Commercialisation of Healthcare and Rampant Profiteering during the Pandemic

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Introduction

"Right to health is a fundamental right guaranteed under Article 21 of the Constitution of India. Right to Health includes affordable treatment. Therefore, it is the duty of the State to make provisions for affordable treatment[1]," the Supreme Court observed when India was fighting a deadly second wave of Covid-19 in the months of April and May 2021.

Article 47 of the Constitution specifically lays down the responsibility upon the State for aiming at improvement in public health and has stated that this is among its primary duties. Yet the central and state governments failed to take appropriate steps to contain the pandemic which resulted in the country seeing a single day peak of 4.14 lakh cases on May 6 and over three lakh deaths in just a span of two months.[2]It was the most devastating humanitarian crisis that the country had to face, yet the fact remains that with effective planning and efficient implementation of policies, this is a tragedy that India could have averted.

The haunting images of patients left gasping for oxygen, begging for hospital beds and the long lines outside crematoriums will be stark reminders of India's policy paralysis and also failure of governance at central, state and district levels. What made this situation an even greater human tragedy was how certain sections saw this as an "opportunity" to extract maximum profits. Many players in the private healthcare sector who had a pivotal role in containing the pandemic instead exploited the helplessness of people and held them to ransom for necessities that were the basic rights of the citizens of this country. Many of the patients were denied treatment in private hospitals citing their inability to pay in what was a gross violation of fundamental rights. The state machinery failed miserably in

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[1]Affordable Treatment A Fundamental Right: Supreme Court On Covid "World War."*NDTV*

[2] Amitabh Sinha. "3 lakh Covid-19 deaths in India: How far is the second wave peak?" *The Indian Express*

curbing the malpractices. Thus, exposing the years of scant regard that it had for implementing laws that were already in place. The way the pandemic was handled in the second wave has given rise to more questions than answers. It is time for India to take a relook at its healthcare policies and draw important lessons from its failures.

Privatisation or Commercialisation of healthcare?

Healthcare in India is predominantly dependent on private sector as it consists of 58 per cent of the hospitals in the country and employs 81 per cent of doctors[3]. The country has an estimated 43, 487 private hospitals as against 25,778 public ones. A study[4] by Princeton University found that out of the approximately 19 lakh hospital beds, 95,000 ICU beds and 48,000 ventilators available in India, most of the beds and ventilators are concentrated in seven States – Uttar Pradesh (14.8%), Karnataka (13.8%), Maharashtra (12.2%), Tamil Nadu (8.1%), West Bengal (5.9%), Telangana (5.2%) and Kerala (5.2%).The growth of private sector has been exponential in India. After independence in 1947, the private hospitals used to provide services to only 5-10 per cent of the patients, but today its accounts for 82 per cent of outpatient visits and 58 per cent of inpatient care. The support given by government has resulted in India earning more than USD 3 billion in medical tourism, a majority of which is due to the contribution of the private sector. According to a survey conducted by *Finline*, healthcare market is expected to grow three-fold to USD 133.44 billion by 2022. The lack of stringent penalties for overbilling has also contributed to the rise of profitability of private sector.

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[3]Thayyil, Jayakrishnan; Jeeja, Mathummal Cherumanalil (2013). "Issues of creating a new cadre of doctors for rural India". International Journal of Medicine and Public Health.

[4] Kapoor Geetanjali , Sriram Aditi , Joshi Jyoti , Nandi Arindam , Laxminarayan Ramanan. "COVID-19 in India : State-wise estimates of current hospital beds, intensive care unit (ICU) beds and ventilators." *CDDEP, Princeton University*

Here, what is seldom noticed is that private healthcare in India is highly fragmented with over 90 per cent of the services provided falling in the unorganised sector. Eighty percent of the private hospitals are small clinics and nursing homes (less than 30 beds). Only six to seven per cent are 100-200 bed size hospitals and merely 2 or 3 per cent of hospitals have 200 plus bed. The rules that apply to private sector still remain unregulated which has resulted in an unholy nexus between doctors, hospitals, pharma companies, insurance companies, diagnostic labs and medical device manufacturers.[5]

It needs to be noted that it was the growth of the private sector that greatly diminished the role of practitioners of general medicine and gave emphasis to specialists. This has resulted in commercialisation of healthcare with people being made to see one doctor after another and getting multiple tests done to arrive at a diagnosis. A loosely formed network called Alliance of Doctors for Ethical Healthcare had acknowledged this problem in at a meeting held in AIIMS in Delhi in 2018. The alliance called upon hospitals to stop imposing "conversion" targets on doctors and ensure transparency in all components and bills. It said that the hospitals must stop receiving all kind of commissions and kickbacks. It urged doctors to not accept gifts, sponsorships or any financial or non-financial incentives from drug and medical device companies. It also appealed to doctors to not give or take any charges for patient referrals and said doctors should become whistle blowers exposing malpractices.

When such an observation comes from within the medical fraternity, it is clear that the bane of commercialisation has its root much deeper than what is outwardly visible. A civil society group All India Drug Action Network (AIDAN) had in 2019 called out pharmaceutical companies for giving unethical incentives to doctors. It is by now well-known that doctors often push particular brands of medicines in return of undue favours

[5] Lekshmi Parameswaran. "Public Health Lessons for India." *India Policy Foundation*

like subscription to medical journals, foreign trips and expensive gifts. The last three decades have seen a tremendous increase in the corporate insurance, pharmaceutical and the hospital industry which has made healthcare in India unaffordable even to the comparatively well-off families. Often a life-threatening disease pushes a family to the brink of poverty. What is unfortunate here is that despite the prevalence of unethical practices in the healthcare industry, there is no legislation holding the doctors accountable to such malpractices. The checks in place are reduced to mere guidelines from the National Medical Commission (NMC) and the Uniform Code of Pharmaceutical Marketing Practices (UCPMP) notified by the Department of Pharmaceutical for voluntary adoption by the industry.

Another major concern is the availability of antibiotics as over the counter drugs. The production and distribution are not regulated which helps the private sector to exploit this market. The end result of this is that people take antibiotics without prescription and do not complete the full course which makes them drug resistant. This is one of the biggest challenges that the country is facing in terms of its increasing disease burden. Though the 'The 2017 National Action Plan on Antimicrobial Resistance and Red Line campaign' mandated that prescription-only antibiotics should be marked with a red line to discourage the over-the-counter sale, these efforts are yet to get sufficient legal backing and financial support.

An interesting fact that comes to light when analysing the Indian drug market is that though India is the world's largest provider of generic medicines, its use is yet to gain steam in India. According to a 2019 report by Ernst and Young, 20 per cent of all global generics, in terms of market value comes from India. The Supply Annual Report of UNICEF (United Nations Children's Fund) recognized India for rendering yeoman service in developing countries by facilitating affordable healthcare. Taking this into consideration, the government implemented the Jan Aushadhi Scheme in 2015 under which over 5000 outlets have been opened with the aim of making available affordable

generic medicines for all. But the sale at these outlets have been below par with the major reasons being lack of awareness in the public, distribution of free medicines by state governments, lack of support for the scheme, poor supply chain, and doctors not prescribing generic medicines. The has especially been encouraging the big pharma companies to continue selling overpriced drugs even for life threatening diseases.

Pathology is yet another area where the private sector has established a significant amount of control. It is estimated that India's diagnostic industry is worth USD 9 billion and with the rise in focus on preventive healthcare, it is expected to witness a strong growth. Despite this sector being a huge source of revenue, it remains highly fragmented with 45-50 per cent of the diagnostic labs in the unorganised sector, 35 per cent in the organised sector and the rest being hospital-based diagnostic centres. According to a report by Research and Markets, the industry will see greater consolidation in the coming years with larger players acquiring the smaller laboratories.

However, the lack of stringent regulation has led to this sector posing a grave threat to the way healthcare system is structured in the country. A large number of labs operating in the unorganised sector are run by under qualified technicians. In October 2019, the Delhi High Court had sent a notice to the Delhi government to close 875 labs that were found to be operating with no legal permits. The incorrect diagnosis and the erroneous reports that many of the laboratories issue can even prove life-threatening to patients.

The focus on Allopathic medicine also led to the 'elitization' of education. Medicine came to be seen as a profession for those belonging to the economically well-off sections that had the finances to fund long and expensive years of study. The current education system does not prepare the doctors to serve the needs of the country and they very easily get attracted by the high pay packages offered by the private hospitals once they graduate. Also, by denying a chance to those students who hail from

economically backward sections and are willing to put in long hours to serve the deprived, India has been stopping real development from taking place. It is telling that in 2011, the total number of doctors serving the rural population of more than 833 million was a mere 45,062. An institution like AIIMS that was started to make medical education accessible to all has contributed most to the migration of doctors to private hospitals. From 1989 to 2000, nearly 54 per cent of the medical graduates migrated out of the country. Of the remaining graduate doctors in the country, nearly 74 per cent live in urban areas serving a mere 28 per cent of the population. There is also the issue of contractual staff in many of the public hospitals which further contributes to the migration of medical and para medical workers. These workers are not given any performance incentives that would have helped them to stay in their jobs.

As per statistics, India has only 10 lakh registered doctors to cater to 1.3 billion citizens. With such a dismal scenario, it is important to understand how the medical education in India is structured and why has it remained inaccessible to large section of meritorious students. According to data released by the Ministry of Health and Family Welfare, with the opening of 90 new medical colleges in the last five years, the number of government-run medical colleges have surpassed private medical colleges for the first time in India. In the academic year 2019-20, there were 279 government medical colleges offering MBBS courses against 260 private ones as compared to 215 private medical colleges and 189 government medical colleges in the academic year 2014-15. There has been a 47 per cent rise in government medical colleges during 2014-19, compared to a 33 per cent increase in the total number of medical colleges in the past five years, from 404 in 2014-15 to 539 in 2019.

For a country where medical education has been skewed in favour of the private sector, the statistics usher in a much-delayed positive change. The donation-based seats given in private medical colleges have been seriously hindering the quality of Indian healthcare system. The authorised sale of

medical seats that is not seen in any other country apart from India has greatly diminished the role of merit and produced doctors who are not competent to treat patients. The wide disparity in costs have meant that private education is available only to students who can afford it. In a comparative study conducted by the Hindustan Times, it was found that the average cost of private medical education is around Rs 40 to 50 lakh, while in government sector, it is around Rs 10,000 to 4 lakh. In the private sector, the students will also have to pay capitation fees that can range anywhere from Rs 1 to 4 crore. At a time when the private colleges were more in number, this meant that quality of healthcare was being compromised for business gains.

In an analysis published in Lancet, every year nearly 16 lakh Indians die due to poor quality care. That's about 4,300 deaths every day due to poor treatment and nearly 5,000,000 Indians dying due to medical negligence every year. The figures are significant and point towards a deeply tilted model of medical education. It has brought into focus the necessity for government control and strict regulation. There is an urgent need to ensure uniformity in admission with focus on merit, curriculum, and accreditation for all degrees in medical, nursing, and other para-medical courses. Several concrete measures have been taken to this end by the Narendra Modi-led government in the past few years such as converting certain district hospitals into medical colleges through public-private partnership. During the last six years, MBBS Seats in the country have increased by 56% from 54,348 seats in 2014 to 84,649 seats in 2020 and the number of PG seats has increased by 80% from 30,191seats in 2014 to 54,275 seats in 2020.

The privatization of medical education is among the primary reasons for the dismal state that India is in at present. Due to the high costs as well as the challenges related to accessibility, many students from rural areas who aspire to be doctors have had to give up their dreams. What India needs currently are doctors who are sensitive to the needs of the patients and who are willing to serve in rural areas and has both social and cost consciousness

to view healthcare as a service. India will have to move away from the system of commodifying medical education and ensure that only the truly meritorious students are given seats not just in the government colleges but in private institutions as well.

Private profiteering during Covid-19

During Coronavirus spread, the facilities at the government centres were found to have reached its saturation point which meant that in the fight against Covid-19, the private sector had a crucial role to play. It should have been equal partners with the government but what followed was blatant disregard for existing rules and profiteering out of a humanitarian crisis. In the national capital Delhi, that was worst affected by the second wave, private hospitals charged anywhere between Rs 25,000 to Rs 12,00,000 for a bed per day. Many hospitals also demanded a huge sum to be paid upfront if a patient needed a hospital bed. The final bill was even more staggering with the rates of RT-PCR tests and other lab tests, Personal Protective Equipment (PPE) kits and medicines added to it. The cumulative bills wiped out the savings of many families and have pushed them on the verge of bankruptcy.

For many private hospitals in the national capital, the adversity that Covid-19 had brought with it turned into an opportunity. They left no stone unturned to reap profits. They overcharged for every service and even denied admissions to many patients who were not in a position to pay upfront to get a bed. When they did not have enough hospital beds, many of the well-known private hospitals came out with home care packages for those affected. The prices ranged anywhere between Rs 5,700 to Rs 21,900 exclusive of taxes.

Seeing the despicable situation in Delhi, a petition was filed in the Supreme Court which called for regulation of private hospitals. As soon as the step was taken, private hospitals which were part of the Association of Healthcare Providers and FICCI member hospitals assured that they would bring in self-regulation. They suggested that fees for a bed in general wards

will be capped at Rs 15,000 per day, for a bed with oxygen Rs 20,000 per day, for a bed in ICU ward Rs 25,000 per day and for a bed with ventilator support Rs 35,000 per day. Many doctors and patient rights groups pointed out that these rates were beyond normal and had been arrived at looking at the profit baselines. With the hospitals losing out on many of the other cases, it was also found that private players introduced new and arbitrary billing heads with no explanation given. The biggest point of contention became the charges levied for Personal Protective Equipment (PPE). Everyday a patient was charged for a minimum of two to three PPE kits with rates ranging from Rs 3000 to Rs 6000 on an average. These kits are often purchased in bulk at wholesale rates by the hospitals and healthcare professionals wear the same gear for six hours to treat multiple patients. So, levying such a huge amount pointed to the exploitation by private players to increase their profits. Kerala High Court had taken cognisance of the situation where a hospital had charged Rs 22,000 for PPE kits and Rs 1,300 for rice gruel. The court termed these billings “unconscionable” and stated that private hospitals were looting patients.

In addition to this, there were also a lot of other arbitrary charges levied like RMO (Resident Medical Officer) charges, biomedical waste disposal, admission charges, medical history assessment charges, equipment use charges, universal precaution charges and also parking charges. There were instances where experimental drugs like remdesivir, tocilizumab, favipiravir were administered without taking the informed consent of the patients. The situation had worsened to an extent that the insurance companies refused to reimburse the Covid-19 rates of some hospitals terming it arbitrary and unreasonable. In an admission before the Supreme Court, the General Insurance Corporation (GIC) brought to light several inconsistencies in billing by private hospitals and noted that due to the exorbitant charges levied, many patients were effectively being rendered uninsured during the period of their treatment. The Ayushman Bharat scheme that offered a protective cover of up to Rs 5 lakh for

families belonging to the economically weaker sections and has about 60 per cent of the listed hospitals from the private sector turned to be of no help in a situation where the rates were being charged indiscriminately. The policies of the state governments also added to the woes of the patients. Governments of Karnataka and Telangana said that insured patients are excluded from access to capped rates. The Delhi government had constituted an expert committee led by Dr VK Paul to look into the charges of overbilling by private hospitals and it eventually brought out a circular fixing the rates of Covid-19 treatment. But there were little attempts to make the public aware of such a circular and no action was taken when the hospitals ignored the government's directions.[6]

A fact that went unnoticed and came to light only when a petition was filed in the Supreme Court calling for the auditing of private hospitals was that many of them are run by charitable trusts on land allotted to them either free of cost or at concessional rates. The petition which was filed by Shubha Gupta and Rajesh Sachdeva sought for auditing Max, Fortis, Manipal, Apollo, BKL, Primus, Holy Angels and other private hospitals. The petitioners claimed that all these hospitals had violated their terms of land lease by not providing free treatment to the needy. None of the governments had ensured strict implementation of the terms of the agreement and had allowed these hospitals to function freely. One more petition was filed in April 2021 by Sachin Jain, a Delhi-based lawyer which drew the Supreme Court's attention to the excessive costs charged by private hospitals for Covid-19 treatment.[7]

Another practice that the private sector advertently and sometimes inadvertently allowed to thrive was the booming sale of black-market drugs. A vial of remdesivir that was in the initial

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[6]Smita Nair, "Interview (MaliniAsola).: How should India regulate private healthcare to avoid pitfalls exposed by the pandemic?" *Scroll.in.*

[7]JayeshRanjan, Amulya Anil. "Deflating India's COVID black market boom." *The Hindu*

stages considered an essential drug and was later taken off the Covid treatment protocol was selling in the black market for Rs 50,000. The problem began when the private hospitals in order to extract maximum amount from a patient began prescribing it to those who did not even need it. Prior to this, various studies had already shown that remdesivir is effective only in reducing the viral load and that too if it is administered within the first five days of the illness. The doctors who prescribed it very well knew that this is not a medicine that is available with chemists as the supply of this is centralised with the central government allocating it to states and which in turn provides it to hospitals based on its needs. With the companies having scaled down production when the cases had gone down, there were not enough stock with the government to meet the growing needs. The family members of the patient were then forced to turn to the black-market to procure the drug. Many a times it was found that hospital attendants and doctors were in cahoots in selling this drug at exaggerated prices. There were incidences where the drug was not even administered to patients who the doctors thought will not make it and the vials were then sold to another patient for an inflated price. In certain cases, fake Covid patients' lists were created to prescribe the medicines. People had also illegally procured them from states where it was available and they sold the vials in Delhi for exorbitant costs. There was a proliferation of fake or questionable drugs in the market. The Food and Drug administration (FDA) which has the jurisdiction to control and regulate the manufacture, trading sale of all pharmaceutical products did not effectively intervene despite having the power to do so.

Contrary to belief, the Centre and the state governments were not caught off guard. The Central Drugs Standard Control Organisation wrote to the drugs controllers of all states as early as April 7,2021 when the cases were slowly increasing that some states were "reporting shortage of remdesivir" and that "this may lead to its hoarding and black marketing". On April 17, the Centre announced that prices of remdesivir had been brought

down by manufacturers — between Rs 899 to Rs 3,490. In fact, what let the black marketers boom was the decision taken by the Centre to centralise the distribution of remdesivir which was being directly supplied to hospitals by manufacturers till that time. It was only after three weeks since the surge that the production levels reached two lakh per day from around 60,000 per day.[8]An important question that needs to be asked here is why did the government not give directions to to Zydus Cadilato ramp up production of the cheapest generic version of Remdesivir in India that was launched in August 2020 when the cases started rising. It was priced at Rs 2,800 per vial and later the company revised it to Rs 899 for a 100mg lyophilized injection in March 2021.[9] The government should have facilitated the sale of this drug at least in all government run outlets. This would have played an important part in curbing pandemic profiteering.

A bench headed by Justice DY Chandrachud, which heard a suomotu case for ensuring distribution of essential supplies and services during the pandemic on April 30 mentioned the issue of black marketing of drugs. The Centre in its affidavit said that it had directed all the state governments to take measures to stop black marketing of drugs under the provisions of the Drugs and Cosmetics Act, The Essential Commodities Act and other applicable rules and regulations. The centre reasoned that law and order is a state subject and it is up to the state governments to constitute special teams and crackdown on those trading in human miseries.[10]

The case with oxygen cylinders was also something similar to that of drugs. According to the Indian Council of Medical Research (ICMR), the need for oxygen went by 6 per cent

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[8]KrishnKaushik ,Mahender Singh Manral, “Delhi: Drugs to oxygen, amid Covid-19 surge, black market flourishes.” *The New Indian Express*

[9]SahayaNovinsnston Lobo and KV Navya, “Humanity lost: A rundown on how essential Covid drugs end up in black market.” *The New Indian Express*

[10] “States must form special teams to 'mercilessly' clamp down on black market of COVID-19 drugs: Centre to SC,” PTI

among the patients during the second wave. The Delhi government stepped in and decided which hospital should buy from which vendor overlooking the fact that each hospital was connected to a supplier. This led to many private parties procuring oxygen leading to acute shortage of oxygen cylinders throughout the state. Individuals also started keeping oxygen cylinders at home even when they didn't need it. A businessman in Delhi was found to have hoarded 400 oxygen concentrators. The affluent were particularly targeted all over the country for the sale of oxygen concentrators. All these factors contributed to the prices of oxygen cylinders which was available for Rs 12,000 each reaching more than a lakh. Absence of proper institutional support added to the crisis.

The Delhi High Court intervened in the situation and asked the chief minister Arvind Kejriwal-led government to check black marketing of oxygen cylinders and crucial medicines for COVID-19 patients. The court went as far as directing the government to take over the plant of an oxygen refiller for not supplying gas to hospitals and allegedly giving it in black market. The court asked the government to take similar action against all errant suppliers.[11]

The diagnostic labs also became part of the nexus with many of them overcharging for Covid-19 tests and by collecting what went far beyond their testing capacity.[12] This meant that the patients who were corona positive lost crucial time in getting their treatment started as the results took up to 90 hours to come. Many medical practitioners had also speculated that for every person tested positive in the country, there were at least 20 others who were not being tested. The unaffordable cost of the tests had contributed to this number in a significant way. Such a situation resulted in 26 of the 28 states having a positivity rate of 15 per

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[11] "'Your system has failed': HC to Delhi govt over black marketing of oxygen." *PTI*

[12] Vikas Pandey. "Covid-19 in India: Patients struggle at home as hospitals choke." *BBC*

cent and above according to the statistics released by the Health Ministry. By all means, this may have been an extremely conservative number as the rural areas did not even have access to testing. The hospitals refused to admit patients who did not have a covid positive certificate despite the serious effects the patient were suffering from.

Private ambulance operators were not far behind in exploiting the patients. A private operator in Delhi charged Rs 1.20 lakh for transporting an elderly Covid positive woman for a distance of 350 km from Gurugram to Ludhiana. The person running the service who happened to be a doctor was later arrested. Even the crematoriums were not exempted from the loot with families having had to wait in long lines and pay a much higher price to get a spot to cremate or bury their loved ones.[13]

Policy apathy led to private profiteering

Knee-jerk reactions have dominated the government policy measures from the very beginning of the pandemic. The sudden lockdown that was imposed in March 2020 should have given enough time for the government to ramp up facilities to deal with a massive outbreak of the virus. Yet what the central government and most of the state governments did was to rely on temporary facilities that were erected. Parliament documents revealed that between April 21 and September 22 last year, the number of oxygen beds increased by 297 per cent, ICU beds by 143 per cent, and ventilators by 151 per cent. However, many of these facilities were closed down once the cases started declining. From December 2020 to May 2021, only 249 new Covid testing labs were established and the widely used T3 protocol (test, treat, track) to contain the virus spread was more or less abandoned by the state governments. Most of the governments had also by early 2021 started overlooking the need for mandatory quarantine. These decisions proved detrimental during the second wave.

[13] "India's COVID crisis spawns black market for oxygen, drugs." DW

Such a lax attitude was seen everywhere. From the government to the common populace, there was a false sense of triumph that India had conquered the virus and all activities could return to normal. Due to this, warning that were issued by experts time and again were ignored. Though the importance of genome sequencing was acknowledged during the first wave, there were no concerted efforts to detect the dominant variants in the country. The only two institutes that took initiative to collect and test samples were the Delhi-based Institute of Genomics and Integrative Biology (IGIB) and the Centre for Cellular and Molecular Biology (CCMB) in Hyderabad.

The delta variant, B.1.617, which was responsible for the deadly wave was detected by CCMB as early as October 2020. But it was only on December 21, 2020 when the UK variant started wreaking havoc in Europe that the Union Ministry of Health and Family welfare formed the Indian SARS-CoV-2 Genomics Consortium (INSACOG) to track the Covid variants in the country. A group of 10 labs was identified and granted funding. But here again, policy bottlenecks hindered its progress. The first problem occurred when the initial tranche of funds was released only on March 31, 2021. By that time, India was already on the cusp of the second wave. A decision taken by the Union Finance Ministry to ban the import of goods valued under Rs 200 crore also posed a problem as many reagents and plastics used by Indian labs had to be imported. This order was lifted only in January 2021. The biggest failure it faced was the state governments' inability to comply with the policy directions. The state governments did not transport the samples to the designated labs, primarily because many of them did not have the adequate infrastructure to do so. As a result, the INSACOG was able to sequence only 3500 samples by February 2021 as against its goal of sequencing 80,000 samples for the period. Due to such a lackadaisical approach, the INSACOG could detect the rapid spread of delta variant only in March 2021 and in an internal paper, it termed these mutations as "high concern." The Centre had taken note of these warnings in a meeting in early April with

the 21 members of the National Task Force for Covid. In the meeting the experts had predicted that at its peak, the second wave will see around 100,000 new cases daily. The gross underestimation is a clear indication of how unprepared the government was when the cases started peaking at an alarming rate. The unfortunate fact was that the government had the mechanism at its disposal to accurately predict the outbreak well before time.[14]But the collective failure of the state governments to send the samples to the labs on a regular basis and the central government to ensure that its policy measures were being adhered to resulted in India losing crucial time to get the infrastructure in place to deal with the pandemic.

Ineffective implementation became a continuing feature of the way the crisis was handled. Even in the case of ensuring adequate oxygen supply, India would not have faltered if not for bureaucratic and political incompetence. An affidavit filed by the Centre in the Supreme Court on April 27 stated that there was a cumulative deficit of nearly 1,765 MT of oxygen per day in six states—Maharashtra, Gujarat, Madhya Pradesh, Uttar Pradesh, Delhi and Tamil Nadu. Here again, it was primarily the approach of the state governments that led to the acute shortage. As early as October 2020, the Centre had issued tenders for the setting up of 162 oxygen generation plants across the country, but by the time the second wave arrived, only about 30 of these were operational.[15] The state governments did not act on the Centre's directives despite being aware that most of the oxygen plants are located in the east of the country. Transporting oxygen from these plants posed a huge logistical challenge because of which a stockpile could not be created and the last mile connectivity was not ensured. The Union Health Ministry also lost crucial time by delaying its decisions. On October 14, the ministry's Thiruvananthapuram-based PSU (public sector undertaking), HLL Lifecare, floated a global tender for the supply of 100,000

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[14] "A tragedy of errors: 10 reasons behind India's catastrophic Covid crisis."*India Today*

[15] ibid

MT of medical oxygen. But as the companies had quoted higher prices, tender was not given and no efforts were made to negotiate prices with the companies. If follow-up action was done diligently by the authorities, India would have been able to build a sufficient stockpile by the time the second wave hit and not let private players take advantage of the dire situation.

The government also lost vital time by not engaging in a consultative process. It was only when renowned cardiac surgeon Dr Devi Prasad Shetty shared his views on a webinar on how to contain the situation that the government took note and implemented his suggestions. He proposed that 25,000 MBBS students, who were about to finish training in medical or surgical specialties, be exempted from their final exams if they agree to work in Covid ICUs for a year. He added that recognition should be accorded by the MCI to diplomas in critical specialties which will add thousands of professionals to the healthcare sector which was facing an acute shortage of trained personnel.

Another area where the government faltered was in its vaccination policy. There was a clear policy paralysis as far as the procurement of vaccinations was concerned. India despite being world's largest manufacture of vaccines failed to rise up to the occasion even when it was ahead of many of the developed nations in starting its vaccination drive. The government had in August 2020 set up a National Expert Group on Vaccine Administration (NEGVAC) for Covid-19 to work out a comprehensive vaccination policy. In the strategy paper it had submitted, it had estimated that India would need 130,000-140,000 vaccination centres, 100,000 healthcare professionals and 200,000 support staff to handle inoculation and logistics for those in priority groups (about 300 million) by August 2021 and for the entire adult population (about 800 million) by the end of 2022. The paper had made it clear that the public sector will be able to provide only 60-70 per cent of the manpower needed and the private sector will have to play a major role if the country's vaccination policy had to succeed.

Despite having all facts at its disposal and a realistic estimate of how to roll out the vaccination policy at its government. After approving the use of the Serum Institute of India (SII) manufactured Covishield and the indigenously developed Covaxin by Bharat Biotech and the National Institute of Virology, the government took too long even to place orders. The first vaccine was approved in December 2020 but it took another two weeks till the first dose was administered. The government did not make adequate arrangements to prebook vaccines because of which the companies ended up exporting a huge pile of what they had produced to other countries that had advanced orders. The government brought only 11 million doses from SII in January even when the company had stockpiled around 50 million doses.[16]Once the demand started increasing, the companies came up with differential pricing which resulted in the private hospitals being able to procure doses and even here, profiteering was the main motive. Some of the private hospitals charged arbitrary rates as "service charges" and vaccination drives were also organised in a few luxury hotels making a mockery out of the whole process and establishing a clear divide between the rich and poor. The Centre also wavered in its vaccination roll out policy as it announced that those above 18 years of sage are eligible for the vaccination, just a month after it had opened up vaccination to those above 45 years of age. As was seen from the high fatality rate in the second wave, the focus should have been on ensuring that people who were in the grip of lifestyle diseases or other chronic illness were vaccinated irrespective of the age groups they fell under. The decision that the government took of providing free vaccination to all should have been taken when the vaccination drive had first begun.

The short-sightedness in the vaccination policy gave rise to the problem of vaccine inequity. The procurement data showed that out of the 1.20 crore doses of vaccines procured by private

[16]Mihir Sharma, 'Modi govt's mistakes are to blame for India's latest Covid crisis,' *The Print.*

hospitals in the first month since the vaccination opened up for the market, 60.57 lakh doses were procured by nine corporate hospital groups. The top nine private entities are Apollo Hospitals (nine hospitals of the group procured 16.1 lakh doses); Max Healthcare (six hospitals, 12.97 lakh doses); Reliance Foundation-run HN Hospital Trust (9.89 lakh doses); Medica Hospitals (6.26 lakh doses); Fortis Healthcare (eight hospitals bought 4.48 lakh doses); Godrej (3.35 lakh doses); Manipal Health (3.24 lakh doses); Narayana Hrudalaya (2.02 lakh doses) and Techno India Dama (2 lakh doses). All these chains predominantly catered to urban centres and small towns were completely ignored.[17] The government failed in ensuring equal access to all and the absence of any grievance redressal mechanism compounded to the woes.

Paper tiger policies

The debate on private profiteering has been going on for many years. There were many studies that were published that warned of the dangers of treating healthcare as a business and many policy measures were also formulated to regulate the private sector. But unfortunately, none of these were heeded to by the governments in power and lobbying continued to have an upper hand in policy implementation or rather the lack of it over public good.

The most prominent among policy measures that were enacted to bring a semblance of regulation to the private healthcare sector was the Clinical Establishments (Registration and Regulation) Act of 2010. Drafted by the Central government, the Act brought under its ambit registration and regulation of all clinical establishments in the country. According to the provisions included, health facilities not complying with the prescribed norms in terms of infrastructure, manpower, equipment, drugs, support service and records will not be granted registration. It includes in its ambit private sector institutions belonging to both

[17]TabassumBarnagarwala. “9 pvt hospitals corner 50% doses, raise questions of vaccine equity and access.” *The Indian Express*

Allopathic and AYUSH schools of medicine. It encompassed recommendations put forth in a report submitted by the Planning Commission titled, "Clinical Establishments, Professional Services Regulation and Accreditation of Health Care Infrastructure" for the 11th Five-Year Plan.

The Act was an important step in addressing many of the issues faced by patients who were turning to private sector for their treatment. It made it mandatory for registration of all clinical establishments, including diagnostic centres and single-doctor clinics across all recognised systems of medicine both in the public and private sector except thoserun by the defence forces. The registering authority was given the power to facilitate policy formulation, resource allocation and determine standards of treatment and also impose fines in cases of non-compliance of the provisions of the Act. It also laid down Standard Treatment Guidelines for common disease conditions, which were to be decided by a core committee of experts. It made it mandatory for all clinical establishments to provide medical care and treatment necessary to stabilize any individual who comes or is brought to the clinical establishment in an emergency medical condition. It made provisions for the establishment of a Council Body called The National Council for Clinical Establishment which will be responsible for setting up standards for ensuring proper healthcare by the clinical establishment and develop the minimum standards and their periodic review. An important provision of the Act was that it made it compulsory for clinical establishments to follow a particular template for display of the various rates related to PD, Investigation /diagnostic, emergencies, etc.[18]The rules enacted in 2013 under this Act stipulated that the charges will have to be within the range fixed by the government which will be arrived at after wide-ranging consultations with all the stakeholders involved.

[18]Rajdutt S Singh. “An Overview of The Clinical Establishments (Registration And Regulation) Act, 2010,” *Mondaq*

It is been more than a decade since this Act was adopted by Parliament but only a few states (Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim, Uttar Pradesh, Uttarakhand, Rajasthan, Bihar, Jharkhand, Assam and Haryana) have adopted it so far. The Act has many lacunae which has raised questions on its effectiveness. The first and foremost is that the Act does not mention anything about instituting a separate regulatory authority to ensure its implementation. It has vested the responsibility with the state and district health authorities who already have the responsibility of monitoring the overburdened public healthcare system. Itdoes not provide a grievance redressal mechanism for patients which would enable them to file complaints against errant private establishments. It is also silent on the aspect of payment in cases where emergency care is given to patients who are unable to afford the costs of the treatment.

The Indian Medical Association (IMA) that is often seen as a "lobby of private doctors" is equally responsible for stalling the implementation of the Act as the body came out strongly against it and demanded it to be more doctor-friendly. It openly voiced its concern that it is not feasible for private hospitals and clinics to provide standard facilities at the rates set by the Act. The private establishments have also opposed the provision that the patients or their kin have the power to lodge a case if the minimum standards prescribed by the Act are not adhered to by the hospitals or clinics. IMA gave a call for strike in June 2012 to oppose the Clinical Establishment Act and one of its representatives cited infrastructural requirements to claim that it will shut down the practice of small practitioners when no such clause existed in the Act. Since health is a state subject, the private lobbies have largely succeeded in convincing the state governments not to adopt this Act and for the states who have adopted it, they have not been able to implement it due to resistance from the private players. When the fact that over 70 per cent on the population is dependent on private health facilities is taken into account, it is clear that the state

governments are also under tremendous pressure to adopt this Act without compromising on the existing healthcare structure. A collapse of the private healthcare system would put undue burden on the public healthcare system and India still does not have the resources to handle the crisis that will ensue.

The Medical Council of India (MCI) which was replaced by the National Medical Commission (NMC) through the National Medical Commission Bill, 2019 which received presidential assent on 8 August 2019 was also seen supporting the doctors' demands and overlooking patients' rights when the protests were going on. In its years of existence, the MCI had failed in its duty to hold doctors accountable for malpractices. It also needs to be noted that despite being a body that was tasked with ensuring ethical conduct in the medical profession, MCI did not have enough resources or infrastructure to follow up on complaints and even when it did, the chances that it would call out someone from its system were grim. Another major constraint of the body was its membership criteria which included only doctors, thus effectively exempting all corporate run hospitals from its ambit. The NMC has addressed some of its issues with four separate autonomous boards: under-graduate medical education, post-graduate medical education, medical assessment and rating and ethics and medical registration. It will also revamp medical licensing procedures and enshrine several recent reform initiatives, such as the standardization of admission requirements at medical schools nationwide. In a bold step, the government has tasked the Board of Governors of the NMC with drafting guidelines for fee structure in private medical colleges so as to slash fees for half of graduate and post-graduate seats by 70 per cent and 90 per cent, respectively.[19] In view of the rising number of students who are graduating from medical schools without having sufficient skills to practice medicine, the Act has provisions for a common final-year MBBS exam, the National

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[19]Sanjeev Davey, Anuradha Davey, AnkurSrivastava, Parul Sharma; 'Privatization of medical education in India: A health system dilemma.' *International Journal of Medicine and Public Health*

Exit Test (NEXT), before an individual can start practising medicine. This is also applicable to those seeking admission in post-graduate medical courses and for enrolment in the State Register or the National Register. For private medical colleges that charge a huge amount of capitation fees for gaining entry into post graduate courses even if a candidate fails to clear the entrance test, this step has dealt a heavy blow. But interestingly, when the bill was first tabled in Parliament, protest against this from the medical community came from the provision that it allows for licensing of 3.5 lakh non-medical persons or Community Health Providers to practise modern medicine. This argument does not hold much ground as the community health providers have already been functioning as frontline public health workers in the rural areas and if anything, this step lends their practice legitimacy and will also help in keeping the illegal practitioners in check. Before issuing licences, the government should ensure that proper training with a national curriculum is given to these practitioners and they are made to undergo a standard testing procedure endorsed by competent government authority. However, even with all the ground breaking provisions of the Act, the larger problem of lack of transparency in its implementation and the unwillingness of the private sector to give importance to the welfare of patients continue to remain.

Absence of proper regulatory mechanisms for the private sector have contributed markedly to the current situation. This has led to complete lack of accountability. The private hospitals and health practitioners have fully commercialised the healthcare sector. The private medical colleges have further aggravated the state of affairs as students who do not possess the requisite eligibility are given seats by paying capitation fees. Once these students enter the workforce, their primary motive becomes to recover the money that was spent on their education. This often happens at the patients' costs. The lobbying by pharmaceutical and device companies have added to the existing woes with doctors prescribing unnecessary medicines and tests.The hospital managements also have a huge role to play in this as the doctors

are given separate revenue targets to achieve every month. Hospitals often force patients to buy medicines from their pharmacies by sending the prescriptions directly to the pharmacist instead of giving it to the patient. Due to such exploitative practices, 18 pharmaceutical companies had posted a net revenue of over Rs 5000 crore in the period 2019-2020.[20]The numbers imply that the amendment introduced in 2009 to the MCI's (Professional Conduct, Etiquette and Ethics) Regulations, 2002 which put an embargo on doctors receiving any gifts or paid trips from pharmaceutical companies were never implemented in a proper manner. A 2018 study by the Public Health Foundation of India (PHFI) had found that out of pocket health expenses have plunged 55 million into poverty every year.

Another factor that has intensified the commercialisation of healthcare is how trust hospitals were allowed to run with the sole aim of reaping profits even when there was a caveat that these hospitals will have to treat the poor and needy for free or at highly subsidised rates. Many of these have received land on lease at nominal rates from the government and also enjoy tax concessions. These benefits are given by the government with the understanding that these charitable hospitals will set aside a portion of their beds to the underprivileged section of society. In a 2011 order, the Supreme Court had mandated that trust hospitals in Delhi should provide 25 per cent of out-patient services (OPD) and 10 per cent of indoor services to patients from economically weaker sections.[21]This was based on the recommendation of a committee constituted under Justice A S Qureshi in 2000 to look into modalities of free treatment for the poor in private hospitals in Delhi. But this order was seldom adhered to by the hospitals and treatment continued to remain accessible to only those who have big pockets. A 2011 study had found that Apollo Hospitals treated only 15-20 patients from the

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[20] "India's most profitable large company is a familiar, if unexpected one." *Mint.*

[21] AnanthPhadke. "Regulation of Doctors and Private Hospitals in India." *Economic & Political Weekly, 2016.*

economically weaker sections annually when they were expected to set aside at 200 beds for this cause. Hospitals also began to take advantage of loopholes in the existing laws to seek exemptions from this clause. In 2012-13, two major private hospitals in Delhi went to the Delhi High Court and argued that they did not receive land at concessional rates, so they are not obliged to provide free treatment to the poor. The Court accepted their argument and freed them from treating the underprivileged. But it was later pointed out by the general public that these two hospitals had received land right after Independence for subsidised rates in the name of public good.[22]In the end, the judgement of the Delhi High Court effectively paved the way for other private hospitals also looking for loopholes to evade their social responsibility.

An important policy paper which was published in 2018 had warned the public of the imminent danger that the country would be facing in the coming years. But this study was not given much attention by the policy makers and the issues it pointed out were ignored. The study which was conducted by National Pharmaceutical Price Authority (NPPA) analysed patient bills from four prominent private hospitals in Delhi-NCR and concluded that the patients were overcharged by several times and the hospitals adopted several unethical practices to bring in revenue. This was done after there was public outrage over the case of Adya Singh, a seven-year-old who died of dengue at Fortis, Gurugram and whose family was given a bill of Rs 16 lakh for her treatment that lasted for 15 days. The report revealed that the private hospitals were making a profit margin of up to 1737 per cent – on drugs, consumables, medical devices, and medical devices and diagnostics. It stated that these hospitals with the aim of increasing the profit margins were largely dependent on non-scheduled drugs, the prices of which are not fixed by the government and used only 4.10 per cent of scheduled medicines in its total treatment costs. The study also

[22]Jyostana Singh. "Delhi hospitals freed of poor." *DownToEarth.*

revealed that pharmaceutical companies were printing higher MRP in order to help hospitals reap huge profit margins. Other unethical ways by which the hospitals earn profits are by not allowing patients to get their diagnosis from other clinics, which resulted in patients paying 15 per cent more than what they would have otherwise paid and by levying exorbitant charges on non-scheduled items like syringes, cannula and catheters.[23]

Following the release of this study, the Delhi government constituted a nine-member panel headed by Director General of Health Services, Kirti Bhushan. The committee released a draft policy that made it mandatory for private hospitals and nursing homes to cap their profit margins for drugs and consumables at "up to 50 per cent", and "up to 35 per cent" for implants. It also stated that non-scheduled medicines can only be billed at their respective procurement prices and it put a cap on administrative handling charges. The draft policy called for transparency in packages offered by private hospitals and stipulated that counselling should be offered to patients and their family members before complicated procedures which will help them take informed decisions. It said that patients cannot be compelled to buy drugs from the hospitals' in-house pharmacy and made it illegal for hospitals to detain dead body for non-payment of dues. Importantly, it also stipulated that the patient's family would be given a 50 percent waiver on the bill if the patient dies within six hours of being brought to the hospital, 20 per cent waiver would be given if the patient dies within six to 24 hours of being brought to the hospital.[24]Though patients' rights were at the core of the draft policy, it did not provide any mechanism for grievance redressal and was silent on the penalties that can be imposed on hospitals in cases when the provisions of the draft law were not adhered to. Since the changes mentioned needed multiple amendments to the Delhi Nursing Homes Registration

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[23]Kundan Pandey. "Measures to curb 'unethical profiteering' by private hospitals not working: Govt report." *Down To Earth.*

[24]"Guidelines to regulate private hospitals set to roll out in December." *The New Indian Express*

Act, it remained as mere policy recommendations without having any teeth to it.[25]In the wake of the pandemic, the Delhi government has decided to re-examine the draft policy. The aim will be to draft a single standard operating procedure for all hospitals.

The policy apathy that had been prevalent was seen even when the country was battling the pandemic. With many aggrieved persons approaching courts to regulate prices, ten states in India issued directions to cap the prices of Covid-19 treatment. Among this was the state of Maharashtra that went a step further and capped the prices of non-Covid treatment too. It imposed price controls on 80 per cent of beds in all hospitals irrespective of whether they were being used for Covid-19 or non-Covid-19 treatments. The Nagpur bench of the High Court of Bombay in its judgment in Hospitals' Association, Nagpur v Government of Maharashtra quashed the restrictions by stating that such controls do not fall within the ambit for Entry 6, List II of the Seventh Schedule which deals with "Public health and sanitation; hospitals and dispensaries" because of which state legislators do not have the power to impose them. This went against the Supreme Court's observations in several cases that such entries should be interpreted in the broadest possible way as affordable healthcare is a basic right of all citizens. The High Court's judgement also gave an interpretation that it was not within the state government's power to regulate prices. The court invoked Article 19(1)(g) of the Constitution and said such price controls are a hindrance on the freedom of trade and profession. It overlooked the fact that such freedom is subject to reasonable restriction under Article 19(6). Such narrow interpretation of the law and constitutional provisions have made the cause of affordable healthcare even more difficult.[26]

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[25]Namita Kohli. "Delhi govt releases draft policy to regulate private hospitals." *The Week.*

[26]Akshat Agarwal. "Pricing and Private Hospitals: The Far-Reaching Implications of the Bombay High Court's Decision in 'Hospitals' Association, Nagpur.'" *Vidhi Legal Policy.*

Another Act that has remained a paper tiger is the Bombay Nursing Homes Regulating Act 1949 which provides for registration and inspection of nursing homes in the state of Maharashtra. An important component of this Act is that a nursing home will have to make an application for registration or renewal every year to the local authority. It vests the power with the local authority to decide if the certificate should be granted or not. The rules mandate that this certificate should be displayed prominently in the nursing home along with detailed information about the qualification of staff and other facilities available. Despite legalising provisions that have the power to prevent profiteering and exploitation, the authorities have never been strict with its implementation and the private exploitation has for all practical purposes forgotten that such a law even exists.[27]In 2018, a division bench of the Bombay High Court had asked the Maharashtra government why it was reluctant to implement this Act as well as the Clinical Establishments Act. It also made an observation that the Maharashtra government was succumbing to the pressure exerted by the nursing homes.

The total failure to implement the existing laws has given rise to a situation where the patients and their family members are made to believe that health is a commodity that has to be purchased and the higher the amount of money that is being spent, the greater are the chances of making a full recovery. The situation can be changed only if the governments ensure more accountability. There should be proper audit of all healthcare establishments, provisions should be made to penalise those establishments that do not comply with the rules and while prescribing drugs, it should be made mandatory that the doctors do not specify the name of the company and patients be given the freedom to choose generic drugs.

The neglect of traditional systems of medicine

[27]Ravi Duggal and Sunil Nandraj. “Regulating the private health sector.” *Medico Friend Circle Bulletin*.

The policy paralysis that India has been facing in its healthcare system extends to all spheres. It is particularly pronounced in the area of traditional systems of medicines which could have provided crucial support in the country's fight against the pandemic. The history of Ayurveda dates back to 2500 BCE and it has at its core the relationship between nature and humankind. The literal translation of Ayurveda is 'science of life' and along with other Indian systems of medicine like Yoga, Siddha and Unani, it advocates for preventive cure by strengthening immunity. It has succeeded on several occasions when the modern system of medicine had failed in finding a cure. Yet, these traditional systems of medicine came to be termed as 'alternate medicines' by the practitioners of allopathy and a significant section of general public robbing them of their credibility. On the global platform, there was a silver lining when the 67th World Health Assembly resolution on traditional medicine paved the way for the development of updated WHO Traditional Medicine Strategy (2014–23) which pledged to increase its contribution and promote effective use. But in India where the traditional systems of medicine had seen a continuous decline from the pre-independence times, the road to making even the acronym – AYUSH – which is used to jointly refer to the systems of Ayurveda, Yoga and Naturopathy, Unani, Siddha, Sowa-Rigpaand Homoeopathy– familiar to the people took a long time. This happened due to the British portraying these systems in a negative light and with Independence, many of the states withdrew the patronage which were earlier given to the practitioners of these systems by monarchies. A 2011 study estimated that out of the roughly 20 health workers per 10,000 population, only nine per cent are AYUSH practitioners.

It was in the year 1962 that the traditional systems of medicine featured in Indian policy making as an important component. Prior to this, the Bhor Committee which was constituted in 1946 to assess the health condition of India had stated in its report that even though it recognised the importance of the indigenous system of medicine, it was not in a position to look into this in an

in-depth way for want of time and opportunities. But it had recommended the establishment of a Chair of History of Medicine in the proposed All India Medical Institute, a function of which would be to study the indigenous systems of medicine with a view of finding out what they can contribute to the sum total of knowledge. After this, the First Health Ministers' Conference that was held in 1946 appointed the Chopra Committee which proposed an integration of the Indian and Western systems of medicine. What was interesting was that such a recommendation was put forth as early as 1922 by the Usman Committee which was constituted by the Government of Madras. The Chopra Committee was followed by the Pandit and Dave Committees which also suggested concurrent teaching of Ayurveda along with modern medicine. The recommendations of the Pandit Committee were instrumental in establishing the Central Institute of Research in Indigenous Systems of Medicine and a post graduate training centre for Ayurveda, both of which were located in Jamnagar. Parallelly, grants were allotted for the research and development of indigenous medicines in the First and Second plans and the Central Health Ministry appointed an Adviser on indigenous system of medicine.

Despite these developments, it was not until the "Health Survey and Planning Committee", headed by Dr. A.L. Mudaliar was constituted that indigenous system of medicine came to be viewed as a branch that needed special focus. Tasked with assessing the performance of health sector, it dedicated a chapter to indigenous medicines in its report. The Mudaliar Committee found the conditions in Primary Health Centres (PHCs) to be unsatisfactory and made many recommendations to improve the situation. Among the policy measures, it recommended utilising indigenous doctors for delivering vertical healthcare programs.[28]Highlighting the constraints in rural areas to ensure good quality treatment, the report emphasised the need to

[28]Mudaliar Committee Report, https://www.nhp.gov.in/sites/default/files/pdf/Mudalier_Vol.pdf

integrate Ayurveda and modern medicine. But at the same time, it argued that it is necessary for students to be taught “shuddh” (pure) Ayurveda. It suggested that chairs be established in major medical institutions to encourage the study of Ayurveda and there should be increased investment of resources in research. Most importantly, it called for standardisation of treatment procedures to prevent misuse and restore patients’ faith in indigenous system of medicine.

Though the recommendations carried substance, there were no effective efforts made to revive the traditional systems of medicine. Subsequently, the National Health Policy (1983) and the National Education Policy in Health Sciences in 1989 also pointed towards the need to improve healthcare access by concentrating on the potential of indigenous systems. The National Health Policy (1983) suggested that the large number of healthcare professionals in the traditional systems should be utilised to fill the skill gap in the country which will in turn strengthen healthcare in rural area. The increasing focus on institutionalising the traditional systems led to the creation of the Department of Indian Systems of Medicine and Homeopathy (ISM&H) in 1995 (later renamed as Department of AYUSH in 2003).The National Health Policy (2002) had its focus on making healthcare more inclusive. It called for a more equitable access to health services and recommended increasing the access to tried systems of traditional medicine. However, yet again no policy measures were drafted and implemented in this direction. These observations only helped in commercialisation and marketisation of indigenous therapies.

After 2005, efforts were made to mainstream AYUSH and revitalise local traditions.[29] The National Rural Health Mission (NRHM) had provisions towards this end. It allocated AYUSH facilities in 10042 Primary Health Centres, 2732Community

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[29] Shweta A.S. and RituPriya. “Validation of the Prescriptions of Government Ayurveda Practitioners and Community Knowledge of LHT by Classical Texts of Ayurveda.” *Paper for 4th World Ayurveda Congress, 2010*.

Health Centres, 501 District Hospitals and 5714 health facilities.[30]It laid down strategies for provisioning of AYUSH drugs, co-locating providers at public health facilities and inter-sectoral convergence with practitioners of traditional medicines for implementing national health programs. During the 12th plan, the department of AYUSH launched National AYUSH Mission with the stated objective of providing affordable, sustainable and accessible care. On 9 November 2014, the department of AYUSH became an independent ministry with an allotted budget of ₹ 1428.7 crore. The ministry has since been doing extensive work to raise awareness about the traditional systems and also collaborated with the Council for Scientific and Industrial Research (CSIR) to set up the Traditional Knowledge Digital Library (TKDL) on codified traditional knowledge on Indian systems of medicines as a means of countering bio piracy. It also facilitated the release of a notification in 2020 by the Central Council of India Medicine, the country's regulatory for Ayurveda education which allowed Ayurveda practitioners to conduct 58 types of surgeries.

But as the pandemic has shown, the renewed focus on traditional medicines couldn't tide over the years of neglect these systems had faced. The National Sample Survey conducted in 2014 had revealed that allopathic system held greater sway over both rural and urban areas, with over 90 per cent of treatment-seeking patients across all socioeconomic groups opting for allopathy care. Another study[31] based on these findings found that people from poorer or richer households are more likely to seek AYUSH treatment than those from middle-income households. The tendency for self-medication was higher in lower income households. In rural areas, the tendency to self-medicate becomes starker with 50 per cent of treated spells being without

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[30] National Health Mission
https://main.mohfw.gov.in/sites/default/files/56987532145632566578.pdf

[31]Rudra S, Kalra A, Kumar A, Joe W. "Utilization of alternative systems of medicine as health care services in India: Evidence on AYUSH care from NSS 2014." *PLoS ONE.*

direct medical advice compared to 22 per cent in urban areas. The study reiterated the importance of public health facilities in strengthening AYUSH care in rural areas with higher utilisation in Chhattisgarh (15.4%), Kerala (13.7%) and West Bengal (11.6%). While Ayurveda was more popular in Chhattisgarh and Kerala, in West Bengal it was homeopathy.

All these were clear indications that there was a need to focus more on the traditional systems of medicines. It was essential to strengthen the infrastructure at the rural and urban levels as well as make people aware of the benefits of these systems. Yet it took the Ministry of AYUSH time till May 2021, more than a year after the pandemic started to launch a dedicated community support helpline number to address the grievances of affected with Covid-19. Experts from various streams of AYUSH, namely Ayurveda, Homeopathy, Yoga, Naturopathy, Unani and Siddha were available to answer the queries of the general public including directing them to the nearest AYUSH facility. In addition to this, the Central government announced the expansion of its network of distribution outlets for free COVID-19 drug, AYUSH-64 only when the outbreak had reached its peak. This step should have been ideally taken even before the first wave of Covid-19 hit the country.

Likewise, there were many decisions that the Central government took to extend the reach of AYUSH as the second wave progressed and took on a deadly characteristic. But none of these could be put into effective use as the general mindset was against traditional systems of medicine. One noteworthy step came in the form of an advisory that the central government issued regarding the introduction of trained AYUSH professionals for clinical management of Covid-19. The AYUSH Ministry in its press release said states and UTs have trained nearly 1.06 lakh AYUSH professionals in different aspects of Covid management, and 28,473 professionals have been deployed for Covid-19 activities. The press release also added that these professionals have already proven their competence in various Covid management roles in different institutions across

the country. The statement gave an indication of a productive workforce that the country was never able to utilise efficiently. Another important measure that the government took was to launch two new insurance policies - Corona Kavach and Corona Rakshak – and mandates that costs of treatment under traditional systems like Ayurveda, Naturopathy, Siddha, Yoga, Unani and Homeopathy will be covered if used.

Dr Bhushan Patwardhan, chairman of interdisciplinary AYUSH Research and Development Task Force on Covid-19 in an interview[32] to an online portal pointed out the folly in terming AYUSH interventions as an alternative approach in the treatment of Covid-19. He pointed out that currently "we are in the evidence-based precision medicine era" and there is "no proven treatment for SARS-CoV-2 infection or Covid-19 in any medical system." He pointed out that there is a global consensus emerging in favour of integrative approach and complementary medicine and there is a need to break existing silos of medical systems and use the best available options in the interest of patients and people. The observations that he made hold true for many diseasesfor which allopathic medicines have been unsuccessful in treating but there are proven cures in traditional systems of medicine. Yet these systems were shunned by more powerful lobbies in modern medicine and the governments also gave in to their demands. The lack of interest in deliberating the recommendations of the various reports and the absence of stringent implementation of the existing policy provisions are the two major factors that led to traditional systems of medicine losing its importance in the country.

Recommendations for the future

The catastrophe that India experienced during the second wave of Covid-19 and the humanitarian crisis that followed do not have any precedent in the country. It exposed the avarice of the country's private healthcare sector and years of neglect in its

[32] "Incorrect to call Ayurveda, homoeopathy alternative medicine for Covid — top AYUSH official." *The Print*

policy implementation. As elaborated, India had several policy mechanisms that had the power to prevent the calamitous situation but lack of awareness coupled with the presence of a strong lobby of private players meant that exploitation kept on continuing in a rampant manner. Once, the cases started receding, what followed was a blame game by all the stakeholders involved for the unchecked spread of the virus. If this continues, India willlose a golden opportunity to overhaul its healthcare system. The pandemic has exposed multiple loopholes in existing policies and has also brought with it a sense of understanding that not all institutions in the private sector can be expected to step up and fulfil their duties towards the nation. Profit motives will continue to drive the sector and now it is upto the government to reverse the wrongs of last many years and bring in stringent legislations that will prevent profiteering at the cost of human lives.

Taking a cue from the Clinical Establishment Act, one way to do this would be to conduct periodic auditing of all private establishments. This way, any attempt at excessive profiteering can be immediately checked. Along with this, a system of accreditation of private healthcare services should be introduced which will ensure that the minimum standards are maintained in the healthcare sector. Even though a National Accreditation Board for Hospitals and Healthcare Providers (NABH) was set up for this purpose in 2006 with the goals of ensuring patient safety and quality of the delivery of services by the hospitals, it has not been effective in curbing the exploitative practices of private hospitals. What is needed are the adoption of stringent standards and regulations that will make it impossible to turn health into a commodity. The major problem with India's healthcare system at present is that it completely ignores patients' rights. The need of the hour is the immediate creation of a grievance redressal system which can be approached by patients with ease and which will ensure early delivery of justice. For so long, the country's healthcare system has dangled a carrot in front of its patients by giving them promises of a better

healthcare. But with an errant private healthcare sector where every institution is run with the profit motive, it is the fundamental right to good heath that is getting compromised.

There is an urgent need to bring in accountability and hold every stakeholder responsible for the timely delivery of services. A separate tribunal should be created and doctors should be brought under the Consumer Protection Act in order to curb any kind of negligence. The government should mount strict vigilance on harmful medicines recommended by doctors for profit obsessed pharma sector and ensure that there is judicious use of allopathic medicines, especially antibiotics. Legal provisions should also be made to bring the BPL families under insurance cover. India should draw from best practices around the world to achieve universal healthcare. In countries like Turkey and Thailand, 80 per cent of the healthcare services are provided in the public sector with an aim to make healthcare affordable while ensuring that the quality of services is at par with that provided by the private sector.

In all probability, the reason why the governments in power have not included the private healthcare sector in its policy formulation is because the contribution of this sector to the GDP of the country is around 4-5 per cent. Added to this are the powerful lobbies that can influence policy changes. The pandemic has clearly shown that Indian healthcare system that is led by the private sector do not have the ability and preparedness to deal with a major crisis. It is time for the government to take stock of the situation and ensure that the existing policy measures are strictly implemented before legislating new ones. Next time if a crisis like this occurs, the government should strictly invoke the National Disaster Management Act of 2005 and take over the running of private hospitals for a brief period. This model was successfully implemented in Spain at the peak of the Covid-19 crisis. There should be penal provisions to punish the management of private hospitals and healthcare practitioners if they go against the ethics of medical science by concentrating only on making profits at the cost of people's lives.

As was evident from the second wave of Covid-19, a holistic approach to healthcare is need of the hour. Traditional Indian medicine systems are built on the concept of strengtheninga person's immunity and preparing the body to fight diseases. The modern medicine should imbibe the best practices of all schools and adopt an integrated system that will have wellness at its core. The government should issue certificates recognising traditional healing practices and should also make efforts to record and research on folk practices. Efforts should be made to make people aware of the benefits of traditional systems of medicine and a greater number of people should be encouraged to follow these systems. The government should come out with a verified database of AYUSH practitioners so that those who are not part of the system do not get an opportunity to cheat the patients. It should use National Digital Health Mission that will serve as a repository of all information related to healthcare in the country.

India should also imbibe lessons from other countries. From the way the CoVID-19 crisis was handled by the West, it is clear that increased budget, a greater number of hospitals, doctors and hospital beds may not necessarily result in better response in a public health emergency. What is important is to have institutional support at the grassroot level like that provided by ASHA (Accredited Social Health Activist) workers in India. An efficient healthcare system is characterised by accessibility and the changes that is brought about at the primary level. The need of the hour for Indian sector is to set realisable goals keeping into account the lack of resources and infrastructure and work towards it. Decentralisation will hold the key for India developing an efficient healthcare system in the coming years. It will also put an end to the upper hand that private players have at present in the country's healthcare system. To achieve this goal, India needs to restructure its primary healthcare. There needs to be increased public awareness on the importance of having a robust primary healthcare system. Lessons should be included on this topic in secondary education and students should be given the option of getting trained in primary education at the 10+2

level in schools. If India has to make its decentralised healthcare system efficient, it needs trained personnel in its rural areas.

The most important step that the government must take is to build surge capacity in health infrastructure. It should also invest sufficiently in research and development so that the dependency of India on life saving drugs and technology can be reduced. At present, many world class research institutions like the Sree Chitra Thirunal Institute of Medical Sciences are in the grip of unionism and its activities have been drastically affected. The government should take note of such institutions and revive them in national interest. India has institutes like the National Institute of Epidemiology in Chennai, the National Centre for Disease Control in New Delhi, the Centre for Infectious Disease Research in Bengaluru, and the National Institute of Virology in Pune which needs to be given a fresh mandate to focus on research. Professionals ranging from research assistants to those heading the institutions should be given time and goal-oriented targets and made personally accountable. India will have to make use of its world-class IT prowess in mining infectious diseases data to help crack the genetic code which may prove crucial to developing vaccines.

It is unfortunate that institutions like AIIMS that were set up as a model of patient care and medical teaching in the country are unable to give enough time for medical research due to overcrowding at hospitals and shortage of staff. In order to remedy this situation, it is important for primary and secondary level healthcare to be strengthened so that the tertiary level hospitals function purely as referral centres. Greater facilities in terms of accommodation and accessibility to services like schools should be provided by the government to healthcare workers who are deputed to rural areas. A greater emphasis must be placed on the training of para medical personnel to fill in the gaps at primary level. For those studying in government and government aided institutions, it must be made mandatory for them to come out with research papers and participate in a

minimum number of conferences every year to be certified eligible to gain a degree in medicine and to practice thereafter.

The coming years will be the age of artificial intelligence and India is among the most well-equipped nations to leverage the benefits and apply it to improve its public healthcare system. At a time when innovative solutions are required to address the gaps in India's healthcare system, Indian start-ups should step up and play a crucial role in bringing about reforms.

Another immediate step the government must take is to bridge the data gap in the health sector which will help measure district level outcomes. The government's proposal that the frequency of the National Family Health Survey should be moved from a ten-year cycle to a three-year one must be implemented at the earliest to understand the demographic changes and the changing needs of a population. For a healthcare system to be efficient, it is necessary to understand the underlying challenges.

The next important step is to educate the medical students on the economics of healthcare. They should be educated on the costs of healthcare and how crippling it is for the country to have a system that is driven by market forces. They should be taught not to recommend expensive treatment where it is not necessary, undue use of tests and procedures that further raises the out-of pocket expenditure of Indian households. The focus on tests often only benefits the manufacturers and patients are made to undergo tests without making an assessment of its usefulness or accuracy of the testing devices.

There should be increased focus on promoting generic drugs and there should be strict clampdown on doctors and hospitals insisting patients to buy expensive drugs from their pharmacies when cheaper versions of the drugs are available in the market. The licence of healthcare professionals who are found to indulge in unfair practices should be cancelled with immediate effect once the charges against them are proved. The public health spending which is at a dismal one per cent of the GDP will have to be increased if the country has to better equip itself to deal

with a situation that overstretches its existing healthcare system. While India expects to create a healthcare market expected to be worth USD 133 billion by 2022, the focus should be on reducing out of pocket expenses and regulating the private sector. The government has already stated that it will increase public healthcare spend to 2.5 per cent of GDP to reduce the out of pocket spend from 65 per cent to 35 per cent. Every effort should be made to ensure that this decision does not become yet another policy measure that will never be implemented.

In the end, the ultimate goal for any government must be to provide universal health coverage. The Ayushman Bharat Pradhan Mantri Jan Arogya Yojana that provides free access to healthcare for low-income earners in the country is a commendable first step towards achieving this goal. But there remain a number of loopholes that need to be plugged and the road to ensuring complete coverage is still a long one. A proper implementation of government policies will make the private sector look beyond profits can make them become equal and able partners in guaranteeing healthcare access to all.

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