Q12

Public health system has limitation in providing universal health coverage. Do you think that private sector can help in bridging the gap? What other viable alternatives do you suggest?

UPSC Civil Services Mains 2015 · GS II · 12 marks · Health, Education and Human Resources

Issues relating to development and management of Social Sector / Services relating to Health, Education, Human Resources.

Core demand of the question

- Public health system has limitation in providing universal health coverage. Do you think that private sector can help in bridging the gap? What other viable alternatives do you suggest?

Revision summary

Public facilities lack staff, drugs and referral, so UHC is incomplete.

The private sector already supplies much care and can be contracted for packages.

Unregulated private care raises costs and leaves remote and preventive work behind.

Alternatives include more public spending, PHC-first care, free medicines and pooled insurance.

Not-for-profit and mid-level providers can sit between a pure State system and a pure market.

Introduction

Universal health coverage means that people get needed care without financial ruin. India's public system - sub-centres, PHCs, CHCs, district hospitals and medical colleges - is the intended backbone, yet beds, doctors, drugs and referral are thin, especially outside metros. The private sector already treats a large share of outpatients and inpatients. It can help close the gap if it is contracted and regulated. It cannot be the only plan, because markets leave the poor, remote and chronic cases behind.

Body

Limits of the public system

- Density of doctors, specialists and nurses is low in many States. Rural PHCs often lack a full team, diagnostics and round-the-clock obstetric care.
- Public spending on health has stayed near 1 per cent of GDP for long stretches, so buildings exist without drugs, diagnostics and maintenance.
- Vertical disease programmes work better than comprehensive primary care.
Non-communicable disease, mental health and geriatric care remain weak.
- **Referral is broken:** patients jump to tertiary hospitals or to private clinics, crowding both.
- Quality and accountability vary. Absenteeism, user charges and stock-outs push families to pay out of pocket.

Can the private sector bridge the gap?

• Yes, in a limited way. Private clinics, nursing homes, diagnostic chains and corporate hospitals already supply capacity the State does not have, especially in cities and for elective surgery.

• Purchasing care for the poor through insurance or trust models (RSBY in 2015, later PM-JAY) can use private beds for secondary and tertiary packages if rates, fraud control and grievance redress are real.

• Public-private partnerships for diagnostics, dialysis, ambulance and medical-college teaching hospitals can fill specific holes faster than new civil works.

• No, if "bridge" means leaving primary care and public health (immunisation, TB, water-borne disease, surveillance) to shops. Those are public goods.

• Private care is concentrated, fee-for-service, and can induce unnecessary procedures. Without standard treatment guidelines, empanelment and audits, insurance only inflates bills.

• Informal private providers and unqualified practitioners already fill rural gaps at high clinical risk. Scaling that is not UHC.

Other viable alternatives

• Raise public spending toward a credible floor, fill posts, and make the Health and Wellness Centre / PHC the first call with drugs, diagnostics and a named family doctor.

• National Health Mission-style strengthening of ASHAs, ANMs and community monitoring remains cheaper prevention than hospital insurance.

• Expand public medical education and rural service bonds; use mid-level providers under law, not as a silent substitute for doctors.

• Drug and device price control, generic pharmacies, and free essential medicines in public facilities cut the largest out-of-pocket item.

• Not-for-profit trusts, cooperative hospitals, ESIC and CGHS-type pooled funds, and State-run empanelled networks can sit between a pure NHS and a pure market.

• Digital health records, telemedicine to specialists, and district knowledge hubs help where specialists will not relocate.

• Regulate clinical establishments, cap unethical referral commissions, and publish outcomes so private help is quality, not only quantity.

Flow diagram

UHC goal -> Public PHC drugs staff

UHC goal -> Regulated private purchase

UHC goal -> Trusts cooperatives pooled funds

Public PHC drugs staff -> Gap reduced

Regulated private purchase -> Gap reduced

Unregulated market -> High OOP and exclusion

Conclusion

The private sector can help bridge a part of the UHC gap in diagnostics, elective procedures and extra beds, if the State purchases and regulates. It cannot replace a tax-funded primary public system. Viable alternatives are higher public spend, a functioning PHC first, free essential medicines, pooled insurance with tight packages, not-for-profit providers, and skilled mid-level care. UHC in India is a mixed system with a public spine, not a privatised hospital market.

Facts & figures

Out-of-pocket spending

A large share of Indian health spending is paid by households at the point of care, which is the opposite of UHC financial protection.

National Health Mission

The main public programme for rural and urban health systems, ASHAs, and reproductive and child health.

RSBY (2008)

Rashtriya Swasthya Bima Yojana was the 2015-era national hospitalisation insurance for BPL families, using public and private empanelled hospitals.

Clinical Establishments Act, 2010

A central law for registration and standards; adoption by States has been uneven, so private quality control remains patchy.

WHO UHC idea

Coverage of needed services with financial risk protection; India still mixes underfunded public care with a large private market.