Corporatisation in Private Hospitals Sector in India
A Case Study from Maharashtra

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Transformation in the Indian private hospitals sector is examined in Maharashtra, employing qualitative interviews, witness seminars, and desk research. Findings point to significant changes: hospitals viewed as businesses to yield profits; adoption of business strategies to ensure financial viability and returns; changes in not-for-profit and small hospitals; and consequences for institutional and medical practice. Policy shifts towards greater private sector involvement in health, industry advocacy, availability of insurance, and patient expectations drive these changes towards corporatisation, which is not just about the growth of corporate hospitals; it entails structural and behavioural changes across the healthcare sector solely favouring economic goals.

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The current policy focus on universal health coverage (UHC) in low- and middle-income countries (LMICs) is predicated on successful state engagement with the private sector (McPake and Hanson 2016). Over the past decade, it has received further support from international agencies (UHC2030 2019; Clarke et al 2019) Although contested, the broad rationale for such measures is that they would lead to more efficiency, better services, and more choice for users. In this context, there is a pressing need for a detailed examination of this private sector, its form, and the consequences of its ways of working for the entire healthcare system.

Features of the private healthcare sector in India have been elaborated on in terms of commercialisation,[1] the dominance of individual and small providers, and the establishment of corporate hospital chains (Bisht and Virani 2016; Narayana 2003; Nandraj et al 2001; Baru 1998). Since the 1980s, hospitals have been set up as business enterprises, as private and public limited companies. In several southern Indian cities, doctors set up the initial corporate hospitals, with support from businesspeople and non-resident Indians (NRIs).

Researchers have described the rise of corporate hospital chains (Jeffrey 2019; Hodges 2013; Lefebvre 2010) and the business models of pan-Indian and transnational hospital companies (Govindarajan and Ramamurti 2013). Lefebvre (2010), in his study of private corporate hospital chains in India, used corporatisation to refer to the entry of publicly traded corporations into healthcare. A first-hand account by Prathap Reddy, doctor-owner of Apollo Hospital Enterprises, details the concessions provided to him in the 1980s, when he returned from the United States (US) to establish his hospital company in Chennai. His aim was to provide in India the kind of super-specialty care available in the US. He describes his meetings with various political leaders and ministers, to set up his hospital as a company in 1982, and his activities with various industry organisations, such as the Confederation of Indian Industry (CII), to promote the hospital industry in general, and medical tourism in particular (Khanna 2014).

Our study builds on the existing research by examining the transformation of the entire sector that has unfolded as a result of the growth of corporate hospitals through the 1990s, and at the systemic ripples set off by their establishment. It moves beyond looking at individual corporate hospitals to show how their inclusion in the existing commercialised private healthcare sector in India has affected and transformed the system as a whole. We argue that these changes

can be understood as a process of corporatisation of healthcare in India.

We begin by briefly clarifying the terms "corporate" and "corporatisation," as they have been used in the context of health systems. The rest of the paper expands on the case study: the methodology, findings, discussion on the process, manifestations, drivers, and consequences of corporatisation for the organisation of medical practice. We conclude by arguing that corporatisation in healthcare needs to be understood not as merely the expansion of corporate hospitals, but also as structural and behavioural changes across much of the sector, and a deep cultural shift in the healthcare system, extending beyond specific firms or organisations. The consequent transformation in how healthcare is provided has important implications for the employment conditions of clinicians, physical and financial health of users, and overall provision of healthcare services.

Corporates and Corporatisation

The corporatisation of public healthcare institutions was introduced as part of new public management during the 1980s, and widely promoted by the World Bank as part of healthcare sector reforms. Here, corporatisation refers to the conversion of public enterprises into corporate entities with legal and financial autonomy "to achieve the efficiency and structure of private organisations, while still ensuring that social objectives are emphasised in healthcare through the continuation of the public ownership of these services" (Harding and Preker 2000). Braithwaite et al (2011) use corporatisation to refer to the establishment of hospitals as corporations or companies—incorporated, separate legal entities with certain rights, powers, and obligations, including financial liabilities. Barnett and Brown (2006: 285) link the corporate institutional form to the goal of profits; according to them, the "corporatisation of hospital services involves private companies investing in health care for the purposes of acquiring and increasing profits, diversifying risk, and increasing dividends to shareholders."

The present study is informed by these latter two formulations of corporatisation, along with an elaboration of the concept in the context of the transformation of universities in the US by Steck (2003). According to Steck, corporatisation can be viewed as a process of fundamental transformation, going beyond business entanglements in education to a far deeper penetration of the university by corporate economy–culture practices. That in a competitive market the modern university must behave like a modern corporation is viewed as a perfectly legitimate, necessary, and desirable occurrence. The corporatised university is characterised by "processes, decisional criteria, expectations, organizational culture, and operating practices that are taken from the modern business corporation" (Steck 2003: 74), and by associated behaviours in the university. These include entering into marketplace relationships, employing market strategies in decision-making, using managerial and fiscal practices drawn from the corporate sector for administration, prioritising customer service, branding universities, ensuring quality control, and establishing cost-cutting measures to increase revenue.

Among the impacts of these changes was the transformation of the academic profession itself, from comprising autonomous professionals to a salaried professoriate.

Study Design and Findings

We conducted detailed case studies in the two largest cities in Maharashtra: Mumbai, the financial capital of India, and Pune, an important manufacturing and information technology (IT) centre. Both these cities have a growing middle-class population benefiting from service sector employment, improved living standards, and rising life expectancy; they are also medical hubs. The private healthcare sector in these two cities has grown significantly. While the two cities conventionally had individual private practitioners and small hospitals (with up to 30 beds), there was a trend towards the establishment of larger hospitals, from 1996 to 2007, most of which were concentrated in the more developed parts of the state such as Mumbai and Pune (Bhate-Deosthali and Khatri 2011). Not-for-profit trust hospitals have been a characteristic feature of the private sector in Mumbai and Pune. The establishment of these hospitals with various subsidies from the state, their non-compliance by not providing free care to poor patients in return, and their linkages with the industry are well-documented (Kurian 2013).

A mixed method, primarily qualitative study design was used, with data generated from qualitative in-depth interviews, witness seminars, and a review of the business literature. During 2017–18, 43 in-depth qualitative interviews were conducted in English, Hindi, or Marathi, with 23 doctors, 11 administrators/hospital managers, one health management professor, one nurse, two government officials, and five patients in the two cities (more details on the respondents in Marathe et al 2020). Respondents were chosen to reflect a broad range of experiences in the healthcare sector. The interviews focused on the changes taking place in the healthcare systems; their effects on how services are provided, medical practice, and the employment of medical professionals; and people's experiences with insurance and online booking platforms. Three witness seminars[2] were conducted in 2018, including one on the transformation of private healthcare in Pune and Mumbai. The witness seminars were recorded, and edited transcripts have been published (Chakravarthi and Hunter 2019a, 2019b). Interview and witness seminar transcripts were thematically coded and analysed in NVivo.

Momentum for change—The national policy environment: The Indian state's commitment to the universal provision of public health services, through a comprehensive national health service, started changing in the 1990s, with the onset of economic liberalisation policies, which included budgetary reductions. Although the central and state governments provide some funding for public healthcare (infrastructure, education, and research), the formal private hospitals sector has also grown tremendously since the 1970s, to fill the quantitative and qualitative gaps in public health services. In the 1980s, the former comprised small hospitals and maternity homes, providing largely curative care, established by qualified

medical practitioners and religious and community organisations as non-profit activities. Big and small business groups also set up hospitals through charitable trusts as philanthropic activities or contributions to social welfare, and to avail the subsidies and tax exemptions provided to such institutions (Nandraj et al 2001). In view of this and the claims by proponents of neo-liberal policies that the private sector is more efficient, the World Bank recommended that the overall health system development strategy take into account the private provision and financing of health services, and enable greater private sector participation in the health sector through "public–private partnerships (PPP)" (World Bank 1997).

In the early years of economic liberalisation, trade in healthcare services—considered to hold a lot of potential—generated investments by NRIs and business houses in super-specialty hospitals. The National Health Policy, 2002 encouraged medical facilities to provide services to overseas patients; in 2003, the Minister of Finance called for India to become a world-class global health destination. To initiate this, land was provided at subsidised rates to corporate hospitals; further, state governments organised medical tourism trade fairs, exhibitions, and conferences abroad in partnership with host country governments and private corporate hospitals, and promoted highly complex surgeries such as hip and knee replacements and surrogacy to foreigners (Murray et al 2016; Medhekar 2014). The 2003–04 Union Budget laid special emphasis on investment in private hospitals and gave them industry status; the 2008–09 Union Budget offered tax concessions to those setting up private hospitals beyond metro cities and permitted 100% foreign direct investment (FDI) for all health-related services under the direct route.[3]

The share of hospitals within the private healthcare enterprises sector in India rose from 15% in 2000–01 to 26% in 2010–11, and the number of large-sized enterprises increased at a faster rate than small- and medium-sized ones (Hooda 2015). Private hospitals became part of industry associations, and promoted healthcare as not only a social good but also a viable economic activity. In 1998, corporate hospitals such as Apollo and the CII came together to create the Healthcare Federation of India, to develop an organised private healthcare sector. Business consultancy firms such as McKinsey and PwC produced reports on commercial possibilities for healthcare businesses (CII and McKinsey 2002; ICC and PwC 2012; PwC 2007), and how industry and the government could increase investment in the sector to create opportunities for PPPs. The National Health Policy, 2017 reported that the government had invested heavily in building a positive economic climate for the healthcare industry, and that there was a robust healthcare industry with double-digit growth, generating revenue and employment (GOI 2017). The Indian healthcare sector was expected to reach $372 billion in 2022 from $110 billion in 2016 (IBEF 2022). A range of financial actors and interests also became part of the hospital industry. Sovereign wealth funds, such as the Khazanah Nasional IHH Berhad of Malaysia, the International Finance Corporation, and global and domestic private equity funds were investing in large- and medium-sized hospitals and diagnostic centres in India (Chakravarthi et al 2017).

Health insurance is expected to have a significant influence on private healthcare in the coming years, as described in the witness seminar on the private healthcare sector (Chakravarthi and Hunter 2019a). The healthcare industry has come up with several proposals for the implementation of the national government health insurance scheme—Ayushman Bharat— through the private sector, and negotiated measures with the government to promote new investments and sustainable business models, to increase penetration in smaller cities and towns (PwC and CII 2018). In January 2019, the union government announced initiatives, such as giving "industry" status, to incentivise private hospitals to provide services under the Ayushman Bharat outside big cities. These included allotting unencumbered land to private hospitals, providing funding for projects considered unviable by the private sector, and speeding up clearances (GOI 2019). According to the Association of Healthcare Providers India, the provision of funding by the government was one of the suggestions they repeatedly made to the government, and these incentives would definitely encourage doctor-investors and others to consider setting up hospitals. In a cross-subsidised model, the private hospital may charge patients who can afford to pay in order to sustain operations and make a profit, while also servicing patients under the Ayushman Bharat at low prices (Bhooyan 2019).

Decline in public hospitals: Respondents shared that problems in government hospitals contributed to the growth of private hospitals in Mumbai and Pune. According to one paediatric surgeon, "The public sector is deteriorating so the private sector is filling in the gap." Some pointed out that in Pune not a single new government hospital has been set up in decades. Respondents in the study and witness seminar described how doctors from public hospitals started moving to private institutions due to several such push-and-pull factors, including the inability to maintain and improve existing public facilities or open new ones; an inadequate number of doctors who were unable to cope with the patient load; frequent transfers, including to facilities in rural areas with inadequate or no infrastructure; and the presence of hierarchies and domination by seniors (Chakravarthi and Hunter 2019a). Private hospitals in turn lured well-trained government hospital doctors[4] with large salaries and resources, and used the reputation of these doctors for their growth.

> In the 1980s and 1990s the doctors who joined the big private hospitals came from the public sector. When Lilavati and other big trust hospitals were set up (in erstwhile Bombay), many doctors left big public hospitals like King Edward Memorial (KEM). They told me that they had no future at KEM: "We have been earning very little, the institution is giving us accommodation but we have no money to buy a flat in Bombay city so the only way we can survive is by joining big private hospitals." (qtd in Chakravarthi and Hunter 2019a: 48)

For specialists it is a matter of pride and prestige to be invited to work in big private trust hospitals in Mumbai; working in public hospitals, once a badge of honour, is now associated with a lack of success, according to one specialist doctor interviewee.

With improvements in tertiary-level care from the 1990s, and the availability of specialised technologies (for example, intensive care units, bypass surgery, transplants, and advanced diagnostics),

the capital requirements for setting up hospitals rapidly increased. The relative reduction in government financing and the founding of new public health facilities, along with favourable privatisation policies, opened up opportunities for private investors to step in, and encouraged the expansion of lucrative areas catering to overseas and wealthy patients as well as the growing Indian middle class. Medical graduates also opted for specialty and super-specialty training, but facilities matching their skills or need for growth were not available in government hospitals. The procurement of advanced technologies by the private sector also facilitated attracting and retaining such doctors.

Changing patient behaviours and the role of health insurance: Factors, such as overcrowding and long waiting times, a lack of certain facilities and hygiene, and distance from home, drove patients from government institutions to private hospitals and nursing homes closer to their homes, again encouraging growth of the private sector (qtd in Chakravarthi and Hunter 2019a). This was accompanied by an increasing patient preference for hospitals that provided all clinical facilities under one roof, or for facilities with a "corporate ambience." Some doctors reported that patients feel a "tiny nursing home" cannot provide good quality care. A mid-career pathologist explained that in diagnostics, the general expectation is for a well-furnished laboratory with a receptionist and air-conditioning, as available in the laboratories of corporate chains. Another doctor pointed out that access to the internet has led to increased awareness and consequently diminished the role of the family or general physician; nowadays, people browse on the internet, and then go directly to big hospitals.

The availability of health insurance and increased earnings in some sections of the population have also contributed to increased expectations and aspirations. According to one gynaecologist, "These days affluent couples have only one child; with insurance coverage, they want a hospital akin to a 5-star hotel, with air-conditioned rooms, television, and other such facilities." According to one hospital owner-cum-healthcare management consultant, the lower to middle classes were a large potential patient pool and his target clients were people with insurance coverage of ₹1–₹1.5 lakh who were looking for affordable healthcare (Iyer 2013).

Structural and Behavioural Changes

This section summarises the findings pertaining to structural and behavioural changes within the private hospitals sector.

Formation and expansion of corporate hospital and diagnostic chains: Doctor respondents described how the provision of healthcare has become profitable, with hospitals and diagnostic centres being set up as investor-owned for-profit companies; this business model has become increasingly accepted as necessary for healthcare provision. According to a radiologist who works in a corporate diagnostic chain,

> when clinics under corporate brands such as Apollo are set up, individual doctors have to compete with these big corporate providers. Personal clinics are therefore registered as limited liability partnerships, proprietary firms, or private limited companies, and thus transformed into businesses.

Another doctor described how a group of doctors have formed a shareholding private limited company and opened hospitals in Pune; yet another observed that "previously, invitations would come from new doctors setting up hospitals, but now they come from companies." Whether they are small, medium, or big, or multi-specialty, diagnostic, or primary care, hospitals are being set up as or by hospital companies. Now there are corporates in nearly all sectors of medical care: primary and secondary care; single- and multi-specialty hospitals; and beyond metro cities, in smaller cities and towns (qtd in Chakravarthi and Hunter 2019a). Pune has several instances of doctors pooling their finances and setting up group practices as a company, adopting a corporate structure (Table 1). Companies with a pan-India presence—such as Fortis, Cloudnine, and Columbia Asia—have also been expanding in Pune and Mumbai.

Business strategies for the business of hospitals: In the move towards market mechanisms for the efficient delivery of services, doctors have been subjected to management control mechanisms that have affected medical professionalism in different ways (Numerato et al 2012). Such features were adopted in Mumbai and Pune, where from the mid-1990s, private hospitals started appointing people trained in hospital administration as hospital administrators and managers; these people may or may not have been doctors. Those with backgrounds in finance or commerce and hospital management were appointed as chief executive officers (CEOs) (Karanjekar 2019 in Chakravarthi and Hunter 2019a). Further, hospital management courses were started by educational institutions and corporate hospitals such as Apollo. A professor of hospital management who we interviewed mentioned that management staff were appointed with the aim of sharing profits, so that they were motivated to run the organisation efficiently.

New market opportunities have been created as a result of this separation of healthcare provision and management. For

Table 1: Hospital Companies in Pune and Mumbai (An Illustrative List)

Hospital	Description
Sahyadri Hospitals, Pune	Established in the 1990s by a neurosurgeon and two businesspeople who acquired smaller hospitals, it is now a branded, multi-specialty hospital chain in western Maharashtra
Shashwat Hospitals, Pune	A local hospital chain set up in 2009 by local doctors
Atharva Nethralaya, Pune	An eye hospital set up in 2013 with investments by more than 50 ophthalmologists. The shareholders purchased advanced and expensive equipment required for their practice. The facility is run and managed solely by these doctor members
Vitalife Health Services, Pune	Incorporated in 2007, it owns primary healthcare clinics and manages some hospitals
Contacare	A chain of eye hospitals in Pune, set up by a company manufacturing ophthalmic equipment and lenses
Wellspring Healthcare, Mumbai	Started by a surgeon, it is a primary healthcare provider with many clinics in both cities
Thyrocare, Metropolis, AG Diagnostics, and NM Medical	Local companies that conduct diagnostics and imaging; they are present in multiple cities
Wockhardt, Surya Childcare, Jupiter, Global Hospitals, Lifewave Hospital, and Pikale Hospital	These are among the many big and small incorporated hospitals in Mumbai

Source: Authors' compilation.

instance, dedicated hospital management and consultancy companies, such as Radiant Lifecare, Vitalife, and Hosmac are contracted to manage the healthcare facilities. Established hospital chains are also contracted to take over operations and management (O&M) for other hospitals, as discussed later, in the case of non-profit trust hospitals.

One doctor respondent observed that corporate management involves much more than the day-to-day administration of the hospital; it also includes marketing, constantly looking for profitable areas, and closing down departments that do not generate much income. In corporate hospitals, doctors did not have much say about the charges, equipment purchase, or service provision, as indicated by a non-medical CEO of a large non-profit hospital in Mumbai:

> In small hospitals the doctor-owner decides everything, but in large hospitals run by professional management, doctors are one part of the hospital and have very limited influence beyond their own charges and practice; they are not knowledgeable about the pricing strategy and tariffs in the hospital.

The importance of advertisement and of creating "hospital brands" was elaborated upon by an advertising professional working with several large private hospitals in both cities. As part of such advertising, hospitals introduce preventive check-ups and packages, and conduct health camps to attract patients. It is pertinent to point out that corporate hospitals and insurance companies do not view the marketing and advertising of facilities and doctors as wrong or unethical. On the contrary, it makes good business sense to want to increase revenues, and to adopt advertising and marketing practices to that end (Bapna 2016).

Impacts on Other Private Hospitals

This section describes some findings pertaining to the impacts of the changes on other private hospitals.

Not-for-profit trust hospitals tie up with for-profits: Non-profit trust hospitals are often managed by those who established them and other trustees. Improvements in technology and increasing patient expectations of more facilities make it difficult to operate these hospitals and retain or employ doctors with limited technology and finances, as described at length in the witness seminar on the private healthcare sector in Mumbai and Pune (Chakravarthi and Hunter 2019a). Small to medium trust hospitals that do not invest in advanced technologies find it difficult to retain doctors and patient flow. To continue to be viable, they have to make changes in their functioning and strategies to generate revenues; some of these strategies imitate those of the larger private hospitals. In some instances, the younger generation of trustees' families have a different outlook on service and charity from the earlier one, and see business opportunities in healthcare's changing scenario. Such factors have led the not-for-profit trust hospitals to adopt what was described as corporate-style functioning: imitating larger corporate hospitals, introducing management practices, emphasising revenue generation, and introducing lucrative services. While trust-run hospitals cannot be sold, many have tied up with for-profit hospitals or hospital management companies for the O&M of hospital services; this brings in funds, and ensures the work (and role) of the original trustees is minimal. Vacant portions of land on the premises of the original trust hospitals are leased out to for-profit hospitals, which construct new medical facilities in return for lease rentals and profit-sharing arrangements with the original owner-trustees. Such changes have led to a rise in the cost of services provided, and consequently the trust hospitals are increasingly reluctant to provide free or subsidised care to poor patients.

Most well-known Indian for-profit hospital chains have made inroads in the Mumbai healthcare sector through this model of tying up with non-profit hospitals, and availing the benefits of subsidised land provided to the original trust, rather than setting up new facilities. Some prominent examples are Nanavati Hospital with Radiant Lifecare, a hospital management company with foreign private equity investments; Raheja Hospital with Fortis Healthcare; Masina Hospital with Apollo Health Enterprises; SRCC Children's Hospital with Narayana Healthcare; Ambani Hospital with Malti Vasant Trust Hospital; and HN Hospital by Reliance Foundation. Likewise in Pune, examples include Jehangir by Apollo and Sanjeevan Hospital by Shashwat Hospital. In Mumbai, "sick trust hospitals" were turned around by the adoption of corporate management practices (Malik 2019 in Chakravarthi and Hunter 2019a).

Erosion of the small hospitals sector: From the 1970s to the 1980s, private practitioners provided inexpensive medical care in small primary- and secondary-level facilities, or even free of cost in some trust hospitals. Not much money was spent on "treating fevers and fractures," as a former CEO described (Karanjekar 2019 in Chakravarthi and Hunter 2019a). Until the early 1980s, on graduating, a doctor would either work at a public facility or set up a small hospital with an outpatient facility and a few beds. Mumbai then had hundreds of small hospitals (with 5–40 beds), which were closing down, and no new ones had come up in the previous few years. In 2013, the Bombay Nursing Homes Association reported that of the 650-odd nursing homes registered with them, about 20% had shut down, and many were closing due to difficulties in sustaining infrastructure and staff; increasing administrative hassles in complying with stringent regulations for biomedical waste disposal and fire safety; and changing expectations of patients (Rao 2012). Several respondents in both cities reported on this phenomenon, claiming that stand-alone units with 10–20 beds were no longer financially viable. Wherever possible, owners scaled units up from having 30 beds to 100 beds. A few (50 bedded which had the potential to become 100–150 bedded) got acquired by hospital chains, or became day-care or polyclinics. New ones were not being established, even by young doctors entering the practice; those whose parents had set units up did not wish to practise in the latter. According to the Association of Medical Consultants, their magazine received several advertisements to rent or sell plots housing nursing homes that have now shut down (Rao 2012).

Small hospital owners are perturbed by the growing corporate culture, and the difficulties and threats to small hospitals

due to the rise of corporate hospitals (Chakravarthi and Hunter 2019b). Some respondents referred to the uneven playing field: "An individual doctor puts up a small board (with their name and qualification) outside their clinic or hospital, because large boards (or hoardings) are seen as advertisements, and then has to just wait for patients to come. Meanwhile, the large corporate hospitals advertise, make phone calls, and give discounts and commissions." An early-career pathologist from Mumbai setting up his own laboratory explained,

> For small diagnostic set-ups marketing is through word-of-mouth publicity, visiting doctors, and distributing pamphlets. Corporates can have hoardings, and advertisements on radio and in the newspapers, all of which costs a lot. It is not possible for single-unit doctors to invest ₹10 lakhs in marketing, as it is for the big chains.

Small hospitals are not preferred for empanelment by insurance companies, hence channelling people towards bigger and/or corporate hospitals. Corporates can afford to provide cashless services, and have entire billing departments to claim the amounts from the insurance companies; this is not possible for small set-ups.

In 2015, the Indian Medical Association formed the Hospital Board of India to represent the interests of small hospitals facing closure and to assist them in securing accreditation with the National Accreditation Board for Hospitals and Healthcare Providers (NABH) (Maya 2016), and empanelment under government health insurance schemes. While there is tension between small hospitals and big corporates, there is space for both—they provide different services and cater to different sections.

Impact on Medical Professionals

According to a doctor-turned-hospital CEO, private hospitals, whether non-profit or for-profit, aim to increase their annual incomes by around 10% every year. Also, they depend on doctors to increase their revenues: while 50%–60% of patient inflow is from insurance, the remaining has to be brought in by the doctor. So doctors are expected to attend conferences and increase their skills so that they can attract more patients, and accompany the CEO on marketing programmes. Most doctors do not like this; they felt restricted by such organisational rules and targets.

Such management practices have affected the medical practice in several direct and indirect ways. Doctors are required to keep the marketing department informed of their achievements for use in advertising. Moreover, marketing people are constantly on the look-out for doctors to approach and offer incentives to join their respective hospitals. Doctor respondents mentioned that managers treat healthcare as a business, are unaware of the realities of healthcare, and are overly focused on turnover and the number of patients. Some managers reportedly try to influence doctors on issues such as surgery.

Respondents raised the issue of individual performance targets. There is no written rule that a doctor has to treat 100 cases per year, or direct interference in the treatment, but there are indirect signals; for example, being questioned about performance or asked to leave after a year or two. According to one surgeon, "When you are in a system like this, obviously, you are under pressure to do more procedures or admit more patients." This surgeon also said that while doctors were not used to being instructed by management graduates, to say that doctors would run their own hospitals was also tricky because there was a huge conflict of interest in doing so. Still, the pressure was lower among those working in big private hospitals. Doctor-owners of small hospitals were under their own pressure as they set their own targets.

Indirect incentives, such as waiving the hospital's deductions from a doctor's fees when a certain number of patients are admitted or operated upon, are offered to encourage medical intervention. Not all doctors seem to face such pressures to perform, although some said that they do hear of such practices.

Another paper from the Marathe et al (2020) study describes at length the impacts of corporatisation on the medical practice and employment of doctors. New employment opportunities and stratified professional relations have emerged, with corporate hospitals taking over from earlier avenues of employment. These hospitals place new constraints on professional autonomy, particularly for early-career doctors, thus impacting patient–doctor relationships. Some respondents regarded the changes positively: corporate hospitals offer advanced technologies and more standardised services; multidisciplinary expertise and back-up; and administrative–managerial support to doctors. This enables the doctors to focus on their practice and on individual patient care, in addition to gaining prestige and good money. Some respondents justified the motivation to make profits, and the adjustments required of doctors working in these facilities. Others viewed the public health concerns of primary healthcare and ethical issues of equity and affordability as the responsibility of the government and not that of the private sector; they felt that the private sector provides services that the government does not. Some also expressed unease about the pressures on doctors; the consequences for professional autonomy, rational care, and cost of care; and access and affordability for the middle and poor classes, especially those that do not have insurance. Several respondents expressed worry about the systemic impacts of profit motives and competition among hospitals. As summarised by a retired paediatrician,

> If you have an increasing number of corporate hospitals, and they compete with each other to earn money, it will lead to malpractice. People will be sent to hospitals whether or not they need to be. So you are creating a very corrupt system. It is already happening to some extent. But it will increase because you need patients to earn and make a business.

Some doctors also felt exploited, as their fees constitute a small portion of the patient's bill; it is not necessarily the case that doctors are all paid well. However, a few doctors were offered hefty salaries to join, and thus coaxed into closing their own hospitals (Karanjekar 2019 in Chakravarthi and Hunter 2019a), or lured into leaving rival hospitals (Pillai 2019).

Doctors in the corporate private sector now don several roles beyond owners, as investors and shareholders in hospitals; in administrative and managerial roles as CEOs; as employees in small and big corporate hospitals; and as part of insurance companies. Such employment and entanglement of doctors in for-profit hospital enterprises is placing economic and organisational pressure on physicians, affecting their professional autonomy and rational care, and increasingly making them self-interested professionals.

Discussion and Conclusions

The transformations set off over the past two or three decades in the private healthcare sector can be understood as corporatisation, a process affecting the entire sector. As Steck (2003) describes, with respect to the corporatisation of universities in the US, our study points to several similar happenings unfolding in the healthcare sector in India, especially in the expansion and transformation of the private healthcare sector. What is happening in the private hospitals sector in Maharashtra goes beyond the setting up of few big corporate hospitals in metropolitan cities to provide specialised care to affluent domestic and international patients. Corporate hospitals have not only introduced new forms of healthcare provision to certain patient groups, but also influenced the ways that the rest of the sector operates, and patient expectations from the healthcare system. The process of corporatisation initiated in the 1980s has since diffused through much of the private hospitals sector, transforming the overall internal dynamics and ways of working of private healthcare. This has been aided by policy measures, organised industry bodies presenting healthcare as a viable economic venture, and NRI doctors who were influenced by the corporatisation of healthcare in the US (Salmon 1987). While there has long been a commercialised private healthcare sector operating as a cottage industry, corporatisation—including the actors involved, its drivers, and impact—is occurring on a much larger and deeper scale. Changes have been affected in the very thinking surrounding healthcare: it has now become common sense that hospitals ought to act as businesses, and this is now accompanied by structural and behavioural changes commensurate with conducting healthcare as a business. Not only is there a retreat of public institutions from healthcare and of the associated thinking of healthcare as a social good, but there are also systemic changes towards corporatisation, converting healthcare into sites for national and global investment and returns (Hunter and Murray 2019).

Changes are currently occurring in ownership and behaviour, and there is an uneasy coexistence of several forms, from small, self-owned, or non-profit facilities to large investor-owned, for-profit hospitals, and companies. There is also the reorganising of trust hospitals, the entry of publicly listed corporations, and the adoption of corporate management strategies and practices. These changes in institutional form and behaviour are shifting institutional goals towards narrow financial concerns. The discourse is largely about the internal dynamics of the industry: how best to set up and run hospitals, raise funds, and negotiate with private companies and the government on insurance. Large organised industry bodies, hospital owners' associations, and insurance companies are now significant stakeholders in the organisation of the healthcare sector, engaging actively with government bodies on policy issues and costs, UHC, the implementation of the government health insurance schemes, and planning for growth in a "new Indian health economy" (PwC and NATHEALTH 2018: 22–24).

The growth and development of the corporate sector has been a distinctive feature of private healthcare in India, as also in some other middle-income countries (Mackintosh et al 2016). It is likely to expand further as it opens up new opportunities for for-profit investors and for the financialisation of the healthcare sector (Hunter and Murray 2019). In this context, the findings on the changing private healthcare sector from one state suggest the need for a disaggregated view of the formal private healthcare sector in India, which has become a structure in itself within the larger public health system. There is a need to deepen the understanding of this corporatisation in the private sector with more studies on the nature, ownership, goals, and activities of private institutions, and their impact on medical practice and healthcare. Some areas requiring attention are the activities of corporate hospitals in other Indian states; medical education and research, including clinical trials and their linkages, if any, with the informal sector in smaller cities; the impact of management on medical professional autonomy; the consequences for medical practice and how individual doctors in different settings negotiate ethical dilemmas and take decisions about patient care; the role of medical education and specialisation in these transformations; the regulation and accountability in healthcare of corporate institutions and investors; employment conditions in private hospitals; comparative studies with public sector providers; impacts on equity; and the quality of care. The larger question that needs to be foregrounded is whether it is desirable for healthcare to be organised as a profit-making business. Can this business be at all organised to serve the public health goals of healthcare systems of equity, solidarity, and justice, enshrined in the Alma-Ata Declaration of 1978 and some interpretations of UHC?

NOTES

1 Commercialisation in healthcare is understood as the provision of healthcare services through market relationships to those able to pay, and the investment in, and production of, those services (and of inputs to them) for cash income or profit (Mackintosh and Koivusalo 2005).

2 A witness seminar is a specialised form of oral history/group interview, for documenting historical events, in which experts and first-hand witnesses of specific events reminisce collectively (Tansey nd).

3 Namely, those without the requirement to seek regulatory approval prior to such an investment. Eligible investors can invest in most sectors of the Indian economy on an automatic basis, except for a very small list of activities where foreign investment is prohibited.

4 In the mid-1980s, the American Association of Physicians of Indian Origin (AAPIO) started to provide medical equipment to government hospitals. Along with the Ministry of Health and the Medical Council of India (MCI), AAPIO launched a scheme to train doctors in Indian hospitals, including Mumbai's KEM Hospital, in the use of new technologies. Over 100 items of large medical equipment, including that used for CT scans, dialysis, x-rays, and mammography, were donated to various government hospitals in India (EPW 1985).

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