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The public versus private health care debate amidst COVID 19 conundrum

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Abstract
This paper critically explores the dichotomy between public and private health care systems in Delhi during the initial wave of the COVID-19 pandemic. Using publicly available health bulletins data, the study reveals how public hospitals bore the brunt of patient admissions, while private hospitals disproportionately handled ICU and ventilator cases. The analysis uncovers stark disparities in healthcare access, affordability, and policy response, indicating systemic bias that favoured private profit-driven models during a public health emergency. The study concludes by advocating for stronger regulation and stronger health infrastructure to ensure equitable health care access in crisis settings.

Keywords: COVID-19, public health care, Delhi

Introduction

The COVID-19 pandemic in India is nowhere near abating. As of 20 May, we have already taken over China in terms of the number of cases and are pressing closely in terms of COVID deaths. The writing on the wall is clear – 'The worst is yet to come.' This is the situation despite India's more than 1.3 billion people having been put through one of the most stringent lockdowns in the history of the world [1]. This pandemic with its attendant problems of massive increase in morbidity and mortality due to unattended medical conditions, the deepening poverty and hunger have rendered rife the otherwise trite but prominent fault line in the Indian health services system – the dichotomy between publicly funded and the private health care. The crisis has put the Public - Private fault line in a sharp profile, as against the official portrayal of both being perfectly segued through publicly funded health insurance schemes to serve the people, despite much evidence that exists to the contrary.

Even if in an undertone, the government itself has acknowledged the failure of the private sector to rise to the occasion in combating the ravaging pandemic or even treating the non-COVID cases. In a letter addressed to the states dated 28 April, the Secretary to the Government of India, Ministry of Health and Family Welfare admitted:

I would like to draw your attention to certain reports received in this Ministry that many hospitals in the private sector, are hesitating in providing critical services such as dialysis, blood transfusion, chemotherapy and institutional deliveries to their regular patients either on account of contracting COVID 19 or they are keeping their hospitals/clinics closed [2].

National Capital Territory (NCT) of Delhi has the second largest number of COVID patients among all states after the state of Maharashtra. In the context of the above, this paper seeks to present the role played by the public and the private health sectors in combating COVID 19 pandemic in, Delhi, and place this in the overall health policy framework to draw lessons for the future.

Materials and Methods

All COVID related data for Delhi was obtained from the daily Health Bulletin Updates uploaded by the government NCT Delhi at its website [3]. Daily Health Bulletins have been available only since 1st April 2020 and provide data of diagnosed COVID-19 cases admitted to the following Public and Private hospitals:

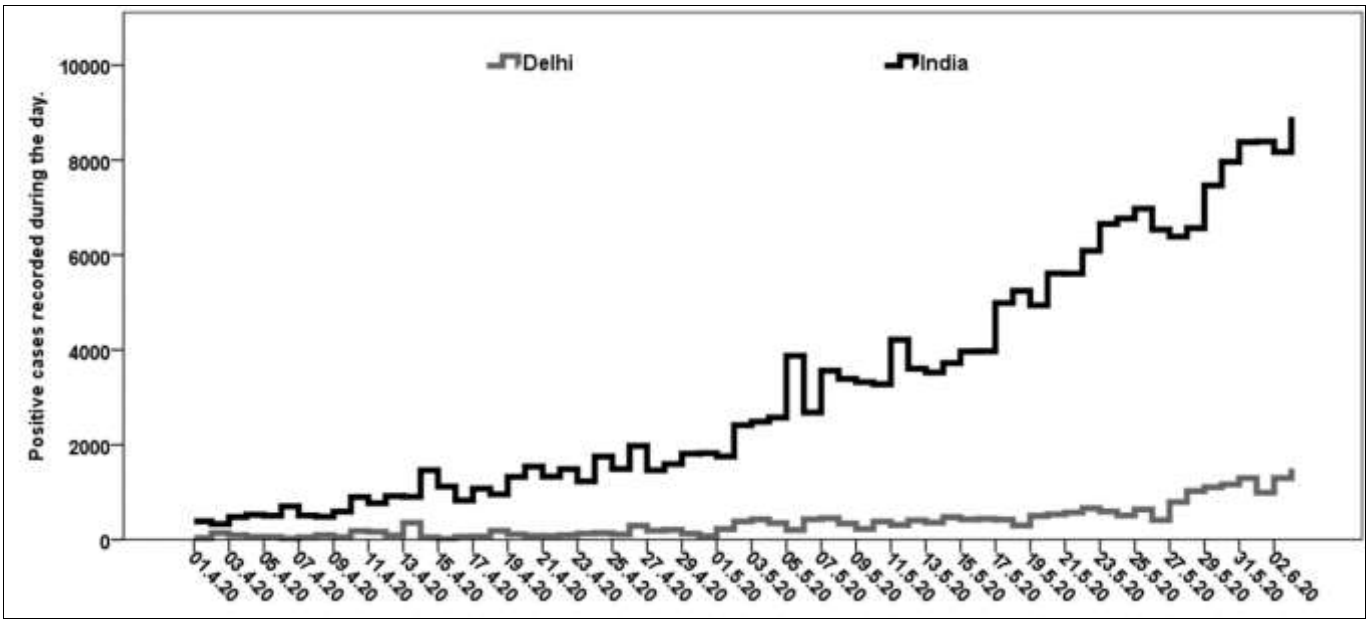
- **Delhi Government hospitals:** Lok Nayak Jai Prakash Narayan Hospital and Rajiv Gandhi Super Speciality Hospital.
- **Central Government hospitals:** Lady Hardinge Medical College, Ram Manohar Lohiya Hospital, Safdarjang Hospital and the All India Institute of Medical Sciences (New Delhi and Jhajjar hospitals)
- **Private Hospitals:** Max Smart Super Specialty Hospital, Apollo Hospital, Sir Ganga Ram Kolmet Hospital, Sir Ganga Ram City Hospital and the Maha Durga Charitable Trust Hospital.

Even though the Health Bulletins listed separately the number of patients admitted in public and private hospitals and the total tests performed in public and private labs for each day, there were some problems with the data which hindered comparability of data between all days included in this study i.e. from 1 April 2020 to 15 May 2020. For example, for days from 4 to 11 April the number of COVID positive cases admitted in COVID designated private hospitals has been combined with that for another category 'Others', which included cases at private homes, homeless

shelters and other such. For a few days after 11 April the figure for the category 'Others' is given separately and then done away with altogether. Hence, the number of cases admitted in COVID designated private hospitals for each day from 4 April to 11 April has been derived by taking the average of the cases admitted in private hospitals three days prior to 4 April and 3 days after 11 April.

Likewise, the division of the total COVID tests between public and private labs has been done away with altogether in the daily bulletin for the month of May; hence, with respect to tests performed in public and private labs only data up to 30 April has been included in this study. COVID-19 deaths have also not been included in our analysis since there has been a major mismatch between the deaths reported by individual hospitals, those reported in Health Bulletins and the COVID-19 related cremations conducted in various crematoria in the city.

The data has been analysed by using IBM SPSS Statistics 23 software.



Source: The figures for Delhi were obtained from daily Health Bulletins of government of NCT of Delhi, while those for India were obtained from [4].

Fig 1: Trend in daily new cases, India and Delhi.

Results

Figure 1 shows the trend in number of new cases per day in India and NCT of Delhi respectively. The country wide lockdown, it was told, was expected to flatten the curve, but evidently the curve continues to rise, both for the country as a whole and in Delhi. This implies that there shall remain continual need for optimal mobilization of precious resources in both public and private health sectors to successfully tackle the ongoing pandemic as also the other health problems which not only continue to exist, but have perhaps been compounded further because of the disarray caused by the pandemic. This brings us to the point of assessing the role played by the public and private sectors in tackling COVID-19 pandemic thus far.

Table 1 below summarises the results in this regard, while figures 2, 3, 4 and 5 highlight the public-private schism in COVID care in bold profile.

Table 1: Contribution in pandemic care by Public and Private COVID designated hospitals in Delhi.

Type of health facility	Minimum	Maximum	Mean	Median	P value
Proportion of hospitalized positive cases by type of health facility					
Public	66	97	82.6	81.6	Mann-Whitney U test p value.000
Private	3	34	17.4	18.5	
Proportion of total hospitalized positive cases admitted in ICU by type of health facility					
Public	1	8	5	5	Mann-Whitney U test p value.000
Private	6	71	19.6	14	
Proportion of ICU cases on ventilator by type of health facility					
Public	0	50	14	13.5	t-test for equality of means p value.000
Private	9	80	33.4	26.5	
Proportion of samples tested by type of laboratory facility					
Public	66	91	78.7	79.9	t-test for equality of means p value.000
Private	9	34	21.4	20.1	

Note: The denominator for parameter 1 is the total cumulative hospitalized COVID-19 cases in both Public and Private hospitals. The denominator for parameter 2 is hospitalized positive cases in a Public or a Private hospital. The denominator for parameter 3 is COVID patients admitted in ICU in a Public or Private hospital. The denominator for parameter 4 is total number of samples tested in a Public or a Private laboratory.

The findings from Table 1 and Figures 2, 3, 4 and 5 can be summarized thus:

The yawning gap between the COVID-19 positive cases admitted in the public hospitals and those in Private hospitals is remarkable. On an average only 14 percent of the hospitalized positive cases in a day were admitted in Private hospitals, while the Public hospitals catered to a massive 86 percent of the cases. The maxi –mum share that the Private hospitals bore was between 25 to 34 percent between 23rd and 29th April.

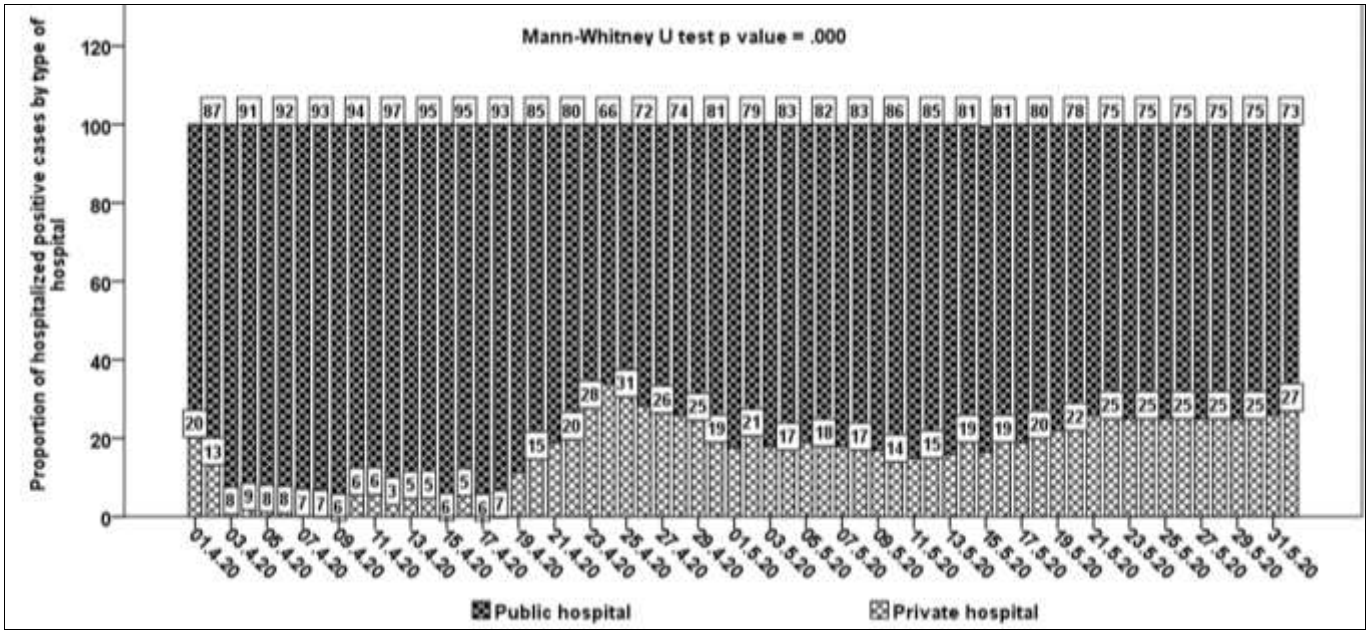


Fig 2: Variation in proportion of hospitalized cumulative COVID positive cases admitted in Public and Private COVID designated hospitals

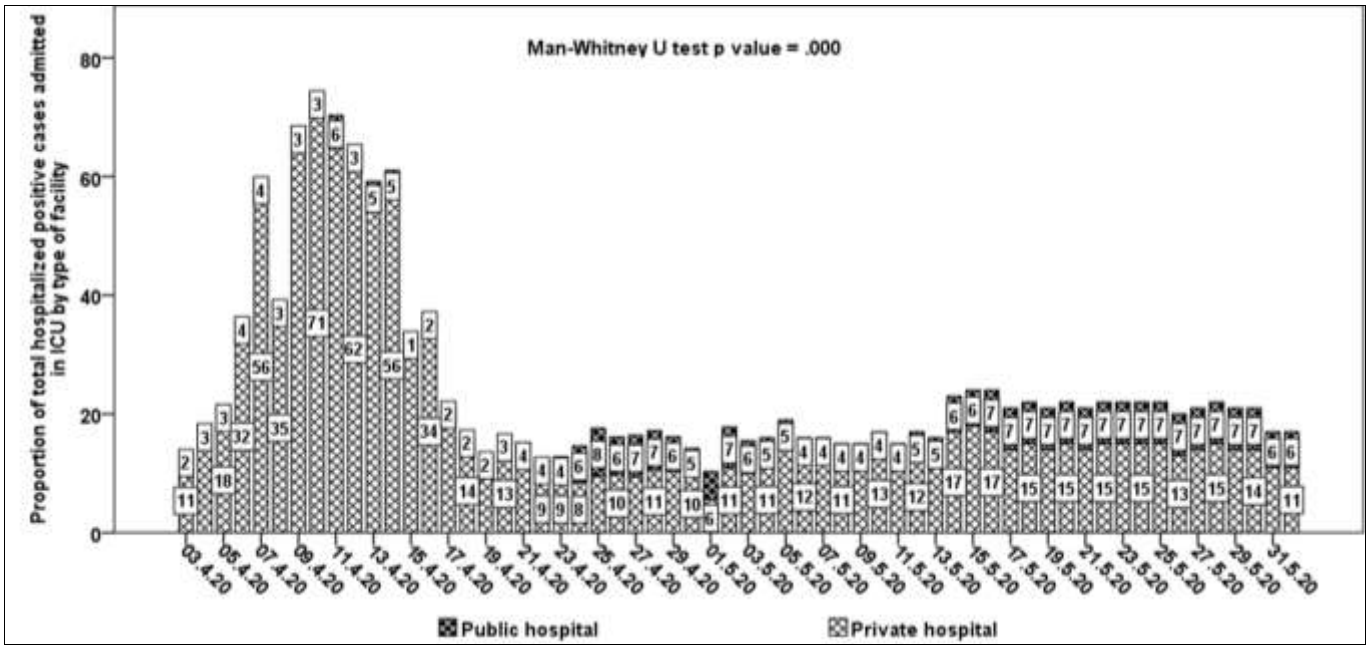


Fig 3: Variation in proportion of hospitalized COVID positive cases admitted in ICU of Public and Private COVID designated hospitals.

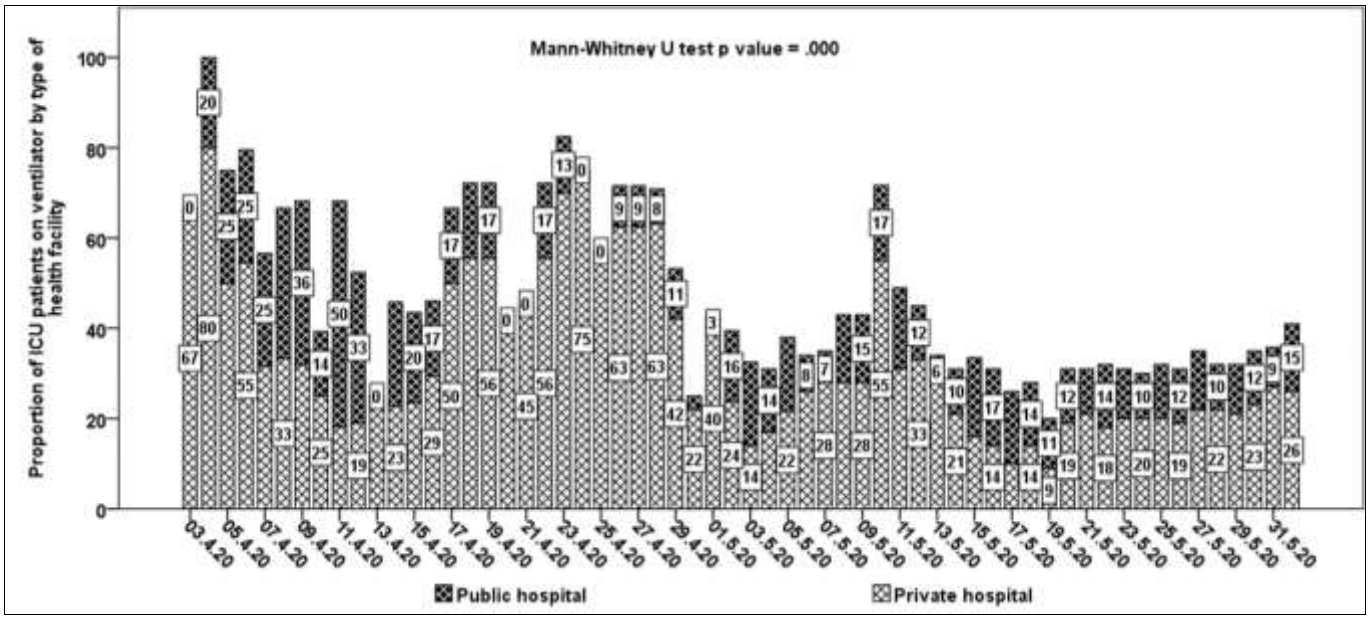


Fig 4: Variation in proportion of COVID positive cases admitted in ICU requiring ventilator support in Public and Private COVID designated hospitals.

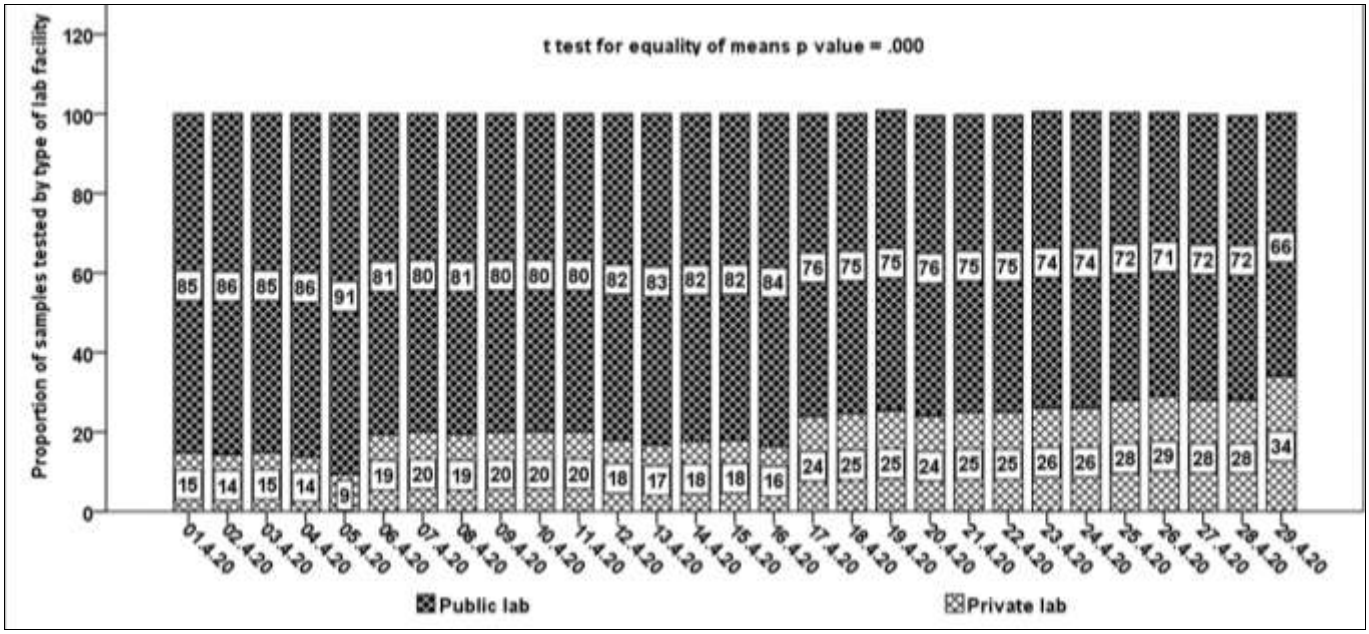


Fig 5: Date wise proportion of samples tested by type of health facility.

- However, the picture gets entirely reversed when it comes to the proportion of hospitalized patients admitted in the ICU or the proportion of ICU patients put on ventilator support. In Private hospitals on an average 27 percent of the hospitalized cases were admitted in ICU while on 50 percent of the days more than 25 percent of the cases were admitted in the ICU, going up to a maximum of 65 to 71 percent. To the contrary, the mean and the median patients admitted in ICU in Public hospitals was just 4 percent going up to a maximum of 7 to 8 percent.
- The difference in the ICU patients put on ventilator support between the Public and the Private hospitals is even more stunning. On an average around 16 percent and 43 percent of ICU patients were put on ventilator support in Public and Private hospitals respectively. On 50 percent of the days for the period included in the study, more than 42 percent of the COVID-19 patients admitted in Private hospital ICU were on ventilator support, going to a maximum of 67 to 80 percent. The maximum for Public hospitals was 50 percent.
- On an average 80 percent and 20 percent of all samples were tested in Public and Private diagnostic labs respectively, while on 50 percent of the days more than 80 percent of the samples were tested in Public labs.

Discussion

The above findings are surprising in the least and reaffirm the shareholder centric profit maximising business model of corporate healthcare. Though a part of 'service industry',

the services provided by private healthcare are conditioned by the demands placed by capital rather than the needs of the suffering humanity. This otherwise trite observation acquires its salience from the fact that even a once in many lifetimes kind of tragedy that the present COVID-19 pandemic is, has failed to shake such behaviour of the for profit private healthcare, its legal (the requirement to treat certain proportion of patients free in return for public subsidies such as free land, duty exemptions etc.) and moral obligations notwithstanding.

The sense of alarm, most of it resulting from the highhanded and ill-planned manner of dealing with the pandemic by the authorities, has kept the people from accessing hospitalized care for non-COVID ailments. Nevertheless, even within the constraints placed by this unprecedented human suffering, the private hospitals have sought to make good the losses by squeezing it out from the COVID-19 patients coming to them. The going rate for treatment of a COVID-19 case in a private hospital has been as high as ₹7 lakhs [5]. High cost of care due to disruption of services, cost of personal protective equipment and greater risks faced by the doctors, were some of the reasons cited by Abhay Soi, chairman of Max Healthcare and Radiant Life Sciences [5]. Notably, Max Healthcare's hospital at Saket, New Delhi is one of the designated COVID hospitals data from which is included in Delhi Government's COVID Health Bulletins.

A treatment cost of Rs 7 lakh can only be affordable for a miniscule section of the society even if backed by some form of insurance. Even otherwise, informal inquiry by the authors from doctors working in all the private hospitals, data from which was included in the health bulletins, with the exception of Maha Durga Charitable Trust Hospital, revealed that if some non-paying COVID patient reported to these hospitals, s/he was *'counselled'* to go to a public COVID designated hospital. Little wonder then that just about 14 percent of the hospitalized COVID cases were treated in private hospitals. But whatever be the cost, it needs be justified, and a seeming justification comes by way of a high proportion of patients admitted in ICU and those on ventilator support among the COVID patients admitted in private hospitals. There is no reason to believe that somehow more serious COVID patients sieved through to private hospitals resulting in a much higher proportion of patients requiring intensive care. In fact, unnecessary procedures, tests and treatment to meet revenue targets are all part of business ethics of corporate hospitals [6, 7].

Private sector's performance has been relatively better with respect to COVID testing as compared to COVID treatment, but that owes to generous efforts by the authorities to sweeten the pie for them. With respect to healthcare, it is the 'regulators' who end up being regulated in India. The participation of private labs in COVID testing is a dramatic example in this regard where the drama was enacted in the highest court of justice, the Supreme Court of India.

In an advisory dated 17 March 2020, ICMR (Indian Council of Medical Research) stipulated the cost of COVID testing in private labs to be Rs 4,500 for a combination of a screening test, and there upon if required a confirmatory test. This, despite there being a public health need to keep the costs low as testing was to be mandatory if the criterion for testing as per ICMR guidelines were met, which meant that testing would have to be done expeditiously irrespective of patient's ability to pay [8]. Interestingly, Partho Sarothy Ray, a molecular virologist and professor at the Indian Institute for Science Education and Research, Kolkata, had worked out the cost of these tests to be no more than Rs 700 per person [9].

Hearing a PIL (Public Interest Writ) against ICMR guidelines, the Supreme Court merited that "Rs.4500 for screening and confirmation test of COVID-19 may not be within means of a large part of population of this country and no person be deprived to undergo the COVID-19 test due to non- payment of capped amount of Rs.4500…." It ordered on 8 April 2020 that whether in Government or Private approved laboratories, the tests "shall be free of cost." The Court went as far to observe that – "The private Hospitals including Laboratories have an important role to play in containing the scale of pandemic by extending philanthropic services in the hour of national crisis" [8].

However, when the 'regulators' become the 'regulated', pretence seldom reflects the essence. The private labs got their act together, and with the government's attorneys playing to their gallery (It was argued that the cost fixed by ICRMR was on the moderate side) the Court reversed its earlier order and while directing the government to pay for the testing of the poor through publicly financed health insurance scheme 'Aayushman Bharat' (Long life for India), it said that – "Private labs would be entitled to charge a fee for the costs of the tests" and "Government may devise a scheme to reimburse private labs if they conduct free tests" [8].

It is indeed remarkable that the government seems too eager to shell out Rs 4,500 to private health sector for tests which could otherwise cost as little as Rs 700, while it insisted upon taking two-way rail / bus fare from unorganized sector workers desperate to escape back to their villages, left trapped and starving as they were in the cities due to the ruthless lockdown [10].

Despite there being nearly 10,000 molecular testing labs in the country (Banerji, 2020), India continues to be lowly placed in terms of number of tests performed per million population among the most affected countries. With 1,973 tests per million India was far behind Spain (64,977), Italy (53,635) and USA (40, 729) [11]. The cost of the test is a big limiting factor in expansion of testing, especially when attended by an unprecedented economic havoc. At a time when the country is witnessing an unrelenting spike in daily new cases and the test positivity curve is beginning to steepen [12]. This cannot but have dangerous portends for the future course of the pandemic.

The COVID pandemic in India continues to expand in volume as well as geographically [13]. This necessitates active mobilization of all health resources and facilities to cater to not just COVID-19 cases but also for other non-COVID health problems which have lapsed into suspended animation during this period.

The 71st round of NSSO (National Sample Survey Organization) data shows that more than 70 percent of spells of ailment in India were treated in private sector [14]. and that the private hospital sector in India is increasingly corporatizing with concentration largely in just a few districts of some states [15]. This apart, in the 'National

Health Policy, 2017' itself acknowledges that - "The Government has invested heavily in the last 25 years in building a positive economic climate for the healthcare industry [16]."

Under the circumstances it is only natural to expect that the Private healthcare sector plays a pivotal role in tackling this pandemic tragedy of epic proportions; however, as always, the Private healthcare sector left the suffering people of India in lurch. As a testament, besides the results of this study another report published in a leading newspaper proclaimed – 'Private hospitals, which account for two-thirds of hospital beds in India, and almost 80 per cent of available ventilators, are handling less than 10 per cent of this critical load' [17].

The indefatigable rhetoric of the ruling elite to 'bring world class health care to the doorstep of the people' notwithstanding, corporate hospitals were never meant to serve the people. Apart from opening the health sector as a profitable avenue for capital investment, corporate hospitals serve as an exclusive healthcare sanctuary for the rich. The Draft form of the National Health Policy 2017 went as far to say that:

"Given that the private sector operates within the logic of the market and that they contribute to the economy through their contribution to the growth rate and by the national earnings from medical tourism, there need not be any major effort to persuade them to care for the poor, as long as their requirements and perceptions do not influence public policy towards universal healthcare" [18].

Such a policy environment has ensured that private hospitals violate their legal obligations to provide free care for the poor patients with impunity. This they do in cahoots with the very bureaucracy that ought to make them comply. The 'Committee on Petitions' of the Delhi Assembly submitted a report in December 2019 in the matter of 'Alleged Non-Compliance of Free Treatment of EWS (Economically Weaker Sections) Patients in Private Hospitals of Delhi.' Not only that the hospitals were in violation of the directives of the Government of NCT of Delhi and the Hon'ble Courts to provide 25 percent of OPD services and 10 percent of beds for EWS patients, but that there was connivance between hospital managements and the officials of the health department. It was further stated that [19]:

"Even some of the Government Liaison Officers posted in identified private hospitals are neither properly monitoring the free indoor & outdoor treatment being provided to eligible patients of EWS category by their respective hospital (s), nor they are coordinating with the Nodal officers/Liaison Officers of Government Hospitals regarding referral of patients from there. The Department of Health and Family Welfare did not cooperate actively with the Committee in various proceedings of this matter."

The good thing is that the pandemic has stirred the debate of 'Public versus Private' with respect to healthcare in many media outlets [20-23].

Conclusion

A Challenge is also an Opportunity. If the pandemic has presented a challenge to the health system of epic proportions, then it has also presented an opportunity to remake the health services system with the singular purpose of 'Serving the People.' However, this shall not happen in the manner of a wish being granted. This would of necessity entail a contestation with entrenched interests and lobbies. The country's health minister, Harsh Vardhan wrote in an opinion piece in The Indian Express:

"The NHA (National Health Agency) has focused on how to get the private sector more actively involved in the response with greater participation from private sector hospitals – for both COVID-19 as well as non-COVID-19 health conditions" (Vardhan Harsh, 2020).[24]

What remains to be seen is whether public health activists, pro-people doctors, nurses, health workers and polity seize the 'opportunity' to reinvent India's healthcare system amidst the challenge thrown by the pandemic. The working masses of India need to be taken aboard in this endeavour.

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