

Between Two Systems: Reflective insight of private healthcare in India versus the NHS.

AUTHOR:

Lavanya Natarajan ^{BM, BS}
ORCID ID: 0009-0008-3338-2072

*Foundation Year 1 Doctor, East Kent Hospitals
University Foundation Trust. UK.*

Keywords

Medical Elective | Ethical challenges | NHS vs
Private healthcare | Cultural insight | Indian
healthcare | Healthcare infrastructure |

Abbreviations

UK	United Kingdom
ED	Emergency department
e-FAST	Extended Focused Assessment with Sonography in Trauma
NHS	National Health Service
US	United States
LO1	Learning Objective 1
LO2	Learning Objective 2
LO3	Learning Objective 3

All author(s) made substantive intellectual contributions to this study by making substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data; drafting the article or revising it critically for important intellectual content; and giving final approval of the version to be published.

Accepted for publication: October 3rd 2025

Address correspondence to: Dr Lavanya Natarajan, Foundation Year 1 Doctor, East Kent Hospitals University Foundation Trust. UK.

E-mail: lavanya.natarajan5@nhs.net

Editor: Dr Neil Chapman. School of Medicine and Population Health, University of Sheffield, Sheffield, South Yorkshire S10 2RX. UK.

AJPP@kent.ac.uk

<https://journals.kent.ac.uk/index.php/ajpp/index>

ISSN Number: Online 2059-3198. Copyright © 2015 by the University of Kent, UK.

FINANCIAL DISCLOSURE: The author has indicated that they have no financial relationships relevant to this article to disclose.



© The Author(s). 2025 **Open Access** This article is distributed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted use, distribution, and reproduction in any medium, provided you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license, and indicate if changes were made.

Abstract: This reflective article offers a personal, first-hand perspective and insight into emergency care within a private, low resource Indian hospital, highlighting structural, clinical and ethical contrasts with the National Health Service (NHS). It emphasises the impact of healthcare system design on patient outcomes, contributing to global health understanding and informing culturally competent, equitable and adaptable future medical care.

Reflection on my Elective

The Elective

During my elective at a private hospital in India, I completed a four-week placement in the emergency department, working closely with a multidisciplinary team. This involved taking patient histories, performing clinical examinations, performing basic procedures such as cannulation, arterial and venous blood sampling, setting up infusions, and assisting senior staff with advanced procedures such as central line insertion, Extended Focused Assessment with Sonography for Trauma (e-FAST) scans, and intubation. I encountered complex

cases such as near hanging, acute poisoning, and major trauma.

Elective Learning Objectives (LOs)

The main objectives for my elective were:

- LO1: Enhance global health knowledge by gaining an insight into the structure and function of the private Indian healthcare system compared to that of the National Health Service in the United Kingdom (UK).
- LO2: Reflect on ethical challenges of delivering healthcare in Indian culture compared to that of the UK.
- LO3: Observe and participate in the Emergency Department (ED) to develop skills such as practical procedures and diagnosing/managing patients in a low resource environment.

Reflection

Healthcare Infrastructure

During my time at the hospital, I gained valuable insight into the structure and function of the Indian healthcare system, particularly the dominant role of the private sector. It is based on the United States (US) model and treatment is largely driven by affordability and insurance coverage. The absence of a nationalised and structured primary care model, such as in the UK, results in fragmented care, limited continuity, and poor early screening and disease prevention (Patel *et al.*, 2015). As a result, emergency departments often face the impact with patients presenting late with advanced or preventable conditions.

In contrast, the NHS's primary care system manages patients living with chronic disease, and coordinates access to emergency services. I also observed the effects of oversaturation of clinics and hospitals in India's urban areas that have lighter patient loads compared to overcrowded government institutions which creates stark resource imbalances. For patients who could afford private care, specialists and rapid diagnostic workups are easily accessible (Rout *et al.*, 2021).

This differs markedly from the NHS, though equitable, faces pressures such as long waiting lists, delayed access to specialists, and strained emergency departments. However, despite NHS' commitment to equity through clinical commissioning, structural barriers such as geography, age, gender and ethnicity continue to influence access and outcomes (Regmi and Mudyarabikwa, 2020). Similarly, equitable healthcare in India is constrained by similar barriers such as caste, socioeconomics, regional disparities.

Ethical challenges:

The placement also allowed me to reflect on ethical challenges unique to the Indian context. A 68-year-old man presenting with confusion and melaena was diagnosed with hepatic encephalopathy secondary to alcohol abuse. Despite requiring urgent intubation due to low GCS, treatment was delayed until the family secured financial funds, during which he was manually ventilated. Although

eventually intubated, his family later discharged him against medical advice, seeking cheaper government care. This experience illustrated how inequitable access to care remains a major concern, as a patient's ability to pay can directly influence the quality and speed of even lifesaving treatment. It also elicits the difficulty of healthcare professionals making financial negotiations that complicate clinical decision making.

Informed consent and patient autonomy can be limited due to low literacy contributing to reliance on doctor's recommendations reinforcing a hierarchical doctor-patient dynamic (Kaczmarek *et al.*, 2025). The case further highlighted the strong role of families in decision making, which may sometimes outweigh patient preferences. By contrast, the NHS emphasises shared decision making and promotes individual autonomy, attempting to overcome barriers.

I also met a 65-year-old female patient with end-stage stomach cancer, where aggressive treatment of hyponatraemia and hypoglycaemia was prioritised over comfort and symptom management. End of life care in India is inadequately delivered, with limited awareness of palliative care among healthcare professionals and patients (Macaden *et al.*, 2014). I have observed how this leads to overtreatment in emergency settings, where invasive measures may be taken despite limited benefit in the geriatric/palliative population.

Personal development:

Clinically, I had the opportunity to be actively involved in patient care. I took histories, performed examinations, and carried out procedures such as cannulation, arterial and venous blood sampling, and catheterisation. I also assisted in more advanced interventions like intubation and central line insertion. Having not yet worked in a major trauma centre in the UK, it was especially valuable to observe trauma care and the emergency use of ultrasound, particularly e-FAST scans. The skills, experience and knowledge I obtained from this elective are easily transferable to my practice as a doctor, shaping my approach to clinical decision making.

I noted that management in India was often more knowledge and experience based rather than protocol led. While this flexibility can be beneficial, it highlighted how the NHS's guideline-based system contributes to safer, more consistent clinical practice, especially in high pressure environments.

Conclusion

My placement enhanced my understanding of healthcare delivery in a private-led, resource limited system but also deepened my appreciation for the NHS's strengths in equity, structure and guideline-based care (LO1). It exposed me to ethical challenges and cultural contexts (LO2) and has developed my practical and diagnostic skills in the ED (LO3). This experience has strengthened me and given me confidence to practice with culturally

sensitivity and ethical awareness, shaping me into a clinician who delivers equitable and evidence-based medicine.

References:

Kaczmarek, A., Żok, A. and Baum, E. (2025) 'Ethical principles across countries: does 'ethical' mean the same everywhere?', *Frontiers in Public Health*, 13, pp. 1-14.
doi.org/10.3389/FPUBH.2025.1579778

Macaden, S. C., Salins, N., Muckaden, M., Kulkarni, P., Joad, A., Nirabhawane, V., Simha, S., Salins, N., Muckaden, M., Kulkarni, P., Joad, A., Nirabhawane, V. and Simha, S. (2014) 'End of Life Care Policy for the Dying: Consensus Position Statement of Indian Association of Palliative Care', *Indian Journal of Palliative Care*, 20(3), pp. 171–181.
doi.org/10.4103/0973-1075.138384

Patel, V., Parikh, R., Nandraj, S., Balasubramaniam, P., Narayan, K., Paul, V. K., Kumar, A. K. S., Chatterjee, M. and Reddy, K. S. (2015) 'Assuring health coverage for all in India', *The Lancet*, 386(10011), pp. 2422–2435.
doi.org/10.1016/S0140-6736(15)00955-1

Regmi, K. and Mudyarabikwa, O. (2020) 'A systematic review of the factors - barriers and enablers - affecting the implementation of clinical commissioning policy to reduce health inequalities in the National Health Service (NHS), UK', *Public Health*, 186, pp. 271–282.
doi.org/10.1016/J.PUHE.2020.07.027

Rout, S. K., Sahu, K. S. and Mahapatra, S. (2021) 'Utilization of health care services in public and private healthcare in India: Causes and determinants', *International Journal of Healthcare Management*, 14(2), pp. 509–516.
doi.org/10.1080/20479700.2019.1665882