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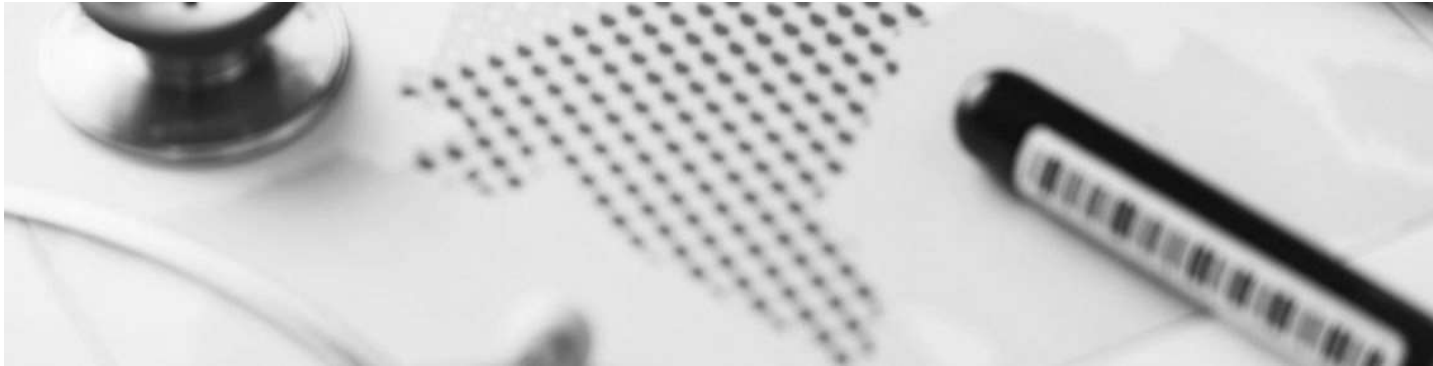


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Lessons from private sector engagement with COVID-19 for universal health care

BY SHWETA MARATHE AND DR ABHAY SHUKLA — DECEMBER 18, 2021





***SHWETA MARATHE and DR ABHAY SHUKLA** provide a critical overview of how private healthcare and the public health system have engaged during the COVID-19 pandemic in India, while also examining the next steps for achieving universal health coverage.*

THE COVID-19 pandemic has severely disrupted health systems across the world, with an unprecedented and massive increase in demand for health services. To cope with the crisis, many countries are turning to the private sector for additional capacity. Given the prominence of the private healthcare sector and low resourced public health systems, the private sector's contribution in providing COVID-19 related care has

been inevitably significant in several low and middle-income countries (LMICs), including India.

However, in many LMICs, the situation of private sector engagement (PSE) with the public health system is not hunky dory, but remains patchy and not well-positioned to effectively complement government health services. For India too, while the private sector's contribution in COVID-19 care is undeniable, widespread regressive practices during the pandemic with serious implications for health rights, cannot be ignored.

Widespread instances of private hospitals evicting COVID-19 positive or suspected patients and shutting down operations despite state-issued orders to reopen services were reported.

With a favourable policy environment, India has become an attractive site for private capital investment in the health sector, leading to burgeoning privatisation and

corporatisation of healthcare services, especially in the last two decades. 70% of healthcare in India is provided by the private sector, while 90% of all allopathic doctors and around 80% of nurses are engaged by the private healthcare sector. It has been estimated that every year, unaffordable costs of privatised healthcare in India push 55 million people into poverty.

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The average cost of healthcare in India has tripled from 2005 to 2015 due to unregulated private healthcare expenditure. However, governments in India have so far not effectively regulated costs and quality of healthcare in the private sector, despite passing of the Clinical Establishments (Registration and Regulation) Act, 2010 (the CEA), which has also been facing regulatory stalemate for nearly a decade.

During the pandemic, several state governments enforced some major regulatory measures over the private hospitals, making use of emergency legal provisions. However, concerns are being raised over the inadequate implementation of these measures, and the response of many private hospitals which continued to gravitate towards profiteering, even in this time of crisis. Although the ramifications of a weakly regulated, commercialised private sector have always been prevalent, the pandemic has brutally exposed the often-contradictory goals of public and commercialised private sectors, concerning provision of healthcare.

It is hence important to critically analyse the experiences of PSE during the pandemic, which can lead to re-examining the modes of public-private interaction in the healthcare sector, while planning a movement towards universal health coverage (UHC) in the coming period.

This commentary aims to provide a critical overview of how the private sector engagement (PSE) with the public health system has unfolded during the pandemic in India, with a focus on Maharashtra, with the highest number of COVID-19 cases and deaths among Indian states. Given the current health policy directions at the national and international level, which appear favourable for private players, it also highlights the need for drawing lessons from COVID-19 experiences, which can contribute towards modifying future modes of effective PSE.

Private healthcare's response in the initial phase of the pandemic

In the initial phase of the pandemic, the private healthcare sector showed a non-uniform response, emblematic of heterogeneity of the sector in India. Most small-to-medium hospitals maintained a low profile, reducing or completely shutting down their services due to reasons like reduced in-flow during the lockdown, not being equipped for COVID-19 treatment and a fear of handling COVID-19 patients.

There were also instances of evicting COVID-19 positive or suspected patients from private hospitals. Despite some states issuing the orders to reopen their services, some

private hospitals chose to remain closed.

While more recent data on the number of patients who have availed free COVID-19 treatment under the PMJAY is unavailable in the public domain, there is considerable evidence that many PMJAY-enrolled private hospitals are not fulfilling the expectation of providing free care to COVID-19 patients.

During the same period, a large section of private and especially corporate hospitals were reportedly operating in a different mode to chase the opportunity to maximise their profits. Some patients were reported to be overcharged INR 50,000 and INR 100,000 per day for COVID-19 treatment. There has also been several public interest litigation filed before courts, on issues relating to healthcare facilities and requesting regulation of rates in private hospitals, filed by patients.

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Both the above-mentioned responses by the private healthcare sector highlights the need for government intervention within the private sector to ensure the delivery of health services in public interest, and the same cannot be left to the private sector alone.

Losses and gains

In the initial three months of the lockdown spanning March to June 2020, there were media reports of private hospitals floundering with significant revenue loss. Several corporate hospitals had sustained revenue losses of up to 90%.

This was primarily due to the loss of local and foreign clientele, as the government had stopped issuing visas for foreign visitors traveling to India. As a result, international medical tourism declined to nearly zero.

Max Hospitals, which received around 5,000 international patients per month, was estimated to have borne an average revenue loss of INR 25 crore per month. Besides this, COVID-19 related safety measures also added significantly to the financial burden of hospitals. While there was a buzz around a dent in the private sector’s profit during the period of lockdown, the ICRA Limited, an independent credit rating agency in

India, noted that the healthcare industry is likely to witness a 20% revenue growth in financial year 2022.

The COVID-19 crisis may be looked upon as a historic opportunity for re-imagining public health systems, as well as their engagement with private healthcare – moving to majorly expand public health services, and to socially re-embed private providers, enhancing their public regulation and social responsiveness, while moving in the direction of universal health coverage.

As per ICRA Ltd, the outlook for the sector remains “stable” with a swift recovery seen in its performance despite the COVID-19 challenges. According to its Assistant Vice President, on the supply side, India currently faces a significant shortage of beds and any

government investments towards hospital bed addition are limited. This provides private sector players with the opportunity to step in to fill the gap.

How to steer the private healthcare sector?

Recognising the limited capacities of the public health system, several Indian states have mandatorily requisitioned private hospitals. This has enforced public obligations of private healthcare providers at non-commercial terms, which extends beyond existing forms of commercial and contractual arrangements through public-private partnerships.

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Various states have either converted private hospitals into designated COVID-19 care centers or taken over private hospitals for COVID-19 care. Taking one step ahead, Maharashtra has declared that the state health insurance scheme (MPJAY), would cover 100% of its population for free COVID-19 treatment and 996 other procedures.

Further, in response to a large number of grievances of overcharging during the pandemic, it is quite notable that around fifteen Indian states have directed private hospitals to regulate rates covering 20%-80% of their beds for COVID-19 patients so far. On the whole, Maharashtra has been at the forefront in declaring the rate regulation,

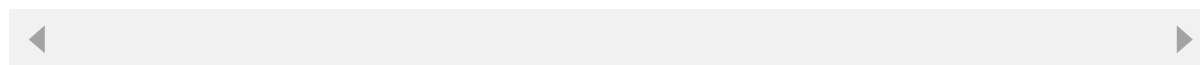
along with taking the above-mentioned decisions on engaging with the private sector (see below).

Key timelines of regulatory measures by Maharashtra

Date	Key decisions
April 2020	Mandatory reservation of 80% of all private hospital beds at regulated rates for COVID-19 & non-COVID-19 treatment, valid until August 30, 2020
May 2020	Provision of free and cashless insurance protection expanded from 85% to 100% of the citizens in the state under MPJAY
June 2020	Appointment of auditors to check bills of private hospitals and conduct audit of bills from private hospitals for COVID-18 and other treatment
June 2020	Fixation of rate for conducting RTPCR test in NABL and ICMR approved private laboratories
July 2020	Fixation of the fare for private ambulances and also requisition of ambulances across the state to provide free services to patients
August 2020, December 2020, and February 2021	Subsequent extensions of notification of mandatory reservation of 80% beds from all private hospitals to treat COVID-19 patients at capped prices
September 2020	Notification on fixing rates for non-COVID-19 patients in private hospitals dated April 2020 was challenged by private

providers

October 2020	The Bombay HC quashed and set aside the provision applicable to non-COVID-19 patients in private hospitals/ health care providers and nursing homes, etc., in a notification dated April 2020 and May 2020
February 2021	Extension of notification of mandatory reservation of 80% beds from all private hospitals to treat COVID-19 patients at the capped prices, until May 2021
June 2021	Rates have been defined as per classification of cities. Also, private hospitals shall give pre-audited bills to patients. Auditors should be appointed for this by respective District Collectors.



Source: Compiled from multiple sources

Rate capping in most states is based on charges agreed upon with the insurance companies. In the backdrop of the states' lackadaisical approach regarding private sector regulation, this commendable decision stands in sharp contrast, bringing this much-contested issue back on the agenda. As far as regulating rates of COVID-19 testing is concerned, despite directives issued by the Supreme Court, most private laboratories did not abide by it.

Resistance to rate regulation

Unsurprisingly, the state-imposed decision of price capping on COVID-19 treatment was met with resistance by many private providers and their associations. The Indian Medical Association branches in Maharashtra and Tamil Nadu as well as the Association of Private Healthcare Providers (AHPI) from Bangalore have demanded revising the rates contending that the rates set by the Government are not viable.

Some doctors had also expressed that fixing the rates of COVID-19 treatment could severely impact the cash flows, as 50%-80% of the sector's costs are fixed.

Further, when Maharashtra declared fixing the prices for non-COVID-19 treatment, private hospitals challenged this before the Bombay High Court. In October 2020, the Court quashed the state order, stating that states have no legislative competence to regulate prices for non-COVID-19 treatments. Subsequently, in July this year, the Supreme Court refused to interfere with the order of the Bombay High Court.

Non-compliance with state directives

Since the PSE has been done in an impromptu manner as an emergency response, invoking the Epidemic Diseases Act, 1897, it does not seem to be well organised. As a consequence, many private hospitals refused to comply with government guidelines and patients continued to be disenfranchised.

Despite state measures, many private hospitals continue to indulge in exploitative and unethical practices, such as exorbitant charging, non-transparency in treatment and billing, not informing patients about rate regulation and public schemes, forcing them to pay hefty advances and denying admission without advance payment, at the cost of affordability, rational care and access to care for large sections of the population.

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In Pune alone, 1,387 complaints of overcharging were received since August 2020. Such practices are not simply a failure to comply with the state orders, but appear to be a manifestation of widespread commercialisation and business-driven strategies, indicating how profit motives of private hospitals override their public obligations even in the face of a crisis.

Audits of COVID-19 bills in Maharashtra

In many cities, state governments promptly issued a show-cause notice to private hospitals for flouting the state orders and the alleged refusal of beds for patients. The municipal corporations of Mumbai and Pune have conducted audits to detect the inflated bills and prevent overcharging by private hospitals. During the second wave of the pandemic, around 70 auditors were put on the job in Mumbai.

A *suo moto* audit of around 11,000 bills generated during December 2020 to April 2021 was done and a total of INR 15.75 crore were reduced or refunded by the hospitals. In Pune too, two teams of auditors were deployed, leading to a refund of INR 6.44 crore to patients.

While the initiative of bill audits is much needed and a welcome step, such audits have been conducted only in a few cities. It does not seem to be an adequate and a sustainable mechanism, given the rising number of COVID-19 patients, hospitalisation and continued looting of patients by private hospitals. Instead, a robust, institutionalised mechanism for grievance redressal needs to be in place where patients can file their complaints and seek justice.

Problems and opportunities

The trajectory of state enforced PSE and regulatory measures implemented during the pandemic raise three significant points.

First, while states attempted to requisition private sector services with a positive intent, the implementation of these measures has often remained only partially effective and contested, mainly due to the absence of an adequate legal framework to ensure public obligations of private providers.

Second, it underlines the impacts of widespread commercialisation and growing corporatisation of private healthcare in India, which is at odds with core public health goals. The pandemic has sharply revealed this contrast and has highlighted the profit-centred operation of the private sector, which is often at the cost of rational, ethical, equitable, and most importantly, affordable healthcare, for large sections of the population.

Third, on a positive note, the pandemic has also exhibited the potential of governments to harness private healthcare in public interest, provided there exists the required political will. Taking this forward, State-enforced ad-hoc regulatory measures taken during the pandemic now need to be up-scaled and institutionalised into comprehensive, systemic regulation, such as ensuring long pending implementation of the CEA across all Indian states.

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Current policy landscape

Since many LMICs have plural health systems with a prominent private sector, the international health systems global movement UHC 2030's Private Sector Constituency opines how PSE is critical for achieving UHC. The National Health Policy of

India includes an objective to align the growth of private healthcare with public health goals, with reliance on strategic purchasing.

In 2019, the NITI Aayog announced a public-private partnership model to link the new and existing private medical colleges with functional district hospitals in the country. These policy documents recommended “moving together with” the private sector for expanding access to care.

However, they do not seem to be taking adequate cognisance of learnings from previous critical experiences of Publicly Funded Health Insurance (PFHI) schemes, the shortcomings in governance and the lack of effective regulation related to various Public-Private arrangements, and widely known ill-effects of commercialisation and corporatisation of the private healthcare sector. Major new schemes with the PSE continue to be launched, without efforts to put in place institutionalised regulatory mechanisms to safeguard public health goals.

PFHI schemes like Pradhan Mantri Jan Arogya Yojana (PMJAY) were supposed to contribute majorly to the provision of free COVID-19 care during the pandemic; however, this promise does not seem to have been fulfilled.

Data as of May 2020 showed a nominal number of patients have availed free COVID-19 treatment under the PMJAY. More recent data on such numbers seems to be unavailable in the public domain. However, there is considerable evidence that many PMJAY-enrolled

private hospitals are not fulfilling the expectation of providing free care to COVID-19 patients. Given this situation, the contribution of PMJAY during the pandemic comes under serious question.

Which way do we turn?

Undoubtedly, the COVID-19 crisis will significantly reshape health systems as well as the mode of operation of private healthcare providers, and their interaction with governments. These changes might unfold in two possible directions – under the pretext of COVID-19 related requirements, policies may promote further privatisation, creating a more favourable environment for financialization and expansion of corporate hospitals. This may be linked with greater public subsidisation and ‘strategic purchasing’ of care from the private sector.

On these lines, the recent report of the NITI Aayog on Investment Opportunities in India’s Healthcare Sector celebrates how the pandemic has created growth opportunities for hospitals and infrastructure, foreign investments, expansion of the healthcare market and so on, without any acknowledgement of widespread overcharging and other major hardships faced by people while seeking COVID-19-related care in unregulated private hospitals.

Taking an alternative view, the COVID-19 crisis may be looked upon as a historic opportunity for re-imagining public health systems, as well as their engagement with

private healthcare – moving to majorly expand public health services, and to socially re-embed private providers, enhancing their public regulation and social responsiveness, while moving in the direction of UHC.

In countries like India with mixed health systems dominated by private provisioning, UHC cannot be envisaged without the involvement of the private sector. However, to ensure the effective contribution of the private sector towards UHC, it is necessary to powerfully realign the goals of private providers with UHC. While envisaging this process, a key lesson from the pandemic is that PSE arrangements which leave control largely in hands of the private providers and continue to promote profit maximisation, and desist from effectively rationalising the content of care (with negative consequences for costs), will fail to achieve the desired public health objective of ensuring access to equitable, accountable and free healthcare.

Similarly, lack of effective social accountability mechanisms of PSE arrangements allows private providers to use various loopholes to subvert core objectives such as the provision of free care. Further, the lack of a comprehensive legal anchoring of regulation allows the private sector to legally challenge emergency-specific PSE arrangements. Hence, there is a need to develop institutionalised frameworks for regulated and accountable PSE, which would place control firmly in the hands of public agencies, and would work in a complementary manner with the public system. Such frameworks will need to confront the large-scale negative impacts of commercialisation, while treating

the UHC goals of ensuring equitable and affordable access to healthcare for all as paramount.

(Shweta Marathe works as a health policy and system researcher with SATHI, Pune. Dr Abhay Shukla is a public health professional and National co-convenor of Jan Swasthya Abhiyan. The authors would like to acknowledge the various discussions among SATHI team members on this theme. The views expressed are personal.)

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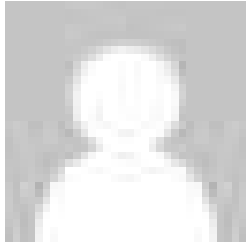
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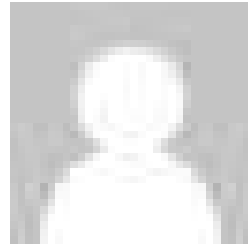
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