COVID-19

Commercialisation of healthcare in India: Covid-19 and beyond

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Abstract

This review of the government's policy during the pandemic flags a number of ethical concerns. The private healthcare sector's treatment of Covid-19 patients has generated mistrust and anger. However, the government has not held it accountable and instead commercialisation has subverted the pandemic needs. Government hospitals weakened by decades of cuts are exposed to internal reorganisation of services through the public-private partnership mechanism, a neoliberal policy that has persisted through the pandemic. There is a need to re-examine the government's policy reliance on scaling-up coverage through the private sector in the pandemic and after.

Keywords: *Government hospitals, public-private partnership, commercialisation, India*

Introduction

As India is in the midst of a second surge of Covid-19, it is once more facing the consequences of privatised provisioning of healthcare services during a healthcare emergency. With the daily increase in cases, the shortage of beds is getting more acute. Patients are being harassed from the point of admission, through treatment, to their release.

The pandemic has amplified the need for a robust public sector healthcare system in India, more than ever before. Despite the constraints it has faced because of the historical neglect of government hospitals and rollback of the state from direct service delivery, it is the public sector which rose to the occasion at a time of great uncertainty and high risk. Yet the finance minister's announcement of the Atmanirbhar Abhiyan economic package came with little stimulus for the government health sector.

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During the pandemic, business leaders in healthcare have complained that though they have suffered financially, there has been "no stimulus for hospitals who have to bear increased operating costs due to Covid related protocols," (1) and they have called for more benefits. The President of the Confederation of Indian Industries (CII) has stated:

> *We should look to spend at least 5 per cent of our GDP on healthcare. We are at 1.3 per cent now. We may say we can't immediately do 5 per cent, but we must gradually move up. My view is that this is time to bring private investments and entrepreneurial spirit back. State has done its bit. It has made a significant amount of investment. The focus on healthcare should be private sector-led now* (2).

This lobbying for private investment in healthcare services continues during the Covid-19 crisis. In conjunction with this unfolding crisis, NITI Aayog presses the respective state governments to implement the public-private partnership (PPP) infrastructure projects for privately financed medical colleges and secondary hospital infrastructure, as a response to the shortage of government facilities during this time (3). This policy commitment to a market model persists even though it is well established that India's highly unregulated private healthcare system is neither more efficient nor more "medically effective" than the public sector (4).

This paper reviews the government's healthcare policy during the pandemic and flags a number of ethical concerns. The private healthcare sector's treatment of Covid-19 patients has generated mistrust and anger. However, the government has not held it accountable and instead commercialisation has subverted the pandemic needs. Government hospitals weakened by decades of cuts are exposed to internal reorganisation of services (split between purchaser and provider of care) through the public-private partnership mechanism, a neoliberal policy that has persisted through the pandemic. There is a need to re-examine the government's policy reliance on scaling-up coverage through the private sector in the pandemic and after.

Neglect of government hospitals

Government hospitals (GH) in India, both secondary and tertiary, have faced decades of neglect (5). Over the last three decades, the rolling back of direct provisioning by the

state government has been reflected in the inadequate GH infrastructure.

Between 1991 and 2001, the central government slashed capital investment on these hospitals from 25% to 6%, forcing state governments already reeling under fiscal stress to generate their own financing for these hospitals (6). The abysmally low budgetary allocations, rising costs, and shortages of workforce (clinical, paramedical and non-clinical) all affected the quality of care these hospitals provided. The Seventh Five-Year Plan (1985-1990) recommended developing mechanisms to address non-communicable diseases (NCDs) through primary and secondary level care. However, the NCD programme, namely the National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Disease and Stroke, was set up only two decades later, in 2010. Today there are NCD outpatient departments in government hospitals but their functioning is hampered by the lack of an adequate healthcare workforce (7).

As per the 71st National Sample Survey Office (NSSO) Round, 2014, OPD consultations in rural and urban public sector hospitals accounted for almost 17% of treatments. Across different quintile classes, the share of in-patient hospital treatment in the public sector varied from 29% to 58% in rural areas, and from 19% to 48% in urban areas (8). By the 75th NSSO round (2017-18), the proportion of people enrolled under the publicly funded health insurance schemes had increased. This contributed to greater utilisation of public health facilities in both rural and urban areas. In this changed situation, the urban poor also utilised public health facilities far more frequently than the urban rich (9). During these two rounds, out-of-pocket expenditure also declined (9). This trend calls for greater investment in strengthening the government healthcare institutions.

Expansion of the private sector

During the same period, the share of private players significantly expanded in breadth and depth through venture capital, private equity funds, external commercial borrowings, and investment by high net worth individuals (10), increasing the role of private financial markets in healthcare. The presence of private financial markets is now felt beyond the metropolitan cities, in the Tier II and III cities (10). They have significantly added to the number of beds, specialised clinical services and diagnostic capacities in these cities. Multi-speciality hospitals have expanded their network and outreach through primary healthcare clinics. Single speciality service providers have also expanded into fields like nephrology and eye care (10).

In India, there are around 19 lakh hospital beds, 95,000 ICU beds and 48,000 ventilators. However, the majority of these services is concentrated in the private sector and in seven states (11). This inequitable distribution of facilities in the public and private sector distorts access to and availability of services.

Table 1: Public and private healthcare infrastructure in India 2020*

India	Public sector	Private sector	Total
Number of hospitals	25,778	43,487	69,265
Number of hospital beds	7,13,986	11,85,242	18,99,228
ICU beds	35,699	59,262	94,961
Ventilators	17,850	29,631	47,481

**Source: (11) https://cddep.org/wp-content/uploads/2020/04/State-wise-estimates-of-current-beds-and-ventilators_24Apr2020.pdf*

Government-private intersections

Healthcare reforms in India have changed the organisational structure of government hospitals through quasi-market interventions such as outsourcing and PPP-based diagnostic and ancillary services. Through these interventions, government hospitals have been opened up to private providers, including investors (5). With the expansion of these interventions and state health insurance programmes, public funding goes to private providers, thus stifling the growth and expansion of the public sector healthcare infrastructure (12).

One sees increasing intersections between GHs and private healthcare, and market expansion through PPPs. This blurring of relationships in the GHs places the interests of private business above patients' needs. The requirement to generate profit or reduce loss can affect the quality of clinical care. This happens for example when the workforce is trimmed, or employed on precarious terms and conditions (13,14).

Private health sector response in the pandemic

The private health sector's response to this emergency has been less than inadequate. It has two-thirds of the bed strength and a majority of ventilators and ICU beds across the country [Table 1] (11), but during the early phase of the pandemic, a number of standalone clinics and small hospitals in Tier II and III cities scaled down their operations, discouraging the poor from accessing care as they would not generate revenue (15). Furthermore, the reports of patients requiring hospitalisation for Covid treatment indicate that there was little co-ordination among private hospitals for patient referrals and bed requirements (16). The private sector has failed in other ways as well.

Overcharging and denial of free care

There are innumerable media reports (16-18) of private hospitals denying care to Covid patients, overcharging them for services provided, and demanding deposits, thus

increasing the household burden and depleting their financial resources.

Initially, it was said that the private sector would not charge for diagnostic tests for Covid-19 cases (19). Later, this policy was revoked, and the Indian Council for Medical Research (ICMR) recommended that the maximum cost of a test should not cross Rs 4,500 (19). Many labs continue to charge higher rates, by *offering* package deals inclusive of the Covid-19 test.

The Courts have intervened in a number of complaints against the private sector. In the early days of the pandemic, public interest litigation was filed to nationalise private hospitals and laboratories "until the pandemic was contained", but this was dismissed by the Supreme Court of India (SC) as "misconceived" (19). The SC did respond to a petition to regulate private hospitals which levied high charges on Covid patients, ostensibly to cover additional tests and protective gear, and asked the central government to explain why private hospitals which had benefitted from free land allotment should not provide free care to Covid-19 patients (20). Orders were also issued to cap the prices of masks and sanitisers, though price regulation did not extend to personal protective equipment (PPE), N95 masks, face goggles, shields, and the cost of ICU treatment and overall treatment in hospitals (21).

In the absence of any order on these items, many private hospitals have overcharged Covid-19 patients under different heads, resulting in huge bills (22). Hospitalised Covid-19 patients with private health insurance packages have not been billed according to the charges fixed under government orders; they have been forced to pay at market rates. In many cases private health insurance companies stopped providing coverage (23). Blatant denial of affordable care is now more visible than ever before. This has worsened catastrophic out-of-pocket expenditure, inequalities in access and availability, and exclusion.

Private providers undermining state regulations

The above practices in the private health sector have created panic. Some states are trying to bring about rate regulation for Covid-19 related services, displaying rates and reserving beds for Covid-19 treatment in private hospitals and laboratories. Different state governments have endeavoured to regulate the private sector through price regulation, reserving beds and coverage of related tests and treatment under the Pradhan Mantri Jan Arogya Yojana (PMJAY) or the state government funded health insurance scheme. As the cases and the demand for isolation beds soared, some state governments used emergency powers under the Epidemic Diseases Act to earmark private hospitals and nursing home beds and services for Covid-19 patient-related services (24). Table 2 lays out the efforts undertaken by different states to regulate the private sector in order to make services accessible and available to the people. However, the states need to publicise these efforts widely and monitor their implementation (25).

Besides the state governments' efforts to regulate private providers, the Federation of Indian Chambers of Commerce and Industry (FICCI) issued pricing guidelines for Covid-19 services, to ensure rational use and costing of PPE kits and other services for Covid-19 treatment. It developed a standardised cost of Covid-19 treatment based on the beds reserved by the government and the number of patients treated under non-reserved beds in private hospitals across the country (34). However, on the ground, there is little evidence of self-regulation and the effectiveness of these guidelines.

Overall, the effort has been not to provide free care to Covid-19 patients by the private sector, but to extend the market to low income patients through price regulation. The private health sector has questioned the feasibility of state regulations, subverted them and asked for renegotiation. Private hospitals justify higher tariffs for providing PPE kits to the hospital workforce as no family members can attend to patients in the Covid wards, for paying staff double wages, transporting patients, and so on. Even though the National Health Authority stated that Covid-19 would be covered under the PMJAY (35), some of the empanelled private hospitals have filed fraudulent claims to earn profits (36).

Private hospitals have issued exorbitant bills lacking transparency, with PPEs emerging as profitable items. They have mismanaged care, harassed patients, and acted negligently (16). Even though different service charges have been capped in many cities, private hospitals and laboratories continue to overcharge patients, violate protocols, and delay test results (37). In Mumbai, private hospitals refused to implement a government order to retain 80% of all beds for Covid-19 patients, reducing the available beds for these patients (38). The Brihanmumbai Municipal Corporation (BMC) has repeatedly had to instruct private laboratories to send test reports on time and even suspended Mumbai's largest private laboratory for a month for violating this order (38). BMC clarifies that in this context private laboratories have to follow guidelines and cannot give false positive tests. In Delhi, eight for-profit laboratories were found to be flouting the ICMR protocols and banned from carrying out tests (39). In Bangalore, licenses of 19 hospitals were suspended for not reserving 50% of beds for Covid-19 patients (40).

The private sector describes such regulation as draconian. Many private laboratories have capped the number of Covid-19 tests to be done per day (41). There is a need for greater testing, not less, in order to isolate the infected, trace their contacts and quarantine them, and thus reduce transmission. This rationing of diagnostic services during a pandemic increases the opportunity for disease transmission.

Table 2: Regulating pricing and beds in the private sector for Covid-19 related services (as on 2020)

State governments	Steps to regulate
Delhi	May: Private hospitals with 50 or more beds ordered to set aside 20% of their bed strength for Covid-19 patients (26). June 20: Cost of a Covid-19 isolation bed in any private hospital in Delhi fixed in the range of Rs 8,000-Rs 10,000 for a bed, and Rs 15,000-Rs 18,000 per day for an ICU bed with ventilator (27). June 20: Natural Calamity or Disaster clause in the Delhi Nursing Home Rules, 2011, was invoked and private hospitals were asked by the Delhi government to dedicate 60% of beds for Covid-19 patients and to provide services at subsidised rates (28).
Maharashtra	March 13: State government invoked the Epidemic Diseases Act. First week of April: 15 private sector laboratories roped in to conduct tests. May 1: State government issued a notice to cap the prices of medical procedures in all private and charitable hospitals under the General Insurance-Public Sector Association - Preferred Provider Network (29). May 3: Ward assistant commissioners were authorised to take possession of private hospitals and nursing homes and designate them as Covid-19 treatment centres (29). BMC granted permission to revive the private Sunrise Hospital, Bhandup, for frontline workers (29). May 6: Director, Medical Education and Research, Mumbai, wrote to nearly 25,000 private medical practitioners in Mumbai to provide services to Covid–19 patients for at least 15 days. May 21: The state government capped the price of treatment for Covid-19 patients in private hospitals: charges for an isolation ward bed were capped at Rs 4,000 a day; Rs. 7,500 a day for an intensive care bed (ICU) and Rs 9,000 a day for ventilator charges. These amounts include drugs, doctor's consultation fees, nursing, food and bed charges, but exclude tests for Covid-19, personal protective equipment (PPE), and the cost of expensive drugs and certain scans (30).
Uttarakhand	March 24: Private hospitals with 100 beds or more required to reserve 25% of beds for Covid-19 patients (24).
Chhattisgarh	March 25: State Public Health Act and Chattisgarh Epidemic Disease Covid-19 Rules, 2020, invoked to take over the privately-run Raipur Institute of Medical Sciences (24).
Madhya Pradesh	March 23: Rules formulated for treatment under Epidemic Diseases Act, 1897, empowering district magistrates to requisition any staff or institution to fight the epidemic (24). March 26: Government announced that private hospitals may be sent requisitions to meet Covid-19 demands, and the hospitals could send requests for PPE to state Public Health Supplies Corporation. The Indore administration took over two private hospitals. State government announced decision to reimburse private hospitals as per the rates for pneumonia treatment. Inclusion of Covid-19 tests and treatment extended under the health insurance scheme to hospitals which are not empanelled under Ayushman Bharat.
Rajasthan	March 26: The Rajasthan Epidemic Diseases Act 1957 invoked to take over private hospitals for Covid-19 patients (24). June 20: Covid-19 testing rates reduced to Rs 2,200; charges for treatment in general ward and ICU also capped (31).
Tamil Nadu	Empanelled hospitals permitted to charge up to Rs 5,000 for a single day's treatment in general ward for asymptomatic patients and for those showing mild symptoms (32). Daily rates for ICU with all facilities capped at between Rs 10,000 to 15,000 for Grade A1 and A2 hospitals, and at Rs 9,000 to13,500 in Grade A3 and A4 hospitals (32). State government announced that minimum of 25% of beds in registered private hospitals must be allocated for Covid-19 patients covered under Chief Minister's health insurance scheme (32).
West Bengal	State-run private hospitals ordered to provide free treatment for Covid-19 patients, with costs to be borne by state government (33). Private hospitals ordered to display a notice stating that treatment to patients is free and cost being borne by government of West Bengal. State government collaborated with 51 private hospitals to treat Covid-19 patients and is bearing all expenses of their treatment.
Telangana	June 15: State government fixed Covid-19 treatment prices for private hospitals and laboratories.

Overall, such practices also highlight the erosion of professional ethics among doctors and hospital managements over the years, a situation that has been worsened during the pandemic.

With Covid-19 now spreading to the rural areas and becoming a pan-India phenomenon, expanding coverage through the private health sector becomes a challenge. In rural areas, a large proportion of private healthcare is in the informal sector. There is a limited number of private hospitals and clinics with trained health workers and adequate technology, and the private sector is incapable of meeting "the gap between existing and required public hospitals in rural areas" (42). With the spread of Covid-19 in rural communities, the challenge to find affordable and sustainable hospital care for the poor and socially marginalised is magnified.

Overall, the private health sector has failed to adequately supplement the public health system; it also undermines the state's legitimacy. Its response prioritises profit, disempowers people through inflated bills, impedes access and neglects the health needs of those affected by Covid-19. The system which prioritises market values has repeatedly ignored the health of the population during this crisis.

Public-private partnerships during Covid

The Task Force on the National Infrastructure Pipeline for 2019-25 and Fifteenth Finance Commission continue to promote greater private sector participation through the public-private partnership route for healthcare infrastructure (43, 44). In a time of unprecedented crisis, NITI Aayog reminds state governments to set up medical colleges based on the PPP infrastructure programme linking district level GHs with private partners (3). Implementation of this model in medical education depends on the availability of private medical colleges and hospitals experienced in providing tertiary level care. Many of these are in the more prosperous districts of southern and western India. More than half of the 499 such medical colleges are in the private sector. According to a study, these institutions have low OPD attendance (20%) and bed occupancy (30%) along with a severe shortage of medical faculty. Between 70% and 80% of private medical colleges do not meet Medical Council of India standards (45), and will be substandard training institutions for our future doctors and nurses. More than the public policy planners anticipate, PPP projects as promoted by NITI Aayog take longer to complete. This is seen in the case of the Shillong Medical College and Hospital PPP project. The concession agreement[i] of this project was signed in 2012 and the project is still far from completion. Reports show that in such delays the government bears the social and policy risk (5).

Over the years, the GH landscape has been transformed through outsourcing and PPPs. Experience from different states show that they have done "little to remove inefficiencies and improve quality of public institutions" (5). Yet, involving the private sector in partnerships with public sector institutions is projected as the win-win policy, uninformed by evidence and contributing to the fragmentation of services. These partnerships have raised multiple concerns about access, financial sustainability, functioning, accountability and transparency (46, 47, 48, 49, 50, 51). The safety and quality of contractual healthcare services depend on how well the complex contracts can be monitored during different stages of procurement and provisioning. Information asymmetry in PPP projects makes it difficult for the authorities to enforce the contract norms, as access to the information is not always easy, and the contractors' functioning not sufficiently transparent (46, 51, 52). This allows the private sector to act opportunistically (46, 51). Studies show that in PPP projects, the private sector operates by the logic of profit making (5, 52). As long as PPP projects are not profitable ventures for the private sector, they will not take them up, as observed in the case of two speciality hospitals in Delhi (at Tahirpur, and Janakpuri) (53). As the PPPs create new structures it requires trained people to govern, monitor and evaluate them (54). In India, with inadequate human resources and capacity, state and district healthcare authorities could do little to address the regulatory issues of PPP projects (46, 51).

As Covid-19 sees a second wave, the need for GHs and public sector primary healthcare is more important than ever. The impact of unregulated private healthcare is evident, as are the limits and challenges of PPP.

Discussion and conclusion

There are several lessons to be learned from the handling of the Covid-19 pandemic. We see how private healthcare continued to focus on profit maximisation rather than the need to improve the quality of care, access, availability and coverage of Covid-19 services. It performed poorly in coordinating healthcare services.

It is the duty of the government is to ensure the availability, accessibility and delivery of good quality healthcare. Publicly-funded health insurance schemes have reduced the financial burden for the poor sections across Empowered Action Group (EAG) and non-EAG states (8). However, fee for service in private hospitals continues to be among the most significant barriers to increasing healthcare coverage and discriminates against the sick, and the poor and marginalised. One year into the pandemic, exorbitant medical charges continue to force people to make out-of-pocket payments. Mechanisms are required to ensure affordability and sustainability of financing related to Covid-19 healthcare services. Patients' reports of their experiences also indicate that private health insurance companies have been "cream skimming", or refusing claims citing unjustifiable grounds – such as that the charges were too high, the patient had pre-existing ailments, or the symptoms were too

mild to justify the treatment. Such practices have increased the burden on the ill. Private hospitals have exploited the vulnerability of patients. Vulnerable groups, such as the low-skilled and informal workers, those with financial problems, have faced increased tensions regarding money, health and healthcare.

The private sector's commercial interests are in conflict with its public duties. This is a challenge for state governments. During the pandemic, FICCI has actively lobbied on behalf of private hospitals and laboratories for government support (55), even as it evades accountability for provision of health services to the people and the government. The private healthcare industry is a powerful constituency and has been asserting its demands during the pandemic as well.

The state has failed to regulate the private health sector, and overlooks its inefficiencies. Furthermore, private sector responses are in direct opposition to the principles of equality, the dignity of patients, social justice and comprehensive healthcare. The need to regulate the private health sector, including in pricing regulation, goes beyond the pandemic.

The pandemic has emphasised the need to invest in and strengthen the public sector healthcare infrastructure. The neoliberal framework permeating public policy agenda raises concerns of care, coverage and access and erodes the public aspect of the government hospital system. For low and middle income countries (LMIC) like India, it is essential to remember that PPPs are an expensive purchasing device and making such projects viable places additional burdens on the public sector. Moreover, long-term hospital contracts can be incomplete, and regulating the private provider for public health priorities can be difficult. This process can contribute to risks when the purpose of contracts is "for the management of risks" (56).

The pandemic has made it clearer than ever that health is a public good, not a commodity. It has shown what happens when the public health sector is weakened by years of underinvestment, what the consequences are of commercialisation. Covid-19 has underscored the need for a health policy and a healthcare service that recognises the basic right to life, health and dignity. We cannot afford a "minimalist state" in healthcare, with a reduction in tax-based services, and services being managed and provided by PPP-based contracts. We need to move beyond the commercialisation framework, and call for increased direct investment in the public sector healthcare facilities. Reforms are needed in infrastructure renewal, and service procurement mechanisms, along with recruitment of workforce at different levels of care, and across rural and urban sectors.

In tandem with these reforms, there is a need to address the lack of understanding within the healthcare system of "ethics and ethical practices in the public imagination" (57). There is a need to work with professional bodies, and to develop accountability through community-based monitoring systems and a patients' rights charter. This can provide the basis for improvement of public healthcare services, and ensure action against the injustices faced by patients.

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[i]*Note: Concession Agreement: In this form of PPP, the government defines and grants specific rights to an entity (usually a private company) to build and operate a facility for a fixed period of time. The Government may retain the ultimate ownership of the facility and/or right to supply the services. In concessions, payments can take place both ways: the concessionaire pays government for the concession rights and the government may also pay the concessionaire, which it provides under the agreement to meet certain specific conditions. Usually such payments by the government may be necessary to make projects commercially viable and/or reduce the level of commercial risk taken by the private sector, particularly in the initial years of a PPP programme in a country when the private sector may not have enough confidence in undertaking such a commercial venture. Typical concession periods range between 5 to 50 years (https://unescap.org/).*

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Research, biomedicine and Ayurveda: From evidence-based medicine to evidence-informed healthcare

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Abstract

As the search for effective treatment for Covid-19 intensifies, traditional medicine systems are receiving increasing attention from researchers as well as the public. While scientific rigour is non-negotiable, there remain fundamental issues to be addressed when bringing evidence from traditional systems. Here we examine some of these issues pertaining to Ayurveda and the underlying philosophical underpinnings, and suggest potential ways to move forward. We find an ability to emerge from the cage of "biomedicalism" and its foundational reductionism essential for appropriate research in Ayurveda. We caution against pursuing research in Ayurveda by just mimicking modern medicine and highlight the need for appropriate use of modern science tools and methods to understand Ayurveda and explore its potential for healthcare. We emphasise the need and potential for transdisciplinary research in Ayurveda. A balance between evidence-based medicine and evidence-informed healthcare is required.

Keywords: *Research methods, Ayurveda, Ethics, Evidence, Covid-19*

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Background

As the world adapts to the changed conditions owing to the Covid-19 pandemic, the global hunt for a medicine to cure Covid-19 intensifies. India, with its rich heritage of traditional medical systems such as Ayurveda, Siddha, Unani and Yoga, may have more to offer than the Western countries. However, basking in the glory of tradition is not enough in the present age of rapid advancements in science. In March last year, the Prime Minister in his address to the expert group of Ayurveda physicians insisted on generating scientific evidence for