Effects of Corporatisation on Clinical Practice in Private Healthcare Institutions

Experiences of concerned healthcare providers[1]

I. Background and Methodology

Over the past five decades, India's healthcare landscape has undergone a significant transformation, marked by the **rapid expansion of the private sector** at the cost of public health infrastructure. From the 1950s to the 1970s, healthcare was largely dominated by government-run institutions and charitable hospitals. Between the 1970s and 1990s, the sector saw a rise in nursing homes and small private hospitals in towns, alongside the emergence of a few corporate hospitals in major cities—signalling the shift of healthcare toward a market-driven model. Since the early 2000s, this has intensified into full-scale corporatisation, with large corporate chains establishing hospitals aimed at **maximising investor profits** across both urban and semi-urban areas. The corporate emphasis on revenue generation has not remained confined to these large institutions—it now **shapes practices** across the private healthcare spectrum, influencing individual practitioners, small and mid-sized hospitals, and even non-profit charitable facilities.[1]

Corporatisation of healthcare has introduced a **layer of managerial oversight** driven by business principles, often limiting the professional autonomy of doctors. In corporate hospitals, specialist doctors are offered high salaries but are expected to meet **revenue-linked targets**, including quotas for admissions, diagnostic tests, and therapeutic procedures. This

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model is also influencing smaller and medium-sized private and charitable hospitals, many of which are now taking loans, hiring specialist consultants, and investing in costly medical equipment to remain competitive. As a result, healthcare costs in these facilities have risen sharply, leading to reduced access or denial of care for economically disadvantaged patients, and contributing to financial hardship for those who seek treatment.[2]

Corporatisation has also strained the doctor–patient relationship, contributing to a **breakdown of trust** and a rise in incidents of violence against doctors and hospital staff. The rapid expansion of the private healthcare sector has been accompanied by **chronic underinvestment in the public health system**. As a result, many patients turn to public facilities only when private care is unaffordable, reinforcing a two-tiered system where access and quality are shaped by one's ability to pay.[3]

Parallel to the corporatisation of healthcare in India has been the **rapid privatisation of medical education**. Today, nearly half of all medical colleges are privately run, with students required to pay substantial fees. Many of these institutions lack adequate infrastructure, faculty, and clinical exposure, affecting the quality of training.[4,5] Upon graduation, students often pursue high-paying specialisations or corporate sector jobs to recoup the significant financial investment made in their education.

This report is based on an exploratory consultation, to understand how corporatisation of health care is affecting health care workers working in private hospitals and the practice of medicine.

Aim

To understand how corporatisation of health care is affecting health care professionals working in private hospitals and the practice of medicine.

Objectives

To identify:

1. Clinical practices that are commercially influenced and their effects.
2. Effects of commercialisation on the relationships between healthcare workers, patients and the hospital
3. The response of health care workers to the commercially influenced practices.

Methodology

We invited interested health professionals to an online brainstorming session on the impact of corporatisation of health care on health professionals.

Each participant was requested to have an informal conversation with 3-5 health care professionals who are working or have worked in private hospitals, with regard to corporatisation and commercially affected practices. A question guide was provided. Questions focused on themes of commercially affected practices, restrictions in autonomy, prioritizing revenue over patient care, overuse of unnecessary procedures, admissions and investigations and relationships between doctors, patients and the hospitals and attempts that they have made to change the system. Information with regard to specialisation of the doctor and the type hospital were recorded without identifying information.

During the consultation each of the participants was asked to share the experiences gathered, while ensuring confidentiality of the interviewees.

The 12 participants included a diverse group of healthcare professionals—primary care physicians, public health experts, medical college faculty, specialists and super-specialists from both public and private sectors, as well as nurses. The session was facilitated by two moderators, with an additional team member responsible for note-taking and technical coordination.

The online consultation was conducted on March 10, 2025 for 2 ½ hours. The first part of the consultation consisted of participants sharing their experiences. The second part consists of reflections on the shared experiences to understand broader trends.

The consultation was recorded and subsequently transcribed. The transcript was then edited for clarity. Two members of the research team independently reviewed the transcript to identify emerging themes in relation to the study questions. Through discussion, the researchers reached consensus on a final set of thematic categories. A compilation of illustrative quotes was prepared for each theme. These quotes were then jointly examined to interpret the significance of each theme and to explore interconnections between them. This detailed analysis informed the development of the results and discussion sections of the report.

II. Results

Commercially influenced practices affecting clinical decision-making

In several accounts, participants noted that the ethos of care was being replaced with a consumer-driven model where patients were seen less as individuals with clinical needs and more as paying clients to be directed toward higher-cost options.

"It is more like a market. We are the provider and you are the consumer—whether you want it or not. And these are the things which are available."

Managerial interference and erosion of clinical autonomy

Participants noted that **managerial priorities increasingly overrode clinical judgment**, with physicians expected to follow standardized protocols aimed at meeting organizational targets, rather than using their clinical expertise to make decisions in the best interest of the patient.

"Frequent meetings were conducted where the message was: prices are fixed by us, you work for us."

"In hospitals backed by foreign investors or multi-national companies, leadership was inaccessible, and clinical staff had no channel to influence policy. Middle management rotated frequently and had no clinical background."

Revenue generation, rather than patient need, frequently shaped key decisions—such as whether a procedure could be performed, who should perform it, or where a patient should be admitted.

"Qualified ER physicians were restricted from performing procedures like central line insertions to enable billing under higher-paid consultants."

Several respondents noted **explicit directives prohibiting discussions of treatment costs** or alternatives with patients, placing constraints on informed consent and ethical engagement with patients.

Others cited policies where **service delivery was contingent upon upfront payment**, including in emergency care settings.

"Nurses were asked to inform patients and families that they would not get medicines if their charges were not paid up to date. Medications were withheld if bills were pending."

While some clinicians reported autonomy in their practice, they acknowledged that such experiences were exceptions in an increasingly target-driven system.

Target-driven culture

A concern raised by participants was the **institutional emphasis on numerical performance indicators**—particularly procedure volumes and departmental revenue — as key metrics for evaluating healthcare professionals in corporate hospital settings. These targets often translated into explicit or implicit pressure to maintain high volumes of interventions, with financial incentives and recognition closely tied to these expectations.

"In chain hospitals especially, there's constant monitoring of the income that each hospital in the chain, department or doctor generates. If you fall short, your job feels insecure all the time."

"If they did not meet their targets, they would receive warnings at regular intervals—every six months or so."

These practices reflect a shift toward a **revenue driven model** of healthcare delivery. Clinical care itself is thus increasingly redefined to serve the institution first, then the patient. This metric driven culture is set, monitored, and embedded into the everyday functioning of corporate hospitals.

Commercial pressures and the overuse of unnecessary procedures

In addition to the pressures outlined above, several participants expressed concern about the growing **normalization of surgical and diagnostic interventions in the absence of clear clinical indications**.

"A neurologist in a corporate hospital would advise thrombolysis for stroke patients even when it wasn't indicated—for example, in chronic or subacute infarcts. This was being done because they received additional cuts for doing so."

"A friend working in a corporate hospital described the health check-up process as a 'fishing net.' Ultrasound scans were routinely offered, and many asymptomatic gallbladder stones were picked up. These patients were then told they needed surgery."

"After a celebrity faced complications from an untreated gallstone, a corporate hospital began promoting routine surgery for asymptomatic cases, using the celebrity in a video campaign"

In some hospitals, physicians were expected to justify their compensation by performing a certain number of procedures. This pressure was reinforced through the celebration of procedural milestones—such as achieving a target number of surgeries.

Unnecessary diagnostics

Participants reflected on a pattern of investigations in some hospitals, where high-cost diagnostics were routinely preferred over simpler, appropriate options. Patients did not have a clear understanding of the options of investigation and treatment and there appeared to be a lack of informed consent.

Examples included:

- Routine full-body scans as part of general health check-ups, Extensive blood panels and MRI scans for patients with conditions like altered sensorium due to hypoglycemia.
- Routine MRI cholangiograms before gallbladder surgery
- Whole body CT scans instead of the recommended first line FAST (Focussed Assessment via Sonography in Trauma) ultrasound exam in emergency trauma cases

Cost escalation through pharmaceutical and consumable practices

Doctors reported being instructed to prescribe costly medications and unnecessary supplements, and to direct patients to in-house pharmacies, which were priced higher than outside alternatives. In some cases, wards had their own mini-pharmacies with even steeper prices—particularly problematic during emergencies when staff had no choice but to use them. Basic items such as hand rubs, underpads, measuring jars, and diapers were issued individually for each patient, with no option to return unused supplies.

Additionally, more expensive brands of the same medicine were routinely prescribed—for example, a ₹4,000 version of Meropenem instead of an equally effective ₹900 alternative.

Unnecessary hospital admissions and inflated billing

Participants reported routine interference in patient admissions and billing, describing institutional strategies designed to maximize revenue—often at the expense of clinical appropriateness, patient preference, or ethical standards of care. These practices included the admission of patients who could have been managed on an outpatient basis, the extension of hospital stays beyond medical necessity, and the strategic allocation of beds to higher-cost categories.

"In some hospitals, because the emergency ward had a higher billing rate, doctors were advised to first admit patients in emergency, keep them there for some time, and then transfer them to the wards."

Nurses described being instructed not to question room allocations, even when patients explicitly preferred more affordable multi-sharing or ward beds. In some cases, general wards were removed altogether, as they were seen as less profitable than private rooms.

Additional costs were often embedded through administrative layers—such as customer relations staff whose services were billed separately. Patients were frequently given only partial cost information at the time of admission—typically room charges—while additional fees for consultations, nursing, and consumables were presented later, resulting in unexpectedly high bills.

Cut practice and referral incentives

Clinicians reported that it is routine for specialists to share a portion of their fees with referring doctors. Similar incentive structures were observed in referrals for diagnostics and pharmacies, where physicians were expected to direct patients in exchange for commissions. In some instances, emergency department doctors were reported to redirect patients to external private hospitals or higher-cost diagnostic centres for an incentive.

Commercialization and the transformation of clinical relationships

Participants reflected on how commercialization has altered not only the delivery of care, but also the **relational fabric of healthcare institutions**. These shifts were visible in how hospitals relate to patients, how healthcare workers engage with patients and with each other, and how clinicians relate to the institutions in which they work. Across accounts, commercial imperatives were seen to erode mutual respect and introduce or reinforce hierarchies within clinical spaces—often along lines of caste, gender, religion, and socioeconomic status.

- **Hospital - Patient relationship**

The hospital–patient relationship has become increasingly transactional, shaped by interactions filtered through billing structures and administrative policies.

Participants described how fragmented, opaque pricing and the involvement of non-clinical staff—such as customer relations executives—contributed to confusion and mistrust. These patient-facing dynamics mirror the institutional strategies outlined in the section on Inflated Billing and Unnecessary Admissions, where administrative decisions prioritize revenue over transparency and care.

- **Healthcare Provider - Patient relationship**

Doctors and nurses described how commercial pressures influenced their capacity to build trust with patients. Emotional engagement with patients' realities was often displaced by the need to navigate institutional demands, sometimes leaving clinicians themselves feeling alienated from the values with which they had entered the profession.

"It was made clear that the primary role of staff was to generate profit."

Nurses reported being responsible for conveying billing details to patients, a task that often created discomfort and led to strained interactions, as patients became more hesitant and less trusting.

"Staff nurses were regularly compared to air hostesses and were told to focus on delivering customer service rather than patient care."

Participants reported systemic and interpersonal discrimination against economically disadvantaged patients, particularly those holding Below Poverty Line (BPL) cards. In some cases, surgeries were refused outright or postponed for BPL patients, while cash-paying patients received immediate attention. Delays, denial of procedures, and the withholding of information about more affordable alternatives were common themes.

These attitudes, participants noted, were internalized by junior staff, contributing to a broader culture of exclusion. These dynamics also reshaped the provider–patient relationship, distancing doctors and nurses from their ethical commitments and fostering mistrust among patients.

- **Inter-Staff dynamics and power structures**

Participants described how internal hierarchies within hospitals were also shaped by financial incentives and positional power. For example, in some institutions, senior doctors dominated admission and casualty rosters to maximize personal income, often sidelining junior staff in the process. These patterns, referred to informally as "admission politics," were closely tied to revenue-sharing arrangements with the hospital management.

Participants further noted that in some hospitals, once a senior doctor secured a high compensation package, others on the team expected similar remuneration. This culture of comparative entitlement contributed to inflated procedure costs and further entrenched revenue-oriented decision-making.

- **Doctor–Hospital relationships and revenue sharing**

Many participants felt they were **positioned as revenue-generating employees** rather than decision-making professionals, with little access to or influence over institutional leadership. This dynamic left clinicians feeling isolated—like replaceable cogs in a larger machine, disconnected from both decision-making and meaningful patient care.

Those who generated higher revenue for hospital management were perceived to enjoy greater job security and institutional support. In some cases, doctors reported that as much as 90% of the consultation fee paid by patients was retained by the hospital. One clinician described eventually withdrawing from the formal consultation process entirely, uncomfortable with how little of the patient's payment actually reached the treating physician. Gender disparities were also evident, with male doctors reportedly receiving a significantly higher share of consultation fees than their female counterparts— as much as 70–80%—further compounding structural inequities .

Ownership, finance, and institutional drift

Hospitals once run by doctors or communities now often rely on external investors and adopt business strategies to stay afloat. In some cases, charitable institutions have taken on significant debt to compete with corporate hospitals, leading to higher costs and reduced access to affordable care.

"After the original founders were removed, local political actors reportedly tripled service charges."

These institutional shifts were not seen as isolated incidents. Participants described the growing entanglement of hospitals with insurance providers, pharmaceutical suppliers, and political actors. Together, these forces have fostered a monopolistic healthcare ecosystem.

"One hospital chain, initially 100% venture capital-funded, has since been acquired by a larger corporate hospital network. This reflects a broader pattern of cartelisation, with a few large players dominating the healthcare market."

There were also concerns about public hospitals becoming dependent on private institutions for critical services like transplants, sometimes due to formal agreements that restricted in-house training and self-sufficiency. Participants observed a gradual but significant transformation in the ethos of healthcare institutions, especially over the last decade. Facilities once rooted in charitable or service-oriented principles are increasingly aligning themselves with market-based models.

"This has resulted in a combination of private-sector pricing with public-sector levels of apathy."

Organisational priorities shaping daily care

Building on the structural changes outlined above, participants noted a corresponding shift in the everyday culture of healthcare delivery. The increasing dominance of commercial imperatives has altered how care is provided, how staff are trained and deployed, and how institutional accountability is upheld—or neglected. In some hospitals, MBBS doctors were hired on a per-shift basis to manage emergency departments, with limited familiarity with the institution's values or protocols. Understaffed ICUs, inadequate supervision, and remote decision-making by consultants contributed to poor patient outcomes, with little internal oversight.

The illusion of quality in private healthcare

Participants challenged the widespread assumption that private healthcare guarantees higher standards of care. Many patients who made significant financial sacrifices to access private hospitals encountered rushed procedures, poor communication, and minimal accountability. Structural understaffing, high staff turnover, and cost-cutting measures were cited as key factors compromising patient safety and dignity.

In some cases, clinical errors occurred due to staff shortages or fatigue—such as incorrect medication timings, injuries during routine procedures, or failure to follow basic safety protocols. Several participants described how patients, particularly those traveling long distances in hopes of being operated on by senior surgeons, were instead treated by junior doctors without being informed in advance.

Essential services—such as epidurals during labour—were sometimes denied due to gaps in staffing, while frequent attrition among healthcare workers was linked to adverse outcomes, including neonatal deaths.

Impact on the healthcare professional

Commercialization has reshaped not only clinical practices and institutional dynamics but also the everyday experiences and identities of healthcare professionals. Across interviews, participants reflected on how commercial pressures influenced their ethical choices, working conditions, emotional well-being, and the education of future doctors. The following subsections highlight how health professionals experience, resist, and are shaped by these systemic forces.

- **Emotional burnout and professional disillusionment**

Participants described a **growing dissonance** between the values that initially motivated them to enter healthcare and the commercial pressures embedded in corporatised medical practice. Many clinicians reported being pushed toward revenue-generating activities that conflicted with their professional ethics, leading to emotional exhaustion and a sense of moral compromise.

Over time, this misalignment prompted some to **withdraw from full-time clinical roles, pursue alternative pathways such as teaching, or accept the commercial realities with resignation**. The resulting emotional burnout was marked not only by detachment from patients but also by a deeper disillusionment with the institutional systems they worked within.

"It has become clear that those working in corporate hospitals tend to fall into one of two categories: doctors who reconcile with the commercialisation of healthcare as an

unavoidable cost of 'quality care,' and those who eventually leave—disillusioned by the systemic exploitation and the erosion of patients' rights."

A nurse in a corporate hospital shared, "*I lost my emotions. I even completed my shifts without knowing the names of the patients.*"

A retired nephrologist shared feeling uneasy in a corporate hospital where he was assigned procedure targets. Attempts to work independently were hindered by inadequate infrastructure, especially for transplants, eventually leading him to return to the corporate setting, albeit reluctantly. Another participant shared that they had stepped away from full-time clinical practice to focus solely on teaching transplant procedures, citing an inability to manage patient care for everyone as the reason for this shift.

- **Exploitation and abuse in private facilities**

Participants highlighted the precarious conditions faced by healthcare workers—particularly nurses and junior staff—in smaller, often unregulated private healthcare facilities. Many of these institutions were described as being run like family businesses, with **informal hierarchies and limited oversight**. Basic labour protections, formal grievance mechanisms, and accountability structures were frequently absent.

In such environments, nurses were sometimes assigned domestic chores, reflecting a disregard for professional boundaries. Institutional responses tended to protect high-earning clinicians rather than support lower-paid employees, reinforcing existing power asymmetries.

- **Attempts at resistance and systemic pushback**

Amid structural pressures, some health professionals actively sought ways to resist practices they found ethically troubling. Acts of resistance ranged from informal peer-monitoring to strategic changes in work patterns to preserve autonomy.

One initiative involved forming a WhatsApp group to monitor a neurologist's overuse of thrombolysis, allegedly for personal commission. The group—comprising staff from across hierarchies—created transparency around each decision, discouraging unnecessary interventions. While participants noted that such accountability may not have occurred if the financial benefit had gone to the institution rather than the individual, the effort was seen as an effective form of internal regulation.

Despite structural constraints, many continued to express empathy and compassion in their interactions with patients, striving to uphold the values that drew them to the profession. Others, unable to reconcile their principles with the demands of a privatized system, chose to leave institutional settings altogether. One respondent explained that part-time work allowed them to maintain ethical boundaries, while full-time clinicians were more dependent on the institution and thus less able to push back.

Effect of commercially affected practices on medical education and de-skilling:

Participants observed a growing shift in medical education toward specialization, profitability, and high-cost interventions—often at the expense of foundational clinical skills and patient-centred care. Many students effectively become super specialists before fully developing key generalist skills expected of an MBBS graduate.

Participants noted that government-employed doctors engaged in private practice often deprioritize teaching responsibilities, treating them as secondary to clinical income. Additionally, some educators were reported to be involved with private coaching centres, where students were incentivized to recruit peers—raising questions about conflicts of interest and cartelisation within the education system. In one postgraduate session, a trainee recommended a CT scan for obstructive jaundice, bypassing the more appropriate and affordable ultrasound. When questioned, a senior consultant responded, “This is what we do in our hospital,”.

In teaching hospitals, students often follow the example of senior doctors. As a result, commercially driven values become embedded in the training environment. Especially in private institutions, students are socialized into revenue-driven practices from the outset and rarely trained to critically examine their ethical or systemic implications. Many assume that high-cost care is always the best care, without learning when simpler, more affordable approaches might be better. Participants reported that at some public institutions, senior alumni working in corporate healthcare are regularly invited to speak, reinforcing the idea that financial achievement is the sole marker of success in medicine. This has destabilised the ethical norms of clinical practice.

Treatment is increasingly viewed as a product to be bought, and access to care as something only available to those who can pay.

There is a growing sense that medical education today is producing a different kind of doctor—to fit the demands of a commercialized healthcare system, rather than the needs of a community.

III. Reflections, analysis, and the way forward

Healthcare institutions being transformed in the era of corporatisation

Until the mid-1970s, India's healthcare system was primarily public, with the private sector accounting for just 5–10% of patient care. As public infrastructure struggled to meet rising demand, the government introduced incentives to attract private investment. This shift deepened after the 1991 economic crisis, when structural adjustment reforms curtailed public health spending and accelerated the privatization of care. The rise of corporate hospital chains in the 2000s consolidated a profit-oriented model that now shapes not only how care is delivered, but also how it is taught, valued, and justified.[20,24]

The themes that emerged from this effort largely echoed findings from previous research on the growing commodification of healthcare and its systemic impacts. However, participants also offered **concrete, ground-level insights**—detailing how these dynamics play out within hospital settings through specific incidents and practices. These are not simply cases of mismanagement or individual malpractice, but rather an implication of the **systemic embedding of market logic** into the very fabric of healthcare delivery.

Participants describe how **many hospitals are transitioning from being doctor or trust-run establishments, to investor-controlled entities,** reflecting trends of finance driven consolidation. Smaller and charitable hospitals are found to be taking loans or submitting to investors to compete in the intensely contested market, which is increasingly shaped by corporate or corporate-type hospitals. Corporate hospitals tend to reshape and hegemonise the commercial space by acquiring the most modern (and generally expensive) technologies which are attractive to patients. They also engage in aggressive marketing tactics, such as giving hefty commissions to referring doctors. This is accompanied by attracting prominent specialist doctors by offering them often exorbitant 'packages' (may be upto 10 million rupees annually or even more). This kind of business environment leaves smaller and charitable hospitals struggling to retain their client base on one hand, and to retain specialist doctors and medical professionals on the other hand. In this situation, many are willing to

adopt corporate practices while seeking investments from **globalised capital, which treats healthcare as a lucrative arena for accumulation**.

The **correlation between entry of large foreign investors into particular hospitals, and change in management structures and practices**, was clearly noted; these transformations were often associated with the **leadership becoming inaccessible**, and the appointment of middle managers having no background of clinical care.

Another worrisome trend is the **broad pattern of oligopolisation** with selected large corporate players moving towards dominating the market. Some processes of **monopolisation** are also evident in certain high-technology areas like specific transplant surgeries, where dominant corporates not only capture a large share of the commercial market for these lucrative procedures, but have even exerted their influence to retard the building of capacity of the public health system to provide such surgeries.

Systemic shifts in healthcare culture and practice

Two striking themes that surfaced were the **growing sense of alienation among healthcare workers** and **the impact of privatisation on medical education**. Several participants described **ethical dissonance, emotional burnout, and a fractured doctor–patient relationship**. Many expressed concern about overcharging, unnecessary procedures, and medical negligence, linking these issues to the **erosion of autonomy and trust** between providers and patients. Similar patterns have been documented in other low- and middle-income countries (LMICs), where public perceptions of malpractice and profiteering have, at times, led to violence against healthcare workers. [2]

Clinicians described a **growing sense of alienation from their ethical commitments**, as patients were increasingly treated as paying clients rather than individuals with complex needs. These institutional priorities are **mirrored in the training of healthcare professionals,** where medical education appears increasingly oriented toward producing a workforce that serves the demands of a commercialized system. **Instead of cultivating critical reflection and ethical reasoning, education has come to assume very market logic it ought to interrogate.**

Corporate hospitals—with aggressive branding strategies and investor-driven models—have become emblematic of a socially disembedded, profit-centric healthcare system. This reflects

broader global trends, as private equity and development finance increasingly view healthcare in LMICs as a lucrative sector. [2]

Business metrics (revenue targets, procedure quotas etc.) frequently override clinical autonomy, leading to **restricting and warping of the skills of practicing doctors**, forcing them to narrowly follow commercially induced directives of the corporate management. This erodes their status as expert professionals, preventing them from exercising their own clinical judgement in line with scientific and social considerations. Examples are the **rise of "fishing net" diagnostics**, for example detection of asymptomatic gallstones linked with pushing clinically unnecessary gallbladder surgeries, and **imposing expensive but unnecessary procedures** like thrombolysis routinely being conducted even for stroke patients where this was not indicated.

Another significant trend is intensified **stratification among medical professionals,** dividing the profession into 'celebrity doctors' and elite specialists who are part of the corporate hospital management, in contrast with the majority of practicing medical professionals who are supposed to follow dictates from the management. **Existing hierarchies based on gender and professional seniority are intensified,** with woman doctors often receiving lower consultancy rates compared to male colleagues. Senior consultants tend to control admission rights (linked with higher income) while often sidelining junior colleagues.

Although higher rates are being charged by corporate hospitals, most clinicians involved in actual provision of care not only have minimal influence over management practices, but they generally receive only a small fraction of the payment made by the patient. This mirrors observations of growing '**de-professionalisation'** of clinical care providers in the global context.

Despite these challenges, participants also spoke of moments of resistance, collective action, and everyday empathy. Some found creative ways to challenge unethical practices or preserve patient-centred care in their own work.

While this effort included participants from diverse professional backgrounds, it has certain limitations. Many accounts were based on observations or conversations with peers, making it difficult to independently verify specific claims. Additionally, the small sample size limits the generalizability of the findings and may not fully capture the range of experiences across India's vast and varied healthcare workforce. Nonetheless, the narratives align with existing literature and underscore the urgent need for deeper, systematic research into the experiences

of both healthcare workers and patients within India's increasingly privatized and corporatized health system.

Privatization and the shifting landscape of medical education

Since the 1970s, India has witnessed a **steady privatization of medical education**. Nearly half of all medical colleges today are privately owned—often by business or political interests—charging high capitation fees while offering inadequate infrastructure, clinical exposure, and teaching support. Even in public colleges, students often observe faculty involved in private practice or coaching academies, reinforcing commercial models of medicine. The rise of National Eligibility cum Entrance Test (NEET) for undergraduate and postgraduate entry has spawned a parallel education economy centred on coaching, test-taking, and high-cost specialization.

This environment of **converting medical education into an industry reproduces a profit-oriented workforce,** which manufactures doctors attuned to private sector demands. The graduates are focused on income-based career paths, and often disconnected from ethical and public health imperatives. The findings of this consultation—on deskilling, moral distress, and a business-oriented mindset—reflect the outcomes of this system.

Shifting employment patterns

In states like Maharashtra, large corporate hospitals are rapidly replacing older employment models such as state-employed positions and doctor-owned facilities. This transition is accompanied by performance-linked contracts, precarious working conditions, and a loss of autonomy—particularly for early-career doctors.[2] Research from India and other LMICs, including Vietnam and Ethiopia, reveals growing concern among medical professionals regarding intensifying competition, rising indebtedness, and limited support from professional bodies. Globally, researchers note that corporatisation in healthcare has far-reaching implications for medical practice.[2] In India, these tensions are felt acutely, as public policy increasingly promotes private-sector provision and insurance-based financing.

Health worker conditions and economic inequality

The economic efficiencies attributed to healthcare privatization often come at the expense of frontline healthcare workers. A systematic review[15] found that privatization frequently leads to worsened outcomes in job security, wage equity, and workload. Similarly, Goodair et al. (2024)[12] note that privatized hospitals tend to prioritize financial gains over care standards,

especially by minimizing staffing and focusing on high-revenue patients. Empirical studies examining hospital privatization across contexts—including South Korea, the UK, and India—found that outsourcing was consistently associated with lower staff-to-patient ratios and weakened employment conditions. Contrary to the promise that competition in mixed markets would enhance quality, the evidence points to a deterioration of care standards, particularly affecting low-income and uninsured populations.[13,14,15] These trends were echoed by participants in this report, who reported similar experiences within Indian hospital systems.

It is important to acknowledge that the expansion of private hospitals has also brought perceived improvements in access and quality for a limited subset of the population—primarily affluent and urban patients.

As Stinson, Pollak, and Cohen (2005)[25] argue, **healthcare cannot be treated as an ordinary market commodity**; the sector depends on trust, teamwork, and continuity. For-profit models that undermine the well-being of the healthcare workforce may compromise not only employment standards but also the quality and integrity of care itself.[7] This highlights the **need for robust regulatory oversight** to protect both patients and healthcare workers.

The path forward: Reclaiming healthcare as a public good

Institutional overreach and the erosion of ethics place health care workers in a critical position—not just as clinicians but as defenders of patients' rights. However, **the personal and professional cost of resisting unethical practices is high**, and many institutions have strong incentives to ensure this cost remains prohibitive. If health is a human right, then profit cannot be the arbiter of who gets care. Upholding this right demands **strong public oversight** to hold both public and private providers accountable to the goal of universal, dignified healthcare.[7,8,9]

Re-centering socially responsive indicators and strengthening accountability

The testimonies from nurses and doctors in our report paint a picture of moral distress – caregivers feeling forced to choose between meeting revenue targets and honouring their professional oaths. To counter this, healthcare leaders (public and private alike) need to

champion a **different set of metrics beyond the corporate balance sheet.** Quality of care, equity of access, patient satisfaction, and staff well-being are all critical indicators of a health system's performance. [10,11]

Such a reorientation requires **internal accountability mechanisms**: for instance, ethics committees with teeth, whistleblower protections for staff, and zero tolerance for policies that undermine patient rights. Globally, many frameworks stress accountability as a pillar of health governance; for example, recent resolutions on social participation and accountability for UHC encourage countries to institutionalize community monitoring and grievance redressal in healthcare .[6]

Strengthen public stewardship, revitalize primary health care and public provisioning

The evidence presented in this report suggests that unregulated commercialization is fundamentally at odds with the goal of "Health for All." It is imperative that government and regulatory bodies proactively **enforce standards for ethical practice, quality, and fair pricing**. Where existing laws (such as the Clinical Establishments Act or patient rights charters) are in place, they must be implemented rigorously with participatory oversight mechanisms.[17]

A robust public sector forms the necessary counterbalance to corporate dominance. Reinvesting in primary care would expand access, reduce dependence on private providers, and restore trust in the public health system. When primary care is strong and community-rooted, hospitals are less likely to become profit-driven entry points for every health need. Policymakers can draw on international norms here – for example, laws that ban discrimination by insurers and hospitals on financial grounds, or require a minimum quota of low-cost beds in private hospitals, have been used in various countries to maintain equity. [18]

Embed ethical training and accountability in medical education

- **Foster critical dialogue**: Create platforms within medical colleges to debate the commercialisation of health and its effects on clinical ethics, public health, and equity. These should include seminars, ethics modules, and cross-disciplinary teaching that embeds reflection into every subject.
- **Promote non-profit and public medical institutions**: Strengthen government colleges and support private not-for-profit institutions with a social mission.

- **Support alternative educational models**: Initiatives like the Rural Sensitisation Program[21], Travel Fellowships[22] and Nirman[31] offer immersive experiences that expose students to grassroots healthcare challenges and community-based practice.
- **Encourage primary care and family medicine**: Elevating the status and visibility of generalist disciplines is key to creating a more balanced and need-responsive healthcare system.
- **Involve civil society and advocacy networks**: Groups such as the Medico Friend Circle (MFC) and Jan Swasthya Abhiyan (JSA) can play a critical role in resisting commercialisation and fostering alternative visions of health care and education.
- **Document and research systemic impacts**: A sustained effort is needed to systematically study how 50 years of privatization have reshaped medical education—its priorities, outputs, and consequences for public health. This evidence is essential to inform policy and advocacy.

Professional associations in India (and globally) need to take a stronger stance as well, developing guidelines on interactions with the private sector, referral practices, and conflicts of interest.

If the trends outlined in this report are met with complacency, the danger is a health system that delivers high-tech clinical care for a privileged few while failing the many. A key takeaway from this effort is the **urgent need to strengthen this discourse and deepen research**—particularly on how medical education shapes clinical practice, and how patients across public and private settings experience the shifting landscape of care. Listening to these voices will be critical to understanding, and ultimately addressing, the real-world consequences of healthcare commercialization.

These dynamics are not unique to India. However India, which has the largest private healthcare sector among LMICs across the world, is witnessing **intensified versions of the global trend of finance capital encroaching into healthcare**. The Indian case underscores the universality of these processes—and the **urgent need for dialogue within and across countries** among medical professionals and healthcare workers, patients' groups, health sector civil society organisations and researchers. This is urgently necessary to challenge corporatisation-commercialisation and its impact in terms of dehumanization of medical practices, and to counter this by ensuring socially anchored, rational and humane health systems.

References

1. Chakravarthi, Indira & Shukla, Abhay & Marathe, Shweta. (2022). Growing Corporatisation of Private Healthcare in India and its Implications.
2. Shweta Marathe, Benjamin M Hunter, Indira Chakravarthi, Abhay Shukla, Susan F Murray - The impacts of corporatisation of healthcare on medical practice and professionals in Maharashtra, India: BMJ Global Health 2020;5:e002026.
3. Ghoshal, Rakhi. What ails India's two-tiered healthcare system? A philosophical enquiry. Indian Journal of Medical Ethics, [S.l.], v. 12, n. 1, p. 25, Nov. 2016. ISSN 0975-5691. Available at: <https://ijme.in/articles/what-ails-indias-two-tiered-healthcare-system-a-philosophical-enquiry/>. Date accessed: 30 Mar. 2025.
4. Bajpai, V. (2023). *Privatization of medical education in India: Challenges and the way forward*. Indian Journal of Medical Ethics. https://doi.org/10.20529/IJME.2023.043
5. Supe, Avinash & Burdick, William. (2007). Challenges and Issues in Medical Education in India. Academic medicine : journal of the Association of American Medical Colleges. 81. 1076-80. 10.1097/01.ACM.0000246699.94234.ab.
6. (UHC2030. (2024, April 11). Open letter to Ministers of Health: About the resolution on social participation for universal health coverage, health and well-being. https://www.uhc2030.org/news-and-events/news/open-letter-to-ministers-of-health-about-the-resolution-on-social-participation-for-universal-health-coverage-health-and-well-being-555656/)
7. Toebes, B. (2008). Taking a human rights approach to healthcare commercialization. In M. J. Selgelid, B. M. Rappert, & M. C. Smith (Eds.), Health Capital and Sustainable Socioeconomic Development (1st ed., pp. 441–454). Routledge. https://doi.org/10.1201/9781420046915-32
8. World Health Organization. (1978). Declaration of Alma-Ata. https://www.who.int/teams/social-determinants-of-health/declaration-of-alma-ata
9. World Health Organization & United Nations Children's Fund. (2018). Declaration of Astana: Global Conference on Primary Health Care, Astana, Kazakhstan, 25–26 October 2018. https://www.who.int/docs/default-source/primary-health/declaration/gcphc-declaration.pdf
10. Agency for Healthcare Research and Quality (AHRQ). (n.d.). *Types of quality measures.* U.S. Department of Health & Human Services. Retrieved from

https://www.ahrq.gov/talkingquality/measures/types.html

11. Olayiwola, J. N., & Beeson, T. (2024). *Measuring and monitoring health equity within healthcare organizations.* Mayo Clinic Proceedings. https://doi.org/10.1016/j.mayocp.2024.04.01
12. The effect of health-care privatisation on the quality of care, Goodair, Benjamin et al. The Lancet Public Health, Volume 9, Issue 3, e199 - e206
13. Maarse H. The privatization of health care in Europe: An eight-country analysis. J Health Polit Policy Law. 2006;31:981–1014. doi: 10.1215/03616878-2006-014.
14. Ovretveit J. Nordic privatization and private healthcare. Int J Health Plann Manage. 2003;18:233–46. doi: 10.1002/hpm.712.
15. Alayed TM, Alrumeh AS, Alkanhal IA, Alhuthil RT. Impact of Privatization on Healthcare System: A Systematic Review. Saudi J Med Med Sci. 2024 Apr-Jun;12(2):125-133. doi: 10.4103/sjmms.sjmms_510_23. Epub 2024 Apr 5. PMID: 38764559; PMCID: PMC11098275.
16. Basu S, Andrews J, Kishore S, Panjabi R, Stuckler D. Comparative performance of private and public healthcare systems in low- and middle-income countries: A systematic review. PLoS Med. 2012;9:e1001244. doi: 10.1371/journal.pmed.1001244.
17. Peer RF. Right to healthcare: the way forward. J Family Med Prim Care. 2013 Jan;2(1):4-8. doi: 10.4103/2249-4863.109929. PMID: 24479035; PMCID: PMC3894012.
18. World Health Organization. (2008). *Primary health care: Now more than ever – The World Health Report 2008.* Geneva: World Health Organization. Retrieved from https://www.who.int/publications/i/item/9789241563734
19. Zullo, Roland & Ness, Immanuel. (2009). Privatization and the Working Conditions of Health Care Support Staff. International Journal of Public Administration. 32. 152-165. 10.1080/01900690802492121.
20. Chakravarthi, Indira & Shukla, Abhay & Marathe, Shweta. (2022). Growing Corporatisation of Private Healthcare in India and its Implications.
21. https://www.travelfellowship.org/the-rsp
22. https://www.travelfellowship.org/Vision-and-values
23. https://nirman.mkcl.org/about/info
24. Dewesh Kumar, Tanya Tanu* and Vidya Sagar. Privatization of Health Sector: An Indian Perspective. Trends Telemed E-Health. 3(5). TTEH. 000572. 2022. DOI: 10.31031/TTEH.2022.03.000572

25. Cohen, M. (2006), The Privatization of Health Care Cleaning Services in Southwestern British Columbia, Canada: Union Responses to Unprecedented Government Actions. Antipode, 38: 626-644. https://doi.org/10.1111/j.0066-4812.2006.00599.x