the highest scale 22.17%.

Figure-2



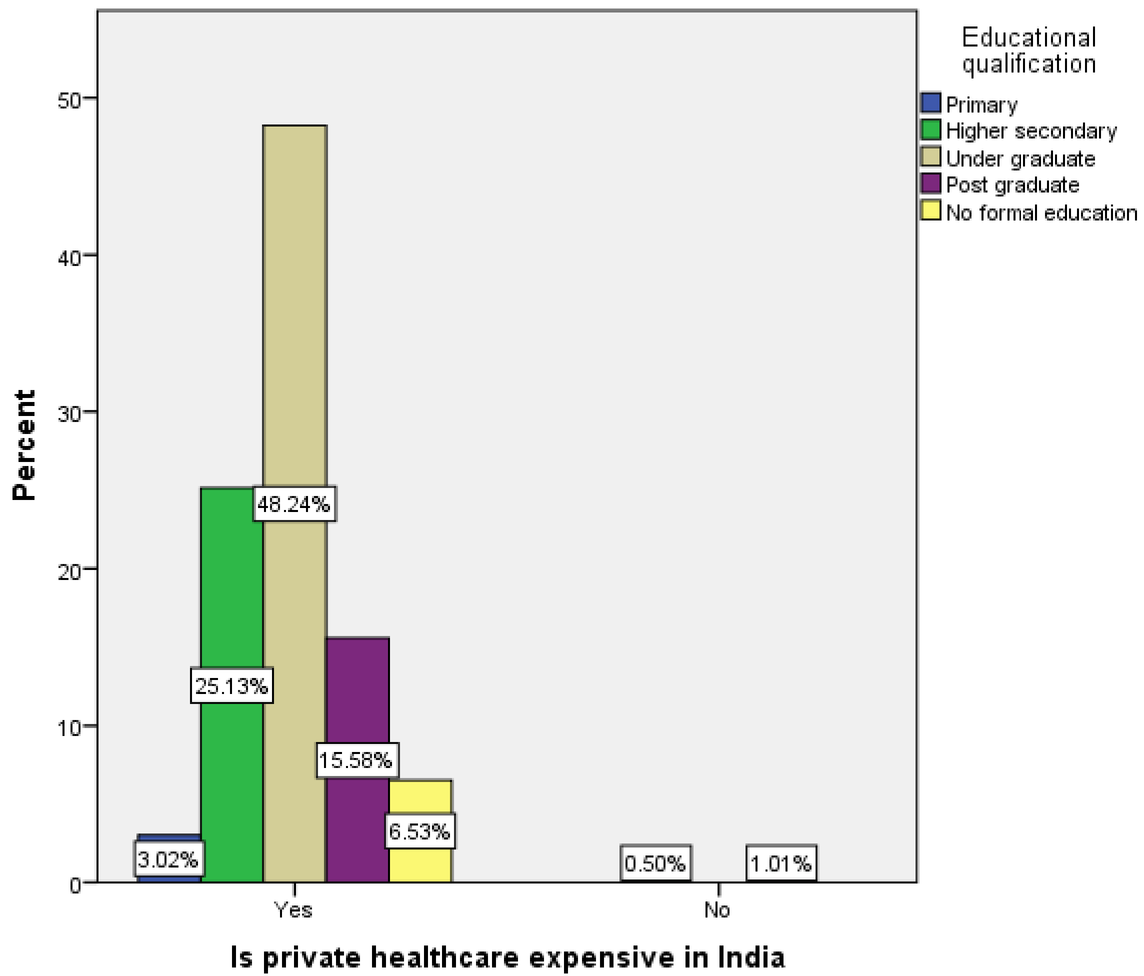
Legend: The figure-2 represents the correlation between the gender and dependent variable according to the gender females have agreed to at the highest scale 21.18%.

Figure-3



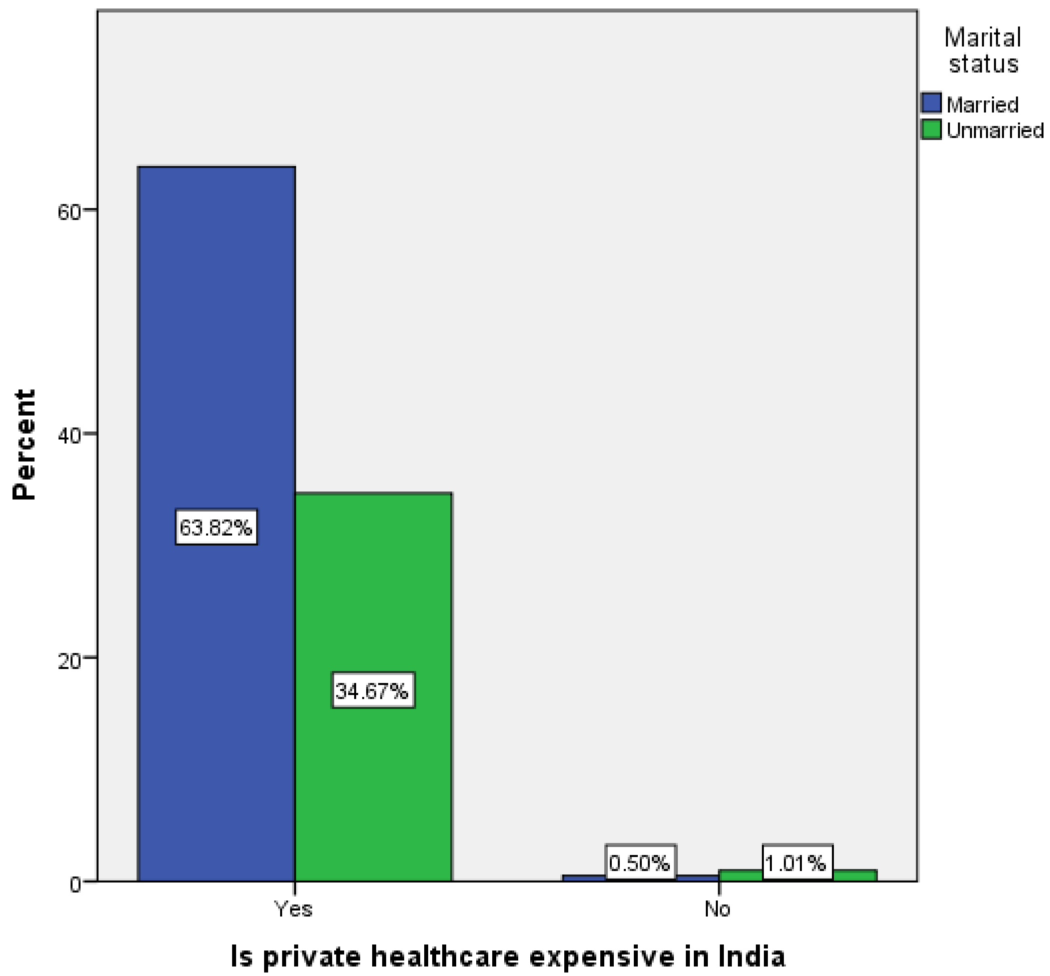
Legend: The figure-3 represents the correlation between the gender and dependent variable according to the gender males and females have answered to the highest scale of 9.

Figure-4



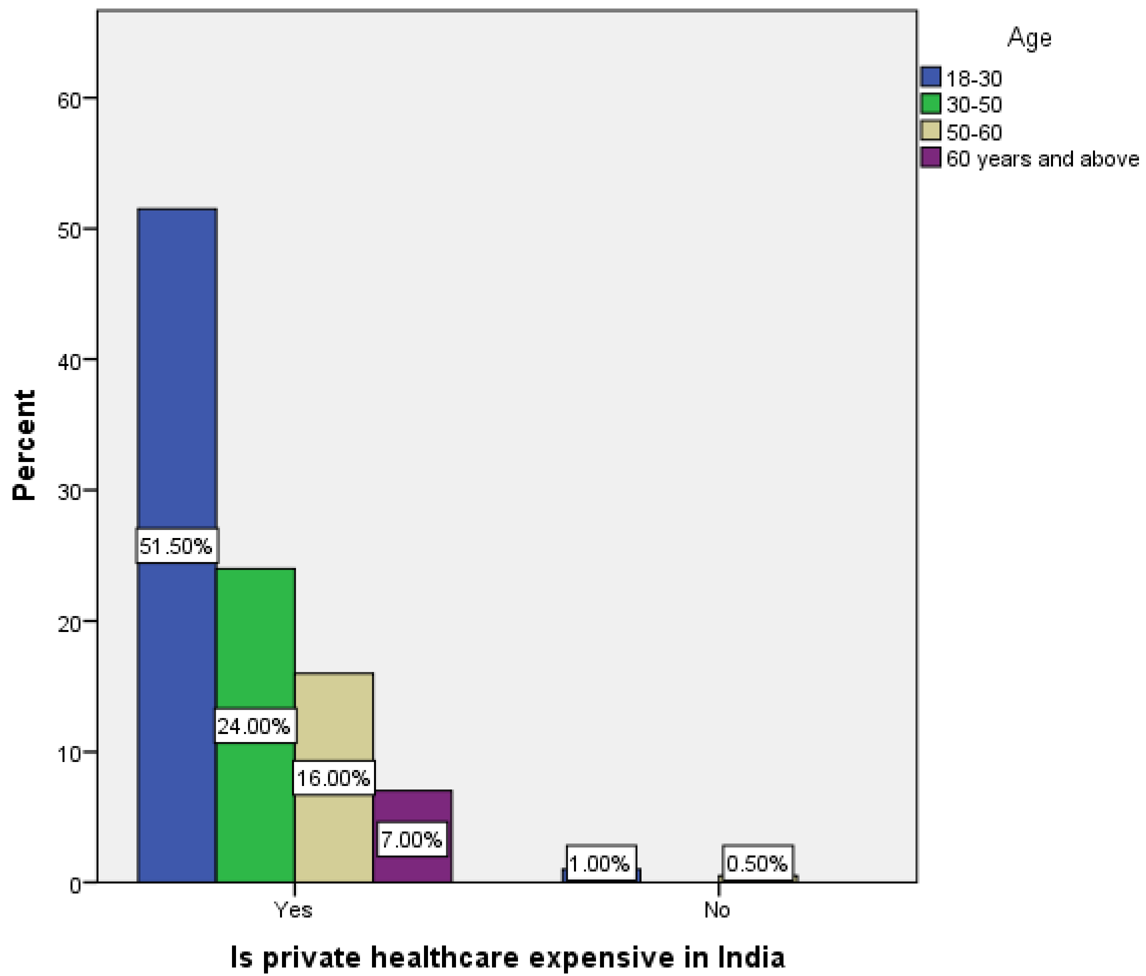
Legend: The figure-4 represents the correlation between the educational qualification and dependent variable according to the educational qualification undergraduate students have agreed to the highest scale 48.24%.

Figure-5



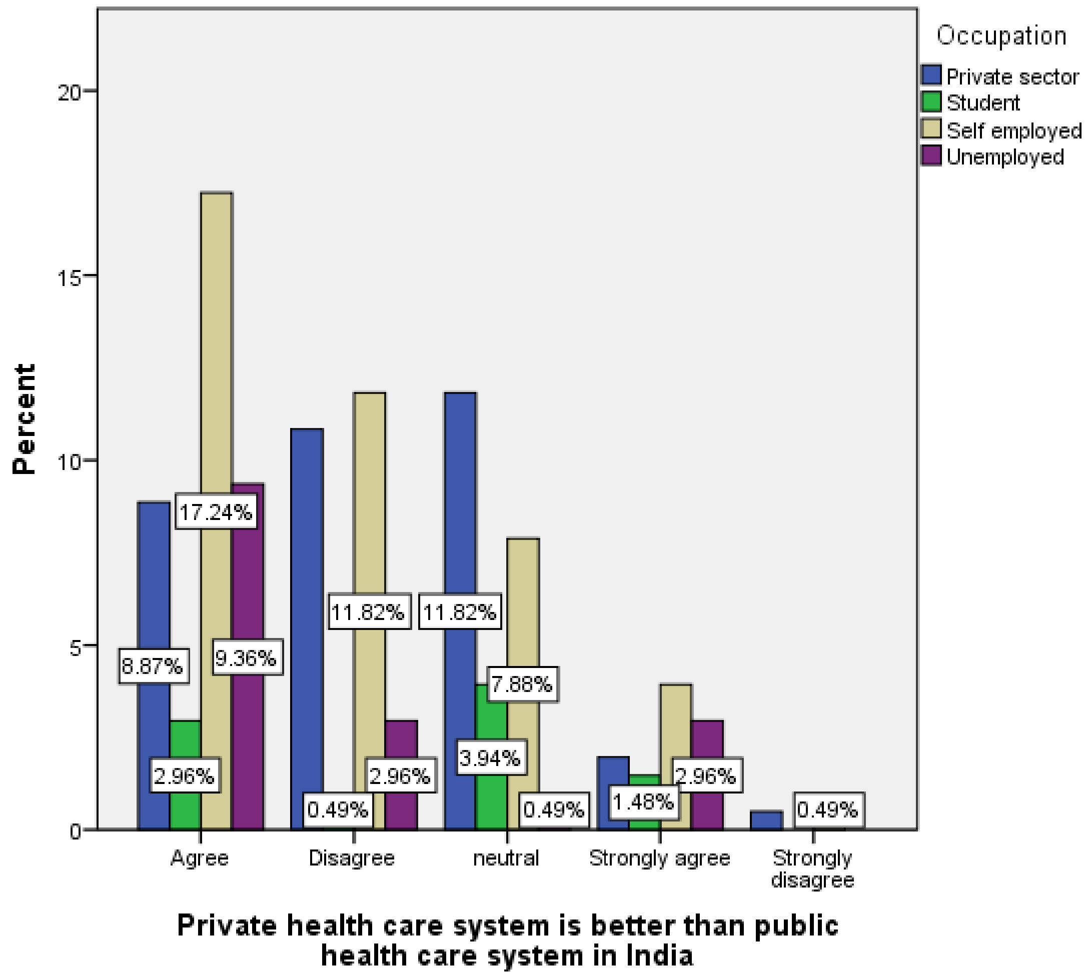
Legend: The figure-5 represents the correlation between the marital status and dependent variable the highest scale is 63.82%.

Figure-6



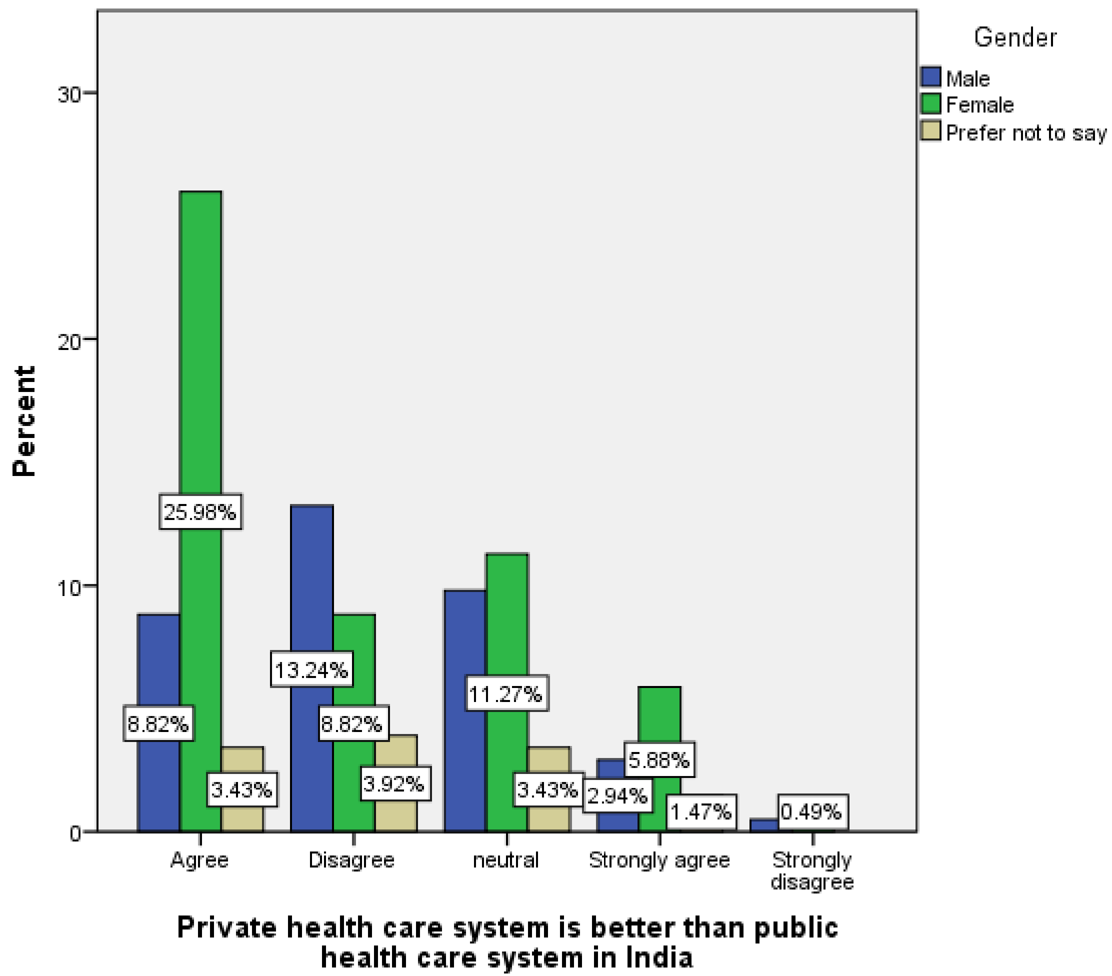
Legend: The figure-6 represents the correlation between the age and the dependent variable here age group of 18-30 have agreed to the highest scale 51.50%

Figure-7



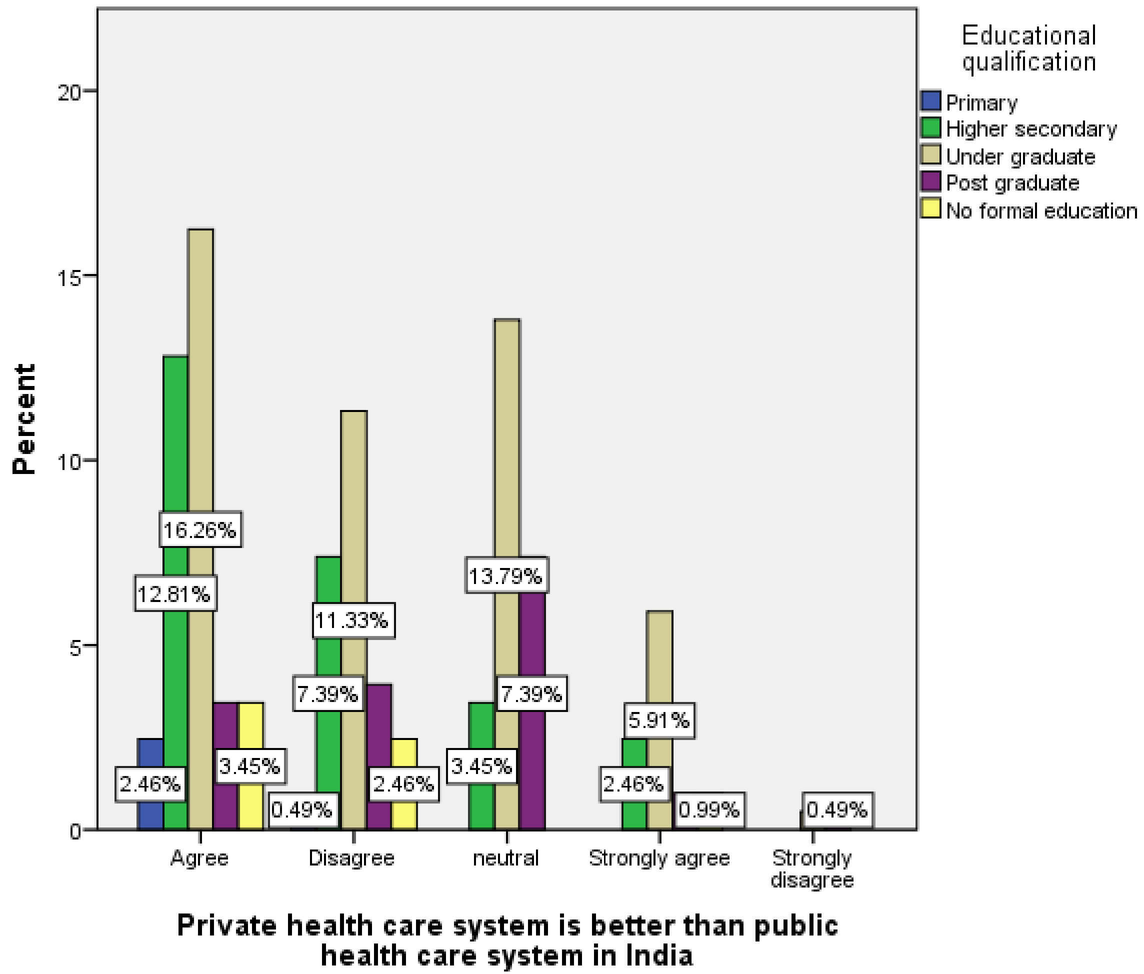
Legend: The figure-7 shows the correlation between the occupation and the dependent variable here self employed have agreed to the highest scale 17.24%

Figure-8



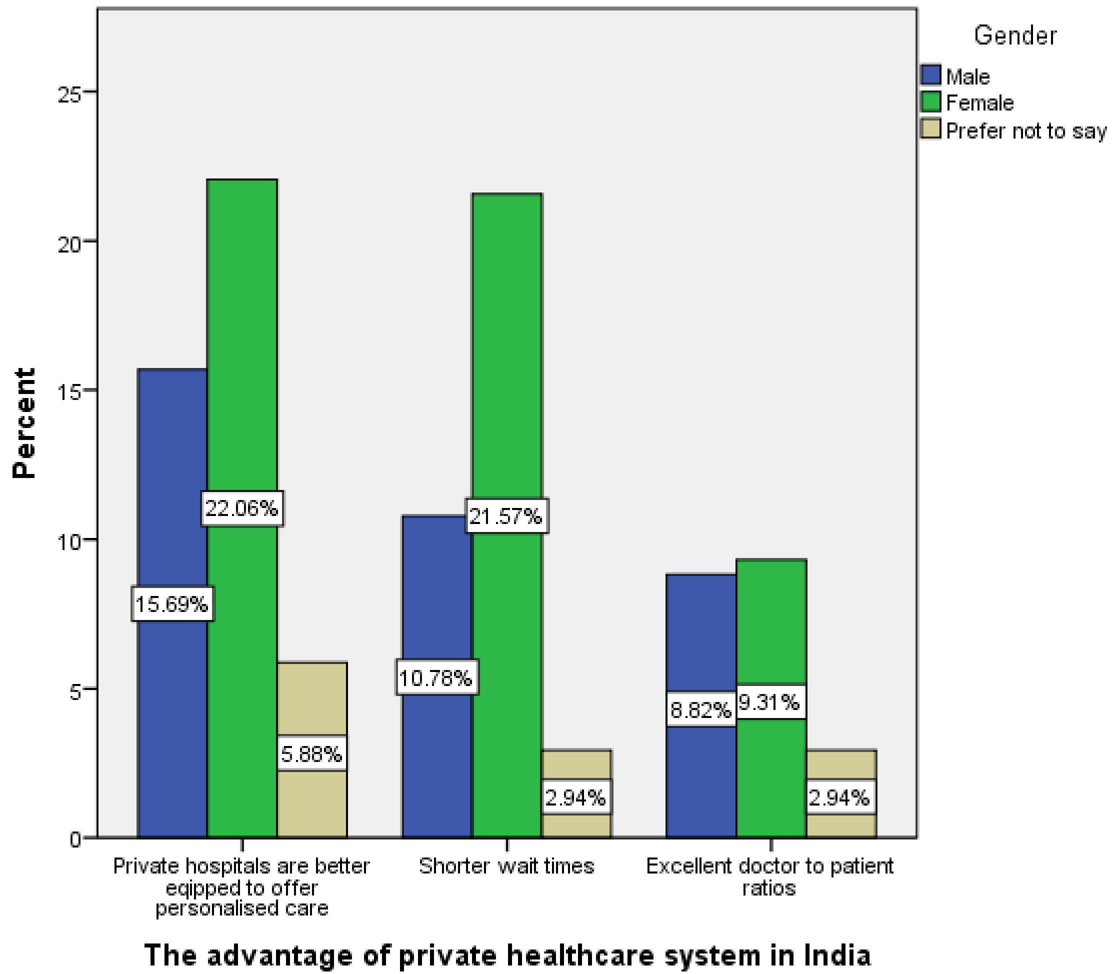
Legend: The figure-8 shows the correlation between the gender and the dependent variable here female have agreed to the highest scale 25.98%.

Figure-9



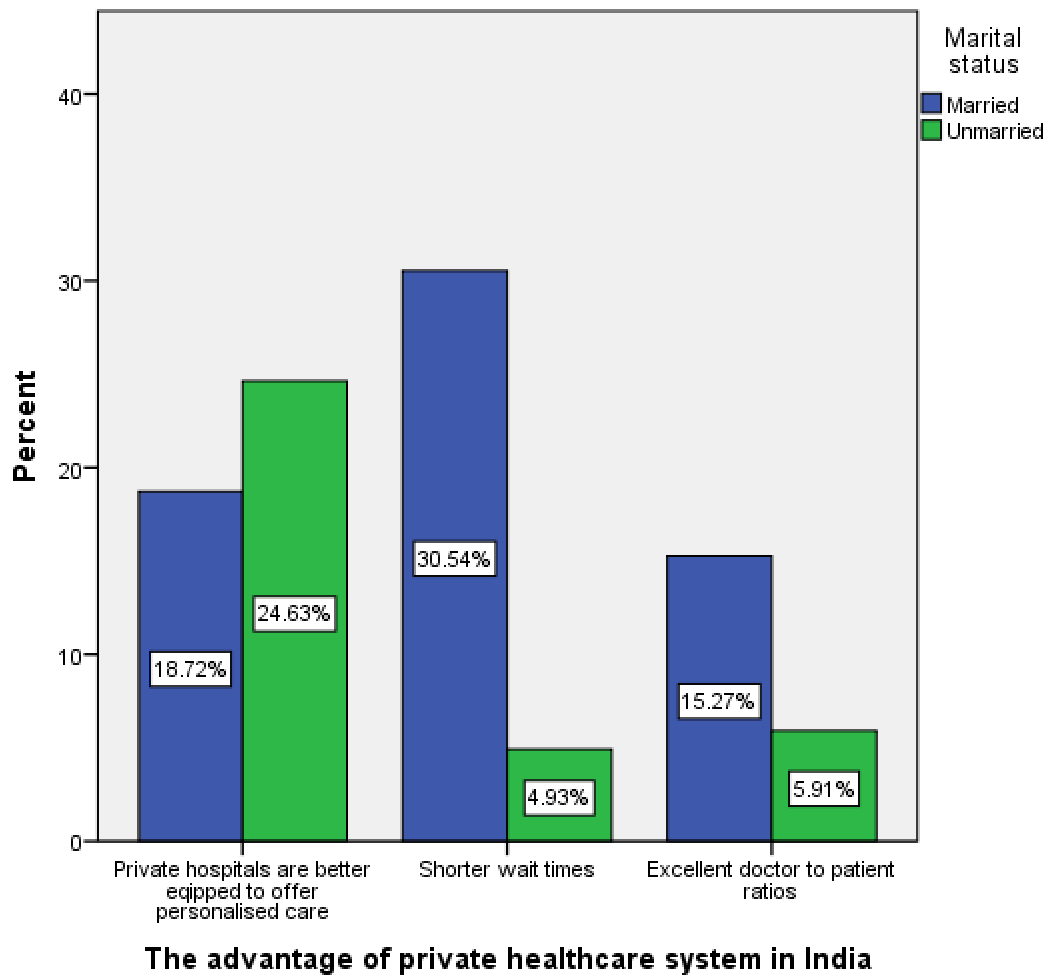
Legend: The figure-9 represents the correlation between the educational qualification and the dependent variable here undergraduates have agreed to the highest scale 16.26%.

Figure-10



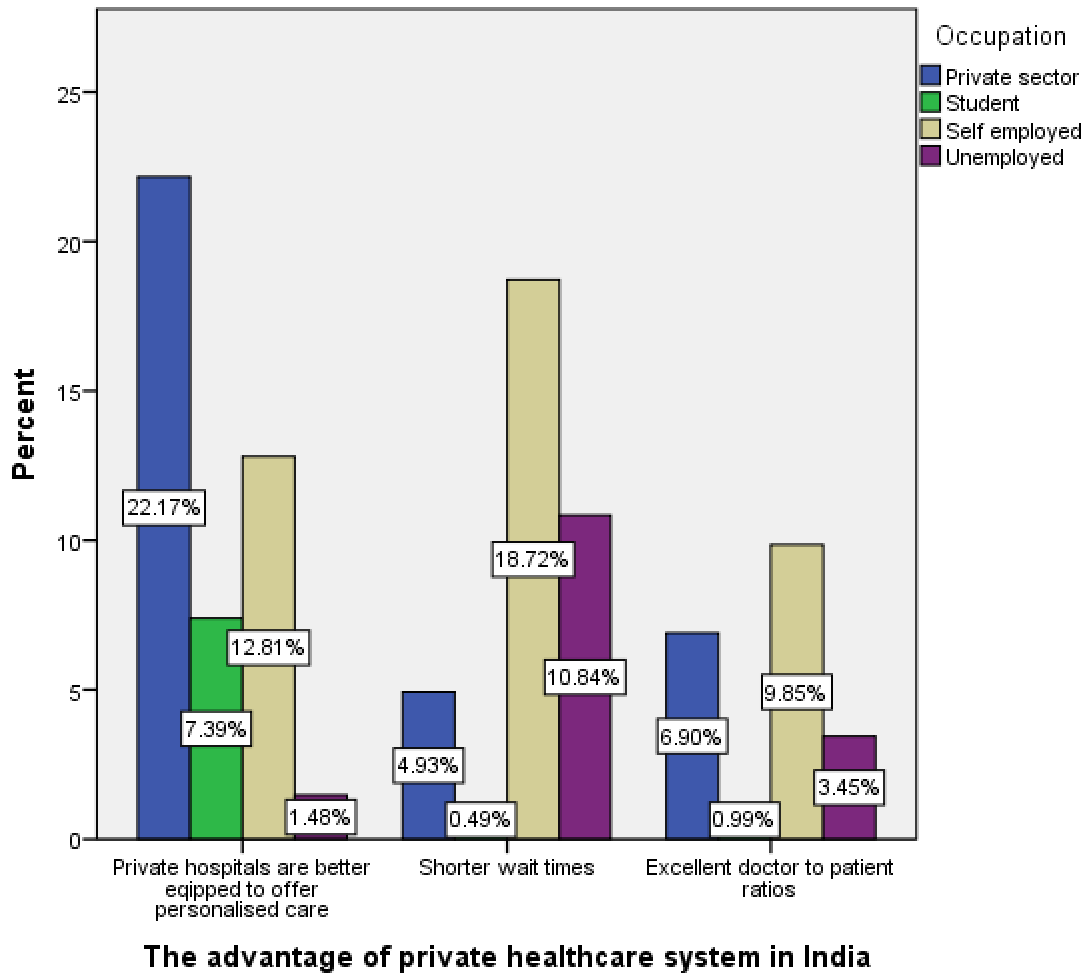
Legend: The figure-10 shows the correlation between the gender and dependent variable here females have agreed to the highest scale 22.06%.

Figure-11



Legend: The figure-11 represents the correlation between the marital status and dependent variable the highest scale is 30.54%.

Figure-12



Legend: The figure-12 shows the correlation between the occupation and the dependent variable here. Private sector people have agreed to the highest scale 22.17%.

Result:

The **figure-1** represents the correlation between age and dependent variable according to the age group 18-30 have agreed to the highest scale 22.17%. The **figure-2** represents the correlation between the gender and dependent variable according to the gender females have agreed to at the highest scale 21.18%. The **figure-3** represents the correlation between the gender and dependent variable according to the gender males and females have answered to the highest scale of 9. The **figure-4** represents the correlation between the educational qualification and dependent variable according to the educational qualification undergraduate students have agreed to at the highest

scale 48.24%. The **figure-5** represents the correlation between the marital status and dependent variable; the highest scale is 63.82%.The **figure-6** represents the correlation between the age and the dependent variable here age group of 18-30 have agreed to the highest scale 51.50% The **figure-7** shows the correlation between the occupation and the dependent variable here self employed have agreed to the highest scale 17.24%The **figure-8** shows the correlation between the gender and the dependent variable where females have agreed to the highest scale 25.98%. The **figure-9** represents the correlation between the educational qualification and the dependent variable here undergraduates have agreed to the highest scale 16.26%. The **figure-10** shows the correlation between the gender and dependent variable here females have agreed to the highest scale 22.06%. The **figure-11** represents the correlation between the marital status and dependent variable; the highest scale is 30.54%. The **figure-12** shows the correlation between the occupation and the dependent variable where private sector people have agreed to the highest scale: 22.17%.

Discussion:

The **figure-1** represents the correlation between age and dependent variable according to the age group 18-30 have agreed to the highest scale 22.17% and here most of the people are aware of private healthcare system in India 60 years and above have answered to the lowest scale 0.49% ,some were not aware of private healthcare system,age group of 30-50 lowest scale is 2.48% and highest scale is 12.32%,50-60 age group lowest scale is 1.48%,highest scale is 12.32%.The **figure-2** represents the correlation between the gender and dependent variable according to the gender females have agreed to at the highest scale 21.18%,lowest scale is 1.97% and male respondents have answered to the highest scale 14.78% and lowest scale is 1.97%. The **figure-3** represents the correlation between the gender and dependent variable according to the gender males and females have answered to the highest scale of 9 and lowest scale is 1.The **figure-4** represents the correlation between the educational qualification and dependent variable according to the educational qualification undergraduate students have agreed to at the highest scale 48.24% and lowest scale is 3.02% and most of the people agree that private healthcare is expensive in India. The **figure-5** represents the correlation between the marital status and dependent variable; the highest scale is 63.82% and lowest scale is 0.50% and the disagree to this questionnaire .The **figure-6** represents the correlation between the age and the dependent variable here age group of 18-30 have agreed to the highest scale 51.50% and lowest scale is 0.50% it shows the disagree ability Of the questionnaire. The **figure-7** shows the correlation between the occupation and the dependent variable where self-employed have agreed to the highest scale 17.24%,student 3.94%,self employed lowest scale is 2.96% ,unemployed 2.96% and most people have agree that

private healthcare system is better than public healthcare system in India.The **figure-8** shows the correlation between the gender and the dependent variable where females have agreed to the highest scale 25.98%,male have agree to the scale of 13.24%,prefer not to say 3.43%. The **figure-9** represents the correlation between the educational qualification and the dependent variable here: undergraduates have agreed to the highest scale 16.26%,primary have answered to the scale of 2.46%,higher secondary answered to the scale 12.81%,undergraduate have answered to the scale of 16.26%,postgraduates have answered to the highest scale of 7.39%,no formal education people have answered to the highest scale of 3.45%.The **figure-10** shows the correlation between the gender and dependent variable here females have agreed to the highest scale 22.06% and male have answered to the highest scale 15.69%. The **figure-11** represents the correlation between the marital status and dependent variable; the highest scale is 30.54% and most of the respondents have said that the shorter wait times is the advantage of private healthcare system.The **figure-12** shows the correlation between the occupation and the dependent variable where private sector people have agreed to the highest scale: 22.17% ,students have responded to the scale of 7.39%,self employed have answered to the highest scale of 18.72%,unemployed 10.84% and most of the people have answered that the advantage of private healthcare is that they are better equipped to offer personalised care.

Limitation:

One major finding that comes out of the review of the private sector is that there is a paucity of studies on this dominant sector. It is only in the recent past that an interest has been shown in documenting and studying this crucial sector. Firstly, there is very little information on the spread, size and characteristics of the providers in the private sector. Data from government sources are questionable, as many of the states do not send timely and validated reports, and do not have a proper system of collecting the data. Secondly, the understanding of the dynamics of the private health sector in India is based on small studies conducted by various non-government organisations and academic institutions.One crucial aspect of the private sector is the number of indigenous medical practitioners it includes, and more effort must be made to estimate their number.The data brought out by the government regarding the growth of and size of the private health sector suggest that in the three states reviewed, there has been a tremendous growth of the health sector.The government’s efforts to regulate in many instances are opposed by powerful medical lobbies using various means. Many state governments that wanted to enact and implement legislation for private hospitals found their efforts thwarted.

Overview:

In India, public and private healthcare providers function as two entities working towards health for all. While public hospitals are run under national and state budgets, the private sector has to work out its operational viability in a competitive market. Over 70 percent of healthcare services in India are provided by private providers. To achieve the goal of Universal Health Coverage, both healthcare providers have key roles to play, recognised by the government of India that has called for increased public-private partnership models during the Covid-19 response and also in the last two budgets.

Nevertheless, there continues to be a perception that private hospitals are against public interest and operate only for profit, are not transparent about their costs, or that hospital treatment packages are unfairly priced. Therefore, it is important to examine a few aspects of overall hospital operational issues and challenges to decode these misconceptions.

1. Operational viability

Firstly, most private sector hospitals do not have subsidies for expenses and utilities, and even if they do, they repay by providing services as per government regulations. They are based on a fee-for-service basis and don't have a price advantage in tenders and procurement of machinery and material as it is for public hospitals. They have to work out their operational viability, investing considerably in the quality of care, certifications, and accreditations.

2. Hospital pricing determinants

Secondly, most private hospitals set treatment or service prices by studying the actual cost involved for manpower, material, machinery, expenses, and utilities—right from setting up to sustainability. This may vary depending on location, the level of care provided, investment in technology and research, size or the scale of the hospital, and adherence to international protocols and quality standards.

3. The land is only 10 percent of the total cost of running a hospital

A very common argument that surfaces time and again, is that private hospitals have been given free or subsidised land, and have certain obligations in return. But the fact is, very few hospitals have made this bargain for land vs poor patients—less than 1 percent out of 60,000 in India. Most hospitals have paid for land at commercial rates. As the land forms a small share of the cost structure, just 10 percent, the hospital's ability to discount is limited, especially when other costs are higher—construction and medical equipment have a dominant share.

With 60-70 percent of hospital costs and overheads fixed, the trade-off of costs between land and the present value of all costs incurred for treating EWS (economically weaker section) patients is actually not viable. Hospitals try to cross-subsidise EWS, CGHS (Central Government Health Scheme), ECHS (Ex-Servicemen Contributory Health Scheme), and other government schemes patients with paying patients.

4. Need to review treatment package costs under AB-PMJAY

Health is an emotive subject, and if it has to have a social mix, there should be clear guidelines and frameworks. Ayushman Bharat-PMJAY scheme is a great step by the government toward universal health coverage, but their treatment packages do not even meet input costs. That is one of the reasons why most hospital chains are not empanelled in it.

5. Barriers in setting up hospital infrastructure in tier 2 and 3 cities

Setting up hospital infrastructure in tier 2 and 3 cities has multiple barriers currently. While the quality of service has to be on par with what is offered in metros, customers and patients have to be given 30-50 percent reduced prices. In terms of infrastructure, there is high capex and high costs of land, building, medical equipment, tech/IT, utilities, and services with fixed overheads and lower, unclear returns. Uncertain patient footfalls and a shortage of qualified healthcare professionals are also challenges in smaller towns. For this reason, a collaborative approach is required to enable a joint working model to develop solutions.

6. Need to regulate quality, not pricing

Out of 50,000-plus hospitals in India, only about 350 are NABH (National Accreditation Board for Hospitals and Healthcare) accredited; out of 100,000 labs in the country, only an estimated 1,000 are certified by NABL (National Accreditation Board for Testing and Calibration Laboratories). Amidst this large pool of unregulated players, we need to recognise and incentivise those who are publishing patient clinical outcomes and are complying with quality standards and protocols. Central and state policies need to be aligned on this with a clear regulatory roadmap.

7. Treatment costs in India are a fraction of what patients pay in other countries-Healthcare costs in India are perhaps the lowest compared to other countries. A large number of international patients come to India every year to get the best quality treatments at a fraction of the prices, generating foreign exchange for the country and earning much goodwill.Achieving the goal of universal health coverage mandates that communities should have access to quality healthcare and that out-of-pocket payments or unrealistically high health expenditures do not prevent or

discourage people from availing of health services.One of the ways of getting there is health insurance needs to be expanded. Apart from that, several other steps are required in this direction: Addressing the shortage of skilled medical doctors and nurses by upgrading medical education and creating PPP models on skilling of healthcare providers, leveraging digital technology to increase access, raise awareness and foster behaviour change, taking the care continuum outside of hospitals, among others.While private providers wouldn't have the answer to all the challenges faced by the healthcare sector in India, they are a strong ally in India's aspiration to achieve a universal healthcare system.

Conclusion:

India's health scenario currently presents a contrasting picture. While health tourism and private healthcare are being promoted, a large section of the Indian population still reels under the risk of curable diseases that do not receive adequate attention from policymakers. India's National Rural Health Mission is undeniably an intervention that has put public heath care upfront. Although the government has been making efforts to increase healthcare spending via initiatives like the National Rural Health Mission, much still remains to be done. The priority will be to develop effective and sustainable health systems that can meet the dual demands posed by the growth in non communicable diseases and peoples' needs for better quality and higher levels of health care.The public sector must reorient its dual role of financing and provision of services because of its increasing inability on both fronts. Under partnerships, public and private sectors can play innovative roles in financing and providing health care services. While reviewing the health sector in India, the World Bank and the National Commission on Macroeconomics in Health strongly advocated harnessing the private sector's energy and countering its failures by making both public and private sectors more accountable.The Indian private healthcare sector is full of opportunities for industry players and has emerged as a vibrant force that contributes to the country's economy and growth. No doubt, India has become a high-end destination for medical tourism with state-of-the-art diagnostics and technology driven healthcare services.In the face of an unprecedented disease, with mystical transmissibility and unprecedented ability to devastate the human population, it is not surprising that the public healthcare sector is under more stress than it can handle alone. A streamlined pathway to facilitate the private sector to join hands with the public sector for a national cause is the need of the hour. Through our study, we have identified gaps in the current contribution by the private sector and identified areas in which they could contribute, by their own admission.We have a large private healthcare sector in our country which is not only equipped but also willing to share the burden of disease. We have identified an encouraging

response from the private health sector in contributions toward the pandemic. Furthermore, there is a positive attitude toward teleconsultation services, which bridge the gap for non-COVID care in the pandemic period. The primary reason why the government should explore partner- ships with the private sector is that the private sector is already playing a substantial role in meeting people's demands for curative care. Another legitimate reason is the government's concern for reducing the financial burden on the poor and ensuring that all health services are safe, high quality, and accountable to the public.

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