Health is not only the absence of illness; it is the ability of people to develop their potential during the course of their entire life. The importance of health is also excogitated in the United Nations Millennium Development Goals; out of the 8 goals, 18 targets and 48 indicators, six goals, 8 targets and 18 indicators are directly related to health. All this has directed the need for the existence of strong health care system.

However, in India health care system is characterized by a pattern of mixed ownership and different systems of medicine - Allopathy, Ayurveda, Yoga, Unani, Siddha, Naturopathy and Homoeopathy (AYUSH). It comprises two major sectors i.e., the private sector that mostly provides curative services and the government sector that provides promotive, preventive and curative health services. An important matter of concern is the differences in the approach of public and private health system. All this has not only created disparities in the health service availability, but also in the health status of people living in urban and rural areas of the country. In this background the study attempted a comparative analysis between the public and the private health sector in rural and urban areas on the issues of availability of health services, utilisation of health services and service quality factors.

The study provided a brief health profile of Karnataka based on the status of health indicators, status of health related MDGs, public health expenditure trends and the availability of public and private health education and service infrastructure. Subsequently, the role of the public and private health sector has been examined in service delivery on the basis of service utilisation with the help of NFHS and NSSO data and primary data collected in rural and urban areas of Mysore and Bellary districts. Finally, the reasons for lower utilisation of public hospitals for inpatient care were ascertained by analysing and comparing service quality in public and private hospitals.

In the process of fulfilling the study objectives and testing the hypotheses statistical and econometric techniques like chi-square test, logit model, ordered logit model, factor analysis, multivariate and univariate ANOVA, multiple regression model and discriminant analysis have been employed.

Both NFHS and NSSO data prove greater reliance of people on the private sector for medical treatment both in rural and urban areas. The results of the primary study also comply with the same. Out of 780 respondents, only 242 (31 percent) respondents reported as having accessed PHCs services in last one year.
of rural areas have emerged as major users of primary health centres (PHCs) services than urban respondents. A significant difference is noticed in the utilisation of public and private primary health services in the study area. Although greater reliance on private sector in the utilisation of primary care services both in rural and urban areas is observed, for higher care services especially for inpatient care people seem to utilise private hospital services than public hospitals. This trend is largely noticed in urban areas. The socially disadvantaged groups such as SC, ST, female and lower income strata are still observed heavily relying on public sector due to un-affordability of private services both at primary and higher care level.

ANOVA analysis revealed a significant difference in the service quality of public and private hospitals. Further, it reflected that the service quality of private hospital is higher than the public hospitals. Out of six SQFs higher differences are accounted in the perceptions on treatment cost and atmosphere between the hospitals. Influence of physician behaviour is found greater on patients’ overall satisfaction than other SQFs both in public and private hospitals. Analysis extended to areas revealed that there is significant difference in the SQFs influences on rural and urban patients’ overall satisfaction. Discriminant analysis indicated the rural patients choice of hospital for inpatient care is highly influenced by treatment cost followed by atmosphere, whereas for urban patients they are atmosphere and treatment cost.

The total expenditure on health is found to be about 0.78 percent of state GDP. The norms relating to human resource under Indian Public Health Standards are not fulfilled in Karnataka. Shortfall is noticed in the number of SCs and CHCs in the state. It is also observed that there are differences in the availability of public and private health education and service infrastructure between districts in Karnataka. The private sector is found to be better in the case of number of hospitals, doctors, doctors per 10,000 population and hospitals per 10,000 population than the public sector.

Thus, the study points out the need for strengthening the public health care system in terms of fund allocation, distribution, access and service quality at both primary and higher levels of care in India and Karnataka, with special focus on growing disparities between rural and urban areas. Further, it suggested the need for controls in private sector on treatment cost and service quality, so that none will be deprived in any type of health care access.