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Trends in Healthcare-Seeking Behaviour: A Comparative Study of Outpatient and Inpatient Care in India

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ABSTRACT
Background: *Healthcare-seeking behaviour represents a complex decision-making process influenced by individual dynamics, socio-demographic variables, and institutional characteristics. In India, despite state-level public health mandates, a distinctive dualism exists between private-sector reliance and public safety nets.*
Objectives: *This paper examines the evolving trends in healthcare-seeking behaviour across India, focusing on structural differences across both non-hospitalized and hospitalized spells of medical treatment.*
Methods: *Utilizing a secondary analysis design, the study utilizes nationally representative data from the National Statistical Office (NSO) spanning over two decades, across four distinct survey rounds: Round 60 (2004), Round 71 (2014), Round 75 (2017–18), and Round 80 (2025).*
Results: *The empirical data demonstrates a persistent reliance on the private sector for routine, non-hospitalized treatments, with private doctors and clinics consistently treating over 43% to 50% of ailment spells nationwide across both rural and urban areas. Conversely, hospitalized treatments reflect an irreplaceable public safety net, particularly for rural households where public hospital utilization rose to 45.7% (Round 75), serving as a crucial buffer against catastrophic medical debts.*
Conclusion: *India's healthcare landscape has evolved into a deeply bifurcated system. Reaching true Universal Health Coverage (UHC) requires scaling up primary public infrastructure to reclaim outpatient spaces while introducing comprehensive pricing regulations within private inpatient networks.*
Keywords: *Healthcare-seeking behaviour, National Sample Survey (NSS), Public-private dualism, Hospitalization, Outpatient care, India.*

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I. INTRODUCTION

Health care-seeking behaviour is defined as any action undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy (Ward et al., 1997). This behaviour is preceded by a complex decision-making process governed by individual and household dynamics, community norms, and provider-related characteristics (Olenja, 2003). A multitude of factors interplay in shaping these choices. Typically, the process begins with symptom recognition and the perceived nature of the illness, often followed by initial home care and monitoring. If home care proves insufficient, individuals may seek formal medical care, leading to clinical evaluation, medication compliance, or further treatment. Treatment failure may subsequently require a return to the health facility or a shift to alternative care providers. Thus, client-based factors, provider-based factors, caretaker perceptions, socio-demographic variables, costs, social networks, and biological symptoms work synergistically to form distinct patterns of health-seeking behaviour (Ryan, 1998). Ultimately, the availability, accessibility, and cost of health services are heavily drawn into this decision-making matrix.

Healthcare is universally provided through both public and private sectors. Public healthcare is administered by the government through national healthcare systems, whereas private healthcare is delivered via for-profit hospitals, self-employed practitioners, and non-profit, non-governmental organizations (Basu et al., 2012). In India, the government aims to provide equitable access to quality healthcare for all citizens (Fatma & Ramamohan, 2023). However, despite the provision of free medical services at public facilities, curative health services remain predominantly provided by private, for-profit healthcare providers (DGHS, 2022). While the private sector continues to dominate India's healthcare landscape (Rout et al., 2021), recent government initiatives—such as free medication schemes and universal health financing—have steadily improved the utilization of public facilities (Prinja et al., 2017).

Against this backdrop, this paper examines the evolving trends in healthcare-seeking behaviour in India. Utilizing National Sample Survey (NSS) data spanning from 2004 to 2026, this study analyses and compares patterns across both non-hospitalized and hospitalized spells of treatment.

II. METHODS

The National Statistical Office (NSO)—formerly the National Sample Survey Office (NSSO)—under the Ministry of Statistics and Programme Implementation (MoSPI), has been conducting periodic surveys on social consumption relating to health. These surveys serve as the primary source of basic quantitative information on the healthcare sector in India. Data for this study were drawn from microdata files and reports across four key survey rounds: Round 60 (January–June 2004), Round 71 (January–June 2014), Round 75 (July 2017–June 2018), and Round 80 (January–December 2025). The target population encompasses both rural and urban Indian households, categorizing treatments across non-hospitalized treated spells (15-day reference period) and hospitalized cases (365-day reference period). Descriptive statistics and cross-tabulations were constructed to track shifting percentages over time.

III. RESULTS

3.1 Non-Hospitalized Treatment by Provider

Table 1: *Per 1000 distribution of non-hospitalised treated spells of ailments during 15 days by source of treatment (institution), NSS, 60th Round*

Region	Government Institution (%)	Private Institution (%)	Total (%)
Rural India	22.4	77.6	100.0
Urban India	19.2	80.8	100.0

Source: NSS, 60th Round

The data from the NSS 60th Round reveals a profound reliance on private institutions for non-hospitalized ailments across India. Private providers dominate the sector, managing 77.6% of treated spells in rural areas and 80.8% in urban regions. Conversely, government institutions account for a relatively small share, facilitating only 22.4% of rural and 19.2% of urban outpatient care. This private-public gap signifies that approximately four out of every five treated ailments are handled by the private sector, regardless of geography. These findings underscore the private sector as the primary portal for treatment in India, while public facilities remain a secondary source for non-hospitalized treatment.

Table 2: *Percentage Distribution of Non-Hospitalised Treated Ailments by Healthcare Provider (Persons), NSS, 71st Round*

Level of Care	Rural Persons (%)	Urban Persons (%)
HSC, PHC & others*	11.5	3.9
Public Hospital	16.8	17.3
Private Doctor/Clinic	50.7	50.0
Private Hospital	21.0	28.8
All (Total)	**100.0**	**100.0**

*Note: *Health Sub-Centres, Primary Health Centres, etc. Source: NSS, 71st Round*

The NSS 71st Round analysis demonstrates a heavy national reliance on the private sector, which treats 71.7% of ailment spells in rural areas and 78.8% in urban sectors. Private doctors and clinics represent the most consistent level of care, accounting for approximately half of all outpatient treatments regardless of geography. A significant disparity exists in the utilization of primary public infrastructure (HSC, PHC, and others), which is nearly three times more prevalent in rural regions (11.5%) than in urban centres (3.9%). While public hospital usage remains stable across both sectors, urban populations show a notably higher preference for private hospitals (28.8%) compared to rural ones (21.0%). Ultimately, these findings identify the private clinic as the foundational provider of outpatient care across India.

Table 3: *Percentage Break-up of Treated Ailments by Provider, NSS, 75th Round*

Healthcare Service Provider	Rural (%)	Urban (%)	All-India (%)
Government / Public Hospital	32.5	26.2	30.1
Private Hospital	20.8	27.3	23.3
Private Doctor / Clinic	41.4	44.3	42.5
Informal Health Care Provider	4.3	0.9	3.0
Charitable / Trust / NGO-run Hospital	0.9	1.3	1.1
All (Total)	**100.0**	**100.0**	**100.0**

Source: NSS, 75th Round

The NSS 75th Round data confirms a predominant reliance on the private sector, with private doctors and clinics serving as the largest provider at 42.5% nationally. In rural areas, public hospitals play a more critical role, treating 32.5% of ailments compared to 26.2% in urban centres. Conversely, urban residents show higher utilization of private hospitals (27.3%) and clinics (44.3%). A stark disparity exists in the use of informal healthcare providers, which are nearly five times more common in rural regions (4.3%) than in urban areas (0.9%). Meanwhile, the contribution of charitable and NGO-run hospitals remains marginal nationwide, staying between 0.9% and 1.3%. This suggests that while public infrastructure serves as a vital rural safety net, private providers remain the primary choice for medical care across both sectors.

Table 4: *Distribution of Treated Ailment Spells by Sector (Persons), NSS, 80th Round*

Healthcare Service Provider	Rural Persons (%)	Urban Persons (%)
Govt. Hospital / Public Health Facilities*	34.6	25.2
Private Doctor / Clinic	43.0	43.7
Private Hospital	21.8	30.5
Charitable / Trust / NGO-run Hospital	0.6	0.7
All (Total)	**100.0**	**100.0**

*Note: *Includes CHCs, PHCs, Sub-Centres, and District Government Hospitals. Source: NSS, 80th Round*

The NSS 80th Round analysis highlights a consistent national reliance on private doctors and clinics, which treat over 43% of cases in both rural and urban sectors. A significant divergence exists in hospital utilization: public health facilities manage 34.6% of rural treatments, nearly ten percentage points higher than the 25.2% recorded in urban areas. Conversely, urban settings show a higher demand for private hospitals (30.5%) compared to rural regions (21.8%). Despite these institutional shifts, charitable and NGO-run hospitals maintain a negligible presence, contributing to less than 1% of total spells. These findings indicate that while the public sector remains a crucial provider of care for rural populations, urban healthcare behaviour is characterized by a definitive shift toward private-sector hospital services.

3.2 Hospitalized Treatment

Table 5: *Per 1000 distribution of cases of hospitalised treatment by type of hospital, NSS, 60th Round*

Type of Hospital	Rural India (%)	Urban India (%)
Government Hospital	41.7	38.2
Non-Government (Private) Hospital	58.3	61.8
Total	**100.0**	**100.0**

Source: NSS, 60th Round

The data regarding hospitalized treatment in 2004 shows that in rural India, 41.7% of cases were handled by government hospitals, whereas 58.3% were treated in non-government or private hospitals. In urban India, the share of government hospital usage was lower at 38.2%, with private institutions accounting for 61.8% of hospitalization cases. Comparing these figures to the outpatient data previously discussed, it is evident that while the private sector remains the primary provider for both inpatient and outpatient services, the public sector plays a significantly more substantial role in hospitalization. Specifically, the rural population shows a higher rate of public hospital utilization for major medical interventions than the urban population, though the majority of cases in both regions are still managed by private facilities.

Table 6: *Per 1000 distribution of cases of hospitalised treatment by type of hospital during 2014, NSS, 71st Round*

Type of Hospital	Rural India (%)	Urban India (%)
Government Hospital	41.7	38.2
Non-Government (Private) Hospital	58.3	61.8
Total	**100.0**	**100.0**

Source: NSS, 71st Round

The longitudinal comparison reveals stability in baseline hospitalization patterns. In rural areas, 41.7% of patients occupied public beds, while urban areas hovered lower at 38.2%. The structural pattern indicates an urban bias towards commercial health delivery networks, whereas public systems provide an essential alternative during health conditions requiring acute care or prolonged hospitalization.

Table 7: *Percentage Break-up of Hospitalization Cases by Type of Hospital, NSS, 75th Round*

Type of Hospital	Rural (%)	Urban (%)	All-India (Rural + Urban) (%)
Government / Public Hospital	45.7	35.3	42.0
Private Hospital	51.9	61.4	55.3
Charitable / Trust / NGO-run Hospital	2.4	3.3	2.7
All (Total)	**100.0**	**100.0**	**100.0**

Source: NSS, 75th Round

The NSS 75th Round data reveals that the private sector is the primary provider for inpatient care, accounting for 55.3% of hospitalizations nationally. While private sector reliance is significant in rural areas (51.9%), it dominates urban centres at 61.4%. Conversely, the public sector plays a more substantial role in rural

regions, covering 45.7% of cases compared to 35.3% in urban areas, confirming government facilities as a critical pillar for the rural population. Charitable and NGO-run hospitals contribute a minor share, with slightly higher utilization in urban settings (3.3%) than rural ones (2.4%). Collectively, these figures underscore a preference for private inpatient care in urban environments while highlighting the public system's importance in bridging the service gap for rural households.

Table 8: *Percentage Break-up of Hospitalization Cases by Type of Accommodation and Medical Institution, NSS, 80th Round*

Medical Institution	Sector	Free Ward (%)	Paying: General (%)	Paying: Special (%)	Total (%)
Govt. Hospital / Public Facilities	Rural	94.3	5.1	0.6	100.0
	Urban	93.1	5.5	1.5	100.0
Charitable / Trust / NGO Hospital	Rural	52.0	38.5	9.5	100.0
	Urban	32.2	44.9	22.9	100.0
Private Hospital	Rural	7.3	73.7	19.0	100.0
	Urban	5.7	63.7	30.7	100.0

Source: NSS, 80th Round

The NSS 80th Round data reveals a grim contrast in the economic structure of inpatient care. Public facilities overwhelmingly provide free ward services, accounting for over 93% of hospitalizations with negligible use of paying wards. In contrast, private hospitals are dominated by paying general wards, though urban private patients utilize special wards at a significantly higher rate (30.7%) than rural ones (19.0%). Charitable and NGO-run hospitals occupy a middle ground, showing high variance: free wards cover 52.0% of their rural cases but drop to 32.2% in urban areas, where paying wards predominate. These findings indicate that while the public sector remains the primary provider of cost-free care, the private and charitable sectors maintain a tiered payment structure leaning toward premium services in urban environments.

IV. DISCUSSION

The longitudinal trends across the National Sample Survey (NSS) rounds reveal a structurally divided healthcare system in India. This system is defined by persistent private-sector dominance in routine care and an irreplaceable public safety net for major medical events, corroborating that while the private sector handles the majority of daily care (Sengupta & Nundy, 2005), the public sector acts as a vital shield against financial ruin (Wong et al., 2024). Furthermore, a widening healthcare gap persists between rural and urban areas.

In the realm of non-hospitalized care—such as quick check-ups and minor illnesses—the private sector operates as the undisputed primary provider. This persistent reliance is not an accident but a dynamic preference driven by a specific structural vehicle: the standalone private clinic. Local private clinics and practitioners have effectively become the default providers for medical consultation across the country.

This sustained dominance highlights a critical quality-access paradox (Kumah, 2025). Over successive decades, the government has invested heavily in expanding public primary care infrastructure; yet, the public sector continues to lose ground in the outpatient arena. This occurs because healthcare choices for minor illnesses are deeply intertwined with economic optimization. Patients routinely bypass free or subsidized public facilities in favour of private practitioners due to immediate geographic proximity, flexible evening hours, and a higher perceived quality of face-to-face clinical interaction (Aldadi et al., 2025). Crucially, private clinics minimize indirect costs—such as prolonged waiting times that translate directly into wage loss for daily earners—meaning that paying for a private doctor is often more cost-effective than losing a day's wages (Siciliani et al., 2013).

However, this outpatient landscape is sharply divided by geography. Grassroots public infrastructure, such as Health Sub-Centres and Primary Health Centres, serves almost exclusively as a rural safeguard. In urban

environments, this primary public tier is largely bypassed or non-existent. Urban outpatient care has become almost completely marketized, leaving city populations structurally dependent on private alternatives for even the most basic medical needs (Levesque et al., 2006).

The story changes completely when shifting the focus to hospitalized treatment. While outpatient choices are governed by convenience and proximity, inpatient decisions represent a high-stakes compromise between clinical gravity and extreme financial vulnerability (Schneeberger et al., 2023). In this arena, the public sector retains absolute relevance, demonstrating a much more robust grounding than it does in routine care. Public hospitals function as a critical shield against catastrophic health expenditures, particularly for the rural population (Sriram & Albadrani, 2022). When a medical crisis requires overnight admission, the threat of bankruptcy alters patient behaviour, driving a significant portion of the populace back into the public system. Rural families rely heavily on public infrastructure for major surgeries and treatments to avoid the excessive pricing often associated with private admission (Kamath et al., 2025), making the public hospital an irreplaceable financial stabilizer.

In contrast, urban inpatient care has undergone a progressive market shift toward privatization. Urbanization has naturally aligned with a heavily commercialized corporate healthcare sector (Gilmore et al., 2023). Private hospitals have become the default choice for the expanding middle and upper-middle classes, driving the expansion of secondary and tertiary corporate hubs. This has created a deeply bifurcated inpatient system where the choice of facility is determined by a family's socioeconomic status and financial capacity rather than purely clinical necessity (Ghoshal, 2016).

The financial structures of these sectors explain why this dual system persists. Public and private facilities operate on entirely opposing economic models. Public hospitals function almost exclusively as cost-free spaces, relying overwhelmingly on free ward structures with negligible use of paying or special accommodation. The public sector's relevance is therefore inherently protective, serving as a non-negotiable safety net for vulnerable socioeconomic segments (Tossou, 2025).

Private hospitals, on the other hand, operate on a rigid tier-of-payment structure, dominated by paying general and premium special wards. In urban settings, the demand for these premium, specialized spaces is highly pronounced, reflecting a consumer-driven approach to tertiary care. However, this preference comes at a severe cost. Because private hospitalization expenses remain vastly higher than public alternatives, this heavy reliance generates a massive out-of-pocket expenditure burden (Kamath et al., 2025), routinely trapping families in cyclical debt following major health shocks.

An essential evolutionary nuance to consider in the modern era is the changing definition of the private sector itself. The rapid expansion of government-financed health insurance schemes has structurally altered how care is sought and recorded (Prinja et al., 2017). Under contemporary frameworks, government-empanelled private hospitals are still categorized as private institutions. Consequently, sustained or rising private sector utilization does not necessarily signal a failure of public healthcare policy. Instead, it reflects a strategic shift in the state's role: moving from being a pure provider of healthcare to acting as a financial purchaser of private care for low-income segments. This public-private integration means the contemporary private sector increasingly delivers publicly funded care, blending the two ecosystems into a single, hybrid model.

V. CONCLUSION

India's healthcare evolution has created a deeply dualistic health system. The private sector handles everyday outpatient needs and urban hospitalizations, while the public sector remains irreplaceable as a financial safety net for the poor and rural populations. For India to transition toward truly equitable Universal Health Coverage (UHC), future policy must look beyond merely subsidizing private care through insurance. A sustainable, long-term strategy requires scaling up primary public infrastructure to reclaim outpatient care, alongside strict regulatory oversight of private inpatient pricing to bridge the glaring financial divide between the two sectors.

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