Webinar Report

"Tackling commercialisation and corporatisation of Healthcare: Highlighting people's experiences in time of COVID, moving towards social regulation and UHC"

28th May, 2021

Webinar Conveners :

- **Dr Dhananjay Kakade - Head of Institution, SATHI**
- **Dr Abhay Shukla - Global Steering Committee Member, COPASAH**

Background:

COPASAH – HARPS[1], hosted by SATHI-Pune, organised a global webinar on '**Tackling commercialisation and corporatisation of Healthcare: Highlighting people's experiences in time of COVID, moving towards social regulation and UHC'** on 28th May 2021. This report provides a brief summary of the discussion in the webinar.

The COVID-19 pandemic is ravaging different parts of the world, particularly in India; consequently, there has been an unprecedented demand for healthcare services. To tackle this public health crisis, many countries are trying to utilize private health care sector capacities to augment overstretched and weak public health systems.

As a pre-emptive step, fifteen states in India proactively intervened to fix the private healthcare sector rates for COVID 19 treatment. Admittedly, rate capping in the private health sector is a makeshift arrangement, but significantly important given the prolonged laissez-faire policies towards private health sector regulation, and more so regarding rate regulation until recently. However, experience of patients from various LMICs, including in India, point to challenges in implementing these regulatory measures. These trends indicate that private healthcare sector engagement in LMICs has been generally ad hoc and improvised for the pandemic, rather than well planned with a view to sustainability.

The private health sector's "business first" attitude, even during the pandemic, is a manifestation of commercialisation, confirming that profiteering is alive and thriving in the midst of the most challenging public health crisis the world has seen.

At this juncture, it appears important to take stock and learn from experiences of public engagement with the private healthcare sector in the COVID context, while exploring implications and policy directions regarding such engagement processes even beyond the pandemic. There seems to be no doubt that the COVID-19 crisis will reshape health systems in many LMICs, including the mode of operation of private healthcare providers, and their intersection with governments. The webinar was organised with the intention to understand the emerging situation better and discuss the following:

(i) Sharing key insights from SATHI's research in India on corporatization of the private healthcare sector, and issues concerning regulation of private healthcare providers, identifying commonalities with regional and global trends.

[1] COPASAH is a global community where practitioners who share an interest and passion for the field of community accountability and social action in the health sector, interact regularly and engage in exchanging experiences and lessons. COPASAH- Hub on Accountability and Regulation of the Private health Sector (HARPS) is currently being hosted by SATHI and focuses on developing frameworks and resources for people centred accountability of private and corporate health care sectors.

(ii) Discussing key policy lessons from selected countries in context of the COVID pandemic, related to experiences of healthcare profiteering, and responses from states in form of regulatory measures and public engagement of private providers.

(iii) Identifying opportunities for collaboration among practitioners, researchers and regional and international institutions working on accountability of private actors in the health sector.

Around 110 participants comprising public health activists, academics, researchers, accountability practitioners from Asia, Africa, Europe and Latin America attended the webinar.

The moderator, Dr Dhananjay Kakde, extended a warm welcome to all the speakers and participants and gave a brief introduction about COPASAH and the purpose of the webinar.

Session 1-

Contending directions for private healthcare: Corporatisation vs. Social regulation Possibilities for health system change emerging from the pandemic- Dr Abhay Shukla

Dr Shukla, COPASAH Global Steering Committee Member, elaborated on the transnational growing phenomenon of corporatization of healthcare with healthcare infrastructure in LMIC countries like India being controlled and heavily influenced by private corporations, backed by multinational finance investors. He referred to the key findings from a recent collaborative study conducted by SATHI and Kings College, London which noted that commercialization of healthcare gathered momentum with the rise of private nursing homes and hospitals, and since the turn of the millennium, multi-specialty and corporate hospitals have emerged as powerful players. This trend has led to a whole range of distortions of the healthcare delivery process with physicians employed in corporate hospitals losing their autonomy to prescribe, forced to meet performance targets, leading to exorbitant treatment costs for patients. This profit centered approach is influencing all other players in the sector as well, including individual practitioners, small, medium, large, and charitable hospitals and changing the entire nature of medical practice, from marketing, admission, treatment practices and referrals.

"COVID pandemic has acted like an MRI scanner for health systems and exposed their weaknesses."

In India, people experienced the impact of understaffed, underfunded public health services. With much hyped government funded health insurance schemes not working to provide succor, people were forced to pay out of pocket for COVID treatment with many falling prey to large scale profiteering in the unregulated and commercialized private healthcare sector.

Two lessons emerged against the background of the COVID-19 epidemic. Firstly, healthcare must be a public good, owned by, embedded in and responsive to society rather than being dictated by the market. Public health systems are vital and irreplaceable and are indeed the only institution which can be relied upon to serve people in a health crisis. – Dr Shukla

Secondly, the stark evidence of uncontrolled exploitation in the private health sector has underscored the urgent need for regulation and social accountability. On the positive side, the political will for regulation materialized overnight in the pandemic. Many governments were forced to regulate private healthcare providers in some form or the other. On the negative side, many of these ad hoc solutions are temporary measures to deal with the public health emergency and are not legally or socially institutionalised and saw mixed success.

Dr Shukla elaborated on the emergence of two contending paradigms in the healthcare sector, which have been sharply highlighted by the pandemic. One paradigm holds healthcare to be a public good and health systems to be core social institutions, whose primary purpose is to provide people healthcare in an equitable manner. The other paradigm essentially views healthcare as a commodity and a locus for capital accumulation and profit maximization with the existing range of healthcare providers lying on a spectrum between the two paradigms.

Offering a historical overview of the transition from one paradigm to another in the Indian context over the past seventy years, Dr Shukla summarized it as a trajectory of commercialization and then corporatization of healthcare and elaborated on the forces controlling private healthcare providers.

Private healthcare providers are compelled to be responsive to society, to offer a certain degree of trust, reliability, affordability and rational treatment to their patients. On the other hand, they are being increasingly pulled by the market imperative to maximize their profitability, thus opting for expensive, unnecessary interventions and irrational care. The market imperative aided by the unseen hand of finance capital is the major attractor and powerful force shaping the private health sector today. The missing actor in this scenario is the State which plays a crucial role to determine which direction healthcare providers will actually be pulled in. In the current situation, finance capital and corporate forces have captured or heavily influenced the state in the direction of further commercialization.

"**The challenge before society today is that it needs a socially accountable welfare state, where society and the state work together to ensure that healthcare works in the interests of society, not just in the interests of the market and corporate forces.**"

Dr Shukla pointed out that the forms of engagement between public health systems and private healthcare are on a spectrum between these two contrasting and contending models. On one hand is the current market-based engagement with public private partnerships and health insurance schemes, which allow for a degree of optional involvement for private healthcare providers, with market rates remaining dominant in a fee for service environment. In this scenario, treatment practices remain irrational, control of admission remains in private hands and there is very weak social accountability.

On the other hand is a contrasting version where health is a social good, public engagement is mandatory, rates are regulated across the board and it would be a free service environment in which admissions would be controlled by the public system, universal in nature with effective social accountability.

Dr Shukla noted that healthcare delivery arrangements which have emerged during the pandemic have moved somewhat in the direction from a purely market based engagement towards the public health engagement which is a significant step. However, this shift is temporary and just may revert to the older pattern unless the principle of public regulation and harnessing of the private sector for universal healthcare basically becomes the dominant paradigm. This paradigm shift towards socialised healthcare will also influence its regulation.

Dr Shukla referred to a working paper recently published by Oxfam India and drafted by the SATHI team, which has attempted to unpack the entire regulatory discourse and pose a more socially embedded and contextualized understanding of regulation of private healthcare and explore solutions to break the regulatory stalemate in India and move towards social regulation of healthcare.

Emphasizing that healthcare is a contentious commodity; Dr Shukla asserted that social embedding of healthcare is critical for its equitable distribution and rational use. The COVID crisis has given society a rude jolt as all actors across the board have recognized that this model of marketized healthcare, increasingly detached from society, is not going to fulfill social needs.

This realization opens up the possibility of reimagining healthcare in the post-COVID scenario with two clearly emerging options. One option is expansion of some healthcare coverage for the poor, continuing on the earlier models of commercialized and market-oriented engagement between public systems and private healthcare providers, leading to a scenario where corporate conglomerates will take over large portions of health care provisioning, being subsidized by the state.

Dr Shukla elaborated on the following steps for converting healthcare into public good moving towards universal healthcare-

- Documenting market failure during COVID; highlighting stories of denial and violation related to private sector; demanding patients' rights
- Exposing large scale irrational care and related exploitation during COVID pandemic
- Campaigns for regulation of private healthcare, with focus on rate regulation, including expanded public regulatory capacity and social accountability mechanisms
- Taking a differential approach to small and charitable vs. large and corporate healthcare providers, with focus on regulation of rates and rational care
- Interrogating State funded health insurance schemes – exposing their failure to respond during COVID
- Demanding transformation of current market-oriented arrangements, into public-centred regulation and harnessing of providers

In his concluding remarks, Dr Shukla emphasized that placing a people centered universal system of healthcare on the socio political agenda was the conceptual shift that needs to happen in the light of the experiences of the COVID pandemic. The pandemic is a window of opportunity for society to completely reconstruct health services and systems by replacing the dominant profit logic with social logic, which holds healthcare to be a human right.

Session 2-

Regional experiences – What has the COVID pandemic revealed about impacts of commercialisation of healthcare?

Speakers- Moses Mulumba, Marco Angelo and Dr Abhijit More

A. Moses Mulumba (CEHURD, Uganda)

Moses described the impact that COVID-19 had on health systems in African countries. The pandemic took all nations by surprise, leaving governments with little time to prepare for the demand for healthcare services, occupied as they were with emergency measures to contain the spread of the pandemic. Health systems of most countries were not ready to deal with a public health crisis of this magnitude. All actions taken were ad-hoc, to somehow tide over the emergency. Weakened due to lack of investment, the public health sector lagged considerably behind the private health sector in responding to the epidemic. The

private health sector, flush with funds and other resources, had a distinct advantage and rapidly took over every aspect that was relevant to the COVID-19 pandemic response, including emergency relief activities, medical supply procurement.

While African countries waited for relief funds and solutions to come from the North, this time was different as initially high-income countries were impacted far more by the unprecedented spread of the pandemic. Relief and support work slowed down as governments took a long time to decide on an appropriate epidemic response; to identify and classify essential services and permit their functioning. The private sector was quick to capitalise on the epidemic as an opportunity for profiteering. The lockdown of non-profit players and accountability practitioners for months, created even more possibilities for the private health sector to profit from the pandemic in the absence of any monitoring.

> *A public health emergency creates even more opportunities than usual for corruption and collusion between the state and private actors. With mobility, international trade and movement grinding to a halt,, countries had to make do with whatever meager stock of medical supplies they had, causing a huge black-market boom for desperately needed supplies of PPE and medicines. There is a marriage of convenience between security, secrecy, private actors and the weakened government – which is a part of the global agenda to replace public health systems and commodify healthcare-* ***Moses Mulumba***

Mulumba pointed out that neoliberal policies and structural adjustment programs in most countries across Africa de-emphasized public health approaches of the eighties and focused on economic market based approaches towards healthcare, with the consequence that the private health sector has become the dominant player today. In Uganda today, people pay out of pocket for 50 % of their healthcare needs and public health systems provide just 15 % of healthcare which is focused on specific diseases like HIV/AIDS or malaria. As opposed to strengthening public health institutions and facilities, weakened states have made way for increasing involvement of private actors in delivering health services through public private partnerships.

The colonial system of provision of healthcare means that regulation is focused on the public system provision rather than on the private healthcare sector which therefore is not concerned with accountability. The COVID 19 pandemic response across Africa was characterised by large- scale exploitation and corruption. In Zimbabwe, the health minister was fired for misallocation of COVID relief funds. In Kenya and Nigeria, money meant for PPE procurement was diverted for personal use while in Uganda and South Africa, PPE were sold at exorbitant prices. In Uganda, oxygen cylinders were procured from the private sector at huge markups. These examples are emblematic of the impact of the highly privatised health sector and lack of accountability during the pandemic.

B. Marco Angelo (Global Health Advocate with WEMOS, Netherlands)

A medical doctor by training, Mr Angelo worked in Lombardy, Italy which was the most affected province in Italy during the COVID-19 epidemic and presented his experience of how privatisation impacted the handling of this public health crisis in the province of Lombardy, which has also been released as a brief by GI-ESCR.

He highlighted the extent of the epidemic in Lombardy, stating that there were 33,000 deaths in Lombardy in the first wave, as compared to 4000 deaths in Wuhan, China. The epidemic started in the two neighboring districts of Lombardy and Venice, but the outbreak was much worse in Lombardy than in Veneto. At its peak, there were 60,000 cases in Lombardy as compared to 15000 cases in Veneto, with mortality an estimated three times higher than in Venice. These numbers are noteworthy considering that Lombardy is the richest province in Italy with a GDP equivalent to that of the Netherlands or Switzerland. It has a highly privatized health sector, which was even praised as it is very specialized, contributing 8 billion euros in GDP. How could such a rich province with a highly developed health sector have such high mortality?

In Italy, provinces have autonomy in their health budgets and in implementing their health systems. Lombardy had introduced a quasi-market health care system – private providers directly competed with public actors for government funding through a system called as Accreditation, where they are reimbursed by the state for services provided to people.

***Privatization does not make up for lack of investment in the public health sector*- Marco Angelo**

In the last decade, there were cuts of 37 billion euros in the public health budget of Lombardy. With more and more people turning to the private health sector, 50 % of healthcare services today are provided by completely private and accredited private health providers. Private hospitals also absorb between 40 to 50 % of the public health budget. As private hospitals invested in more lucrative, profitable and in-demand services such as rehabilitation centres and old age homes, public hospitals were left to provide intensive and acute care. Since a high percentage of the public health budget went to private actors, the public sector was chronically underfunded, leading to a decrease in the number of acute care beds in publicly funded hospitals along with proportional decrease in practitioners of non-lucrative branches of family medicine and preventive care. Furthermore, in 2015, Lombardy introduced a reform in the health care system due to which the fifteen public health institutions responsible for infectious diseases surveillance, tracking and testing and coordinating in health emergencies were reduced to eight.

With this background, it was clear that the system was quite unprepared to deal with the COVID pandemic, with the response in Lombardy being hospital centric. As public health authorities did not have the capacity to coordinate with all the family doctors, they were completely left out of the response, with patients going to understaffed and under equipped public hospitals. These then turned into de facto multiplication centers, where patients and doctors infected other patients and visitors.

Fully private hospitals didn't participate in the epidemic response at all, preferring to close down and only re-opened after the pandemic was over. Accredited hospitals initially also refused to be involved in the response, saying they didn't have the capacity to deal with infectious diseases. It was after two weeks that the government began to force private providers to intervene and join in the epidemic response and even then it was able to mobilise a far lesser number of acute care beds than any other region in Italy.

In conclusion, Mr Angelo stated that the experience in Lombardy showed that it was a mistake for the government to think that it could step away and dis-invest in healthcare and use the private sector to deliver health services. This shift in priorities significantly affected the spread of COVID 19 in Lombardy. The public health sector was unprepared to deal with the epidemic because it was underfunded and the private health sector failed to step in as it was hyper specialised and built to deal with completely different healthcare needs.

C. Dr Abhijit More (Jan Swasthya Abhiyan, India)

Dr Abhijit presented experiences from Maharashtra, one of the most Covid affected states in India. In the beginning of the pandemic, only public health facilities were providing COVID care to people and many small nursing homes and private hospitals shut down, with doctors refusing to treat COVID 19 patients. When state governments issued legal provisions to force private hospitals to treat COVID 19 patients, they charged patients very high rates from 25000 to 150000 rupees per day, to dissuade them from admission.

High rates of admission in private hospitals were and still are a major area of concern to ordinary citizens. In the beginning, there was major profiteering through overcharging of PPE kits, inflated bills for COVID 19 tests and irrational treatment such as plasma transfusions. Later, antiviral drugs like Remdesivir, Tocilizumab were over – prescribed to such an extent that there was a huge shortage; with patients and their families forced to procure these drugs on their own, often at exorbitant prices in a black market. The government was again forced to step in and regulate the prices, procurement, distribution and prescription of these medicines. Amidst public outrage and media coverage of blatant profiteering, the government of Maharashtra announced the following measures to regulate rates of COVID 19 treatment in private hospitals.

- 80 % of beds in private hospitals were acquired to supplement public capacity
- fixed charges of COVID treatment in three tiers : ICU, ICU with ventilator and wards

- Bills ofmore than 150,000 rupees were subject to auditing by state health authorities.
- Coverage of the MJPJAY – a state PPP health insurance scheme extended to all citizens of Maharashtra, instead of just the poor.

> *Rate regulation, which was hitherto declared to be impossible by the private health sector thus became a reality during COVID 19, albeit temporarily. Though these progressive measures were welcomed, they remained largely on paper as they proved to be ineffective, particularly in rural areas and their implementation suffered due to lack of capacity and human power*- **Dr Abhijit More**

A study from Pune, one of the worst affected cities in India showed that a scant 1.86 % of total numbers of bills were audited, with a large number of patients still awaiting scrutiny of their bills. Studies also showed that a mere 4 % of COVID 19 patients benefited from the MJPJAY (state insurance scheme) due to lack of awareness amongst beneficiaries, unavailability of empanelled private hospitals and red tape. With a majority of people paying out of pocket for COVID care, the limitations of PPPS were thus proved.

The civil society response to the crisis was a first with massive protests in many cities, demanding hospital beds, ICUs and ventilators. The Maharashtra chapter of the People's Health Movement organized the first public hearing of patient's rights denial during the pandemic with patient victim testimonies. Activists demanded an increase in the state health budget and investment in the massively underfunded public health system, along with protection of patients rights. Dr More expressed the hope that this movement would bring sustained change in the health system with better regulation of the private health sector.

Session 3-

Panel discussion- Panel discussion- Reimagining health systems in the pandemic recovery and post-pandemic scenario.

Panelists- Dr Sundaraman - Global Coordinator, People's Health Movement, Anna Marriott- Health Policy Advisor, Oxfam GB

Panelists were requested to speak on the following three aspects-

- Insights regarding commercialized private health care and market-oriented PPPs during the pandemic
- Key lessons from the pandemic regarding state initiatives for regulation of private health care
- Action points in a to-do agenda for accountability practitioners and researchers

A. Anna Marriott - Oxfam, Great Britain.

Anna stressed on the critical need to focus on the dominance of certain invisible actors in the discourse on privatization and regulation of healthcare; namely the global finance development agencies and so-called donor or rich country governments in the global health architecture and their disproportionate role in using public financing to encourage and promote an ever-greater role for commercial actors in healthcare.

> *To deliver the right to health, the vast majority of health care needs to be financed and delivered by governments. A strong, accountable, universal and equitable quality public health care system, that everyone can access close to where they live and work, that is free at the point of need is also the only effective way of regulating commercial health care providers in health. Unless that foundation of universal, accessible and quality public health care exists, private actors actually have nothing to compete against and there is nothing to stop the inevitable race to the bottom on standards and a race to the top on pricing* - **Anna Marriott**

Elaborating on the role of the development actors in the global health architecture in the commercialisation and financialisation of healthcare, Anna highlighted that international financial institutions such as the World Bank and the IMF and their structural adjustment programs have had an impact that not only continues to decimate investment in public health care systems even today, but also directly or indirectly promotes the role of commercial actors in healthcare systems. Since 2005, a more purposeful narrative and role for development finance institutions has emerged in actual sponsorship and investment of public monies in these corporate actors that are violating people's rights today in the global south.

Elaborating on the research conducted by Oxfam, she disclosed that investments of around $1 billion were made on behalf of the World Bank by the International Finance Corporation across Africa's private healthcare market over the past few years, the overwhelming majority of which was going to corporate high-end hospitals that were out of reach for ordinary people and targeted elite nationals and medical tourists. Oxfam also analysed the scope and scale of development finance funding from France, Germany, UK& the EU commission who have been bankrolling many of the same corporate actors in India and across Africa and found that a significant funds from the aid budgets of developed countries went into these corporate actors to the tune of over 1.5 billion dollars of direct investment, but billions more in indirect funding through financial intermediaries which makes these funds unaccountable and difficult to track or prove a direct relationship.

The majority of financing was through loans, requiring repayment with high returns, which then puts pressure on the corporate actors to maximize their profit at every turn. Another

finding from their primary research in India in which they documented patient experiences of patients who sought care in these hospitals was a notable change in the way that many of these profit centered corporate actors behaved and ruthlessly exploited patients, once they became financialized with equity funds playing a big role in bankrolling them.

Other findings include that the vast majority of this development money was going into large transnational businesses, public private partnerships, and hospital complexes and to corporate hospital chains through equity investments, financial intermediaries or joint ventures between the two. The Indian health care market is increasingly related to the African healthcare market with some of the same companies being invested to stretch their tentacles into new markets and to buy local hospitals as a resource of this monopoly ownership. The majority of the investments were in middle income countries where income disparity and the accumulation of wealth meant that there is more of a market for health services. By studying the investments made by the major four European donors, Oxfam found that at least 88% of the private healthcare providers funded through development funding were charging fees that were too expensive for those living in poverty or on low incomes, and in many cases even beyond the means of the middle classes in these countries, without incurring considerable debt.

Oxfam's research concluded that the UK, French, German governments, as well as the European commission and the International Finance Corporation are paying minimal or no attention to whether their development funding to for-profit private actors improves health outcomes or meets their development mandates to reduce poverty and suffering. Their follow-up research in India where they interviewed patients, utilizing the services funded through these aid budgets revealed violations of patient rights such as unnecessary procedures and treatment, malpractice, negligence, as well as repeated refusal of treatment. Hospitals funded in countries like Uganda and Kenya have frequently detained patients for nonpayment of bills, which is again a gross violation of people's human rights.

She stated that **Oxfams message to the likes of the UK, French and German governments is to divest from these healthcare providers; to stop bankrolling and sponsoring the commercialization and privatization of healthcare in the name of development. Development money, which is given with the intent to improve people's access to health care, improve equity and achieve sustainable development goals should absolutely not be plowed into these commercial actors when there is clear evidence of the large-scale abuse at their hands.** There is a need to confront these funders who are either unaware or in denial about the ground level impact of their funding, choosing to look at their investment as business transactions when they need to be held accountable for their obligations to the right to health.

Reiterating that regulation of existing private healthcare actors cannot happen in a vacuum of public provision, Ms Marriott concluded her remarks by calling on donor governments to invest now more than ever in strengthening public health care systems and ensuring

provision of universal and equitable care, as well as in the regulatory systems necessary to help boost the State's capacity to hold private commercial providers to account.

2. Dr T Sundararaman, Global convener of the People's Health Movement

Dr Sundararaman observed that the whole thrust towards the private sector and the commercialised, purchase based architecture of healthcare delivery had failed spectacularly in the COVID epidemic. The attempt of the government to shift its role from that of a provider of a public service of a public good under the rubric of universal health coverage into a purchaser of healthcare from a largely private sector delivery mechanism using market forces, market competition, and market mechanisms did not work as intended as was evident from the presentations from Africa, Italy and Maharashtra.

Dr Sundar pointed out a common pattern, wherein the private health sector initially took a hands-off approach and refused to join in the epidemic response, claiming that infectious disease control was not its business. It was not willing to take personal or other associated risks or bear the stigma associated with dealing with COVID-19. The government intervened later and tried to re-invigorate mechanisms of different types of partnerships to get them to provide care in a public health crisis. Most important were the state funded health insurance programs which are supposed to provide cashless services while purchasing care from the private health sector. In India, many beneficiaries were unable to access the central government's main vehicle of publicly funded health insurance - PMJAY. A number of private hospitals were then designated as COVID hospitals where again many people reported experiencing denial and cherry picking of care where only low risk cases were taken up or patients were admitted based on their ability to pay. Certain states like Maharashtra and Tamil Nadu then brought private hospitals under government control to admit patients and reimbursed them for provision of care. But to a large extent across India, bulk of COVID 19 care was provided through public tax funded institutions.

> ***The paradox in the post COVID world was that a strong case was made for the public sector, but in practice, it has been observed that there is actually a push in the opposite direction*- Dr Sundaraman**

Dr Sundar remarked on the irony of the fact that as India stood on the cusp of an inevitable second wave of COVID 19 on 31st March 2021, NITI Aayog, the government's chief advisory body organised an event to encourage foreign direct investments in the Indian health sector, promoting a gold mine of opportunities to make profits out of healthcare. He emphasized that the state was creating policy to support a shift to corporate development in healthcare and it wasn't the market but state investment that is shaping the private health sector at a time when its ability to provide care has collapsed. This agenda of

commercialization is a global phenomenon as evidenced from the three case studies presented in the webinar.

Another clear example of policy change to support commercialization comes from the Indian experience with COVID 19 vaccines, wherein up to February 28th, 2021, the government policy was to essentially procure vaccines from the only two manufacturers in India and distribute them free through public institutions and at a fixed price inempaneled private hospitals, prioritizing health care and frontline workers along with high-risk groups. This scheme was working reasonably well with all its limitations, when the private health sector with its own profit logic eventually decided that the vaccine policy was not working for the market.

On 21st of April 2021, the government did a volte-face and announced a new policy to come into force on May 1st, which basically stated that the central government would procure 50% of the vaccine supplies, with State governments and the private sector competing for the remaining 50% of the supplies, with both domestic and international manufacturers able to set the prices and negotiate with buyers, thus opening the markets.

Dr Sundar observed that vaccines were available in only four or five corporate hospital chains, with many fixing vaccine prices according to their own choice. He questioned why the central government would leave a perfectly viable and functional vaccine policy, that has no public complaints, even from the manufacturers, in favor of a market -centered policy to enable various actors to make so called 'super profits'. This proposed model tanked as states who floated global tenders didn't find any takers and international vaccine manufacturers indicated that they would only negotiate with the central government in a seller's market. The government also didn't consider options for increasing vaccine manufacture through the public sector or contracting the domestic private sector in its thrust towards market competition. Moreover, market competition cannot exist with only two monopoly providers within the country and a very few limited providers outside the country.

Pointing to the rollout of IFC investments as mentioned by Anna Marriott, promotion of foreign direct investment in healthcare, ongoing governance changes, Dr Sundar highlighted the overall trend of the relentless push towards privatization and commercialization, contrary to the evidence of its failure and the dependence upon the public health sector during COVID 19.

Dr Sundar offered two explanations for this paradigm. Firstly, capitalism has not willingly conceded space for the public sector to exist, but it was forced to do so due to popular resistance. Referring to the examplle of sickness funds in Germany which were initiated by trade unions and formed the base for universal health coverage and to the NHS in the UK, Dr Sundar stressed the need for a united movement of the people and the working classes to mobilize for public healthcare.

COVID-19 has reduced the space for democracy at all levels, whether it is in parliament, civil society organizations or protests on the ground. The marked reduction in the demonstration of public resistance with undermining of democratic processes is one reason why corporate controls and influences that exist over government are able to go on unchecked.

The second explanation is the lack of a coherent intellectual discourse around the public health system and its improvement. The intellectual hegemony on privatization and the commercial alternatives, the role of market competition and how markets will affect healthcare dominates the narrative on development of healthcare.

In summary, Dr Sundar emphasized that it is the people who will have to play an important role in challenging both of these areas, on the democratic front and in maintaining an open discourse and continued resistance to the hegemony of the private sector. He stated that it was not only important to propose alternatives, but also to expose the problems that would result with the collapse of the public health system. It is critical to develop an understanding of how public discourse leads, justifies and legitimizes a change and the imperative for the academic community and civil society to build a certain discourse around universal coverage before bringing in large-scale shifts to purchase of healthcare.

The third session focused on discussion with participants, some of which key questions and answers are outlined below.

Q: Do you think the mindset associated with quality health care and services and private hospitals and nursing homes is a consequence of the rise of private hospitals and nursing in the 20th century? Or is it vice versa?

Dr Abhay Shukla replied to the question, stating that the parameter of healthcare quality, at least in Northern India, was a public hospital like AIIMS and similarly JJ and KEM hospitals in Mumbai. In the 1980s, public hospitals were not only the largest hospitals but also the ones which were associated with medical colleges in most situations. With public hospitals being gradually starved of funds thereafter, senior doctors with decades of expertise migrated to the private sector over the next three decades for better pay and working conditions. The private health sector was also able to acquire sophisticated technology, which public hospitals had no access to, leading to a shift in perception of quality from the nineties onwards. The simple solution to reverse this perception is to resurrect, strengthen and expand public hospitals, to retain skilled and trained human power and invest in infrastructure and technology.

Q: Are there any details about budget donations or grants received from private donors to government of India? Is there any analysis of the cost of healthcare in the COVID-19 period?

Dr Sundar believed that there has not been any analysis of crossover health care so far, except a study of the package costing for COVID-19 and gaps. Budgets are transparent

documents, but are not necessarily the expenditure documents in India. Increasingly so, under the current government, there are huge differences between sanctioned amounts, revised amounts and actual expenditure. Data of health budget expenditure of the COVID 19 year 2020 -21 would come much later. He suggested that documentation and analysis of cost of healthcare and out-of-pocket expenditures during the COVID epidemic across the country should be done by researchers to show what has been happening in the private health sector despite rate regulation and PPP schemes.

Q: Do you consider Big Pharma promoted research has taken a position against the utilization of more available and affordable drugs like Ivermectin to prioritize the use and purchase of other more expensive drugs?

Dr Sundar admitted that while big Pharma invests in research and has ways of aligning it with their priorities, it is a bit of a stretch to assume that it has conspired against cheaper drugs which have not necessarily proven to be efficacious. There have been far too many agencies, including academic and expert committees which have examined the evidence and found it wanting. However, expensive drugs like Remdesivir, which didn't work were aggressively promoted; cheaper drugs like Ivermectin which didn't work either have not been promoted to that extent and therefore did not have that credibility or exposure.

Q: Enterprises merge big health insurance companies owning at the same time private hospitals and private hospital pharmacies. Is this not a conflict of interest?

Dr Shukla agreed that there is a conflict of interest regarding this issue, pointing out that the main income for many private hospitals is from the in-house pharmacy and from diagnostic laboratories which they declare as separate enterprises. So the return on investment in a corporate hospital flows more from the deployment of technology rather than service delivery including medical consultations. The conflict of interest is more when patients are especially limited to purchasing medicines from within the hospital pharmacy, where generic drugs are not available.

Q : In terms of the COVID-19 experience, what are the new research frontiers or agenda that could be pursued for the next 18 months or so ?

Panelists and speakers outlined the following research possibilities:

1. Collation of case studies from places like Lombardy, Maharashtra and even from the UK where contracted private providers had empty facilities during COVIDand were yet rewarded with lucrative contracts for practically doing nothing, even at the height of the pandemic.
2. Collaborative research on the impact of privatized health systems on the COVID response, combined with analysis of efforts and policies that governments have

attempted to implement in these chaotic architectures and the reasons for their failure or success in bringing the private sector under control.

3. Research on prerequisites of resilience in health care systems, amongst which is the ability to maintain essential non Covid services in the middle of a pandemic and to document good case studies of best practices where health systems have done so successfully.
4. Analysis of domestic manufacture and scaling up of manufacture of essential services in pandemic times and to explore conditions and processes to enable scaling up across different areas in short turnaround times.

Q : Global tenders for vaccines floated by state governments have failed. NITI Aayog defended allegations against the central government by stating that health is a state subject. What could be the immediate remedy to procure and distribute vaccines, in such a situation?

Dr Sundar underlined the fact that health was not a State subject, but a Concurrent list subject, especially when the Centre had assumed all powers to manage the pandemic through the National Disaster Management Authority. There has never been a case for the states to procure vaccines independently as they have traditionally always been procured by the Centre on behalf of the states, with financing divided between States and Centre. Dr Sundar stressed that the Centre has to be held accountable for its stand on COVID vaccine policy, adding that states did not have the capacity to undertake complex global vaccine tender and procurement processes and that procurement from a monopoly is best done by a monopsony.

Anna Marriott added that the Indian government has a real opportunity to demonstrate global leadership on the need to change the current inequitable model of COVID vaccine distribution. India has made a proposal for a waiver of intellectual property but it could be doing so much more to make its case stronger, such as issuing compulsory licenses to domestic manufacturers and have in effect, an industrial policy to manufacture these vaccines at scale. India could thus be at the forefront of the global stage in terms of its capacity to maximize vaccine production to meet needs beyond India as well.

Concluding Remarks:

Dr Marco Angelo pointed out though Lombardy was actually praised as a positive model of private contracting in World Bank discourse, problems with this model of healthcare delivery existed even before the pandemic exposed them and needed to be explored further. The former president of Lombardy was arrested for corruption related to the health care system. Underpaid nurses in accredited private hospitals had organized protests against a system which exploited healthcare workers to maximize profits. There were also

many cases in which private providers conducted unnecessary treatments, even surgical operations on patients to get state reimbursement.

Dr Abhijit More observed a clear pattern amongst the three case studies of a weakened public health system and overdependence on a private healthcare system, led by corporate influences and publicly funded health insurance. The pandemic response clearly proved that even if the State intervened with corrective measures, it lacked the capacity to implement them effectively.

Moses Mulumba noted that the shared experiences were illustrative of the truth that the primary responsibility of provision of healthcare inevitably comes back to the state in public health crises like the COVID 19 pandemic and reiterated the need to revisit colonial era regulation that was restricted to the public health sector and expand its reach to the private health sector as well.

Dr Abhay Shukla added that the COPASAH HARPS could be used as a platform for further such experience exchange and even collaborative, action oriented research such as putting together case studies from different countries to refine and exchange practical strategies regarding advocacy and campaigns around this entire theme of moving towards Universal Health Care.

In his concluding remarks, Dr Dhananjay Kakade discussed the possibility to document people's lived experiences of dealing with the health system during the COVID pandemic in an archive as a collage of voices. COPASAH, being an accountability practitioner's forum, also needs to reinvent tools to capture people's expectations and demands from the health system in the aftermath of the epidemic.

He thanked all the attendees from different parts of the world for their enthusiastic participation and comments, the webinar coordinators and acknowledged the presence of COPASAH global steering committee members from Asia, Africa, and Latin America.

Webinar report compiled by Dr Kanchan Pawar

Annexure

Tackling commercialisation and corporatisation of private healthcare: Highlighting people's experiences in time of COVID, moving towards Social regulation and UHC

Organised by COPASAH – Hub on Accountability and Regulation of Private Sector
28th May, 2021

Timing (IST)	Topics	Presenter/Moderator
4.30 to 4.40 pm	Introduction to the webinar and context setting	**Dr Dhananjay Kakade** (Head of Institution - SATHI, India)
4.40 to 5.00 pm	Contending directions for private healthcare: Corporatisation vs. Social regulation Possibilities for health system change emerging from the pandemic	**Dr Abhay Shukla** (COPASAH Global Steering Committee Member and SATHI, India)
5.00 to 5.40 pm	**Regional experiences** What has the COVID pandemic revealed about the impact of commercialisation of healthcare?	**Panellists** **Moses Mulumba** (COPASAH Global Steering Committee Member and CEHURD, Uganda) **Marco Angelo** (Global Health Advocate, WEMOS Netherlands) **Dr Abhijit More** (People's Health Movement, Maharashtra, India) (12 mins each)
5.40 to 6.20 pm	**Panel discussion-** Reimagining health systems in the pandemic recovery and post-pandemic scenario • Based on the pandemic experience, what are the insights regarding commercialised private healthcare and market-oriented PPPs? • What are key lessons from the pandemic regarding state initiatives for regulation of private healthcare? • Given this context, what could be a forward-looking agenda for accountability practitioners and researchers?	**Moderator - Dr Dhananjay Kakade** **Panellists**- **Anna Marriott** (Health Policy Advisor- OXFAM, GB) **Dr T. Sundararaman** (Global Coordinator, People's Health Movement) **(15 minutes each)**
6.20 to 6.50 pm	Questions and Answers – discussion with participants	
6.50 to 7.00 pm	Summing up – SATHI representative	