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Original Article

Overcharging by Private Hospitals during the COVID Pandemic in India: A Patient-based Analysis of Rate Regulation

Shweta Marathe*, Abhay Shukla, Deepali Yakkundi

Support for Advocacy and Training to Health Initiatives (SATHI), Pune, Maharashtra, India.

ABSTRACT

Introduction: Responding to raised demand for health services during the COVID-19 pandemic, many countries turned to private healthcare providers to augment public capacities. In India, to deal with price inflation by private hospitals, many state governments implemented regulation of rates for COVID-19 treatment. **Materials and Methods:** In Maharashtra which pioneered the hospital rate regulation among Indian states, we conducted a mixed-methods study to examine the impact of rate regulation. Using purposive sampling, we interviewed 100 previously hospitalised COVID patients or their relatives, along with 12 health sector stakeholders. **Results:** Analysis shows that in 82.5% of hospitalisation episodes, patients were overcharged compared to official packages The majority of private hospitals utilised diverse stratagems to circumvent rate regulations, including double charging on items included in official packages. **Conclusion:** With a background of commercialisation of healthcare and pre-existing regulatory hiatus in India, gaps in design and implementation of COVID-period regulatory measures and state's inadequate regulatory capacity formed the context for the limited effectiveness of regulatory measures. India and other LMICs with large private healthcare sectors should develop comprehensive yet pragmatic frameworks for regulating private healthcare, including standardisation of rates, which can strengthen regulatory efforts, enabling equitable and affordable access to healthcare for all.

Keywords: Regulation, Profiteering, Health policy, Policy implementation, Private sector accountability.

Correspondence:
Ms. Shweta Marathe
SATHI, Aman E Terrace, Lane Number 20, Chandralok Nagari, Dahanukar Colony, Kothrud, Pune, Maharashtra 411038, India.
Email: shweta@sathicehat.org;

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INTRODUCTION

Private healthcare has widely been acknowledged for its critical role in providing health services during the COVID-19 pandemic. However, the scale of expenditure incurred by patients in for-profit private hospitals during COVID seems less discussed in academic literature. In India, private hospitals played a significant role during the pandemic in many states when government hospitals lacked sufficient facilities, but at the same time the high cost of private healthcare caused financial hardship for many. The pandemic exposed and exacerbated already existing inequities in access and affordability of healthcare in various countries where the private sector was dominant. However, global discussions[1-3] on private sector engagement seem to pay less attention to the negative consequences of the commercialised nature of much of the private healthcare sector. WHO defines the health system's goal as "improving health and health equity in ways that affect synergies, and the emergent behaviour is responsive, financially fair, and makes the best or most efficient use of available resources".[4] However, given the diverse experience of private sector engagement during the pandemic[5-7] on the one hand, and increasing public engagement with the unregulated private sector in many countries on the other hand, the achievement of this goal seems to be under serious question.

Since the beginning of the pandemic, India has remained in the spotlight not only for large number of COVID cases, but also for price gouging by private hospitals. Nevertheless, price gouging was not unique to India; overcharging by commercialised private healthcare providers has been widely reported during the pandemic in Lower-Middle-Income Countries (LMICs). Some hospitals in Asia and Africa charged exorbitantly for PPE and testing.[8-11] In India, during the early stages of the pandemic, particularly corporate hospitals were capitalising on the 'market opportunity' to maximise their profits.[12] COVID treatment was charged at rates as high as INR 50,000 to 100,000 per day of hospital stay for COVID-19 treatment.[13] A major corporate hospital in Delhi had set their COVID-19 rates at INR 72,500 daily for ICU with ventilator support.[14] In response to extensive

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complaints about overcharging by private hospitals, various state governments were induced to intervene with regulatory measures to prevent price gouging. Fifteen Indian states declared price capping for COVID treatment, stipulating such regulated rates for COVID treatment in private hospitals to be applicable for 20%-80% of hospital beds in different states.[15] In contrast to hesitancy by central and state governments in India regarding regulating the private healthcare sector before the COVID epidemic,[16] the decisions to regulate treatment rates during the COVID period stand out as remarkable. Some LMICs, including Bangladesh, Malaysia, Philippines, and Indonesia, had also set price caps for COVID-19 treatment to prevent the private sector from charging excessively.[17-19] In Nepal,[20] along with directives of rate capping on private hospitals, the Health Ministry threatened action against facilities charging excessive fees. Taking a different approach, Thailand introduced legislation in April 2020 to prevent private providers from charging COVID-19 patients any user fees.[21]

However, despite such official rate capping, the practice of price gouging in private hospitals for COVID treatment, coupled with non-transparency regarding regulated rates, and detaining dead bodies as a form of duress to extract high charges, was widely reported in the media in India.[22,23] Although the private sector's patchy response to rate regulation during COVID in LMICs such as India has been reported anecdotally, there is a need to systematically analyse how this significant attempt at regulation actually unfolded in practice. Addressing this research gap, this paper aims to examine the fate of official efforts to regulate COVID treatment rates in the Indian state of Maharashtra and to assess the patterns, mechanisms and scale of charging in the context of COVID hospitalisations. We also examine the perspectives and responses of key stakeholders to rate regulation, particularly since regulation of private hospital rates has always been a contentious area.

Study setting

The study was carried out in the Indian state of Maharashtra, the second most populous state of India which has been in the spotlight for having maximum number of COVID cases and deaths among various states in the country.[24] As of June 2022, India had recorded the second-highest number of confirmed cases worldwide, with over 43.2 million COVID cases, and the third-highest number of COVID-19 deaths, with 0.525 million reported deaths, figures which are widely estimated to be underreported.[25] Maharashtra was the country's worst-affected state, accounting for 22.35% of all cases and 30.55% of all deaths during the second pandemic wave.[26] While the dominance of a heterogeneous private sector in the health service sector is notable in India, in Maharashtra 77% of hospitals are in the private sector,[27] and 78% of hospital care utilisation is from private providers.[28] In light of the widespread reports of overcharging in commercialised private hospitals, the Maharashtra state government took two notable hospital rate regulation decisions early in the epidemic. The first decision taken in April 2020 concerned regulation of rates for COVID treatment in private hospitals, to contain inflated billing. Among Indian states, Maharashtra covered the highest proportion of hospital beds by regulatory measures, with 80% of beds of private hospitals being rate-regulated.[29] Interestingly, this first notification was not limited to rates for COVID treatment but also included non-COVID illnesses. However, these orders were legally challenged by the private hospitals lobby, and the Mumbai High court (writ petition no.1936 of 2020) quashed the state order, stating that states have no legislative authority to regulate prices for non-COVID treatments. Given the continuation of the first wave and then the emergence of the second and third waves of the pandemic, the state subsequently issued nine extensions to this decision until September 2021. Given the continued flow of complaints of excessive charging despite the rate capping, the state declared a second remarkable decision in June 2020 to conduct an audit of COVID bills. As per this decision, district collectors in each district or municipal commissioners in cities were expected to appoint auditors to pre-audit the bills, reducing substantial amounts from bills in those cases where hospitals had levied excessive fees.

MATERIALS AND METHODS

Data collection

We followed a concurrent mixed-methods design integrating quantitative and qualitative data. Qualitative data were gathered through in-depth qualitative interviews of patients and key stakeholders, while quantitative data were extracted from the billing records of patients. In-depth interviews with 100 respondents were conducted between November 2021 and February 2022 to understand patients' experiences regarding the expenses incurred for COVID treatment in private hospitals. Respondents were selected purposively using a set of criteria, such as those who complained of excessive charges for COVID-19 treatment in private hospitals during the second wave of the pandemic, the availability of their medical bills, and their willingness to share their experience and documents. Respondents were identified with referrals from voluntary networks in Maharashtra active in COVID-19 relief work. In case of deceased patients, their immediate family members were interviewed. Interviews were conducted telephonically using a structured interview instrument covering areas of enquiry such as the patient's overall experience in the hospital, type of hospital, transparency in treatment and billing, details of expenditure, status of obtaining medical reports, and any attempt to access a grievance redressal mechanism.

Additionally, we purposively interviewed selected twelve key stakeholders, including private healthcare providers, concerned government officials and health and civil society activists. Questions asked during these interviews focused on understanding the experience and opinions of respondents regarding hospital

rate regulation during COVID, its implementation on the ground including observed gaps if any, and the viability of private hospitals observing government rates. All interviews were conducted in Marathi and audio-recorded with prior consent.

Data analysis

Audio-recorded interviews with an average length of 45 min each were verbatim transcribed. The transcripts were de-identified to ensure anonymity and coded with assistance from the RQDA library of R software. Codes were developed deductively as well as inductively after carefully reading the transcripts. Similar codes were categorised, and broad themes were developed for thematic analysis. Quantitative data from hospital and medicine bills for each patient were entered and analysed in MS Excel using a well-defined template informed by the study instrument. We analysed headings under which various items and services were built and a cross-tabulation analysis was conducted to identify hospital-type-wise overcharging of bills against the rate cap. Qualitative and quantitative data were synthesised to develop a comprehensive understanding of private hospitals' compliance with the rate regulation.

Profile of patients

The total 100 patients included in the study were drawn from 15 districts of Maharashtra. The mean age of patients was 47 years. Of the total patients, 28 had some co-morbidity. Thirty-four patients recovered at the end of treatment, while 66 died in the hospital (Table 1). The study covered total of 100 patients who were treated for COVID with hospitalisations. Of these, 58 patients had been treated in more than one hospital and had undergone successive hospitalisations in two to five hospitals. Hence, our analysis focuses on the number of hospitalisation episodes instead of the number of patients. Of the total 183 episodes of hospitalisation, 21 episodes were reported from government hospitals, while 162 episodes were from private hospitals (Table 2). In 77% of episodes, the hospitalisation stay was shorter than 14 days, while in the remaining episodes, the stay was more than 14 days. Twenty patients had first approached government hospitals but resorted to private hospitals since government hospitals lacked beds or critical care services. In keeping with the study focus, this paper analyses 120 episodes out of 162 episodes of hospitalisation in private hospitals, for which detailed hospital bills were available.

FINDINGS

Overcharging in comparison with regulated rates

Maharashtra state government had determined the COVID treatment rates applicable to all types of private health establishments, based on insurance reimbursement rates set by the General Insurance Public Sector Association (GIPSA). According to the government notification on rate capping, there were three categories of rate packages for hospitalised COVID treatment: for General Ward-INR 4000 per day; for ICU without ventilator – INR 7500 per day; for ICU with ventilator- INR 9000 per day. These packages were supposed to include bed charges, the cost of monitoring and basic blood investigations, X-Ray, ECG, oxygen charges, consultation charges, nursing charges, meals, and basic procedures like Ryle's tube insertion and urinary catheterization. Hence all these components of care were not supposed to be charged separately above the package rates.

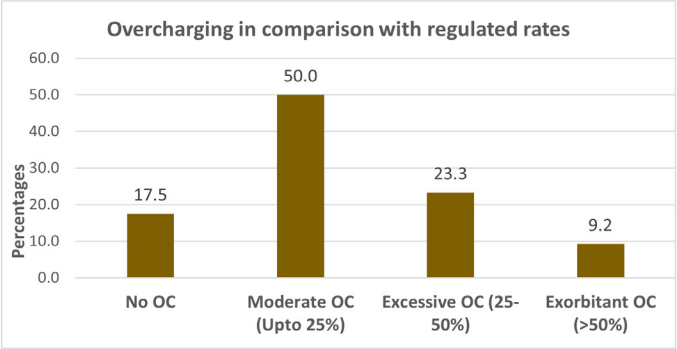
Scale of overcharging against official package rates

While medical professionals interviewed for the study endorsed the need for rate regulation, its implementation was met with mixed responses from different hospitals. A bill-by-bill comparative analysis (n=120) against the benchmark of official rates for respective COVID packages was conducted, which shows that large number of hospitalisations (82.5%) involved overcharging compared to official rates. Further, on assessing the scale of overcharging for COVID treatment, 50% of hospitalisations were characterised by moderate overcharging, 23.3% episodes displayed excessive overcharging, and the remaining 9.2% were associated with exorbitant overcharging (Graph 1).

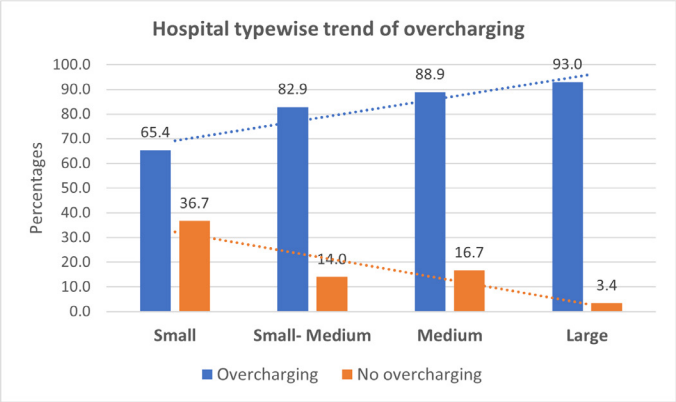
Notably, in a small but significant proportion of hospitalisations (17.5%), the official rates were observed, revealing that official rates were viable for a section of the hospitals. However, the

Table 1: **Profile of patients.**

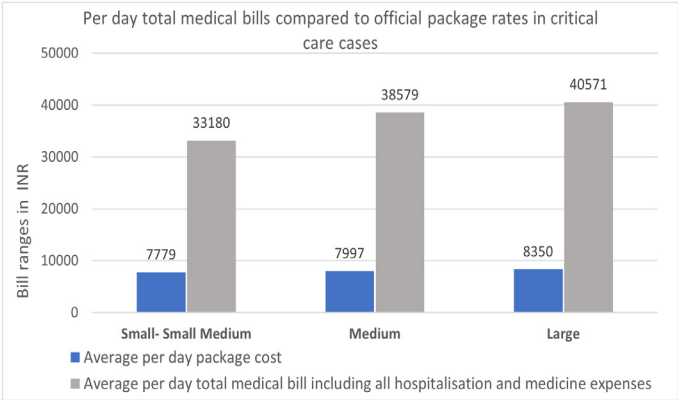
Characteristics
Total patients 100
Sex
Male 85
Female 15
Mean age in years 47
Patients with comorbidity 28
Recovery
Recovered 34
Died 66



Graph 1: Overcharging in comparison with regulated rates.



Graph 2: Hospital type-wise trend of overcharging



Graph 3: Per day total medical bills compared to official package rates in critical care cases

Table 2: Details of episodes of hospitalization.

Episodes of hospitalisation 183 episodes in 100 patients
Types of hospitalisation episodes Number of Episodes
Admissions in Government hospitals 21
Admissions in Private hospitals 162
The breakup of private hospital admissions (162)
Type of private health facility
Small hospitals (<30 beds) 48
Small-Medium hospitals (30-50 beds) 60
Medium hospitals (50-100 beds) 22
Large hospitals (>100 beds) 32
Duration of hospitalisation
less than 14 days 125 (77%) more than 14 days 37 (23%)
Total episodes with detailed hospital bills available 120

viability of official rates has been a critical concern among the medical community; one practising doctor from a medium-sized hospital succinctly expressed:

'*State-declared rates were affordable for patients but not for doctors*!' (Respondent, doctor_08).

However, a state official noted that despite the issue of non-viable rates, doctors' lobbies did not oppose upfront the COVID-specific rate regulation in Maharashtra, perhaps because they felt obliged to observe these measures in the time of public health emergency.

Varied responses to rate regulation

Although overcharging was evident across all types of hospitals, further analysis (n=120) shows that the scale of overcharging increases from small to large-sized hospitals (Graph 2). When asked whether there was any difference in compliance with rate capping among different types of hospitals, a doctor from small-medium sized hospital explained:

'most corporate hospitals have an in-house diagnostic centre with pathology and radiology, a pharmacy store, and expanded infrastructure and facilities. So compared to small and medium-sized hospitals, they have more scope for overcharging the patients and recovering the rate capping costs from various other expense lines.' (Respondent, doctor_03).

Some respondents stated that since large-corporate type hospitals have a larger number of beds, they were closely monitored by government officials, and hence were more likely to follow the rate capping. Contrary to this, others opined that small to medium-sized hospitals are more concerned about their local credibility and hence were more likely to observe rate capping. As a practising doctor explained:

'People in rural areas usually know the doctors from small and medium hospitals, so doctors feel a moral obligation and concern about their reputation among people. They will create a negative image in the area if they overcharge patients. (respondent, government doctor_09).

Double charging on services included in the official packages

Despite the mention of the components included in the rate package as per government notification, many hospitals routinely imposed double charging. For example, if a patient was admitted to ICU with ventilator package (maximum daily rate INR 9000), the cost for a room inclusive of doctors and specialists, nurses' charges and obviously charges for a ventilator, monitor and oxygen supply (Table 3) were supposed to be included in that package. However, many hospitals charged separately for these items which were supposed to be included in the rate package and patients were double-charged for several services, resulting in substantial inflation of bills. Further, charges for the same service at different hospitals varies dramatically (by 5-15 times), reflecting the variation in billing practices and varied scale of profit margins. With concern regarding declining doctor-patient trust over the past years, a doctor from a small hospital expressed:

'*the COVID-19 pandemic was an opportunity for the medical fraternity to provide rational and ethical treatment and regain patients' trust, but barring a few exceptions, most doctors and hospitals missed this opportunity.*' (Respondent, doctor_08).

High total daily bills compared to official package rates

Analysing the data further, we examined per-day total expenditures for hospitalisation and medicines against the official benchmark of per-day rates. This analysis was conducted in case of the critical care episodes with admission to ICU or ICU plus ventilator; given the lack of available standardised bills, we could calculate per day hospitalisation and medicine expenditure for 77 critical care episodes out of a total of 97 critical care episodes. These cases were likely to require more intensive treatment and hence involved higher-end expenditure (Graph 3). The analysis (n=77) reveals that per-day total medical bills were 400% to 500% higher than the official rates, indicating that rate capping did not have the desired impact in practice, in terms of keeping medical bills affordable for people. The hospital-type-wise analysis clearly shows an increasing trend of total bills from small and small-medium-sized hospitals to large hospitals, which further confirms that medium and large-size hospitals overcharged more.

Escape routes to evade rate capping

Inflated charging on services outside the official packages

Private hospitals used multiple channels to circumvent rate regulations while earning on items not explicitly covered under the rate capping packages. As one doctor candidly expressed:

'*Most doctors and hospital managements have cleverly followed the rates capping of inclusions and compensated for their possible loss by overcharging the exclusions*' (Respondent, doctor_08).

Unfortunately, in the name of observing COVID protocols, some hospitals charged exorbitant prices for Personal Protective Equipment (PPE) kits. While not covered in the packages, the government had set a daily limit of charging for PPE kits at INR 600 for general ward patients and INR 1200 for ICU patients. A doctor from a small hospital shared:

'*Also, even though staff used one PPE kit for checking multiple numbers of patients, each patient was charged for a PPE kit for every day of hospitalisation. Such charges inflated the bill for patients and increased hospitals' profits!*' (Respondent, government doctor_09).

Some patients reported that hospitals charged them for three to four PPE kits per day. In this sample, for 40 patients the total PPE bill ranged from INR 9000 to 72,500; among those, seven patients were billed amounts more than INR 40,000 just for PPE kits.

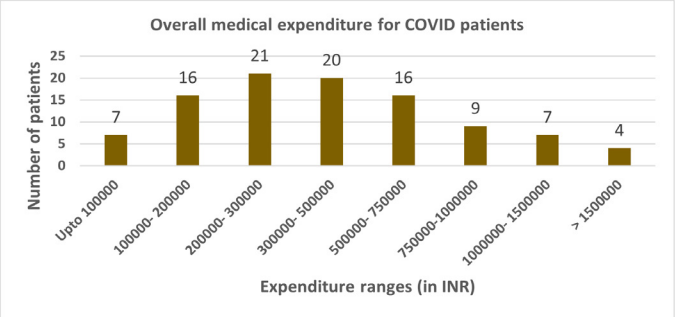
Diagnostic tests were another critical area leveraged by hospitals to make up their profits, with one respondent reporting daily pathology bill was INR 12,000 to 13,000 (RR17). Given the defined mandate of government audits of COVID bills, auditors examined only the main hospital bill, focusing on expenses included in the official package. Hence audits were often unable to address inflated charges for services not clearly mentioned in the package, including medicines, diagnostic and other procedures, equipment and biosafety materials (Table 4) which account for a significant portion of the overall bill.

Lack of standardised and proper bills

Currently, there is no rule or accreditation guideline requiring standard format for hospital bills, enabling many hospitals to charge patients in non-transparent manner. In this study most hospitals did not issue detailed itemised bills; for example, in one case, INR 48,000 was charged as 'procedure charges' with no mention of the procedure. Although corporate hospital bills were more systematic and itemized, these also contained irregularities in mentioning charges. Some respondents reported receiving handwritten bills for large amounts in the INR 200,000. In one case, even the hospital's name was missing on the handwritten bill.

Table 3: Frequency of double charged services and related rates.

In-patient services	Number of episodes	Range of charges INR per day
Nursing care	30	300-3000
Doctors' consultation	42	150-2000
Specialist consultation	31	1000-5000
Ventilator charges	39	1500-7000
BiPap machine charges (type of ventilator)	19	2500-3450
Oxygen charges	31	1000-4500
Support services	Number of episodes	Range of charges INR per episode
Administrative charges	54	4255-36220
Biomedical waste management	25	3900-42000



Graph 4: Overall medical expenditure for COVID patients.

Huge burden of medicine expenditure

Sale of medicines by the hospital appears as another major channel through which private hospitals inflated charges during the pandemic. Out-of-Pocket Expenditure (OOPE) on medicines annually pushes 8 million Indians into poverty and the expenditure on medicine constitutes about 70% of the total out-of-pocket expenditure in India.[30] In India there is no legal restriction on the additional markup which hospitals can charge while providing medicines. This study reveals an exacerbation of such trends during COVID, with 66 patients having medicine expenditure above INR 100,000. Medicine expenditure was more than half of the total hospitalisation bill in 29% of the episodes. For example, in one case, the medicine bill was INR 900,000, while the total hospitalisation bill was INR 568,882. Since medicines were not explicitly covered in the official rate packages, this became an avenue for high charging levels.

Heavy overall expenditure for COVID-19 treatment

Given the limitations of official COVID packages and considerable expenditure on items which were not included in the official rate packages, we analysed the total medical expenditure for each patient for COVID treatment (n=100 patients). We added the cost of various bills from all hospitalisation episodes for each patient, including medicine expenditures. Quite strikingly, more than half (56 patients) of the patients had a total expenditure of more than INR 300,000 (Graph 4) while 93 of the patients had total expenditure above INR 100,000, which was higher than the average annual per capita income of Indians in 2020-21 (INR 91,481). Given the fact that 77 of the patients in this study had hospital stay of less than 14 days, and most of the patients were from rural areas or smaller towns, such large bills are likely to have been both unjustified and unaffordable.

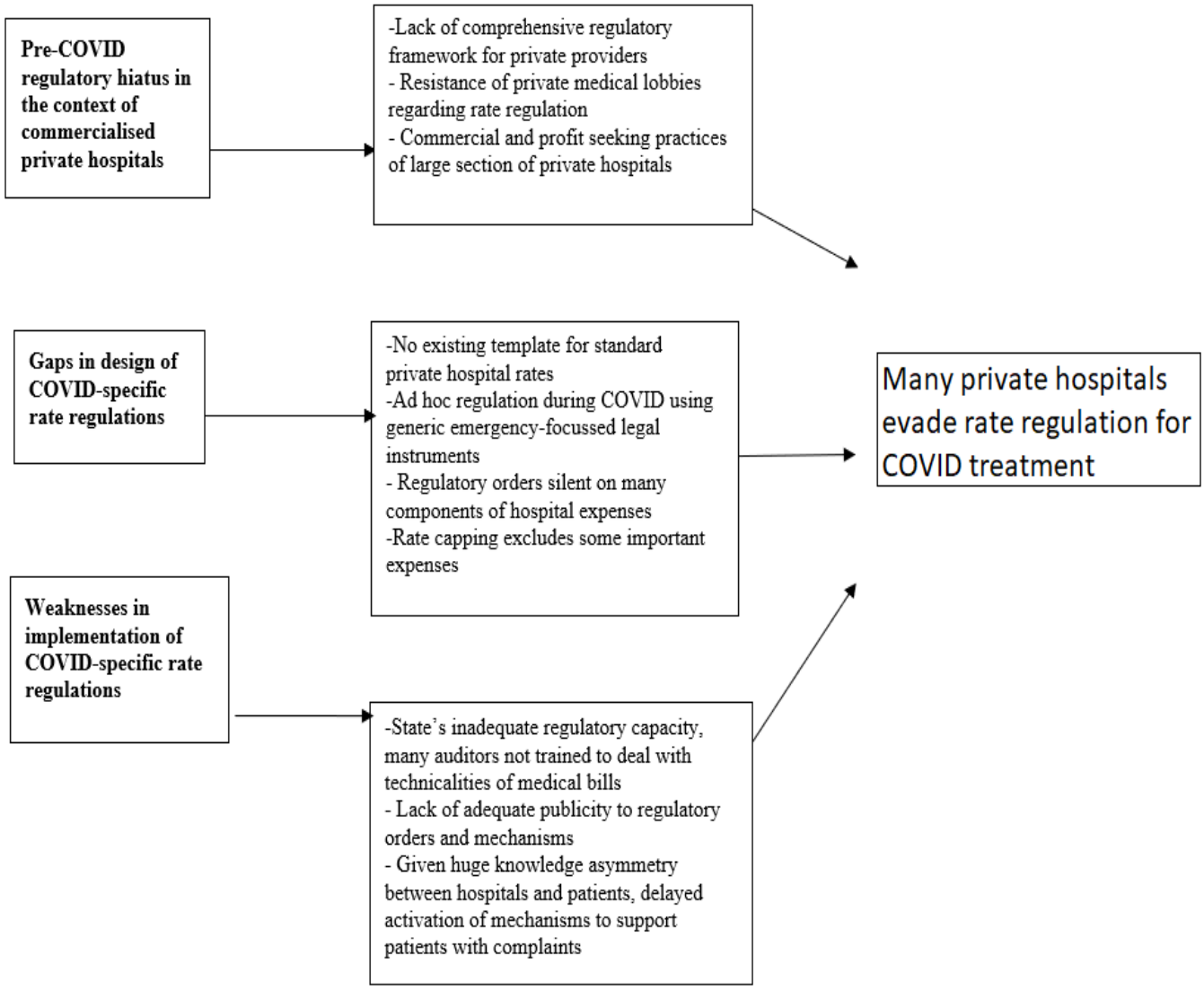


Figure 1: Determinants of constrained effectiveness of rate regulation during COVID-19.

Table 4: Charges for services per hospitalisation episode.

Services	Number of hospitalisation Episodes	Rate in INR (Lowest)	Rate in INR (Highest)
Pathological investigations	80	1400	97900
Biosafety material	40	1200	72500
Procedures	34	225	48000
Equipment	23	4650	55000

Multiple responses were noted when asked how respondents managed to pay the hefty bills. In 93% of the responses (*n*=239 responses), the family had to take some form of loans, mortgage land, or sell off assets like animals, tractors etc. Only 17% of these responses were regarding private health insurance coverage. The critical condition of women who have lost their husbands to COVID sharply came to the fore in this study, with families of deceased patients now facing a dual burden - the emotional trauma of losing a close family member, and loss of a major breadwinner, frequently coupled with enormous debt incurred due to hospital bills.

The state-supported health insurance scheme (Mahatma Jyotiba Phule Jan Arogya Yojana-MJPJAY) in Maharashtra aims to provide cashless medical care for low-income households. Moving further, during the pandemic the Maharashtra government had expanded the coverage under this scheme and announced that all residents of the state will be provided free treatment under this scheme.[31] However, in this study out of 33 hospitalisations which were related to hospitals empanelled under the MJPJAY scheme, in only three instances the patients were reported to have received the scheme entitlements, indicating inadequate effectiveness of the scheme to protect patients from heavy medical expenditures.

Inadequate government capacity to ensure rate capping

Inadequate implementation of hospital rate regulations and consequent high burden of healthcare spending for patients, raises a question about the government's capacity to ensure effective implementation of regulations.

There were serious gaps in implementation of the audit process, which was introduced to ensure hospitals' compliance with the rate capping measures. Auditing seems to have worked well mainly in a few larger cities (tier I and II), while in several smaller towns and rural areas across the state, either auditors were not placed, or clerical staff was appointed as auditors, who were not competent to understand medical terminology and review the medical bills. A medical officer from a public health facility pointed out another critical issue in audits:

'*the district level machinery was a bit hesitant to conduct audits of private hospitals since in the times of scarcity of resources in public hospitals, patients were often referred to private hospitals, and many of these private hospitals had informally taken the stand that they would refrain from taking patients if they had to undergo government audits*'. (Respondent, government doctor_09).

This implies the government's dependence on private hospitals during the pandemic situation, which hindered its ability to ensure the desired outcome of regulated rates.

DISCUSSION

Investigating regulatory deficits in the context of commercialised healthcare

Maharashtra state's measures to regulate rates of private hospitals for COVID treatment were notable and unprecedented since until COVID no Indian state had managed to ensure legal regulation of rates in private healthcare. Our findings show that COVID-specific rate regulation did not have the expected impact on keeping hospital bills affordable for patients. These significant deficits could be interpreted as partial regulatory failure. Regulatory failure[32] and regulatory capture[33] are well-known phenomena in the context of private economic actors. In the Indian healthcare sector, regulatory failure[34] and regulatory capture[35] have been analysed in specific contexts before the COVID epidemic.

Karl Polanyi has described the historical process of 'double movement' in market economies, where the first movement is in form of expanding commodification and extension of the market, which leads to major social disruptions. Following this during the second movement, society compels the state to socially re-embed the economy and control the impacts of commodification, by creating various social protections and regulations. Growing commercialisation of healthcare in India from 1990s onwards[36,37] may be regarded as a form of the 'first movement' in the healthcare sector. This trend has been accentuated by the growth of corporatised healthcare, which propagates maximisation of financial returns as highest priority.[38] This ongoing tendency for maximising profits by exploiting market opportunities was further sharpened during the early stages of the COVID epidemic in India. The unregulated 'free market' setting allowed many private hospitals to charge arbitrary and excessively high rates for care, exploiting the demand-supply disequilibrium created by rapid surge in number of cases in the COVID first wave. Then with impending widespread denial of care or devastating expenses affecting COVID patients across various sections, the 'reality of society' came to the fore. This triggered the 'second movement', with numerous state governments including Maharashtra

enacting ad hoc regulations on maximum rates to be charged for COVID treatment by private hospitals. The complex, unfolding and often intense contestation between the long-standing first movement for commercialisation of healthcare, and the emergent second movement during COVID which was focussed on regulation of rates, constitutes the contentious terrain which shaped the fate of official efforts to regulate COVID treatment rates in Maharashtra.

Our findings suggest multiple determinants for the limited effectiveness of the state government's impromptu regulatory measures (Figure 1). Here we analyse how the pre-existing regulatory hiatus concerning the private healthcare sector, coupled with gaps in the design as well as implementation of regulatory measures during COVID, including weakness of concerned legal instruments and insufficient regulatory capacity of the state, allowed commercialised hospitals to evade the emergency rate regulation measures often.

Pre-COVID regulatory hiatus concerning private healthcare

Despite a large and predominant private healthcare sector in India, historically its regulation has been weak due to various reasons, including inadequate political will and continued resistance from the private sector lobby.[39,40] Most current regulatory acts concerning private healthcare sector in India are confined to registration, licensure, and elementary infrastructural standards. Given the earlier lack of regulation in most Indian states, including nursing home-centric, outdated regulatory legislation in some states like Maharashtra, enactment of the Central Clinical Establishment Act (CEA) in 2010 by Parliament of India was a milestone. However, the status of its implementation across Indian states may be characterised as regulatory stalemate. After more than a decade, only 11 Indian states (out of total of 28 states) have adopted this act, and even there it is not effectively implemented. In Maharashtra state, despite huge presence of private healthcare providers, the Central CEA has not been adopted, and regulation remains limited to continuation of an obsolete legislation enacted in 1949[41] which is mainly confined to registration of facilities. Among issues considered for regulation concerning the private healthcare sector, regulation of rates has been characterised by ongoing contention between private providers and governments, and no Indian state was able to standardise rates for treatment in private hospitals prior to the COVID epidemic.

Despite this background, during the COVID epidemic the hitherto stalled agenda of regulating private healthcare was suddenly reactivated. The pre-existing state of 'market anarchy' now threatened to precipitate into 'market catastrophe' due to severe demand-supply imbalances, acute shortages of hospital beds and lack of standard admission protocols, within the larger atmosphere of generalised panic during the pandemic. Hence several state governments including Maharashtra government regulated rates for COVID treatment, by invoking generic emergency provisions such as the Disaster Management Act (DMA) and Epidemic Diseases Act (EDA). These generic, emergency-oriented provisions had inherent limitations regarding enforcement of standard hospital rates, contributing to the weakness of regulatory measures adopted during COVID.

Design of COVID-specific rate regulations: inadequate to deal with reality of private hospitals

Given the historical deficit of regulation, there were no existing templates for standardisation of private sector hospital rates, along with absence of standard billing formats, with each hospital adopting different patterns of billing. The orders for rate capping were issued with the assumption that standard billing procedures would be universally followed, and that packages for COVID treatment would cover various components of care required for management of COVID patients. However, neither of these assumptions correlated with the practices of private hospitals in reality. Several hospitals did not provide proper bills, or just mentioned a few broad categories of expenses, while other hospital bills ran into several pages with detailed lists of various items being charged. While the regulatory orders covered some inclusions and exclusions related to the COVID packages, they were silent on some important hospitalisation related expenses, allowing many hospitals to exploit the gaps and charge exorbitantly for items which were not specifically mentioned. Rate regulation orders were re-issued several times during 2020 and 2021 to extend their validity, providing opportunity to review the evolving regulatory experience, and to eliminate ambiguities by refining the regulatory directives; however, this was not done as required.

Implementation of COVID regulations: private hospital manoeuvres in context of inadequate regulatory capacity and healthcare complexity

While Maharashtra government's decision to audit private hospitals' COVID bills was remarkable, as per media reports the reach of government government-appointed auditors was primarily focused on larger cities, being less effectively implemented in smaller towns and rural areas.[42] Hence the overall deficit of state regulatory capacity regarding private healthcare which predates the COVID period, appears to have been a major contributor to regulatory deficits during the pandemic. Not much analysis has been published regarding the effectiveness of rate capping in other Indian states[43] yet according to anecdotal reports and grey literature, it seems rate regulation was not fully effective in other states also.[44] Researchers have analysed the failure of private sector in LMICs during the pandemic, in the context of pre-existing market failure. Overall, the considerable technical complexities involved in the regulatory process, combined with asymmetry of capacities between private hospital managements

and less technically equipped official auditors, created an unequal terrain where various stratagems could be used by commercial private hospitals to evade regulation of rates for COVID treatment.

While our findings show that all types of hospitals tended to overcharge during the epidemic, overall trend there was higher frequency and scale of overcharging in larger hospitals. This may be explained by factors such as differential levels of commercialisation, operational practices and profit-seeking behaviour across hospitals. The growing corporatisation of healthcare has generally translated into higher charges for services in large for-profit private hospitals compared to smaller facilities. The rates for COVID treatment were fixed irrespective of hospital size, and larger hospitals may have felt greater compulsion to charge beyond the official rates due to their baseline higher service charges. Combined with this, larger hospitals tend to have their own pharmacies, imaging centres and laboratories, which could be readily used as a major channel for additional charging beyond defined package rates.

Regulation in the healthcare sector is characterised by considerable complexity, presenting a scenario of competition, confrontation and compromise.[45] In more complex settings, regulatory outcomes tend to be more biased in favour of the provider, due to greater domain expertise of the latter. Based on developing a model of regulation in complex policy environments, as carpenter and Moss[33] concludes that –

The main result of the model is that as policy becomes more complex, regulatory outcomes are increasingly biased toward those preferred by the firm… Because of its expertise advantages, the (regulated) firm may influence the (regulatory) agency without shifting its policy preferences.

CONCLUSION

This empirical study seeks to contribute knowledge in private healthcare regulation. In our understanding, this is one of the first empirical studies in India to assess how emergent government responses during COVID for regulation of rates in private hospitals unfolded while analysing mechanisms through which overcharging took place in these hospitals despite official rate capping. Such critical analysis can inform further regulatory processes, which remain a high policy priority for the healthcare sector in India and many other LMICs.

The traumatic yet instructive experience of the COVID pandemic can become an occasion for re-imagining how public bodies engage with private healthcare provisioning, with implementation of socially responsive and effective regulation becoming a frontline for such engagement. A key component of such regulatory processes would be designing and implementing effective legal and operational arrangements which explicitly address the current anarchy concerning standards in private healthcare. For example, legal specification of standardised hospital billing categories and formats is an essential precondition for transparency and rationalisation of hospital charges. Whenever rate regulated packages for healthcare are mandated, there must be detailed and comprehensive specifications of the range of services and items that are covered by such packages, minimising regulatory ambiguity. There is also a specific need to regulate added charges on medicines which are levied by private hospitals or their ancillary units, to prevent large-scale inflation of prices which can take place at these points of supply. Designing such pragmatic standards and procedures should be accompanied by major strengthening of public regulatory capacity in both quantitative and qualitative terms. There is a need to ensure adequate medical and auditing capacities of assessors, so that public regulators can match the domain knowledge advantages of private healthcare providers. It would also be important to provide wide publicity and accessible public information regarding rate regulation provisions, along with setting up patient helplines or similar mechanisms to advise patients and caregivers. As demonstrated during the unprecedented participatory audit of private hospital bills in Maharashtra, civil society health experts and social networks' involvement in assisting patients with their overcharging complaints can provide a valuable complement to official auditors. Such measures for patient support would go a long way towards reducing the huge knowledge asymmetries which usually characterise patient encounters with commercial healthcare providers. Such a range of measures would be necessary to bolster frameworks for regulation of private healthcare, to complete the movement from 'regulation on paper' to 'effective regulation in practice.'

Further, it is obvious that in such a complex setting, regulation of private healthcare providers cannot be treated as a one-time set of actions, rather this needs to be developed as a learning process which is continuously refined over time based on emergent experiences. The hospital rate regulation experience in Maharashtra during COVID shows that moving beyond issuing of legalistic orders, the 'second movement' regarding regulation of private healthcare needs to be designed and implemented in a manner which is cognisant of both technical and social aspects. Such regulation must concretely address various profit-maximising strategies adopted by commercial hospitals on the one hand, while promoting social responsiveness and engagement on the other hand, to become optimally effective in achieving its public goals of ensuring affordable, quality healthcare for all.

Limitations

There are a few limitations to our study. Firstly, many hospitals did not issue standardised and item-wise bills, which made it challenging to conduct an in-depth analysis of all bills on parameters such as service-specific per-day expenditures.

Secondly, the severity of the illness and the medical appropriateness of treatment could not be considered while analysing the medical cost. Third, due to the inherent difficulty in identifying respondents for the study, we could not include patients in equal proportion related to diverse categories (small to large hospitals) of hospitals, which placed constraints on specific aspects of the analysis. Nonetheless, our study attempts to provide solid empirical evidence and analysis concerning overcharging by private hospitals during the COVID epidemic based on a synthesis of qualitative and quantitative data, attempting to address a complex area which connects health policy and ground-level practice.

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CONFLICT OF INTEREST

The authors declare that there is no conflict of interest.

Ethical Approval

Ethics approval for the research was received from the Institutional Ethics Committee of Anusandhan Trust, Mumbai (IEC24/2021).

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