

Witness Seminar
on
Private Healthcare Sector in
Pune and Mumbai since the 1980s
Held on 24th June 2018, Mumbai



Organized by
SATHI, Pune and King's College London

Transcript edited by
Indira Chakravarthi and Benjamin M. Hunter

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ACRONYMS

ACASH Association for Consumer Action on Safety and Health Mumbai

AIIMS All India Institute of Medical Sciences Delhi

ART Assisted Reproductive Technologies

AYUSH Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homoeopathy

BJ Medical College Byramjee Jeejeebhoy Medical College Pune

BMC Brihanmumbai Municipal Corporation

CEHAT Centre for Enquiry into Health and Allied Themes Mumbai

CEO Chief Executive Officer

CGHS Central Government Health Scheme

CII Confederation of Indian Industry

CPA Consumer Protection Act

FICCI Federation of Indian Chambers of Commerce and Industry

FMES Forum for Medical Ethics Society Mumbai

GIPSA General Insurance Public Sector Association

GT Hospital Gokuldas Tejpal Hospital Mumbai

HN Hospital Sir Harkishandas Narottamdas Hospital Mumbai

ICICI Industrial Credit and Investment Corporation of India

ICU Intensive Care Unit

IFC International Finance Corporation

IIHMR Indian Institute of Health Management and Research

JCI Joint Commission International

JJ Hospital Sir Jamsetjee Jeejeebhoy Group of Hospitals Mumbai

KEM Hospital King Edward Memorial Hospital Mumbai



MHA	Master in Health Administration
MLA	Member of Legislative Assembly in the state
NABH	National Accreditation Board for Hospitals
NHSRC	National Health System Resource Centre, Delhi
NSSO	National Sample Survey Organisation
PPP	Public Private Partnership
RSBY	Rashtriya Swasthya Bima Yojana
SAARC	South Asian Association for Regional Co-operation
TISS	Tata Institute of Social Sciences

Numerical units commonly used in India

1 lakh = 1,00,000 (100,000)

1 crore = 1,00,00,000 (10 million)

ABOUT WITNESS SEMINARS

The witness seminar is a group oral history method – a way of chronicling important contemporary events. This is done by getting together the people who have been directly involved in these particular events or processes; those who have experienced it first-hand; made it happen, and have in-depth knowledge and observations to share. This group then recollects about those events in a collective and systematic manner, based upon their personal knowledge of the events, places, processes and people involved. The witness seminar is a structured, moderated conversation between these key people in the format of a panel discussion or a seminar, with a small invited audience. The purpose is not to arrive at an agreement or consensus but is rather to produce a collective memoir or account of significant events. The seminars are recorded, transcribed, annotated with key notes, and then published.

Witness seminars have been used to document a wide range of developments in the history of medicine and public health in the UK. Witness seminars have explored topics such as the development of obstetric ultrasound, monoclonal antibodies, human gene mapping, rural medicine, and abortion laws, and also broader changes such as transformations in public health and the introduction of internal markets in the UK National Health Service. The Wellcome Trust has supported many of these witness seminars and transcripts from the seminars are available from the Wellcome Library: <https://wellcomelibrary.org/collections/about-the-collections/archives-and-manuscripts/>.

SATHI Pune and the Department of International Development, King's College London, conducted three witness seminars in 2018 in Mumbai and Pune, in the course of a study undertaken on corporatisation, emergent practices and regulation in the private healthcare sector in India, through a case study in Maharashtra (<https://unsettlinghealthcare.org/2018/07/04/bearing-witness/>). This is the first report of such a witness seminar on transformations in the private healthcare sector in Mumbai and Pune.

INTRODUCTION

The private healthcare sector in India, in general and in several states specifically including Maharashtra, has undergone substantial transformation over the past three decades, including changes in the composition, organisation and financing of healthcare. These transformations reflect a combination of economic, social and political factors. Focusing on the two cities of Pune and Mumbai, this witness seminar aimed to document this transformation in more detail, highlighting roles of key events, people and places.

Maharashtra state – economy and demography in brief

Maharashtra is the second largest Indian state in terms of population and is highly urbanised, with 45% of the population residing in urban areas. It is also one of the most highly industrialised states in India, with industry and service sectors contributing more than 85% of the state income. With a gross state domestic product of Rs 18,26,296 crore (US\$ 261 billion) and per capita state income of Rs 1,65,491 (US\$ 2,364) in 2016-17,¹ it is India's largest state economy and has benefited from decades of rapid economic growth and service sector expansion.

Mumbai, the capital city, with the largest population in the state is the financial capital of India, housing the headquarters of most of the major corporate and financial institutions. India's oldest and main stock exchange, capital market and commodity exchanges are also located here; the city is an important centre for the global financial industry. Pune, the second largest city in the state, is among the most important IT centres in the country, characterised by the formation and expansion of IT parks around the city. Both cities are characterised by a growing middle-class, benefiting from service sector employment opportunities, improved living standards and rising life expectancy.

In terms of health status, the state faces a double burden of communicable diseases and an epidemiological transition towards chronic, non-communicable diseases. While economic growth rates have been high, state budgetary allocations to health and per capita expenditures on health have been low, and have fallen since the mid-1990s as proportion of state expenditure (4.1%), as well as a proportion of state domestic product (0.5%).

¹ Government of Maharashtra 2018. Economic Survey of Maharashtra 2017-18. Mumbai: Government of Maharashtra Directorate of Economics and Statistics.

Transformations in Maharashtra's healthcare sector

The private sector in healthcare has grown rapidly over the years, to fill gaps in the quantitatively and qualitatively inadequate government health services. Multiple concurrent shifts have been taking place in and around this private healthcare system in Maharashtra since the 1980s (and in several other states as well).²

Around 1947 the private sector accounted for 8% of healthcare facilities; it had risen to 60% by the early 1990s.³ In 1992 the Bombay Municipal Corporation listed 907 nursing homes and private hospitals in Bombay city alone (excluding Thane), and currently this number stands at 1,319 hospitals and nursing homes.⁴ The Pune Municipal Corporation currently lists 705 healthcare facilities. No new public facilities have been set up over the past three decades and hence much of the increase in numbers can be attributed to increasing private facilities.

Apart from these increases in numbers, there are also changes in the services provided, and in the ownership and management of private facilities. In the 1990s private healthcare services comprised mainly of fee-for-service practitioners who played a dominant role in the provision of individual curative care through ambulatory health services.⁵ In addition there were small hospitals (up to 30-40 beds), nursing homes, clinics and pathological laboratories, set up by individual doctors or by religious/charitable trusts and philanthropists. Now larger hospitals offering multiple, on-site, high-technology services are the preferred choice for many users, and large private hospitals have grown to meet this demand.

According to the National Medical Directory of the Ministry of Health, as of September 2015 there were 42 corporate⁶ hospitals in Maharashtra, of which 23 were in Mumbai and 18 in Pune. In Mumbai, several large healthcare companies have become established, including Wockhardt, Asian Heart Institute, Thyrocare, Metropolis, Surya Childcare, Jupiter, Global Hospitals, Lifewave hospitals, Healthspring, Cloudnine. Renowned trust hospitals such as Nanavati, Raheja, Masina and SRCC Hospitals have undergone important changes in the way they are run, affording greater roles to management companies. In Pune, Surya Hospital was set up in the mid-1980s, followed by Sahyadri Hospitals in the 1990s. The latter has since become a chain of multi-specialty hospital across western Maharashtra and acquired Surya Hospital in the process.

2 Nandraj, S., Muraleedharan V.R., Baru, R.V., Qadeer, I. and Ritu Priya (2001) Private Health Sector in India: Review and Annotated Bibliography. Centre for Enquiry into Health and Allied Themes, Mumbai; Indian Institute of Technology (Madras) Chennai; Centre of Social Medicine and Community Health, Jawaharlal Nehru University, Delhi.

3 Radwan I. 2005. India – Private Health Services for the Poor – Policy Note. HNP Discussion Paper 33579. Washington DC: World Bank

4 A list of healthcare facilities registered under the Bombay Nursing Homes Registration Act was obtained from the Brihanmumbai Municipal Corporation. This is the most comprehensive registry of private healthcare facilities available, although these could be underestimates.

5 World Bank. 1997. India - New directions in health sector development at the state level: an operational perspective. Washington, DC: World Bank.

6 The term corporate was not defined.

Changes in demand for healthcare have led to new markets in the sector. Single specialty chains have emerged, offering tailored services for areas of health such as ophthalmology, oncology, gynaecology, obstetrics, fertility, cardiology and imaging. Management companies such as Radiant Lifecare, Vitalife and Hosmac now offer a range of services to the hospitals sector, from support for healthcare project development to contracted management of healthcare facilities. Companies such as Portea exclusively provide home-based medical care, including doctor consultations, and a range of companies such as Practo and Justdial offer online lists of providers, replete with ratings and reviews, to assist bookings and management.

There have been important changes in the way private healthcare is paid for. In the 1990s, private healthcare was financed almost entirely out-of-pocket by healthcare users. Since 2000 private health insurance has grown increasingly important, and health insurance has become a separate segment in the insurance sector. Since 2006 stand-alone health insurance companies have been set up, including Max-Bupa, Apollo Munich and Religare. Alongside the growth of commercial health insurance, government insurance schemes continue to offer services to specific segments of the population such as civil servants or low-income populations.

Medical education has also undergone substantial change. In 1984 the Maharashtra state government permitted private investment in professional courses, including medical colleges, on the grounds that the government could not set up enough institutes to cater to growing demand, and if the state did not sanction private medical colleges then Maharashtra's talent and money would go across the border to colleges in Karnataka. Thirteen new private medical colleges were established in the decade of 1981-1990, and more than half of the 48 medical colleges in the state are now privately owned.⁷

National policy environment

Although health is constitutionally a state-level subject in India, national policies have played an important role in creating an enabling environment for the above expansion and transformations. The 1980s and 1990s were marked by liberalisation in the healthcare sector which allowed loans and investment for capital development, and the subsidised sale of public land for healthcare projects.⁸ In the late-1990s, tariffs on medical equipment imports were lifted and the insurance sector was opened to private investment, then in 2000, restrictions on foreign direct investment (FDI) were lifted to allow 100% FDI for health-related services under the direct route.⁹

7 Diwate A. 2016. Social Characteristics of Private Medical Colleges in India: A Study of Select States. (Unpublished Doctoral Thesis). Centre of Social Medicine and Community Health, Jawaharlal Nehru University, New Delhi.

8 Lefebvre, B. 2010. Hospital chains in India: the coming of age? Institut Français des Relations Internationales

9 Namely - allowed without any requirement of seeking regulatory approval prior to such investment. Eligible investors can invest in most of the sectors of Indian Economy on an automatic basis, except in a very small list of activities where foreign investment is prohibited.

It was during this period that the World Bank sponsored a series of state-level Health Systems Development Projects (HSDP), including the Maharashtra HSDP (1999-2005) - a US\$ 130.9 million project aimed at strengthening of health systems and improving access and quality, through policy reforms that included enhancing roles for the private and voluntary sectors. This project included support for a public-private partnership (PPP) for a super-specialty hospital that would adopt modern management practices and provide a model for future projects. This Gokuldas Tejpal Hospital (GT) was a joint venture between the state government and pharmaceutical company Wockhardt, in which the government provided land and building at a nominal cost while Wockhardt would run the hospital. Despite some early progress in development, including completion of the necessary studies and policy decisions, implementation of this activity was delayed and, at the mid-term review in 2003, a decision was taken to terminate the joint venture and cancel the unused allocated funds. Since then, the Maharashtra government has entered into service provision contracts with other private hospitals, such as Seven Hills Hospitals and Wipro GE-Enso.

The 2002 National Health Policy set out a policy framework that was broadly supportive of expanding private healthcare provision and emphasised the need to offer financial protection systems for the poor. The policy framework had been informed by central (federal) Ministry of Health research and consultations with support from international agencies, and brought together central and state government officials, private healthcare providers, insurers, not-for-profit providers, legal experts, academics, research groups, consumer organisations and medical associations. At the same time, the Ministry of Health's National Commission on Macroeconomics and Health came up with a country report on health in India, recommending a gradual shift in the role of the state from being a provider to a purchaser of care.¹⁰ The policy environment was further liberalised in the years following the 2002 National Health Policy: the 2003-04 union budget further reduced tariffs on medical equipment imports and offered tax exemptions for large hospital projects, and was then followed in 2008 by further tax exemptions focused on tier-2 and tier-3 cities.

The 1990s and 2000s also marked an important period in the formation of an organised healthcare industry. In 1998, owners of large hospitals and the CII came together to create the Indian Healthcare Federation – an industry association which would actively work to develop an 'organized private sector' for healthcare provision. The CII worked with management consultancy firm McKinsey to produce a 2002 report *Healthcare in India: The Road Ahead*,¹¹ followed in 2012 by India *Healthcare: Inspiring Possibilities, Challenging Journey*,¹² providing recommendations for industry and government on how to increase levels of investment in the sector and how to create opportunities for PPPs in healthcare. These recommendations echo those made in World Bank-commissioned reports at this time, such as *India - New directions in health sector*

10 Government of India 2005. Report of the Commission on Macroeconomics and Health, Ministry of Health and Family Welfare.

11 CII and McKinsey. 2002. Healthcare in India: The Road Ahead.

12 Gudwani, A, Mitra, P, Puri, A, and M Vaidya. 2012. India Healthcare: Inspiring Possibilities, Challenging Journey. McKinsey and Company, Prepared for Confederation of Indian Industry.

*development at the state level: an operational perspective,*¹³ and *Better health systems for India's poor: findings, analysis, and options.*¹⁴

Sources of investment

The shift from fee-for-service practitioners to larger healthcare facilities and chains has been accompanied by changes in the source of investment. While personal savings and loans remain important for some physicians setting up smaller practices, some larger companies have gone public and are listed on the stock exchange, such as Thyrocare, Apollo Hospitals, Narayana Health. Support from private institutional investors has become increasingly important and healthcare has become an attractive sector for investment by venture capital and private equity funds.¹⁵ Domestic financial institutions such as ICICI have provided investment to support expansion of smaller healthcare companies such as Sahyadri Hospitals and Vikram Hospitals. The World Bank's private equity investment arm – IFC – has been providing loans and investments to Indian healthcare companies since 1999, but accelerated its activities during the 2000s to fund expansion into smaller cities and towns. Its investments have included Apollo, Max and Fortis. International equity investment firms such as Advent International, Abraaj Group, TPG, KKR, and Carlyle Group have purchased and sold stakes in Indian healthcare companies, and investment funds owned by foreign governments have also started to expand their role, including the UK government's CDC Group, German government's DEG, and IHH Healthcare Berhad, which is majority owned by the Malaysian government's sovereign wealth fund – Khazanah Nasional.

Documenting these changes

The following broad themes were identified for discussion at this witness seminar:

- Describing key changes in the private healthcare sector: changing scenario of private healthcare sector, the process, signs and milestones, trends in the private sector and the growth and consolidation of hospital chains.
- Factors or drivers of the process: government policies and actions towards private sector and on medical education, state of public hospitals, technology, laws and regulatory measures, medical tourism, health insurance, patient awareness.

13 World Bank. 1997. *India - New directions in health sector development at the state level: an operational perspective*. Washington, DC: World Bank.

14 World Bank. 2002. Peters, DH, Yazbeck, AS, Sharma, RR, Ramana, GNV, Pritchett, LH, and A Wagstaff. 2002. *Better health systems for India's poor: findings, analysis, and options*. Health, Nutrition, and Population series, Washington, DC: World Bank Group.

15 Chakravarthi, I, Roy, B, Mukhopadhyay, I and S Barria. 2017. *Investing in Health: Healthcare Industry in India*. *Economic & Political Weekly*, 52(45): 50-56

WITNESSES

Amar Jesani, a medical graduate, is currently an independent consultant, researcher and teacher in bioethics, public health and regulation of the private healthcare sector. He is a founding Trustee of CEHAT (1994-1999) and of FMES.

Arun Bal is a surgeon and holds a doctorate in Political Science on 'Healthcare as a Human Right'. He is a practicing diabetic foot surgeon and has worked across public and private hospitals in Mumbai for more than three decades. He is also a founder member of FMES and ACASH.

Avinash Kulkarni is a Medical Consultant in Pune. He has his own practice and has been working with several private hospitals in Pune for more than three decades.

Ravi Duggal is a public health researcher and activist, with expertise in health economics. As part of CEHAT, he was involved in research in the 1990s on the private hospitals sector in Mumbai. He has more than three decades of experience in research and advocacy on health systems issues.

Ravindra Karanjekar is a medical graduate, with over two decades of experience in hospital management. He has been involved in setting up and managing several large private and corporate hospitals, in several cities across the country. At the time of the Seminar, he was Chief Executive Officer of Jupiter Hospitals in Thane and Pune.

Sanjay Nagral is a consultant in surgical gastroenterology, with experience of working across public and private hospitals in Mumbai. He is also founder member of Forum for Medical Ethics and publisher of the Indian Journal of Medical Ethics.

Seema Malik is a medical graduate who has worked in Bombay Municipal Corporation as administrator for more than two decades. She is currently a consultant in hospital management.

Shekhar Ambardekar is a cardiologist from Mumbai, who has three decades of experience in public and in several corporate hospitals. He has been lecturer in Cardiology in Grant Medical College and JJ group of Hospitals, Mumbai.

Shriram Geet is a senior family physician from Pune with more than four decades of experience. He was associated with large private hospitals in Pune for more than ten years. He is the Founder Secretary of General Practitioner Association, Pune.

Subhash Salunke is a medical graduate, who worked as an administrator in the state Public Health Department for over three decades, and was Director General Health Services. He has also been in the World Health Organization – South-East Asia Regional Office, and is currently in Public Health Foundation of India.

Chairperson: Ramila Bisht is a Professor and Chairperson of Centre for Social Medicine and Community Health (CSMCH), Jawaharlal Nehru University, Delhi. She was earlier at the Centre for Health Policy, Planning and Management at the Tata Institute of Social Sciences, Mumbai, during which time she had conducted studies on the private healthcare sector in Maharashtra.

Members of the audience

1. **Abhay Shukla**, Senior Scientist, SATHI, Pune
2. **Anant Bhan**, President, International Association of Bioethics
3. **Archana Diwate**, Researcher SATHI, Pune
4. **Arun Gadre**, Coordinator, SATHI, Pune
5. **Deepali Yakkundi**, Researcher SATHI, Pune
6. **Kishor Khilare**, SATHI, Pune
7. **Sanjida Arora**, Researcher, CEHAT, MUMBAI
8. **Shweta Marathe**, Researcher SATHI, Pune
9. **Surindar Jaiswal**, Tata Institute of Social Sciences, Mumbai

PROCEEDINGS OF THE WITNESS SEMINAR

Session I
Status of trust and charitable hospitals

Session I

Status of trust and charitable hospitals

Ramila Bisht: Today's witness seminar is about the recent history of the private healthcare sector in Pune and Mumbai, and concerns the developments of the last 40 years. We begin by asking certain witnesses to tell us about the development of the private health sector in Pune and Mumbai. So, we will request two people initially to tell us about the changes that they saw in the trust and charitable hospitals in Mumbai, followed by two others to tell us about the changes in Pune. Thereafter, we will open to all witnesses. May I invite Dr. Arun Bal to recollect the changes you saw in the private health sector in Mumbai since 1980. We could go back further, but for the purpose of this seminar we will be looking at 1980 as the starting point.

Arun Bal: I entered medical college in 1968. In 1980 there were, mainly in city of Bombay, the charitable trust hospitals – Bhatia Hospital, HN Hospital – that were not part of the private sector.¹ The first hospitals that really started as private were Hinduja and Jaslok Hospitals. At that time the practice was quite different; I don't think most of the private hospitals were so costly, or they were not predators, which is the perception now - it was not so in 1980. But over time, as the policy-makers changed their attitude and brought in the concept of PPP, more and more private hospitals were established. So the public sector adopted more PPPs, and government provision slowly went downhill. As a simple recollection, when we were Registrars in the 1970s even the ministers would come to the public sector hospitals then; now even the government clerk doesn't go there. If government itself loses faith in its own hospitals I don't think anybody else can be blamed for that.

There has been this steady decline in the public sector, in spite of investment, so that opened the field for the private sector which, being a market, has employed marketing strategies with no regulation as such. There was regulation for doctors, not to prescribe branded medicines, but who licenses the branded medicines? It is the government. Doctors became a focus point for controlling the cost, controlling the prescription of medicines. I don't remember government taking action against any private hospital, in spite of repeated announcements in Parliament, in State Assemblies and in newspapers that 'we will take action'. There never has been concrete

¹ All four listed hospitals are private hospitals: Bhatia, HN, Hinduja, and Jaslok. They were established between the 1940s and 1970s by individuals or business houses. They aimed to provide healthcare in the city as a charitable service. Usually a trust was formed, comprising family members and which established and managed the affairs of the hospital. Since around the 1970s, with improvements in technology and other factors, these hospitals were improved, expanded and more services started to be offered. For example, the management of the HN was taken over by the Reliance Foundation of the Reliance Group of Industries, and the hospital building was completely renovated and tertiary level services were offered. These trust hospitals are non-profit hospitals run by the respective charitable trusts registered under the Maharashtra Public Trusts Act 1950. Such hospitals receive tax exemptions and concessions on land, electricity, building rules, and import of medical equipment; in return they are expected to provide free and subsidised medical care to economically weaker sections, up to 20 % of their total patients.

action against any private hospital in Bombay, in spite of lot of complaints and inquiries.² Government has opened this field of medical care provision to the private sector and gradually withdrew from medical education. The condition of the public sector hospitals in Bombay, which were the premier hospitals when we were students in the 1970s and early 1980s, is now very pathetic. This is the main reason why private hospitals are flourishing. And when the education was also handed over to private medical colleges, then the whole thing became majority private, minority government.

That is going to affect a large section of the population. Our consumer organization ACASH,³ in the early 1990s did a survey in King Edward Memorial hospital,⁴ which showed that 35% of patients coming to KEM hospital in Bombay were from outside Bombay. That reflects on the status of the public health in the entire country. And that is a big strain. Alongside the poor administration and lack of human resources, the whole scenario has become very pathetic. So it is an open field for private hospitals. And once you have a marketing philosophy, without regulation, anything can be done. The perception, which is widely prevalent, is that doctors in private hospitals charge amounts way beyond what is required. That may be true in selected cases, but I would urge anybody to visit any private hospital in the city of Bombay and see the total bill. The doctors' fees are never more than 10-15% of the bill. The remainder of the fee is to cover the consumables and technology used. And the doctors are under tremendous pressure. One of the main reasons for this situation is that doctors have not united to create the concept of group practice, which would provide protection to younger doctors from the pressures of the employment market. That is the main failure. Ethical doctors have been championing the need for ethical practices; however none have entered the healthcare market and opened a hospital, and demonstrated that hospitals can run in a cost-effective manner, whilst having ethical practices. Unless one enters the marketplace, simply stating the marketplace is bad does not help because the marketplace will remain unchanged.

Regardless of what is said in these seminars, it is the government policy that is at fault. Unless health becomes a political subject, as it was in the American Presidential election, change will not happen. We have to be very realistic that schemes such as this Ayushman Bharat - National Health Protection Scheme,⁵ are all political stunts. And they are not going to help anybody at ground level. Unless ethical doctors come together and open even a small hospital – 50 bedded

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- 2 In the early 1990s a public interest litigation was filed in Bombay High Court on the death of a person in Parsi General Hospital due to receiving a transfusion of an unmatched blood group. The Court set up a committee to look into the functioning of nursing homes and private hospitals, which conducted a study and found many problems and inadequacies in these private facilities. See Nandraj S (1994) *Beyond the Law and the Lord: Quality of Private Health Care*, Economic & Political Weekly, 29(27), pp 1680-85.
 - 3 ACASH – Association for Consumer Action on Safety and Health – was founded in 1986 by a group of doctors, lawyers and other concerned individuals, as an independent, non-profit, voluntary organisation, to address health-related consumer issues and advocating for the rights of the consumers and the general public. Dr Arun Bal, Mumbai based surgeon, was President of ACASH.
 - 4 King Edward Memorial Hospital (KEM) in Mumbai, established in the 1920s, is a public hospital run by the BMC. It is attached to Seth Gordhandas Sunderdas Medical College (SGMC)
 - 5 On 1st February 2018, the Finance Minister of India announced a flagship health insurance scheme: the National Health Protection Scheme (NHPS), also known as Ayushman Bharat, which provides coverage of up to Rs 500,000 per family per year for secondary and tertiary hospital care.

– and show that one can do most of the work without high technology, within a reasonable charge and with an ethical practice. Unless one creates a model which challenges the current corporate models, it is impossible to stop these models from spreading. Words alone cannot create change as these corporate hospitals are backed by the government. Policy also will not change, in spite of all these advertisements and schemes; at the ground level nothing will change unless one has a countervailing model and show that such models can work.

Since the CPA was made applicable to medical care,⁶ nothing further happened; it is not helping patients because there are delays of 10-15 years in the courts to arrive at decisions. However, something ethical organizations could have done, which only our consumer organization ACASH was doing since 1992, is to help the patient verify the complaints; verify whether there was real negligence. We would receive complaints from across India and our findings showed that only 3-4% of the cases had a justiciable negligence - the rest were related to infrastructural matters. Now, if you consider the whole healthcare infrastructure, doctors constitute only 25%; 75% is constituted by drug companies, technology, hospitals. What are the controls on all these components? So society, as well as the government, want to control doctors, and create a false perception that everything is wrong with the medical profession itself while everything else is hunky-dory, which is absolutely wrong. A large component of this is driven by change in society itself. With the increasing availability of technology and the increase of the middle classes, society has bought the concept of value for money. If a patient goes to a doctor and pays a fee, they expect a product, a definitive result; like purchasing a television - it should work properly. This does not happen in medicine.

The economics in the private sector, even for ethical doctors, is an additional pressure. The cost of setting up a private practice in city of Bombay is huge, so who will bear that cost? Loans are not cheap, and all this cost has to be, at least partly, shared by society. The middle-class pay Rs 300 for a washing machine technician to just come and see the machine, but are reluctant to pay Rs 1,500 for a top consultant. So there is a problem in society: if society does not want to support the ethical doctors then they will decline and the younger generation will not want to enter the medical profession.

Ramila Bisht: Thank you so much! Could we move to Dr. Avinash Kulkarni - if you could recollect the growth of the private sector in Pune?

6 The Consumer Protection Act, 1986, enacted to protect consumers from poor commercial services, was made applicable to medical services in 1995. This was seen as an important step towards regulation of the private medical sector and ensuring quality care to patients. Studies of how the Consumer Protection Act has been used in relation to medical services point to difficulties including the emphasis on complainants to prove negligence and the length and cost of cases lodged in an under-resourced and inefficient judiciary system. See: Bhat R (1996) Regulating the private health care sector: The case of the Indian Consumer Protection Act. *Health Policy and Planning*, 11 (3), 265-79.

Peters D. H. and Muraleedharan V.R. (2008) Regulating India's health services: To what end? What future? *Social Science and Medicine*, 66, 2133-44.

Avinash Kulkarni: I had this unique situation, where I was brought up and educated in Bombay but never practised in Bombay. After my MD I had to travel abroad for my work, and when I returned after six years I moved to Pune. So I have this partial understanding of Bombay, and since 1990 I have been practising in Pune. Pune is historically a sort of idyllic city, a little more laid back, and most of the medical practice was that of consultants working on their own, a group of prominent consultants forming their own hospital, or a single consultant who is more ambitious, or more efficient, opening a hospital. There are clumps of hospitals for gynaecology, orthopaedics, general medicine and surgery. In the group hospitals everybody is expected to have their own consulting room and in some hospitals receive admission facilities. The cost of setting up a hospital was never a problem until about 1995, 2000.

As a student in Mumbai I would see a lot of my colleagues, and their friends and relatives, willingly going to government hospitals in Mumbai to get treated there, partly because some of us were always there to help them out. I have this unique advantage of having my father-in-law and mother-in-law working as professors in medical schools. So many of my relatives and acquaintances would happily go to government hospitals and get treated properly. Somehow I didn't find that in Pune. In Pune the only government medical college and hospital was not a very popular place for middle-class people to go to. By the time I started private practice I would say, 'if you can't afford private, go to government hospital' but people would be very reluctant to do so unless they were absolutely poor. I am not saying that people were not going to government hospitals – there were plenty of people who definitely could not afford private healthcare and used to go to government hospitals. But I saw this reluctance to use government hospitals. There were big private hospitals, like Ruby Hall and Wadia hospitals, that were doing well and bringing in a lot of technology, but they were also considered overpriced. Generally, when people needed some sort of high-tech therapy or intensive therapy, or had a serious emergency, they preferred those private hospitals. Another hospital was the KEM⁷ in Pune, which would cater to the much lower classes, had a very good group of consultants willingly joining, as well as teaching programmes. KEM maintained that kind of atmosphere; most of us newcomers, who get into big hospitals, could go as panel consultants but were not appointed there, because the positions were filled. We used to work with much smaller private hospitals. Most of the private hospitals started as charitable trust hospitals and remained trust hospitals, although not everyone stuck to the principles of trust hospitals. There may have been some incidents and a general unhappiness, but overall the picture was not bad - people would pay, charges were not too high, and we were not considered to be overcharging. The CPA was not being utilised by a lot of people in those days.⁸

After 2000-2003, the corporate culture entered and the picture turned upside down. I was attached to a hospital, which, though not a corporate, adopted the corporate culture. It was off – putting - we were unhappy with the change. The technology they were bringing in was good but we saw the pricing going up steeply. The mentality of, let's call it 'market people', entered into the health

7 King Edward Memorial Hospital (KEMH) in Pune, established in 1912, is a private hospital, run by the KEM Hospital Society, a registered charitable trust.

8 See Note 6 above for the CPA.

sector, which we found odd. For example, we were called in for consultants' meeting and the first ten slides that were shown to us were about how much business physicians were giving to the hospital, which was a bit upsetting, so most of us stopped attending those meetings. There's no point in pointing out that last month you were doing so much business and this month it is so much. That is more like a manufacturing firm and we would say that's not the way hospitals should run. But we had no idea how they should run otherwise and slowly that culture sunk in. It is difficult to blame hospitals for every evil that happens, but they were a part of it. Where pricing is concerned, overpricing became more obvious in the hospital because it was becoming almost overburdened with the paramedical staff and assistants. More and more people were employed and I kept wondering why so many people are required in our hospital. We had a 'social worker' who was a social worker just in name and whose work was more about advertisement outside the hospital, and visiting the public and talking to doctors and other people.

There is this cultural difference now; unfortunately, a corporate tradition is growing, and people are accepting the culture out of hopelessness. A lot of consultants have to join corporate hospitals because the medical infrastructure is there. Those who join the hospitals become used to the corporate culture, like the concern with patient numbers. To narrate one incident: one of my patients, who has been with me for last 10- 15 years, walked into a corporate hospital for an emergency. When the primary treatment was done, he walked out of that hospital saying, 'It's okay, I'll go and talk to my consultant tomorrow'. The consultant from that hospital later called to inform me that an inquiry was being launched to look into why the patient had walked out of the hospital. That was the kind of culture that was setting in. Some people are going overboard, some people are not, but the culture is definitely there. It has become more like manufacturing goods: selling the product and making profits. People who have the financial ability have walked into the hospital sector, people from outside healthcare, but I don't know what sort of training they receive for health sector management.

But it is not that other hospitals are dying out; they are still there. Patients' bills have been going up, even in other hospitals, and sometimes we do find it is very difficult for them to pay. Here I am talking about the middle-class, who were willing to pay in the medium sort of hospitals, or what we call it sometimes second-tier hospitals, where costs are not too high. Only if it is absolutely required, are they transferred to third-tier hospital, where charges are very high. If you go to a third-tier hospital, you have to do so with lot of mental preparation as it is going to cost much more than what they can pay. Both systems have a sort of uneasy coexistence. And the younger consultants are finding it rather difficult to cope with the two.

Ramila Bisht: Thank you Dr. Avinash. Now we move to Dr. Sriram Geet. As we heard from Dr. Arun Bal and from Dr. Avinash Kulkarni, both Pune and Mumbai have a very rich history of trust and charitable hospitals. So tell us from your experience of working with a trust hospital, what kind of transformation you've seen over this time period?

Sriram Geet: Arun and Avinash have summarised things very nicely. Regarding the finances and ethical practices, I'll share one experience. In 1993 past students of Jnana Prabodhini, an educational trust in Pune, who had become doctors, formed the Jnana Prabodhini Medical Trust to provide rational, ethical medical care. These doctors were largely young freshers, not more than 35 years old and I was associated with that experiment,⁹ for ten years until 2005. In the early 2000s this group of doctors shifted to the management of the Deenanath Hospital, a well-known hospital which has an all-India ranking of five. A culture of ethics, like Arun Bal said, was the main rationale behind Sanjeevan Hospital. In Sanjeevan, not a single rupee was requested as an advance. And in 1995, in Pune, there were hardly any say about two charitable hospitals with more than 100 beds. KEM was there, as was Tarachand Hospital, but the rest of the hospitals were government hospitals. That was the difference. Ruby Hall, Jahangir, just touched or crossed the 100 beds mark at that time. But going to Ruby Hall or going to Jahangir, as Avinash said, was unthinkable - one had to think ten times before entering those hospitals; think about your pocket and only then could you enter. That was not the case in Sanjeevan, from 1995-2005. I have to point out, that was possible only because Sanjeevan Hospital was an old non-viable hospital that was handed over to this group of doctors to manage. The cost of land and building a new hospital is extremely high. To give an example: Aditya Birla Hospital, a private hospital, was opened in 2003 or 2004 and cost Rs 140 crores. Deenanath Hospital was opened only with Rs 45 crores, with free land.

Between 1995 and 2000, CT scans, dialysis, MRI and cath labs were not widely available in Pune. But they became widespread and every hospital started thinking 'why should we too not get one?' So the price tag became much higher. A person admitted for a heart-attack had to be moved, say to Ruby Hall or Jahangir Hospital, or to Mumbai; this was not acceptable. So, to the question of where should one go, the choice was to go those hospitals that had a cath lab. The cost of a cath lab at that time was, as Shekar Ambardekar knows, over Rs 80 million. Things were changing, leading to distortion in the private trust hospitals in Pune. But unless you do a minimum of ten CT scans, ten MRIs, or five cath lab procedures, it is not viable to have these technologies. I have done various costings. A general ward patient, where we were charging barely Rs 150 per bed, was not viable unless the cost of investigations or procedures goes beyond Rs 1,500. All these factors were distorting hospital practices. Some speciality hospitals – orthopaedic hospitals and obstetrics and gynaecology facilities like ONP Tulip or Cloud Nine hospitals – have come into Pune. These are like 7-star hotels with doctors, just like Breach Candy in Mumbai, so things have been distorted in this way.

One last comment: the problems with every Pune hospital still lie with a scarcity of skilled staff, such as good qualified surgeons and counselling support, in almost every specialty except bariatrics surgery. You cannot see a single counsellor in any of the Pune hospitals. Before going for a bypass or organ transplant, all the information is given but real medical counselling, with an ethical psychologist, is not done. As Avinash said, transparency in billing is a problem, all the

9 Refers to the management, by Jnana Prabodhini Medical Trust, of a trust hospital in Pune called Sanjeevan Hospital.

time. And this is the cause for rampant attacks on doctors. From 2010, even Deenanath, even Sanjeevan Hospital suffered attacks, at least twice while I was working there.

Ramila Bisht: Could we move to you Dr. Shekar Ambardekar, because you have been with the Jeevan Vikas Hospital for a long period of time, before you moved to the Asian Heart. If you could share your experiences of working in a charitable trust hospital and the transformation that you saw over the years?

Shekar Ambardekar: I joined medical school in 1972 and worked there for several years as a lecturer after qualifying, and then came into private sector. In the private sector, initially I started working with a small nursing home and a trust hospital, Jeevan Vikas. When the trust hospital had to compete with bigger hospitals, they tried to keep the prices down but they also found that it was not very practical and then they started cost-cutting. This led to lower quality of medical services. We would always say that in intensive care units you require a particular ratio of nursing staff to patients, but they were cutting costs there. They would try to cut down on providing newer medical facilities and on the staffing. They would also not operate the laboratory on Sundays, or the x-ray department would not work at a particular time, to cut the cost, because during those periods there would be fewer patients. It's just like discussions about public transport system in Mumbai and suggestions that it should be handed over to private operators, especially the bus services. The first thing that would always happen, if it is given to private operators, is that they would cut down some routes where there are not many passengers. So the same thing was happening in these trust hospitals.

At the same time, there were other hospitals emerging. As a cardiologist you require certain facilities to allow further investigations for your patients, so we needed an affiliation with another hospital and I went to Asian Heart and Raheja hospitals. The trust hospital that I had joined went downhill and it was about to close down because it was financially unviable - they could not run it the way they wanted to. They are now trying to hand it over to a private firm. So I have seen this trust hospital becoming a corporate hospital. It seems to be accepted that more and more facilities and services are needed in hospitals; as medicine advances, accordingly the treatment modalities change and they have to be available. But all that costs money. The hospital administration found that they could not manage it and it had to be handed over to a corporate.

What I see is that any corporate, in whatever field we are talking about, is a body trying to generate revenue and nothing else. Not necessarily in their field of speciality: any corporate can become a medical corporate, or a manufacturing corporate, or can go into public services - they can take over the electric supply and so on. Then what happens is that revenue needs to be generated from everything. Now, as Avinash was saying, they suddenly had to have a corporate office in the hospital so the corporate office comes, a marketing department comes, and the billing department grows from one or two persons to a large department. Everything would cost money and whatever does not generate revenue is stopped. There was a hospital where they started yoga classes for patients and staff. Yoga consultants were appointed who had to be paid a salary, which was not a very large amount, but they would not generate any revenue

because patients did not have to pay much and classes for the staff were free. So they soon stopped the yoga classes. Another big trust hospital Nanavati, has an agreement with a hospital management company. We have seen doctors who were heading the departments being asked to leave. With just one letter, people who had worked there for 35, 40 years, were asked to leave because they wanted to create a different system.

I always believe that the field of medicine consists of doctors and patients and there is the governing body, that is, government. These together, should run the medical field. But when corporates come, it is a failure of all three. As Arun Bal has said, if doctors are not united, they can't come together to form a hospital. Of course, even if they came together they would require money, and if they start collecting money by taking more fees from the patients, that is never popular. One doctor tried to make his own hospital – Dr. Mandke – he tried to make it on his own but after his death the managers found that it was not possible to maintain its practices so it had to be handed over to a corporate. That is generally happening all over the place. The hospitals which are not corporate are becoming corporate because money is required. There has to be somebody who can invest money in the hospital. But the person who puts in the money also wants something in return, and 'something' means much more than what was invested! Otherwise nobody will put in the money. So this is the change I have seen in my practice over the last 34-35 years.

Ramila Bisht: We will open it to other witnesses now.

Ravi Duggal: Somewhere in the 1970s was the period of transition in India. That's the era, where you had these small nursing homes and smaller hospitals, which came up in many of the cities. Up to the 1970s you find that there were virtually no hospitals in the private sector. There were charitable institutions, but no private sector of any kind of significance for hospital care. General practice has always been predominantly private within the country, but even that general practice was more kind of petty bourgeois, a home production kind of scenario, where even the doctors compounded their own medicine.

Post-1970s, certain factors in the whole political economy of health became the drivers of change. The first was the pharmaceutical industry. Until the mid-1970s, there was very good regulation and control of the pharmaceutical sector. Then gradually policies of liberalisation were adopted and some controls were eased: price controls were weakened and pharmaceutical marketing became much more aggressive. The private sector started expanding very rapidly because of the patent policy that we had at that time. We did not allow product patents, only process patents. This was a state subsidy for which price control was the quid pro quo, but gradually over the 1980s price control started declining. That made pharmaceutical companies bolder and they started marketing much more aggressively. Their first target was general practice, and so the compounding of medicine that the general practitioners did in their own clinics, in the 1960s and 1970s, that stopped; there was a shift to prescription drugs.

The second was medical education - an increase in post-graduate studies and allowing the private sector to enter education provision. In the 1970s, you had a major shift in medical education, where the focus shifted to specialisation and so, you had more people coming out with specialisations and the number of degrees being offered increased. There was this expansion of higher medical education, postgraduate education, which resulted in more people in the market.

The third was the new medical technologies that came in: CT scans, MRIs, etc. These were very expensive technologies coming into practice. And relatedly, the fourth is the whole diagnostic boom that you are seeing where the diagnostic industry reaches out to you at your residence. You don't have to go through your GP or any other physician; they approach you directly, leading to an independent economy coming in. Then there was corporatisation. And the fifth one is insurance, without which corporatisation cannot survive.

So, these became the key drivers of commodification of the private health sector. As you move towards the 1980s and 1990s, this was the brutalisation of healthcare that we saw happening. Compared to what we saw earlier, where doctors were much more ethical and compassionate, this was a completely commodified, marketised environment where healthcare became a commodity. And then, vis-a-vis the public healthcare sector, I know the public sector is not really the topic for discussion but there was the weakening of the public healthcare sector which boosted the private sector; the middle classes deserted the public health sector. I remember, until even the early 1990s, I was using the public healthcare system, but public facilities became inadequately equipped and their budgets went down substantially. You saw that shift and you were forced to go to the private sector.

Ramila Bisht: Dr. Salunke, the other speakers have alluded to how this growth in the private sector was backed by certain things that were happening in the government. Could you talk a little bit about that, based on your experience, and then maybe we can also ask Dr. Malik about the role of the BMC?

Subhash Salunke: These private sector involvements, and what is happening in medical education, they are all interlinked. It is no longer a profession, it is a business. Hospitals, healthcare, whether private sector or otherwise, it is purely a business now. The moment you call something a business, your motto is to earn money, whether you want to earn money by hook or by crook. That's where the corporate culture comes in. Corporates in the hospital sector are least worried as far as ethics are concerned. Their worry is financial: 'you are a consultant, you shall earn this much of money'; 'we are investing 'X' crores of rupees in new equipment so the money has to be recovered'. Doctors are pawns they are not the major players. They are the conduit to earn money. That's how the roles are now being redefined. In the 1970s, as Ravi has said, doctors were major players. But now doctors are not major players, particularly in the major hospitals, corporate hospitals. But fortunately there are still smaller hospitals or nursing homes where doctors play a significant role. We can't afford to ignore their presence in the city of Mumbai, or in Pune; they are there. And the situation is evolving, wherein their existence is being

threatened. It is very difficult for small or medium nursing homes to survive because of a number of issues that have been brought out. That's the ground reality.

Now, who is responsible? All kinds of socio-economic issues have come into the picture. As a politician, instead of starting a sugar factory, I found that it was better to start a medical college. It is a roaring business and a white-collar business. If I have Rs 500 crore, I will prefer to start a medical college because you are dealing with a good class of people. That's how so-called 'shikshan maharishis' [education experts who wield power in medical education] arose and are flourishing in Maharashtra and they will continue to do so. This change has occurred in last two-three decades in the state of Maharashtra.

As far as the role of government is concerned, primarily, we felt that it is our own house that has to be put into order rather than looking at the private sector. I'll quote a simple example: with the help of SATHI under the Maharashtra Health Systems Development Project (discussed later in the seminar), we tried to do a lot of work in having the national Clinical Establishment Act initiated in Maharashtra. We involved the private sector, we involved doctors, hospital administrators, a lot was done. And when we came to the final stages, our own health secretary asked me, 'we have so many complaints of our own government hospitals, why do you want to bother with private hospitals? First get your house into order and then let us think about all that'. The administrators, the policy-makers in the government, they were not concerned with what was happening on the private side. They were more concerned with issues discussed in the legislature; that XYZ hospital, where 10% of beds¹⁰ were supposed to be reserved, was not catering to the needs of the people. The MLAs were more interested in passing off their own relatives as poor patients than helping genuinely poor patients. The focus was geared towards ensuring that their patients are being taken care of, rather than really improving the quality of care or ensuring that the legislation is designed in such a way that the interests of the poor, the interests of the common people, are taken care of. We had a lot of meetings with the administrators of bigger private hospitals, with the health minister as chair, and we would have no response for the way they used to present the picture. They used to ask, 'have you given electricity to us at the concessional rate? You are taxing us at commercial rates, so on what grounds are you insisting on these concessions that we should give free care to the poor?'

If you speak to any of the players or stakeholders in this affair, you will find there are some very strong grounds on which their points are really well taken. We have to accept that corporate hospital culture will continue, and their sole motto is to earn money. The government's role is going to be compromised because the government has lots of problems. If you visit the medical college hospitals and government hospitals it is a pathetic situation - they have no money for medicines. It seems impossible for anyone, including the government, to find the medium through which everyone is going to be happy.

¹⁰ See Note 1.

Ramila Bisht: Dr. Malik can you share your experience with private sector as an administrator at BMC?

Seema Malik: What has happened in government hospitals is that the budget was slowly decreasing from 1970-2000 compared to what was required. You may see that the budget increased, in absolute terms, but the requirements are high as the volume of patients is very high in public hospitals. BMC runs three medical colleges¹¹ with attached hospitals; the institutions in the suburbs are general hospitals and do not have medical colleges. The expectation of patients is that the hospitals will provide the best technology and emergency care, like intensive care units (ICU), and will be run by the most-skilled doctors. The middle-class expects all this care, but the general hospitals are not able to provide it. The skilled doctors are in the medical colleges but the general hospitals cannot afford that much. A person staying in Borivali suburb cannot go to KEM in the centre of the city, so they will go to private hospital. The expectation is also very high. ' The education level of patients and the internet have made patients ask, 'why this is not being done?' The public hospitals have to try to meet their expectations and that is why PPPs were started.

Now, the best doctors expect good salary, which the government is not able to provide. So what has happened is that the BMC has started allowing the professors to practice outside the government hospital. Naturally, this affects both of us - the government and the private sector. The private sector will flourish and at the same time the public sector is not getting full-time doctors. These steps have been taken because we have to try to retain doctors in the public sector, otherwise they will leave and go to the private sector; there are corporate hospitals that are paying very well and we cannot, so naturally they will leave. Similar things have happened with the nursing schools - we have trained good nurses who leave the public sector and go into the private sector. What is happening is that the government is not able to retain good doctors, nurses and paramedics and they are leaving. So the private sector is flourishing and the government sector is facing problems.

The budget is low for the public sector. You cannot have so many medical colleges and hospitals with, as Dr. Arun Bal said, 35% of patients coming from outside the city; people coming from all over the state, and all over India. So medical colleges are overloaded and general hospitals do not have even 50% occupancy rates, in spite of being free, because the expectation is of good technology and skilled doctors, which they are not able to provide because of inadequate budgets and lack of doctors. The resident doctors are backbone of the hospitals. Resident doctors are only affordable for a medical college or for a corporate, which also offers some qualification like a Diploma of National Board (DNB), or post-graduate certificate courses. These are the things which are affecting the government hospitals, while on the other side, private hospitals have good budgets and can attract doctors.

¹¹ The three medical colleges and their respective hospitals are: Seth Gordhandas Sunderdas Medical College attached to KEM Hospital; Topiwala National Medical College attached to Nair Hospital, and Lokmanya Tilak Municipal Medical College and General Hospital.

Sriram Geet: One comment: malls and multiplexes are now attracting common people. In the same way corporate hospitals are attracting those who have money.

Seema Malik: I wish to add something about the trust hospitals, as I am now working as a consultant to trust hospitals. It was said here that the small trust hospitals don't want to make money, but they are not able to continue with that mind-set. Some of the hospitals have got occupancies of 10% because of cost-cutting and cutting down on staff. They don't know what to do so they cut the costs on staffing and now cannot secure skilled staff. They can't afford good technology either. Even if somebody donates the technology, you have to have the skills to operate that technology and they do not want to do marketing. So, these hospitals are also thinking of handing over to the corporate sector.



Session II
Growth of corporate hospitals

Session II

Growth of corporate hospitals

Ramila Bisht: I think it is time now to turn our attention to the corporate sector, and I request Dr. Sanjay Nagral to initiate the discussion of your own experience, what you saw, of the functioning of the corporate sector, and others could then join.

Sanjay Nagral: The hospital that I largely work with in Mumbai, Jaslok Hospital, is on paper not a corporate hospital, but which is attempting to be corporate. I don't even have a precise definition of a corporate hospital.

I worked in KEM hospital for almost 11 years after my post-graduation. I was asked by Jaslok to join them because they wanted to develop a certain specialisation, and I was one of the few people, one of two or three people in the city, or in the country, who had trained in that particular specialisation. I sat on that offer for almost two years. One of the reasons my balance tilted and I left KEM was because some of the experiences that I had were not very nice. It was over-bureaucratized and there was a very strong hierarchy - the word of the Head of Department would be the last word. There was no lateral entry and no scope in the system for somebody who is working more to rise up faster. We must also understand that very often an average doctor at a certain stage in his or her career wants to have a certain sort of 'identity' or 'freedom', and move away from a certain hierarchical structure. And one of the banes of public medicine in this country is the hierarchies and hugely top-down approaches. I decided to join Jaslok and this was because they were committed to developing the speciality that I was interested in and because they were encouraging postgraduate education. From day one, I was involved in developing a teaching department and in setting up a super-speciality course, and not in the classic practice as it is called.

Jaslok is situated in a part of Mumbai where the population is limited and there are lots of new hospitals. The change I have seen in the last 20 years is that they have been forced to partly imitate, change, into a more corporatized ideology. You have a big marketing department, which then attempts to encourage staff to behave in certain ways, like you have everybody trying to say 'good morning' and 'good evening'; that is a classic feature of corporate hospitals in Mumbai - all the staff are trained to say 'good morning'. The whole ambience of the hospital changes. Partly what I saw in this hospital was this change, and this change is due to the fact that they were losing patients. They called themselves a trust hospital, and they are still on paper, a trust hospital. I have benefited from the hospital's trust status because they have 20% of beds which are reserved for free and I do a lot of work in that 20%; I am the highest user of those beds.

The other point, which I have said publicly also, is that a lot of doctors are quite happy and excited by this change; this change from the small so-called 'friendly hospitals' - friendly to patients - to these big hospitals. And the reason they are quite excited is that these hospitals are offering three things. Number one is a lot of technology. I think Ravi is right in pinpointing that there is this era of specialisations and super-specialisations, involving technology. Number two is that a lot of our doctors are trained abroad; which is a common practise now. I don't know the exact figures, maybe about 10%, 20%, 30% of the postgraduates have trained abroad. When they return, and many do, they need that support in terms of technology and facilities like intensive care units, which are lacking in the public hospitals. And finally we must also remember that one of the manifestations of corporatisation is that, unlike in the past where consultants would go from hospital to hospital and were attached to four or five hospitals, a lot of these hospitals are now offering full-time jobs to doctors. They are being paid high salaries, so there is pressure on them to finance that. I think this is a good development because now the doctor is available from 9 o'clock in the morning to 6 in the evening, and there is a possibility to develop departments. In the older model doctors would be in running around between five, six hospitals. Not only was this highly commercial, but it was also sometimes substandard because the person would not be available when they were needed.

My final comment is that I think corporatisation is an ideology which is got a lot to do with neoliberal economics taking over India. It is aspirational. And whilst one is not trying to put the blame on the victims, the fact is that even medical care, for a section of the population, is aspirational. And therefore corporatisation is a combination of the temporary fascination with aspirational care and the complete retreat of public medicine. When we say 'complete retreat of public medicine', what perhaps you should know is that there is still a substantial proportion of the population – I don't know the figures but I suspect it would be around 50%, 60% – who cannot afford to even enter a private hospital. You must keep that in mind. We tend to sometimes, because of our own bias, talk largely about the middle-class and the upper middle-class, but there is a substantial proportion who cannot even dream of walking into a Lilavati or any of the private hospitals in Bandra. I still work in a public hospital as an honorary consultant, in one of the peripheral hospitals of the Bombay Municipal Corporation, and we see these patients there. There is still a substantial proportion which is being served by the public hospitals and it is served reasonably well. I tried a few years ago to investigate whether there is any good data on outcomes and results of treatment given in the private hospitals compared to public hospitals. I don't know whether anybody had this kind of data, but this assumed difference is a problem with perceptions to some extent.

To summarise, I think corporatisation, though we don't have a good definition, is an ideology, and is aspirational, accompanying the changes in India. As the rest of the aspirational ideological change is reaching a crisis point, so the corporatisation of medicine is also reaching a crisis point.

Amar Jesani: I wanted to comment on the expansion of the private sector during the 1970s and 1980s. I have never seen medicine from inside because I never practised medicine, neither in the public sector nor private, except when I was a medical student in Baroda, Gujarat. The rest of the time what I saw in medicine and development of healthcare sector was as an activist who was in conflict with the system - I came to be known as a renegade doctor by my classmates from the 1970s. I entered medicine in 1973 and finished in 1979. Gujarat is somewhat a continuation of Bombay and what I saw there confirms what Ravi was talking about - that the establishment of private sector and its initial roots have to be seen in the 1970s. The 1980s was a phase when the private sector became hegemonic.

I saw two major phenomena when I was a medical student. One was substantial exploitation of the public sector for private purposes, which I am sure is a highly documented issue, as doctors who work as honoraries are bringing their private patients to the government hospital. As a medical student you learn from your registrar and the postgraduates who tell you 'these are the patients of the boss and so we have to work hard'. I don't know whether anyone of you had that kind of experience in 1970s - to run around because you have private patients from whom you are taking money but they are being treated through the public hospital? It was the same as influential people exploiting the system; bringing their relatives to the hospital. That was one area that struck me when I was a medical student.

The second was that complete saturation of the public system took place. The doctors were no longer being absorbed into the public system in significant numbers after education. From Gujarat about 70% of the doctors used to migrate out of India and from my class about 80% must have left India. I wanted a government job but never got one, even though the government had taken a bond from me when I joined the medical college, stating that I will have to serve for five years in the medical college, in the public sector. But I never got a job. During my study I remember the ethos of my classmates, and being told by our seniors, to 'prepare yourself for the private sector - learn to be a businessman'. This was what was taught all the time. One thing I found during my days at medical college was that as the examination days approached, private doctors would be organising coaching. You would go to their small hospitals or clinics and they would organise these classes. There would be about 120 students in a jam-packed small room, where these doctors would explain how medicine is practised and how to answer the questions. They also had connections with the medical college. At that time I was left with the impression that I have to learn to be an entrepreneur if I want to survive in medicine. This was the 1970s, where entrepreneurship as a general practitioner or as a specialist running your small hospital, was inculcated among the students and that continued.

I came to Bombay in 1979 and interacted with many of the doctors; Sanjay Nagral was one of them. KEM hospital was the place where I would go quite a lot and, JJ hospital.¹² I found that similar things were happening here as they were in Gujarat. But during the 1980s, I also

¹² Sir Jamsetjee Jeejeebhoy Group of Hospitals refers to four hospitals in South Bombay: Sir J. J. Hospital, St George Hospital, Gokuldas Tejpal Hospital, and Cama and Albess Hospital (women and children hospital), attached to Grant Medical College. These are operated by the Maharashtra state government.

saw a few areas here that were very different from Gujarat. One was the big trust hospitals. As an activist we always looked at Jaslok Hospital, Bombay Hospital and Hinduja Hospital as corporate hospitals. I became a more serious researcher after 1983, and I realised that these were non-profit hospitals, which were run in a corporate manner. For me at that time the concept of a corporate was that of an institution which is running in commercial manner as compared to the government; and where only certain kinds of people can go because these institutions are very costly. I don't think that it was very cheap. But at the same time, as an activist who didn't have much income, I used to go to small charitable hospitals run by religious trusts and other such bodies, which were very cheap. For Rs 5 you could have a consultation with a doctor and if you are hospitalised then the charges will run into hundreds, but not thousands, of rupees. So there were these two different kinds of non-profit hospitals that I encountered.

I saw that Mumbai, at that time, had mostly trust hospitals; corporate hospitals were set up only after the 1990s. I used to work in the Foundation for Research in Community Health in Worli, and I used to commute from Borivali. I remember quite well the advertisement boards of various kinds of diagnostic companies coming up at that time along my commuting route. In the 1980s, I started studying the private sector and having more interactions with it as I saw a movement developing around the issue of irrational practices. One of the areas of my interest as a researcher was to see how the private sector was accumulating capital in order to set up their institutions and found that much of the economy in the private sector was a cash economy, even up to 2005. When I went for my hearing aid to a very famous doctor in a 5-star hospital, he said, 'I will not take your cheque for 25,000 rupees for the hearing aid'. So, I saw that cash economy was very strong and it has a direct connection with cut-practices, cash-for-referral arrangements. I think cut-practices emerged in Bombay in the late 1960s, early 1970s, and during the 1980s they became institutionalised, systematised. I know that quite well because in the 1980s we started the whole campaign on medical malpractices and negligence and many patients told us about problems within medical practice, for example about a doctor who runs a low-quality ICU in a suburb. That was another area we were fighting about - the quality in the private sector. Non-MBBS doctors were employed in ICUs, as doctors in the casualty departments, and in one case, when a hospital owner suffered cardiac arrest, he said 'don't treat me in my hospital, take me somewhere else,' but there was a delay and he died.

These were the kinds of stories that I remember from the 1980s; an entrepreneurial class was emerging within medicine and they were using the same means that any trader would be using. I think this is one of the reasons why, when a transition takes place from entrepreneurs running small hospitals, to corporate hospitals, there is no real clash between the doctors and the corporate hospitals. Everybody complains but everybody complies with it because there is an entrepreneurial culture that has developed and is very much part of the corporate model. People running small nursing homes are exploiting people. I remember having a small fracture and going to an orthopaedic in Borivali at night, and he charged a huge amount of money, knowing full well that I am a doctor. That was happening in 1980s. In 2000 when the corporate hospitals come and they are charging large fees, they are not taking money directly so we have less of an ethical problem; in corporate hospitals the fees are taken by a billings department but in the

small nursing homes the doctor himself is saying, 'give me this much of money then I will put the plaster on for you'.

The other part that I saw is the process of capital accumulation. I had only a few personal experiences of this. In Bombay, the 1980s was a decade of gang wars, with the rise of Dawood Ibrahim and others, so this was a time when there was a lot of black money circulating. A couple of doctor friends of mine were setting up their nursing homes at that time; 5-bedded, 10-bedded, 20-bedded nursing homes were being set up in the residential apartments constructed by co-operative housing societies. The builders and the underworld had very strong connections and you needed to have one floor in the apartment complex in order to open your nursing home. I found that many of those nursing homes, at least the few that I looked at, had a direct partnership with the builders; that's how the money was raised. It may cost crores of rupees. I saw that the ones that were raising their own capital were those doctors who were from upper castes and the strata, which had a very high social capital that they were able to mobilise. I look at my classmates and those who have set up hospitals - they were poorer than I was and still they were able to raise money, because of their connections within the caste system or the religious system. You can talk about malpractices, you can talk about cut-practices, you can talk about very arbitrary pricing systems, but it is also very important to look at where the money came from.

Ramila Bisht: We see that corporatisation has taken place, but there are other kinds of trends that you've seen. You see a consolidation of hospital chains happening and certain hospital chains are now moving to tier-2 and tier-3 cities.¹³ If somebody would like to reflect on those trends, maybe share their own experiences or experience of their hospital?

Avinash Kulkarni: See, there is probably some connection between the government requirements for setting up a hospital and why these hospitals are successfully going to tier-2, tier-3 cities. The reason I think is that, as we practice Western medicine the standard Western requirements for a hospital were blindly adopted by our government. For example, imagine a doctor raising money from relatives, friends or religious circles, and then buying a place and setting up a hospital; for that hospital to be viable it has to have a certain number of beds. The government requirement of 150 sqft per bed is arbitrary and came directly from Western standards. We could have adapted, rather than adopted, the system and made it more practical for the conditions in which the doctors are working in small towns. That's where most of the people go to start their own practice now because big cities are completely unaffordable. When this rule about area started being implemented in the last 15-20 years, nursing homes and smaller hospitals became less viable. That is why they started closing down - because it was not affordable. They were not given permission to add more than a fixed number of beds and it was not viable. So they had to have a bigger building and invest more money, otherwise drop out. There should have been some adaptation from government side - that 150 sqft per bed is ideal, but if you are doing this kind of practice then 80 or 90 sqft per bed will be acceptable. This is why the number of practices started going down in 2-tier, 3-tier cities and a vacuum that has been created that allows corporates to

¹³ Classification by Reserve Bank of India, of cities based on population size: Tier 1 – above 100,000; Tier 2 – 50,000 to 99,999; Tier 3 – 20,000-49,999

enter. It is much cheaper for corporate hospitals to do business in the smaller cities, with less capital investment, and the doctors who could have otherwise started their own clinics now have to join those hospitals.

Ramila Bisht: Is there not also a possibility that these corporates find that the market is quite saturated in city of Pune or Bombay, and therefore they feel the need now, to spread out into tier-2, tier-3 towns? And also, the money available with the citizens of those cities is now better and they can afford these hospitals? Has there been some experience of anybody who has been part of a hospital which has spread itself outside Pune or Bombay?

Subhash Salunke: I don't have direct experience, but I know a few colleagues. Sahyadri Hospital is one chain, or one group, which has expanded within the city of Pune and even outside of Pune. That is one success story, you can say. I interacted with Dr. Devi Shetty - he has not set up hospitals in Pune or Mumbai but I have heard of Devi Shetty's experiment in South India,¹⁴ and in also the North Eastern states where I work with different state governments. Devi Shetty has been able to generate revenues, without much compromise; 'much' is my word, which he doesn't like - he says he doesn't compromise with the ethics. The experience of Devi Shetty's kind of hospital chains seems to be that it has not only survived, but it has expanded with the framework of proper hospital management principles; even though I have not seen it functioning in Maharashtra. I had invited him to set up in Maharashtra.

The point that I am trying to make is that there are very few success stories in this sector because of a number of difficulties. The moment you go outside major cities like Mumbai and Pune, then you come across serious problems as far as human resources are concerned. The doctors employed in the private hospitals are all Bachelor of Ayurvedic Medicine and Surgery (BAMS) doctors¹⁵ – none of them are Bachelor of Medicine and Bachelor of Surgery (MBBS) – and they all provide allopathic care. All or majority of the nurses employed in the private hospitals are either Auxiliary Nurse Midwifery (ANMs) or some kind of other courses; very few have done BSc Nursing or a three year course, as per the nursing law. A BSc nursing graduate is going to insist on at least Rs 20,000, which private hospitals can't afford to pay. And MBBS doctors are not available for less than Rs 50,000, whereas these BAMS doctors are available at Rs 8,000, 10,000, 15,000. This seems to be one of the major reasons why the propagation of the hospital chains is not occurring outside the city, because running a corporate hospital itself is fairly challenging.

14 Dr. Devi Shetty is Founder and Chairman, Narayana Health (NH) group of hospitals of Bengaluru. In January 2016 the group had an initial public offering on the Mumbai Stock Exchange. Since 2017 NH is managing a children's hospital in Mumbai, built on the land of the SRCC trust and with large donations from industrialists and other wealthy people in Mumbai. As of 2018 this group was reported to encompass 23 hospitals, 7 heart care centres and 19 primary care facilities across 14 cities in India and to be in the process of establishing hospitals in Africa and Cayman Islands.

15 Ayurveda is an indigenous system of medicine in India. While practitioners of allopathic or 'Western' medicine hold MBBS degrees, practitioners of ayurvedic medicine hold BAMS degree. Nonetheless the latter often prescribe medicines used in allopathic practice in what is referred to as cross-practice.

I have seen one example, very recently – that of Jupiter Hospital, Thane, has very successfully opened a hospital in Baner, Pune, and they are doing a fairly good job. The reports that I am getting from colleagues and colleagues' relatives is that they seem to be happy with the rates and the quality of service.

Sanjay Nagral: I want to flag an issue that Avinash Kulkarni brought up, which is that regulations, or attempts to regulate medical practice, have perhaps promoted big hospitals and corporate hospitals. It's a theme that keeps recurring - that too much regulation is killing small hospitals, killing nursing homes, and therefore indirectly it is promoting corporatisation. I just want to share the experience that I had when I was the member of the state government committee for the Clinical Establishment Act. There was a big campaign at that time, specifically by the Indian Medical Association (IMA), which is largely run by small hospital owners, to say that the Clinical Establishment Act is a conspiracy by big hospitals to kill small hospitals. I was attacked many times by my colleagues. But in the committee even a suggestion of standard treatment guidelines was completely opposed. This narrative that regulation promotes big hospitals and therefore has indirectly promoted corporatisation is a very tricky one because we are the very people who opposed corporatisation, but at the same time also support regulation.

Avinash Kulkarni: I have one observation about corporate hospitals regarding the way they function. There are two models I have seen. One is like Birla Hospital, which came from some extra-terrestrial space and lodged itself in Pune without allowing any of the Pune doctors to work there. They just got everybody on their own initially.

Sriram Geet: It was related to medical tourism

Avinash Kulkarni: Yes, that was the idea. Those who had some foreign degree or had worked abroad were brought in. Pune doctors were not entertained by Birla at that time. It went on for a while and then it started deteriorating, because most of the consultants who came from Bombay, from US, from UK, after some time they had no work and they started slowly deserting the hospital rather than working full-time, saying 'I'll come part-time' or 'I'll work there as a consultant'. Slowly, that model didn't work. The second model was that of Sahyadri hospital, where I worked. What they did was to go to a new place, set up a hospital, and get nearby doctors to run the hospital. That kills the small nursing homes but at the same time gave some avenue or some space to the local consultants. You have to ask 'which Sahyadri are you working with?' because even within Pune itself there are six Sahyadri hospitals. Patients would ask me, 'to which Sahyadri I am supposed to come?' If the hospital is in a suburb then it is mostly run by the people around them. This model seems to be working in some ways, whereas the other model – you just plant it there and invite doctors and patients from all over the world saying that we have this state of the art technology – does not care about locals but ultimately they had to depend on the local population as medical tourism never picked up in that area. There were these two models: one slightly beneficial to the local medical fraternity, the other probably not.

Ramila Bisht: What about consolidation of hospitals. Do you see those kinds of trends? Mergers and consolidations taking place?

Sriram Geet: Corporate hospitals or even Sahyadri hospital looked towards sick hospitals, so did Vitalife. Jahangir has opted for the same model in Pune - they have taken over at least two or three hospitals. They look for a sick hospital, contact them, start running the show and make the owner a medical director, the way Avinash said. But that has flopped at Nashik, at Bibewadi, at Nagar. So it is not that this model will always work.

Amar Jesani: I think the market never gets saturated in health - it is the issue of how they find market that is very important. As long as you continue finding markets, everything remains sustainable. How do they network and try to get the patients for their corporate hospital? That is very important to look at. You will find that India has a culture of people going from small cities and villages to the big cities, and that's where the networking comes in. If you have seen the Cobrapost exposure,¹⁶ what it shows is that it is not about doctors having cut-practices, but how the institutions actually network and create the markets. That's very important to make them sustainable.

The restructuring that you are talking about is already taking place in a way. When we talked about trust hospitals being taken over by corporations, like you have Nanavati, you have HN hospital, it's not a formal merger, it's a takeover.¹⁷ This takeover is possible because there is a peculiar history of the large trust hospitals which are controlled by certain families coming from certain communities. Different communities set up these hospitals. If you look at the early 20th century, the different communities set up their own hospitals and they had control. When you are exhausted and if you are not really able to run the hospital, you are not able to put your charitable money into it, then you sell it off. And that restructuring is definitely taking place. I think Bombay is in many ways very different from the national trend among metropolitan cities as it is a city of migrants where different communities came.

Another issue of interest in the 1980s was the attempts by users to set up services. Bombay has a co-operative hospital model where users can participate and have some control over the hospitals. A particular community sets it up – like the Brahmin Sabha¹⁸ running hospitals for the Brahmins, and the Parsi community doing something similar. They all stopped in 1980s. I remember, we tried to work out a plan to set up a very ethical hospital in the early 1990s with the help of some of our American friends. At that time we realised that most of these pro-user attempts, where users participate in running it, had all failed and are all facing crisis - either they were being changed or being sold.

16 Cobrapost is an Indian non-profit news website, which reported in 2017 on the large commissions given by large private hospitals in Delhi, Mumbai and Bangalore to doctors and smaller hospitals, in return for referrals. See: <https://www.cobrapost.com/blog/cobrapost-expose-operation-white-coat/948>

17 Nanavati Hospital entered into an operations and management contract with Radiant Lifecare Limited, a hospital management company based in Delhi. The management of HN Hospital was taken on by Reliance Foundation (see Note 1). The hospital itself has not been acquired but rather has seen changes in the way it is managed. Trust hospitals cannot be sold.

18 Forum of Brahmins, the upper-most caste in the caste hierarchy among Hindus in India

Ravi Duggal: Just to add to what Amar said, insurance also plays a very important role for expanding corporatisation, because that's where the clientele is. Regarding consolidation, I was doing a costing study in Pune district and specifically in Saswad Taluka (Pune district) in 2004 or 2005. I found that five or six smaller nursing homes were actually coming together to form a 100-bedded hospital. They had realised that they could not function independently and needed certain economies of scale, given the new technology that was coming in. So they set up a 100-bedded hospital with one orthopaedic specialist, one gynaecologist, one surgeon, one physician and so on. That is the kind of transition that one was seeing.

I think the next transition that we are going to see is the emergence of branded chains of hospitals in a big way. As a consultant I keep getting phone calls from the US asking me about the feasibility of setting up chains in tier-2 and tier-3 cities. There is Devi Shetty setting up a chain, and there is Fortis and Wockhardt, but you are going to see a much larger phenomenon where these branded hospitals move from the metros and other larger cities to smaller towns. Another interesting thing about Mumbai is, even if you look at the public hospitals in Mumbai, they started with capital from merchant capitalists.

Amar Jesani: They handed it over to the public system.

Ravi Duggal: They provided the initial capital to set it up and then handed it over, they even provided running expenses for few years until the municipal corporation was able to take it over fully with its resources.

Amar Jesani: It is connected to the nationalist movement.

Ravi Duggal: That is a very interesting feature and continued right up to the 1960s. In the 1970s hospitals emerged with the bourgeois capital provided by business houses. Breach Candy Hospital was set up by Godrej, Jaslok by the Chanraj Group, and Hinduja by the Hinduja Group, and they were very different in character from the older charitable hospitals like Sarvodaya Hospital in Ghatkopar. Sarvodaya was genuinely charitable but these others were not really charitable - they were working with market-based costs and such features. So, a very different trend of hospitals emerged post-1970s and one sees a complete change from a genuinely charitable approach to the new trend for corporates, and now all these old hospitals are gradually entering that mould also.

Sriram Geet: On the topic of co-operative hospitals, 15 doctors and 15 paediatricians came together at Karad to start a hospital, where the services are shared among them, and they have run it successfully for the last ten years. Another hospital to be mentioned is Hedgewar Hospital in Aurangabad, and Vivekananda Hospital in Latur. About four months ago, a linear accelerator was installed and inaugurated at Vivekananda, so they are flourishing.

Ravi Duggal: Hedgewar has expanded to Nashik and Assam.

Subhash Salunke: I think these three hospitals, which are run by religious organisations or are fully dedicated to charity, are totally different from a corporate hospital. Their principles are different and they are being run by people who are totally dedicated. Can you imagine a doctor-couple earning Rs 15,000 a month and running this hospital for last 20 years? That cannot be seen in Hinduja Hospital or hospitals run by corporations. These three are examples, where dedicated ethical practices are possible if we have people like that.

Sanjay Nagral: Like these three hospitals in Maharashtra, we have a history of missionary hospitals like Christian Medical College (CMC) in Vellore and St. John's Medical College in Bangalore. When you have faith-based, ideology-based hospitals obviously you produce a different type of culture; the doctors who are working in such hospitals are probably working with a certain ideology of the mind. Whether that's a good thing or not is a matter of discussion.

Since there was mention of co-operative hospitals in Mumbai, there is one such hospital - Shushrusha Hospital I work at. Its history is that a gentleman called Dr. V.S. Ranadive from the Congress Party – in order to help the middle-class of areas like Dadar and Prabhadevi to get healthcare at a relatively cheap cost – decided to have this co-operative hospital where people got shares. I have been working there for the last 15 years or so. I joined with a lot of hope because I thought it's a co-operative hospital, but my hopes have been partly not realised. It's the same reason again - I think that they have also realised that to continue to function they have to change their strategy and unfortunately that means imitating the larger private hospitals: earning and sustaining a hospital by volumes, as in the Devi Shetty model, the Yashaswini scheme model and similar. In a city like Mumbai, it is difficult because there is demand for technology, so the consultants ask for these facilities. For many years Sushrusha did not have an in-house CT scanner and consultants were saying that 'unless you buy a CT scanner we cannot work here', or 'we cannot bring our patients here'. Then the cost factor comes in. There is an ICU which I think is about 20% cheaper than other large private hospitals I work in, but when I started it was 50% cheaper. Recently the management there asked me why I was not doing much work there and I said, 'because you are no longer distinguishable from the other big hospitals I work in'. That's the problem - the alternative models have to be subsidised, for example by money that comes in from the Church, or in the case of Hedgewar Hospital, it could be from the Rashtriya Swayamsevak Sangh (RSS).¹⁹ Otherwise these models need large volumes, like Yogesh Jain who went to work in Chhattisgarh on a non-profit basis.²⁰ Any attempt to create alternative models either has to have a high subsidy from somewhere, or it fails because it is competing in the same market as bigger hospitals.



19 The Rashtriya Swamsevak Sangh (RSS) - National Volunteers Organisation – is a right-wing Hindu nationalist organisation in India.

20 Dr Yogesh Jain is one of the members of Jan Swasthya Sahyog (JSS), founded in 1996 by a group of health professionals during their postgraduate studies at the All-India Institute of Medical Sciences (AIIMS), New Dehli. JSS has developed a community-based healthcare programme in Bilaspur district of Chhattisgarh in central India. See www.jssbilapur.org

Session III
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Subsidies to private and corporate hospitals and their implications

Ramila Bisht: Following on from this subsidy issue, the government has, over the years, given a lot of concessions to the corporate sector, for example in the form of tax breaks. Initially, when different equipment was imported into the country import duties were not levied on them. Land was given at concessional rate, tax breaks were given, then FDI was opened up, and the insurance sector was opened up. So there were lots of government measures in the forms of different concessions for the private sector. Dr. Salunke, in your opinion how have these contributed to the growth of the private sector?

Subhash Salunke: I think that's history now. The government doesn't give any land concessions in cities like Mumbai and Pune because the government itself doesn't have land and is facing difficulties expanding hospitals in these two cities.

Ravi Duggal: Now they give extra Floor Space Index.²¹

Subhash Salunke: They'll give extra Floor Space Index. But for that too there are lot of riders, a lot of difficulties and politics. These so-called concessions, which were once upon a time fairly prevalent, are not given now.

Ramila Bisht: But at that point of time, did it not give a boost to the private sector?

Subhash Salunke: It did. I've signed a lot of papers to get their equipment free of cost. But all these concessions have slowly dwindled. If you have to set up a big hospital now in these two cities, or even for secondary cities like Thane or Aurangabad, these concessions are practically not available. But these bigger hospitals now have to independently earn their own money. Things are now changing between the government and private sector, thanks to the approach of the existing government. There used to be always suspicion between the two: the private sector would accuse us in the government of corruption, and we would say that 'you show us that 10% quota for concessional care but actually you earn money out of that'. That used to be a routine kind of dialogue between these two sectors, but I am told now that it is slowly going away. That's a good thing.

²¹ Floor Space Index (FSI) or Floor Area ratio refers to the ratio of the livable area on all floors of a building to the area of the plot of land on which it is built. The permitted FSI is set by the Development Control Regulations for Mumbai. It refers to the extent of construction, height of building on a given plot of land. In view of the shortage of land in Mumbai, the state government was considering making concessions in FSI to enable hospitals to expand.

But the point that I am trying to make is, these concessions to begin with in these two cities were to a certain extent helpful, but it did not last long. Even fulfilling this 10% concession is seen by private hospitals as a burden and they try to do away with it; they try and show they have given concessions for 10% of beds, but it is for their employee's relatives. This was destroyed when I was there. My minister and I said that you will admit only referred patients from public hospitals, for example 10% of the patients at one trust hospital will come from GT Hospital for concessional care, or in another trust hospital they will come from JJ. But that didn't work because none of the patients from JJ were keen to go to Jaslok. They said 'who will take care of the remaining expenses we have in that private hospital?' The concessions that were given to the private hospitals were initially useful but now-a-days they don't have any relevance.

Ramila Bisht: Dr. Ambardekar, what about Asian Heart Hospital? Would you like to go over your experience of that corporate hospital?

Shekar Ambardekar: It's a full-fledged private hospital, but is not a corporate hospital. It is a trust hospital run by a board of trustees. The trust has its own money that does not come from anywhere else. In that respect, it is like any other corporate hospital as they must generate their own revenue. So they have to see that they are up to date because they have to give the most modern facilities to all the patients. As far as patients are concerned, only those who can afford it can get treated there. Whatever initial concessions may have been given to the hospital by the government, they have not continued.

Ravindra Karanjekar: As far as the concession issue is concerned, I happened to be associated with almost all hospital groups of this country, right from Chandigarh to Chennai. Our experience is that hardly any concession is given, either in terms of concessions on land, electricity or otherwise. The concession you talked about were primarily for the hospitals which were doing charity for 10-20% of the patients. But all corporate hospitals in the city of Mumbai, Delhi, or even in Chennai, they had to shell out their own money to buy the land, to build the hospital and get the patients; there was not much government help. There may be some soft support in terms of getting some permissions and such other things, but I don't think concessions are used now. No private hospital is on government concession. The hospitals generate their own money and they invest their own money.

Secondly, about the alternative models, I would say that healthcare across the country will cost the same, except for manpower cost. Consumables and other things are the same for all hospitals, whether we are running a charitable hospital, trust-run hospital, missionary hospital, RSS hospital, or government hospital. The difference is in the money that is paid to the doctors - some are paid Rs 10,000, 15,000 in a private hospital, some are paid more. To attract good talent, the hospitals have to pay the money. This is the only difference for hospital costs. Who subsidises the costs is a different question: either the government or municipal corporation subsidises it, or there is a charitable trust or religious trust. The money has to come from somewhere, but it is spent in the same way.

Now, the thing is that, as Ravi said that, around the 1970s and 1980s, there was a considerable change in the healthcare scenario in India. At that time, there were charitable hospitals, largely by charitable trusts and religious bodies, and the treatment available was at the primary and secondary levels. That is where Shushrusha hospital comes into the picture. Much of the treatment provided in the name of charity was generally at primary, secondary or higher-secondary level; high-end medical treatment was not available and it was also not happening in government sector for almost 10-15 years. The first heart transplant in India was done in the government hospital in Mumbai²² but it was 35 years before it was done again in Mumbai, this time in a private hospital, in Fortis Hospital. Government hospitals couldn't carry out the procedure further as they lacked the resources, skilled manpower or infrastructure. Such was the state of affairs that in the 1970s or 1980s, when I was leading some of the few big hospitals like Lilavati, some of the patients needed to be sent from Mumbai to other places, because the treatment was not available. Even the cardiac patients or ophthalmic patients, were sent from one place to other.

Ramila Bisht: Dr. Karanjekar, because you had such a long experience with setting up different corporate hospitals, working with almost all corporate groups, could you reflect on the transitions and transformations that you have seen in the corporate sector over these years?

Ravindra Karanjekar: Corporate hospitals generally started as a single speciality hospital, though this is not true for all the corporates. Primarily, a doctor who had a big name and reputation, who was well-known in the society, had a group of friends and enough money to put into the hospital. These doctors started the corporate hospitals. That is how Asian Heart developed, and Dr. Mandke's cardiac institute and Dr. Trehan's Escorts Hospital [in Delhi]. We had a discussion at that time, around the 1980s, with Dr. Ramakant Panda. Our group had some doubts about the financial viability of single speciality hospitals after 5-10 years because they concentrate on a single speciality and revenue sources dry up or remain static after some time, while the expenses keep on mounting. So you need to change to a super-speciality hospital. From 1980s to 1990s, to 1995, 1996, you saw the change: hospitals moving from single speciality to multi-, super-speciality. And from multi-, super-speciality, they went to the quaternary type of care, where you have transplants and other such services.

Treatment was initially regional or national. If you consider cardiac bypass surgery: in 1996 we were doing it at Lilavati in Mumbai, and people came from across Maharashtra to get that bypass surgery. Over the next 20 years, hospitals in Pune started doing the surgery and now hospitals in smaller cities like Kolhapur and Solapur have also started doing it. It has percolated from Mumbai to these other cities. This has dried up the flow of patients to the main hospital in Mumbai, so they have to get the expertise of level-8, -9 and -10 surgeries: heart transplants, liver transplants

22 The first heart transplant in India was attempted in 1968 at the KEM Hospital in Mumbai. The first successful heart transplant was done in 1994 at All India Institute of Medical Sciences Delhi (AIIMS). Both of these are government hospitals. See:

Jones, S.D. and Sivaramakrishnan, K (2018) Transplant Buccaneers: PK. Sen and India's First Heart Transplant, February 1968, *Journal of the History of Medicine and Allied Sciences*, 73(3), pp 303–332; and

Venugopal P (1994) The first successful heart transplant in India, *National Medical Journal of India*, 5(4), pp213-215.

and similar major surgeries. For that type of surgery you need high-cost expertise, really high-cost. When doctors with such expertise come from abroad to settle in Mumbai or Delhi or some other place, you need to create the appropriate infrastructure. Such a surgeon will not work in an operation theatre where he must make any compromises or adjustments regarding infrastructure and equipment; because that puts the life of the patient at risk. The doctor will just leave that place. Over the last 7-10 years, 350-400 bedded hospitals were being set up for this.

In the last five years there has come an onslaught of government regulations. Certain provisions have been made compulsory for private hospitals and government insurance schemes have been introduced. Under this new scheme – Ayushman Bharat – and even in the previous insurance scheme RSBY, you had to treat the patient at a very low cost that is not affordable to the hospital. If the hospital does not adopt the scheme then it will lose a large chunk of society - about 50 crore people from this new scheme would be out of the purview of the private sector. Our thinking – among CEOs and others in the healthcare industry – is that you need to have a no-frills hospital where the rates are same for everybody and investigations are the same for everybody. But, this hospital might be set up as an adjunct to the existing hospital, not as a primary part. This will be a transition: eventually most of the groups will have similar hospitals in tier-2 or tier-3 cities, and in tier-1 cities they will have a super-speciality hospital where you will be treating about 100, 150, 200 patients for super-speciality care to generate the money.

Ramila Bisht: Are there any members of the audience who have a question for the witnesses?

Arun Gadre: I have owned a nursing home and I belonged to a lower middle-class family. Many of my friends were like me and we had only our skills and education. When I went to ask for the loan, because I had no money, the branch officer in the bank in my town told me, 'doctor, you are most welcome.' Then I realised that Indira Gandhi's nationalisation of banks in 1969 was helping me.²³ It became very easy in that period, when I started my hospital in 1990, for all of us, lower middle-class, to get a loan. The branch officer told me that the doctor's loan is the safest loan, as 100% of doctors returned the loan. That was one of the important factors, a game-changer, because other types of loans were not available to me. If doctors like me could not set up their own small hospitals, we would have all been working in the state health department, under Dr. Subhash Salunke.

Secondly, as Amar has said, I used to count the notes and the money every month, every day. We were doing both roles together: we were surgeons as well as entrepreneurs. Then patients started demanding more, and to keep up with the competition we had to invest in technology. As Dr. Arun Bal said, the community's expectations were changing. Those who adjusted to this reality very early became successful entrepreneurs and then many doctors also came together to form multi-speciality hospitals. The multi-speciality hospitals were funded by the contractors, by the politicians. So investors providing money and expecting returns is not new.

23 In July 1969, then Prime Minister of India, Indira Gandhi, nationalised 14 major commercial private banks.

Abhay Shukla: Regarding the concessions, I think one very important source of subsidy we have not mentioned is medical education. Perhaps all the doctors sitting here were educated in public medical colleges, if I am not mistaken? I am not talking about the younger generation in the room, I am talking about the older generation. Today, if we take the total number of doctors practising - about 70%, at least have been educated in public medical colleges. This is a huge subsidy. The trend after 2000 has been towards private medical colleges and today approximately half of the medical colleges are private. But the entire older generation, all the senior super-specialists today, probably 90% were educated in public medical colleges. That is a huge subsidy which is invisible. They were educated at public expense, and now they are working in the private sector. Let us not forget this important form of subsidy.

Subhash Salunke: Ravindra Karanjekar and I paid fees of Rs 150 per term at B.J Medical College in Pune

Abhay Shukla: Exactly. I was at AIIMS. My fee was Rs 60 per month. That is a huge subsidy.

The second point that came up, like Arun Bal said, is that some good doctors should have set up an alternative model of low-cost care. But we have been hearing how most such experiments have not succeeded unless they were subsidised. Either the subsidy may be a self-subsidy, where very skilled doctors offer their services at low costs, or it may be social subsidy where some religious, or other non-governmental setup, puts in the money. But some subsidy is required, otherwise, in the pure market framework, we are paying commercial rates to senior specialists and doctors. Those kinds of models have by and large, not worked. There is a structural logic which is operating in the way in which hospitals either survive or don't survive in the market. If it's purely working according to market logic, the hospital must do certain activities, otherwise it has to be subsidised in some form, directly or indirectly.

Arun Bal: Regarding subsidy of education, and studying in a government medical college such as that of JJ hospital, then why are we working in the private sector? I worked for five years in JJ, as an assistant professor, and associate professor. The reasons why I left JJ are the same as those pointed out by Dr. Sanjay and which will be the experience of Shekar also. I had no influence among government officials, and every year I was transferred. When I was transferred to Ambejogai [small town in a rural district of Maharashtra] and I went there, what did I find? In the ward there were dogs and sheep. And I was supposed to do surgery there? I was disgusted and quit. This is the reason we left; not by choice, we were forced to leave government service. This subsidy was given to us by the government, but the government was not willing to give us a proper job and job satisfaction. That is never documented. People only say, 'you have been given subsidised education, but you left the government hospital'. But why did we leave? Why did Dr. Sanjay leave KEM? This is something which needs to be documented. The government has never been able to retain their staff. The government was never interested in healthcare. I remember that doctors used to be transferred like a *Mantralaya* clerk²⁴, every year. As a surgeon

24 Mantralaya in Mumbai is the administrative headquarters of the Maharashtra state government

in a private hospital you can establish your reputation and stay there, but in government service you are transferred to another place every year.

Shekar Ambardekar: Subsidising medical education for individual doctors is one thing, but those doctors are not the ones regulating the medical field. All the doctors who are trained in government and municipal institutes do a lot of charity in their own private practice, because there they can control their own activities. I have some patients who come to me for consultations and they pay very low fees. For example, one patient is a domestic worker who takes pride in paying me Rs 50 when I have done a full consultation and electro-cardiogram. I am not the only such example. There are many doctors who charge very little for consultations where they can control fees. Now, we are talking about the entire medical scene today, which is not in the control of the doctors. If it was so, maybe we would have seen a different scene.

Avinash Kulkarni: It's not unique to doctors, even engineers were subsidised, all other education was subsidised.

Shweta Marathe: I have one question for Dr. Avinash. In Pune there are several examples of group practice. When we interviewed doctors in our study, many have suggested that, in the context of challenges in the present situation, group practice could be a good model and a good option. So, can you share your experience about this and any challenges this model has?

Avinash Kulkarni: I tried hard to develop group practice but I have not been successful. I think we are too egoistic.

Sriram Geet: The answer is very simple. The group disappears within say about five years. That is the reason. In the case of one large orthopaedic hospital in Pune, the group was distorted when someone's son joined. The same thing happens with every group - a new batch joins and distorts the older group.

Ramila Bisht: We are going to continue on the topic of the corporate sector and I was wondering if Dr. Karanjekar would share his experience of setting up one corporate hospital: the finance part, the government part, the regulatory part?

Ravindra Karanjekar: I have been part of setting up several hospital groups: Fortis, Wockhardt, Global and Jupiter Hospital in Thane and Pune. I will talk about Global group. We started the hospital from scratch. Global group is a different model wherein the practising doctors are partners. It is one of the successful models in Indian healthcare. In the other hospitals that I started the investment primarily came from either investment houses or rich people who were non-doctors - they put in the money and they expected returns on investment. I had an opportunity to go with our chairman from Wockhardt for a major meeting where most of the people were entrepreneurs and top businessmen. I thought they would talk about returns on investment, but they talked about returns on investment per square inch; they were not bothered about what was set up in that square inch – whether it was an IT set-up or a garment/leather factory or a medical

facility – their mindset is that you have a 2 lakh square feet building so how much returns are you are going to get out of that?

My experience is different where people with medical backgrounds invest money in setting up hospitals. Fortunately, Global group was such a model. The five investors, the partners, were well-established doctors – Dr. Ravindranath himself and four other partners – and our Metropolis Chairman was a doctor. So the approach and attitude towards the patients and the hospital was much different from that of previous hospitals I've worked with. But this hospital had definite investment issues. At some point of time, they had to sell the shares as finance for this type of hospital is generally an issue when it is in the middle-stage of growth: they underestimate the cost of the place and they spend a lot on brick and mortar rather than equipment. They say in phase one we will do this, and in phase two we will do this. In phase one you are bringing in machinery and equipment but phase two never comes.

As far as hospital revenue is concerned, my experience in all twelve hospitals that I have started is that there were only five or six main earners in the hospital. In any of the big hospital, 85-90% of the revenue was generated by four or five people; the remaining 150 consultants hardly made 10%. So you identify those valuable areas and concentrate on them.

Investment in hospitals is not about investing in marble, glossy paints and furniture. Those are required, but primarily one should be talking about the equipment and infrastructure for medical services. If you have good infrastructure, doctors will be attracted to the hospital. While establishing Global, over two years, I used to go to Chennai, Hyderabad, Bangalore for two days of the week and for three days I used to be in Mumbai. I was there when the first brick was laid and it was built over 2.5 years. This project was delayed by about 6 months and each day's delay meant a loss of Rs 25-50 lakhs per day, so delays should be avoided.

The biggest challenge for this hospital, apart from finance, was attracting good, skilled staff. How do I lure the top doctor in the market to come to my hospital? The doctor is earning a lot of money already, so this is where medical infrastructure plays a role. I talked to the top cardiologists in Mumbai and offered them Rs 3 crores, 4 crores, 5 crores, but still they were not willing to come. They were already earning that much money - why would they shift? Money has no meaning to them. Any top consultant in Mumbai is earning enough that they will not move from one place to other. I talked to hundreds of doctors in Mumbai and Pune; nobody wants to move from their existing place to another place. The shift can happen only if you have an ambition to set up something beyond what they are doing. They can make a move if they have a dream to create something. Medical people feel good when their medical colleagues praise them and respect them, and for that you have to do something extraordinary. If I am doing joint replacements, everybody is doing joint replacements, so what is great in what I am doing? If I want to do something great I need to create infrastructure. If I offer somebody that infrastructure, full support, and ownership of that department, the chances are higher that doctor will come. And therein lies the skill for negotiation, the key point of appointing the owner. Every doctor who came to me mentioned only two things: 1) that he will need a little more money than what he was

already earning as he would have to bring his own patients and do a little marketing; 2) fees for surgery should be lower so they can convince the patient to come to this new hospital.

The hospital is extremely labour-intensive: for a 300-bed hospital, one is talking of getting about 1,500-1,800 people to join, of which 80% have to be skilled. Getting that kind of manpower is the biggest challenge. Every department needs specialised people. It does not matter that doctors are in surplus in Calcutta or Sri Lanka, the question here is how many doctors are available in Parel area in Mumbai, or from where can I get them? My doctor is not going to come from Borivali or Colaba areas in Mumbai. I need them to be concentrated in Parel. This was one of the problems faced when I set up the Krishna Heart Institute in Ahmedabad. That was a group practice, where the cardiologist and cardiac surgeon had very good group practices. And at that time Ahmedabad did not have any cardiac institutions and this was the only one in the state of Gujarat. Initially, being a single-specialty hospital, I could get everything. The moment other hospitals proliferated, people stopped coming to our hospital. Doctors had a hospital next door to work with so they stopped coming to us. Ultimately, that hospital got sold to Shalby group.²⁵

What happens with all hospitals, without exception, is that the Detailed Project Report they present to banks does not reflect reality. They show a very rosy picture to the bank: they show progressive growth and earnings over the next 10-15 years, which is not true, it doesn't happen. I have seen one of my hospitals, Seven Hills Hospital in Mumbai, going down the drain with a loan. I was CEO when it had a loan of Rs 1,200 crore, but it just cannot survive; every day it has to earn a crore of rupees, which is not possible.

Ramila Bisht: What about hospital management and consultancy firms? Those also entered the healthcare sector in a big way.

Ravindra Karanjekar: Yes, they have entered the sector. In 1970s-'80s, few of us in service in the municipal corporation hospitals studied hospital administration to get promotions in our own careers. At that time there was only a diploma course; the MHA had not been introduced. It was never thought that it would become a good profession. From 1991 onwards a few of my students started working with Lilavati Hospital, straight-away starting as their Director. Over the last 20 years there has been a sea-change and now the mentality of all hospital owners is to have a well-trained MHA doctor as administrator. They may or may not be doctors, but you need a trained MHA from institutions such as TISS Mumbai, Symbiosis Pune, or IIMMR Jaipur. There are niche areas now such as finance, materials management, insurance and housekeeping. These activities are outsourced, given to the other people to run, who can better control the activities. In two hospitals I have been with, the finance and human resources departments were outsourced, human resources was totally outsourced, especially the pay function and the training function. Outsourcing of nursing was tried out by some hospitals but was never successful. Most hospitals wanted their own nurses.

25 Shalby Hospitals Limited is a Gujarat-based group set up in 1994, which has hospitals in several cities in India.

Shekar Ambardekar: As Ravindra has said, established doctors will change their hospital only when they want to do so. For example, if I am at Asian Heart Institute and another hospital offers me a position, I would change not just for money but only if I am going to do something there that I was unable to do so far in Asian Heart Institute. As he rightly said, we doctors generally don't work only for money, we want to be recognised in our own community. It is not even outside the profession as doctors already have recognition from the public. A cardiologist going from one hospital to another wants other cardiologists to say, 'yes he's successful'. Only then he will think that he has achieved something. It is not for money.

Subhash Salunke: It is about personal satisfaction.

Amar Jesani: A few points on what Dr Karanjekar said. I think, one question that arises is, 'who gets the market?' Is it the individual doctor or the institution? When you crave for the well-established doctor to come and be part of your hospital, it means the well-established doctor also brings the market for you. So that means the old system, which was based on the consultants being the main attractor, the ones who drew in the patients, that continues in the corporate sector. I think that's an important point. It is not that doctors are not there in the market; it is the kind of doctors that you want, that's what seems to be an issue. The exhibition is now of the brand of the hospital, rather than the individual.

Ravindra Karanjekar: Over 20 years, maybe since 1996 or 2000-2001, this issue of brands has changed quite a bit. I used to be associated with Tata Memorial Hospital [in Mumbai] and it was the top brand, where the doctor's name was not as important as the name of the hospital. Even if the top doctors leave the hospital, 10-15 doctors still continue with Tata. But as you said very rightly, in 1996, when we started Lilavati, we had a brainstorming over how should we start it? The doctor was the first focal point – we needed a doctor who had a big name, to bring in the big business because at that time the practice was completely doctor-driven.

From 1996 onwards insurance has made a big change. Today nearly 90% or 85%-87% of the patients at Jupiter Hospital, Thane, and 60% at Jupiter, Pune, come with insurance, where they are more worried about what facilities are available, what categories of beds there are, and what their insurance will cover. Generally, if there are good doctors and a reputed name the patients are happy, but they will not necessarily pay out-of-pocket for a good doctor and get it reimbursed from their insurance. That is happening. So, insurance is making a change in the whole process.

The issue of branding is like water and oil. If you put oil into water, you can't separate it; it is the same with brand and the doctor. But hospitals have an existence of 50-70 years, while a doctor has an existence of 12-15 years. Initially he will bring in patients and will become synonymous with the hospital for the next 3-5 years. After 5 years the hospital will get the patients which it can give to the doctor. After that particular doctor leaves, the hospital's brand will continue and new doctors will start coming.

Sriram Geet: What you say is largely correct in Mumbai but in Pune the situation is rather different. Take the case of Ruby Hall Hospital. In Ruby, whoever comes with training in advanced technology from abroad is taken as a consultant. In the case of Inlaks and Budhrani hospitals, the hospital name is secondary as the focus is on who is working there and which country they come from. One oncology surgeon left Budhrani suddenly; still, the oncology department and Budhrani Hospital remained the same, there is no change. In Deenanath Hospital, only a few names keep the hospital going. As Ravindra said, about 10% of the doctors bring 90% of the revenue. He is talking about mainly corporate models with large funding. About a year ago Hinduja Hospital in Mumbai employed one doctor with almost Rs 90 lakhs as an annual salary, plus a two-bedroom flat in Dadar in the centre of Mumbai and a chauffeur-driven car, all because of his reputation.

Ravindra Karanjekar: Reputed doctors are very highly paid. I pay a doctor in Pune Rs 3 crores per year.

Amar Jesani: I have two points. One is about these hospitals attracting doctors. My experience is that in the 1980s and 1990s the doctors who joined the big private hospitals came from the public sector. So there was not only a push factor but also a pull factor. A lot of them were pulled, and lot of them went there because they were pushed out of public hospitals. I remember from 1990-1997 I used to go very regularly to KEM hospital. Every week I used to be there and meet the staff there. When Lilavati and other such big trust hospitals were set up, many of the staff left public hospitals like KEM and went to the private sector. Some of them were very prominent doctors and they told me that they had no future at KEM, 'We have been earning very little, the institution is giving us accommodation but we have no money to buy a flat in Bombay city so the only way we can survive is by going and joining big private hospitals'. So, you will find in these two decades, the 1980s and the 1990s, they were easily able to pull those prominent doctors who could get market-share. It is in the last 20 years that they are finding it difficult because public sector hospitals do not have as many prominent doctors and those who stayed back are perhaps so committed that they don't want to go out easily - they have a different ideology or a different commitment.

My second point is this hospital consultancy issue, and the role of the state in it. In the 1980s, while working on the private sector, I discovered the origins of the hospital consultancy business. I discovered that it started with the Government of India; it had set up a Hospital Services Consultancy Corporation in 1983,²⁶ and until 1987, at least, they were giving 15% returns on it. It was supported by the Government of India and their job was to set up hospitals whether public or private, get all the high-tech technology and run the hospital. This consultancy service was available not only for Indian hospitals, but they were also providing it for foreign hospitals. I remember in 1980s that was the only health department that was making money. So we can see the contribution of the government in encouraging and reinforcing the private sector; by providing consultancies to the private sector to organise the business.



26 Hospital Services Consultancy Corporation Limited is a company set up in 1983 by the Government of India to provide consultancy services for design and setting up of new hospitals and medical colleges, to both public and private sectors. See www.hscltd.co.in

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involvement in the public sector**

Session IV

Initiatives for promoting private sector involvement in the public sector

Ramila Bisht: Now, at this point, we turn our attention to the industry's interest in the hospital sector. We find that in the 1990s CII becomes very active within the hospital sector and sets up this Indian Healthcare Federation. Then you find that a lot of international consultancy groups enter India and are collaborating with CII. Reports started to come from 2003, by McKinsey, KPMG, and you may go on till 2014 and you have PricewaterhouseCoopers report.²⁷ Every other year there was a report, and there were sections written out on the hospital or healthcare industry. Now, when all this was happening, in what way do you find that it really translated to something for the healthcare or hospital industry? Did you find any significance of these reports for the private health sector?

Avinash Kulkarni: Not in my experience, not at all. There was more talk of healthcare management issues – what the government can do and what others can do – but in my perception it did not percolate down to our day-to-day practice.

Ravi Duggal: These reports are basically looking at the market and providing information for investors, ultimately. As Amar said, the Hospital Consultancy Corporation was actually leading that to begin with. Now a lot of private companies are providing market research and advisory services on how investors can fund new ways of running the hospital care.

Avinash Kulkarni: Some of the reports were also directed to government, actually to how and how much they can invest into the healthcare sector, where should the money go, how should it go, and through what channels? At least a couple of reports were from McKinsey. One latest Price Waterhouse Cooper report did mention more of public health issues rather than about the private sector.

Subhash Salunke: Some of these reports eventually got into the policy of the Government of India. That did happen. The functioning of the bureaucracy at the central government level is rather peculiar. The bureaucracy that functions at central government level and the bureaucracy that functions at the state level have some kind of common approach in overlapping areas, but the day-to-day functioning of hospitals, both in the public sector and in the private sector, is left to the wisdom of the state governments. Even though people keep saying that there are a lot of legislations and rules, I think the health sector in India is the least governed and it is governed in a very patchy fashion. For four years we worked on the model Public Health Act, covering

²⁷ See Introduction for list of these reports on the Indian healthcare industry.

public health related issues, and on this Clinical Establishments Act. In these two areas we have 'n' number of laws and rules but they have no relevance, except for harassment to a certain extent at the periphery. And that is the reason we worked with NHSRC on these Acts. Our own government, or rather the Prime Minister, kept saying that there are so many laws and acts which are absolutely redundant, so we said, 'let's have only few Acts that are implementable and work on that'.

Ramila Bisht: But there was a Chief Minister's task force, which came out with a report in 2004 for Maharashtra government. Did you in your experience, see anything of that Task force report percolate down?

Subhash Salunke: No, it did not. It did not, because what happens, the bureaucracy, both at the central and state level, are quite interested and enthusiastic to design something. And then afterwards they leave it to the gods, 'let's see what happens'. Only seven to eight states are implementing Clinical Establishment Act; in many states there are no proper rules and Maharashtra is one of them. We shouldn't be very proud of it.

Ravi Duggal: Incidentally, in the states where Clinical Establishment Acts have been established, there is no significant private sector so that's why there was no resistance.

Subhash Salunke: Yes, so there was no resistance. I am trying to say that - if you read these reports, you'll say, why don't you simply do what the reports say? You don't have to do any de novo exercise, just translate these into an implementation phase. But that doesn't happen. The people sitting in Mumbai Municipal Corporation or Pune Municipal Corporation who give the license have no clue about running of hospitals. They have no clue of what a hospital looks like except when they go as a patient. Our health officers wake up when there is a death in the hospital, like one death occurred due to H1N1 in Ruby Hall Hospital, and we criticise the health officer so he goes running to get the information. That is the worst kind of a situation and it is in a state like Maharashtra which is a so-called progressive state.

See, we made sincere attempts and we were the first in the country to design a lot of things. But what happened? Government systems are peculiar in nature. And they are really dependent upon the leadership. As long as I am interested, passionate, things keep moving. But how to turn that passion and work into a part of the system is a real challenge. And that's why you see ups and downs. You go to Delhi now, with the Aam Aadmi Party government and our colleagues sitting there on the health side, they are really doing excellent work. *Mohalla* clinics²⁸ are one of the best things that have happened in this country but the moment that government goes, or leadership goes off, it will decline; that I am sure of. So, the point that I am trying to make is that - in spite of many reports, in spite of good recommendations and in spite of legislations, which are very helpful, what matters is sustainability and implementation.

28 *Mohalla* clinics are community clinics set up by the Delhi government since 2015, to provide primary and secondary care to people living in slum areas. See: Lahariya, C (2017) *Mohalla Clinics of Delhi, India: Could these become platform to strengthen primary healthcare?* J Family Med Prim Care. 2017 Jan-Mar; 6(1), pp 1–10.

Ramila Bisht: Dr. Salunke, let me just ask you to speak in some detail on the Maharashtra Health Systems Development Project.²⁹ The project recommended that the government engage with the private sector. What were the concrete steps that were taken towards engaging with the private sector? And what was the outcome of those?

Subhash Salunke: What we recommended and attempted, first and foremost, was to try and get away from this feeling, that we were two separate opposite parties, the public and private, and that we should engage in war. I said private sector and public sector are supposed to be assisting the community from the public health and clinical point of view. This premise, on which we have to come together, means the public healthcare system and the private hospital should have a cordial relationship. How can that be established? It was a formal mechanism of inviting and working together, at least on some programmes, whether it is on HIV-related programmes, or some interesting innovation in the civil hospital for which the private sector needs to be incorporated. We also encouraged appointment of honoraries in specialities which were not available in the existing civil hospitals, 'let us invite these people to the public hospital and pay some kind of honorarium'. Another area we were lacking in was that of diagnostics, and we thought of how we could co-ordinate with the private sector for this service. In this way we tried to have an enabling environment in the public sector to engage with the private sector.

We really attempted, and to a great extent succeeded, in developing the Health Surveillance System or Integrated Disease Surveillance System, to get reports from the private sector. Even today Maharashtra should be happy that a system has been established. We are very happy that Pune is one city in the country where reporting is fairly good for H1N1, dengue and all major communicable diseases. After continuous efforts on the part of the Pune Municipal Corporation and the state government, 9,000-odd doctors are now registered with surveillance system and there is fairly regular reporting of the notifiable diseases. I think that happened because we initiated a system of collaboration.

Ravi Duggal: Regarding the Health Systems Development Project and its impact related to the private sector. The BMC set up a privatisation cell and one of the first activities was related to re-development of its Cooper Hospital. A Floor Space Index of four was given to the private developers engaged for re-developing Cooper Hospital. On the existing land area and around the hospital the private company would build a new Cooper hospital for the public sector at Floor Space Index of one, and the Floor Space Index of three would be taken by the private sector. So they get more built-up space to build malls there, or another private hospital.³⁰ I think something similar happened with the GT Hospital of the state health department. The public responded with the 'Save Public Health Campaign' against these attempts to give public land to the private; I was a part of that campaign.

²⁹ See Introduction for details on this project.

³⁰ In 2003 the BMC privatisation cell invited expressions of interest from developers willing to re-construct Cooper Hospital, which was declared unfit for occupation, in return for lease of civic land to construct their own private tertiary-level hospital. In 2006, the BMC decided to instead redevelop the hospital itself. The redevelopment work started in 2009 and the re-developed hospital was inaugurated in November 2013.

Subhash Salunke: Yes, GT hospital in Mumbai and Indira Gandhi Medical College, Nagpur. This was part of involving the private sector in an area where they are comfortable, but they are also helping the community.

But our main focus at that time was improving secondary level care, in rural hospitals, community health centres, and sub-district hospitals. During those four to five years an investment of about Rs 600 crore was made to ensure that healthcare in rural areas improved. For example a very rudimentary hospital in Indapur, Pune, is today conducting routine surgeries. It's not a super-speciality hospital, but now caesarean sections are being carried out. The private doctors within that vicinity were engaged on per case basis; such as anaesthetists were engaged at Rs 2,000 per case.

Ramila Bisht: We are now moving towards PPPs, and that is the next theme which we would like to discuss. Dr. Malik could first share her experience, because a large part of her career in BMC has been spent working with different kinds of PPPs

Seema Malik: The 2000s was the era of PPPs. Partnerships with private entities were entered into for anaesthesiology, ICU and diagnostic services in the municipal corporation hospitals, for example a PPP with NM Centre for diagnostics. As far as hospitals were concerned, the first PPP was with Brahma Kumari, to develop BSES [Bombay Suburban and Electricity Supply] Municipal General Hospital.³¹ BSES helped to run one of the maternity homes, Nehru Maternity Home, that was to be developed as a multi-speciality hospital but BMC did not have much money to spend on the staff, so Global Hospital and Research Centre of the Brahma Kumaris was called to run it and some money was also given by Reliance. Brahma Kumari had a different ideology but it worked for many years, for almost 15-20 years. Slowly they have also gone for a corporate style management but there was a dispute and there is an ongoing court case.

Then there was a PPP with Seven Hills Hospital. The private party constructed a building with 300 beds but they spent so much; they took a Rs 1,200 crore loan. There was no medical Memorandum of Understanding (MoU) - the agreement was only for the utilisation of the space. The private party had to pay some rent, around Rs 2-3 crore, and the public were thinking that they will benefit from the hospital. Then there were a lot of political problems due to the rivalry between the Congress Party and the Shiv Sena [Hindu nationalist political party in Maharashtra], for example they called the Congress Party but didn't call the Shiv Sena. Finally, an MoU was signed in 2013 and it said 20% of the beds would be reserved for providing subsidised care to the poor patients. Patients under the state health insurance scheme, the Jeevandayee Yojana,³² were included into that 20% because the cost of the hospital was very high. Mr. Maganti, the owner

31 In 2002, Global Hospital & Research Centre, a trust hospital managed by a religious organization Brahmakumaris, entered into a PPP with the Bombay Suburban Electric Supply (BSES) and the BMC. The BMC allocated land for a hospital at Andheri, BSES covered the cost of constructing the building and buying equipment; and the management of BSES Municipal General Hospital was entrusted to the Global Hospital & Research Centre.

32 The state government in Maharashtra launched a health insurance scheme, Rajiv Gandhi Jeevandayee Arogya Yojana (RGJAY) in July 2012. It aimed to provide poor people in the state with free access to medical care in about 500 empanelled hospitals, covering 971 types of surgeries and therapies at a cost up to Rs 1.5 lakh per year per family.

of Seven Hills, had thought of running it by appointing full-time doctors, a practice followed in some southern states, but in a place like Bombay getting full-timers was not easy. The company had a lot of plans to have a research centre but nothing was done about running the hospital. There was some fault from the government side also.³³ Changes were made, the full frontage was also taken away by BMC, and given to some shops.

And who was in the PPP cell while making a tender for the PPP hospital? There were engineers but no doctors, so nobody was talking about medical side. Engineers were talking about this much space, this much Floor Space Index and so on, but nobody was talking of the arrangement for the medical services. So, it did not work. Later on it worked with a casual attitude of 'let things be'. Once the MoU was signed, everybody had lost interest. Dr. Karanjaker can say more on this PPP because he was on the operational side at Seven Hills at a later date.

The third PPP, for re-development of Cooper Hospital, failed.³⁴ The people in Juhu-Vile Parle Development (JVPD) scheme went to court, and finally BMC decided to have its own hospital and medical college. Another example was Kandivali Shatabdi hospital, where 50% of the space was to be given to the private party to build and run a super-speciality private hospital, and 50% was for the public hospital, but that also did not work.

For PPPs to succeed there must be clear-cut margins and policies, and everybody should adhere to them. Every three years government officials and commissioners change, and everybody has their own ideas.

Ravindra Karanjekar: The story about Seven Hills is that we had a tie-up in which the municipal corporation did not abide by its agreement. It didn't give the old place, didn't fulfil whatever it had committed to, so the project halted at a particular stage. This was to be the biggest hospital in Asia, 1,500 beds over 20 lakhs sqft; 16 towers were built up, and one tower was given for this purpose, where 60 people were working.

I have had an opportunity to witness PPP models on two, three occasions. The first occasion was that of the GT hospital that was to be run by Wockhardt. I was in Wockhardt and I knew exactly what happened. And the second time was when we wanted to buy D.Y Patil Medical College and Hospital, there was another PPP model we had explored, but the basic distrust between the government sector and the private sector was too intense. The government was changing the terms of the agreement, which the private sector does not like; the terms should be laid out from the beginning. If the private partner likes them, they will agree, otherwise they will not agree. After spending crores of rupees on GT hospital, at the last minute the terms were changed, about

33 BMC entered into talk in 2002 with Seven Hills Healthcare Private Limited, at that time based in Andhra Pradesh, to open a multi-specialty hospital in Mumbai. According to the PPP agreement, signed in 2005, BMC gave Seven Hills a 60-year lease of a 6.9 ha plot in the Mumbai suburb of Andheri, near Mumbai International Airport. In exchange, Seven Hills agreed to reserve 20% of its 1,500 beds for low-income patients who come through the BMC healthcare system, charging them fees at the same rate as in public hospitals.

34 See Note 30.

the majority share from the government. In the process Wockhardt lost interest and said, 'forget about it, we lost Rs 5 crores, forget about it'.

This happens time and again. This happened in Amritsar, in the state of Punjab. We wanted to buy the 400-bedded Bhagat Singh Hospital and initially we were told that the private partner will provide free secondary and primary level care, and the remaining 100 beds could be used by it for super-speciality services. Mid-way the government said that the private partner should add in a super-speciality hospital also. So that PPP model did not take off. There is distrust and change of rules. The private sector will not provide services only for charity. Even if there is a meagre profit, they will do it. No private hospital is averse to doing some kind of charity, but not from its own pocket.

Sriram Geet: In Pune, Dalvi hospital as well as Kamla Nehru Hospital were to be handed over to the private sector but the deal was distorted by corporators ³⁵ from the Pune Municipal Corporation.

Avinash Kulkarni: We haven't heard of a single success story yet!

Subhash Salunke: This Wockhardt GT Hospital story I've seen, I was present there along with my health secretary, finance secretary, and the Chief Minister Vilas Rao Deshmukh. In the Chief Minister's presence the Wockhardt people and the finance secretary signed the MoU. After that came a new finance secretary who made some notings in the concerned documents and then the Chief Minister had to take a step back. Today the situation is worse; no bureaucrat, no minister will dare to take any step if it is somehow suggested that you are likely to come under scrutiny for corruption. Things don't move. So, that's how Pune Municipal Corporation PPPs also did not go ahead. There was a possibility of that one being a success, but all politicians have their own axe to grind, they have their own agendas, so PPP is not an easy option. PPP is an option only when government is forced or cornered by the community or by the High Court. When they are in the corner, only then will they start looking at PPPs.

Seema Malik: They are cornered for anaesthetists and ICU, that is why PPPs are working in those services.

Subhash Salunke: See, hiring an anaesthetist and paying him Rs. 2,000 per case is easy; paying Rs. 3,000 per patient under the government health insurance scheme such as Rajiv Gandhi Yojana to go for CT scan is easy. Even if there is are allegations of corruption, they are minor, comparatively. But to handover a hospital building or crores of rupees to a private party invites lots of complications.



35 An elected member of a municipal corporation.

Session V
Medical tourism

Session V

Medical tourism

Ramila Bisht: We now move on to medical tourism. The Medical Tourism Council of Maharashtra was set up in 2004 and we've seen a lot of medical tourism-related activities taking place in Mumbai and Pune. How has this impacted the private sector?

Ravi Duggal: I think in 1980s also there was a lot of medical tourism.

Sriram Geet: Right from 1965 to 1980, medical tourism was going on at Miraj in the southern part of Maharashtra. There were 50-bedded to 200-bedded hospitals which were only run for patients from the Middle East. A small city like Miraj, had 200-bedded orthopaedic hospital at that time. This happened to some extent also in another town, Solapur, but not in Pune and Mumbai. Then it was started to a small extent in Pune by Aditya Birla Hospital and Sahyadri, although the latter was of a different sort; they went to other countries with orthopaedic and cardiac teams and patients came from those countries. For example every third month a team was sent to Fiji and services were provided there with the support of the Fiji government. Deenanath Hospital had limited patients from outside India. And medical tourism per se started from 2005 in many of the Mumbai hospitals.

Ravindra Karanjekar: We started medical tourism first at Wockhardt group. Krishna and Fortis didn't have much. Fortis had some people coming from Canada, and much of it was for the addiction rehabilitation programme. Most of the insurance companies insist on JCI accreditation for hospitals participating in medical tourism. Those from the African and Middle Eastern countries want a JCI-accredited hospital; for those from other countries, especially the SAARC countries like Sri Lanka, NABH is okay.

The nature of medical tourism is different in different parts of the country. Overall medical tourism is increasing and we treat patients with serious medical complaints like cancer and heart conditions, whereas places like Thailand cater more to cosmetic purposes. A large chunk of medical tourism comes to Delhi, about 60-65% of the total; 20-22% of it comes to Chennai and another 10-12% comes to Hyderabad. The remaining comes to Mumbai. Initially Mumbai hospitals got patients from Middle Eastern countries, but now they are coming also from African countries. Kolkata and other cities do not get anything. In Chennai we used to get patients from Iraq, Tamil speaking patients from Sri Lanka, and even from Bangladesh. There is accommodation for these Bengali patients - Bangla Bhavans - and interpreters for them. Patients from Middle-East preferred Hyderabad and patients from the African, Middle Eastern and other countries come through their respective governments and the High Commissions and Consulates in Delhi. The payments would come through the government and it is very difficult to break that network. Delhi is well-connected and it is easier to get permissions and other official procedures from

the embassies. The Delhi hospitals would get the information about such patients much before others got them, and they would try to corner all the patients. In Mumbai we find it difficult to get embassy permissions.

Medical tourism has two elements: doctor-driven and hospital brand-driven. Among all these places, Mumbai is a known destination; and people will come here more readily than go to places like Pune, Solapur or Kolhapur. Availability of expertise and good hospitals with proper websites helps attract patients, as does the availability of post-operation tie-ups with doctors in their home country. We are part of the efforts of the state tourism department to make Mumbai a medical tourism centre as there is no difference between Mumbai and Delhi as far as medical treatment goes.

Sriram Geet: Another form of medical tourism is in Kerala, where there are many centers offering treatment of Ayurveda system.

Seema Malik: Saifee Hospital in Mumbai is running on medical tourism; patients from Dubai who would earlier go to Bombay Hospital now go to Saifee. The hospital has links with the consulates in the Middle East. And the earning is in two ways – one is through the patients coming from there, whether paid by government expenditure or privately. The other route is that all people going to countries in the Middle-East have to undergo health check-ups. These check-ups are done in the centres of Saifee hospital. They have set up diagnostic centres in Bombay and in other places all over India also, through Saifee. Patients from Dubai used to go to Bombay Hospital, now they have shifted to Saifee. So, that is one type of medical tourism that I am seeing, which is by a particular religious community and for that community.

Amar Jesani: There is domestic tourism too, catering to lot of a government employees. In 1994 or 1995, during a survey on patient satisfaction in Lokmanya Tilak Hospital, Sion, with a randomised sample of in-patients, I found that 70% of the patients were from outside Mumbai. Presenting this data at that time was a big dilemma, because the Shiv Sena party that was in power in the state considered people from other Indian states as non-Maharashtrians and their presence here was considered a major problem.

Even in 1980s there were instances of patients coming from the Middle-East to Mumbai for illegal transplants, which were also reported in medical journals. And of course the entire ART industry and some of their pioneers are all from Mumbai. They are called the 'ART gang', the 'ART mafia'. They have created their own franchises everywhere and they help smaller centres to set up ART facilities. When I was interviewing them, they did talk about the large number of clients coming from abroad. I don't have exact figures.

Ravi Duggal: I think Mumbai has been a hub for a longer time. Even the public hospitals were serving patients from countries around South Asia or even African countries. And these were free of cost, as at that time there were no user charges. So you had patients coming from not only rest of the country but even from neighbouring countries. Today I see a reversal. As our organ

transplant law is very difficult, people from Punjab go to Pakistan because you can easily buy donors and get kidneys there.

Amar Jesani: Even if you look at the patient profile of Christian Medical College, Vellore, in Tamil Nadu, you will find a large number of them are from the Indian state of West Bengal.

Ravi Duggal: Apollo has set up a hospital in Dhaka now.

Ravindra Karanjekar: Yes but Apollo hospitals in places like Sri Lanka, Mauritius and Dhaka are not performing well. Those in Sri Lanka and Mauritius closed down. Retaining Hindu doctors in a Muslim-majority setting like Dhaka is becoming a problem. About six doctors whom I know, from Mumbai as well as Chennai, were uncomfortable with that situation and at the end of their tenure felt it would be better to return to India.

Ramila Bisht: We could have a quick question from the audience if there are any?

Anant Bhan (audience): There was a very interesting documentary made in 2006, called 'Health Matters'. In that a doctor from AIIMS, Delhi has said, 'the medical tourists I care about are the ones lined up on the footpaths outside my hospital, who come from Bihar and spend two-three days waiting for an appointment'. Around November 2017 there were reports of a paralysed girl from a village in Maharashtra who spent 45 days getting to Mumbai for surgery. We also need to talk about this kind of domestic medical tourism, while talking about catering to foreign medical tourists. It is a result of the inefficiency in our public sector and failure of primary and secondary care facilities, because of which a lot of people from rural areas and smaller cities and towns come to the cities for tertiary care.

Subhash Salunke: Should we call that as tourism? The purpose behind medical tourism is, 'I have money with which I can enjoy tourism and also get the medical aid, I get treated in Mumbai then go see the Taj Mahal, and return home'. What you quoted is related to the failure of the referral system in our country.



Session VI
Public and private health insurance

Session VI

Public and private health insurance

Ramila Bisht: In the last session for the day we are focusing on health insurance, both private insurance and public insurance. Government health insurance schemes are also being used by the private sector. Dr. Karanjekar said that currently the popular model of accessing private healthcare is one where patients no longer care about who the physician is but rather whether they will get reimbursed. Could you elaborate a bit on that and start the discussion on how insurance has really been a game-changer for the private health sector?

Ravindra Karanjekar: In the private health sector insurance is indeed a game changer. Even though insurance pays hospitals about 10% less money compared to other sources, it is being used by almost 70-75% of our patients. That is one of the major changes that has taken place. The volume comes not from walk-in patients but from the corporate, organised sector, whether it is Siemens, L&T or big companies that have thousands of employees. Previously, employees would fund their healthcare costs themselves and get it reimbursed from the employer. Now they pay a premium. To implement this process most of the companies have gone for insurance through a third-party administrator (TPA). Around 75-80% of the business in insurance sector is with the GIPSA³⁶ government insurers, and 15-20% is in private insurance companies. So there is hue and cry in the hospitals when GIPSA says something, because a large number of patients are using GIPSA companies.

Insurance has also become much more systematic and now we see there is not much problem in getting payments from the insurers. Initially there were problems. There was a meeting in Delhi through CII or FICCI or some other body, where the service providers were saying that medical bills were being rejected and people were losing faith in insurance. Now I get payments back in 15 or 16 days. For other hospitals it normally takes around one and a half to two months, but I get them faster than that. Insurance has progressed a lot. Five years back pre-existing diseases were not included in insurance plans, nor cancer, but insurance companies are now becoming bolder and, with some riders, they are giving insurance coverage for the diseases that generate large bills and which push people into debt, such as cancer, heart disease and liver disease; these are the major ailments where you can spend Rs 25, 30, 40 lakhs. I am seeing 20, 30, 40% of patients coming with private insurance. Star Insurance offers policies that include cancer, existing cancer, so insurance has changed its approach, and it is becoming easier to manage policies online.

36 The Public Sector Insurers, National Insurance Co Ltd., New India Assurance Company Ltd, Oriental Insurance Co Ltd & United India Insurance Co Ltd, have negotiated special package rates from many hospitals across India for a number of common procedures. Cashless facility for those procedures is available only in the General Insurance Public Sector Association (GIPSA) Network Hospitals. Nearly 30 hospitals, which were part of the Preferred Provider Network (PPN) programme started by insurance companies, have stopped offering cashless services to patients citing harassment by the third-party administration (TPA) firms.

Avinash Kulkarni: I think the perspective of the insurance company and the hospital are different. In clinical practice, at least from what I have seen in my practice and of my colleagues, doctors have not become irrelevant. Doctors are relevant. As far as my patients go, they say 'I'll go wherever my insurance covers, but primarily if you are there, I will be comfortable'. By and large patients don't desert their doctor.

Sriram Geet: Cashless is the attraction. And so many companies now include parents – they cover the employee, wife, children and parents. But with IT companies there is a different problem now. If suddenly the employee gets a pink slip [made redundant], and if doesn't get a job within a month and the parent becomes ill, there is a big problem if they don't have insurance. And such problems are arising. There are quarrels within families, and with hospitals, 'my cashless has not been approved so I have to pay, and the insurance company only reimburses 70%'. That is a major problem. There is also a problem with rejected claims for long treatments. Say investigations are conducted for heart surgery, transplant surgery or joint replacement surgery in an aged patient, but this takes time and it is not possible to get a surgery slot for another three months. The insurance company then says that the investigations are not covered because there is a difference of three months. Then there is the issue of ceiling and limits.

Indira Chakravarthi: Is there any impact of insurance in altering the activities of the private hospitals?

Sriram Geet: Focus is altered.

Ravindra Karanjekar: If you go across Mumbai, Pune or even Delhi, you will find the bed rates are Rs 2,000, 3,000, 5,000, 8,000 or 10,000. However good my facility is, I don't increase my bed rates beyond this. The primary reason is insurance: it pays 1% of your insured amount [total cover] for the bed charges. Cover is Rs 2 lakhs, 3 lakhs, 5 lakhs, 8 lakhs or 10 lakhs, so bed rates are maintained within that, whatever the charges may be. If the bed rates in a hospital are more than 1% of the insurance cover, the patients will have to pay the difference. The hospitals are trying to see that the patient does not have to pay anything as far as possible, so they modify the fee system in such a way that everything falls under the insurance scheme.

Ramila Bisht: What about some negative things that we read about regarding insurance, like growing rates of surgery?

Sriram Geet: About 15 years back, the General Practitioner's Association conducted a seminar calling hospital authorities, insurance authorities and government authorities, together on one stage, held in Indian Medical Association, Pune. That time, I approached a GIPSA chief and asked him to deliver a lecture at the seminar, for clarifications and perspective. He said to me, 'do you see the pile of files to my left? All of these are fraudulent files, and I have to process them; hardly 10% of files are normal'. This was 15 years ago. Subhash Salunke must be knowing about CGHS scheme; many hospitals were banned. In Pune, the insurance problems were very tough for GIPSA for three years. For a simple cataract operation Pune doctors were charging not less

than Rs 20,000, and the insurance companies were saying only Rs 12,000 will be sanctioned. Who is going to pay the remaining Rs 8,000? For normal hernia the average charges were Rs 60,000, and GIPSA companies were saying, 'we'll pay maximum Rs 28,000'. For almost six months cashless was totally stopped.

Sriram Geet: Pune was categorised as a tier-3 city and so hospitals would be reimbursed at a lower rate; that's why the discrepancy was there. But 90% of the Pune hospitals had to succumb to GIPSA companies. There were fights between the hospital authorities, over whether to succumb or not. These things are not known to patients. That is the worst part.

Subhash Salunke: We are going in the direction of the US health system. Where around 20% of their GDP is spent on health, and still there is a sizeable section of society which is not covered by health insurance. It is one of the worst healthcare systems and India is following that model. Insurance drives hospitals and health systems into providing services in ways that can be modulated and manipulated, although to some extent patients do benefit. Just take the examples of various states: last year Maharashtra spent Rs 1,200 crore on this Mahatma Phule health insurance. Modified versions have been adopted in several states, like Karnataka, Tamil Nadu, Maharashtra, Andhra Pradesh, Telangana, Gujarat, and that's being evaluated for this insurance scheme of the Honourable Prime Minister which is going to be declared on 15th August – the Ayushman Bharat of the central government. In Maharashtra last year 2.5 lakh patients were treated in different hospitals under particular schemes. And they are happy guys, no doubt about that. To a certain extent not every hospital is happy, but this is an assured amount of money for 950 conditions that is going to be available. Now with Ayushman Bharat, there will be 10 crore families covered, and an allocation of Rs 2,000 crore, things are going to become more complicated and exaggerated in coming years. Some hospitals will benefit; those who stick to ethics will not. The insurance companies are going to benefit from this, and the majority of them are government-owned bodies. The ultimate beneficiary is the companies at the receiving end, while the public health system will suffer. The Prime Minister says that public sector hospitals – district hospitals, sub-district hospitals and medical college hospitals – will be supported through these budgetary allocations but I have my doubts, because today in the states of Maharashtra and Karnataka, district hospitals have not benefited from insurance. Maharashtra is a classic case: out of a Rs 2,000 crore budget, Rs 1,200 crore is the contribution of the state government to this central government insurance scheme, while Rs 800 crore comes from the central government; there is no money for the development of public health.

Avinash Kulkarni: In this new scheme they are offering Rs 9,000 for caesarean. Arun has been a practising doctor - did he ever do a caesarean in Rs 9,000? Was it feasible to do so even ten years ago? Acceptance of these schemes is voluntary for hospitals, and how many can do it at these rates?

Ravi Duggal: Amrita Hospital in Kerala says they perform caesarean sections for Rs 10,000

Avinash Kulkarni: In Pune the charges are Rs 100,000 for a good caesarean section and stay in the hospital, or maybe Rs 80,000. Who is going to accept Rs 9,000? How much is the surgeon supposed to get? How much is his hospital supposed to get? How many consumables and disposables? Or theatre charges? Looking at the cost structure, they have designed this as a purely political issue. Just a publicity stunt. I am very sure the people who formulated that policy must have paid at least Rs 50,000 for the same surgery for their own daughters and daughters-in-law, and now they are going in for Rs 10,000, 9,000?

Subhash Salunke: This is one issue, the point that I am trying to say is insurance is going to distort the entire healthcare system in this country. Primary healthcare is going to suffer and public health is going to suffer. That is the ground reality and you will see it in the next 5-10 years.

Ravi Duggal: One thing in practice is that if you are an insurance patient, the hospital will try to exhaust your entire insurance cover in one go. Suppose you have Rs 2 lakh cover, they design your treatment package in such a way, and especially with the government schemes, that the amount is exhausted in one go. When health insurance emerged it destroyed the public health sector. Mumbai is a classic example. In Mumbai everybody used the public health system, the municipal health system, until the late 1980s at least. So when insurance came into the public sector in 1984-85, they offered to buy insurance for their employees, they had the choice to go to the private sector, so the middle-classes went to the private sector. They deserted the BMC's public health system and it became a system for the poor and it became a poor system. The middle-classes were the voice of the public health system and when they deserted it, the BMC budget allocation for the public health system fell from 25-30% up until 1990, to 9-10% now. This budget slashing and the neglect of the public health system drove migration of the middle-class into private hospitals.

Subhash Salunke: The connections between primary, secondary and tertiary should be maintained. It is not that the policy designers are ignorant; they too are aware that these connections won't be preserved. Then there are also plans to set up 1.5 lakhs health and wellness centres, to be staffed by MBBS doctors, AYUSH doctors or a trained nurse, with one counsellor, one technician, two auxiliary nurse-midwives and one multi-purpose worker. The government would not be able to appoint one multi-purpose worker in centres in most states till now, and yet they are talking about five or six persons, in the space of five years. What nonsense are we talking? So-called progressive states like Maharashtra have a debt of Rs 5 lakh crore, let alone states like Bihar and Uttar Pradesh. Do you think that these state governments will be able to take care of this? It won't happen. The money for health is going to be diverted. This is the biggest negative point for Ayushman Bharat which they will never accept because it is political gimmick for the 2019 election.

Avinash Kulkarni: It is insurance that, directly or indirectly, drives and increases the cost of therapy. This is exactly what happened in the U.S. There was news just two days ago that three of the major corporations have come together and appointed Atul Gawande as a CEO of a health initiative just to try and reduce the cost of healthcare for their employees. The launch statement

was eye-opening; Jeff Bezos said that, 'we know that we are going to find stiff resistance from politicians and insurance, and there is a very good chance that we will fail, but one should not say that we didn't try'. That is the state of affairs they are in now. Insurance will drive cost of healthcare and make it less affordable. I have a very close relative in the U.S who works for a hospital and he told me that, insurance companies register thousands of families and then approach hospitals looking for the lowest price for a treatment and will then tell all the families living in city A that none of the nearby hospitals are covered but they can drive 60 miles to a hospital that is covered.

Ramila Bisht: Dr. Karanjekar, would you like to respond to what Ravi and Dr. Avinash Kulkarni were talking about?

Ravindra Karanjekar: We had a meeting with Vinod Paul, a member of the NITI Aayog³⁷. The committee was told to identify the ways and means by which to detect fraud in Ayushman Bharat, 'find out at least 100 different ways by which a fraud can be committed'. The committee sat and came up with 1,000 different ways.

Since around 2006-2008, I have seen medical officers or doctors visiting hospitals on behalf of insurance companies. The insurance company now has a mediator who has a team of doctors, and they hand over a case to mediator the moment they have a doubt regarding high cost surgeries, or high cost claims; the person comes to the hospital physically and sees the papers. Medical science is an inaccurate science and defensive medicine is increasing. For a headache I can say, 'take aspirin', or I can say 'get a CT scan and then take aspirin'. And you can't challenge what I said. You cannot challenge this on medical grounds, but insurance companies are going to be stricter in controlling treatment. Most of the insurance companies have now capped expenses on particular diseases: you may have Rs 10 lakh insurance cover but you can use only Rs 2.5 lakh for cardiac care, and Rs 3 lakh for cancer care. You may receive 100 investigations but the hospital will not get more than Rs 3 lakh.

The insurers are coming up with guidelines for every disease, on what should and what should not be done, and that is the most concerning thing for healthcare. Once the volume of insurance cases reaches 85% of hospital users, then these insurers will start dictating terms, 'clinically you should have done this, or done that'. Only super-speciality hospitals will survive in this because they have specialists who know more about the subject than the inspectors; smaller hospitals will not survive. The insurers will not argue about treatment protocol for liver transplants, but they will set guidelines for routine cases.

Regarding caesarean sections, they are saying there is a conscious attempt from the government to reduce the numbers because the caesarean section rate is too high. The government does not wish to incentivise caesarean sections. They are using fixed rates, whether it is a normal delivery or caesarean, so hospitals will not do that kind of treatment possibly.

37 The National Institution for Transforming India, also known as NITI Aayog, was formed in January 2015, to function as a policy think tank and provide policy inputs and technical advice to the Government of India. The NITI Aayog replaced the Planning Commission of India that was instituted in 1950. See <https://niti.gov.in>.

Insurance is definitely going to help poor people. Whatever form Ayushmaan Bharat comes in, it will change the whole complexion of healthcare. Healthcare is an extremely profitable business; I must have been associated with about 600 hospitals as NABH Chairman and not a single hospital is making loss. What is shown on the balance sheet is a different thing, because there is a cash business, like in small to medium eateries and restaurants. Patients from outside Mumbai will give you a bundle of money, but how much you show on your balance sheet is up to you. I was offered a job in South India – ICICI bank said seven hospitals were making loss – but I realised that they were making a profit, they were just not showing the profit in their accounts, they were showing losses. Why are big groups putting in crores of rupees into healthcare? Because healthcare is a profitable business. Whether it is private, semi-private or charitable, it makes money, and everybody wants to join in. Insurance will try to regulate it to a certain extent, but beyond a point it cannot because at a certain level insurers have to give in. Public health is a public good and that is the business of the government, but unfortunately it appears that Ayushmaan Bharat is likely to be counter-productive.

Ramila Bisht: We can now open it to the audience, if they have any questions?

Kishore Khilare: There is a nexus between the multi-speciality hospitals and the insurance inspectors. I witnessed one case of a construction worker, with around Rs 1.5 lakh family insurance coverage, whose 21-year old son was admitted to a well-known multi-speciality hospital in Pune. For a simple skull fracture, that hospital advised neurosurgery. I had seen the case papers and an MRI was done and the neurosurgeon had clearly written that no surgery was needed. I met the owner of that hospital and said that the neurosurgeon has seen the case and there no need for surgery. The surgery was not done and when the patient was discharged the hospital's owner-doctor told that patient that we have not done the surgery because of your doctor, otherwise we would have done it. I enquired whether the bill was sanctioned and indeed the insurer paid the hospital Rs 1.5 lakh. So, this type of nexus is there.

Abhay Shukla: I am hearing two contradictory things. One is that insurance schemes benefit private hospitals, but also that the rates are not attractive for private sector. Within the earlier state government's Jeevandayee, which is now Mahatma Phule scheme, I understand many hospitals did not join the scheme, so there is some category of hospitals which takes interest in these schemes and some category of hospitals which stays outside these schemes. The Rs 5 lakh coverage is supposed to encourage corporate hospitals to join, but Rs 9,000 for caesarean is low and I am pretty sure no corporate hospital or even a large private hospital will do a caesarean for Rs 9,000. Given this contradiction, are hospitals really going to jump onto this bandwagon? Which hospitals are generally interested in these schemes, and which hospitals stay out of these schemes?

Subhash Salunke: What you have said about Jeevandayee Yojana is absolutely true, some hospitals did not join. This Ayushmaan Bharat scheme with Rs 5 lakhs is a political gimmick. They just want to say Rs 5 lakh, 10 crore families, because Rs 5 lakh is a political statement that is excellent for elections. When it comes to the real nitty-gritty and operations, this Rs 9,000 for

caesarean sections is going to come into the picture. They are fixing rates now, and these rates are not going to be very attractive. Still, hospitals that are financially weak will jump into it, saying 'at least we will have this sort of an income source, where we may be able to manipulate'. But, that Rs 5 lakh, I was also told that eventually capping will be done at Rs 2 lakh.

Abhay Shukla: Let us leave out Ayushmaan Bharat for the time-being. What is the existing situation? Those of you who are working in the hospital sector, which hospitals are going for the insurance schemes? Which hospitals are staying out it?

Avinash Kulkarni: Sahyadri did it, is still doing it. In Sahyadri, we are doing almost 100 cases, because they come to us. We are doing a lot of excellent work in paediatric cardiology.

Ravindra Karanjekar: Rs 9,000 is a figure that doctors are quoting everywhere, so it has caught on. I have a list of all 1,134 ailments and their rates and I would say 70% of the rates are okay, not as great as my standard rates, but they are okay, manageable. 30% of them are not manageable. In Jeevandayee, I could select the speciality for which I wanted to be empanelled, so I selected radio-therapy and paediatric cardiac surgery. But in Ayushmaan Bharat it will be an all-or-nothing situation. If you join the scheme then all your specialities are included. At a nursing home level or a small hospital level, to have the business they will join it. Even Seven Hills had taken that rate and managed it. Smaller hospitals that are not doing well will join this scheme for survival purposes. That is why I am starting a no-frills ward. One fear is that I will be compelled to join it, because otherwise 50 crore people are out of my hands. The healthcare system will have to change to cater to these 50 crore people on the rates that the government is offering.

Amar Jesani: We are talking without information on the cost of the services. You can always say that every doctor has a right to earn, say Rs 1 crore a month and then you can do the costing. Or you can use the market price, or some benchmarks. These things being reported are part of a bargaining process before a compromise and I wouldn't take it very seriously. A large amount of it is posturing in order to get better things in the market. Otherwise how is this high-end private sector going to cater to this 50 crore patients? This is an opportunity for them to expand the market to those people who are not in their sphere.

Both in the government insurance system as well as the private one, people end up ultimately spending more money than what they were insured for. Say somebody has insurance for Rs 5 lakh but then in a catastrophic illness they go to a private hospital and actually require Rs 10 lakh for treatment. I understand that there will be some negotiation between insurance companies and the hospital, but the patient has to pay the extra Rs 5 lakh. In Gujarat the government started a Chiranjeevi scheme, under Dr. Amarjeet Singh who was the commissioner of family planning there; that was about 15 years ago. They were offering around Rs 1,800-2,000 for caesarean section. When we were interacting with the women in south Gujarat it emerged that people were looking at it as a kind of a subsidy for the larger bill that they get in the hospital. Most of them were paying extra money.

That brings me to the issue of regulation - much of the private business as well as the insurance business is not well regulated. When I am being asked to pay as much as Rs 10 lakhs per year, what is the logic of having this insurance? And what is the insurance regulator doing? It does not make my entire transaction cashless at all if most of the time I end up paying from my own pocket. What is happening at the ground level is very different for the patient; the hospital and the insurance company each will try to protect their own interests and so the loser is the patient because there is nobody regulating the insurance cover. Forget about socialized or nationalized health system, even in this market-based system if there is no regulatory framework the interests of the patient are completely lost.

What happens even to the middle-class, who buy directly from the insurance company and are at the insurance company's mercy because there is no recourse available for them. They may pay lower premiums and have lower cover, but in the end may still be paying out-of-pocket. Who says that government service is today free? Even when we access government service we pay lot of money. A cardiology procedure in KEM hospital is not free of charge. I pay a lot of money. So as a patient what I see is that if you are paying Rs 25,000 to a private hospital on top of the insurance reimbursement, and would otherwise pay Rs 25,000 in a government hospital, then the private hospital's bill seems fine because I would have paid this same charge in the government hospital. What we are talking about this entire business transaction, is leaving out large number of these consumers, who have no idea of why it is happening.

Ravi Duggal: If you look at data from the NSSO, out-of-pocket spending has gone up in the states which have had these insurance schemes, government schemes. And if you look at the insurance sector, currently a total of Rs 35,000 crores is paid annually as insurance premiums, covering 45 crore people. The majority of these people – 34 crore people – are covered by government insurance schemes, but the government's contribution to insurance premiums is only 3,500 crore. This means that there is a huge burden falling on the middle-class that uses private insurance.

Abhay Shukla: How can we find out about the rates for common procedures in private hospitals, such as surgeries for cataracts, caesarean-sections, hysterectomies, knee replacements and angioplasties?

Subhash Salunke: You have to go individually to this hospital.

Ravindra Karanjekar: Every hospital gives its rack rate to the insurer and then starts negotiating. So insurance companies have all the rates of all the hospitals empanelled with them.

Ramila Bisht: Let's finish now and on behalf of the entire project team I thank all our witnesses for their contributions. Thank you.





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