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"India's Health Financing Crisis"

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India's Health Financing Crisis

Abstract

India's rapid economic growth is challenged by a health financing crisis that has been marked by a typically high out-of-pocket expenditure (OOPE), causing limited financial protection, inequality and access to health services among the poorer populations. While the flagship Ayushman Bharat scheme intends to bridge the gap, there still exist a lot of institutional barriers that have blocked the scheme from fulfilling its objectives and outcomes. The OOPE remains high, while the missing middle is a problem within the section of society who are not poor enough to qualify for subsidized healthcare and are unable to access quality healthcare. This paper aims to assess the effectiveness of the Ayushman Bharat scheme through a comparative policy analysis. The paper compares the Ayushman Bharat schemes with the policy structures in 4 other countries, namely Indonesia, the United Kingdom, Brazil, and Mexico. The paper finds its theoretical foundation in evolutionary theory while its methodological framework depends on the idea of critical multiplism. The paper deploys the use of quantitative comparative analysis as well as index-based comparison along with Callaway & Sant'Anna (2021) difference-in-differences with multiple time periods to understand the efficacy of a PP model on the longer run.

Keywords: Ayushman Bharat, Health Financing, Comparative Policy Analysis, Evolutionary Theory

Introduction

India is trying to reach an ambitious target of being the third-largest economy by the end of the decade. But what is crucial to note is the very fact that without healthy people, the nation

itself won't be healthy. While India might have become the fourth-largest economy by nominal GDP, when it comes to its ranking or healthcare access and quality index, it ranks 145 among 195 other countries (Singh, 2023). While there are various other healthcare indicators, such as life expectancy, infant mortality, and health coverage, among others, India has arguably done much better on these aspects. There is one crucial aspect of inclusivity that is still often missing.

India's top priority has to be universal health coverage, which in itself has 3 key dimensions. The first dimension is providing health coverage to all, ensuring that every member of society has access to health coverage or health services. A second dimension is reducing the cost of health services, which in itself can act as an important barrier for socioeconomically vulnerable classes, as they might not be able to afford quality healthcare because of the high prices compared to their incomes. The third component of universal health coverage is lowering the out-of-pocket expenditure or OOPE. OOPE refers to the extra expenditure that the family has on top of the coverage provided by the government when they're availing any kind of health services. OOPE can hence also be counted as the extra money a family pays for doctor visits and medicines, hospital stays, etc., merely because the limit of the total bill is beyond what is covered by any kind of insurance provided to them (Nundy et al., 2025). The government has timely recognized that high out-of-pocket expenditure has been a significant challenge especially for families that come from low-income backgrounds as they believe that these spendings are often large portions of the earnings of these families and the financial burdens that their expenses can have can push families into poverty or debt cycles, making it harder for them to even afford other necessities, like food and education (*Ministry of Health and Family Welfare*, n.d.).

While the government claims that the out-of-pocket expenditure as a percentage of total health expenditure has fallen significantly from 62.6% in the financial year 2014-15 to 39.4% in

the financial year 2021-22, we still see that reports are suggesting otherwise, particularly for the expenditure that families must incur (*Ministry of Health and Family Welfare*, n.d.). Gaurav Gupta, the CEO of CarePay, mentions that still 48% of total healthcare remains out-of-pocket. He also highlights that there is a huge uninsured population and coverage gap of nearly 50 Crore people, which are the 30% that are the missing middle, who earn not only too much to qualify for subsidized insurance, but at the same time are unable to afford the private premium healthcare that is offered in the urban centers in the country. While non-essential procedures such as cosmetic procedures, hair restoration, dental care, and IVF, among others, are simply not undertaken because of high out-of-pocket expenditures. Even essential services often take a hit because of the huge costs that come with them (FE Healthcare, 2025).

It is hence clear that out-of-pocket expenditure is one of the key health financing crises that the country is going through. Under the Ayushman Bharat scheme launched by the Government of India, there were 2 key components. One of the components was the primary healthcare (PHC) and wellness systems (HWS), which basically ensured adequate and sustainable financing for the PHC system. The other component of the Ayushman Bharat scheme is pooling of expenditure, or basically a mass insurance scheme for the bottom 40% of the population (Kadarpeta et al., 2024). The government claims that it is the success of the scheme that has actually reduced the percentage of out-of-pocket expenditure as a proportion of total health expenditure. I hence aim to assess whether the Ayushman Bharat scheme and its health financing component have been a successful component/policy or not. My problem statement is whether the Ayushman Bharat scheme and its health financing strategy are a successful model or not, and whether other policy alternatives could have better solved this problem.

Relevance of the Problem

There are multiple reasons why the health financing strategy and the Ayushman Bharat scheme are at a crucial juncture where they require introspection. One of the arguments in its favor has been that India lacks the state capacity to have a completely public-owned quality healthcare system. The simple cost of developing a healthcare system that rivals the quality offered by private players is too humongous for the state and cannot be undertaken (Manchanda & Rahut, 2020). At the same time, states such as Rajasthan have brought in bills that make refusal to give healthcare service a crime, drawing a significant backlash (Biswas, 2023). Even the financing strategy focuses narrowly on hospitalization alone, leaving out more crucial aspects like outpatient visits, diagnostics, maternity services, mental healthcare, preventive services, and even dental healthcare. These are crucial drawbacks that warrant a look into the scheme (*India's Healthcare Affordability Crisis: A New Financial Approach to Medical Bills - BW Healthcare World*, n.d.).

There are other challenges as well when it comes to the scheme. While there has always been a persistent financial constraint in fulfilling all such schemes, there is also a visible deficit in enrollment, with enrollment being inconsistent, something that can be blamed on low awareness and errors in beneficiary registration. There are also significant provider gaps with the private sector still showing hesitation to take up a more integral role in the same, and low quality of service provided by both private and public systems to the poorer communities. Institutional gaps, such as a lack of accountability and transparency, the absence of proper grievance redressal mechanisms, and the limited capacity of purchasers, also plague the system, ultimately affecting the outcomes, such as low utilisation and poor coverage in the system (Nundy et al., 2025). All of these reasons make the problem statement relevant for study.

Methodology

In order to understand the efficiency of the Ayushman Bharat scheme as a whole, as well as identify whether it is the most efficient approach to reach its stated objectives, I will undertake a comparative policy analysis. Comparative policy analysis is the methodology in public policy analysis, wherein different policies across different countries or contexts are taken and compared. To identify the best practices. I will hence be comparing India's Ayushman Bharat scheme to 4 different countries, namely: Indonesia (Jamnian Kesehatan Nasional), the United Kingdom (NHS), Brazil (Sistema Único de Saúde), and Mexico (Seguro Popular). While the UK and Brazil both have a public healthcare system, hence becoming an effective control group, the remaining 3 have a national insurance scheme, hence roping in Private players to provide health services.

Theoretical Framework & Rationale

The paper will be using Evolutionary theory as the theoretical foundation of the study. The evolutionary theory highlights that a policy change is brought about by systemic processes such as variation, selection and retention, similar to Darwin’s theory of evolution and natural selection (Kay, 2019). It highlights the importance of gradualism, contrasting it with punctuated equilibrium theory and it illustrates that the existence and flourishing of an institution depends on habits, routines and functionality.

Evolutionary theory is the most suitable framework for exploring Ayushman Bharat and PPP model of healthcare in India particularly as evolutionary theory focuses on path dependence while highlighting how the stated goals have been achieved. It also provides for conducting longitudinal analysis as the factors such as adaptation and selection pressures have their effect on

the basis of time. The concept of bricolage of policies is important as it accepts the phenomenon that there can be more than one way to fulfill a particular objective, which is a crucial assumption for qualitative comparative analysis (QCA).

Methodological Framework & Rationale

The methodological framework of my study will be building on the idea of critical multiplism (Dunn & Peters, 2020). The idea clearly suggests that a single method of data analysis is insufficient to compare policies merely because of the complex nature of the policies. While the core idea of critical multiplism is the fact that no single method is perfect and gives the clear result without any fallacy, it also advocates for the use of mixed methods, both quantitative and qualitative. Hence, to avoid missing either the institutional context or the greater international trend, I would be using both qualitative and quantitative methods. They're the use of both qualitative comparative analysis as well as index based evaluation.

Qualitative comparative analysis (QCA) uses a combination of set theory as well as boolean logic in order to understand which combination of conditions would lead to specific outcomes (Thomann, 2020). While QCA is used for medium-N as well as small-N cases, what can be seen is that as I'm using only 5 countries, including India, for my comparative analysis, QCA would be an appropriate measure. This method also captures complex causality, or the very idea that multiple conditions might be required for certain outcomes. The analysis also embraces equifinality, which is the belief that there can exist multiple ways to reach to the same outcome. Hence, because of the given reasons, I will be using this method to create a truth table by using all the 5 countries as 5 separate cases and identifying conditions within them and then using the table to try and derive a boolean formula for achieving universal healthcare. Out-of-pocket

expenditure as a percentage of the complete health expenditure shall be taken as the indicator to assess the major goal, that is whether the scheme has been able to reduce the catastrophic incidence of health expenditure and at the same time has been universal, or has been able to benefit the citizens. The conditions for the truth table will be domestic general government health expenditure, scope of the policy, provision for mandatory pooling, health infrastructure in terms of physician/hospital bed density and Universal Health Coverage (UHC) Service Coverage Index.

Index based evaluation is a quantitative method which is simply the comparison of the different policies over standard or fixed global indices (Erkkilä, 2020). While the QCA might act like the qualitative component for my analysis, I shall use the index based evaluation as a more objective and standardized method too. Back up the analysis done by the QCA. There are multiple metrics available for the same, making index based evaluation a fit method. Comparison of 2 key indicators namely universal health coverage and out-of-pocket expenditure shall be done for all the five nations. General government expenditure as a percentage of the GDP, the domestic general government health expenditure as a percentage of the general government expenditure and the GDP per capita will also be assessed in order to identify the state capacity. The Callaway & Sant'Anna (2021) difference-in-differences with multiple time periods will be used to assess the impact of the schemes of Mexico, Indonesia and India on the OOPE with the treatment of UK and Brazil as control for the test. These quantitative results will highlight the efficiency of the PPP model.

Results and Analysis

Qualitative Comparative Analysis

Country	**C1**	**C2**	**C3**	**C4**	**C5**	**C6**	**O**
India	0	0	0	0	0	0	0
Brazil	0	1	1	1	1	1	1
UK	1	1	1	1	1	1	1
Mexico	0	1	0	1	1	0	0
Indonesia	0	0	1	0	1	0	0

Table 1: Truth table for the QCA for the outcome of OOPE (Source: WHO, n.d.-a; WHO, n.d.-b; *World Development Indicators (WDI),* n.d.)

In the aforementioned Truth Table, the conditions are as follows:

- C1: Is Domestic General Government Health Expenditure as % of Complete Health Expenditure more than/equal to 50%
- C2: Is the Universal Health Coverage (UHC) Service Coverage Index more than/equal to 68 (Global Score (WHO, n.d.-b))
- C3: Is the scheme having provision for mandatory national pooling/universal scheme
- C4: Is the Physician Density per 1,000 more than 2.5 OR Hospital Beds per 1,000 more than 2 (Global Standard as set by WHO (World Health Organization, 2016))
- C5: Is the scheme having provision for a comprehensive coverage (inpatient, outpatient and long-term essential medication included) ((*Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana*, n.d.; Grosios et al., 2010; Ortega and Pele, 2023; Pueblita et al., 2013)
- C6: Is the Domestic general government health expenditure as % of GDP more than 3% (Global Standard as set by WHO)

The outcome for the Truth Table is as follows:

O: Is the Out-of-pocket-expenditure (OOPE) as % of Complete Health Expenditure less than 30%

From the Truth Table, we can infer the following QCA-minimization:

C2 * C3 * C4 * C5 * C6 → O

The QCA minimizations suggest that the five criteria C2, C3, C4, C5, along with C6 are important and must be satisfied in order to achieve the outcome. It suggests that the universal health service coverage index should be more than 68 (which is the global average), along with that, the scheme should have a provision for mandatory national pooling or should be a universal scheme, the physician density per 1000 should be more than 2.5 or the hospital beds per 1000 should be more than 2, the scheme should have provision for comprehensive coverage and the domestic general government health expenditure should be more than 3% of the GDP in order for the out-of-pocket expenditure to be less than 30% of the complete health expenditure. These criteria are met in the UK and Brazil, both of which have public health service and do not have a public insurance scheme like Mexico, Indonesia or India.

Comparison of the Indices

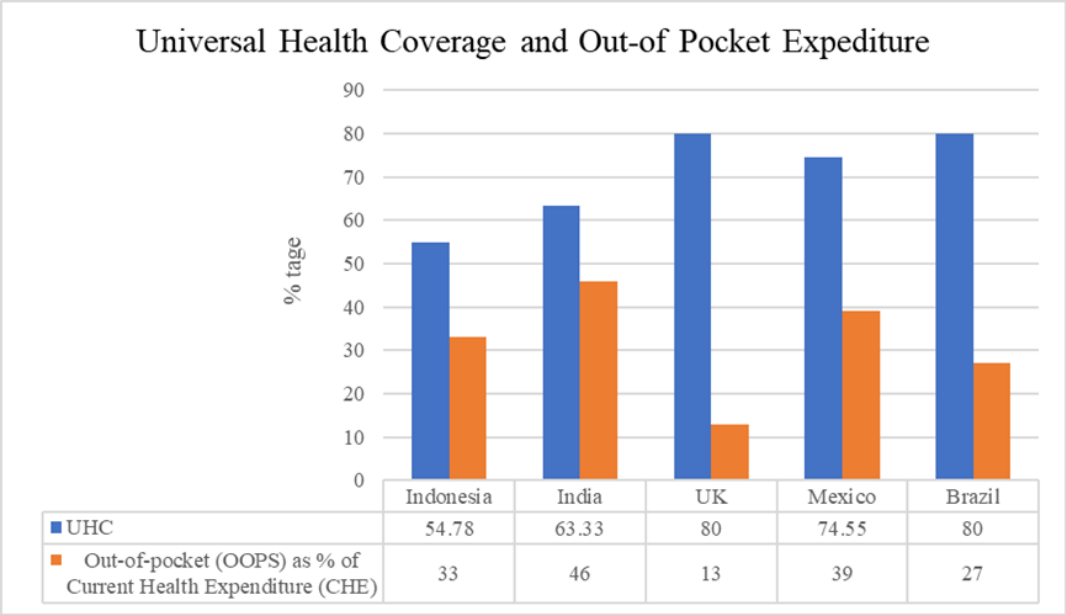

Figure 1: UHC and OOPE of the 5 countries (Source: WHO)

The figure highlights that how, while countries like UK and Brazil with public health coverage have virtually more than 80 as the index score on universal health coverage, the out-of-pocket expenditure for these 2 countries is also low, as seen in the Truth Table above, while for

the other three countries, the universal health coverage is not as per the global standard and the out-of-pocket expenditure is significantly higher compared those with public health system.

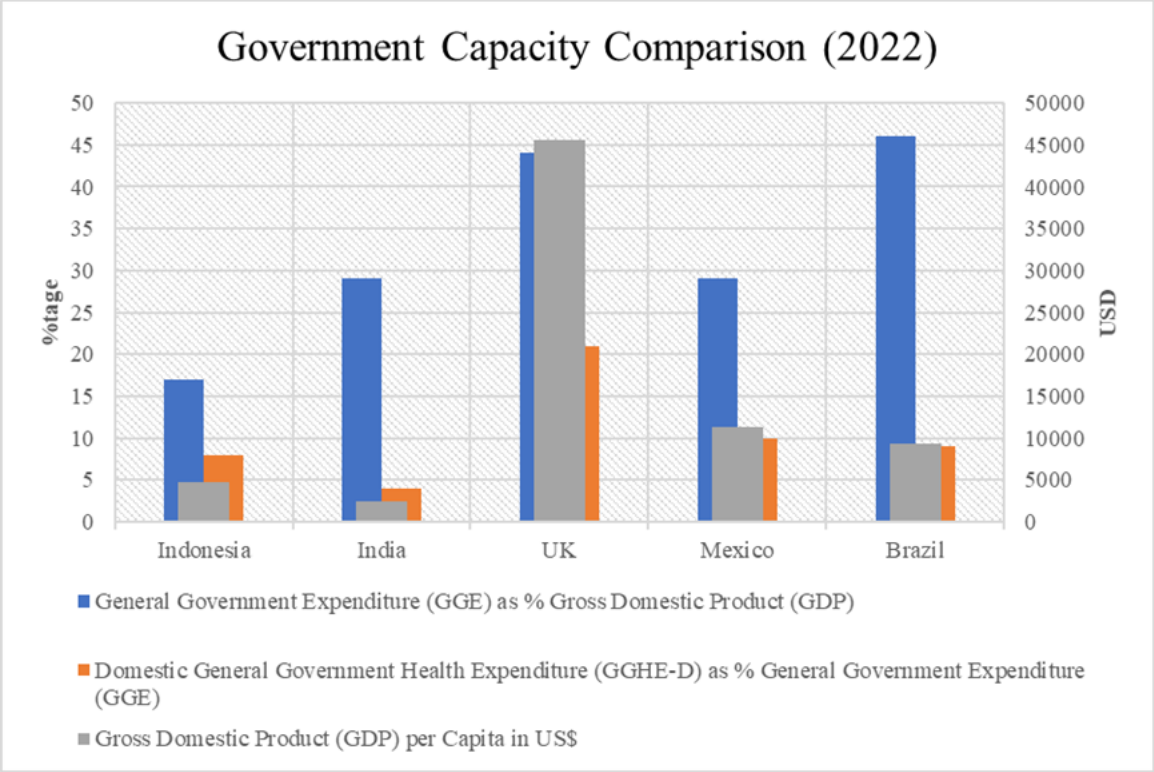

Figure 2: Data showing the government and their spending capacity (Source: WHO)

While comparing UHC and OOPE, it also becomes important to identify the capacity of the government to provide a public health system, as it is an important factor that can shape the policy decision with regards to provision of healthcare. The figure above highlights how the United Kingdom has significantly larger GDP per capita compared to all the 4 countries suggesting that they have a higher ability to spend, which is also seen in the higher share of government in the overall GDP. While Brazil has a lower GDP per capita compared to the United Kingdom, it is still higher than Indonesia and India, while the government's contribution to GDP is way larger compared to all other nations. India has the lowest GDP per capita, when compared to all the countries and it also has the lowest percentage of domestic general government health expenditure, when compared to general government expenditure. This highlights how India's state capacity when it comes to spending on health from the government side is significantly low. Hence, any policy decision should take into account the low state

capacity and should be designed accordingly. Mexico, Indonesia and India, aware of their low state capacity, also introduced a nation-wide insurance scheme, which also can be used at private healthcare centers. It is important to observe whether these policies, all three of which were rolled out after the 2000s, had a meaningful impact on OOPE.

Statistical Results

Cohort (Reform Year)	**ATT Estimate**	**Std. Error**	**95% CI**	**Significance**
Mexico (2004)	−7.38	2.16	[−11.61, −3.15]	$p < 0.05$
Indonesia (2014)	−12.27	0.71	[−13.66, −10.87]	$p < 0.01$
India (2018)	−5.97	1.77	[−9.45, −2.49]	$p < 0.05$
Overall ATT	−8.54	0.58	[−9.69, −7.39]	$p < 0.01$

Table 2: ATT estimate, calculated using *R*

The results of Callaway & Sant'Anna (2021) difference-in-differences with multiple time periods, using outcome regression and "not-yet-treated" controls suggest that ATT (Average Treatment Effect on the Treated) for all the interventions overall is −8.54 percentage points (SE = 0.58, 95% CI: −9.69 to −7.39, $p < 0.001$), highlighting that Mexico, Indonesia and India, on average, show an almost 9 percentage points decrease in their OOPE after the roll-out of the national insurance schemes, above and beyond what was shown by UK and Brazil who did not introduce any new scheme during this period. Mexico's 2004 reform reduced OOPE by −7.38 percentage point. (SE = 2.16), Indonesia's 2014 reform reduced OOPE by −12.27 percentage points (SE = 0.71), and India's Ayushman Bharat Scheme reduced OOPE by −5.97 percentage points (SE = 1.77). All estimates are statistically significant. It is important to note that though Ayushman Bharat might show a comparatively lower reduction, it is also because of how new

the scheme (rolled out in 2018) is compared to the other two (rolled out in 2004 and 2014), given that data has been used up to the year 2022.

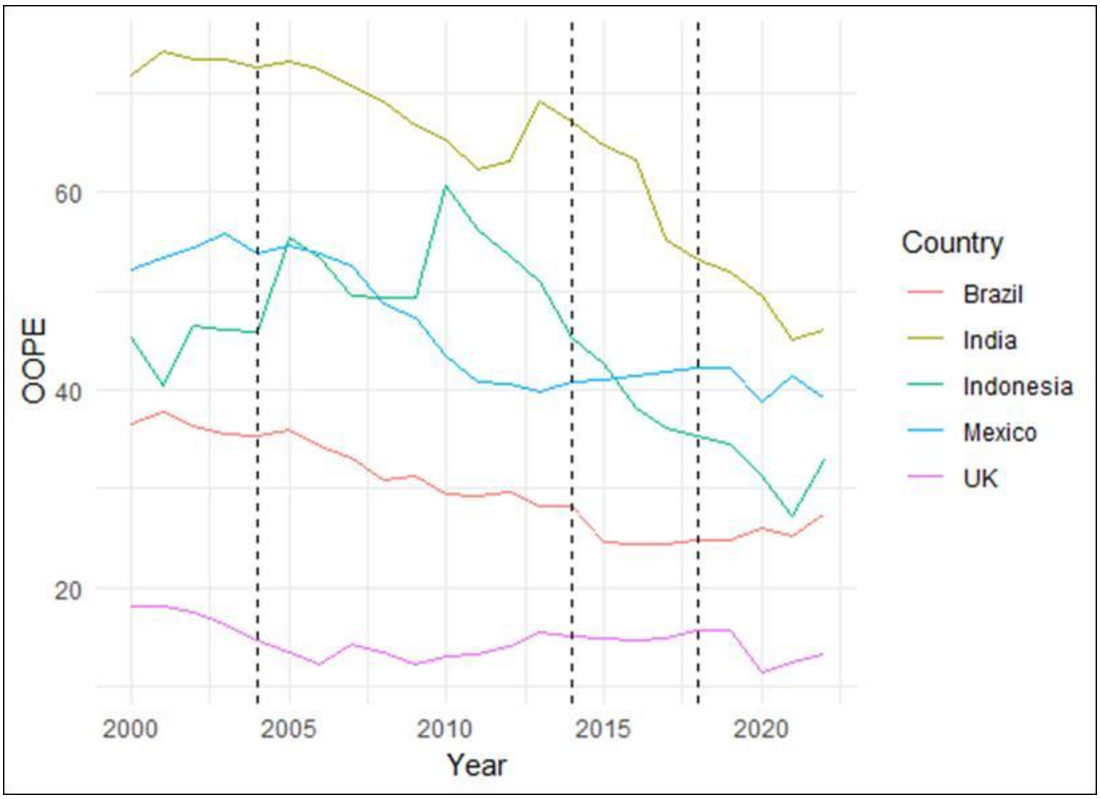

Figure 3: OOPE over the years, along with years of intervention, visualized using *R*

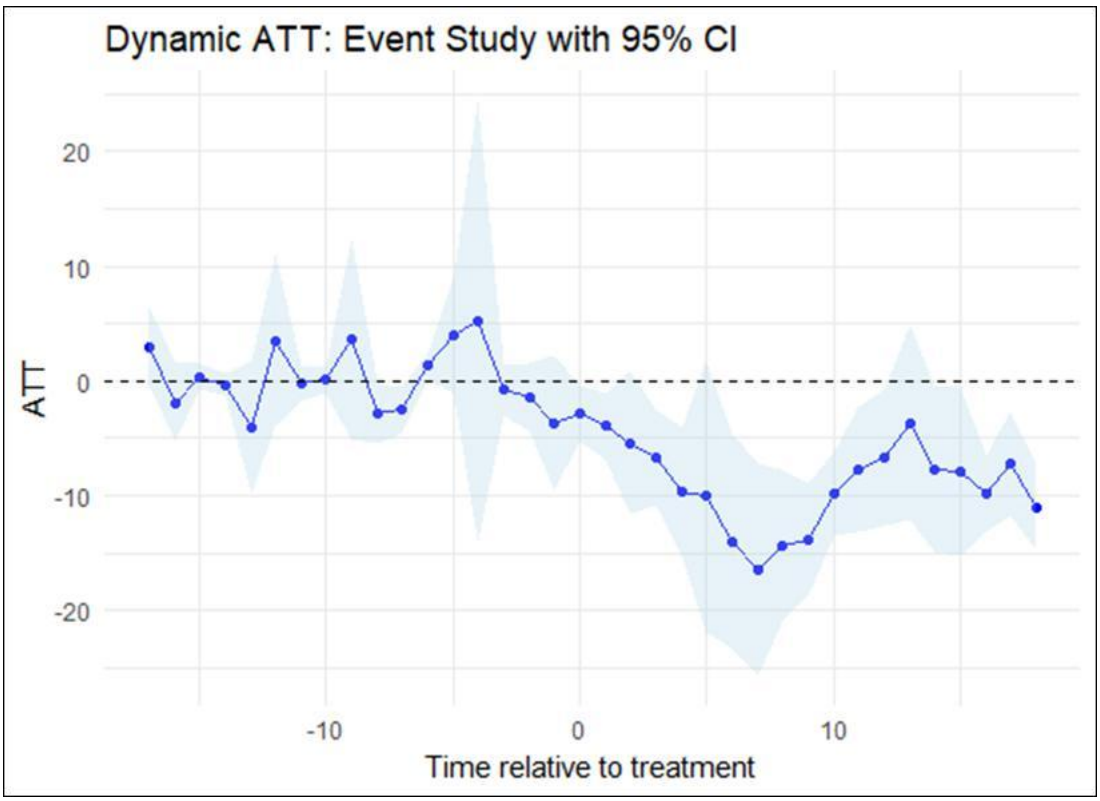

Figure 4: ATT Trend relative to the year of intervention, visualized using *R*

	ATT Estimate	**Std. Error**	**95% CI**	**Significance**
Dynamic Effect	-8.88	1.83	[-12.46, -5.29]	$p < 0.05$

Table 3: Average Dynamic ATT estimate, calculated using *R*

The average dynamic ATT is calculated to be -8.88 percentage points. (SE = 1.83, 95% CI: −12.46 to −5.29, $p < 0.001$). The results highlight that the co-efficients before treatment were around 0, and most of them non-significant while they become negative after the reform, and become more negative with time, highlighting that as time proceeds, the insurance schemes have a larger reduction in OOPE of the countries. It is coherent with the idea that after the scheme is announced, it would take time for registration of all citizens and for the scheme to increase the coverage and provide benefits to all (there are other reasons including the aspect that it will take time for people to develop awareness of the scheme and become a beneficiary).

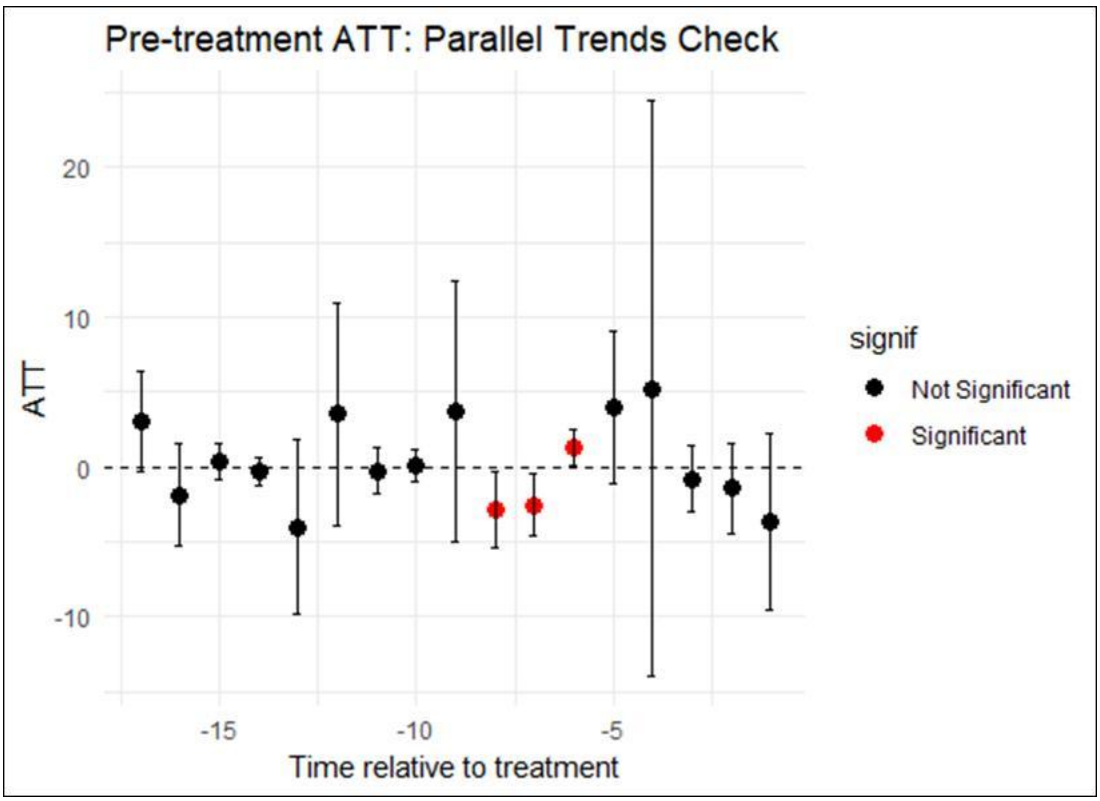

Figure 5: ATT levels before treatment, visualized using *R*

One major assumption of the difference-in-differences framework is that treated and control countries will have the same parallel trends when there is no insurance scheme rolled out. In order to verify that assumption, the aforementioned figure highlights the co-efficients before the roll-out of the scheme. It is observed that most estimates are fluctuating near zero and are not significant (as shown by the black coloured dots) and there is no systematic upward or downward trend. While there are only 3 exceptions where the dots are red, highlighting that the co-efficients are significant, there is no consistency in their divergence, which suggests that that parallel trend assumption of the analysis is correct and the causal interpretation of the ATT estimates is accurate.

Discussion

The results highlight 3 clear aspects when it comes to universal health coverage. The qualitative comparative analysis highlights that while public health systems like that of the UK

and Brazil are strong, what is seen is that these states also have a significantly higher state capacity to provide, as shown in the aspect of indicator comparison and a scheme that is much older, when compared to countries such as Indonesia, Mexico and India. The third aspect is the idea that the insurance scheme as a policy brought about by all the 3 countries actually shows a significant reduction in OOPE, highlighting that it is a good initiative, when it comes to directly reducing OOPE.

The Ayushman Bharat scheme falls well into the concept of institutional layering as the policy is well aware that the existing private health infrastructure and the role of the private sector in health is particularly large. As seen, not only through their percentage of composition in the complete health expenditure, but by the fact that 75% of outpatient consultations before 2018 used to happen through private healthcare centers (Basu, 2024). There is also a critical aspect of learning that comes over here as we identify how there have been cases that highlight the role that private players can play when they're integrated with policies that aim to achieve universal health coverage. Khan et al. (2024) highlight how private practitioners, including private hospitals etc. have played a key role in bridging the healthcare gap in various countries, and they can also be crucial to help further India's goals. Even from India, there have been studies that highlight how the public-private partnership model has proven beneficial when it comes to controlling the incidents of malaria in high burden districts of India (Rahi & Sharma, 2022), giving it a clear case to adapt and to implement on a national scale. Public-private partnerships, particularly in healthcare services, have proven to work, particularly in those cases where there is a weak public infrastructure or the public capacity in general is poorer when compared to the demand of its population. This connects to the concept of path dependence that the evolutionary policy framework proposes, highlighting that it's important as to what path a government takes

while achieving its goal, and in the same sense, the study by Ghasemi et al. (2022), suggests that having a PPP model can actually improve the goal achievement.

Another factor that could be associated with the success of the Ayushman Bharat scheme is particularly self-organization as research from both West Bengal and Maharashtra (Furtado et al., 2022) and even Gujarat (Thomas et al., 2023) highlight one particular aspect that is how the private hospitals and their network connect quickly with the government insurance scheme, largely widening the pool of resources available to its citizens. Though the case also highlights the problems that stopped selection pressure from allowing the market to choose the best possible provider for the healthcare facilities. As every hospital is empaneled on the larger scheme, only the better hospitals would be selected or would rather be the ones preferred by the citizens, which would ultimately lead to competition and would cause other hospitals to also improve, particularly a selection pressure. The problem lay in having a non-gradual shift towards the scheme, as many bureaucrats struggled in quickly empaneling all the hospitals onto the scheme.

It is important to highlight that in a PPP, it is crucial that the private sector is brought onboard quickly, as is even visible in the 2 other comparative cases. In this study. Indonesia, who sees a large reduction in the out-of-pocket expenditure after the new scheme was unveiled, also does the same as they were able to quickly bring the private sector onboard as more than 60% of the hospitals in the new scheme were from the private sector which also led to a significant reduction in OOPE, not only overall, but also in private sector in particular (Health Policy Plus and National Team for the Acceleration of Poverty Reduction, Indonesia, 2018). This is also the very reason why Mexico, in spite of its policy being rolled out in 2004, is still high on OOPE, particularly as self-organization did not take place effectively within the country and there is still

a fragmented private sector that is not onboarded on the national scheme as enrolled by the government (Garcia-Diaz 2022).

It is important to highlight that the Pradhan Mantri Jan Aarogya Yojna (PM-JAY) also can be seen as a bricolage of various schemes. Particularly the Rashtriya Swastha Bima Yojna (RSBY) and the Rashtriya Swastha Suraksha Mission, which highlights the important role that, unlike the punctuated equilibrium framework, gradualism, might be a key aspect, particularly in a country as large as India. The building onto the new scheme is crucial as it builds substantially on the existing schemes such as the new scheme provides a health coverage that is 17 times larger than the older scheme (Garg et al., 2024). At the same time, it has been proven that it is because of such adaptation of schemes that we observe, that it has led to improved accessibility and given a certain degree of financial protection to patients (Khetrapal et al., 2019). Retention of these schemes and improvement of the schemes through adaptation has been successful.

With all the success of the Ayushman Bharat Scheme, it also has its fair share of drawbacks that need to be resolved in order for the scheme to better adapt to the Indian landscape. A major contention that is noted with the scheme is that it might disrupt the process of continuous strengthening and development of a government health system (Kamath & Brand, 2023). Why did a strong scholarship highlight that the government must move towards a public-private partnership model on either of the two lines, that is either the government can use contracting strategy or use concession strategy to improve the healthcare system, and onboard the private entities, hence significantly improving the question of access (Dutta & Lahiri, 2015; Tyagi, 2020), There are concerns over problems that might occur in a PPP. It has been observed that when a PPP model is implemented, there have been cases of abuse of provisions by either charging too much or by overusing or the scheme by providing overtreatment or unnecessary

surgeries (Kumar et al., 2018). Due to such incidents, there have been calls for stronger and a more complex regulatory framework for the private sector so that the rights of people are not undermined (Gupta & Keshri, 2019), an aspect that can hamper innovation.

Policy Recommendations

It is important to note, before exploring the various recommendations, that a complete public-private partnership model or a PPP model might actually be politically unviable or difficult as the political economy of the nation will provide significant resistance to such a system (Odhiambo et al., 2020). Unless there is a political consensus, it will become politically very volatile for the ruling dispensation to move towards such a model. In such a political background, where there are still few states that are ruled by completely left-leaning parties as well as the more recent left-ward shift of certain previously centrist parties (Sonpimple, 2025), a focus on privatization could attract significant backlash. In the political economy of India, it hence becomes an imperative that one of the key principles of evolutionary theory, gradualism, is followed. Gradualism advocates for the fact that changes should not be done rapidly or in a large-scale manner, but should be done in a staggered or in a phased manner. The following recommendations can be implemented in the broader healthcare sector, in order to enhance the functionality of the policy at the same time, ensuring that there is no fiscal burden on the state to provide beyond what its capacity could permit.

In order to efficiently implement a PPP model without sacrificing on the social objectives, such as inclusivity in healthcare and a universal health coverage, it is important that the government makes 2 key distinctions in order to respond to the existing criticism of the Ayushman Bharat Scheme. The government should distinguish between a multi-speciality

hospital that provides various kinds of services and doctors, at the same time, the other category being primary healthcare centers along with specialized centers such as that of dentistry, diagnostics and lab testings which are standalone and can operate independently. The idea of the standalone centers is basically those centers that do not require a proper and immediate integration with other services. Beyond the previously given examples, eye-care (or ophthalmology) centers along with oncology centers and dialysis units can also be standalone systems that can run completely on a PPP basis.

The previous examples of exploitation of customers by private, multi-speciality hospitals, particularly through overinvoicing or conducting unnecessary test warrants that state-of-the-art, multi-speciality hospitals must remain under the government ambit, and it should be the government who should have a complete public healthcare system in the country through multi-speciality hospitals (Nagral et al., 2024).

Even when it comes to the specialized institutions that the government shall run in a PPP model, it is important that certain safeguards are put in place that will ensure that there is no exploitation by the private entity, while at the same time, there is no overburden to the state's exchequer. The foremost step has to be clear and visible entitlement information at all the points of care. The government should have a requirement for uniform and legible signage that is made available in both the official languages as well as the local vernacular languages which can serve as benefit boards at every empanelled facility. These boards can provide information regarding which particular schemes are applicable at the given facility and what services are covered under it with the monetary cap, if applicable. To exemplify the dental clinic instance, there could be a list of covered dental procedures including extractions or root canals and fillings while at the same time excluded cosmetic dentistry procedures such as tooth-whitening or elective veneers,

can be mentioned as those services that are not covered. This will ensure that people who cannot afford these otherwise hefty procedures can choose to opt out of it and can only get those operations done that are covered under the schemes. Additionally, these boards can also provide grievance redressal and fraud reporting channels such as toll free numbers or the government website. The essential idea over here is that there should be a reduction in the information asymmetry and such an information board can tackle key complaints of hidden charges or duplicate claims across various schemes.

When it comes to the payment made to the private contractor or operator by the government side, there can be a mixed payment architecture where the idea is that they could either be capitation or per person monthly payment for PHCs, or other routine health services, while there can also be case-based bundle payments for secondary or tertiary care systems that can be predefined by standard guidelines. The government can also bring in an incentive structure for promotion of better quality measures across these facilities by including performance bonuses in the payments, making it competitive for the private operators to enhance their quality and to act better when compared to other facilities that are on a similar model in the given geographical location.

A centre-state integration is also important over here and while the government is already planning to have a fully operational digital ID for every citizen accessing healthcare services with the idea that the same can reduce any kind of operational inefficiencies, it is important, that such an ID is well integrated and interoperable between the databases of the state as well, as the centre so that there are no cases of double reimbursement or dual entitlement, and there is an efficient use of financial resources (Misra & Chandna, 2025).

Finally, it must be reiterated that critical public hospitals, as well as centers of excellence, shall be restricted to government ownership as they can not only be politically too sensitive to roll out into a PPP scheme, but they can rather be kept for a later phase, particularly after there has been significant results over a larger timeframe, highlighting the success of PPP schemes and with the reduction of any kind of misuse of the scheme. With the recent judgment passed by Hon'ble Andhra Pradesh High Court that declined to stay on PPP model for medical colleges (Aluri, 2025), it hence becomes clear that even larger healthcare institutions and hybrid institutions, such as medical colleges, can come sooner under the ambit of a public-private partnership, ensuring a more efficient utilization of resources, particularly when the state will be undergoing a financial crunch.

Conclusion

The results of the study highlight that while qualitatively, it can be seen that traditional public healthcare systems have lower out-of-pocket expenditure, when it comes to countries with lower state capacities to invest and to provide for healthcare, it is important that they follow a public-private partnership model, as implemented by India, Indonesia and Mexico, as that significantly improves out-of-pocket expenditure without a large burden on the exchequer. Similarly, it is also important for the government to better utilize its resources in a political economy, by focusing on concentrated and multi-specialty hospitals alone, when it comes to government infrastructure and calling for the participation of the private sector for larger areas, including primary healthcare services, dentistry, diagnostics and testing etc. It is only with such a hybrid model with public-private partnership that countries with lower state capacities can significantly improve the health outcomes.

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