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Growing Corporatisation of Private Healthcare in India and its Implications

Key insights from a collaborative study conducted by SATHI, Pune, India and Department of International Development, King's College London

The background - major changes in private healthcare in India

In India, over the last few decades the earlier state commitment to social welfare and redistribution of benefits of economic growth has been replaced by the goal of economic growth promotion by support for private enterprise; politics and policies have moved in a pro-business direction. The financial crisis in 1991 was followed by adoption of neo-liberal economic policies. Such policies have strongly impacted on the social sector, and since then both public health system and private healthcare sector have undergone significant transformations. Health care is being converted from a social good into an 'industry', having potential for double digit growth and generating substantial revenues for investors. According to Dr. Devi Shetty, cardiac surgeon and founder-owner of the hospital company Narayana Health, "The global healthcare and wellness industry is going to drive the world economy of the 21st century. All I can tell you is that India's healthcare industry will grow phenomenally" (ET Now, 2016).

In this context, in the 1980s the first corporate hospitals were set up by affluent doctors and non-resident Indians (NRIs), to provide largely tertiary level care such as cardiac surgeries in metro cities, catering to rich Indian patients and patients from other countries. There began strong advocacy and

promotion by industry bodies such as Confederation of Industry (CII), Federation of Indian Chambers of Commerce and Industry (FICCI), arguing for a paradigm shift in our healthcare policy, viewing this sector as a highly profitable arena for investment and economic growth. There has been organized interaction of industry with the government since the 1990s to promote healthcare services as a big business opportunity, wherein provision of health services through hospitals is projected as a major profit-generating activity, having the following features:

- Healthcare becoming an active component of services sector in the economy
- Emergence of corporate hospitals
- Promotion of medical tourism
- Emergence of an organized healthcare industry

Keeping in view this scenario, a collaborative study was undertaken by SATHI, Pune and Department of International Development, King's College, London during 2017-19, on 'Practices, Regulation, and Accountability in the evolving private healthcare sector - lessons from Maharashtra State, India'. Understanding corporatisation of healthcare in India (with focus on Mumbai-Pune region) was one of the objectives of this study. This research brief presents some key findings from this study along with relevant secondary information.

What is corporatisation of healthcare?

Corporatisation refers to the process of forming corporations, a way for conducting business associated with emphasis on economic performance, economic efficiency, and maximising revenues and returns for the owners and shareholders of the corporations.

In the context of health systems, corporatisation refers to:

- the process of establishing hospitals as corporations or companies
- private companies investing in health care for increasing profits and dividends to shareholders;
- entry of publicly listed companies in setting up of hospitals or listing of hospitals on stock exchanges

Such adoption of corporate structure is accompanied by several behavioural changes within the organisation, in order to maximise revenues and profit. These changes are not limited to setting up of corporate hospitals; rather this 'corporate culture' also influences functioning of other kinds of private hospitals. In India there has been a process of corporatisation of the private health sector over the past two decades, and a penetration into the entire health sector of the corporate economy, management practices and culture.

The term healthcare industry is an umbrella term used to refer to hospitals, diagnostic centers, pharmaceutical-medical equipment and devices, and the insurance industries. The hospitals sector is reported to be the major segment among all these, and hence the term healthcare industry is commonly used in India to refer to corporate and other big private hospitals.

The spread and scale of corporate investments in healthcare in India

From the 1980s onwards, hospitals in India began to be set up as private and public limited companies. By 2016-17 the hospital industry in India was estimated to be worth Rs 4 trillion (US\$ 61.79 billion and

was expected to almost double to Rs 8.6 trillion (US\$ 132.84 billion) by 2022 (IBEF 2019). There is a declining trend in individual-run enterprises in the private health sector between 2001–02 and 2010–11 and an increasing trend towards small-, medium- and large-sized enterprises. The share of hospitals within the private healthcare enterprises sector rose from 15% in 2000-1 to 26% by 2010-11 (Kumar 2015). In 2010 business rating and business intelligence institutions (such as CRISIL and CMIE) were reporting attractive returns in the healthcare industry, and an increase in sales of healthcare sector companies in 2003-2008.

Business reports show that healthcare in India has become an attractive sector for private equity (PE) investments, with international companies and investors making major investments in hospitals in India. Foreign investment in the hospital sector in India increased from a meager Rs 31 crore in 2001–02, to Rs 3995 crore in 2013–14 (Hooda, 2015).

Until 2017, the Apollo chain was 45% owned by foreign investors while Fortis healthcare has been acquired by International Healthcare Holdings Berhad (IHH) of Malaysia. Narayana Health has a major investment by JP Morgan and CDC Health with veto powers and so is now effectively 'foreign controlled' (Chakravarthi et al, 2017). In 2015 US-based Carlyle Group acquired a 37% stake in Metropolis Healthcare pathology laboratories (Balakrishnan, 2015). Columbia Asia and Da Vita (US), Fresenius (Germany), Sakra Hospitals (Japan), Abraaj (Dubai) are other multinational companies that are investing in a major way in the Indian healthcare sector. The following table shows the range of projects funded by International Finance Corporation (of the World Bank group) during two decades up until 2017.

Key findings emerging from the SATHI-KCL study

a. Changes in managerial practices linked with corporate hospitals

Corporatization is not just about structure and incorporation – it also shapes modes

Table 1: Indian Corporate Hospitals' projects funded by the International Finance Corporation, 1997-2017.

No.	Corporation	Project cost (US\$ millions)	IFC loan/ investment (US \$ millions)	IFC input as percentage of total project cost	Year of signing
1	Duncan-Gleneagles	29	7	24%	1997
2	Max Healthcare	84	18	21%	2002
3	Apollo Hospitals	70	20	29%	2005
4	Artemis	40	10	25%	2006
5	Max Healthcare	90	67	74%	2007
6	Rockland	76	22	29%	2008
7	Max Healthcare	93	30	32%	2009
8	Apollo Hospitals	200	50	25%	2009
9	Apollo Hospitals	n.s	60	n.a	2012
10	Global Hospitals	60	25	42%	2013
11	Fortis	n.s	100	n.a	2013
12	Portea Medical Bengaluru	37	7	19%	2015
13	Eye-Q Vision Private Haryana	10	5.7	57%	2015
14	Regency Hospital Kanpur	25	9	36%	2016
15	Apollo Hospitals	135	68	50%	2016
16	Glenmark	200	75	38%	2016
17	Granules	84	48	57%	2016
18	HealthCare Global	n.s	15	n.a	2016
19	Max Healthcare	325	75	23%	2017
20	Biological E	n.s	60	n.a	2017

Source: (Jeffery, 2019)

Notes: n.s. = not stated, n.a. = not available. The loan to Eye-Q was denominated in Indian rupees; the exchange rate applied was Rs 60 = US\$1.

of functioning, the approach to running an organization. Corporate governance and accompanying business practices which are more appropriate to corporations have percolated through the private healthcare sector, such as:

- ✓ Overwhelming emphasis on financial viability, cost recovery, and revenue generation from medical care.
- ✓ Management and finance personnel play important roles in the running of hospitals; most private hospitals

appoint persons trained in Hospital Administration as hospital administrators and managers; these may or may not be doctors. People with a background in finance or commerce and hospital management are being appointed as CEOs, who may be unaware of the realities of healthcare, but treat healthcare like any other business and are heavily focused on increasing turnover and numbers of patients. There is performance-based remuneration for management personnel.

- ✓ Competition between different providers and increasing adoption of marketing and advertising; it is not considered by them to be unethical for companies to do so. Organized marketing, as well as the creation of brand value, is looked upon as a necessity. Corporate hospitals indulge in the business practices of marketing and advertising of facilities and doctors to increase their business, and see no contradiction with the codes of Medical Council of India (MCI) for individual doctors, which prohibit any form of advertising by doctors.

b. Trust hospitals being managed or taken over by corporate bodies

Many not-for-profit trust hospitals are now adopting the corporate style functioning - imitating the larger corporate hospitals, with introduction of corporate management practices, emphasis on revenue generation, and introducing services that bring in more money. Several such hospitals have tied up with for-profit hospitals or hospital management companies for operations and management of hospital services. On the other hand, the role of original trustees who may have initiated these institutions to offer charitable care, becomes minimal. Vacant portions of land in the premises of the original trust hospitals are being leased out to for-profit hospitals, which are constructing new facilities there, and offering services while having profit-sharing arrangements with the original owner-trustees. Such changes have led to increase in cost of services provided in these not-for-profit trust hospitals, and the trust hospitals have become increasingly reluctant to provide free or subsidized care to poor patients as stipulated.

All the well-known Indian corporate hospital chains have made inroads in the Mumbai healthcare sector through this model of partnering with non-profit hospitals. Some

prominent examples are: Nanavati Hospital has linked up with Radiant Lifecare, a hospital management company with foreign private equity investments; Raheja Hospital has tied up with Fortis Healthcare; Masina Hospital with Apollo Health Enterprises Ltd; SRCC Children's Hospital with Narayana Healthcare; Ambani Hospital runs Vasant Malti trust hospital; Parsi General Hospital taken by Medanta-Global Health Private Ltd. In April 2019 Jaslok Hospital, one of the oldest trust hospitals in Mumbai entered into such profit-sharing agreement with IHH Malaysia, which also operates the Gleneagles Global Hospital in the city.

c. Nursing homes and smaller hospitals are either closing down or emulating corporate practices

Over the past several years, in Mumbai and Pune a large number of nursing homes and small hospitals with less than 40 beds have closed down, while virtually no new, individual owned small hospitals have come up. Some bigger ones (50 bedded which had the potential to become 100-150 bedded), have been acquired by some hospital chain. According to the Bombay Nursing Homes Association, many nursing homes were winding up or on the way to closure, due to difficulties in sustaining them in terms of both infrastructure and staff. More people are opting for insurance who then prefer to go to better equipped hospitals; there is also fear of violence in case something goes wrong. According to an office-bearer of this association "Out of the 650-odd nursing homes registered with us, about 20% (mostly in South Mumbai) have shut down". Doctors who owned small hospitals pointed to the lack of level playing field. They are not able to offer a range of exotic, luxurious facilities as corporate hospitals can".

Respondents pointed to different marketing norms for individual doctors and corporate

bodies. According to a small hospital owner, *'big hospitals put up big hoardings, whereas if I published an advertisement in the newspaper I will be questioned, I will be given a suspension and a show-cause notice'*.

d. New segments in private health sector

Dedicated hospital management companies have been set up, such as Radiant Lifecare Private Ltd, Vitalife, Hosmac which provide a range of services to hospitals, including contracted management of healthcare facilities. Hospital management is an important source of revenue in the hospital industry. Most big corporate hospital chains such as Apollo, Narayana, Fortis, etc. beside running their own hospitals, also manage other hospitals.

Companies and chains of companies are also emerging in the diagnostics sector, in pathology and imaging, such as Thyrocare, NM Medical, Medinova, Metropolis. Franchising of small diagnostic centers, specialty clinics and pharmaceutical stores is also increasing notably. Certain specialized companies provide short stay surgery such as Apollo Spectra and Nova. Companies such as Portea exclusively provide home-based medical care, including doctor consultations. Online platforms like Practo have come up, which are being widely used by doctors to increase their visibility.

e. Implications of corporatization for doctors, medical practice and patients

Corporate hospitals- a double-edged sword for doctors

The emergence of corporate hospitals seems to have created several opportunities and advantages for doctors. However, it has also thrown up various challenges for them. Several respondents pointed out that, *'doctors go to a corporate hospital because they will get good salary, they get access to a lot of advanced equipment, and they have much*

better infrastructure and personnel compared to small set ups'. Some doctors find it better to work with corporate hospitals as doctors need not make their own investments, need not worry about administrative aspects like staff, renewal of a license, etc. All this is taken care of by the hospital, and the doctor can focus on medical practice and get their income. According to a pathologist, *'Corporates have a good legal team with them that handles all these things, but solo practitioners have to manage everything single-handed. That does make a difference'*. Being attached to big corporate hospitals also conferred status, prestige, credibility and according to some, it also provided security against violence from patients, as compared to small-medium sized hospitals.

However, doctors also shared their unease and discontent, and raised serious concerns about challenges such as differential terms of employment, insecurity in employment, constrained professional autonomy and pressure of performance targets, which they have been facing while working with corporate hospitals. While senior specialist and super specialist doctors are considered elite professionals, and get red carpet treatment from corporate hospitals, early career doctors struggle to get entry in corporate hospitals and often experience a tough time working with them. While reflecting about the differential approach of corporate management towards senior, mid and early career doctors, it was mentioned that, *'Corporates are always after the big names to get more business'*. On the other hand, for young doctors getting entry into the corporate setup is also quite difficult. It was told that, *'If a senior doctor is already occupying a post of consultant in a major corporate hospital, there is no space for a junior doctor to get the slot'*.

Regarding payment, although it was largely agreed that pay in corporate hospitals is certainly better than small hospitals, however

the situation is different for junior, mid-level doctors and for senior or established doctors. Juniors are said to be not well paid in corporate hospitals. According to a small hospital owner, *'A fully private corporate hospital is a place of exploitation for the doctor'*.

The entry of management cadre in the hospitals is also redefining the role and professional autonomy of doctors. Doctors felt that *'Managerial staff apply the principles of some other branch of economic activity to healthcare. They do not doubt that healthcare is to be run as a business and they are quite brazen about it'*.

Most of the doctors mentioned that their autonomy gets constrained in corporate hospitals. An ophthalmologist remarked that, *'I don't have autonomy in taking decision about patients. Sometimes I can be pressurized because of those targets. I don't have autonomy in deciding whether I need this equipment or not, which is decided by the management'*. Regarding performance targets, most respondents expressed their concern: *In corporate hospitals each and every consultant is given target to achieve that much revenue at the end of the month. - 'Each one in corporate is given a target - from sweeper to doctor. Full timer as well consultant doctors are told to get x number of patients, depending upon specialty'*.

Corporatization is promoting healthcare corruption and is affecting the doctor-patient relationship

The challenges doctors have been facing in the context of corporatization of healthcare are having wider implications for overall medical practice, as well as for the doctor-patient relationship. Linked with corporatization, overall medical practice is being affected in terms of prevalent malpractices and increased cost of care. Cost of care has gone up because of so much of investment into the healthcare setup; and setting targets leads to a lot of

unnecessary investigations and treatment modalities.

Performing unnecessary diagnostic tests and treatment bills, etc. ultimately burden the patient with the increased cost of care. While discussing inflated cost of healthcare, one respondent expressed concern that, *'When the small and medium-sized hospitals close down, it is the middle class, lower-middle class - the majority in this country - suffer. They are the real sufferers because they cannot afford the corporate hospitals'*.

Corporate hospitals charging hefty bills

In September 2017, a seven-year-old girl, Adya Singh, suffering from dengue, died in the course of treatment in a corporate hospital in the National Capital Region of Delhi. A bill of 1.6 million rupees was presented to the family for 15 days of treatment, including charges for 2,700 pairs of gloves and 600 syringes and providing medicines at massively inflated prices.

Further, it emerges that with the shift from a patient-centric model to a revenue generating model, frictions between doctor and patients have increased. Many respondents agreed that in family practice or small hospitals, doctors are much more connected with their patients and pointed to the impersonalized nature of doctor-patient interaction in corporate hospitals. Patient respondents pointed out that *'earlier doctors personally used to take rounds and spend 15 to 20 minutes with each patient. These days mostly the Registrar is in touch with the patient, and the Consultant is involved only for specific matters. The doctor comes, greets and leaves'*.

Conclusion and directions for change

The overall trajectory of the health sector in India during the last three decades has been of increased commercialisation of health care, accompanied by stagnation and weakening role of public health

Corporatization of healthcare in USA - a major concern

Even in a highly market-oriented society such as USA, where it would be deemed odd to inquire into the implications of making a business of providing services or of making money from such a business, the rise of investor owned companies and for-profits in healthcare in the 1960s-70s raised concerns. These developments led to a study in the early 1980s by the Institute of Medicine, of For-Profit Enterprises in Health Care, to examine the characteristics and influences of investor versus not-for-profit ownership. Four broad issues were identified (1) ethical problems raised by physician involvement in for-profit enterprises that provide health services, (2) the effects of such involvement on professional autonomy and power, (3) the behaviour or performance (cost, efficiency, quality, and types of patients served) of institutions with different types of ownership, and (4) the effects of for-profits on medical education and research (Gray B.H, 1986).

services. The dominant discourse in India during 1950s to 1970s treated the healthcare sector as a set of socially embedded institutions – mostly public or charitable hospitals, along with individual private practitioners – whose primary logic consisted of responding to health care needs of the people they served. From 1980s onwards, commercialisation of healthcare gathered momentum with rise of private nursing homes and smaller private hospitals; health care was being converted into a market-based commodity, and profit making emerged as an important dynamic. This set the stage for the next phase - from the turn of the millennium, large private and corporate hospitals have emerged as significant players, whose overwhelming driving logic is maximization of profits. Corporatisation of health care has emerged as a process which while centred on corporate hospitals, is also influencing other players in the sector in various ways - including individual practitioners, small, medium, large and charitable private hospitals.

Overall, commercialisation and corporatisation of healthcare have converted the health sector in India from its earlier mould of socially embedded institutions, to becoming an arena for aggressive maximization of profits, often at the cost of affordability, rational care and access to care for large sections of the population. In this setting, to reinforce the character of health care as a social good and basic social right, there is need for major strengthening of public health services, along with developing a policy framework related to health care which will contain the negative impacts of commercialisation, while tackling the phenomenon of corporatisation of health care.

Development of such a policy framework requires large scale discussion and consensus building among concerned stakeholders, keeping public interests paramount. In this research brief only a few preliminary ideas are presented as contribution towards such a discussion. Regulation of private healthcare would be central to this process, however this must be developed in a manner which would be socially accountable and maximise positive social impacts. For example, from people's perspective regulation of rates in private hospitals should be a critical component of such regulation, although this may be resisted the most by corporate hospitals. Similarly while designing regulation, although considerations of quality of care would be important, we must be aware that imposing overly demanding infrastructural standards would favour corporate and large private hospitals, but may be difficult to fulfill for rural and small town setups, leading to their closing down and thus favouring corporatisation of healthcare.

Corporatisation is based on expansion of unbounded profiteering in healthcare, which is inherently inimical to delivery of affordable, rational and equitable care. Some options for dealing with corporatisation may include a moratorium on expansion of corporate hospitals and beds, ensuring zero foreign investment in healthcare, emulating the Japanese model which allows operation of private actors but legally prevents any profit making in the health care sector, differential taxation, and range of regulations to control profiteering through unethical marketing, kickbacks and commissions, and unfair competition. Ultimately we need to move towards

a public-centred system of Universal Health Care, which would be based on robust public health systems combined with regulated and socialised private providers, where profiteering from sickness

would become a matter of the past, and healthcare would become a social good enjoyed by all as a basic right.

About the study on corporatization of the private healthcare sector in India, by SATHI and Department of International Development, King's College, London

This research brief draws on findings from a project entitled Practices, Regulation and Accountability in the Evolving Private Healthcare sector: Lessons from Maharashtra state, India. The mixed-method study was conducted in the cities of Mumbai and Pune in 2017-2019. Data collection methods included: in-depth qualitative interviews, review of business and narrative literature, data from government registers on private hospitals and witness seminars. Qualitative interviews (n=43) were conducted with general practitioners and specialist doctors selected purposively from different types of hospital ownership, hospital managers, public health academics, officials, nurses, and patients. Witness seminars were conducted to document the transformations in and regulation of the private healthcare sector, through recording personal experiences, knowledge, observations, key events, people and places. The project was conducted with support from a UK Joint Health Systems Research Initiative grant (MR/R003009/1), funded by the UK Medical Research Council, Economic and Social Research Council, Department for International Development and Wellcome Trust. Project team: Professor Susan F Murray (PI), Indira Chakravarthi (India Co-PI), Benjamin Hunter, Shweta Marathe and Abhay Shukla.

For reports of witness seminars, blogs and further information, please visit:

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Brief prepared by-Indira Chakravarthi, Shweta Marathe and Abhay Shukla (SATHI) and based on an upcoming academic article 'Corporatisation in the private hospitals sector in India: case study from Maharashtra, India' by Indira Chakravarthi, Benjamin Hunter (KCL), Shweta Marathe and Susan F Murray (KCL).

Published by - SATHI (Support for Advocacy and Training to Health Initiatives)

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Printed by – Sanskruti Designers & Printers, Pune

The authors acknowledge the contributions to the conceptualisation and execution of the study from Arun Gadre and Sanjay Nagral. They also thank all the interviewees and participants at the Witness Seminars.