A Comparative Analysis of Healthcare Governance in Kerala and Gujarat: Public- Private Partnerships, Policy Frameworks, and Health Outcomes

Akankshya Pani

Abstract

This paper is a comparative study into the governance of healthcare in Kerala and Gujarat. The two Indian states vary in their economic and social aspects, which also reflects in the different public health systems they manage. The present research uses an interdisciplinary method to analyze the public-private partnerships (PPPs), policy frameworks, governance structures, and, last but not least, the effects of these partnerships on healthcare outcomes. The community-led health initiatives in Kerala stand in stark contrast with the market-driven, privatized healthcare expansion approach adopted in Gujarat. The research utilizes evidence from 2008 to 2025 to demonstrate the influence of governance quality, the regulation of public-private partnerships (PPPs), and participatory policy frameworks on maternal health, life expectancy, infant mortality, and equitable access. The proposed work exhibits that regulatory frameworks should be stronger, that public-private partnerships (PPPs) that focus on fairness should be better, and that Kerala's decentralized approaches should be added to Gujarat's policy framework.

Keywords: *Public-private partnerships, Healthcare governance, Policy frameworks, Governance structures, Regulatory frameworks*

Introduction: Ways to Manage Healthcare in India

India's healthcare governance has gone through a lot of changes over time. The colonial period saw the establishment of public health institutions which were mostly meant for the administrative and military needs rather than the health needs of the general population. The health care planning in the first few decades after independence was based on an ambitious state-led welfare vision, with the public sector holding nearly 92 per cent of all hospitals. But eventually, the public system got weakened because of chronic underfunding, administrative constraints, and what has been termed as "policy drift," thus creating an opening for the rapid emergence of private providers (Bali & Ramesh, 2015). This change led to the coming into being of a "mixed health economy," where private sector became dominant and controlled more than 90 per cent of healthcare delivery. Governance has made another change in recent years to a model in which the state plays the role of a "strategic purchaser" of services increasingly, the financing of care through private and public providers alike being done with the help of large-scale insurance schemes such as the Rashtriya Swasthya Bima Yojana (RSBY) (Bali & Ramesh, 2021).

These sweeping changes in healthcare governance on the state and federal levels have not led to the same consequences in all states. State administrations have very different policies regarding health care despite having the same policy framework, mainly because of the differences in the governing political ideologies, the prioritization of socio-economic development, and the manner of economic governance. Kerala and Gujarat, in fact, are two states in the same national system, yet they are perfect examples of this divergence. The healthcare paths of both states have been significantly influenced by diverse political cultures, different investment strategies, and varying degrees of interaction with the private sector, which, in turn, have led to considerably different institutional outcomes and modes of service delivery.

This study undertakes a detailed examination of the healthcare governance structures of both states, focusing on their public–private partnership arrangements, policy orientations, health outcomes, and the broader social and economic implications of their healthcare models. The Kerala model is defined by a human development approach that prioritizes social well-being through proactive state intervention and the successful integration of local

decentralization via the three-tiered Panchayat system (Israelsen & Malji, 2021). This participatory framework relies on community-led projects like Kudumbashree to mobilize volunteers and ensure inclusive social development, fostering what scholars call a "high energy" participatory democracy (Israelsen & Malji, 2021). This framework is reinforced by "Mission Aardram," a policy launched in 2017 to transform Public Health Centers (PHCs) into Family Health Centers that prioritize patient dignity and high-quality "people-friendly" services (Sagara, 2024). In contrast, the Gujarat model centers on neoliberal economic policies, emphasizing rapid industrial expansion and business-friendly environments to drive high economic growth rates (Sagara, 2024). This strategy favors the privatization of key sectors and the use of public-private partnerships (PPPs), shifting the delivery of services toward the private sector based on the philosophy that the "government has no business being in business" (Aiyar, 2021).

With regard to Public-Private Partnership (PPP) Structures, Gujarat heavily utilizes PPPs like the Chiranjeevi Yojana, which provides financial incentives to private practitioners to manage deliveries, and the Mukhyamantri Amrutum (MA) Yojana, which uses an empanelled network of private providers for surgical care (Sagara, 2024). By 2014, the population relying on public healthcare dropped to 15%, as the state prioritized private capital over state provision (Israelsen & Malji, 2021). On the other hand, while privatization exists in Kerala, it currently aims to reinvigorate the public sector through Mission Aardram to force the private sector to lower its prices to remain competitive, thereby reducing out-of-pocket expenses. In terms of comparative health outcomes and infrastructure, Kerala has a significantly stronger medical workforce, with 300,988 nurses compared to Gujarat's 160,192. Furthermore, vacancy rates for Medical Officers at PHCs are only 2.4% in Kerala, whereas they reach 30.2% in Gujarat (Central Bureau of Health Intelligence [CBHI], 2019). Also, Kerala achieved 100% immunization for infants aged 9–11 months, while Gujarat reached approximately 92%. The Neonatal Mortality Rate is nearly four times higher in Gujarat (21) than in Kerala (6) (CBHI, 2019).

Kerala and Gujarat are completely different when it comes to the structuring and governance of their healthcare systems, which in turn is determined by different political economies and development paths usually characterized as the "Kerala model" and the "Gujarat model." Kerala has made a rights-based

and welfare-oriented choice that puts a lot of stress on public provision and social justice. On the other hand, Gujarat has a very much growth-driven and market-oriented approach that is heavily reliant on the private sector and public-private partnerships (PPPs). The "Gujarat model" has faced criticisms for putting economic growth first and not adequately addressing social development issues, whereas the "Kerala model" has been under a microscope too. For example, Shah (2010) argues that the impact of welfare policies in Kerala on social development has been more limited and they have had a more negative effect on economic growth than is usually assumed.

What Are PPPs in Health Care?

Public–Private Partnerships (PPPs) in healthcare are defined as durable, collaborative relationships between public and private actors aimed at achieving common goals through a structured cooperation (Singh & Prakash, 2010). Koppenjan (2005) characterizes a PPP as a type of managed collaboration involving public and private partners in the planning, construction, and/or operation of infrastructure facilities, where they share or redistribute the risks, costs, benefits, resources, and responsibilities among themselves. Public–private partnerships (PPPs) refer to arrangements in which private actors are involved in, or support, the delivery of infrastructure, with projects structured around contracts that assign responsibility for providing infrastructure-based public services to private entities (Torchia et al., 2015). Unlike traditional privatization, PPPs involve partners with different ownership structures—public and private—who share or reallocate risks, costs, resources, and responsibilities to provide public or quasi-public goods for society. From a governance perspective, this shift represents a "modernization narrative" where the role of the state evolves from being a direct provider to acting as a regulator and coordinator, relying on the market for service delivery and infrastructure to meet community health needs (Torchia et al., 2015).

The importance of PPPs stems from their ability to address "wicked problems," such as aging populations and rapid disease transmission, which are considered too complex for governments to solve in isolation (Torchia et al., 2015). Healthcare infrastructure gaps and service quality enhancements are targeted by these partnerships that mix private sector management abilities, technology, and financial resources with the public sector's regulatory oversight.

Economically, public-private partnerships are frequently regarded as a solution for governments to handle the challenges posed by the growth in healthcare costs along with the reduction in public budgets, particularly through the pursuit of Value for Money (VFM) by enhancing operational efficiency and innovation. (OECD, 2008).

However, PPPs are not a "panacea", and their actual effectiveness and efficiency remain subjects of debate (Widdus, 2001). Because private partners prioritize profit while public partners focus on social and budgetary objectives, there is a constant risk of unbalanced partnerships or a "recommodification" of healthcare that could harm the public interest (Torchia et al., 2015). The primary argument in the debate about Public-Private Partnerships (PPPs) in the health sector is whether they are more effective and efficient than traditional state provision. Supporters of PPPs see them as desperate measures to cope with complicated issues that exceed government capacity while opponents maintain that the private sector's emphasis on the organization's profit will always come at the cost of the public interest, thus, equity and service quality may eventually suffer in case of weak public control. Additionally, there are differing views on financial costs and operational flexibility; while some authors contend that public financing is always less costly than private financing and that the very detailed, long-term nature of PPP contracts creates inflexibilities that prevent easy adjustment to fast-moving medical or technological changes. Eventually, the evidence points to the fact that nothing, but an appropriate regulatory framework guarantees the success of a PPP where the private sector participates; that framework must be marked by state sincerity in its dual role as the coordinator and the protector of social welfare. (Torchia et al., 2015).

The Kerala Healthcare Governance Model: Rights, Justice, and Decentralization

The Kerala healthcare governance model is rooted in a social democratic system that prioritizes human development and views health as a fundamental human right. This approach measures progress through human well-being rather than just economic indicators, fostering a "vibrant" and "high energy" participatory democracy (Israelsen & Malji, 2021). The governance in the state takes the form of a government's pro-activity which is aimed at an even distribution of services across the board. This is a principle that all political parties over time have

acknowledged and implemented. State has opened the doors to development by promoting health awareness through mass education and women empowerment—they have got 94% literacy and 76.15 years life expectancy which are the same levels as those in the case of the middle-developed countries (Nabae, 2003).

A cornerstone of this model is radical decentralization, which was formally operationalized in 1996 by transferring funds, functions, and institutions to Local Self-Governments (LSGs) (Nabae, 2003). Under this framework, the three-tiered Panchayat system manages primary and secondary health facilities, ensuring that healthcare is responsive to local needs and managed by the communities it serves (Sankar et al., 2023). This system utilizes a unique dual responsibility matrix where the state government maintains the medical care and pays salaries, while local bodies exercise managerial and disciplinary control over health personnel (John & Jacob, 2016). The integration of LSGs allows for a constant feedback loop between the government and citizens, fostering high levels of public trust and direct accountability in the delivery of healthcare.

Social justice is embedded in the model through inclusive policies that deliberately target historically overlooked groups, including women, Dalits, and religious minorities (Israelsen & Malji, 2021). Programs like Kudumbashree, a woman-focused anti-poverty project, provide a vital support network that mobilizes volunteers and ensures that vulnerable populations are not excluded from government responses. This commitment to justice is further evidenced by the state's historical land reforms and public distribution systems, which reduced poverty and provided poor people with the resources needed for health stability (Nabae, 2003). Consequently, Kerala exhibits minimal urban-rural disparities in child immunization, infant mortality, and maternal mortality rates (Cherian et al., 2023).

Modern governance has evolved through the Aardram Mission, which seeks to transform Public Health Centres into people-friendly Family Health Centres (FHCs) with expanded services and equipment (Israelsen & Malji, 2021). This transformation relies on collaborative governance, primarily through Hospital Management Committees (HMCs), which provide a platform for elected representatives, health officials, and civil society to work together (John &

Jacob, 2016). By focusing on Universal Health Coverage (UHC) and reinforcing the public sector, the state aims to force the private sector to lower prices to remain competitive, thereby reducing out-of-pocket expenditures for the poor. This collaborative model proved its resilience during the Nipah virus and COVID-19 crises, where decentralized structures allowed for rapid mobilization and containment efforts (Cherian et al., 2023).

The model also addresses the economic paradox of sustaining high health indices despite historical economic backwardness and a stagnant domestic product (Nabae, 2003). While the state previously faced fiscal crises that led to an under-utilized public sector and a burgeoning private sector, recent initiatives leverage Gulf remittances and industrial restructuring to revitalize public systems. The "second generation" of health challenges, including an aging population and the rise of non-communicable diseases, are handled through innovative state-level insurance schemes like the Karunya Arogya Suraksha Padhathi (KASP) and specialized FHC clinics for depression and respiratory care (Cherian et al., 2023). By maintaining public expenditure on health at nearly 6% of total state expenditure, Kerala ensures that health does not become a commodity purchased solely by "ability to pay" (Sankar et al., 2023).

Finally, the success of the model is rooted in coproduction between government machinery and civil society through resource mobilization. A prime example is the Malappuram Zilla Panchayat, which successfully implemented innovative projects like the Kidney Patient Welfare Society and Palliative Care units primarily through community donations and school- based philanthropy rather than relying solely on state grants (John & Jacob, 2016). This integration extends to medical pluralism, where Allopathy, Ayurveda, and Homeopathy are all accessible through the decentralized network, ensuring a holistic approach to patient well-being (Nabae, 2003). This participatory framework transforms citizens from passive beneficiaries into active stakeholders, ensuring the sustainability of health gains through direct community oversight (Israelsen & Malji, 2021).

The Healthcare Governance Model in Gujarat: Focus on Growth and Market Logic

The healthcare governance model in Gujarat is fundamentally driven by a neoliberal economic philosophy that prioritizes rapid industrial expansion

and business-friendly policies as the primary engines for social development (Mor, 2025; Sagara, 2024). This regulatory arrangement is based on the notion that "the government is not supposed to be in business," thereby resulting in a government structure supportive of privatization of services and massive utilization of public-private partnerships (PPPs). (Israelsen & Malji, 2021). The administration is organized in a way that it has a three-tier rural healthcare network consisting of Sub-centres, Primary Health Centres (PHCs), and Community Health Centres (CHCs), where the PHC system is specifically managed through the Zilla Panchayat (Raut & Sekher, 2013). In this structure, the Chief District Health Officer (CDHO) reports directly to the District Development Officer (DDO), reflecting a centralized administrative oversight integrated within the local government machinery.

A defining feature of Gujarat's model is its extensive reliance on PPP structures to expand access and improve service quality, particularly for underserved populations (Patel et al., 2007). Notable state-level initiatives include the Mukhyamantri Amrutum (MA) Yojana, which provides Below Poverty Line (BPL) families access to high-quality surgical care through an empanelled network of private providers, and the Chiranjeevi Yojana, which incentivizes private obstetricians to manage deliveries for poor women (Sagara, 2024). The state also utilizes a "Hospital-First" vertical integration strategy in its dense urban markets, where large tertiary systems and corporate chains like Apollo or Narayana dominate, often necessitating integration with owned insurance programs to stabilize revenues (Mor, 2025). This market- oriented approach has shifted the delivery of services toward the private sector, resulting in only 15% of the population relying on public healthcare by 2014.

Despite the state's industrial wealth and a high hospital capacity of 4,300 (exceeding Kerala's 3,450), the governance model faces significant challenges regarding the continuity and sustainability of its structures (Sagara, 2024). Research indicates that healthcare decision- making in Gujarat is often more dependent on individual actors and political leaders than on established, sustainable institutional processes (Sanneving et al., 2013). When leadership changes, long-term memory and lessons learned are frequently lost, leading to a cycle where new innovations are prioritized over the evaluation and monitoring of existing policies. This dependency on "heads" rather than "systems" hinders long-term planning and creates a lack of continuum of care within the

administrative framework.

The model's approach to decentralization is characterized by a "decision space" that, while legally operationalized early via the Gujarat Panchayat Act of 1963, shows mixed results in practice (Raut & Sekher, 2013). While Gujarat scores relatively high on the Index of Health System Decentralization (IHSD) due to its institutional readiness and the transfer of rural healthcare functions to Panchayats, actual decision-making authority is often constrained. For instance, Village Health and Sanitation Committees (VHSCs) frequently lack ownership and clear role clarity among members, while Panchayat leaders often feel powerless to voice grievances or hold the government accountable (Hamal et al., 2018). Furthermore, the management of healthcare manpower remains a supply-side challenge, with vacancy rates for Medical Officers at PHCs reaching as high as 30.2%. (Sagara, 2024).

Monitoring and data quality constitute another critical area of the governance framework, where the system is often burdened by parallel and fragmented reporting mechanisms (Sanneving et al., 2013). Health officials in Gujarat have reported being required to fill the same information into five to six different versions of software, leading to data duplication and a lack of reliance on official figures by both senior and junior staff. This "hotchpotch" of reporting makes it difficult to assess the actual needs of specific areas or to use data effectively for evaluating progress. To fill these gaps, social accountability mechanisms led by civil society organizations have become vital, using tools like "report cards" and social autopsies of maternal deaths to demand responsiveness from a sometimes-unreceptive district health bureaucracy (Hamal et al., 2018).

The socio-economic results of this model reveal a paradox: while Gujarat achieves high institutional delivery rates (91.6%) and notable industrial growth, it continues to face higher mortality rates and financial risks for its citizens compared to other models (Sagara, 2024). The neonatal mortality rate in Gujarat is nearly four times higher than in Kerala, and rural medical expenses for a hospital stay are significantly higher (Rs. 29,954 vs. Rs. 14,091 in Kerala). Additionally, the model has been criticized for exclusionary outcomes, where vulnerable groups like Dalits report high rates of discrimination in accessing medicine, and a significant portion of the population (nearly 43%) lacks basic on-premise latrine facilities (Israelsen &

Malji, 2021). Consequently, while the Gujarat model excels in industrial-linked healthcare infrastructure, it faces persistent challenges in ensuring that its growth translates into equitable and low-cost health outcomes for all social strata (Sagara, 2024).

Conclusion

The analytical comparison reveals that the distance between Kerala and Gujarat in health outcomes is not exclusively a difference but indicates different fundamentally health care governing ways. The model of Kerala, which is based on decentralization, social justice, and collaborative governance, is not only a demonstration of the above-mentioned factors but also the exception of the economic condition where the health system is made to be resilient and equitable. One of the states, Gujarat, has been relying on the public-private partnership model of governance which has not only increased the availability of infrastructure and services but also has had continuous problems with institutional continuity, accountability, and distributive equity. The proof shows that public-private partnerships do not have a problem at all but rather they are effective depending on the market and regulatory capacity, monitoring mechanisms, and the embedding of the public sector. The comparison ultimately brings out the fact that healthcare performance is less dependent on economic wealth and more on the quality of governance, political priorities, and the institutional design of state-society relations. Acknowledgment of this fact is necessary for India to move towards health reforms that are not limited by the narrow efficiency or growth-centric frameworks but are rather based on rethinking health reform in a more comprehensive and broader manner.

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