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INSTITUT DE HAUTES ÉTUDES INTERNATIONALES ET DU DÉVELOPPEMENT

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Profitable Medicine

An Ethnography of Corporate Hospital Care in South India

THESIS
submitted at the Graduate Institute
in fulfilment of the requirements of the
PhD degree in Anthropology and Sociology

by

Andri TSCHUDI

Thesis N° 1411

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Sur le préavis de M. Aditya BHARADWAJ, professeur à l'Institut et directeur de thèse, de Mme Shalini RANDERIA, professeure à l'Institut et membre interne du jury, et de Mr Carlo CADUFF, Reader, Department of Global Health & Social Medicine, King's College London, UK, et expert extérieur, la directrice de l'Institut de hautes études internationales et du développement autorise l'impression de la présente thèse sans exprimer par là d'opinion sur son contenu.

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RESUME / ABSTRACT

Titre de la thèse / Title of thesis : Une médicine rentable : ethnographie des soins hospitaliers privés en Inde du Sud / Profitable Medicine : An Ethnography of Corporate Hospital Care in South India

Résumé en français: La prolifération des chaînes d'hôpitaux privés dans le monde fait redouter une hausse du coût des soins et une aggravation des inégalités en matière de santé. Ces inquiétudes sont particulièrement pertinentes en Inde : depuis les années 1980, le secteur hospitalier privé connaît une croissance rapide dans un contexte où l'État investit peu dans les services publics de santé et où les frais médicaux sont principalement couverts par les patients. Cette thèse explore comment la promesse d'une médecine haut de gamme et l'impératif de rentabilité se manifestent dans la pratique quotidienne des soins hospitaliers privés. À partir d'une enquête ethnographique de douze mois dans un grand hôpital privé d'Inde du Sud, ce travail rend compte des considérations thérapeutiques, financières et éthiques qui façonnent la prise en charge des patients. La recherche montre comment les médecins et administrateurs, plutôt que d'appliquer des règles uniformes, font varier les standards de prise en charge en fonction du profil des patients, de leurs ressources, et des attentes de l'hôpital. La thèse propose le concept de « variabilité standardisée » et décrit le rôle crucial des médecins charismatiques dans l'institutionnalisation de cette variabilité. Les résultats soulignent que le secteur privé ne contribue pas nécessairement à la standardisation des soins et que la variabilité ne concerne pas uniquement les hôpitaux marginaux. Au contraire, il s'agit aussi d'un phénomène central dans les instituts de pointe, où les médecins utilisent des technologies avancées pour traiter des patients aux profils très divers, ce qui donne lieu à une approche du soin rentable, mais sélective et imprévisible.

English Summary: The proliferation of private hospital chains around the world has given rise to concerns about spiralling healthcare costs and deepening health inequities. These concerns are particularly pertinent in India, where the rapid growth of corporate hospitals (for-profit hospital groups offering specialised services) since the 1980s has coincided with low investment in public healthcare services and where health expenditures are predominantly covered out of pocket. The thesis explores how the promise of high-end medicine and the requirement of making a profit play out in the everyday practices of Indian corporate hospital care. Based on twelve months of ethnographic research in a leading corporate hospital in South India, the dissertation details the therapeutic, financial and ethical considerations that shape the treatment of patients with highly unequal resources at their disposal. The research shows how doctors and administrators do not apply uniform rules but vary standards depending on patients' circumstances and the shifting requirements of their institution. To capture these practices, the thesis introduces the concept of "standardised variability" and delineates the crucial role played by charismatic doctors in institutionalising this variability. The findings demonstrate that corporatisation does not necessarily lead to the standardisation and rationalisation of healthcare delivery and that variability is not restricted to marginal healthcare settings. Instead, variability also emerges in centres of biomedical practice where advanced medical tools are applied to a highly diverse pool of patients, resulting in profitable but selective and unpredictable forms of care.

Contents

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Introduction: Standardised Variability

Corporate hospitals, as for-profit hospital chains in India are commonly called, are about making profit. As limited liability companies raising money from investors and shareholders, the bottom line occupies a central role in their operations. To their advocates and critics alike, they are the quintessential economic agents that have introduced business thinking and corporate managerial methods to healthcare delivery. Corporate hospitals are also about providing specialised medical care. Since the first for-profit hospital companies were established in India in the early 1980s, their promise has been to establish a new form of "word-class" hospital care in India by using the latest medical equipment and recruiting doctors who have honed their expertise in premier institutions in the country and abroad. At the same time, the proliferation of these hospitals in the metropolitan regions throughout the country has been accompanied by complaints and scandals, and concerned doctors, journalists, and social scientists have argued that these providers jeopardise patients' safety by administering unnecessary treatments and make treatment unaffordable for the poorer sections of society.

The thesis addresses the question of how profit-making and medical care relate to each other in corporate hospital care. Specifically, I examine the everyday interactions and practices of doctors, administrators, patients, and marketing and corporate social responsibility (CSR) officials to understand how commercial and medical aims are negotiated in for-profit hospital care: how do hospital administrators offer services profitably to patients with very different financial resources and expectations of care? How do doctors adjust treatment methods based on patients' medical condition and socioeconomic situation? How do patients and their relatives navigate unpredictable treatment costs alongside the vagaries of health conditions? How do marketing and CSR officials seek to attract patients to the hospital and manage its reputation? By paying close ethnographic attention to these practices, I highlight the work involved in reconciling

therapeutic benefit and commercial gain in producing profitable medicine. The main argument of the dissertation is that such reconciliation is characterised by variability[1]: the various actors in the hospital use variable rules to align medical benefit and financial profits, leading to contingent, uneven results.

To analyse the relationship between therapeutic and commercial practices in healthcare delivery, I conducted twelve months of ethnographic fieldwork in Bengaluru, focusing on the central hub of a private hospital chain, which I call here Vishvam Hospitals. Vishvam Hospitals is, in many respects, a typical example of an Indian corporate hospital group. Established by one of India's best-known cardiac surgeons in the early 2000s, Vishvam Hospitals has quickly expanded to become one of the largest for-profit hospital chains in the country, with over twenty facilities in metropolitan regions and cities throughout the country. Like other corporate hospital groups, Vishvam Hospitals offers specialised treatments such as heart surgeries, cancer treatments, and organ transplants. Its main facility in Bengaluru attracts not only patients from Karnataka and neighbouring Southern states but also from Bengal and Northeast India, and medical travellers from Bangladesh, the Middle East, and Africa.

At the same time, Vishvam Hospitals has acquired a distinct reputation as a provider that has pioneered a model to make specialised treatment available to patients irrespective of their capacity to pay. Representatives of Vishvam Hospitals claim that they achieve this goal by using standardisation and large volumes to reduce costs through economies of scale and by employing a cross-subsidisation model in which affluent patients pay a premium for better facilities, making it possible to subsidise treatment for the poor. Other Indian healthcare providers equally espouse such principles. However, Vishvam Hospitals is particular because its success and the fame of its founder and chairman have turned it into a nationally and internationally recognised example of how business principles can be leveraged for the common good. Journalists and health experts have portrayed the

[1] In the thesis, I use the term variability – the propensity to vary – to describe situations and practices that involve the alteration of, or deviation from, standards and norms and lead to contingent and uneven results.

Chairman as a visionary business leader and compassionate doctor who is uniquely positioned to solve the quandaries of how to deliver specialised hospital services profitably to diverse patient populations with highly unequal resources at their disposal.

My ethnographic research revealed crucial differences between existing accounts of Vishvam Hospitals and other Indian corporate hospitals and the practices I observed on the ground. First, while much organisational research has focused on the way Vishvam Hospitals and other Indian corporate providers standardise and rationalise health care delivery (Burns, Srinivasan, and Vaidya 2014; Govindarajan and Ramamurti 2018), I found that the alteration of and deviation from standards and norms was the dominant tendency characterising the everyday workings of corporate hospital care. Hospital administrators elaborated on how they could not charge patients uniform prices and needed to grant individual price reductions because patients' socioeconomic circumstances were not the same. Doctors explained how they needed to deviate from treatment protocols and guidelines because some patients could afford to follow the standard treatment while others could not. Patients related that they had received financial help from the hospital earlier, but now the rules had changed, and they were stuck. Instead of standardisation and rationalisation, variability characterised the everyday practices of healthcare delivery.

Second, the widespread notion that Vishvam Hospitals has pioneered a revolutionary model of healthcare delivery allowing it to radically lower treatment costs is not supported by my research. Instead, I found that prices were comparable with those of other corporate hospital groups, and most hospital employees did not perceive the way the hospital operated to be radically different from other for-profit providers. Moreover, doctors and administrators of other hospitals I interviewed in Bengaluru claimed that their institutions used similar cross-subsidisation models to make treatment affordable to patients from all sections of society. Therefore, reports about Vishvam Hospitals' revolutionary model served primarily to set its brand apart from other providers in a competitive healthcare field. At the same time, the way these reports focussed on the Chairman as a visionary figure was mirrored by the employees of the hospital who nevertheless believed Vishvam Hospitals to be unique, not due to some revolutionary principles but because it was built and operated by the Chairman as an exceptional doctor and compassionate leader. Other corporate hospital chains are similarly identified with charismatic star doctors (Gupte 2013; Ketan and Ghosh 2006; V. Krishnan 2015). The centrality of these star doctors to the perception of these hospitals contrasts with prevalent analyses suggesting

that corporate hospital care undermines physicians' professional autonomy by subjecting them to pervasive managerial control. Instead, I observed a more complex situation in which complaints about a crisis of medical authority due to the rise of corporate hospital chains point not to the decline but to a heightened significance of the figure of the doctor, which is central, both symbolically and practically, to the variable alignments of care and profit in corporate hospitals.

Based on these findings, the argument I make in the thesis is two-fold. First, I argue that variability is essential to the medical business of corporate hospital care in India. Variability is part of clinical practice everywhere due to the need to tailor treatment methods to the specific situations of patients and the uncertain trajectories of illness. However, its significance is particularly pronounced in the context of Indian health care, where private providers seek to offer treatment profitably to diverse patient populations without strong mitigating institutions such as comprehensive health insurance coverage or clear-cut referral systems in place.

Second, I argue that medical authority assumes heightened significance in healthcare arrangements characterised by variability. The uneven application of rules creates suspicions about the intentions guiding such variability. The medical authority of doctors is central to such disputes because patients expect clinicians to make decisions that maximise therapeutic benefits from them, while doctors are also involved in making treatments financially profitable. In this situation, clinicians may be challenged about the decisions they take, but such challenges remain within the framework of medical authority as dissatisfied patients invoke the ideal of medical authority as a guiding principle to question the doctors' actions.

In the thesis, I use the concept of *standardised variability* to capture and analyse this situation. On the one hand, standardised *variability* describes the alteration of and deviation from standards and norms in the medical business of corporate hospitals, which does not operate according to uniform rules but through variable alignments of medical care and financial profit. In my thesis, I describe how administrators and doctors varied prices and treatment depending on the needs of the situation so that patients with similar conditions ended up paying different prices and receiving different treatments. On the other hand, the concept highlights that such variability is *standardised* in the sense that it emerges as a norm and comes with its own rules and regularities. Doctors and administrators did not vary standards arbitrarily but sought to align treatments and prices with

their interpretation of patients' socioeconomic circumstances. Such alignments were never fully standardised and produced inconsistent results. In this situation, patients could never be sure whether standards were followed or not, which is why they appealed to the medical authority of doctors to receive care and treatment.

The argument that corporate hospital care in India is characterised by standardised variability has theoretical and practical implications. Theoretically, it challenges conceptualisations of for-profit hospitals as monolithic institutions dominated by a uniform economic logic (Welker 2014). Studies of private health care have tended to either discuss for-profit medicine in terms of its underlying capitalist structures (see, for example, McKinlay and Stoeckle 1988; Navarro 1976; Waitzkin 2000; 2018) or to assume that medicine and commerce belong to separate spheres, highlighting how medical care is appropriated and distorted by economic prerogatives when these two spheres meet in for-profit healthcare delivery (see, for example, Farmer and Rylko-Bauer 2002; Light 2004; Starr 1982). In these studies, scholars have highlighted that for-profit healthcare providers strategically pursue their profit in ways that are detrimental to equitable care and patients' wellbeing, but they have not explored how profit-seeking and medical care relate to each other in the everyday realities of healthcare delivery. By arguing that therapeutic benefit and commercial gain are variably negotiated in corporate hospital care, I advance, instead, a perspective in which medicine and business are seen as mutually interacting (Zelizer 2011). In this view, the dynamics of the medical business in corporate hospital care do not follow an abstract capitalist logic but emerge from open-ended, and contingent, profit-making practices, which are situated in specific constellations and demand sustained ethnographic attention (Gibson-Graham 2006).

The argument also has implications for the practical question of whether corporate hospitals are a viable solution to deliver specialised services equitably to diverse patient populations. This question is particularly pertinent in the context of Indian health care, where patients predominantly pay their medical bills out of pocket and rely heavily on private providers because public healthcare provision has been unable to keep up with curative demands due to one of the lowest levels of public spending on health worldwide (Baru 2016; Chaudhuri and Datta 2020; Godajkar 2017; M. Mackintosh et al. 2016, 3–4). Management and innovation theorists have suggested that this situation provides opportunities for entrepreneurial providers to develop innovative solutions to these problems (Govindarajan and Ramamurti 2018; Parikh and Raghavendran 2014;

Ramdorai and Herstatt 2015). Most health experts and social scientists challenge this view and argue that for-profit health care deepens inequities by burdening poor patients with catastrophic health expenses while overtreating the rich for commercial gain (Duggal et al. 2013; Gadre and Shukla 2016; Surana and Dongre 2020). In their view, corporate hospitals are at the heart of the problem because they promote a consumerist view on health (Baru 2005; Lefebvre 2008), undermine medical ethics through commercial incentives (Gadre and Sardeshpande 2017; Marathe et al. 2020), and skew healthcare delivery towards expensive and therefore lucrative services (Chakravarthi 2010; 2013; B. Roy 2016). While I agree with much of these critical assessments, I seek to add further nuance to these accounts by highlighting the contingency of healthcare provision characterised by variability. The shortcomings of corporate hospital care are not consequences of a uniform logic but of the variable alignments of medical care and profitability.

Finally, highlighting standardised variability allows for a new understanding of for-profit hospital care. As I will discuss in the next section, medical sociologists and anthropologists have looked at corporate involvement in health care as part of a standardised healthcare system where new forms of bureaucratic management rationalise delivery processes and commercial actors set new treatment standards according to commercial prerogatives to expand their markets. In contrast, medial anthropologists have predominantly described variability as a response to uncertainty and institutional instability at the margins of biomedical practice. By highlighting how standardised variability characterises cutting-edge institutions in India, I seek to challenge narratives that too easily dismiss variability and the accompanying emphasis on medical authority as outdated and vanishing aspects characterising the "not yet" (Chakrabarty 2000, 8) of healthcare delivery in the Global South. This dissertation shows that variability is not restricted to conditions of resource scarcity but characterises centres of biomedical practice in a multipolar healthcare landscape that cannot be neatly divided into a backward Global South and leading Global North (Adams et al. 2019, 11).

Standards and Variability in Corporate Hospital Care

In the following sections, I will first discuss the sociological literature on standards and standardisation, which place the investor-owned hospital at the cusp of a trend towards rationalisation and commercialisation of healthcare delivery. This discussion provides a

point of departure for my analysis and clarifies why an analysis of variability is an important contribution to studies of corporate hospital care. In the following section, I turn to anthropological studies highlighting the limits of standardisation in clinical practice to situate my understanding of variability. I then discuss the role of medical authority in corporate hospital care. I conclude by providing an overview of the structure and transformation of Indian health care to explain why standardised variability comes to the fore in Indian corporate hospitals.

Standardisation in Health Care: Rationalisation and Commercialisation

Standards and standardisation have been central to debates in the sociology and anthropology of science, where scholars have discussed how scientific findings travel outside the confined space of the laboratory and transform the world (Fujimura 1996; Latour 1987; Star and Griesemer 1989). Summarising this scholarship, Stefan Timmermans and Steven Epstein (2010, 71) define standardisation as a "process of constructing uniformities across time and space" through the generation of standards or "agreed-upon rules" (see Bowker and Star 1999, 13–14). The definition of standards as "agreed-upon rules" is broad, so that it cannot be clearly distinguished from social norms (Lampland and Star 2009, 24), which are themselves a fuzzy concept (Olivier de Sardan 2015, 24). Scholars, therefore, have introduced various qualifications to make the concept useful to their analyses. Standards tend to span more than one site of activity or community of practice, they make things work together over distance (Bowker and Star 1999, 13–14), and they are often backed up by external bodies (Brunsson and Jacobsson 2000, 3–4). Common to these analyses is a sense that standardisation has become a central way of governing modern life (Brunsson and Jacobsson 2000; Busch 2011; Lampland and Star 2009; Thévenot 2009). In this thesis, I do not intend to propose a new definition of standards to clean up the "messy imbrications" (Lampland and Star 2009, 24) of the concept. My intention is, instead, to trouble the assumed universality in sociological discussions about standards and standardisation, in which they appear as "omnipresent conduits of a globalizing and modernizing world" (Timmermans and Epstein 2010, 71) and as "a central feature of social and cultural life in modernity" (Lampland and Star 2009, 10) by arguing that the impulse to standardise meets an equally powerful impetus to vary in cutting-edge healthcare institutions in India.

Questions of standards and standardisation are important for discussions about corporate hospital care because medical sociologists and anthropologists have predominantly analysed for-profit hospital groups as part of a tendency towards increasing standardisation in healthcare delivery. Scholarship on corporatisation in health care has focused on the rise of for-profit hospital groups and managed care companies in the United States since the 1970s (Gray 1983; Light 1986; Robinson 1999; Salmon 1995), which had its roots in the introduction of health insurance programmes and regulatory changes aimed at reining in costs of the prevalent fee-for-service system (Light 2004, 16–20; Starr 1982, 428–44). With this situation in mind, medical sociologists have theorised corporate involvement in healthcare delivery as a process of rationalisation imposing means-end calculations and bureaucratic rules on medical practice (Alford 1972; Clarke et al. 2003, 169–70; Hafferty and Light 1995; Ritzer and Walczak 1988; Starr 1982, 444–48). In this view, corporate healthcare organisations are the most recent manifestation of a broad trend towards standardising medical practice, which has replaced clinical reason with protocols and algorithms that rationalise costs and control clinicians' decision-making (McKinlay and Marceau 2002). Scholars looking at how such rationalising and standardising measures unfold in medical practice have argued that these tools have unintended consequences and do not result in standardised medicine because they depend on the contingent work of heterogeneous actors and evolve through complex politics of standardisation (Berg 1997a; Timmermans and Berg 1997; 2003). However, these studies do not question the broad trend towards rationalisation and standardisation and the role of corporate healthcare organisations in it (see Berg 1997b, 1086; Timmermans and Berg 2003, 8–24).

Apart from rationalisation, medical sociologists and anthropologists have discussed for-profit hospitals as forces of commercialisation in health care by drawing attention to how commercial logics drive the proliferation of new standards in healthcare delivery. The notion of the "medical-industrial complex" has been central to these discussions. Scholars have used the concept to analyse and critique an increasingly corporatised and privatised healthcare system dominated by business interests and operating according to market principles. Introduced in the late 1960s, the concept suggests that for-profit hospitals, insurance companies, diagnostic laboratories, pharmaceutical enterprises, and manufacturers of medical equipment form an integrated industry that sets healthcare

standards according to its commercial interests at the expense of the equitable distribution of healthcare services (B. Ehrenreich and Ehrenreich 1969; 1970; J. Ehrenreich 2016; Estes, Harrington, and Pellow 2000; Relman 1980; Wohl 1984). In particular, scholars have argued that the centralisation of healthcare services under the control of a few for-profit companies skews healthcare delivery towards specialised, lucrative services, resulting in inflated costs (Relman 1980; Salmon 1985; Waitzkin 2000; 2018), and that it deepens health inequities as these providers cream-skim lucrative patient groups, thereby drawing resources away from healthcare provision for the uninsured and poor (Farmer and Rylko-Bauer 2002; Maskovsky 2000; Whiteis 1997). The appropriation of health standards by actors following commercial logics has also been analysed with a focus on pharmaceutical research and marketing (Dumit 2012; Greene 2007; Sunder Rajan 2017) and on the "technological imperative" resulting from the ever-increasing influence of commercialised technoscience on clinical practice (Clarke et al. 2010; Fox and Swazey 1992; Kaufman 2005; 2015; Koenig 1988)

These studies provide important insights into how commercial interests set new standards in healthcare delivery, leading to a situation where more and more treatments are administered to those able to pay or covered by health insurance while others are excluded from healthcare services. These are important insights, and questions of corporate control, overprescription, and exclusion are pertinent to the analysis of corporate hospital care in India. However, these analyses link for-profit hospital care to standardisation by highlighting how corporate administrations rationalise treatment processes or by emphasising how for-profit hospital chains are part of an integrated industry focused on establishing new treatment standards that fit commercial prerogatives. In doing so, these accounts tend to portray corporate healthcare groups as powerful conglomerates whose "underlying objectives are to boost the efficiency and uniformity of services, to centralise and rationalise decision making about service provision, to capture more markets and arenas of health for profit, and to exert greater economic control within these arenas" (Clarke et al. 2003, 169), providing little resources to analyse the situation of standardised variability I observed in Indian corporate hospital care.

In fact, studies of Indian for-profit health care predominantly use the same conceptual language of "commercialisation" (Baru 2005; 2016; Marathe et al. 2020) and "the medical-industrial complex" (Baru 2018; Chakravarthi 2013; Chakravarthi et al. 2017), and they highlight similar issues to those that have been raised concerning the situation

in the United States. Thus, scholars have argued that the focus on lucrative specialised treatments in corporate hospital facilities results in rising costs and catastrophic health expenses, while the healthcare needs of the poorer sections of society are neglected (Baru et al. 2010; Hodges and Rao 2016; M. Mackintosh et al. 2016; B. Roy 2016; Selvaraj and Karan 2009; G. Sen, Iyer, and George 2004). Others have contended that the growth of private hospitals is hurting the public sector by draining it of resources and trained personnel and because the lobbying and power of private healthcare providers skews policies towards private interests (Chakravarthi 2010; 2013; Chakravarthi et al. 2017; Duggal et al. 2013; Lefebvre 2009; Qadeer and Baru 2016; Sengupta and Nundy 2005). At the same time, there is an underlying sense in some of these studies that corporate hospital care does not lead to the standardisation and rationalisation of services but is instead characterised by deviations and irregularities, which are generally explained in terms of increasing corruption and a decline of medical ethics due to the corrosive influence of money-minded corporate culture (Gadre and Shukla 2016; Kay 2015; Nagral 2014; S. Nundy, Desiraju, and Nagral 2018). In this thesis, I aim to take these observations further and provide a more robust analysis by showing how such variability is not simply a result of lacking professional ethics but a response to the demands of profitability in a healthcare situation where private providers cater to patients with highly unequal resources at their disposal.

Variability in Clinical and Commercial Practice

In medical anthropology, the notion of variability has most prominently been used by Adriana Petryna (2005; 2009), who described an "ethical variability" at work in the globalisation of pharmaceutical research. According to Petryna, variability emerges as a tactic of commercial clinical research organisations in their quest for cost-effectively recruiting treatment-naive populations for clinical trials. To this end, these organisations tweak ethical regulations to allow for variable standards of care in clinical trials by using the differences in local contexts and healthcare capacities as a pretext to suggest that applying uniform global standards is unviable. Therefore, the notion of ethical variability suggests strategic calculations by the research organisations and regulators involved that are informed by a market logic trumping other ethical concerns. While my analysis of standardised variability in Indian corporate hospital care also emphasises the role of profit concerns, my use of the concept does not necessarily imply a clear-cut rationale. Instead,

I highlight how variability emerges from the intersection of competing practices and logics.

Apart from Adriana Petryna's discussion of "ethical variability", medical anthropologists and sociologists have generally looked at variability as a consequence of, and response to, medical uncertainty and institutional instability. Drawing on Talcott Parsons (1951, 466–69), medical sociologists and anthropologists have identified uncertainty as a defining characteristic of medical practice. Some scholars have looked at how uncertainty emerges from the open-ended, imperfect state of medical knowledge and have analysed how medical students are trained to deal with this uncertainty (Fox 1959; 1980; 2000; Light 1979; Gerrity, DeVellis, and Light 1992; for a critique, see Atkinson 1984). Others have identified uncertainty as central to trajectories of chronic illness (Becker and Kaufman 1995). Still others have looked at how uncertainty is inherent to diagnostic technologies, highlighting that new technologies such as genetic screening produce new uncertainties instead of eliminating them (N. Armstrong 2019; Griffiths, Green, and Bendelow 2006; Timmermans and Buchbinder 2010). The upshot of these analyses is that the clinical gaze can never be entirely standardised. Some degree of variability is inevitable despite the significant investments in organisational and technological measures to control uncertainty (D. Armstrong 2007; N. Mackintosh and Armstrong 2020; see Latimer 2013).

Ethnographic studies of hospitals have highlighted that such variability is increased in conditions of heightened uncertainty and instability, resulting from the absence of biomedical tools and widespread precarity in resource-scarce settings. In the study of a hospital in New Guinea, Alice Street argues that "deep ontological uncertainty and instability" (Street 2014, 13) pervades clinical practice, where available diagnostic technologies are often inadequate to make disease visible. Biomedical visibility is highly variable in this context. Some patients succeed in employing X-rays or ultrasound as "relational technologies" (Street 2014, 118) to establish meaningful relationships with doctors, relatives, and administrators, while others fail to do so and languish in a state of unspecified illness. Other studies have highlighted the glaring "gaps in the gaze" (Gibson 2004) in situations of deprivation and scarcity where the allocation of treatments and care varies along the fault-lines of class and gender (Brown 2012; Zaman 2005) and religious affiliations in situations of sectarian conflict and state-inflicted violence (Varley 2016; Varma 2020). Still other studies have highlighted variability as a consequence of

infrastructural and bureaucratic divisions within hospital spaces, which are partially included in and partially excluded from global therapeutic economies (Hull 2012; Sullivan 2012) and haunted by (post-)colonial legacies (Chabrol 2018; Kehr 2018; Street 2012; Towghi 2018). These scholars highlight how variability is the norm in situations of precarity and heightened uncertainty, suggesting that variability in healthcare delivery is primarily a function of inequality.

In an influential study of cancer care in Botswana, Julie Livingston (2012, 7) emphasises, instead, the inventiveness behind improvised biomedical practices in precarious and uncertain conditions (see also Zaman 2004). Livingston describes how clinicians and nurses need to constantly tinker and improvise to make oncology work in a situation where cancer is a "fuzzy" disease due to the lack of diagnostic infrastructures and its co-emergence with tuberculosis and HIV, and which thus greatly differs from the technological, biological, and social conditions in high-resource settings where international oncological standards are developed. From this perspective, variability is a way to "hold the pieces together" in a situation where biomedical tools are limited (Livingston 2012, 175).

By building on this scholarship, I aim to take it into new directions by analysing variability in a healthcare setting that is not defined by uncertainty and the absence of biomedical tools. Vishvam Hospitals and other Indian private hospital chains employ clinicians who have received their training, and practised, in some of the world's most renowned institutions. These hospitals attract celebrity patients and treat highly complex cases referred to them from the whole of South Asia, Africa, and the Middle East. Rather than being marginal institutions, they are centres of biomedical practice. This does not mean that the healthcare arrangements discussed in the thesis are not characterised by scarcity and inequality. To the contrary, the variability analysed in the thesis reflects the need to provide treatment to people with plenty of resources at their disposal and those with very few. This variability is, however, not a consequence of lacking biomedical tools. Instead, it comes to the fore in a situation where advanced biomedical tools interact with highly diverse patient groups in a for-profit context. Variability is thus particularly visible in Indian health care, with fewer mitigating institutions than in countries with stronger welfare provision, but it is not restricted to a particular geographical location.

Medical Authority in Corporate Hospital Care

The rise of corporate hospital care is closely intertwined with anxieties about the decline of medical authority. In the last decade, Indian doctors and health experts have raised the alarm about a deterioration of medical ethics due to revenue targets in corporate hospitals where managers are more interested in making profits for their shareholders than in patients' well-being (Berger 2014; Gadre and Sardeshpande 2017; Gadre and Shukla 2016; Kay 2015; S. Nundy, Desiraju, and Nagral 2018). Such concerns about the decline of an ethical and autonomous profession due to corporate involvement in healthcare delivery have also been raised in sociological studies of the medical profession. Scholars have argued that the rise of for-profit hospitals, alongside cultural and technological changes, has led to the "deprofessionalization" (Haug 1988) and "proletarianization" (McKinlay and Stoeckle 1988) of the medical profession as medical work is increasingly routinised and deskilled in institutional practice, resulting in a loss of clinicians' control over their work (see also Rothman 1991). Subsequent studies have revised this picture of professional decline by highlighting how novel administrative and regulatory settings afford doctors opportunities to reassert their professional status and result in the establishment of new professional elites (Evetts 2003; Freidson 1985; Light 2010; Noordegraaf 2007).

In the thesis, I argue that the focus on professional autonomy in these studies does not fully capture the role of medical authority in Indian corporate hospitals. At Vishvam Hospitals, I encountered conflicts between administrators and clinicians, as doctors resented the control administrators exerted over financial matters and criticised the reward structure that created fissures within the medical community by awarding most funds to senior clinicians while junior doctors struggled to establish a thriving practice. However, doctors did not suggest that they lost control over their field of expertise through corporate control. Instead, they felt exposed to attacks by patients and resented that the administration did not provide more support for establishing a successful practice. Moreover, scholars studying Indian health care have noted that the proliferation of corporate hospitals has been accompanied by the rise of charismatic star doctors who are the founders and owners of these companies or who are employed as central assets due to their command over a loyal patient base (S. Nundy, Desiraju, and Nagral 2018, 160; Marathe et al. 2020, 8). The "symbolic capital" (Bourdieu 1990, 119; 1993, 75–76) yielded by these charismatic doctors is vital for the operation of these hospitals because it helps bridge the gap between the need to generate financial profit and reassuring patients that

treatment decisions are made irrespective of commercial interests (see Stone 1997). The role of charismatic doctors is of particular importance in a context where standards are variable, raising suspicions about malpractice and profiteering.

Max Weber (1978, 244) described charismatic authority, which accrues to individuals who are seen as being endowed with exceptional qualities, as a form of authority based on the "extra-ordinary". It is, therefore, a form of authority that is "foreign to all rules", in contrast to traditional and rational types of authority, which are bound to rules and principles (Weber 1978, 244). Consequently, Weber's analysis focuses on the inherent tension emerging when charismatic leadership is institutionalised and becomes routine (Shils 1965, 199–200). In contrast, social anthropologists and historians studying leadership and authority have highlighted that institutions and the charismatic individuality of leaders are not opposed to each other but mutually constitutive in South Asia. For example, Mattison Mines and Vijayalakshmi Gourishankar (1990, 762) have used the notion of "institutional big-man" to describe a prevalent type of leaders in South India whose charismatic quality is closely intertwined with the institutions they control. In contrast to big-men described in Melanesian contexts who rely exclusively on their personal powers (Sahlins 1963, 283), the charisma of these leaders in South India is expressed through their institutions, which they use to establish themselves as generous leaders protecting and caring for their constituents. In turn, the institutions express the charismatic uniqueness of their leaders and often decline and splinter when the latter grow older or die (Mines and Gourishankar 1990, 762–64; Mines 1994, 15). Like kingship and related forms of charismatic leadership on the subcontinent (see, for example, Appadurai 1981; Copeman and Ikegame 2012; Dirks 1987; Price 1989), the authority exerted by such big-men is tied to morality because it depends on the perception of being a good person, whose duty is to protect their supporters and constituents and whose goodness is enacted through selfless acts of support and charity (Price and Ruud 2010, xxiv–v; see Burghart 1993; Price 2006).

These studies provide a framework to analyse the relationship between medical authority and the institution of the corporate hospital. Charismatic doctors are essential to the economic viability of corporate hospitals as institutions because they attract patients and are central to their brand image. At the same time, their charisma depends on how they can use their institutional affiliations to establish themselves as compassionate and

benevolent actors capable of making exceptions to financial logics in the interest of patients. In contrast to Weber's assertion that institutionalisation leads to the decline of charismatic authority, the charisma of doctors and the institution of the corporate hospital depend on each other (see also Dow 1969, 315–18).

Health Care in India

Corporate hospitals are not insular institutions but embedded in the broader healthcare landscape in India. Standardised variability in corporate hospital care comes to the fore in a situation where patients with highly unequal resources at their disposal are treated in the same hospital for a profit. To contextualise this situation, I provide an overview of the structure and transformation of healthcare delivery in India.

Studies of Indian health care have highlighted that public health infrastructures in India are weak and that the existing provision of health care is biased towards urban elites and hospital-based curative services, whereas rural health needs and preventive measures are neglected (Balarajan, Selvaraj, and Subramanian 2011; Banerji 1985; Baru et al. 2010; Gangolli, Duggal, and Shukla 2005; Qadeer 2000; see R. Jeffery 1988, 115–17). The weakness of healthcare infrastructure and the rural-urban divide have their roots in the colonial period. In the "colonial mode of health care" (Ramasubban 1984), health care facilities were concentrated in cities and health measures focused on policing the boundary between the army and the European population on the one hand and the rest of the population on the other hand through localised, disease-specific interventions rather than building a comprehensive healthcare system (Arnold 1994, 338–43; Amrith 2007; R. Jeffery 1988). Only in the last years of colonial rule were plans made for a massive expansion of the public health system, but these plans never materialised due to the parsimony of the colonial state and the arrival of independence (Arnold 1994, 349–52).

The newly independent nation-state attributed primary significance to improvements in health for establishing its political legitimacy and envisioned a vastly expanded public healthcare system modelled on the National Health Service in the United Kingdom (Arnold 1994, 349–52; Baru 2016, 123–24; R. Jeffery 1988, 112–14). To put this vision into practice, the state invested considerable resources in building a publicly funded urban and rural healthcare service network in the 1950s and 1960s. This led to a situation in which hospital services were generally part of the public sector, while most medical

practitioners worked in the private sector (Duggal et al. 2013, 24–26). There was considerable interdependence between these sectors as many doctors employed in government hospitals also practised privately (Baru 1998, 48–55). Despite this "mixed economy" (Baru 1998, 43), health planning generally ignored the private sector in this period. While health policymakers were aware of the large number of private practitioners and repeatedly suggested a ban on private practice by government doctors, the expectation was that private clinics and practice would be marginalised as the public healthcare system would grow stronger (Baru 2016, 123–24).

Instead, there was a significant growth of private clinics in the 1970s as public investment failed to keep pace with the increase of curative needs due to population growth. At the same time, the number of trained doctors multiplied with the expansion of medical colleges, and a newly wealthy class of entrepreneurs from the agricultural sector began to invest in health care (Baru 1998, 150–59). The first National Health Policy of 1983 recognised these changes and, for the first time, called for an active involvement of the private sector in the delivery of healthcare services (Government of India 1983, 7). This shift on the health policy level coincided with the emergence of the first corporate hospitals (see Chapter 1) as government policies now actively promoted private investments in healthcare facilities by lowering import duties on medical equipment, granting tax benefits, and relaxing investment rules (Shah and Mohanty 2010, 81–82). This trend accelerated with economic liberalisation after the debt crisis of 1991, which introduced further government subsidies for private providers while investments in public healthcare facilities were cut. As a consequence, the share of patients using government hospitals dropped from 59.7 per cent to 32 per cent in urban areas and from 60.3 per cent to 42 per cent in rural areas between 1986 and 2014 (Government of India 2006; 2014), and has since remained on this level (Government of India 2019b, 14).

In the last two decades, the central and state governments have abandoned the aim of providing a comprehensive state-funded healthcare delivery system. Instead, state efforts have focused on expanding government-funded health insurance schemes that allow the purchase of services from both public and private providers. Thus, the National Health Policy of 2017 envisions "[s]trategic purchasing by the Government to fill critical gaps in public health facilities [and to] create a demand for the private healthcare sector, in alignment with the public health goals." (Government of India 2017, 3) In 2018, Prime

Minister Narendra Modi announced the Pradhan Mantri Jan Arogya Yojana (Prime Minister's People's Health Scheme) under the Ayushman Bharat or "Healthy India" initiative. The scheme integrated and replaced various central and state government-funded health insurance schemes to provide health insurance coverage of up to Rs. 500'000 per annum to more than 100 million poor and vulnerable families (Hooda 2020a, 107–8). Comprehensive research assessing the scheme's impact still has to emerge (Desiraju 2021, 33). However, studies of earlier government-funded health insurance schemes show that these schemes have failed to significantly reduce out-of-pocket expenses so far (Hooda 2017b, 12–13; see Baru 2015). The transition towards universal healthcare coverage is thus still far from accomplished as more than eighty per cent of the population do not have any form of health insurance coverage (Government of India 2019b, 17) and over sixty per cent of total health expenditure are paid out of pocket (Government of India 2019a, 13).

The limited public healthcare provision and the incomplete transition towards universal insurance coverage are critical contexts for the analysis of standardised variability in this thesis. Corporate hospitals are concentrated in metropolitan areas and compete for lucrative patient groups to sell specialised hospital services to. However, because options are limited, patients from the lower socioeconomic strata and from rural areas also find their way to corporate hospital providers, often after long and complicated treatment pathways (see Chapter 3). Corporate providers like Vishvam Hospitals thus cater to a broad range of patients whose differences in income and wealth are largely unmitigated by health insurance. Varying prices and treatment makes it possible to provide medical care to diverse patient groups in a context of profitable medicine where medical and commercial concerns are inextricably intertwined.

Sites, Methods, Interlocutors

The thesis is based on twelve months of field research from late August 2018 to late August 2019. My fieldwork focused on the main hub of Vishvam Hospitals located on the outskirts of Bengaluru, and I used in-depth ethnographic immersion into this specific locality to analyse the workings of corporate healthcare delivery in the everyday. In so doing, I did not conceive my research as a study of a bounded field-site (cf. Candea 2007) but rather as stringing together multiple sites in tracing the medical business of Vishvam Hospitals (Marcus 1995). Making these connections involved tracing linkages between

sites within the campus, including medical wards, waiting areas, doctors' offices, administrative units, corporate headquarters, social work and charitable departments, research units, warehouses, and accommodations. It also involved travels to various clinics and hospitals across the city, attending marketing and outreach activities in surrounding neighbourhoods and towns, and accompanying doctors on visits to other hospitals in neighbouring states. I made detailed observations in these sites and noted down conversations with doctors, administrators, social workers, CSR and marketing officials, and patients, and conducted 257 semi- or unstructured interviews. I also collected and analysed an archive of media reports and advertisements and consulted financial reports, industry analyses, and government policy documents for further analytic depth.

Vishvam Hospitals

Early sociological studies conducted in the 1950s and 1960s described hospitals as "total institutions" (Goffman 1961) characterised by a closed social order and strict disciplinary control (Caudill 1958; Coser 1962). More recently, social anthropologists studying hospitals have highlighted that hospitals are layered, permeable spaces where multiple social spheres and medical and non-medical arrangements intersect (Chabrol and Kehr 2020; Kehr and Chabrol 2018; Jullien, Lefebvre, and Provost 2019; Long, Hunter, and van der Geest 2008; Street and Coleman 2012). In addition to a theoretical reorientation towards mobility and biomedical globalisation (van der Geest and Finkler 2004), this shift of perspectives owes to the transformation of hospital care itself through the outsourcing of services and the replacement of prolonged hospital stays by short, repeated admissions due to economic incentives and the rise of surveillance medicine (D. Armstrong 2002; Kaufman 2005).

The central hub of Vishvam Hospitals fits analyses highlighting the openness and heterogeneity of hospital spaces as it encompasses various sites and exudes the air of a lively community centre instead of a closed institution governed by a strict biomedical regime. The large campus of around 25 acres consists of two main hospital buildings: a cardiac hospital and a multi-speciality facility with around 700 beds each. The two buildings are architecturally distinct: the older cardiac facility cites Kerala's temple architecture with its sloping tiled roofs and verandas, while the newer all-white multi-speciality building draws on neoclassicism with its pillared portico and clear-cut geometrical shapes. The different styles also extend to the interior, where the visitor is greeted either by a towering

Vishnu statue or by a big copper mural depicting kites flying towards the sun. Apart from the iconic hospital buildings alluding to the sacred and the aesthetic, there are several smaller, functionally built facilities: an administrative unit, a blood bank with laboratories, a nursing school, a warehouse, and pharmacies. Besides, an international wing with air-conditioned rooms for medical travellers and a simple, tin-roofed shack with cheap lodgings for the poor offer accommodation on the campus, while most patient parties stay in nearby guest houses. There are parking lots, places of worship, and green lawns with well-kept trees and bushes where people rest in the shade and consume drinks and food that they brought from home or bought from one of the eateries or tea stalls between the buildings. The corporate headquarters of the hospital group are located in an anonymous glass building some hundred metres away from the campus, safely concealed from the eyes of visitors to the hospital. There is a constant coming and going through the campus gates as cars, auto-rickshaws, and pedestrians move in and out. Security guards blow their whistles not to prevent people from entering but to make sure that the flows of traffic and people do not stop and block access to the hospitals.

Established in an industrial development zone in the early 2000s, Vishvam Hospitals tapped into the rapid transformation of Bengaluru into a global centre for information technology (IT) companies. The IT industry boom had its roots in the public-sector research and production facilities established by the government of India in the 1950s, which provided the conditions for the development of IT corporations with economic liberalisation and the globalisation of telecommunication and software services from the 1980s onwards (Heitzman 1999, 199). This boom was supported through land deals and dispossession of the local population in the rural periphery orchestrated by government agencies (Benjamin 2010; Goldman 2011). Vishvam Hospitals was part of a subsequent wave of development projects, constructing its campus in the vicinity of the central hub of the IT industry and next to the highway connecting it to the city centre. With the plan of establishing a “medicity” combining several specialised hospitals on one campus (Murray, Bisht, and Pitchforth 2016), Vishvam Hospitals itself has become a motor of real estate development in the area. In addition to its facilities, an orthopaedic and eye hospital owned and operated by other companies have been established. Around the compound, restaurants, hotels, guest houses, supermarkets and retailers, pharmacies and medical supply shops are being set up, quickly encroaching upon the remaining farmland.

The fact that Vishvam Hospitals is intertwined with broader economic circuits and land deals does not mean that it is an anonymous "non-place" (Augé 1995). A considerable number of employees working for the hospital have been recruited from the local neighbourhood. One employee's grandfather had even owned the land on which the hospital was built and was buried there. Apart from such histories and attachments formed through connections to the area, repeated visits, or long working hours, many patients and employees felt that the presence of the Chairman made the hospital special and set it apart from a purely "commercialised" hospital provider (see Chapters 1 and 4).

Access and Interlocutors

Against my expectations, I faced few obstacles obtaining permission to conduct my study at Vishvam Hospitals. Before coming to India, I had contacted a Swiss consulate in Bengaluru, which was established to forge business and research ties between Swiss and Indian companies. A senior doctor at Vishvam Hospitals cooperated with the consulate because he was involved in biotech and pharmaceutical research, and I was introduced to him. This connection was extremely fortunate because the senior doctor took a vivid interest in the project and provided it with his support. Marcia Inhorn (2004, 2100) has highlighted how such patronage is often indispensable in studying private healthcare providers, which was also true in my case even though the infertility clinics she studied in Egypt were a much more sensitive environment than the large multi-speciality hospital I studied. Through contact with the senior doctor, I was able to present my project to the hospital representatives, and they agreed that I could conduct the study. A few days after my first visit, I had secured a badge and could roam freely on the hospital premises. I familiarised myself with the processes and structures of the hospital in the following weeks while preparing a submission to the medical ethics committee of the hospital that approved the research protocol.

Apart from the specific connection, the ease of access owed to the fact that relations with doctors and researchers abroad were integral to the hospital's medical business. The senior doctors at the hospital fostered connections to colleagues and institutions in the United States, Europe, and Australia and received trainees spending some months at the hospital to gather surgical experience (see Shapiro 2020). The heads of the hospital's research units also encouraged start-up companies from countries such as South Korea

and Japan to develop and test their technologies at the hospital. These transnational connections were a matter of prestige for the persons involved. As a white European scholar, I fit into this category and benefited strongly from post-colonial legacies ascribing privileged status to specific localities and racial categories. In addition, the reason why such openness extended not only to doctors and biotech start-ups but also to a social science researcher was that opening the doors of Vishvam Hospitals to journalists and social scientists interested in its business model has been a highly successful strategy for the hospital (see also Bharadwaj 2000). As I will discuss in Chapter 1, such studies have contributed to establishing the institution's name and have turned it into an internationally recognised exemplar of successful social entrepreneurship. While studying commercial actors is often tricky because of prevailing concerns about secrecy (Sunder Rajan 2006, 296), the desire to establish a reputation in a competitive field may, in this case, have facilitated rather than prevented access.

Despite the openness towards research, the hospital representatives clarified that the hospital's commercial activities were a highly sensitive matter. In general, securing and maintaining access was a process of constant negotiation, which proceeded along the fault-lines of the various groups in the hospital and was shaped by my position as a young male European researcher. In general, doctors were very comfortable and willing to talk to me, feeling secure in their position and interested in sharing their analysis of the hospital's situation, mainly because they felt that they had lost their connection to the hospital's leadership to some extent in recent years. The same was generally true for CSR officials and marketing officials, who saw it as their duty to explain the hospital's activities to outsiders, and for lower-ranking administrative staff, who often received little attention from their superiors and were therefore happy that somebody took an interest in their work. In contrast, senior administrators were generally very cautious and receiving information from them required sustained effort. I could not interview the chief strategists of the corporate group because they only agreed to talk to me under a non-disclosure agreement with conditions I did not want to accept. Except for senior nurses, my conversations with the predominantly female and young nursing staff were also limited because they often had very little time at their disposal and did not feel entirely comfortable talking to me, mainly, I suspect, because interactions across genders among the younger staff were closely observed and commented upon by their peers.

While I interacted with the people working for the hospital on my own, I usually collaborated with Sumitra Christina, whom I employed as a research assistant and translator, when I conducted interviews with patients. Sumitra has much experience working on health-related issues. Collaborating with her helped immensely to establish first contacts with patients because she knew exactly how to initiate a conversation and when to place a reassuring hand on somebody's shoulders to ease anxiety. Sumitra translated conversations in Kannada, Telugu, Hindi, and Tamil, and she possessed a quiet confidence, as a woman in her fifties having made her way through life, that immediately instilled trust in interlocutors. When approaching patient parties, we explained the research project and asked for informed consent to conduct the interview and record the conversation using a consent form prepared in Hindi, Kannada and English. Some people we approached did not want to sign the consent form, and some patients, especially in the private rooms, did not want to be recorded due to privacy concerns. In general, however, we did not have problems finding interlocutors for interviews.

Interviews

There are four groups of people with whom a total of 257 semi- and unstructured interviews were conducted. First, I conducted 36 interviews with hospital administrators and senior managers of Vishvam Hospitals to understand how the medical business of the hospital operated in the everyday, how price reductions were granted, and how the various parts of the administration worked together to ensure the profitability of the hospital. Second, I conducted 49 interviews with doctors, nurses, and researchers to understand how cost calculations affected what treatments patients received, what role research activities played in the medical business of the hospital, and how the medical staff understood their role in a for-profit hospital and vis-à-vis the administration. In addition, I conducted 11 interviews with doctors and senior managers of other hospitals in Bengaluru to be able to situate Vishvam Hospitals in the broader healthcare landscape of Bengaluru. Third, I conducted 25 interviews with marketing officials, social workers, and corporate social responsibility (CSR) representatives to analyse how these actors sought to attract patients to the clinic, how they maintained their reputation, and what role social and charitable activities played in these endeavours. Fourth, Sumitra and I interviewed 136 patient parties who were seeking or undergoing treatment at the hospital to examine (a) what kind of patients came to the hospital and what treatment they received; (b) what

their treatment trajectories were and how they chose healthcare providers and treatment options; (c) how they financed treatments. The sample was not selected to be representative but to cover the variety of patients coming to the hospital regarding illnesses, ward categories, sponsor types, and geographical regions of origin.[2]

The interviews took place at the various sites of activity and treatment inside the respective hospital and its surrounding areas. I also accompanied patients, doctors, and administrators to their accommodation and on various trips but used these occasions for informal conversations and making acquaintances, not for interviews. I chose to interview a large number of patient parties instead of concentrating on a few cases because I wanted to cover the diversity of patients coming to the hospital, in line with my objective of analysing the medical business of Vishvam Hospitals rather than conducting an in-depth exploration of illness narratives.

Doing interviews at the hospital sites had the advantage of having plenty of opportunities to conduct interviews, especially with patients, who usually had much time at their hands because they stayed in the ward or waited for a consultation. At the same time, it affected how Sumitra and I were perceived, especially because we were carrying badges granting us access to the hospital. While many hospital ethnographers report that they were invariably perceived as doctors or nurses and usually worked in medical garments (van der Geest and Finkler 2004, 1998–2000; Zaman 2008), this was not the case in this study, and I did not experience such confusion (Thompson 2005, 16; Wind 2008). Interlocutors perceived us as observers even though they presumably harboured doubts

[2] These are the characteristics of the patient parties I interviewed:

- Illnesses: 59 patients visited the hospital for cardiac diseases, 41 for cancer, 11 for kidney diseases, 4 for gynaecological treatment, 4 neurological disorders, 3 for lung conditions, 2 for vascular diseases, and the remaining 10 for various other ailments.
- Ward category: 65 patients were admitted to the general ward, 21 to intermediary ward categories, 7 to the highest ward categories, 5 to the Intensive Care Unit, 12 to the Bone Marrow Transplant Unit, and 26 were outpatients.
- Sponsor type: 65 patients paid for their treatment out of pocket, 16 were covered by their employer or private insurance, and 55 were eligible for government-funded health insurance schemes.
- Region: 35 patients came from Bengaluru, 49 from the rest of Karnataka, 18 from Bangladesh, 13 from Tamil Nadu, 9 from West Bengal, 8 from abroad (4 from Uganda, 1 from Nigeria, 1 from Kenya, 1 from Iraq, 1 from Burundi), 2 from Andhra Pradesh, 1 from Maharashtra and 1 from Assam.

about our motives, which we could not dispel by explaining the research project. However, we were associated with the hospital (Bharadwaj 2016a, 33), which may have prevented some patients from relating negative experiences with the hospital.

Observations and Media Archive

Apart from interviews, observations and informal conversation were essential to understand the everyday processes of the hospital and to contextualise the information obtained from interviews. This strategy was particularly important when doing research with hospital administrators, as it allowed to observe their interactions with patient parties and with each other. I made observations at registration desks, in cost estimation and financial consultations, discharge procedures, and social worker assessments. I attended medical consultations and accompanied doctors on rounds and visits to other hospitals. I observed marketing and CSR events, including medical screening camps, doctor round-tables, movie screenings, program launch events, educational talks in companies. While I met and interviewed patients in waiting rooms or wards, I also accompanied them on their rounds through the hospital, to their guest houses, and on shopping trips. Finally, I visited other clinics of Vishvam Hospitals, two government, four non-profit, and four corporate hospitals in Bengaluru and neighbouring areas, and I attended the annual conference of the private healthcare providers' association in New Delhi. On these occasions, I recorded field notes of observations in a field diary.

To further contextualise my field notes and interview data, I collected and analysed an archive of media reports to examine how representations of Vishvam Hospitals and corporate hospitals have evolved since the 1980s. To this end, I conducted an online search for Vishvam Hospitals and its Chairman and corporate hospitals in English-language newspaper sources on the Factiva database. In this way, I obtained 3898 newspaper articles for Vishvam Hospitals and 5365 items for corporate hospitals from July 1981 to July 2019. Because the Factiva database only includes articles from Indian newspapers published from the mid-1990s onwards, I also searched the Times of India digital archive provided by Proquest Historical Newspapers. In this way, I obtained 97 articles and advertisements searching for Vishvam Hospitals and 180 items for other corporate hospitals between May 1981 and June 2010. From this collection, I created a sample of 679 articles for Vishvam Hospitals and 402 items for corporate hospitals by excluding duplicates, irrelevant formats such as stock market updates, and articles which only fleetingly referred

to the search terms. I then systematically coded the sample using Nvivo Qualitative Data Analysis software. To complement the analysis of newspaper articles and advertisements, I also collected and examined 86 video reports, promotional materials, annual reports, investor presentations, industry analyses, legal cases, hospital websites, and social media content.

Chapter Outline

In the thesis, I analyse the medical business of Vishvam Hospitals to understand how medical care and commercial profit are negotiated in corporate hospital care.

In Chapter 1, I trace how the arrival of the corporate hospital transformed Indian healthcare delivery, and I situate Vishvam Hospitals in the wider healthcare landscape in India. I discuss how Vishvam Hospitals acquired a reputation as a provider making specialised hospital services affordable to all people and I analyse the role of the media and the charismatic Chairman in establishing this reputation.

Chapter 2 focuses on how hospital administrators used discounts to tailor the prices of treatment to the resources available to patients. I show how the allocation of discounts depended on interpreting patients' socioeconomic status and analyse the economic and symbolic benefits of this practice.

In Chapter 3, I examine how the hospital offered different standards of care to cater to diverse groups of patients with unequal resources at their disposal. I analyse how clinicians varied treatments depending on patients' conditions and socioeconomic situations in ways not foreseen by international protocols. This practice raised suspicions as treatment could be varied to save patients unnecessary expenses but also to increase profits for clinicians and the hospital.

In Chapter 4, I analyse doctors' relationship with business administrators. Doctors invoked an ideal of medical authority epitomised by the Chairman against what they viewed as the corrosive influence of "corporate culture". The chapter shows how the sense of crisis among doctors indicates not the decline but the centrality of medical authority in corporate healthcare delivery.

The focus of Chapter 5 is on the role of prevention and outreach activities in the hospital's marketing. I discuss how Vishvam Hospitals' marketing team used medical

screening to attract patients to the hospital and how its corporate social responsibility (CSR) programmes provided opportunities to engage with industry partners interested in testing new healthcare technologies.

1 The Transformation of Indian Hospital Care

In this introductory chapter, I discuss the transformation of the Indian hospital sector by the emergence and proliferation of corporate hospital chains since the early 1980s. I show how corporate hospitals were established with the promise of introducing a new form of healthcare delivery matching international standards, and how the spread of these hospitals throughout metropolitan areas resulted in a sense of crisis, both within the industry and in common perception, that pointed to the limits of the potential of corporate hospital care to address the curative needs of broad sections of the population. In response to this situation, Vishvam Hospitals positioned itself as a "corporate hospital with a difference", offering a much-publicised vision of making treatment affordable to the masses without compromising on quality standards. I show how this vision resonated widely in the media and academic studies and assumed the status of an undisputed fact even though there was no evidence that Vishvam Hospitals operated radically differently from other corporate hospital providers.

To analyse the shifts in the perception of corporate hospitals in general, and Vishvam Hospitals specifically, I draw on an archive of newspaper reports and advertisements going back to the early 1980s. Media play a vital role in corporate hospital care because these hospitals, which arrived at the same time as novel broadcast media in the early 1980s, depend heavily on media exposure to attract investors and create a customer base for their premium services due to restrictions on advertising for medical services (Bharadwaj 2000, 66; see chapter 5). At the same time, such heightened publicity comes with the risk of scandals, which have frequently embroiled these providers (Cohen 2011, 48). The media attention explains why corporate hospitals have been at the heart of debates about private health care although they only provide a small fraction of hospital services in the fragmented Indian healthcare sector (Burns 2014, 92).

Historian Sarah Hodges (2013; 2016) observes that corporate hospitals' publicity has given rise to pervasive myths about this form of healthcare delivery. Hodges (2016, 145–46) describes how stories suggesting that the arrival of the corporate hospital

fundamentally changed the way health care was delivered in India circulated widely among medical practitioners she interviewed in Chennai. Hodges (2016, 161–63) argues that these stories are mythical because the notion of a revolutionary impact does not stand up to historical scrutiny and because the stories conceal that corporate hospitals have only succeeded selectively, by offering a narrow range of lucrative services that leave the curative needs of the general population unaddressed.

In this chapter, I use Hodges' argument about the centrality of myth in the perception of corporate hospital care as a point of departure to analyse three different mythical stories. The first section focuses on the establishment of the corporate hospital model by Apollo Hospitals in the early 1980s through advertisements promising to introduce international standards to Indian hospital care by employing the latest medical technologies and specialists trained abroad. This marketing message has been highly successful and established the corporate hospital as "a new hegemonic form that became a symbol of world class, quality care" and "the standard of good quality care with respect to which all other forms of institutions were judged", as Rama Baru (2016, 136–37) observes. I argue that the idea of global modernity was critical to that success, as advertising linked the Indian corporate hospital to the imaginary elsewhere of "world-class" hospital care (Mazzarella 2003, 257).

In the next section, I examine a second pervasive story about corporate hospital care that took shape as corporate hospital chains expanded in metropolitan areas. Much media reporting in the early 2000s focused on the role of corporate hospitals as industry leaders turning India into a global hub for medical travellers, but a more sinister narrative gained traction at the turn of the decade. This narrative highlighted the scandalous activities of corporate providers and portrayed them as suspicious and corrupt institutions that strategically deviated from proper standards of medical care to maximise their profits. While scandals had been part of corporate hospital care from the beginning, the economic slowdown in the early 2010s and the government's decision to increasingly leave the provision of hospital services to private providers drew new scrutiny on corporate hospital care and established an image of corporate hospitals as systematically engaging in nefarious activities. This scandalous reporting pointed to the contradiction between the claim to offer superior standards of service and the purported aim of becoming the dominant providers for specialised hospital care meeting the curative needs of the masses. At the same time, the scandalising narrative produced its own myth, prevalent among medical

practitioners, that health care would return to a pristine state if only corporate hospitals were reigned in or abolished.

The second part of the chapter concentrates on the narrative that Vishvam Hospitals pioneered a revolutionary healthcare model offering a solution for making corporate hospital services affordable to broad sections of the population by standardising treatment processes and using cross-subsidisation. I trace how the Chairman of Vishvam Hospitals established his reputation as a compassionate surgeon with a big heart for the poor by offering surgeries to needy children for free or at a reduced price. He used the ensuing media attention to spread his vision of a corporate hospital that makes specialised treatment affordable to the poor. By focussing on the claim that Vishvam Hospitals is "the cheapest hospital in the world", I show how this assertion made by representatives of Vishvam Hospitals gradually emerged as a widely reported fact. The claim had its origins in the variable practice of offering charitable help and price reductions to selected patients (see Chapter 2). However, media reports and business studies presented it as a consequence of innovative business principles based on standardisation and technological innovation. Despite the lack of evidence that Vishvam Hospitals had succeeded in radically reducing treatment costs, I argue that the idea assumed credibility through citations and re-citations of this claim in the media that presented it as an established fact.

The validation of stories through media circulation resonates with Michel de Certeau's argument that contemporary advertising and news media have created a "recited society", in which reality is defined by the ceaseless narration of facts and stories (de Certeau 1984, 186). Drawing on Jean Baudrillard's (1993) suggestion that reality and the media representing reality have become indistinguishable in the circulation of signs without original referents, de Certeau (1984, 185–87) argues that mass mediation has restructured the foundations of belief. While people once used to believe that reality was ultimately inaccessible to vision, what is real is now equated with what is visible. In this situation, the media have become the primary means of making people believe by constantly showing what is real and citing what others believe to be real (de Certeau 1984, 187–89).

The case of Vishvam Hospitals is a striking illustration of the way media reports citing other reports institute what is believed to be real. However, I argue that the extraordinary success of Vishvam Hospitals' narrative did not result from media coverage alone but also depended on the figure of the Chairman and his charitable acts, which

played a critical role in giving credibility to the narrative. William Mazzarella (2003, 18–21) has argued that advertising does not simply impose an encompassing narrative on its recipients. Instead, advertising depends on the "gap" between the abstract ideas it seeks to convey and the concrete life-worlds it inserts itself into, which always exceed the intended message. This gap makes advertising vulnerable to misappropriations but also allows it to resonate with its targeted audiences (see also Nakassis 2013). In the case of Vishvam Hospitals, the persona of the Chairman that was part of the media narrative and at the same time exceeded it proved to be a powerful way to connect specific instances of charitable help with the broader vision of revolutionising for-profit hospital care, making the story compelling to diverse audiences.

The Birth of the Indian Corporate Hospital

On 14 December 1984, *The Times of India* ran an article headlined "Concept of corporate hospital catches on" (*The Times of India* 1984). The article referred to the recent opening of Apollo Hospitals in Chennai (still called Madras at the time), which was inaugurated in September 1983 and began operating in February 1984. In the article, the journalist explained the concept of the "corporate" or "investor-owned" hospital that set Apollo Hospitals apart from other hospitals in the country:

> The concept of an investor-owned hospital in the corporate sector, which combines medicine with management, and which concentrates not only on comprehensive medicare but also on making profits to fund expansion plans and ensure a good return on investment, seems to be catching on in the country. This is demonstrated by the success achieved by Apollo Hospitals Enterprise, Madras, in the past one year. This company has been modelled on the highly successful hospitals in the U.S. In the U.S.A., shares of such corporate hospitals are selling alongside those of other corporate giants including IBM, GEC and Xerox.

Apollo Hospitals was the first hospital provider in India that was organised as a public limited company selling shares to the public. As the description highlights, the reason for running the hospital as a publicly listed company was to professionalise management and to raise the financial means required to set up a chain of hospitals. Citing the "investor-owned" hospitals in the United States as a model emphasised the ambition and global aspiration of this new hospital concept: to build a hospital chain that could match the vast hospital conglomerates in the US.

Apart from the corporate form, in what ways was Apollo Hospitals modelled on the "investor-owned" hospitals in the US? The article further states that "this 250-bed hospital in Madras has become reputed in terms of quality medicare", and that "[i]t has so far

handled 15,000 patients from every state in the country and even from West Asia and the Far East." The hospital had "handled 370 open heart surgery cases in less than five months" and had "an outstanding success rate in kidney transplants and total hip replacements." After explaining that the hospital had incurred a marginal loss this year, the writer reported that the hospital management was confident that it would run profitably and pay a dividend to its shareholders by next year. In addition, the journalist laid out that the founder and chairman of the hospital, the cardiologist Pratabh C. Reddy, already planned to open a second facility in Hyderabad, which would include "a hotel with all facilities for friends and relativees [sic] of patients, a health spa equipped with latest devices, a nature cure centre, an advanced teaching school, international conference facilities and a bio-medical research department." Unsurprisingly for a for-profit hospital, Apollo Hospitals focused on offering specialised surgeries and procedures such as cardiac surgeries and transplants, which were expensive and therefore lucrative. It also sought to provide superior facilities and to purchase state-of-the-art medical equipment to attract affluent patients from all parts of the country and medical travellers from abroad. This focus resembled that of for-profit hospital chains in the United States, which tended to concentrate on areas with few uninsured patients and often invested in infrastructure and equipment to offer more expensive services (Light 1986, 42–45).

However, the comparison risks obscuring the very different contexts in which Apollo Hospitals and US for-profit groups like Hospital Corporation of America (HCA) operated. The rapid proliferation of so-called investor-owned hospitals in the United States resulted from the spread of health insurance after World War II and, more importantly, from the influx of public funding through the creation of Medicare and Medicaid in the mid-1960s, which turned healthcare delivery into a lucrative area of investment (Starr 1982, 335–78). Multi-hospital corporations were formed to take advantage of this opportunity because they could more easily raise the significant capital necessary to expand and renovate facilities than independent hospitals (Light 1986, 40). As a consequence, for-profit hospital groups rapidly expanded by acquiring facilities and forming large conglomerates. Thus, six months after it had been established in 1968, HCA already controlled 11 hospitals, and by 1983 the firm operated 364 hospitals with over 52'000 beds (Kleinfield 1983a).

The situation was very different in India in the early 1980s. While the return to power of Prime Minister Indira Gandhi in 1980 signalled a shift towards pro-business

policies (Rodrik and Subramanian 2005), restrictions on investment were in place that made the consolidation of hospitals under corporate ownership impossible (Hodges 2016, 143–44; Lefebvre 2009, 85). Apollo's founder Pratabh C. Reddy famously met the Prime Minister personally to lobby for his project and obtain permission to receive foreign investment and issue shares to finance the hospital (Gupte 2013, 210–25; R. Jeffery 2019). Despite such powerful connections and support, Apollo Hospitals grew slowly, opening its second facility in 1988 and the third one in 1995 (Burns, Srinivasan, and Vaidya 2014, 206–7). In general, large investors hesitated to enter the hospital sector until economic liberalisation in the 1990s. Besides restrictions on capital investment, this was due to the fact that health insurance was almost entirely absent, nor was there an upsurge in public funding for health as had happened in the United States (Bhat 2006). To this day, the private hospital sector is fragmented among many providers, and Apollo Hospitals, as the largest for-profit hospital group, manages around 9'000 beds (Khandekar, Shah, and Agarwal 2019) out of 1.02 million hospital beds in the private sector and 739'000 beds in the public sector (Rajagopalan and Choutagunta 2020).

Given these different contexts, the advent of the "corporate" hospital evoked different associations in India than the rise of for-profit hospital chains in the United States. In the US, proponents of these hospital groups described themselves as "investor-owned", suggesting that they bore responsibility not only to their patients but also to their shareholders who had invested in the company's success (Rondinaro 1981). Journalists and physicians used the notion of "corporate medicine" to warn against corporate control of the hospital sector (Kleinfield 1983b; Hilfiker 1986). In India, in contrast, the notion of "corporate" hospital care primarily evoked an exclusive form of health care available to those able to pay. Crucially, exponents of Apollo Hospitals themselves introduced the label "corporate hospital" to set themselves apart from other healthcare providers by evoking a sense of power and glamour associated with multinational corporations and the global business world (see, for example, *The Times of India* 1982a; *The Times of India* 1989).

The aspiration to be part of global modernity, particularly associated with the United States, is manifest in the early advertisements of Apollo Hospitals. One of the first advertisement campaigns, which was launched in late 1982 to announce the hospital's opening in 1983, consisted of a series of full-page newspaper notices. "The torch-bearer of a new generation in Medicare", read the catchline of one ad showing a large Olympic

torch – the company's logo – whose flame merged into an electrocardiogram (*The Times of India* 1982a). "Comprehensive medicare under one roof", proclaimed a second one, displaying an electrocardiogram with a large cross-shaped collage in front that showed the hospital building in the centre surrounded by various medical devices floating freely around it as if arriving from outer space (*The Times of India* 1982c). A third advertisement showed an electrocardiogram and a globe centred on America in the form of a saline drip under the headline "Medicare leaps ahead to match the West" (*The Times of India* 1982b).The accompanying text stated:

> For the first time in India, a hospital in the corporate sector. Apollo Hospitals.
> What's special about it?
> It will be manned by leading international doctors. Supported by the latest medical equipment available anywhere in the world.
> A hospital that will obviate the need for Indian patients to go abroad for advanced treatment. In fact it will attract patients from abroad, particularly from the Middle East countries.
> That's not all.
> The hospital will have an advanced research centre that will concentrate on the curative and preventive aspects of medicine. And will provide facilities for post-graduate medical education.
> In short, Apollo promises to be the medical centre of Asia.
> Work is in full swing – and the hospital will be commissioned by July 1983.

The sense of catching up with the "West" and enjoying the benefits of "world-class" health care at home conveyed by these advertisements was at the heart of the marketing promise of corporate hospital care. The capital raised from shareholders would make it possible to import the newest medical equipment and to offer advanced surgeries for which Indian patients previously had to travel abroad. The capacity to offer such surgeries would reverse the brain drain of skilled doctors by allowing them to hone their skills at home in the service of their country, much like Pratabh C. Reddy himself had returned from the United States because, as he claimed, he could not imagine seeing his children growing up abroad (Gupte 2013). In contrast to nursing homes offering few beds and limited services, the corporate hospitals would have the size and capacity to offer "comprehensive" hospital care, including research and teaching facilities on par with, or even surpassing, the flagship government hospitals in the country. Subsequent marketing campaigns continued to spread the message that the corporate hospital model introduced by Apollo Hospitals offered treatment according to international standards with the newest medical equipment and technologies, which had not been available in the country until then. Advertisements in this period often depicted medical machines with catchlines proclaiming the revolutionary transformation of healthcare delivery. They also invariably

included large visual representations of the hospital buildings themselves with their massive concrete structures, shining glass fronts, and prominent corporate logos to attest to the reality of the promised revolution and convey a sense of grandeur and power.

By means of such marketing campaigns, Apollo Hospitals established the "corporate hospital" as a new type of hospital in the Indian healthcare landscape. Competitors began to set up hospitals modelled on the same template, and the term started to be widely used in media reports to describe costly but state-of-the-art hospital care in the private sector. For example, a journalist of the *Times of India* reported in 1995 that the concept of the corporate hospital had become firmly entrenched in the last decade: "The corporate hospital concept had arrived, and within a decade more hospitals plunged into the same route to grow beyond what a single doctor envisioned when he began a small clinic in a suburb. Today, multi-speciality, capital intensive hospitals like Devaki Hospital, Tamilnad Hospitals and Malar Hospitals are either issuing or have just issued rights or preferential shares and are using the funds to add or upgrade rooms and facilities. And doubtless there are many more hospitals and specialist centres making plans to go public […]." While the journalist lamented that medicine was no longer considered "a service for the poor and the unfortunate" in these institutions, they did not doubt that these hospitals were the healthcare providers of choice for people who could afford: "Poor hygiene and frequent breakdown of medical equipment is the norm in government-run hospitals. That explains why the middle classes would rather go to private medical centres, despite their higher charges." While the shift to for-profit medicine propagated by these corporate hospitals was not unproblematic, there was no doubt that they were here to stay: "Like economic liberalisation, there is no going back. But not everyone is comfortable […], believing that once the profit motive comes into the picture, genuine care is bound to suffer. At the same time, most agree that corporate hospitals can provide state-of-the-art treatment." In other words, corporate hospitals spread a commercial mindset in medicine and provided costly services unaffordable to the poor. Nevertheless, they had transformed the hospital care sector for good and would continue to set the agenda in the absence of adequate care in public facilities.

Historian Sarah Hodges (2013; 2016) has systematically debunked such claims about corporate hospital care, propagated by providers, doctors, and journalists. Hodges (2016, 151–52) argues that there is no evidence to suggest that Apollo Hospitals had emerged because existing healthcare institutions were not providing adequate care. She

highlights that, by the time Apollo Hospitals was established, Chennai had long been known as a centre of medical excellence with a thriving private healthcare sector and that significant public investments in health care occurred in the 1970s and 1980s before the opening of the first Apollo facility (Hodges 2016, 151–52). Besides, she (2016, 155–57) points out that Apollo Hospitals did not seek to address unmet healthcare needs in the country because its initial focus had been on catering to medical travellers from abroad. Finally, Hodges (2016, 160–63) highlights that there was nothing new about the multi-speciality "comprehensive" care offered by corporate hospitals, given that the large governmental and non-profit hospitals also had provided specialised surgeries and treatments and combined several specialities under one roof. Nevertheless, Hodges (2016, 140) found a consensus among physicians in Chennai whom she interviewed in 2009–10 that Apollo Hospitals had introduced a radically new model of hospital care delivery. This view directly echoes the marketing message spread by Apollo Hospitals since the 1980s and attests to the success of branding corporate hospital care as a revolutionary new type of health care. Therefore, Hodges (2016, 140) concludes that "Apollo's greatest success may perhaps be its story." According to Hodges (2016, 162–63), this mythical story not only obscures the specific historical processes that allowed for the establishment and growth of Apollo Hospitals. It also conceals the fact that the care provided by these hospitals has been highly selective and focused on lucrative medical specialisations and on affluent sections of the population.

These points are highly pertinent, but they do not explain why the myth of the revolutionary corporate hospital that introduced a new standard of healthcare delivery has been successful in the first place. The analysis of the early advertising campaigns shows that a key promise of the corporate hospital has been to bring "world-class" health care to India, which had so far only been available in the "West". Such appeals invoking the "West" were not limited to health care but common to the cultural politics of marketing in this period. William Mazzarella (2003, 251–58) has argued that the appeal of foreign consumer brands in the 1970s and 1980s emerged from the fact that awareness of these goods far outstripped their supply, which was limited by trade restrictions. The "close distance" between the powerful presence of these brands as aspirational commodities and the actual absence of such "Western" commodities generated their auratic appeal and allowed them to serve as powerful markers of distinction. Similarly, advertising for corporate hospitals used such a "spatial configuration of value" (Mazzarella 2003, 262)

by linking the actual hospital buildings, prominently displayed in the advertisements, to the mythical elsewhere of "world-class" health care. Advertisements stressed the attraction of patients from abroad and doctors' international expertise to strengthen the appeal of exclusivity aimed at attracting affluent patients and justify the additional expenses compared to other hospital care providers. Hence, the myth of corporate hospital care as a revolutionary model does not simply obscure the narrowness of the actual care provided. Exclusivity was part of the original appeal that created the myth in the first place.

Liberalisation Gone Wrong

After the pioneering years of the 1980s, the financial crisis of 1991 provided new opportunities for promoters of corporate hospitals. On the one hand, technocrats within the government implemented pro-market policies under pressure from the International Monetary Fund and the World Bank (Ganguly and Mukherji 2011, 84–87). The shift towards economic liberalisation brought reduced import duties on medical equipment and relaxed investment rules in the hospital sector (Baru 1998, 54–55; Shah and Mohanty 2010). On the other hand, the crisis led to cuts in public spending on health, which was already low by international standards (Qadeer 2000; Sengupta and Nundy 2005). Public healthcare spending increased from 0.98 per cent of GDP in 1975 to 1.36 per cent in 1986, but was reduced to 1.28 per cent in 1991 and fell to 0.9 per cent in 2000 (S. K. Rao 2017, 17). This decline in public spending on health in a period of rapid economic growth provided an unprecedented window of opportunity for private healthcare providers in the 1990s (Lefebvre 2010). Nonetheless, the importance of 1991 as a watershed moment should not be overstated. The 1980s were characterised by economic growth, and a shift towards pro-business policies had occurred as early as the mid-1970s (Rodrik and Subramanian 2005). In the hospital sector, the share of beds in the private sector compared to the public sector had already begun to grow in the 1970s, a trend that merely continued in the 1990s (Hooda 2017a, 19).

Moreover, despite the celebratory announcements surrounding the arrival of corporate hospitals, private hospital chains struggled to expand during the 1980s and continued to do so for much of the 1990s. *The Hindu Business Line* reported on 22 February 1997 that "[t]he experience of investing in corporate hospitals in India has not been pleasant. Except Apollo Hospitals, almost all the corporate hospitals are either in the red or making only marginal profits" (Vageesh 1997). This assessment is supported by a study

of health economist Ramesh Bhat (2006), who found that private hospitals struggled to succeed and performed below expectations despite a wave of new investments in the 1990s. Indeed, some of the corporate hospitals established in the late 1980s were sold to other investors or went out of operation (Baru 1998, 127; Hodges 2016, 154–55)

In the face of these difficulties, industry exponents lobbied for further deregulations of the sector and more incentives for private providers. The founder of Apollo Hospitals, Pratabh C. Reddy, was cited in an article from 4 March 1997 complaining that the hospital industry was disadvantaged compared to other industries: "'Why does no industrialist in India invest in hospitals?' [Reddy] asks. The reasons he lists are: Hospitals are not treated on a par with other industrial activities. While others get free or subsidised land and tax holidays, hospitals have to pay a higher tariff for power than other industries, pay more for water, and are 'loaded with disincentives like having to give free beds and free treatment', he says, demanding to know which other industry is required to give away a certain percentage of its services or products free." (Kalyani 1997) The government supported private hospitals substantially in this period by offering land at subsidised rates and duty-free import of medical equipment. In return, hospitals were obliged to offer a certain percentage of their services free of charge to the poor, a commitment they often did not live up to (Baru 2000).

In the early 2000s, a new series of liberalisation steps followed. Industry and infrastructure status was conferred on the healthcare industry, allowing private hospitals to raise cheaper long-term capital. In addition, import duties on medical equipment were lowered to 5 per cent, and the deprecation rate for essential equipment and devices was increased to 40 per cent, allowing for significant tax savings. Finally, 100 percent Foreign Direct Investment was allowed in the hospital sector, leading to an influx of foreign investment into tertiary care services (Hooda 2017c). With these measures accompanied by rapid economic growth in the first decade of the new millennium, corporate hospitals began to boom in metropolitan areas throughout the country. Apart from doctor-entrepreneurs who set up facilities with the help of venture and shareholder capital after the model of Apollo, pharmaceutical companies now also began to invest in the hospital sector to build integrated healthcare conglomerates (Chakravarthi 2010).

Newspaper reports in this period focus on the place of corporate hospitals within India's "sunshine story" as one of the world's fastest-growing economies in the 2000s (Hodges 2016, 160). For example, a *Times of India* article from 9 January 2003 proudly

reported that Non-Resident Indians were increasingly seeking health care in their country of origin:

> A decade ago, falling ill in India could be a nightmare for those used to the far superior hygiene and health care in their adopted countries. Now, NRIs are flocking to India for medical attention. The reason: medical services here are coming of age. At about one-fifth (in the Gulf) to one-tenth (in the US, Europe) the cost depending on where he lives, the NRI now gets quality medical treatment combined with that back-home feeling. The cost factor was earlier no factor at all as the best doctors were available only at premier government facilities like the All-India Institute of Medical Sciences. Treatment cost less then too, but ancillary services were just not up to the mark. Used to the hygiene and better nursing and paramedical services abroad, the NRIs would balk at queuing up at AIIMS for their turn. The advent of the corporate hospital has changed that. Competition has hotted [sic] up, forcing hospitals to offer better facilities. There is a premium on Indian doctors the world over. And the costs are still low. For the last five years NRIs have been visiting India in droves for medical treatment, particularly cardiac surgery, angioplasty and organ transplants. (N. B. Jha 2003)

While capable doctors had been practising in premier government institutes for a long time, corporate hospitals were credited for the "coming of age" of medical services in the country. Now, the writer suggests, as premium hospital services were available without the need to queue up at overcrowded government facilities, India offered medical services on par with the best facilities worldwide and would become a global destination for medical travel.

Even critical writers who pointed to the mismatch between glossy hospitals attracting medical travellers and the "fundamental policy failures in public health" acknowledged admiringly that "India's tertiary healthcare sector [was] on the road to global fame" (Ananthakrishnan 2006). A string of articles reported that a minister or governor had inaugurated a new corporate hospital in an urban centre and expressed the hope that the city would become a significant hub of healthcare delivery (see, for example, *The Hindu* 2002; R. Sharma and Pathak 2003; *The Hindu Business Line* 2004; *The Indian Express* 2010). Other articles stated that corporate hospitals were why the "brain drain" was reversing and doctors were returning to India (Ghose 2006; Kanth, Ramachandran, and Sivaramakrishnan 2007). These reports attest to how central corporate hospitals were to narratives about the rise of India as a global player in healthcare delivery. In addition, they show the extent to which corporate hospitals had come to signify a certain style of hospital care in the first decade of the millennium. For example, several articles quoted representatives of non-profit and government hospitals claiming that they offered care "at corporate hospital level" (*The Hindu* 2003; see also *The Hindu* 2004; R. Sharma 2007).

A crucial shift happened in the early years of the following decade when the upbeat narratives about the role of corporate hospitals in India's rise to a global power gave way to more sinister stories. On 13 June 2011, *The Hindu* ran an article headlined "Corporate hospitals rip off patients":

> Exorbitant consultation fee [sic] of doctors in the outpatient wings of corporate hospitals has become a source of outrage for patients in the State capital [Hyderabad]. Till recently, an outpatient visit to a doctor at corporate hospital [sic] was an affordable affair. Not anymore. These days the visit will set you back by Rs. 2,000. And if the hapless patients are unsuspecting, they might end up in the inpatient wards of the hospital with medical bills worth lakhs to clear. (*The Hindu* 2011b)

The journalist went on to explain that consultation fees that used to be around Rs. 100 and Rs. 150 now ranged between Rs. 300 and Rs. 1000, to which diagnostic tests and medications were added. The writer also cited a senior physician and former member of the Indian Medical Association who stated that "[c]orporate hospitals [had] become revenue driven" and were "collecting money from patients at every stage." The hike in consultation fees does not seem particularly dramatic in light of an annual inflation rate of around 10% in this period. Similarly, nothing is shocking about these hospitals being "revenue driven". Nevertheless, a new narrative took shape in this period, centred around the ways corporate hospitals charged unsuspecting patients with outrageous bills (see Golikeri 2010; Gopal 2015; Nagaraja 2012; Nagarajan 2014; *The Hindu* 2011a).

Costs were only one of the grievances voiced with increasing urgency. Some other headlines in this period read: "No regulation to prevent hospitals from paying doctors" (*Hindustan Times* 2011); "Rs 40 L[akhs] for death due to negligence" (*Deccan Chronicle* 2012); "Big hospitals connive with stockists to sell cheaper version of heparin to heart patients" (Nautiyal 2014); "All is not well in the high corridors of hospitals" (Cama 2015). These reports not only highlighted the high cost of treatment in corporate hospitals but focused on scandalous medical practices in these hospitals as well. For example, corporate hospitals were accused of giving dengue treatment to patients who did not have dengue (*The Times of India* 2011); using ill-matching organs for transplants (Singh 2012); and charging for conducting surgeries on patients who were already dead (*New Indian Express* 2015). These scandalous reports contrast starkly with earlier portrayals of corporate hospitals as providing "world-class" care. Instead, a new, equally powerful picture emerged in which the corporate hospital appeared as a deeply corrupt and suspicious institution where treatment did not follow proper medical standards but the expedient and variable logics of rampant profit-making.

Indeed, corporate hospitals had been criticised from the beginning, and they had been repeatedly embroiled in scandals. In a famous case that made international news in the early 1990s, table tennis player Venugopal Chandrashekhar sued Apollo Hospitals for medical negligence. He claimed to be disabled for life after faulty knee surgery at the hospital in 1984 (*Agence France Presse* 1993). Pratabh C. Reddy disputed the claim by arguing that the player was regularly seen running around the Madras Race Club grounds "like a bullet" (*Agence France Presse* 1995). However, Apollo Hospitals lost the case and was forced to pay 1.7 million rupees in damages in 1993. In the 1990s and 2000s, such medical-negligence cases against corporate hospitals hit the news with predictable regularity (see, for example, *The Times of India* 1997; *The Hindu Business Line* 2002; Sarma 2004; *The Hindu* 2006). These cases were the flip-side of the image they had promoted of themselves as premier healthcare delivery institutions visited by the rich and famous. Treating influential people was excellent marketing, but it came with the risk that these people could sue the hospital and mobilise the media if they felt mistreated, as they had the money and influence to do so. In 2000, a senior government minister was misdiagnosed in New Delhi's Indraprastha Apollo Hospital. A *Hindustan Times* headline read: "If this happens to a Minister, what about us?" (see *Dow Jones International News* 2000). The worry that, if influential people faced erroneous medical treatment, ordinary people suffered even worse seemed to be corroborated by reports that the poor could not afford necessary treatment and were turned away at the doors of corporate hospitals even in emergencies. Such reports tarnished the reputation of corporate hospital care, but they did not supersede celebratory reports about the achievements of corporate medicine in bringing Indian health care up to global standards. Crucially, only at the beginning of the 2010s did reports about scandals and negligence give rise to a comprehensive picture of deeply corrupt institutions that systematically exploited helpless patients. What had changed?

On the one hand, the shift in perception coincided with the economic slowdown in 2011 that marked the end of India's "dream run" as one of the world's fastest-growing economies in the first decade of the second millennium (Nagaraj 2013). This was also the time of mass mobilisation against corruption by the Maharashtrian activist Anna Hazare and a steep fall in popularity of Prime Minister Manmohan Singh's government, which had been embroiled in a series of corruption scandals. Manmohan Singh was associated like no other political figure with economic liberalisation, which he had helped devise

and implement in various functions – as governor of the Reserve Bank and deputy chairman of the Planning Commission in the 1980s, as finance minister in the 1990s, and as Prime Minister from 2004 onwards (Ganguly and Mukherji 2011, 84–87). Shortly after the general election in 2009, a series of corruption scandals regarding the organisation of the 2010 Commonwealth Games, the 2G spectrum allocation, and the allocation of coal blocks tarnished the Prime Minister's reputation as an incorruptible leader (Jose 2011). His fall from grace shed new light on economic liberalisation in popular perception. The scandals seemed to show that the dismantling of the "License Raj" – the system of "red tape", or licenses needed to do business in pre-liberalisation India – had not created a more level playing field for economic activity. Instead, it had ushered in the era of "crony capitalists" in which influential businessmen and politicians fraudulently amassed wealth on an unprecedented scale (K. Sen and Kar 2014, 14). Such a shift in views on India's growth story, coupled with uncertain economic prospects, certainly affected the perception of corporate hospitals that, like no other institutions, stood for the post-reform changes in the Indian healthcare sector.

On the other hand, the shift in popular views on corporate health care is also related to the broader transformation of the Indian healthcare sector and the place of corporate hospitals in it. The National Health Policy of 2002 had formulated a segmentation of the market as the vision for the healthcare sector, whereby those who could afford to pay should procure services from private providers to free up the capacities of government facilities for those unable to pay (Government of India 2002). Corporate hospitals were therefore assigned a vital role in healthcare delivery. With these changes and with ambitious expansion plans announced by hospital groups, it seemed as if not only the rich and medical travellers but most Indians would soon rely on corporate hospitals for major surgeries. In the early 2000s, the government also liberalised the insurance industry, which allowed for the growth of private-sector insurers alongside public-sector insurance companies (Burns 2014, 91). More importantly, state governments and the central government began introducing increasingly ambitious tax-funded insurance schemes for the poor in the following decade (see Baru 2015). Because these schemes covered treatment in public as well as private facilities, they were potentially a huge business opportunity for private providers. At the same time, they opened a new avenue for the state to set standards and prices for services and put private hospitals under public scrutiny because tax money was used to procure services from them. Thus, the central

government introduced the Clinical Establishments (Registration and Regulation) Act in 2010 that required all clinical establishments to register themselves and set minimum standards for facilities and services provided by them (Phadke 2016, 50–53).

Importantly, regulations and rates set through insurance schemes affected not only large hospital providers but also doctors who worked as individual practitioners or ran small clinics and nursing homes. Doctors were up in arms against these changes because they feared interference with their practice (Narayan 2010). At the same time, they equally resented the large hospital providers and their management methods, whom they blamed for undermining their professional status and commercialising health care, thereby corrupting the relationship of trust between doctors and patients (see Chapter 4). For example, the Indian Medical Association (IMA) publicly demanded a ban on hospitals run by corporate groups in 2005. In an article, the president of the IMA was quoted saying that corporate hospitals were "a blot in the medical profession": "Our doctors are being exploited in corporate hospitals. Patients are being charged exorbitantly but the doctors are getting only a small margin (of the huge profits). Moreover, they are earning a bad name" (*Hindustan Times* 2005). Under mounting pressure through new regulations and public outrage against the corrupt healthcare sector, doctors increasingly turned to the media in the early 2010s to expose the pressures they faced from corporate hospital providers and to decry unethical practices in an increasingly commercialised healthcare sector. In articles written by doctors themselves or citing their opinions, doctors exhorted their colleagues to overcome greed and remember their true, selfless vocation (Ramayogaiah 2011). Other writers denounced revenue targets set for doctors by corporate management that pushed practitioners towards unethical practices (Gupta et al. 2011; *Deccan Chronicle* 2011; Kabir 2014; *Deccan Chronicle* 2015; Nagarajan 2015).

The issue of corruption in the Indian medical sector spilled beyond India when the UK-trained general practitioner David Berger (2014) wrote an article in the *British Medical Journal* about his stint as a volunteer physician in a small not-for-profit hospital in the Himalayas. He detailed how corruption pervaded every aspect of Indian healthcare delivery and eroded trust in the Indian medical profession. Several other pieces followed that detailed how kickbacks and lack of regulatory oversight created a situation where profit rather than patients' well-being guided medical practice (Gadre 2015; Jain, Nundy, and Abbasi 2014; Kay 2015; Nandraj 2015). In the same period, doctors also started to write books to voice their dissatisfaction and enlighten the broader public about the sorry state

of affairs (Chatterjee 2015; Gadre and Shukla 2016; Lingegowda 2017; Mahawar 2016). These accounts focused on unethical practices in all parts of the Indian healthcare sector, including drug research and development, medical education, state regulation, and small and large providers in the public as well as the private sector (S. Nundy, Desiraju, and Nagral 2018). However, they generally identified corporate hospitals as chief culprits for flagrant commercialisation in the healthcare sector, which had caused the deterioration of medical ethics. These voices of doctors, a powerful group with authority on the subject and good connections to the media, helped cement the view of corporate hospitals as deeply suspicious institutions that not only overcharged patients but undermined the quality of medical care by interfering with the professional autonomy of medical practitioners to act in the best interest of healthcare seekers.

The negative publicity hit the corporate hospital sector at a time when its growth prospects were worsening. In the late 2000s and early 2010s, representatives of corporate hospital chains surpassed one another in announcing ambitious expansion plans (Anand and Misquitta 2009; Kannan 2008; *The Hindu Business Line* 2008; A. Krishnan 2011; Golikeri 2012). Their spokespeople predicted that they would move beyond metropolitan areas and establish facilities in smaller cities and towns all over the country in order to build an integrated healthcare delivery network within the next few years (see Chakravarthi 2010; 2013; Lefebvre 2009; 2010). Such plans never came to pass (see Lefebvre 2015).[3] In general, the bed capacity of the major hospital chains increased only

[3] For example, Apollo Hospitals announced that it would open 200 hospitals in district headquarters with 120–150 beds under its Apollo Reach initiative (Golikeri 2012). However, this initiative never took off, and according to its website, the company operated only two Apollo Reach hospitals in October 2020. Fortis equally claimed that it would set up 25 hospitals with 100–200 beds in Tier II and III towns (Golikeri 2012). But after running into financial troubles and being sold and restructured in 2018, it managed only 3'663 beds in 2019 (Khandekar, Shah, and Agarwal 2019). In 2009, a Bengaluru-based hospital group announced that it would expand to 30'000 beds within five years (*United News of India* 2009). However, it had only 6'323 beds by the end of 2019 (Khandekar, Shah, and Agarwal 2019). The discrepancy between planned and actual growth is not per se surprising, given that such widely publicised announcements are primarily attempts to attract potential investors and therefore inherently speculative. Nevertheless, the gap between expectation and reality is particularly striking in these instances.

marginally or stagnated after 2011.[4] Not only were these hospital groups unable to expand massively, they also struggled to maintain their profitability. An analysis of the financial result of five large corporate hospital groups shows that their profit margin declined, on average, from 7.15% in 2010–11 to 3.71% in 2019–20 (see Rai 2016).[5] This decline in profitability suggests that it will be difficult for these groups to attract the massive investment necessary to add significant capacities in the foreseeable future.

On the one hand, the failure of corporate hospital chains to expand rapidly beyond core metropolitan areas is not particularly surprising. Indeed, announcements of large-scale expansion may have been more of an attempt to get the attention of potential investors than the outcome of realistic planning, given the structural difficulties for massive expansion. Most notably, such impediments include market saturation in metropolitan areas and the structural difficulties of expanding to semi-urban and rural areas due to low public spending on health, the chronic shortage of qualified doctors and nurses outside urban centres, and the continued predominance of out-of-pocket spending despite the growth of insurance coverage (Burns 2014; Hooda 2020b). These conditions will likely continue to limit the expansion of corporate hospital chains despite efforts by the central government to incentivise private hospital providers to set up facilities in underserved areas. Under the Ayushman Bharat initiative, the Modi government launched the ambitious tax-funded health insurance scheme Pradhan Mantri Jan Arogya Yojana (PMJAY) in

[4] The India Brand Equity Foundation has tracked the growth of six key hospital providers (Apollo Hospitals, Aravind Eye Hospitals, CARE Hospitals, Fortis Healthcare, Max Hospitals, and Manipal Hospitals) from 2010 to 2017. In 2010, its report showed that the six providers combined had a capacity of 26'393 beds (IBEF 2010). This increased to 30'085 in 2011 because Fortis doubled its capacity by acquiring facilities from the competing corporate hospital chain Wockhardt Hospitals (IBEF 2010). Between 2011 and 2017, the capacity hovered around 32'000 beds (IBEF 2017). By October 2020, the six providers' capacity had decreased to 26'665 according to the information provided on their websites. This was mostly due to the fact that Fortis had to restructure after financial troubles in 2018 (Rajagopal and Layak 2019).

[5] The numbers are calculated based on the data reported on the market analysis website www.moneycontrol.com for five public limited hospital groups (Apollo, Fortis, Narayana Health, Shalby and Aster DM). It shows that the average net profit margin of these companies was around 7% in 2010–14, declined to around 4% in 2015–17, and dropped to almost zero in 2018 and 2019 before rebounding to 3.7 % by the fiscal year 2020, which ended on 31 March right before the Covid-19 pandemic hit. On average over the whole period, the profit margin for these providers was 4.68%. This is significantly lower than in the pharmaceutical sector, where the five largest companies (Sun Pharmaceuticals, Dr Reddy's, Divis Laboratories, Cipla, and Aurobindo Pharmaceuticals) reported a profit margin of 17.30% on average in the same period.

September 2018. As part of the scheme, the central government has also introduced viability gap funding to incentivise private providers to invest in disadvantaged rural districts. However, such financial incentives do not remedy the lack of specialists and skilled healthcare workers in rural areas (Kandhari 2020; Hooda 2020a, 115).

On the other hand, the negative image of corporate hospitals has increased popular pressure on authorities to hold private providers accountable and regulate their prices (see, for example, P. Jha 2017; M. Rao 2018). In 2017, the Delhi government revoked the license of a corporate hospital after newly born twins had been falsely declared dead at the facility (K. S. Rao 2019). In the same year, the National Pharmaceutical Pricing Authority introduced price ceilings for medical devices, cutting the profit margins of hospitals on stents and knee implants (Bhat and John 2017). In addition, several state governments have introduced measures to control the prices of procedures (Balakrishnan and Somvanshi 2019). Industry representatives argue that these regulatory measures and the increased bargaining power of government agencies and insurance providers in setting prices for procedures have put severe financial pressure on private hospital providers (FCCI 2019, 33). As the central government seems determined to assign an ever-larger role to private providers in the hospital sector, popular pressures to regulate the sector more tightly and keep it accountable will likely increase as well.

Scandals surrounding corporate hospitals play an important role in demands for such accountability (Nagral 2014). Lawrence Cohen (2003, 680–82) has argued that scandals about kidney transplants in Indian corporate hospitals are mobilised by rivals in business competition and used to settle political disputes as these hospitals are enmeshed in complex webs of political patronage and alliances. Cohen (2003, 672–73) cautions that the "scandalous publicity" focused on nefarious machinations fuses real and imaginary exploitation and obscures the tight interlinkages between private hospitals and state agencies. Following these observations, I argue that the negative image of corporate hospitals as corrupt and sinister institutions that gained traction as a result of the changes traced in this section similarly provided a selective picture. The media's coverage of scandals suggests that all patients are equally hapless victims of corporate machinations, thereby obscuring how many of the reported scandals focused on rich and powerful people. More importantly, if corporate advertising eclipsed the narrowness of care provided, the scandalising publicity came with its own myth: that if only corporate hospitals were reigned in or could be made to vanish, health care would return to a pristine state of equity and

ethicality. This narrative, which receives credibility through medialised scandals and voices from the medical profession, neglects the broader situation of underinvestment in public healthcare services and the stark rural-urban divide.

Corporate Hospital with a Difference

Vishvam Hospitals was established in the early 2000s at the outset of the boom in corporate hospital chains. Set up as a private limited company, it opened its main facility, dedicated exclusively to cardiac care, on the outskirts of Bengaluru in the vicinity of the central hub of the burgeoning information technology industry. The 280-bed cardiac hospital was opened with much fanfare by the Chief Minister of Karnataka and hailed as the "world's biggest heart hospital" once it would reach its full capacity of over 700 beds (newspaper report December 2000). Apart from the massive size of such a single-speciality hospital, the opening made headlines due to its promoters' promise that the facility would "reach out to the poor" and mainly "cater to the needs of the middle and working classes" (newspaper report April 2001). To achieve this, the hospital would reduce costs by performing many surgeries per day, allowing it to use the capacity of medical machines optimally and negotiate discounts with suppliers through bulk purchasing (newspaper report April 2001). In addition, it would use a "Robin Hood inspired" cross-subsidisation model, according to which 40% of the capacity would consist of superior facilities offered to well-off patients at a higher price to subsidise treatment for patients with lower incomes (newspaper article January 2001). Finally, a certain amount of treatment would be offered for free to poor patients with the help of individual donors and charitable organisations. In this way, its representatives argued, the hospital would help meet the huge need for cardiac surgeries in the country and "show the way for the governments in providing medicare for the poor" (newspaper report April 2001).

The idea of building a "corporate hospital with a difference" (*The Hindu Business Line* 2001) by moving away from the image of exclusivity associated with the model of corporate hospital care introduced by Apollo Hospitals was nothing new. In 1991, the public limited company Kameni Hospitals had opened a hospital in Hyderabad targeting the "lower and middle income group" to compete with "the large government hospitals". According to its representatives, it focused on "general health services" while 20 percent "super specialities/diagnostics" were to make the project financially viable (Ravi 1991). The promoters expected the hospital to become profitable by attracting "a greater number

of patients coming for a range of health services under one roof." In addition, they planned to cross-subsidise services by offering private rooms for Rs. 250 per day and general ward beds for Rs. 75–100 per day. Indeed, such differential pricing for facilities and services was standard among many Indian healthcare delivery organisations because it allowed them to cater to a broad range of patients with different financial means who paid for services out of pocket (Richman et al. 2008, 1263). Attempts by for-profit hospital providers to cater to the lower and middle classes were not limited to general or secondary care. In the early 2000s, several providers claimed to provide "corporate hospital care at government hospital rates" by offering specialised tertiary care at prices affordable for broad sections of society and by providing free treatment to the poorest patients with the help of charitable funds (*The Hindu* 2001; *The Hindu* 2003). Similarly, providers claimed to offer specialised surgeries at lower prices than their competitors through cross-subsidisation, high volumes, and efficient use of medical equipment (Nutan 2001; Richman et al. 2008; Shapiro 2020).

There was thus nothing inherently new or different in the hospital care model proposed by the promoters of Vishvam Hospitals. In contrast to other providers with similar models, however, Vishvam Hospitals was spectacularly successful. In less than a decade, it became one of India's largest hospital chains and received national and international acclaim for making specialised care affordable to the masses. In particular, it remained remarkably unscathed by the scandals and negative publicity that engulfed some of its competitors. Given that this success cannot be explained by the originality or uniqueness of the proposed healthcare delivery model, it can only be understood by examining the specific trajectory by which its reputation was established.

Much like the founder of Apollo Hospitals, the founder and chairman of Vishvam Hospitals was a non-resident Indian doctor who had practised as a cardiac surgeon in the United Kingdom for some time before returning to India in the late 1980s. He started to work as a director and chief cardiac surgeon at a heart hospital in Kolkata sponsored by an Indian industrial conglomerate. In the following years, he made a name for himself as a skilled paediatric cardiac surgeon by pioneering several heart surgeries on children, which had not been performed in the country before. He also established a charitable reputation. In a newspaper article from April 1996, he stated that the hospital offered 25 per cent of surgeries at a concessional rate to needy patients, in which case he and his

colleagues did not collect any fees. He also claimed that they offered complex heart surgeries that could cost up to fifteen lakhs at a flat fee of 75'000 Rs. to poor children (newspaper report February 1997). In the mid-1990s, he made international news by being part of a doctoral team treating a charitable figure who was globally revered for attending to the poor and ill. He later claimed that this encounter had a lasting impact on his life and equipped him with a purpose: to alleviate the suffering of children and poor people with cardiac ailments. This occurrence further contributed to turning him into one of the best-known cardiac surgeons in the city. According to a newspaper article from July 2000, he had become a "heart stopper": "In the Nineties, almost half of Calcutta was in love with this […] cardiac surgeon. The other half wanted him to operate on their hearts. But what really makes [him] popular is his love for people, especially poor children who suffer from cardiac complications."

In the late 1990s, the Chairman returned to his home state of Karnataka to oversee the establishment of a new cardiac hospital in Bengaluru owned by a private hospital group. According to newspaper announcements, the hospital was to be run on the same principles later used by Vishvam Hospitals: making treatment affordable for the "common man" by performing cardiac surgeries on a large scale and using cross-subsidisation to offer treatment at concessional rates to patients from poorer backgrounds (newspaper report May 1997). Not content to run a hospital belonging to another group, he soon left to establish his own hospital enterprise, Vishvam Hospitals, a private limited company controlled by him and his family in which he served as chairman.

At the outset, the company operated two facilities dedicated to cardiac care. One hospital in Kolkata had already been commissioned at an earlier stage with the financial help of an industrial conglomerate (newspaper article August 1997). In addition, the central facility with the headquarters of Vishvam Hospitals was built on the outskirts of Bengaluru. The money for the acquisition of the land and construction of the facility was provided by the Chairman's father-in-law, who owned a construction company (newspaper report January 2003). According to the Chairman's statement, his brother-in-law convinced his father to sponsor the hospital to "leave a legacy behind" (news magazine July 2013). As a sign of appreciation, the hospital group was named in honour of its sponsor. Such sponsorship was in line with a long tradition of wealthy businesspeople sponsoring hospitals to gain prestige in their community and receive recognition from state authorities and the broader public for their philanthropy (M. Nundy 2014, 198; see

Arnold 1993, 268–74). A few years after the opening of the main facility, a multi-speciality hospital was added to the cardiac hospital in the same compound. The multi-speciality clinic, focused on cancer treatment, was sponsored by and named after the owners of a pharmaceutical company who explained that the investment was a "personal passion" to them after they had seen friends and family members suffer from cancer (newspaper report July 2009). Together, the hub of two hospitals in Bengaluru and the cardiac hospital in Kolkata were the primary sources of revenue for the company and provided the basis for financing the construction and acquisition of smaller facilities throughout the country.

Crucially, the costs for setting up these hospitals were not borne by Vishvam Hospitals. The main facility was gifted to the company by the Chairman's father-in-law (business case study 2007); the facility in Kolkata was owned by a trust, which the Chairman and his family controlled, and leased to Vishvam Hospitals for operations (red herring prospectus 2015); the multi-speciality hospital was a personal investment by a pharmaceutical entrepreneur who was part of the Chairman's network of friends (personal conversations; newspaper articles July 2009). In addition, the establishment of the hospitals was supported with state subsidies, as was usually the case in the corporate hospital sector (Shah and Mohanty 2010, 81–82). The facility in Kolkata received land from the government of West Bengal (newspaper report November 1998). The central hub in Bengaluru was constructed on land acquired from the Karnataka Industrial Development Board (KIADB), a state agency established to facilitate industrial growth.[6] Therefore, the establishment of these hospitals was made possible by the wealth of the Chairman's family and his connections to wealthy entrepreneurs and government officials due to his work and reputation as a cardiac surgeon.

This network and reputation were needed to set up the hospitals and turn Vishvam Hospitals into a successful enterprise. While the main heart hospital in Bengaluru was given to the company for free, the facility faced several problems. It was located some twenty kilometres from the city centre in an area that mainly encompassed wasteland and

[6] I filed a Right to Information (RTI) request with the KIADB inquiring about the terms of the agreement between Vishvam Hospitals and the KIADB. The written reply to the request stated that the land on which the main hub of Vishvam Hospitals was built had been sold on an outright basis to the construction company of the Chairman's father-in-law.

agricultural land at that time. The Chairman had established his reputation in Kolkata, where he was famous among patients from West Bengal, the Northeast, and Bangladesh. However, he lacked a solid patient base in Karnataka. As a large single-speciality hospital offering comparatively expensive surgeries, it needed to attract enough patients that were able to afford cardiac treatment. To tackle these problems, the Chairman and the management of Vishvam Hospitals took several steps. First, the Chairman used his political connections to get the Karnataka state government to introduce a health insurance scheme for farmers in Karnataka. For a monthly premium of Rs. 5, to which the Karnataka government added another Rs. 2.5 per insured person, members of the state's agricultural co-operative societies and their families would be fully covered for a range of surgeries at listed private hospitals. The scheme was subsequently expanded and often cited as a model for schemes introduced in other states and at the national level in the following years. Second, the hospital established telemedicine facilities to connect doctors to patients in Northeast India and rural Karnataka. These efforts were widely discussed in the media and presented as evidence that Vishvam Hospitals was a technologically innovative provider with a social consciousness, reaching out to underserved population groups.

Finally, the hospital offered free or subsidised surgeries to patients who could not afford the treatment, as the Chairman had done in the places he had previously worked in the 1990s. As a famous cardiac surgeon with excellent connections to the IT and pharmaceutical industry in Bengaluru and industrialists in West Bengal, he raised a considerable amount of charitable donations to finance heart surgeries for poor patients. Ideally, such charitable investments created a virtuous circle in which offering treatment for free attracted media attention and established a reputation as a compassionate provider, which again led to more philanthropic donations. In 2003, the Chairman landed a veritable media coup by waiving the fees for heart surgeries on Pakistani children, who came to Vishvam Hospitals shortly after bus services between the two countries had resumed after years of heightened tensions. The story of compassionate care across political divides made national and international news and resulted in an influx of charitable donations to the hospital (media reports July 2003). Such charitable acts also further helped establish the Chairman's saint-like reputation, which he had begun to acquire in the 1990s. An Australian TV clip from 2002 showed patients bursting into tears and touching the Chairman's feet to express their gratitude for surgeries they had received for free or at a reduced price. In the clip, a patient from West Bengal addresses the Chairman as his

"saviour" and his "god in flesh and blood", and a Bangladeshi patient states that the Chairman is revered as a "saint" among his compatriots.

At the height of the corporate hospital boom in the late 2000s, Vishvam Hospitals focused on massive expansion. It was in this period that the multi-speciality hospital was added to the main cardiac facility in Bengaluru. The Chairman announced that the hospital group aimed to establish hubs consisting of several hospitals across the country within the next five years. In this way, it would expand its capacity to 30'000 beds, thereby becoming the largest hospital provider in India (newspaper report February 2008). In addition, the management also announced plans for a facility in the Cayman Islands to attract medical travellers from the United States (newspaper article November 2009). To finance these expansions, two private equity firms invested Rs. 400 crore ($72.5 million) in exchange for 25 per cent of shares in the company. In line with these changes, the focus of media reports began to shift from charity to business principles. Newspaper articles in 2009 reported that the Chairman was aiming for a "Walmartisation of health care" by using economies of scale to bring down costs (newspaper article September 2009). According to the Chairman, large volumes enabled the firm to negotiate lower prices with suppliers of medical equipment. In addition, specialisation and standardisation increased productivity and reduced errors by letting surgeons and healthcare workers perform the same procedures more frequently (newspaper article November 2009). The Chairman was at pains to point out that this strategy was not a move away from the broader goal of making specialised treatment affordable to the poor. Instead, it was the next step towards attaining that goal because scaling up operations would reduce costs. As he subsequently put it, charity was "not scalable", only a sound business model was (newspaper report June 2012). The vast unmet need for specialised treatment in India required provision on a massive scale, which could only be financed by operating profitably on small margins.

As was the case with other ambitious expansion plans by corporate hospital providers in this period, this massive expansion never took place. Vishvam Hospitals opened its facility in the Cayman Islands and continued to grow, but at a much slower pace than predicted. It had a capacity of around 3'000 beds in 2009, according to newspaper reports (November 2009), which had expanded to 5'347 operational beds by 2016 (annual report 2016). This number has remained more or less constant since then (company website June 2021). Instead of expansion, the focus shifted to improvements in efficiency and

accountability through technology. In a newspaper article from January 2013, the Chairman was quoted arguing that the adoption of digital technologies in hospitals would make treatment safer: “Most people across the globe think American hospitals are the safest place to get treated, but getting admitted to hospitals there is 10 times riskier than skydiving. At least 10,000 people die in America due to erroneous prescriptions. These lives can be saved with software which helps in giving errorless prescriptions. […] I believe, with the help of smart software, hospitals will be able to make smarter diagnosis than doctors after five years […].” Software would not only support doctors in arriving at the correct diagnosis. Electronic medical records and digital hospital management systems would also make doctors and nurses more accountable by tracking the decisions they make. Reducing medical errors in this way would make treatments not only safer but cheaper as well. Indeed, Vishvam Hospitals and other Indian providers boasted a latecomers’ advantage over providers in the United States and European countries because there were few entrenched technological structures in place and because Indian citizens were less concerned about data privacy, not to mention the talent available in the Indian IT sector. The rhetorical focus on technology offered a way to generate expectations of future growth without expanding physical infrastructures. Technological management of patient flows promised to make processes more efficient and increase revenue without adding more beds. In addition, the management began to develop their own software solutions and envisioned that digital hospital management software might itself become a product to be sold to other providers.

The focus of media announcements on digital solutions coincided with Vishvam Hospitals going public in the mid-2010s. Apart from raising fresh capital, this decision also signalled an enhanced role of the Chairman’s children in the company, especially his eldest son, a civil engineer with an MBA from an elite American university. A distinct division of tasks in media appearances emerged. The Chairman, usually in his surgical garment, reported on clinical developments and outlined broad visions for the company and the healthcare sector as a whole, whereas the son, impeccably dressed in business attire, discussed the latest financial reports for investors and market analysts. Turning the hospital group into a public limited company did not change the fact that the Chairman and his family controlled it. However, it took steps towards professionalising the management and allowed the Chairman’s children to become publicly recognizable faces of the company.

Remarkably, the public reputation of the Chairman as a cardiac surgeon with a big heart for the poor remained firmly in place throughout all these changes. Newspaper articles continued to report that the Chairman had revolutionised health care by making specialised treatment available to the masses as proven fact, even though many of the plans and predictions never materialised and the hospital group had grown from its modest beginnings into a publicly listed hospital network. Notably, while the hospital's reputation of making corporate hospital care available to the poor was based on the Chairman's charitable reputation, the promise of radically lowering treatment costs through standardisation and technological innovation came to increasingly dominate the narrative. In this process, the actual conditions that had made the establishment of Vishvam Hospitals possible increasingly vanished from view as the idea that the Chairman had found a revolutionary business model that could be replicated elsewhere to lower the cost of specialised hospital services took hold.

"The World's Cheapest Hospital"

There was nothing per se unique about the business model of Vishvam Hospitals. In many respects, Vishvam Hospitals' representatives reported practices most private hospital providers claimed to adhere to: offering competitive prices thanks to technology and efficient management and combining business with a social mission through special services for the poor and underprivileged (Richman et al. 2008). What set Vishvam Hospitals apart from its competitors was the attention it received from the media, in India and elsewhere, as a provider that had "revolutionised" health care by making treatment affordable to broad sections of the population. In addition, Vishvam Hospitals became an example of innovation in private hospital care frequently cited in the health management literature. I have discussed how this attention emerged from the extraordinary popularity of the Chairman as one of South Asia's most revered surgeons and his ability to formulate compelling visions that galvanised journalists and scholars alike. However, how did the Chairman's *vision* for affordable health care turn into the *fact* that Vishvam Hospitals has made hospital care affordable? To understand this process, it is helpful to examine in detail the claim that forms the basis of most arguments for Vishvam Hospitals having initiated a healthcare revolution: the claim that Vishvam Hospitals has succeeded in significantly reducing the cost of specialised hospital care.

Since the early days of Vishvam Hospitals, newspaper articles have reported that Vishvam Hospitals offered surgeries at significantly lower prices than its competitors. As recently as 2019, a lengthy article on Vishvam Hospitals by an international business magazine claimed that the company was "the cheapest full-service health-care provider in the world" because it could "profitably offer some major surgeries for as little as half what domestic rival charge" (newspaper article March 2019). The claim that Vishvam Hospitals is the "world's cheapest hospital" is extraordinary because of its vagueness. The cheapest hospital compared to what and for whom? Many tax-funded hospitals in India and elsewhere offer patients surgeries for significantly lower fees than any private provider. Therefore, the claim only makes sense if one assumes that publicly-funded hospitals are not comparable to for-profit providers like Vishvam Hospitals because they benefit from subsidies from the government. However, private hospital providers in India also benefit from a range of subsidies (Duggal et al. 2013). In any case, the price charged for treatments cannot indicate the "cheapness" of the hospital if such subsidies are not to be taken into account.

Moreover, there is little evidence that Vishvam Hospitals offers treatment at half of its competitors' rates. A search on Medibuddy.in, a rate comparison website provided by an Indian health insurance company, showed that Vishvam Hospitals charged Rs. 17'000 for a coronary angiogram and Rs. 210'000 for a coronary artery bypass graft in the general ward category at its main facility in Bengaluru in June 2019. These rates are similar to those billing executives reported to me during my field research in the hospital.[7] According to the price comparison website, five other large for-profit hospitals in Bengaluru charged Rs. 16'000–19'000 for an angiogram and Rs. 190'000–240'000 for bypass surgery. Smaller, not listed for-profit providers quoted around Rs. 14'000 for an angiogram and Rs. 140'000 for a bypass and not-for-profit hospital around Rs. 10'000 and

[7] Price comparison between hospitals is notoriously difficult because there are different rates depending on the sponsor type (cash, corporate, insurance, government-funded health insurance schemes) and ward category (concessional, general, semi-private, private, deluxe). Moreover, rack rates are individually tailored to the needs and purchasing power of patients by offering discounts and charitable subsidies, as I will elaborate on in Chapter 2. The rates quoted on Medbuddy.in are package rates for patients with private health insurance, which may differ from the rates asked from patients who pay out of pocket. In my field research at Vishvam Hospitals, I found that cash and insurance package rates were quite similar and corresponded to those found on the website.

Rs. 100'000 for the same procedures. The prices at Vishvam Hospitals for these treatments were therefore very much in the same range, if somewhat on the cheaper end, as those of other publicly listed hospital chains. This finding is supported by the fact that the doctors I interviewed in and outside of Vishvam Hospitals did not believe that Vishvam Hospitals asked for exceptionally cheap rates. Some suggested that the prices were the same at Vishvam Hospitals as in other corporate hospital chains. Others felt that treatments were cheaper at Vishvam Hospitals but not because of some revolutionary business principles but because it paid lower salaries and tended to opt for less expensive equipment. Therefore, the claim that Vishvam Hospitals offers treatment at uniquely low rates does not stand up to scrutiny.[8]

Instead, I contend that the claim must be understood as an intertextual reference to earlier statements and media reports. Due to the Chairman's popular appeal and heavy media presence, his statements had been cited and re-cited by media reports. In this process, the statements were gradually stripped of contextual information and reified as seemingly objective facts. This process can be illustrated by tracing the genealogy of the claim that Vishvam Hospitals provides the cheapest procedures in the world. In 2003, the Chairman stated in an interview that "a cardiac bypass that costs about Rs. 1.50 lakh to Rs 1.75 lakh is done here [at Vishvam Hospitals] in [sic] half that price" (newspaper article January 2003). In the same period, he also reported that the hospital performed heart surgeries on poor people for Rs. 65'000. However, he also conceded that it was losing money in these cases and therefore needed to cross-subsidise or use charitable

[8] A different question is whether Vishvam Hospitals charged much lower prices in the initial years. My interlocutors in the hospital did not report that the prices had been strongly increased except for gradual adjustments to inflation and rising cost of medical equipment and salaries. However, they felt that the hospital in general had become more "business-minded" and lost some of its charitable orientation (see Chapter 4). As I discuss in the following paragraphs, the claim that Vishvam Hospitals offered exceptionally low rates was based on the fact that it offered treatments at subsidised prices, significantly below its normal rates, to patients who could not afford their treatment, using charitable donations and hospital funds. It seems plausible that this practice was more important in the early days when the hospital needed to build its reputation and had large unused capacities to fill, but it continues to subsidize treatments to this day (see Chapter 2). The crucial point is that reports claiming that Vishvam Hospitals is "the world's cheapest hospital" do not clarify that the rates quoted are subsidised rates offered to a small percentage of patients and, more generally, that they do not conduct any in-depth research to back up their claims with evidence independent of statements by Vishvam Hospitals' representatives.

donations to finance surgeries offered at this rate (newspaper article September 2003). This price was not unusual in this period. Another heart hospital in Bengaluru, Trinity Hospital, claimed that they offered bypass surgeries for "as low as 70,000 in deserving cases" (newspaper report February 2001). In the following years, Rs. 65,000 for an open-heart surgery became a frequently cited number in newspaper reports about Vishvam Hospitals (newspaper reports September 2007, August 2008, November 2008). Gradually, some reports dropped the crucial information that this was a subsidised rate offered to patients in need, thus suggesting that this was the standard rate. For example, a business journalist wrote in August 2008: "[Vishvam Hospitals'] costs are already the envy of other hospitals with the price of major heart surgery at Rs 65,000 compared with an average Rs 1,50,000 elsewhere." (newspaper report August 2008; see report December 2012). Instead of a subsidised rate offered to a small percentage of patients with the help of cross-subsidisation and charitable donations, these reports made it appear as if Vishvam Hospitals could offer heart surgeries at Rs. 65'000 to most of its patients as a result of revolutionary business principles.

The claim of offering heart surgeries for Rs. 65'000 also played a part in the claim that Vishvam Hospitals was the cheapest hospital in the world. In an interview from July 2009, the journalist suggested that Vishvam Hospitals not only conducted "the largest number of cardiac surgeries in the world" but also was the only hospital that provided "the cheapest cardiac care for the needy – 65,000 for an open heart surgery – without compromising on the quality." Early that year, the same claim was made by a doctor from Tanzania visiting Vishvam Hospitals. The doctor claimed that, after visiting heart hospitals worldwide, she found that Vishvam Hospitals offered "the cheapest health package in the world" (newspaper article January 2009). These quotes indicate how the notion of the world's cheapest hospital became a staple in media reports about Vishvam Hospitals in this period. The notion emerged in analogy to the launch of the Tata Nano, dubbed the "world's cheapest car", at that time. In a newspaper article from August 2010, the writer argued that Indian companies were the world's leaders in "frugal engineering" and cited the Tata Nano, "the cheapest car in the world", and Vishvam Hospitals providing "the cheapest heart […] treatment in the world" as examples. By 2011, media reports routinely introduced Vishvam Hospitals as "the world's largest and also the cheapest heart care institute" (newspaper report January 2011; see also newspaper articles December 2012, May 2013, November 2013). It became a label that was used almost by default in media

reports about Vishvam Hospitals from then onwards. Notably, the claim had never been backed up by research or cost comparison. Instead, it was solely based on statements by proponents of Vishvam Hospitals and on other reports based on such statements.

This was also the case for a series of business case studies about Vishvam Hospitals that began to appear in the mid-2000s. The first of these studies was written by two professors and a doctoral student from Harvard Business School. It described the business model of Vishvam Hospitals in detail and highlighted that it offered treatments at "approximately half the cost at other Indian hospitals" (Harvard Business Case study 2005). In conclusion, the authors wrote: "There can be no doubt that [the Chairman] and his team had [sic] revolutionized cardiac care at his hospital […]." That the authors had chosen Vishvam Hospitals was no coincidence. In interviews, one of the lead authors described the Chairman as a "good friend" (newspaper article 2010) and mentioned that they were working together "to try to figure out ways to institutionalize his hospital model and spread it" (blogpost 2005). These relationships and interests are, however, not mentioned in the study. More importantly, the study was exclusively based on a few interviews with the Chairman and selected representatives from Vishvam Hospitals, who provided all the data presented in the study. The standard disclaimer that such studies were solely "for class discussion" and "not intended to serve as endorsements, sources of primary data, or illustrations of effective or ineffective management" was therefore apt. Nevertheless, other authors cited it in subsequent studies as evidence of how much Vishvam Hospitals had reduced treatment costs.

Most of these studies were written by scholars of Indian origin working at Ivy League universities. Their stated aim was to show how developing countries like India were claiming their "moment in the sun" through innovative business solutions that could outcompete the best of American enterprise (newspaper article 2010, journal article 2013). In this context, Vishvam Hospitals served as an example of "frugal innovation" from the Global South that illustrated the innovative capacity of Indian entrepreneurship in a low-cost setting with minimal government regulation (monograph 2018). These study authors mentioned the role of family wealth and donations in setting up the company and supporting poor patients. However, they squarely attributed its ability to offer affordable health care to its innovative business principles. The authors used statements by the Chairman and his close associates, other studies, and newspaper reports as evidence to back up their findings. This web of citations obscures the fact that the invariable

conclusion that Vishvam Hospitals had achieved an "affordable solution, with results that were impressive to Western observers" (monograph 2018) never had been scrutinised through in-depth research and was solely based on anecdotal data provided by Vishvam Hospitals. Irrespective of the lack of conclusive evidence, these studies were highly successful. By the early 2010s, Vishvam Hospitals had been firmly established as a canonical example of healthcare innovation from the South that could be mentioned in international publications without further context or elaboration (see, for example, newspaper reports January 2011, March 2011, March 2012, June 2012). In addition, Vishvam Hospitals started to be included in lists of the world's most innovative companies by international business publications (newspaper reports February 2012, October 2019, October 2020).

The lacuna of evidence at the heart of reports and studies about Vishvam Hospitals shows that the remarkable fame it achieved cannot be explained by actual innovation taking place at Vishvam Hospitals. Instead, it was an outcome of the Chairman's ability to tell compelling stories about his vision for health care and the desire of various publics to hear such stories. Indeed, the tale about compassionate care and innovative entrepreneurship struck a chord with various audiences. To a general audience in Australia, Europe, and North America, stories about this charitable hospital offered a positive twist on the long-standing theme of Indian poverty by showing how a new generation of Indians developed innovative solutions to the country's persistent problems without breaking with its spiritual past. In response to an Australian television report, a commentator remarked: "[The Chairman's] benefice combines the most modern satellite technology and the oldest human emotional attribute compassion. [...] You want an upbeat story of man's benevolence to man for a change? Here it is" (newspaper report February 2003). In a letter to the director of the TV report, the Chairman wrote that the TV feature had generated much response: "Our emails have not stopped coming and it is getting jammed very frequently and help is pouring from all over Australia. […] Everyone who has written to us had mentioned that they were in tears when they watched the documentary, made by you" (newspaper report March 2003). The saint-like doctor who was at the same time a successful innovator and entrepreneur provided a compelling illustration of "the complexities and dilemmas of modern India", as another director wrote.

To an Indian audience, the international attention showered on Vishvam Hospitals was an occasion for national pride and a symbol for the country's rise as an emerging economic giant. More importantly, the Chairman's association with a renowned charitable

figure and his compassionate care for the poor fed into the long-standing characterisation of doctors as gods who perform the divine task of healing (see Chapter 4). Thus, TV presenters frequently allowed the Chairman to elaborate on his experience of working in the presence of a divinely charitable figure and how it inspired him to attend to poor patients (TV programmes). In comments sections, viewers expressed their admiration for his work by calling him a "real hero of my country" (YouTube video August 2009), a "true god for millions of people suffering" (YouTube video May 2012), or a "manifestation of god" (YouTube video March 2020). Such depictions of the Chairman as selfless and compassionate offered a welcome counterpoint to the increasingly prevalent perception that the Indian healthcare sector was rotten to its core. In 2012, a popular TV show hosted by a Bollywood actor explored the various problems ailing Indian health care in depressing detail. In the last section of the show, the Chairman was interviewed and given the opportunity to present his model to fix the deeply corrupt medical sector in the country. In the closing statement, the anchor called him an inspiration and example to all the doctors in the country, and the audience stood up applauding (TV programme May 2012).

To an audience of American health and management experts, the example of Vishvam Hospitals reinforced the point that private healthcare delivery was efficient, with benefits for the population as a whole. In the mid-2000s, the Chairman started to receive global recognition as a social entrepreneur combining sound business principles with a social agenda. For example, he received the Social Entrepreneur of the Year – India award by the Schwab Foundation and was invited to the World Economic Forum (newspaper reports November 2005, October 2006). This recognition happened in the context of a discourse about social capitalism, which posits that market mechanisms and private entrepreneurship are the most efficient tools to alleviate poverty (Dolan and Roll 2013; Elyachar 2012a; A. Roy 2012). South Asia played a vital role in these discussions because chief proponents such as the Bangladeshi economist Muhammed Yunus, who pioneered the concept of microcredit for the poor, and the Indian-American organisational theorist C. K. Prahalad, who argued for capitalising on the entrepreneurial capacity of people at the "bottom of the pyramid", developed their ideas with a focus on this region (A. Roy 2010, 62–66). Health experts and management scholars used Vishvam Hospitals as compelling proof that social entrepreneurship worked, highlighting how the Chairman had succeeded in reducing the cost of treatments, making them accessible to the poor. This example was especially compelling to pro-market advocates in the United States because

it allowed them to argue that the problems of the American healthcare sector were due not to too little but too much government involvement. They described the Indian healthcare sector as a free-market laboratory where innovative providers like Vishvam Hospitals could move quickly to put their ideas into practice without being impeded by stringent regulations (see Govindarajan and Ramamurti 2018). Vishvam Hospitals' example showed that free entrepreneurship provided solutions beneficial to all and that healthcare delivery in the United States would soon be outsourced to more innovative Indian providers if American providers were not freed from restrictive regulations (see Richman et al. 2008; Govindarajan and Ramamurti 2018).

The polysemy inherent to the narrative of Vishvam Hospitals as a both compassionate and profitable healthcare model allowed it to appeal to various audiences. These publics bought into the narrative of a revolutionary model of hospital care even though there was no compelling evidence that it operated very differently from other private hospital providers or that it had significantly lowered treatment costs. Instead, the narrative gained credibility through constant re-citation in media reports and business case studies, which referenced each other and created a dense web of intertextual linkages that turned the claims into widely accepted facts. In this respect, the process illustrates what Michel de Certeau (1984, 186) has called “the recited society”, in which the ceaseless citation and re-citation of stories through news media and studies establishes what is real and what people are compelled to believe in.

At the same time, the extraordinary success of Vishvam Hospitals’ narrative cannot be ascribed to media circulation alone. Instead, the power of the narrative critically relied on the persona of the Chairman and his charitable activities, which formed part of the media narrative and exceeded it. William Mazzarella (2003, 18–21) has argued that advertising does not entirely subsume lived reality into an all-encompassing narrative. Instead, its powers emerge from the interaction between the generic message marketing aims to purvey and the concrete life-worlds on which these messages draw and which always go beyond the intended marketing messages (see also Nakassis 2013). This observation suggests that the idea of Vishvam Hospitals’ revolutionary healthcare model was compelling to various publics not only because other reports constantly validated it but also because it was linked to concrete instances of the Chairman helping patients through charitable acts. The persona of the Chairman bridged the gap between these instances of

charitable help and the broad vision of a revolutionary healthcare model and endowed it with its affective resonance, making it into an extraordinarily compelling story.

Even the employees of Vishvam Hospitals, who were intimately familiar with the discrepancy between the media narrative and the everyday realities of the hospital, were affected by its persuasive power. Thus, my interlocutors at the hospital were often critical of the claim that Vishvam Hospitals served the poor and had found an innovative way to lower treatment costs. They did not feel that Vishvam Hospitals did anything radically differently from other hospital providers, nor that it provided a solution for reducing healthcare costs. Some reacted with mild ridicule when I told them that I wanted to understand the hospital's affordable care model, telling me that it could not be done. Others expressed disgruntlement about the unjustified claims the Chairman made. Nonetheless, most of my informants strongly believed that Vishvam Hospitals was different from other corporate hospitals, not because it offered affordable care but because of the Chairman and his vision. In other words, the narrative about the hospital mediated by the persona of the Chairman made it unique.

Conclusion

The emergence of the corporate hospital has transformed Indian hospital care by ushering in a new phase in Indian healthcare delivery. However, the novelty of the care provided by these hospitals cannot explain this transformative impact (Hodges 2016). Indian health care has long been a "mixed economy" (Baru 1998, 43), in which private providers play an important role in healthcare delivery. Corporate hospital groups set up facilities on a significantly larger scale than hitherto available in the for-profit sector and promised a new healthcare experience by providing sophisticated medical equipment and luxurious amenities to those able to afford such services. However, the premier public and not-for-profit institutions equally offered specialised hospital services on a comparable or even larger scale. Moreover, corporate hospitals have struggled to expand beyond metropolitan areas despite ambitious expansion plans and state-sponsored subsidies.

Beyond the services offered, the impact of corporate hospitals resulted from the wide publicity they generated through advertising and media reports. Such publicity poses reputational risks to corporate providers, but it helped establish the corporate hospital as the yardstick by which all other institutions were judged (Baru 2016, 136–37). It

is this publicity, together with their close ties with politicians and other power brokers (Cohen 2011, 43), that has allowed exponents of corporate hospitals to become spokespeople of the industry and exert disproportionate influence on health policy (V. Krishnan 2015). Corporate hospitals also featured prominently in debates about the impact of economic liberalisation, and advocates and critics alike perceived them as key institutions for determining the future of Indian health care.

Corporate hospital providers used the media attention to promote the idea that they offered "world-class" healthcare delivery matching the highest international standards. This promise of a standardised hospital experience was haunted by the inverse image of corporate providers wilfully deviating from proper medical standards to maximise their profits. This image began to increasingly dominate media reports with the economic slowdown after 2011 and the new scrutiny placed on corporate providers with the expansion of government-funded insurance schemes. Vishvam Hospitals promised to offer a solution for making care affordable to the masses by lowering treatment costs through standardisation and technological innovation. The focus on innovative business principles in media reports and academic studies obscured, however, how the success of Vishvam Hospitals depended on the reputation of the Chairman gained through publicised instances of offering charitable support to needy patients.

2 Medical Business and Price Discounts

In the grand lobby of Vishvam Hospitals' multi-speciality complex, a desktop computer station with a sign reading "price information" was prominently placed next to the entrance. It stood out within the lobby, otherwise bustling with activity, because nobody ever approached it. As it turned out, the computer station remained unutilised because it was switched off and thus of no use for actually checking prices and treatment costs. During my twelve months of research at the hospital, it was only switched on for one week of hospital audits. However, this did not make much of a difference because the station was password-protected, and none of the staff present in the lobby knew the passphrase. The abandoned station contrasted markedly with the omnipresent and heavily utilised infrastructures for payment and financial matters. These facilities included the various admission desks where patients needed to obtain financial clearance depending on their sponsor category before being admitted to the hospital. Ten to fifteen per cent of patients went to the scheme office in the basement, where administrators assessed the eligibility of patients seeking admission under a government-funded health insurance scheme. Another twenty to twenty-five per cent of patients visited the insurance and corporate counter on the first floor to obtain the financial clearance that their treatment was covered by private insurance or their employer. The majority of patients, sixty to sixty-five per cent, were self-paying. They gathered in large droves around the various cash counters on the ground floor to make a deposit. Besides, there were package and estimation offices where executives calculated the cost of treatments, and billing desks and financial consultation rooms where patients received their bills and made payments. Finally, various financial services allowed patients to make transactions: ATMs to withdraw cash, a Western Union desk for foreign patients to convert their local currencies to US dollars, and a bank branch to make transfers.

Apart from a rate list showing the price differences between ward categories and the unusable computer station, no information was available about the cost of treatments offered by the hospital. This absence seemed surprising given the predominance of self-

paying patients, who had a considerable interest in knowing about the expected costs and comparing prices between providers. Instead, a financial executive calculated the expected treatment cost based on the information about the treatment provided by the doctor and on pricing tables, which listed surgeon fees, operation theatre charges, bed and nursing charges, costs for medications and consumables, investigation charges, and costs of implants according to the sponsor type and ward category. Partially, the non-transparency of the pricing system resulted from the complexities of cost calculations. Because the hospital administration sought to offer treatments for different budgets, similar treatments did not cost the same for all patients. The price depended on nationality (Indian or foreign), sponsor type (self-paying, private insurance, government-funded health schemes), ward category (from general ward to platinum suite), types of implants (imported or domestic), and categories of medications (innovator or generic) used. At the same time, the administration tried to let patients know as little as possible about its pricing mechanisms. Executives did not share the tables used to calculate prices with patients, and I was generally not permitted to copy them because financial executives told me that they were not allowed to make them available to outsiders. Such information asymmetry was important because the prices calculated for each patient were not settled for good. Instead, they were open to negotiation as patients received individually-tailored discounts on their bills.

In this chapter, I analyse the role of discounts in the medical business of Vishvam Hospitals. I discuss how administrators used discounts to vary treatment prices to ensure that the hospital ran at optimal occupancy levels and to maintain its reputation as a provider that supports patients who are struggling financially. I show how administrators categorised patients by judging their appearance and socially formed way of behaving to determine what kind of discount they should receive. These informal rules provided a structure to the discounting process. At the same time, I highlight how various actors with distinct concerns had a say in decisions about discounts, which is why the allocation of discounts did not follow clearly defined rules but was variable in practice.

There were multiple reasons why patients received discounts. Some patients could make a credible claim that they were poor and could not afford to pay the usual rates. Other patients hesitated to go ahead with treatment or were dissatisfied with treatment outcomes. Still other patients received concessions in acknowledgement of their special relationship with the Chairman or senior doctors. The price reductions granted were often

minor, between ten and twenty per cent, but could run up to seventy per cent, in which cases the charity department of the hospital or external philanthropic funds usually needed to cover part of the revenue loss to the hospital. Importantly, a significant number of patients received discounts in one way or the other. According to financial executives, around sixty per cent of patients admitted for major surgeries in the cardiac hospital received some form of concession. A cardiac surgeon claimed that Rs. 20 million were waived every month in the cardiac hospital, which would amount to ten per cent of total revenue from inpatients according to the company's red herring prospectus. In the multi-speciality facility, clinicians estimated that twenty per cent or more of their patients received some form of discount. None of the senior managers, who possessed reliable data about the quantity of discounts given, were willing to confirm such estimations, but my interviews and observations in the hospitals corroborate that a substantial number of patients received price reductions. Discounts, therefore, were a common and essential feature of business practices in the hospital.

Discounts are not a unique feature of the medical business at Vishvam Hospitals. My interlocutors at Vishvam Hospitals pointed out that discounts were commonly used in both charitable and for-profit hospitals across the country. Indeed, clinicians I interviewed in other corporate hospitals and not-for-profit hospitals suggested that the hospital and doctors would waive fees when a poor patient could not afford to pay the standard rates at their institution. Aditya Bharadwaj's research on fertility clinics (2016a) and Gabriela Hertig's study of stem cell therapies (2019) confirm the ubiquity of patient fee reductions among private providers of medical services in India (see also Zaman 2004). Other studies show that voluntary or government-mandated fee reductions for healthcare services are common in many low-and-middle-income countries (Aryankhesal et al. 2016; Bitrán and Giedion 2003; Meng, Sun, and Hearst 2002). Research on healthcare services in Europe and the United States also suggests that exemptions and waivers have been present in fee-for-service situations (Freidson 2001, 84; Gosling 2017; Pfeffer 1992). Discounts are particularly visible and prevalent in Indian health care, however, due to the predominance of self-paying patients. Even patients covered by some form of health insurance often needed to pay part of their costs out of pocket because government-funded health insurance schemes only covered a limited range of treatments, and private insurance coverage was usually limited to Rs. 5 lakhs annually.

In practices of reducing prices through discounts, it is often difficult to determine where ”genuine altruism ends and commercialism begins”, as Bharadwaj (2016a, 232) notes. At Vishvam Hospitals, the hospital administrators argued that offering price reductions was necessary because they did not want to reject patients for financial reasons. Offering discounts to patients struggling to pay their bills was particularly important for Vishvam Hospitals due to its reputation as a provider with a charitable orientation seeking to make treatment affordable to all people (see Chapter 1). In general, avoiding the perception of being more concerned with financial matters than with the well-being of patients was of key importance in the medical field, which thrived on a humanitarian ethic of helping patients and a rejection of commercialism (see Chapter 4). At the same time, offering treatment at discounted prices was a sound business principle because it made it possible to flexibly set the price of treatments and to steer admissions depending on the capacities available. In the first section of this chapter, I discuss this double function of discounts: they fulfilled an economic function by making sure that the hospital's capacities were optimally used. At the same time, they had a symbolic value by maintaining the reputation as a provider with a heart for the poor that was willing to help patients who struggled to pay for their treatment.

Pierre Bourdieu (1990, 120) argued that symbolic capital – which he defined as a form of “credit” or prestige – is particularly important in fields where commercial activity is viewed with suspicion and disavowed. According to Bourdieu (1986, 18–19; 1990, 112–21; 1993, 75–76), the accumulation of symbolic capital operates according to its own rules, which involve the denial of economic interests, and may entail a short-term financial loss. Nevertheless, he suggested that symbolic capital is ultimately derived from economic capital and converts into material benefits with the passing of time because he argues that “the exhibition of symbolic capital [...] is one of the mechanisms which (no doubt universally) make capital go to capital.” (Bourdieu 1990, 120) Bourdieu's analysis is useful to make the point that discounts partially functioned according to reputational logics following distinct rules, which were not reducible to financial metrics, but nevertheless ensured the economic profitability of the hospital in the long run.

However, the analysis of such general logics does not fully capture the complexity of discount allocation in the everyday operations of the hospital. Economic anthropologists and sociologists using an interpretative approach have suggested that prices are not just economic entities but convey cultural meaning and encapsulate social relations (see

Beckert 2011; Beckert and Aspers 2011; Fourcade 2011; Geismar 2001; Luetchford and Orlando 2019; Zelizer 2011). For example, Olaf Velthuis (2005, 73) argues that price discounts serve "relational and economic purposes simultaneously" in his study of the art market. According to Velthuis (2005, 73–76), the discounts art dealers grant their clients are not simply outcomes of the bargaining power of the actors involved but symbolise the ties at stake in the transactions and are used to establish the quality of artworks. This perspective highlights how discounts were also a means to express and maintain relationships at Vishvam Hospitals. Such relational use of discounts was not opposed to their economic function. Instead, I show how the success of discounts in the medical business depended on the ability of administrators and doctors to employ them to create and convey ties to patients according to the requirements of the situation.

In the second section of the chapter, I discuss how the Chairman and the doctors at Vishvam Hospitals used discounts relationally to forge relationships and establish their reputation. While the senior administrators were primarily concerned with patient flows and financial data, the Chairman sought to manifest his charitable persona by publicly giving discounts to the needy. The clinicians sought to establish their name and a thriving practice by giving price reductions for risky interventions and to maintain relationships. These different concerns did not generally contradict each other, but neither did they always neatly overlap. The multiple concerns and interests involved in the allocation of discounts highlight what economic geographers Nigel Thrift and Kris Olds (1996, 319–20) have called the "disorganization of organization": instead of fixed rules and processes, discounts revealed the ongoing and open-ended negotiations about the rules according to which the medical business of the hospital operates (see Welker 2014, 26–32).

In the third section, I turn to the specific process by which executives decided what price patients should pay for their treatment. Intriguingly, there were no formal requirements for a patient to receive discounts. Instead, the administrators judged the patients' appearance and habitus to determine which patients expected some price reduction or needed financial help. The administrators were keenly aware that patient parties could change their appearance in order to be perceived as needy and make a claim for financial help. For this reason, they considered the patient parties' approach towards bargaining and discounts as signs of their social class. Thus, they argued that wealthy patients would never ask for discounts and would find the suggestion insulting. Poor patients, equally, would never demand discounts but would instead let their desperate situation speak for

itself. Only the middle-income group would actively ask for concessions and bargain the price. Based on such reading of the patients' habitus, executives sought to establish a price for the treatment that was appropriate to patients' social status and socioeconomic situation.

For the executives, granting price reductions appropriate to the patient's situation was not just an economic rationale but also an ethical principle justifying the commercial operations of the hospital. They argued that variable prices were more just than standard prices because patients' circumstances were very different, and it was their duty to take account of this fact by granting discounts of varying quantity. These arguments are reminiscent of Georg Simmel's discussion of unequal prices in the *Philosophy of Money* (see Dodd 2014, 316–30). Simmel (2004, 318–22) criticised the medieval theory of just pricing, which in his reading assigned each commodity an objective price, as static and arbitrary. He equally rejected standard market prices because they do not take account of the circumstances of the person buying the commodity. Instead, he argues that only unequal prices are analytically correct and ethically just because they "adequately express at every sale all the individual circumstances on which they were based" (2004, 319) and thus do not distort the relations present in the transaction. Among the examples approximating this ideal, he discussed variable doctor's fees where patients "pay the doctor 'according to [their] circumstances'" (2004, 318).

The practice of giving discounts at Vishvam Hospitals rarely measured up to this ideal of fairness. There was considerable scope for interpretation in judging patients' circumstances and financial needs, which depended on the specific assessment by executives. Moreover, the actual decisions about discounts hinged on the hospital's occupancy level and financial situation and the specific constellation of interests between the treating doctors, the Chairman, and the administration. While the actual allocation of discounts was variable, the idea that discounts were given in recognition of patients' specific circumstances was nevertheless important because it made discounts work symbolically.

Doing Business with Variable Prices

At the heart of the discounting processes was the head of the administration, Mr Thomas, who was charged with overseeing the hospital's everyday operations. In his capacity, he and his team were responsible for meeting the financial targets set by the corporate office

while making sure that the services were delivered smoothly and to the satisfaction of patients. Mr Thomas was a tall man in his fifties with an athletic build and a booming voice, always impeccably dressed in fashionable business suits. He moved tirelessly through the hospital's corridors, answering phone calls, giving instructions, and attending business meetings. Always on the move, he would sternly acknowledge the respectful greetings from staff by silently raising his hands. In contrast to lower-ranking administrators and doctors, he would rarely be seen having leisurely tea breaks, and his duties seemed to allow him only rarely to stop for a chat. In conversations, his stern expression would give way to reveal an engaging interlocutor with a booming laugh. In these situations, the toll his job was taking on him became apparent as he exhaustedly picked up his phone every other minute to mute incoming phone calls with an air of resignation.

In contrast to many of the other senior employees, who had worked for Vishvam Hospitals continuously since its early days, Mr Thomas had honed his managing skills at other corporate hospital chains before joining Vishvam Hospitals as an operating officer. He defined his mission in terms of reorganising established but wasteful processes according to business principles. He fondly recalled an incident with the nursing superintendent who distributed sweets to the managers during a huddled meeting because the hospital was running at full occupancy. He laughed when he remembered how the assembled staff thought he had gone “bonkers” when he started to scold them for celebrating this event. Clearly, they had not understood the business principles of running a hospital, and he first needed to teach them that the mark of successful business administration was not to fill every bed in the hospital, which would inevitably lead to delays and waiting periods in the treatment process. Instead, the hospital's profitability depended on optimising the “throughput” of patients to maximise the number of procedures and surgeries conducted every day.

Firmly attached to cool business calculations, Mr Thomas was not inclined to discuss discounting practices in sentimental terms but preferred to explain them in terms of sound business practices. Discounts, it emerged from our conversations, served several purposes for the management. First, discounts were part of deals with insurance providers and suppliers of medications and consumables. Such agreements defined the services people insured by the insurance company or corporation could avail in the hospital and the amount to be reimbursed to the hospital. The rates agreed in these Memorandums of Understanding (MoUs) would usually involve a discount of around fifteen per cent on the

cash rates as concessions to the insurance providers to motivate them to cover the hospital's services. In turn, Vishvam Hospitals used its position in the market as one of the largest private hospital chains to negotiate favourable prices with its suppliers. As a purchase manager explained to me, the hospital employed a central purchase unit to buy supplies centrally for all its hospitals and tried to restrict the range of drugs used in the hospital to only one brand per molecule in order to maximise its purchasing power, allowing it to negotiate discounts of thirty to forty per cent on supplies.

Second, discounts served as incentives for patients to go ahead with their treatment at the hospital. Cash-paying patients were routinely offered a ten to twenty per cent reduction on their treatment package to persuade them to get admitted to the hospital. These discounts were usually offered to patients who were perceived to have the resources necessary to pay the rack rates, which meant that they could relatively easily shift to another hospital offering similar treatment. Offering them a discount was a way to convince them that they were getting good deal. "Like all people, especially we Indians have the tendency to bargain", an executive charged with negotiating prices for incoming patients told me laughingly. "So if you say the price of a general ward package, they will still ask: 'Can you please give [the package for] a little bit less?' We have a margin for that. Those kinds of patients […] want the satisfaction that the hospital has reduced the amount for them." Such a sales logic was also at work in price reductions offered to senior citizens or to patients who had undergone a health check-up organised at the hospital. These patients would also be offered discounts on further treatments to keep them from switching to another hospital.

Third, discounts were offered to patients covered by a government-funded health insurance scheme to motivate them to pay for their treatment out of pocket. Such schemes were a hotly contested issue among practitioners and private healthcare providers, who claimed that the rates set by the schemes were not too low to run their business profitably (Raghavan 2018). According to a report by the healthcare industry, the rates reimbursed by government-funded health insurance schemes were only 25–50% of the rates private providers asked from self-paying patients in metropolitan areas (FCCI 2019, 33). In addition, hospital administrators told me that they temporarily blocked accepting patients under these schemes because large sums had not yet been reimbursed. Motivating the patient to pay cash upfront by offering a discount on the cash rate was thus good business for the hospital. "Instead of blindly giving them a scheme", Mr Thomas told me, "we say:

‘I give you a discount on our rack rate’ and then get it done. It's just the time value of money. I rather do it on a discounted cash rate and get cash upfront than wait for a scheme to give me cash after five months. So your cash flow improves.” Obviously, few patients would willingly pay for a service they were entitled to avail for free. The context of these offers was that the hospital limited the number of patients funded by government schemes because it would not be sustainable to run the hospital otherwise. Patients were thus offered the options of waiting until they were admitted under the government-funded health scheme or paying out of pocket at a discounted rate to get admitted immediately. Depending on urgency of treatment, waiting was often not a viable option.

Finally, patients received discounts when the hospital officials judged considered them unable to pay the standard rates. When patients who claimed that they lacked the means to pay the regular rates came to the hospital, administrators would assess their needs and offer them a discount. These concessions were more substantial than those offered to patients who were believed to have money but wanted a financial incentive to choose Vishvam Hospitals over its competitors. To be considered for a significant concession, patients needed to be able to pay at least one third of the rack rates from their funds. According to Mr Thomas, the hospital was neither making nor losing money in these cases, but rates charged could not go below the break-even point for the hospital unless other sources covered the difference. In instances of discounts of more than thirty or forty per cent on the usual rates, the hospital would therefore expect its own charity department or other philanthropic funds to cover some of the difference; otherwise, such reductions were not given.

In general, the hospital administration treated patients admitted at a significantly discounted rate like patients covered by a government-funded health insurance scheme. Both of these categories were not considered lucrative business, which is why the administration sought to limit them to maintain the hospital's profitability. According to Mr Thomas, the administration aimed to limit the percentage of patients admitted under government-funded health insurance schemes to fifteen per cent of its admissions, which matched the information and numbers I received from other administration members. However, such a general target was a too static approach to determining how many such patients would be admitted on a given day. Thus, Mr Thomas used financial analytical tools to define how many patients covered by government-funded health schemes or getting a significantly discounted price could be admitted on a given day: “We have period

analysis: How many admissions for the day, how many cash admissions for the day, from which the areas have they come, current trend, what are we trending against budget. So based on that, what I do is, I say okay fine, don't go too hard. […] If it is a good month, it's looking good, I say we can still take some more." Using such analysis, the administration could, Mr Thomas suggested, admit a certain number of poor patients without compromising its profitability.

When I pushed Mr Thomas and other administration members on the question of why they admitted patients at a subsidised price or covered by a government-funded insurance scheme at all, despite their claim that such patients were not financially lucrative, their responses allowed for considerable interpretation. On the one hand, they suggested that they admitted such patients for reputational reasons. After all, the Chairman was known for his "Robin Hood" model of making treatment available to all people and as a pioneer of health insurance for the poor rural population. For this reason, the administrators could not "altogether veto" the admission of such patients, but they were "controlling" it, as Mr Thomas put it. On the other hand, even patients admitted at a discounted price could improve profitability under certain circumstances, namely, when their bed would otherwise remain empty. "A slot lost for that day can never be postponed", Mr Thomas explained, "a slot lost for the day is lost forever! So I'd rather be penny wise than pound foolish." Profitability was not a fixed threshold but depended on the occupancy level of the hospital. When beds were available, admitting patients at a heavily discounted price was still more lucrative than not using the capacity at all.

To some extent, the administration's perspective on discount practices turned the Chairman's Robin Hood model upside down: rather than treating wealthy patients in order to be able to offer subsidised treatment to the poor, the hospital was treating patients at subsidised rates to the extent that there were no more profitable patients available. For the administration, discounts were a valuable tool because they could function at two levels simultaneously. On the one hand, discounts fulfilled an economic function because they allowed to adjust prices to the needs of the situation. On the other hand, discounts also operated on a symbolic level, creating a reputation for the hospital as a provider that was not only concerned with profits and had a "soft spot" for poor patients. This duality of purposes turned discounts into a highly flexible solution for medical providers.

However, navigating the economic and symbolic dimensions of discounts also created problems for the administration because there was no proper "exchange rate"

between economic and symbolic capital (Beckert and Aspers 2011, 6; cf. Bourdieu 1986). The administrators could never be sure whether they were wasting money by giving away a treatment slot at a discounted price because a patient willing and able to pay the regular price might just be waiting around the corner. Besides, the reputational benefits accruing from being perceived as a provider willing to accommodate patients with constrained financial resources could not be quantified in economic terms. To a business administrator like Mr Thomas, who was primarily concerned with financial metrics, giving discounts was a somewhat imprecise practice, which he seemed to tolerate as a necessity rather than advocate as an ingenious business principle.

The Multiple Logics of Discounts

The management's ability to streamline the discount process according to their financial prerogatives was complicated by the fact that it depended on the collaboration of other actors in the hospital. Apart from the administration, the Chairman also had his specific logic of giving discounts to patients. Generally speaking, while the administration tended to prioritise economic considerations with an eye on maintaining the hospital's reputation, the Chairman placed primary importance on the symbolic dimension of giving concessions. The Chairman was widely revered in West Bengal and Bangladesh, from where many patients came to the hospital who, having made the long journey, wanted to meet the Chairman personally. To respond to this demand, the Chairman would see as many patients as possible in his outpatient consultations and then refer them to other cardiologists and cardiac surgeons for further treatment. Given that the Chairman's motto, frequently repeated in the hospital, was that no patient should be rejected for financial reasons, doctors and administrators agreed that the Chairman seldom denied the requests of patients who approached him for financial help. As one doctor put it: "The Chairman leaves mentioning the difficult things to others, which is fine. It is his job to say yes." To ensure that discounts given by the Chairman did not drain the hospital's finances, administrative staff would be charged with screening patients to distinguish people who had a good reason to seek his advice for medical reasons from those who only wanted to see him to ask for financial concessions, and to restrict the latter group. However, such rules could not be enforced too strictly, as the opportunity to meet the Chairman personally was important for maintaining his status among the Bengali and Bangladeshi patient communities.

The giving of discounts by the Chairman was a public act, which was intended to be witnessed not only by the patient party receiving the financial help but also by others. To this end, more than one patient party would usually be called into the consultation room and made to wait on the sofa in one corner while the Chairman was consulting patients at his desk. For example, a young IT professional told me how he had witnessed such acts of benevolence by the Chairman: "Have you seen the room where he checks his patients? While he's taking one patient, the other patient is waiting inside the office in another corner so that there is no time gap. Once he leaves, the other patient just goes, no break for him. The patient that was before me, I guess she was having some financial issues, and the Chairman made a call and asked can you waive off her operation fees. That just happened in front of me. He's done a charity I'm pretty sure. I heard of it, but I saw it also." In this way, giving discounts to poor patients demonstrated the Chairman's benevolent powers to other patients, who did not need financial support themselves but felt moved by the charitable help they witnessed.

The Chairman did not only reduce fees for poor patients, however. He also gave treatment for free or at discounted rates to expand his network and establish connections. For example, a sociology professor stated that he had received heart surgery for free at Vishvam Hospitals because he knew the Chairman. Similarly, financial executives told me that they were instructed not to ask for payment when patients were personally known to the Chairman or senior doctors, and that such patients had received significant discounts on their bills.

Such discounts were not given selflessly but served certain strategic ends. Thus, many doctors believed that the Chairman primarily gave discounts to people from West Bengal and Bangladesh, where he was most revered. Doctors disapprovingly interpreted this as a personal preference for people from that region over local people. However, as one executive pointed out to me, it also had to do with the fact that government-funded insurance schemes did not cover these patients, and the belief that the Chairman was helping those who struggled financially was an incentive to convince them to make the long journey to Bengaluru. Similarly, giving discounts to patients known to the Chairman or senior doctors was a way to maintain social relations, create a network of potential patients, and establish ties with people in positions of influence. These people could afford to pay the standard price, but giving them treatment for free or at a discount served to create a certain indebtedness and establish a special relationship with the hospital. In this

way, giving discounts to the poor and to people of importance to the hospital was part of the medical business. However, such practices did not follow the logic of financial calculations used by Mr Thomas. Instead, they manifested the benevolent powers of the Chairman as a charismatic leader (see Chapter 4).

Besides the Chairman, doctors also played an important role in suggesting discounts. Officially, the hospital administration was in control of financial matters, while doctors decided about treatment. However, in practice, financial and medical spheres overlapped (see Chapter 3), leaving doctors with several avenues to influence the decision process. Formally, doctors could suggest to the administration that a patient should receive a discount, and they were asked to provide information if patients approached the administration for discounts. "I say [to the administrators]: 'This patient has come; he is poor in my opinion. He is unable to pay his bill. Please do help'", a cardiologist explained. "I call them if it is really urgent, and then they see if they can help. Most of the time, they do help to some extent." Doctors disagreed to what extent they could influence the administration's decision. Senior consultants suggested that the administration never denied a discount to a patient if they suggested it, while some of the younger doctors felt that they did not have much of a say. This perception reflected the difference in power vis-à-vis the administration between senior doctors in high-revenue generating departments with an established patient clientele and younger doctors in less lucrative departments who struggled to establish their reputation. Doctors who generated much revenue for the hospital had more freedom to suggest discounts because they had more power within the hospital community and could compensate for the loss of revenue at a later stage.

Apart from formally approaching the administration, the doctors had several informal ways to tweak the patients' bills. Doctors suggested that "under-billing" was something they had learned in "grad school" and was commonly practised. When I asked a young doctor whether she needed to approach the administration to waive a bill for a needy patient, she answered: "I can decide on my own because I'm the one writing [the bill]." She abruptly stopped speaking and refused to continue discussing the topic, mentioning that she was scared now. Indeed, changing bills was a sensitive topic, not only because it was against the policy of the hospital but also because it raised suspicions since if doctors under-billed patients, they might as well over-bill them. Nevertheless, off the record, doctors discussed freely how they informally found ways to influence how much patients were charged. These ways included: dropping items from the bill; billing patients

for a different treatment; shortening the time spent in the operation theatre; using free sample drugs to treat patients; allowing patients to purchase drugs outside, which was cheaper than buying them from the hospital; asking colleagues to see a patient for free. One senior consultant suggested that doctors often combined a discount from the hospital with dropping items from the bill in order to "spread out" the costs "both to yourself and the hospital."

Why would doctors offer discounts to patients even if this involved some professional risks or a financial loss to them? Some doctors argued that they had learned from early on to "try to find solutions" and "make things happen" for the patients without letting "money stand in the way." This imperative to treat patients without letting monetary matters stop them was a critical part of doctors' (self-)image (see Chapter 4). Clinicians often framed this commitment as a form of humanitarianism that emerged from being directly confronted with the suffering of patients. "Doctors are in the top 5-10% of earners in India", a senior consultant pointed out. "Most of us are not in a financial crisis. But the guy in front of you is taking a loan [to pay for the treatment]. So we do what we can." Such humanitarian concerns were not opposed to sound business principles, as the consultant readily agreed. Thus, he suggested that discounts were also an "investment in Vishvam Hospitals' name" and that giving discounts provided "returns of investments" apart from the "bottom-line". As for the hospital as a whole, helping patients also contributed to building a reputation for the individual clinicians who needed to establish their name to flourish financially because their earnings in the hospital depended to a considerable extent on performance-based incentives calculated from the number of procedures they conducted. The perception that they "made things happen" for the patients was thus critical for their reputation.

Doctors were, however, not only interested in financial rewards but also in attaining and expanding their professional credibility by doing research and performing complicated, novel surgeries (Bharadwaj 2016b). Thus, doctors also suggested that they gave discounts to patients whom they found medically interesting to treat (see Solomon 2016, 198–99). "Every time we want to do something which is fairly exciting or new which we have not become experts in yet", a senior consultant explained, "we don't believe it is right to charge patients without having acquired expertise. We go to the Chairman or the director. They will say: 'Yah, we can waive off this, get your expertise in this area first.'" Such discounts offered to patients undergoing risky or novel surgeries point to an implicit

contract according to which patients who paid good money for their treatment expected a good outcome as well (Bharadwaj 2016a). The discount in this arrangement is thought to compensate in advance for the additional risks taken. At the same time, the fact that the patient in question was, according to the senior consultant, a “poor patient” suggests that such discounts were primarily extended to patients who needed financial help to go ahead with the treatment. This was the case in clinical trials conducted at the hospital, in which predominantly patients from the lower socioeconomic strata participated as upper-class patients often were suspicious about taking part and were not dependent on the benefits of participation such as free treatment or medications, as consultants explained. While doctors suggested that they extended discounts to patients they found interesting to treat, they denied using poor patients as guinea pigs. When I made this suggestion to a consultant, he pointed out that taking risks and trying novel techniques went “both ways”, as avoiding risks could be detrimental to the patient while taking them could lead to excellent outcomes.

For the clinicians, the desire to treat patients seeking their advice, the concern for establishing their reputation and the interest in attending to medically challenging cases drove the allocation of discounts. These intersecting concerns were not a priori opposed to the aims of the administration, which also wanted clinicians to establish a good name and a thriving practice. However, the fact that doctors used informal ways of tweaking bills suggests that the interests of individual clinicians and the administrators looking at the company's revenue as a whole did not always neatly align. In addition, doctors’ ability to informally influence how much patients were charged meant that the administration could not simply ignore their wishes but needed to accommodate them to some extent at least. For this reason, the administration’s prerogatives did not necessarily take precedence over those of individual clinicians. Instead, the actual allocation of discounts resulted from compromises between the administration and the treating doctor.

Due to the fact that the Chairman, clinicians, and hospital administrators had different concerns with the allocation of discounts, the actual dynamic of giving discounts in the hospital did not follow a uniform logic. Instead, it emerged from open-ended negotiations between these actors, in which it was not pre-determined whose concerns would prevail in a given situation. To be sure, the hospital's profitability provided the framework in which these negotiations took place, and none of the actors involved

wanted to or could allocate discounts in ways that went against the overall aim of profitability. However, the complexity of medical business resulted from the fact that the various actors did not necessarily agree on how profitability was best achieved. While the administration was concerned with financial metrics, the Chairman's public actions were primarily geared towards maintaining a beneficial image of himself and the hospital. The clinicians, in turn, were convinced that their professional reputation was vital for the success of the institution as a whole. These various concerns were not incompatible, but they did not neatly align, either.

Categorising Patients and the Just Price of Treatment

To understand the workings of discounts in medical business, it is not sufficient to discuss the various interests of the actors involved. It is also necessary to understand how the actual practices of allocating discounts unfolded in the everyday. To this end, I visited the estimation office located in the basement of the cardiac complex. The office was a simple windowless room furnished with two faux leather sofas and a wooden desk with a computer and a pile of patient dossiers. Patients came here after their consultation with a doctor in the hospital who had suggested a treatment plan. Self-paying patients received an estimation of the expected cost, according to which they had to make a deposit before continuing with their treatment.

On this afternoon, a Bangladeshi couple was sitting on one of the sofas, huddled together. The woman was dressed in a green salwar kameez and a headscarf draped loosely around her head. She tried to restrain a baby on her lap that had started to empty her handbag and was now playing with the golden bangles it had found there. The man wore simple cotton trousers and a plain shirt. He was whispering with his wife while Aarthi, an energetic financial executive in her early thirties, was silently typing on her computer. After a few minutes, she printed a paper with the estimated cost of 2.6 lakhs for the heart surgery the baby required and told them that they needed to pay at least Rs. 80,000. The remaining amount would be partially covered by charity and partially deducted as a concession by the hospital. The man calmly objected that they could not afford this amount. Aarthi replied sternly that they had reduced the amount a lot for them and that they should be very grateful for the help. The woman started to cry and dried her tears with the edge of her headscarf. Ignoring her, Aarthi called a colleague to guide them to the charity department, where the next steps would be decided. After they had left, I

asked Aarthi in a hushed voice if the couple did not need more help, still shocked by the suffering I believed to have witnessed. Aarthi dismissed my consternation and asserted that the family was somewhat poor but that they had some money, which they were unwilling to spend. I asked her how she knew. She inquired in return whether I had noticed that the woman had hidden her bangles in the bag, and how uneasy they became when the baby took them out. They were trying to appear poorer than they were.

Throughout several mornings and afternoons I spent in Aarthi's office, I watched her calculate the expected cost of treatments and negotiate the payments the patient parties needed to make and observed how she subtly adapted the style and content of the interaction to the needs of the situation. Giving these estimations was challenging because prices for the treatments were not fixed but negotiated with the patient. While there existed tables to calculate the cost for each ward category, these prices often served only as a reference point for the discussion with the patients. If there were no specific instructions from the Chairman, senior management, or doctors, executives were free to decide what discount a specific patient needed. The process of allocating discounts was not random, however, but was partially standardised through a set of tacit rules. For example, executives knew that they could routinely give a deduction of up to twenty per cent on the general ward package if they felt such discounts were necessary to convince the patient party to go ahead with the treatment. Executives could also suggest more significant deductions, in which case charity often covered part of the cost, as in the case of the Bangladeshi family. Such deductions could, however, only rarely be given, and the executive needed to be ready to defend such decisions vis-à-vis their superiors.

Importantly, the executives and managers did not rely on documents in making decisions about discounts. Hospital staff explained that documentary requirements for discount decisions would prevent deserving people from receiving help because documents could easily be forged. "In our country, anybody can get any kind of certificate", an administrator put it. This claim had some credibility because some hospital employees showed me their below-poverty line certificates and ration cards, which they possessed without fulfilling the requirements as they readily admitted. Therefore, many administrators felt that asking for documents would only introduce bureaucratic hurdles impeding the proper allocation of financial support. "Sometimes", a billing manager explained, "the husband is the patient, and the wife is looking after him. She is not a working woman. Obviously, anybody's family, if that happens, he'll be bankrupted because he's earning,

and he himself is the patient. There's nothing you ask for a document for it." At the same time, not having specific requirements prevented discounts from becoming a right patients could demand. It thus allowed the hospital administrators to give discounts as they saw fit and to flexibly manage the patient flow depending on the situation and in accordance with the variable logics underlying discount allocation. In the charity department, photographs and some information about patients were collected, but this information was mainly used to inform donors about the way their contributions were used, rather than to decide who received help first, as the officials explained to me. Patients needed to provide documents such as income certificates or ration cards only in applications to certain philanthropic funds. Documents were thus required in dealing with external agencies, but hospital administrators did not consider them to be necessary for making internal decisions.

To determine whether a patient should receive a discount or charitable support, hospital administrators asked patient parties some basic questions to inquire where they lived, how they earned their income, and how they had travelled to the hospital. In some cases, they also discussed the case with the treating doctor or inquired with the administrative staff, who often had a surprisingly extensive understanding of the patients' situation based on small talk with the various relatives of the patients while completing the admission formalities or during the long hours spent waiting for the doctor or visiting the patients. Such information was only available if the patient had spent some time at the hospital and, for practical reasons, it was not feasible to discuss every case with the doctors. Instead, estimation executives like Aarthi often relied on their impressions gained in a couple of minutes of discussion with the patient to make initial assessments.

In assessing a patient's financial situation, the administrators stressed that the interpretation of bodily signs played a central role. "If you see, one eye watered as soon as I said [the estimated amount]", Aarthi explained. "So much you need to see when you sit in an estimation desk. Not always will people open their mouth and ask for a concession." Some executives told me that they looked at the hands of the patient parties to see if their skin was rough from manual labour. Others suggested that they looked for marks left by jewellery to understand whether the patient parties had removed their ornaments to conceal their wealth and social status. Whatever their methods, they argued that they could make out if a patient had money or not by looking at them. "A lady carrying a small child", a manager explained, "you can look at them, and you will be able to judge what kind of

affordability they have. If they are going to do the surgery here or elsewhere." Looking in these instances referred not only to judging people's physical appearance because the administrators stressed that patients could take off their jewellery and put on old clothes to appear needy. Crucially, looking involved scrutinising their socially formed behaviour, what Bourdieu (1990, 53; 1984, 172–73) described as *habitus*, the set of "durable, transposable dispositions" that regulate practices and mark a person's social class. Thus, a billing manager explained that he could evaluate whether patients were really poor or just pretending by considering their "attitude": "See, you can identify the person by looking at the face, body language or personality. […] The approach will be different. You see, if you're just looking for some discount, your approach will be different, and if you're really not affordable, your approach will be different. […] The attitude you will get to know." Did a patient confidently demand a discount or humbly beg for financial support? The manager suggested that these socially ingrained ways of behaving would shine through even when patients changed their appearance by taking off their jewellery and putting on different clothes.

During estimation sessions, executives like Aarthi classified patients broadly into three categories and interacted with them in distinct ways. The first category consisted of affluent patient parties for whom the cost of treatment was not much of a concern. These patients usually opted for the private wards and received estimations with standard package prices calculated with the help of tables for the various treatments. Unless they were known to the Chairman or one of the doctors, discounts never figured in these conversations, and mentioning them could even be considered insulting. During an estimation session, a middle-aged woman wearing a smartwatch and jeans interrupted quickly when Aarthi began quoting the prices for the cheaper ward categories and told her that she only considered private or deluxe categories. Aarthi took up the unmistakable hint and treated her with special amiability. She also shared the number of the deputy general manager of the hospital so that the patient could reserve a room in advance and would not need to wait when arriving at the hospital. When the patient could not decide whether to choose a private or a platinum ward, she recommended the cheaper room given that there was not much benefit in the suite rooms and the stay would only be for two days. Afterwards, Aarthi asked me if I had noticed the difference in how she talked to the patient and explained that giving the contact number and not appearing greedy were crucial strategies to make well-off patients feel welcome.

Apart from patients from the upper socioeconomic strata who took pride in not having to pinch pennies, there was a broad range of patients who were sensitive about the cost of treatment and wanted to receive some discount. This group was subdivided into those patients who were able to cover the cost of their treatment by themselves and those who were unable to do so. Distinguishing between these groups of patients was an essential task of estimation executives. The former category included patients who were covered by some government-funded insurance scheme but unwilling or unable to wait until a bed in the scheme wing became available and therefore agreed to pay in cash out of their pocket. It also included patients who were unwilling to pay the standard package price because it strained their resources or because they felt they could get the same treatment at a lower price elsewhere. Finally, some patients wanted to stay in a higher-priced ward without being able or willing to pay more, for example when a patient party required a semi-private ward so that a relative could stay with the patient, which was not allowed in the general ward. In these cases, patients would be offered discounts of about ten to twenty per cent of the treatment costs. In deciding the amount of the reduction, the executives were faced with the problem that this group included a wide socioeconomic range of people, from small-shop owners who struggled to make ends meet to professionals with a good salary, and the severity of the illness and the cost of the intervention required mattered as well. The executives' skill was to give as much discount as was required to convince the patient to get admitted to the hospital but as little as possible to ensure the highest profitability for the hospital.

According to the executives, a vital characteristic of this category of patients was that they actively asked for the discounts and bargained the prices. At times, these negotiations proceeded in a seemingly easy-going and playful fashion. In one of the sessions, a man in his thirties wearing Crocs shoes, jeans and a polo shirt who explained that he worked “in the mango business” inquired in meticulous detail about the costs and the admission process. When Aarthi explained to him that the total costs for the surgery were 4.69 lakhs plus Rs. 800 for administration charges, he laughed and quipped that “at 4.69 [lakhs] you’re not gonna jump at 800 bucks.” “Since I’m putting cash down”, he continued, ”is there any sort of discount I will get or is there somewhere you can help me out? […] I was prepared up to maybe four [lakhs], four is where I was running at. Now it is 69,000 more than that. Fifteen per cent increase, no, more than that, twenty per cent increase.” – “That is what I’m thinking as you’re talking,” Aarthi replied, “so approximately

I can reduce 30,000." "Fair enough, fair enough. So it brings it about 4.38 for the general [ward]. Should I decide for the semi-private [ward], it will be five [lakhs]?" – "Yes, but I can give you only one estimation." – "So for now, give me the general. See, going up is easy; going down will be challenging. So give me the base. I will work on the price", he concluded and sighed.

In other instances, the discussions were more heated. A Bangladeshi patient and his brother, both dressed in jeans and T-shirts, were visibly agitated when Aarthi told them that the coronary artery bypass graft would cost them 2.3 lakhs. "I just came here for checking purposes. That's why we're not prepared for …", the patient objected and paused, "can you get us some discount?" He explained that he only had Rs. 70,000 but could maybe borrow some money here and bring it to 1.2 or 1.3 lakhs. Aarthi replied that she could give a discount of 10 to 15,000 but that 2.1 lakhs was the lowest amount she could offer. When she would not lower it any further, the brother of the patient intervened angrily. "We're very poor persons, and we came here from a poor country." – "That is right, sir," Aarthi replied, "but you also have to think. With 1.20, 1.30, we cannot do it." – "The patient here is my brother. He's doing a lowly job." – "I'm working here in a company, and I cannot tell what I can't do." – "Yes, I know, but if you want, then you …" "This is not my hospital to give concession on my own." After they had left, she explained to me why she wouldn't give a larger discount. "He is not poor. And he has kept all his blazers, suits at the office, in his room and must have come in this costume. Did you see the way he was bargaining?! He was telling: 'I'm only having 70,000. If I manage something from other people and all, I can arrange 1.20 lakhs.' You're in a foreign land, who will give you money? When those people also have come for medical needs? […] That means he has the money, but he is not willing to spend. He will again come back. We won't be losing." This interaction highlights that executives generally frowned upon aggressive bargaining. In this and other instances, outright demands for discounts were interpreted as a sign that a patient was not really poor and was just seeking some financial benefits.

The "truly poor" were the third category of patients, those whom executives believed could only bear a small part of the treatment cost themselves. These patients required a significant reduction of more than twenty per cent on the cheapest package. Such discounts were only given in specific cases and generally required charity to cover

at least part of the outstanding amount. Paradoxically, not to bargain was a crucial criterion for being considered for such a discount. As one doctor put it: "Poor patients, they don't bargain. Only rich patients will bargain. Poor people, if it is 1.5 lakhs, they say: 'Sir, it is costly for me, but I will come back with money.' Only the richer community will ask for concessions." The logic of this belief appeared to be that bargaining requires a sense that one has something to offer in exchange for the price reduction. In other words, it requires the conviction of being important enough to demand a discount. In contrast, in this view, the "really" poor did not have this sense of entitlement and therefore did not press for a price reduction. Instead, they let their poverty and desperation speak for themselves and put themselves at the mercy of the hospital representatives witnessing their distress and responding accordingly.

One executive told me a story that contrasted this behaviour of the faux poor who concealed their wealth and asked for discounts with the really poor who let acts of desperation speak for themselves.

> Ten years back, one patient came. He was looking soooo poor. Then he asked for a discount. I gave around 10,000 discount after discussing with [the billing manager]. While going, he came with a big sweet box and a very big bracelet, two, three neck chains and a 36 lakhs car. Then I really felt bad. From that day, I decided not to help anyone. But one day, one old lady came, she did not have money. I requested my boss; he said no. Then that lady, what she did, she was removing her nose ring. I did not know for what. She said: 'Please keep this and discharge my patient.' I felt bad. Luckily, [the billing manager] saw that: 'Really, don't take that!' And then I said: 'Regarding this patient, I spoke to you.' Then he said: 'Okay, okay, close the bill and send.'

Such stories highlighting the difference between patients who were trying to trick the hospital and those who truly needed help were popular among administrators and clinicians, all of whom had stories to share of how some patients had tried to delude them about their true situation and how they had helped some deserving patients in need. These stories demarcated the realm of bargaining for the best price and the sphere of charitable help. The latter sphere did not operate according to the logic of the "bazaar", where the bargaining power of the actors involved defined the price (see Alexander and Alexander 1991; Fanselow 1990; Geertz 1978). Instead, it involved making claims for discounts through symbolic acts that powerfully demonstrated the desperate need of the patient and their family.

At the same time, these stories also pointed to a specific sense of justice and fairness that executives considered to form the basis of discount allocation. Executives were concerned that the price established through discounts should reflect the true situation and

identity of the person receiving the discount. They suggested that they had an obligation to "help" patients in need, while it was the patients' "duty" to pay according to their socio-oeconomic circumstances. Consequently, executives were upset about the "big shot guys" who presented themselves as persons of importance and influence but asked for a large discount on their bill. They also derided patients who claimed to be in dire need but were later seen "going on shopping" and "wasting their money" in front of them. In contrast, they fondly remembered the gratefulness of patients whom they had been able to help and who still contacted them after many years. They also pointed out that they made considerable efforts to prevent concessions to the wrong people. For example, Aarthi related how a couple from Bangladesh went to see the Chairman, who ordered that they should receive a discount on their surgery. When they came to her for the billing, she found out that they had relatives in Dubai and had come from Bangladesh by plane, which implied, in her view, that they were relatively well-off. She therefore refused to give them the package despite the Chairman's wishes. When the patient party went to the Chairman again with the estimation to complain, his secretary called her and said that the Chairman would scold her. Nevertheless, she refused to change the estimation: "I know [the Chairman] will scold me. But he doesn't know that drama down here." While Aarthi would presumably not be questioned for giving a discount the Chairman approved, she nevertheless did not want to give the concession based, in her view, on a wrong assessment of the patient's identity.

The idea that patients should pay according to their means corresponds to Georg Simmel's notion of "perfect money" as an ideal form of money that does not disturb the structure of society in which it circulates (Dodd 2014, 316–30). To achieve this ideal, prices must be adjusted to the person purchasing a good so that the price adequately reflects the situation of the individual in relation to society as a whole (Simmel 2004, 318–22). Administrators similarly suggested that discounts allowed them to vary prices according to the specific situations of patients. "Here at Vishvam Hospitals," Aarthi explained, "we don't believe in fixed price like that. Each patient is different. Each patient will be having a different background or different set of things and all that. We'll talk to the patient, and then we will come to know what type of person they are. Based on that [we make a decision]. […] We cannot operate with thumb rules here. We deal with patients separately. Because, in the outside world, all the people's life is not the same."

Varying prices according to patients' circumstances was not only a sound business principle in the executives' eyes but also an ethical proposition ensuring the fairness of the process.

Even as an ideal, varying prices through discounts was not a benevolent arrangement. Instead, it demands that patients pay as much as they can afford for their treatment. "Nobody will walk without money, right?" an executive said, "they may have at least 50'000 or something. Whatever they are able to afford that we will take from the patient." Moreover, discount allocations were often highly contingent in practice and thus did not correspond to the ideal of fairness proposed by the executives. Executives could easily misjudge a patient's situation, as the frequent stories of trickery suggested. Moreover, executives had considerable leeway for making decisions but they needed to stay within the limits set by the senior administrators. In practice, they often had to balance the requests of doctors asking for a discount for their patient and the prerogatives of the administration concerned with limiting the amount of discounts given. According to Aarthi, executives were "like the *tabla* [twin hand drums], getting beaten from both the places" because they had to accommodate the wishes of different masters.

For this reason, whether patients received discounts depended on several factors and the specific concerns of the various actors involved. For example, patients told me that they received a discount because they managed to contact the Chairman, while people in similar circumstances they knew did not get a discount because they could not arrange a meeting. Other patients stated that they had received a substantial price reduction on bone marrow transplants at the hospital, which they otherwise would not have been able to afford. After some time, the cancer had come back, but the treating doctor told them that no financial help was available this time. Instead of following a clearly defined system, the allocation of discounts happened variably, depending on what kind of concerns prevailed in a given situation. Nevertheless, the idea that discounts should reflect patients' socioeconomic situation provided a certain structure and an ideal of fairness that was important for justifying discount decisions and providing patients with a sense that doctors and administrators did not just follow bureaucratic rules but considered their unique circumstances.

Conclusion

In this chapter, I have analysed discount practices at Vishvam Hospitals to understand the workings of the medical business in corporate hospital care. Hospital administrators at Vishvam Hospitals employed discounts as a flexible solution to navigate seasonal fluctuations and ensure that the hospital's infrastructure was optimally used. In a situation where most patients were self-paying, variable prices provided an additional incentive for undecided patients to go ahead with the treatment, depending on whether unused capacities were available. At the same time, giving discounts to needy patients was an important symbolic act allowing to demonstrate that the hospital representatives were concerned with their patients' well-being and not only with their balance sheets. As a tool that allowed to vary prices without any formal obligation to grant concessions, discounts offered a compelling solution to navigate the vagaries of for-profit hospital care.

However, the allocation of discounts came with challenges. On the one hand, several actors with their specific concerns were involved in decisions about discounts. The Chairman used discounts symbolically to manifest his benevolent persona and market the hospital through word of mouth and media reports. Doctors granted discounts to deepen relationships with their patients and to establish a reputation of not letting financial considerations stand in the way of providing care. The administration's role was to make sure that the discounts suggested by clinicians and the Chairman did not negatively impact the hospital's profitability while allowing a certain amount of discounts to accrue reputational benefits. This task was complicated because there was no way to measure the symbolic benefit of discounts and because the administration could not simply ignore the wishes of doctors as a powerful group within the hospital. In the absence of clearly defined rules, discount allocation resulted from ongoing and open-ended negotiations between these various actors in the hospital.

On the other hand, discounts needed to be allocated to the right people in the hospital's everyday operations. From the overall perspective of profitability, it mattered little which patients received what kind of discounts as long as the concession granted did not exceed a specific limit. However, in actual practice, administrators needed to ensure that the right patients received a reduction appropriate to their circumstances because executives and patients perceived discounts as personalised concessions. For example, I interviewed an elderly couple that was deeply upset that they had only received a discount of Rs 10'000 on their bill of 5 lakhs even though they were struggling financially and were

in a difficult situation because their sons were not supporting them. They had been able to finance the surgery without going into debt, but they felt treated unfairly because the hospital employees had failed to recognise their plight. For a bond to be established and the hospital to be successfully marketed, patients needed to feel that discounts were distributed fairly and that their specific situation had been taken into account.

Instead of requiring, and relying on, certain documents, administrators judged patients' appearance and habitus to decide what discounts should be offered to which patients. This intriguing approach of informally awarding discounts was a practice with a cultural pedigree. In a study of market practices in Cairo, Julia Elyachar (2011, 84; 2012b) suggests that readings of embodied gestures are prevalent in former colonies that once were part of empires where bodily practices acquired particular significance as signs of social status resulting from "historically generated systems of privilege and power". More specifically, such practices are common in Indian medical practice. For example, Mark Nichter (1983, 958) describes how clients made an initial offering to healers and practitioners in rural Karnataka, who would then decide on the adequate course of treatment. The amount offered and the manner in which clients presented the offering determined what treatment the specialist advised and its price (see also Bharadwaj 2016a, 229–30). Such reading of appearance and habitus to determine the price of treatment thus imitates the diagnostic gaze of doctors. The fact that such practices have been common to the medical field in India suggests that corporate hospitals continue established business practices rather than radically altering them.

3 Variable Treatments and Profitable Medicine

In front of the cardiac building at Vishvam Hospitals, surrounded by a well-kept lawn and artfully pruned bushes, a shrine was located, divided equally into four places of worship. The sections were devoted to the main religious faiths of the patients visiting the hospital: a Hindu mandir with a black Ganesha statue adorned with garlands and saffron cloths; a Christian chapel with statues of Mary and Jesus Christ; a Muslim masjid with calligraphic inscriptions, a table with prayer timings, and a store of prayer rugs; and a Sikh gurudwara with a decorated stand and pictures of the Golden Temple. Patients and hospital staff frequently visited the shrine to pray or to simply sit in the shade under the protective presence of their god or deities.

Such places of worship are a familiar feature of hospitals in India. However, this shrine had a special significance for the employees of Vishvam Hospitals. Apart from its religious function as a place of worship, to the doctors and staff it symbolised the mission of the hospital: to provide care to all patients, whether they came from nearby or far away and whether they were rich or poor. For example, a senior consultant described how he first saw the shrine when he visited the hospital to discuss the terms of his employment, and he immediately made up his mind that he wanted to work here: "Frankly one of the things I loved about this place as I walked in [was] that little religious centre in the front, which had four different religions together. I worked for a few months in a private corporate hospital, where I was only seeing rich people. Then I came here and was seeing people that were not obviously as rich. People from all classes. And I said: 'This is the place I want to be.'" For the doctors and staff, the shrine represented the diversity of patients at the hospital, not only in terms of religions but also with respect to geographical origins and social classes.

In this chapter, I examine how the promise to offer medical care equitably to diverse patient groups worked in the actual practice of healthcare delivery. As a provider offering specialised hospital services, Vishvam Hospitals attracted patients from all parts of Karnataka, the neighbouring states, Northeast India, Bangladesh, the Middle East, and Africa.

These patients arrived with conditions that were shaped by their social and economic circumstances. Some patients had received extensive medical care from highly qualified practitioners and clinics, while other patients had not experienced adequate treatment for months or years. Crucially, the patients coming to the hospital were not only drawn from the upper socioeconomic strata but included a sizeable number of patients from less privileged backgrounds.[9] People with little financial resources and from remote areas faced considerable economic and logistical obstacles when seeking treatment at a provider like Vishvam Hospitals. They nevertheless came to the hospital, often after having tried out several options, because they did not find the required treatment in public hospitals and private clinics, which were overcrowded or did not offer the specialised treatment they needed. At the same time, Vishvam Hospitals catered to patients with the means to choose among a large number of providers offering specialised hospital services. These patients expected to be presented with carefully selected treatment options to choose Vishvam Hospitals over its competitors.

In this chapter, I show how clinicians reacted to this situation by varying treatments in ways not foreseen by standard protocols. The doctors at Vishvam Hospitals argued that they could not prescribe the same treatment to all patients with similar conditions because they needed to consider the cost of treatment incurred for the patients, who predominately covered the expenses out of pocket and had very different resources at their disposal. In this situation, cost-benefit calculations pervaded every step of the treatment process. Clinicians would prescribe extensive tests, sophisticated implants, and proprietary drugs for affluent patients while skipping tests and resorting to cheaper treatment methods and generic drugs to lower the price for patients struggling financially. Doctors suggested that they could not rely on standard protocols in making these changes because these international guidelines were based on different populations and reflected other economic realities than those they faced in their practice (see Brives, Le Marcis, and Sanabria 2016; Simpson and Sariola 2012).

[9] The lowest ward category, where twelve to fifteen people stayed in one room, accounted for three-fourths of total beds in the cardiac facility and one third of beds in the multi-speciality hospital. In my research, I encountered and interviewed daily labourers, drivers, small-shop owners, and factory workers who were undergoing treatment at Vishvam Hospitals.

Medical anthropologists have highlighted that international treatment protocols poorly reflect the realities of hospital care in the Global South and that clinicians need to tinker and improvise to adapt treatments to local conditions (Livingston 2012; Street 2014; Zaman 2005). However, these accounts describe situations where biomedical tools are very scarce or absent, which is not the case at Vishvam Hospitals. The variability I analyse in this chapter did not occur in conditions of generalised scarcity and deprivation. Instead, it responded to a situation where diverse patients groups with unequal resources were treated in the same facility for a profit. The point I make in this chapter is that variability affected the poor and the rich in these circumstances. In a situation where doctors varied treatments according to the financial resources available, patients could never be sure whether the treatment methods proposed were medically warranted or primarily chosen so as to maximise profits for the clinicians and the hospital.

In the first two sections of the chapter, I discuss the diversity of patients coming to Vishvam Hospitals, who differed in terms of illnesses, available financial resources, health status, and treatment trajectories. Such differences were exacerbated by the structure of the Indian healthcare system, which makes treatment pathways complex due to varying quality standards and lack of a structured referral system. Drawing on my research and on studies of healthcare provision for the poor in India (V. Das and Das 2006; J. Das, Hammer, and Sánchez-Paramo 2012), I discuss how people from the lower socioeconomic strata did not simply lack access to medical care but struggled to find adequate treatment options, often shifting between multiple facilities and providers over months or years. In contrast, affluent patients from metropolitan areas had access to an abundance of high-quality treatment options. However, they were reluctant to commit to a treatment path due to the plethora of expert opinions and suspicions about providers' financial interest in overtreating them.

In the third section, I describe how these conditions, in which medical and financial aspects were tightly interwoven, shaped clinical practice in the hospital as doctors tailored treatments to patients' expectations, conditions, and resources. In doing so, they deviated from international protocols which, they suggested, did not adequately reflect the "situated biologies" (Lock and Nguyen 2018, 313) and socioeconomic conditions of their patients. Such modification of treatment protocols was a source of professional pride for many doctors, who saw such adaptions as hallmark of their clinical skills, but it also raised

worries about making treatment decisions without the safeguards provided by international guidelines.

In the last section, I discuss the famous "Robin Hood model" of Vishvam Hospitals that seemed to offer a compelling solution for how to provide treatment profitably to diverse patient groups. According to the model, affluent patients paid an extra amount for additional services and more comfortable amenities, while poor patients could benefit from specialised treatment at comparably low costs. Doctors were sceptical of this model for two reasons. Some of them argued that the hospital's facilities and services were not sufficiently adapted to the specific needs of the poor and that this was why the hospital did not live up to its charitable reputation. Other doctors criticised that the hospital did some good work for the poor but cheated its wealthy patients by not providing them treatment of an adequate quality for the price they paid. Such discussions highlight the problems of offering different standards of care within the same facility. They also point to the worry that the cross-subsidisation model obscured a more pervasive variability as the administration cut costs and underinvested in the medical personnel and equipment to improve its profit margins.

The Patient Populations at Vishvam Hospitals

The central hub of Vishvam Hospitals catered to a very diverse population of patients. As a specialised centre, the hospital attracted patients with various disorders needing specialist attention, mostly cardiac diseases and cancers, but also neurological disorders, gynaecological conditions, gastrointestinal, urogenital, and vascular diseases, and lung and skin conditions as well as diabetes and kidney problems. Patients came from near and far, from the Bengaluru metropolitan area, the smaller cities and rural districts of Karnataka and the neighbouring South Indian states, from West Bengal, Bangladesh, the Middle East, and East and West Africa. They included affluent professionals, entrepreneurs, and celebrities, who stayed in the secluded and luxurious rooms of the platinum ward, and daily labourers, small business owners, and factory workers who were admitted to the functionally equipped general wards where twelve to fifteen beds were crowded together.

The patient population consisted of four major groups. The first group encompassed patients and their families from the Bengaluru metropolitan area and the neighbouring

Krishnagiri district in Tamil Nadu. This group was the largest in the multi-speciality facility (between one third and half of total patient visits) and the second-largest in the cardiac hospital (around one-fifth of total patient visits).[10] This local patient group was the most diverse one in terms of the diseases they sought care and treatment for at the hospital. It not only included patients from various parts of the city who came for the specialised services the hospital was best known for, such as cardiac surgeries and bone marrow transplants, but also people from the neighbourhood who came in emergencies and for treatment of chronic conditions such as diabetes or diseases necessitating dialysis because the hospital was located close to their homes. Since the hospital is located on the outskirts of the city but close to industrial areas and IT companies, these local patients included professionals with high salaries as well as some daily labourers and factory workers. In general, however, these people belong to the fuzzy category of "middle class" patients (see Mazzarella 2003, 271–72), as the doctors in the hospital described them. The category of local patients did not include many poor patients, who primarily visited the government hospitals and smaller clinics instead, nor many very rich patients, who preferred the less crowded facilities and better amenities in prime locations in the city centre.

Medical travellers from Bangladesh and patients from West Bengal and Northeast India were the second largest group. These patients predominantly sought treatment for cardiac diseases. Consequently, they were the largest group in the cardiac facility (around one-third of total patient visits) but also a sizeable group in the multi-speciality hospital (around one-fifth of total patient visits). The principal reason why Bangladeshi and, to a lesser extent, Bengali patients flocked to the hospital was the Chairman's popularity in this area, combined with a general sense that medical advice was more trustworthy in South India than in their home regions. This group encompassed very wealthy patients who sought out the advice of the Chairman as one of the most famous cardiac surgeons in this region, with whom some patients' families had personal ties going back many years. It also included patients from modest backgrounds – schoolteachers, farmers, construction workers – who had to take out loans or even sell their land or house to finance travel, accommodation, and treatment at the hospital. They explained that they sought

[10] The data is based on various figures shown to me by marketing and administration executives as well as on my interviews with the various actors in the hospital.

treatment under the auspicious presence of the Chairman at the hospital, and they had heard from friends, neighbours, and relatives that the hospital administration offered discounts and charitable support to those in desperate need. While cardiac diseases and, to a lesser extent, cancers were the primary reasons for Bangladeshi patients to come to the hospital, those who could afford to do so often travelled in larger groups of kin, neighbours, and friends who then underwent various check-ups and treatments for minor or chronic conditions at the hospital.

The third-largest group were patients from the smaller cities and rural areas of Karnataka and the neighbouring states of Tamil Nadu and Andhra Pradesh. These patients contributed around one third of total patient visits in the multi-speciality hospital and one fourth in the cardiac facility. Especially those from the rural parts of northern Karnataka were among the poorest patients to visit the hospital. Generally, these patients were not familiar with either the hospital or the Chairman. They were referred from district hospitals with severe cardiac illnesses and cancers, often at advanced stages, and told to come to the hospital because it provided specialised care and accepted patients under the government-funded health schemes for below-the-poverty-line people.

The last group were medical travellers from Middle Eastern countries like Yemen and Iraq and countries in East and West Africa such as Kenya, Nigeria, and Uganda. This group was the smallest, whose percentage ranged in the single digits of the total patient population. It included many children with cardiac diseases and cancers, who required complicated surgeries that their parents stated were unavailable in their countries of residence. Agents often organised the travel of patients from abroad. These agents also helped them navigate the admission and treatment processes in the hospital and acted as translators. Such agents were usually young men from the same region as their clients who had come to India as students and decided to stay. They were either directly employed by the hospital's marketing department or worked as independent agents for a commission. The patients either financed their treatment by themselves or received money from non-governmental organisations or religious trusts to seek treatment in India.

To accommodate these diverse patient groups, the hospital provided dedicated infrastructures intended to offer distinct experiences of care and keep patients from different socioeconomic strata and geographical origins apart. Thus, there were unique

waiting rooms and wards with translators for medical travellers, who had to pay a surcharge for these additional services. Administrators argued that foreign patients needed more support to navigate the hospital. Doctors and staff also suggested that medical travellers from the Middle East and Africa were loud and demanding and therefore best kept among themselves not to disturb the Indian patients. In addition, patients willing and able to pay a surcharge could visit "executive admission" counters granting privileged access to doctor consultations and diagnostic services without having to wait or mingle with the ordinary patients. Nevertheless, these different groups were still treated in the same hospital by the same doctors, who had to adjust their treatment methods to accommodate widely divergent socioeconomic realities and medical histories.

For example, Sumitra and I interviewed Govindamma, a lean woman from Bijapur in northern Karnataka whose bent posture and wrinkly face made her look considerably older than her forty-six years. Her sister and brother-in-law accompanied her. A couple of days ago, she had been admitted as an emergency case, suffering from a heart muscle disease, and the doctors told them that Govindamma had almost died. According to her sister, who did most of the talking, only Vishvam, the Lord of the Universe giving the hospital its name, had saved her. Govindamma had started to suffer from heart problems five years ago when she had complained of breathlessness. However, according to her sister, it was only last year that her condition worsened, and they took her to a hospital in Sangli in nearby Maharashtra. The doctors told them to seek treatment in Bengaluru immediately, but they waited for almost another year. During the interview, the reason for this delay emerged: Govindamma was alone and had no one to care for her. Her husband had left her shortly after marriage, and she stayed with her parents and helped them with the household. Govindamma's sister and husband had very little money themselves, doing some small business and cultivating a small piece of land, and therefore had hesitated to make the expenses to travel to Bengaluru. In the end, they had taken a loan and brought Govindamma to the hospital because they wanted her to live, as the sister put it.

The illness narrative of another middle-aged woman, Rohini, offered a striking contrast to Govindamma's story. Rohini ran a construction company in Bengaluru together with her husband. She was an energetic woman in her forties with full black curly hair and gave the impression that she was used to being in charge of her life. Only her dry and cracked lips revealed that she was undergoing her fifth cycle of chemotherapy when I interviewed her. Rohini had problems with her cholesterol levels and used to go for half-

yearly check-ups at a corporate hospital in Bengaluru. There, she observed that her globulin levels always were high. Worried, she asked her doctor, who suggested she could do some further tests, which eventually revealed that she suffered from multiple myeloma. Her doctor sent her to another corporate hospital, where she was advised to wait and undergo regular immunofixation and monitor the readings. When she decided to do a transplant, she opted for Vishvam Hospitals, although it was inconveniently located for her across the city. However, she felt that it had the most experienced stem cell unit in Bengaluru.

Govindamma's and Rohini's stories provide a perspective on the fundamentally different conditions of life that shaped highly divergent experiences of illness and disease. Several doctors stressed that poor patients like Govindamma, especially those from rural areas, generally came to the hospital with advanced, complicated diseases because they lacked the resources, knowledge, and access to services to detect and treat diseases early. In contrast, patients from the upper socioeconomic strata like Rohini monitored their health status very closely and consequently often noticed signs of disease even before they experienced symptoms (see Chapter 5). In addition, doctors pointed out that patients from the lower socioeconomic strata generally were poorly nourished and did more taxing physical work than patients from privileged backgrounds, so that their bodies responded differently to treatment. Apart from such biosocial differences (Lock and Nguyen 2018, 313–14), patients and their families had highly unequal resources at their disposal, both in terms of money and social support systems, leading to diverging possibilities of treatment and expectations of care.

Complicated Treatment Pathways

The differences between the health status of rich and poor patients were not simply due to no medical treatment being available to the poorer sections of the population at all. Studies on healthcare-seeking behaviour show that poor people in India frequently visit medical practitioners and do not lack access to healthcare services per se (J. Das, Hammer, and Sánchez-Paramo 2012; see A. Banerjee, Deaton, and Duflo 2004). Nevertheless, there are large disparities in health outcomes between the poor and the rich because the quality of health services accessible to the poor is often questionable (J. Das and Hammer 2007; J. Das et al. 2018). Studies also show that people turn to a plurality of providers, including practitioners trained in biomedicine and other traditions (V. Das 2015). My

research shows that patients admitted to a specialised hospital like Vishvam Hospitals for a serious condition have often gone through complicated treatment pathways, stretching over several months or even years and including various medical and diagnostic services. To some extent, this is true for both poor and rich patients, but in very different ways that exacerbate inequities.

Inside the general ward for paediatric cancer patients, it was very cool. Between half-drawn curtains, the child patients shivered under their blankets on six beds. There were no windows, and the cold artificial lighting with the blue linoleum floor created a sombre, claustrophobic atmosphere. Only the busy nursing station and the chatting among the different patient parties, who seemed to know each other from extended or repeated stays, lightened the mood. Sumitra and I talked with Shantu, a man in his mid-forties with thick black hair and a full beard that started to turn silvery. His leather sandals, grey trousers, and red cotton shirt spanning over his belly were ill-fitting, and he walked with some difficulty, but his dreamy eyes and sombre way of talking gave him a sage-like aura of a man who had coped with hardship and could no longer easily be shocked. He and his family were here for his 10-year-old son, Manoj, who was suffering from thalassaemia. They hailed from Talikota in northern Karnataka, a small city famous for a fateful battle between the Vijayanagara Empire and the Deccan sultanates in the 16th century. Manoj had been ill since he was one year old, when he started to suffer from frequent bouts of high fever. His parents took him to a private hospital in Bijapur, where he received a blood transfusion. After a month, however, the fever returned. They went to the hospital again, where the boy was admitted for fifteen days, for which they had to pay around Rs. 20'000. Because they felt that this was too expensive, they went to another private hospital where he was also given blood transfusions. Every month, the fever returned. The boy's face swelled, and he would stop eating. After several visits to the hospital, the doctor suggested a blood bank in Solapur in the neighbouring state of Maharashtra run by the Indian Red Cross Society where they could get transfusions for free. They regularly went there for three years, during which Manoj's condition remained unchanged.

One day, Shantu recalled, he met one of his neighbours who told him about a child with a similar illness who received treatment at Vishvam Hospitals and felt better, so they also decided to seek treatment here. For several years now, they had been coming to the hospital for treatment, travelling fourteen hours by bus from Talikota. Each such visit

would set them back around Rs. 12'000. The family made rubber stamps, which they sold to offices for Rs. 450 per piece. Sometimes the money was not there, and they had to take loans from friends and relatives. At Vishvam Hospitals, the doctors had tested Manoj's blood and told them that the child needed a bone marrow transplant. However, there was no matching donor available. The boy was their second child. The first and fourth child had died a couple of months after birth, presumably due to the same condition. Five years ago, their fifth child had been born in the hospital, where the doctors tested the umbilical cord blood and found the stem cells to be matching. They kept the blood, and now the boy was receiving chemotherapy to prepare for the bone marrow transplant. The family had a below-poverty-line ration card and was thus eligible for government-funded health insurance schemes, which, however, did not cover bone marrow transplants. They had received four lakhs from a charitable fund and put up a profile on the crowd-funding website Milaap, where they had only managed to raise Rs. 35'000 so far. They had already taken a loan of four lakhs and asked the bank for another loan on their house.

During our conversation, an older man in a white shirt and *panche*, a cloth wrapped around the legs and knotted around the waist, had joined us to listen and agreed to tell his story. He was a daily labourer from a village near Ballari in Northern Karnataka attending to his granddaughter, Vishnavi, a nine-year-old girl undergoing treatment for blood cancer at the hospital. Vishnavi's father had died, so he came along with the girl's mother as a male attender during the treatment. They had first noticed that Vishnavi was ill when she had developed an intense fever three years ago. They took her to the local government hospital in Ballari, where the girl was given injections and some pills, but her situation did not improve. After some time, they took her to a private hospital in Ballari, where she received blood transfusions for three months and was diagnosed with leukaemia. The doctors at the hospital suggested going to Bengaluru and continuing treatment at Vishvam Hospitals. Here she underwent chemotherapy, on which they spent four lakhs, after which she felt better for some time. One year ago, the condition had returned, and they again took her here for treatment. In total, they had spent around ten lakhs, for which they sold the house and the two acres of land they possessed. The family had obtained a ration card before coming to Vishvam Hospitals for the second time, but here they were told that Vishnavi needed a bone marrow transplant, which was not covered by the government-funded health schemes. Now they were applying to charitable funds and trying to raise money through the crowdfunding platform Milaap. They needed 25

lakhs to pay the transplant. People in their village told them that there was no cure for cancer and that they were wasting their money taking her to the hospital. After all, she would die after a couple of months or years. However, one of their relatives had visited another corporate hospital 15 years ago with a similar condition. He was still alive and doing well. So they felt cancer was curable, and they were getting treatment here, which made the child feel better.

Such complicated treatment pathways were typical for patients from the lower socioeconomic strata with severe or chronic afflictions. Like Manoj and Vishnavi, patients and their families had usually visited several clinics and hospitals before coming to a specialised hospital like Vishvam Hospitals and had already tried out several treatments over months or years. Partially, these winding treatment paths were a consequence of lacking financial resources. Such constraints did often not stop treatment altogether, but they imposed delays until sufficient money was raised or influenced decisions about what treatment to pursue (V. Das and Das 2006, 75–76). As the comments by Vishnavi's grandfather about the curability of cancer allude to, patient parties faced onerous decisions about what treatments bring worthwhile improvements and at what cost they should be sought out, taking into account that medical bills could lead to debt burdening patient parties for years or even decades to come (see A. Sharma et al. 2020).

Such decisions were particularly complicated because many patients from lower-income backgrounds struggled to find treatment that improved their condition due to low standards of care in the facilities available to them. Thus, many of these patients reported that they had received tablets and injections without being informed of their affliction. Establishing a diagnosis often proceeded on a trial-and-error basis by exploring different treatment options and noting which treatment brought about satisfactory improvement (V. Das 2015, 19–22). This process involved much travelling because patients with severe illnesses were generally referred to specialised providers because services were not available. As some patients suspected, providers did not want to take risks with patients suffering from complicated afflictions with very limited financial resources at hand. Indeed, the patients interviewed stated that they were not rejected outright due to lack of money. Instead, they received basic treatment and were sent home or referred to another provider.

Patients from the upper socioeconomic strata, too, often had visited several providers before coming to Vishvam Hospitals, although for different reasons. Instead of facing

problems finding a provider willing and competent to treat them, patients from high-income backgrounds complained that providers were too eager to admit them, raising suspicions that they suggested unnecessary treatment for commercial gain. I interviewed Bhola in the executive day care unit of the cancer ward. Except for the nursing station, the unit was quiet. A TV on silent mode showed the cricket World Cup match between India and South Africa, but Bhola did not seem interested. He was a tall, strong man in his mid-thirties with a round, friendly face. He seemed tired, and he immediately mentioned that he had been away from his home in Darjeeling in West Bengal for one year and was longing to go back. He was wearing a surgical mask because he just had visited his father, who had received a bone marrow transplant and was staying in the "platinum wing", the most expensive ward category of the hospital.

Bhola's father was the retired director of a tea plantation in Darjeeling in his late sixties. One year ago, he had started to complain of headaches. He visited the family physician and asked for a "CBC", a complete blood count – Bhola peppered his story with much medical terminology, highlighting that he had turned himself into a medical expert in the course of his father's illness. The number of blood platelets was very low, and the doctor immediately advised to fly him to a corporate hospital in Kolkata. At the hospital, Bhola's father was diagnosed with myelodysplastic syndrome (MDS). The doctors advised Bhola not to go for any "severe treatment", which his elderly father would not survive. Instead, they should take him home or to a hospice and let him be at peace for the remaining five or six months he had to live.

This suggestion upset Bhola greatly, and together with his brother, who lived in Germany, they started looking for a hospital to conduct a bone marrow transplant. They spent much time searching websites and patient forums. They also talked to doctors, friends, colleagues, and relatives and sent people to inquire about the doctors and conditions in certain hospitals. They even considered going to Germany for the treatment but eventually discarded the idea because of the prohibitive costs. Once the brothers had narrowed down the options, they visited several hospitals but felt that the providers' response was not encouraging. Leading government and not-for-profit centres were unwilling to admit their father immediately and told them that they would have to wait until a bed was available. Some corporate providers hesitated to take on the case because they felt it was too risky. Other corporate hospitals, in contrast, seemed overly eager to go ahead with the procedure, telling them to make a deposit on the same day so they would do the

transplant tomorrow. “It’s basically a pre-paid thing”, Bhola recalled angrily. “You pay about 50 lakhs. Then you come, the meter keeps on running like in the auto [rickshaw] over here. We didn’t like it. […] My father was just a statistic, a number [for them] […]. You can be proactive, but not to this extent.” In the end, they chose Vishvam Hospitals because the head of the haematology and bone marrow transplant unit was willing to go ahead with the treatment without trying to rush them to make a decision. A couple of months ago, the transplant was conducted successfully. However, just when their father was about to be discharged, he got a fungal infection and thus needed to remain in the hospital. Bhola hoped that they could soon return home for a month to rest before coming for further check-ups and consultations.

Extensive inquiries about institutions and consulting multiple opinions before committing to treatment were common among patient parties from the upper socioeconomic strata, much to the chagrin of doctors who considered such caution a sign of mistrust towards their professional judgment (see Chapter 4). While not constrained by lacking financial resources, treatment pathways were often serpentine for these patients, not because they struggled to find doctors with the adequate skill and willingness to treat them but because they had many options at their disposal. These patients were well aware that treating them was lucrative for practitioners and providers, and this knowledge created suspicion and doubt whether the proposed treatment was indeed the best option for the patient or would primarily generate the most revenue for the provider. Thus, several patient parties mentioned that they felt treated like a “commodity” or a “number”, which did not inspire confidence that doctors saw the individual patient in front of them rather than just the potential revenue.

At the same time, such statements also reflected the conviction of patients from privileged backgrounds that they had the right to be treated in the best manner possible without delay. For some of these patients, the reluctance to commit to a specific treatment course and the search for alternative options seemed to be, at least partially, driven by a desire to bend fate to their will, based on a conception that they were people who could achieve what they wanted in life. For instance, I met Vipan, a tall man in his-mid thirties, whose young daughter suffered from cancer. With his muscular build and shoulder-length black hair and thick beard, he embodied with every inch the vigorous masculinity he ascribed to Shiva, the deity to whom he had pledged his allegiance. He owned much property, including a nightclub in a trendy neighbourhood, and described himself as a

power broker involved in politics and playing an essential role in the local temple. He was not willing to talk much about his daughter's illness, but he had taken her for treatment at Vishvam Hospitals. However, he aborted the treatment when the doctor advised that surgery and chemotherapy were necessary to treat her. He related with visceral disgust how the surgery would have left an L-shaped scar on his girl's torso and that he could not submit his child to such treatment. Instead, he took her to Mexico and later to San Francisco in the United States for an ozone light therapy, which cost him about 80 lakhs. The therapy, however, did not bring the desired results, and he admitted her again for treatment at a corporate hospital in Bengaluru. She died a few months later.

The divergent treatment trajectories of poor and rich people illustrate the different demands and expectations regarding care with which patients came to a specialised centre like Vishvam Hospitals. Patients from the lower socioeconomic strata arrived with resources already depleted by spending on travel and visiting several providers, and with advanced conditions due to delays in diagnosis. Patients from the upper socioeconomic strata invested considerable time selecting a provider and were concerned with being presented with the right treatment options as they were generally suspicious about the providers' commercial motives. To accommodate these different circumstances and demands, clinicians at Vishvam Hospitals did not propose a standard treatment path to all patients with similar conditions. Instead, they adjusted treatment options depending on the financial resources available.

Clinical Reasoning beyond Standard Protocols

"Being a physician or a surgeon in the West is relatively easy", Dr Anthony said, "because you got just to do the medically right thing, it is just medical care. Out here, you have to juggle the financial aspect people have, what their social aspects are, you don't have a social security network, you don't have a nursing home to get people to recover, you don't have an unlimited healthcare system." The "West" Dr Anthony was referring to is the United Kingdom, where he had worked for several years before returning to India because he and his wife felt their children should grow up in the vicinity of their extended family. We were sitting in his consultation office, and I had noticed the diploma on the wall from a university in the UK, which was placed next to a gold medal certificate for the highest mark in general surgery from the (Indian) Ministry of Health and Family Welfare. I was curious about how the experience of working under the British National Health Service

compared with practising at Vishvam Hospitals, where he worked as a senior consultant. Dr Anthony readily took up the opportunity to elaborate on the challenges in his daily practice. These challenges were a subject he had apparently given some thought before and which weighed on him.

The main difference between medical practice at Vishvam Hospitals and in the UK, Dr Anthony highlighted, was that the available financial resources strongly shaped treatment options. “Say somebody comes to me with stomach pain”, Dr Anthony explained, “what tests I would choose to do would have to take into account where they are from, what they can afford, how keen they are to establish a diagnosis. In the West, if somebody comes to me with stomach pain, it does not matter what he has, he gets same tests. Over here, it would be ethically wrong for me to order a test which would cost somebody his two months’ wages while for the next patient who walks in with identical symptoms, it is five per cent of the wages.” Dr Anthony quickly admitted that patients’ financial and social situation also affected treatment plans in the “West” and elsewhere. He recalled how he had modified the treatment regime for an older man in the UK so that he needed to come to the hospital less frequently because the man had no one to drive him, nor could he afford the taxi fare. However, he argued that the range was narrower in Europe, not only in economic but also in social and cultural terms. “In the West, most people live a similar lifestyle. They have a good house, eat similar kind of food, the experience is very similar and shared. While here, who lives in a slum or small village in Karnataka, you don’t have this understanding. All this is much harder. At the same time, you have somebody who travels all over the world. In the same clinic, you will see vastly different patients with vastly different expectations.”

Having a wide variety of people with different social, economic, and cultural backgrounds rendered establishing the right diagnosis and determining the appropriate treatment course challenging. Born and raised in North India, Dr Anthony struggled to communicate in the South Indian languages and with patients from Bangladesh who were not fluent in Hindi or English. In addition, he highlighted the difficulties of assessing patients’ needs and situation accurately. “It is very difficult just to eyeball somebody and see: Can he afford it? What does he want? Is he somebody who is going to be very unhappy and very adversarial if he misses a diagnosis? Or is he somebody who is going to be very unhappy if you do a test with negatives? This is the whole challenge when you

deal with this mix of patients in India." Because clinicians needed to consider the socio-economic circumstances of the patient in question, deciding on appropriate treatment path relied as much on a medical assessment as on a socioeconomic reading of the patient (see Chapter 2). Such readings were difficult because patients may inhabit life-worlds very different from that of the treating doctor. At the same time, Dr Anthony made clear that such readings were indispensable because the doctor needed to make decisions and exercise his medical authority in the best interest of the patients (see Chapter 4).

Because the majority of patients were self-paying, cost calculations pervaded every part of the treatment process. For example, doctors explained that they would choose diagnostic tests depending on patients' financial resources. Oncologists told me that they administered positron-emission tomography (PET) scans if the patient could afford it but resorted to a computed tomography (CT) scan or ordered an x-ray if the patient was struggling financially. If the patient was poor and no financial support was available, clinicians would skip tests altogether, and treatment proceeded solely based on clinical examination. Apart from diagnostics, the equipment and medical devices used also varied. For example, cardiac patients would be offered imported drug-eluting stents or administered bare-metal stents depending on what they could afford. Similarly, doctors suggested innovator drugs if the patient could afford it, whereas otherwise they would propose generic drugs. In this way, doctors were faced with making decisions based on the available resources at every stage of the process. "Triage does not only exist at the time of entering the hospital", one doctor explained, "it happens at all steps of the process."

Financial resources were a decisive factor in such triaging mechanisms but, in most instances, not a fixed limit. If doctors felt that a specific procedure or test was direly needed, they could find ways to drop some items from the bill or to get the hospital administration to subsidise it (see Chapter 2). Similarly, patients and their families could often somehow mobilise funds if they desperately required them, even if it meant that they had to run up debt with possibly dire consequences. Instead of clear-cut treatment options, medical and financial calculations were intertwined, resulting in taxing cost-benefit calculations with unpredictable results. To illustrate this situation, Dr Anthony provided the example of the diabetic foot syndrome, a condition he encountered frequently:

> A diabetic population is very prone to getting wounds in their feet, which can very rapidly progress to gangrene. The wounds tend to either not heal or heal poorly or get infected because of a combination of poor blood sugar control, infection, poor blood supply and/or

> neglect. In the West, you would see patients coming with a small ulcer on the foot. They would get admitted or attend a paediatric clinic on a regular basis. They would have access to high-end health care. They would get angioplasty to salvage the limbs. Here the reality is, interventions are expensive, resources are limited. We have to tell them that we can do this to save your foot. We may be able to save part of it; we may not be able to save it completely. The alternative is to go for amputation. Patients will often think: 'This my father, he is 70 odd, and I'm the sole breadwinner and have to look after him. I have now two kids who are ready to go to school or college. I earn 30,000 Rupees a month. Can I afford to take a gamble of 1.5 lakhs to try to save his leg? Or am I better off spending 100,000 for amputation and saving what I can for my family? Those are real choices that people make.

The crucial point in the example is that the conditions of certain patients visiting Vishvam Hospitals were similar to those for most patients in the "West", while other patients faced very different circumstances. The example of diabetic foot conditions also highlights that doctors needed to consider the "local ecology of care" (V. Das and Das 2006, 73) because the success of interventions depended on the possibility of monitoring and controlling blood sugar and avoiding infections. In addition, doctors pointed out that they needed to consider patients' nutritional status or exposure to dust in deciding about treatment because wounds would heal differently, and patients would respond variably to medication due to biosocial differentiations (Lock and Nguyen 2018).

In making these deliberations, doctors could only partially rely on international guidelines that set the global standards for treatment because these protocols did not adequately reflect the clinical realities faced in Indian healthcare institutions. For some specialities like oncology, the Indian Council of Medical Research (ICMR) provided national guidelines, and some large centres were conducting pharmacogenomic studies investigating how their patient population metabolised drugs. In general, however, the consultants relied on protocols created in the United States or Europe, and they condemned the postcolonial predicament that prevented Indian associations from establishing their national guidelines as their counterparts in Japan did. "In India, especially", Dr Anthony pointed out with reference to cardiac specialities, "there is this almost blind faith in the guidelines of the European Society of Cardiology or the American Heart Association without modifying it to an Indian situation."

Using guidelines drafted by American or European bodies posed problems for doctors in their clinical practice. Firstly, the guidelines did not "give much thought to costs in recommendations", as one senior cardiologist put it. The problem was not only that some patients could afford to be treated according to these protocols while others could not. The protocols also reflected specific economics of health care that were different in India than in the "West", as Dr Anthony pointed out: "International protocol saying you

should do this, this, this does not apply because the driver is different. Ultimately all protocols are based upon the economic resources of the system. You can talk of it as science or whatever, but science is heavily tempered by what your country and your nation can afford. Which is why it is unfair to transplant Western protocols to India." Dr Anthony highlighted that diagnostic tests were relatively expensive in India because they often required imported medical equipment. In contrast, therapy was comparatively cheap due to the availability of inexpensive generic drugs and the low salaries of healthcare workers: "The Indian healthcare system is so skewed that the cost of doing the test is more than the cost of doing the therapy for a patient. And for people who are close to breadline already, you end up saying, let's not do the test, let's just do the therapy. That reflects some of the health economics. In India, diagnostics are expensive [and therapy cheap]. In the West, it is exactly the reverse." Protocols did not adequately take account of this situation where clinical examinations and medication often replaced diagnostic tests due to constrained financial means (see also V. Das and Das 2006, 77–78).

Secondly, doctors needed to adapt international guidelines because these protocols were drafted using data on populations in Europe or the North America and did not adequately reflect the "situated biologies" (Lock and Nguyen 2018, 313) of the patients coming to the hospital. For instance, Dr Anthony had conducted a study on the size of the aorta where he and his co-authors found that it was on average one fifth smaller in the Indian population than in the Caucasian population, which made surgeries more difficult. He also suggested that the population in South Asia had an "entirely different" disease pattern, which he attributed to a combination of genetic and environmental factors. Similarly, oncologists pointed out that they could not follow the standard international guidelines because their patients did not tolerate the suggested dosages for chemotherapy. They attributed this variability in the ways drugs were metabolised to different pharmacogenomics, high exposure to toxic conditions, and the prevalence of infectious diseases in the South Asian context. "The Caucasian population tolerates chemo much better than the Asian population", a medical oncologist explained. "Part of it is nutrition, part of it is a higher rate of infections. There are a lot of factors. For example, there is so much construction going on; it pre-disposes patients to fungal infections. It's a combination of genetics and environmental factors." Because international protocols did not adequately reflect these situated biologies (Lock and Nguyen 2018), doctors needed to probe and use their experience to find the appropriate dosage for their patients. "What

we do is", the oncologist explained, "in those patients whom we suspect likely to develop complications because of the general nutritional status and performance status, we start with a lower dose, and if the patient tolerates it, we increase it."

Using clinical reasoning to vary treatments in ways not foreseen by standard guidelines was a source of both professional pride and angst for the clinicians at Vishvam Hospitals. Many doctors proudly pointed out that their clinical skills and experience were on par with or better than their Western counterparts, who did more research and had "their protocols" but only saw a fraction of the number of patients they consulted or operated upon daily. "It's very easy to give somebody a protocol", a senior oncologist explained, "and say: 'every week you come and do twenty-five lab tests, x-ray, some other imaging', [which is] default in the protocol because you will not miss anything. But here what happens we will ask the patient, come and see us, we will examine him and after I will only order some few tests relevant, which I think is absolutely required, and thereby I'm gonna save cost. With good clinical examination, you can pick up a lot of things." In a similar vein, a senior consultant in gastroenterology recalled with a mixture of shock and pride how an Indian who lived in London came to see her and how she realised that the doctors in the UK had utterly missed the cancer developing in his bile ducts because they only relied on the ultra-sound rather than their clinical intuition. "There in the West", she concluded, "they are very investigation-driven. Here we have to be driven by clinical impression and skills because the patient is paying for it." In these interpretations, the need to rely on clinical examination to adapt treatments for patients with constrained resources instead of simply following a standard protocol is actually a strength because it throws doctors back to their crucial competence, that is, clinical skill and reasoning, which the over-reliance on technology and guidelines may paper over (see Livingston 2012, 62–70).

Operating without the firm grounding of standard protocols came with risks, however. "The profession of medicine has become extremely delicate", a senior cardiologist elaborated. "How people react, you don't know. If you apply whatever is the recommendation, it is not going to be viable for a large section of the population. But that same people can look back, turn back at you, and [ask]: 'Why didn't you offer it to me?!' The governmental agencies, the press, it's pressure from everywhere." Many doctors felt increasingly threatened in their medical authority by demands from patients to have a say in the decision-making process, the regulatory oversight of government bodies, and the

scrutiny of a press eager to report scandals in corporate set-ups (see Chapter 4). Without a standard protocol to fall back upon, doctors felt vulnerable to reputational and legal challenges. In addition, some doctors, at least, were well aware that their socio-medical reading of the patient's situation could be wrong, with potentially grave consequences. For example, Dr Anthony clarified that the need to adapt guidelines due to constrained financial resources felt like a heavy burden. Towards the end of our conversation, he fell silent for some time and visibly struggled with his emotions. "With that, you are left in a, you know …," he started, followed by a long silence, before he continued: "It does put stress on you. It is easy to follow a guideline. Nobody challenges you for what you have done. So, when you deviate from that, you wonder: 'Have I made the right choice, maybe financially, maybe medically? Have I missed somebody who had a treatable disease, which should have been done?' There is a lot of all that that you have to think about."

Making Variability Profitable

In discussions about the need to vary standard treatment protocols, doctors generally elaborated little on the fact that treatments also needed to be financially profitable. Commercial interests mainly emerged as topic in discussions about the money-making strategies of the management and the bad example of a few colleagues who lacked the maturity to withstand the lure of quick money and engaged in unethical practices by suggesting treatments that were financially lucrative but not necessarily medically warranted. The clinicians I interviewed genuinely believed, I think, that patients' well-being always came first in their deliberations about the appropriate treatment paths. At the same time, they also accepted that they worked within the framework of a for-profit institution and that their practice needed to be sufficiently profitable to sustain it. This raised the question of how the aim of giving patients the best possible treatment and the demands of financial profitability were reconciled.

The Chairman's model of cross-subsidisation offered a seemingly compelling solution to the problem of treating a highly diverse patient population profitably. According to his "Robin Hood model", affluent patients paid surcharges for additional services and superior amenities, which subsidised the treatment of patients who only had access to basic facilities but essentially benefited from the same medical care. This form of cross-subsidisation was not exceptional but commonly used by healthcare providers in the country (see Chapter 1). Apart from for-profit hospitals like Vishvam Hospitals, many not-

for-profit and government hospitals also included private wings for patients willing and able to pay the additional charges for better amenities and services. Corporate hospitals offered a whole range of ward categories in order to provide solutions for every budget.

At Vishvam Hospitals, the “platinum wing” was the highest category. It was used by the most affluent patient parties willing to afford a 120–150 per cent surcharge on their procedure costs in addition to seven times higher bed and nursing charges compared to the most basic category, the general ward. In exchange, patients and their families benefited from large suite rooms and amenities comparable to an expensive hotel, a unique selection of food, and a separate elevator with an attendant who could be called in advance so that the patient parties avoided waiting in front of the other elevators, which were notoriously crammed. Unlike other patients, who had to move through the hospital searching for billing desks, doctors’ offices, and investigation rooms, patients in the platinum ward could avail of doctor consultations, investigations, and administrative services without leaving the comfort of their rooms. The reception and nursing station were staffed by specifically selected nurses who were mostly young, good-looking, and well-versed in English, as a manager explained to me. In the multi-speciality building, the rooms and corridors were decorated with colourful surrealist paintings created by the hospital's medical director, which were very popular among the patients who took selfies with them.

Below the platinum category were the private rooms. Here, patients could stay with two attenders in their private air-conditioned room for a 70 per cent increase on all surgeries and procedures and three times higher bed and nursing charges. In semi-deluxe and semi-private wards, the patient and one attender shared the room with one (semi-deluxe) or two (semi-private) other patient parties. The additional costs for these categories were a 50 per cent or 30 per cent increase on procedures and surgeries and two times higher bed and nursing charges for semi-deluxe and semi-private rooms, respectively. These rooms were generally air-conditioned, and patients had access to amenities like an attached bathroom and a TV. However, no administrative or investigational services were offered in the room. The lowest category was the general ward, where twelve to fifteen patients stayed in one large room. Instead of air-conditioning, ventilators rotated above each bed. In some wards, curtains could be drawn around each bed for some privacy, while there were no curtains in others. Sometimes, attenders were resting or sleeping on the floor next to the patient's bed, but the general rule was that they could not stay in the

ward. Instead, they had to stay in a nearby guesthouse or the hospital's *Dharmashala*, a tin-roofed building cramped with iron beds where the poor could stay for Rs. 40 a night.

These various ward standards allowed the hospital to accommodate patient groups with different financial means in the same facility and to increase the revenue per bed through additional charges for superior amenities and services. Importantly, representatives of Vishvam Hospitals claimed that the ward category did not affect the quality of medical care patients received. "Irrespective of how well-off you are", a cardiac surgeon explained, "what money you paid, which ward you're staying in, the treatment remains the same in the operation theatre and ICU, which are the main critical areas. The equipment, the staff, is the same. Once the patient is wheeled into the theatre or ICU, we don't differentiate how much the patient has paid. […] The finance thing is only there in the file to say which room the patient gets. After that, everything remains the same." The surgeon argued that the same doctors attended to patients irrespective of their ward category and operated on them in the same operation theatres. The more luxurious amenities and special services in the superior ward categories were therefore comfortable but inconsequential additions to the core medical care that remained the same for all patients, rich or poor.

Other clinicians pointed out that this was not the case because the quality of medical care did not solely depend on doctors and their surgical skills. "Doctors don't run the hospital", an oncologist explained. "The people who run the hospital are the nursing staff." Doctors made the diagnosis, conducted the procedure or surgery, and checked on the patient on their rounds. For the remainder of the day, patients were left to the care of the nurses, who monitored their status, administrated medications, cleaned wounds, kept the ward in order, fed and washed patients. Depending on the ward category, the standards of this care work varied because more nurses were available in the higher ward categories, and they were generally better qualified. In the top category, one nurse was taking care of one to three patients. This ratio was reduced to 1:3 and 1:5 in the private and semi-private categories, respectively. and could be as low as 1:9 in the general wards. In addition, the attention of doctors also varied by ward category. When following doctors on their rounds, I observed how doctors moved quickly through the general wards, shaking patients awake rather abruptly and leaving others desperate to catch their attention while spending considerable time discussing treatment details with patients in the private

wards. Finally, doctors also suggested that the standards of the amenities themselves influenced treatment quality. “You see, the treatment you get is not just the physician you talk to or the surgery”, a cardiovascular surgeon elaborated. “It is how good the guy cleaning the dishes is. What’s the quality of clothes they use for buying curtains? Are they more bug resistant, are they less bug resistant, are they the cheapest they could get? It is all of those things.” While not readily apparent, the standards of furnishing and maintaining a room or ward affected rates of infections and thus the chances of recovery.

Intriguingly, doctors were often critical of the different ward standards, not because the standards differed between the rich and the poor but because there was too little differentiation. Some doctors felt that Vishvam Hospitals was not doing enough for the poor patients given its reputation of being a hospital with a charitable orientation. Dr Simon, a spirited man in his early seventies with a silvery moustache and a mischievous glint in his eyes, was one of the main people involved in planning the multi-speciality hospital. The provisions for the poor patients were an issue of concern and some embarrassment to Dr Simon, and he asked me somewhat apologetically that I should not judge the hospital too harshly on that account. In fact, Dr Simon explained that he had envisioned a different plan for the hospital, which he claimed would have solved the problem of caring adequately for the poor, but the plans could not be realised. In his original conception, Dr Simon had envisioned two buildings with an open pavilion in between them, protected by a glass roof. One building would serve as a specialised centre, as the hospital was doing now. The other building would be dedicated to general medicine. Patients would first be seen by nurses and general practitioners who would make an initial assessment and only refer them to a specialist if this was really necessary. The in-between pavilion would provide patient parties a space to rest in a pleasant environment where charitable organisations would distribute food and tea for free.

This arrangement would address two problems plaguing Indian hospital care. On the one hand, it would make sure that only people who really need a specialist are seen by one. In the present situation, anybody who suffered from a headache could directly see a neurosurgeon if they were willing and able to pay for it. On the other hand, the open pavilion would provide a space where the poor and their families, who often travelled from far away, could stay in an environment where they would feel comfortable. In fact, Dr Simon argued that people from impoverished backgrounds felt more comfortable in the open air than in closed air-conditioned spaces. In other words, not only was the

focus on highly specialised treatments instead of preventive and community medicine not suited to the healthcare needs of the poor. The architecture of corporate hospitals with its marble, glass, and air-conditioning, taking its cues from a global business culture (Lefebvre 2008), also made them feel uncomfortable and out of place. Dr Simon's ideas were an implicit critique of the Chairman's model because he suggested that it was not enough to simply offer the same services cheaper to poor people without considering their specific healthcare needs. In this view, the kind of cross-subsidisation envisioned by the Chairman could not work within the same hospital because the rich and the poor needed different healthcare services and, given that the hospital depended on the rich for financial viability, their concerns would always take precedence over those of the poor.

In contrast, a senior consultant rejected the notion that the standards of the hospital were not made for the poor. When I told the consultant about Dr Simon's plans, he said: "You almost feel that you're discriminating against the poor and offering them a poorer class of care and service. You don't know which comes first. Do you think the poor man would object to the room being cool and comfortable? I doubt it." Instead, the consultant worried that the cross-subsidisation system did not fail the poor but the wealthy patients who paid good money for their treatment but were not getting adequate care in return: "A paying patient in a private room or the platinum wing is paying top dollar for quality service. But because you're in a structure where you're also trying to drop down costs and work with the lowest price point, what service you get or the percentage you get of it will not be differentiated based upon what services you are paying for even though you will be billed for them. Even though you might be paying the top rate for the medicine, they might be buying it from the cheapest pharmacy they can get it from, which might not be as particular about quality as somebody else. It does not make a difference in what you pay for it." In this line of argument, it was not the poor whose needs were neglected, as Dr Simon suggested. Instead, some doctors argued that Vishvam Hospitals truly applied a "Robin Hood model", albeit in a different sense than the Chairman wanted it to be understood. While claiming to make specialised services affordable to the masses, the hospital failed to deliver the best possible care to the patients in the higher ward categories, who paid a high price for their treatment without benefiting from an adequate quality of medical services in exchange.

The key point of these arguments was the difficulty of offering different treatment standards within the same facility. When I asked a consultant whether it was possible to

offer completely distinct standards of care to rich and poor patients in the same hospital, he answered: “You cannot. In a sense, they try to do that with the platinum wing. In the platinum wing, you got your x-ray machines, your ultrasound machines and all of that. But I don’t know whether it is even possible to put both of them together. I don’t know if it could be financially viable or not. You would be duplicating so many things. Ultimately economies of scale will say: ‘Why should you have two separate sterilisations units?!’” If the quality of medical care depended on all services and infrastructures of a hospital, a different hospital facility was ultimately needed in order to offer truly distinct treatment standards. Indeed, some doctors argued along these lines and suggested that separate hospitals should be set up for the different social classes and cross-subsidisation should then work between these facilities rather than within a single hospital. The disagreement about whether the hospital’s cross-subsidisation model favoured the poor or the rich highlights that the differences between patients from the upper and lower socioeconomic strata seemed so vast and entrenched to the doctors that they doubted the possibility of optimal treatment for both of these groups within the same facility.

At the same time, these concerns also reflected the worry that the “Robin Hood model” justifying the use of different health facility standards by cross-subsidisation served as a pretext for undermining treatment standards for all patients. Some consultants derisively called the hospital a “glorified government hospital” or a “glorified nursing home”, suggesting that it did not have the rigorous organisation and quality standards that they believed other hospital chains, which primarily focused on attracting wealthy patients, had. In particular, consultants felt that the hospital cut corners by employing underqualified medical personnel. The Chairman had for a long time advertised that some tasks usually performed by doctors could be delegated to nurses or technicians with additional training to lower costs by deploying the precious and expensive work-time of doctors more productively. Clinicians suggested that this upskilling strategy was used to employ nurses and practitioners without adequate qualifications. Moreover, nurses and technicians were paid poor salaries, leading to constant fluctuation of medical personnel that left as soon as better employment opportunities became available. In this situation, doctors suggested that the quality of care was variable because it depended on which nurse was taking care of a specific patient and whether the doctors were paying specific attention. “If I really care about a patient, I will stand over there for one hour till the sister gives the chemotherapy to make sure everything goes okay”, an oncologist said. “I can do

that for one patient. I can do that for two patients. I cannot do that for all patients. The backbone of the hospital is your sister, and the problem is the sisters are not treated well." For the consultants, the claim that costs needed to be kept as low as possible to make treatment affordable to all people served as an excuse for the hospital management to not invest enough in recruiting well-trained nurses and technicians, who were vital for good treatment standards.

These concerns suggest that employing different standards was not only a necessary tool to treat diverse patient populations but also permitted to reduce costs in order to generate more profit for the company. For some consultants, the logic of cross-subsidisation was, therefore, not only that varying standards allowed to treat poor patients but also that treating poor patients allowed to deviate from standards. "[Due to its Robin Hood model], people who come to Vishvam Hospitals have a better impression of how the healthcare provision is going to be, and [believe] that the physicians are not entirely financially driven", a senior consultant said. "It is also a reflection of the patient profile, which includes many who come from deprived healthcare backgrounds. Either because they cannot afford it or because it is not there, they tend to be much more grateful for what they get here. The trade-off is that we probably set us not as high a standard as we should. We see that across the board in the hospital. We do a lot of good work, but we are a significant a few percentage points below where we should be because the patients accept it." Without strong patient pressure and in the absence of strict regulatory oversight, Vishvam Hospitals' model suggesting the need to minimise costs and use cross-subsidisation to treat poor patients was always at risk of becoming a pretext for lowering standards for all patients in order to generate more profit.

Clinicians doubted the efficacy of quality control and accreditation standards (see Lefebvre 2019), which they suggested were primarily "tick-box exercises", for ensuring that standards were maintained. Instead, doctors considered themselves to be the primary guardians of treatment quality and argued that they were making sure that the variable treatment methods served the interests of the patients. At the same time, they acknowledged that they also had to consider commercial interests. "Nobody advocates for the patients", a consultant said. "The only advocates left are often physicians. We are in [an] odd place. We have to generate revenue for ourselves and the hospital. And we have to advocate for the patients. We might not always have the right balance."

Conclusion

In this chapter, I have analysed how medical care operates in a situation of profitable medicine where commercial and medical aims are inextricably intertwined. I have discussed how clinicians varied treatment according to the bodily condition and socioeconomic situation of patients, who not only differed in terms of their afflictions and treatment trajectories but also had highly unequal resources at their disposal. Making adjustments to treatment methods and deciding how best to use available biomedical tools is part of any clinical practice. However, the treatment variability I described in this chapter is embedded in the context of Indian healthcare delivery, where inequalities in income and wealth are largely unmitigated by health insurance, and specialised hospital providers cater to diverse patient groups. Some patients could afford sophisticated tests, devices, and interventions, while others could not, leading to a situation where patients with similar conditions received different treatment.

Clinicians pointed out that international protocols were not adjusted to these circumstances. Standard guidelines were based on evidence derived from different populations and reflected different economic realities, which is why they provided little support on how to proceed with treatment for patients who metabolised drugs differently or to whom certain interventions or diagnostic tests would be a massive financial burden. Clinicians highlighted that their experience and clinical skills compensated for the shortcomings of guidelines and allowed them to save costs for the patients. However, the emphasis on doctors' judgement was ambivalent in a for-profit context where doctors varied treatments not only to make them affordable to patients but also to generate revenue for themselves and the hospital.

The alignment between medical care and commercial gain did not only depend on clinicians because the care patients received also hinged on hospital facilities and the nursing staff. Vishvam Hospitals' cross-subsidisation model promised a standardised and transparent solution for offering equal treatment to patients with different resources. Patients paying a surcharge for a higher ward category benefited from superior amenities and additional services, yet hospital representatives claimed that patients in the lower ward categories received the same medical care. However, the model did not work as promised because the nursing care and infrastructure provided in a ward also affected treatment outcomes and, notably, infection rates. Moreover, the doctors I interviewed

pointed out that the different ward standards did not guarantee a consistent care experience due to underinvestment in personnel and equipment. This variability certainly affected patients in the lower ward categories but also touched those in the higher wards because the different care provisions in the hospital were not completely separated. Ultimately, clinicians believed that standards did not guarantee the quality of medical care. Instead, they suggested that they themselves were primarily responsible for maintaining treatment quality, pointing to the heightened emphasis on medical authority in a situation of standardised variability.

4 Corporatisation and Medical Authority

> Doctors in India were always revered and held high on the pedestal that they literally enjoyed the status of 'God'. Practising medicine was considered a very noble profession. Alas! The scenario has changed drastically in recent times. Every other day the news channels broadcast attacks on doctors; criticism is on the rise leading to the doctors feeling that their job is a thankless one. It is really unfortunate to see this wide gap emerging in the relationship between a doctor and a patient. It is important to note that it is a no-win situation for both (Lingegowda 2017, 4).

These are the opening lines of the novel "Pan-Pan Doctor" (2017), initially written and published in Kannada by the radiologist Dayananda Lingegowda, a former consultant at Vishvam Hospitals. The book is part of a series of publications in the last decade that have highlighted an increasing unease among doctors about their perceived loss of status and the tarnished reputation of their profession, which they attribute to widespread corruption and greed fuelled by the involvement of corporate actors in health care (see Chapter 1). In the novel, Lingegowda intriguingly connects the desacralisation of medical authority to the management practices in corporate hospitals, positioning the Chairman of Vishvam Hospitals as a pivotal intermediary between the medical and corporate world.

A first-person narrative in the form of a *Bildungsroman*, the story tells the journey of a poor farmer's son from growing up in a remote village in Karnataka to becoming an established surgeon in a corporate hospital in Bengaluru. The first part of the book relates the formative years in school and medical college, focussing on the trials and tribulations resulting from poverty and class-related humiliations. At every step of his education, the protagonist experiences the difficulties of getting ahead without cheating and bribery and realises that Indian society in general and the medical field in particular are deeply corrupt. The second part of the book explores the protagonist's medical practice in a corporate hospital, using thinly fictionalised references to actual people and events in Vishvam Hospitals. The story's focus shifts from the pastoral life of the village to the pastoral power of the doctor, as the protagonist comes to realise the necessity of doctors being treated as gods. Such a status does not simply serve the vanity of doctors but is essential for their curative function because healing requires unquestioned trust in and

complete submission to doctoral judgement. While working as a surgeon in the corporate hospital, the protagonist witnesses first-hand how medical authority and patients' trust are eroded by corporate control and pressures to maximise profit. Doctors are encouraged to overprescribe tests and treatments through the incentive system, cost-cutting undermines safety standards, and doctors follow standard protocols instead of using their clinical judgment due to fear of patient violence and lack of protection by the management, leading to unnecessary costs and causing harm to patients.

These problems come to a head in a series of confrontations between the protagonist and the Chairman, in which the former challenges the latter with the fact that he portrays himself as a great innovator and philanthropist, who has come up with a charitable, low-cost model of hospital care, which in truth leads to unethical practice and tarnishes the reputation of doctors. In a dramatic turn of events, the Chairman realises his mistakes when his nephew dies after surgery in the hospital because an underqualified operation theatre assistant contaminated the surgical instruments by touching them with her bare hands. Shaken by remorse, he uses his appearance on the television format "Satyamev Jayate" (truth only triumphs), hosted by Hindi cinema actor Aamir Khan, to make a passionate case for leaving the medical field to the authority of doctors, who need to be treated with unquestioned devotion. "Give us our 'Doctor is God' status back," the Chairman tells the audience. "It is not for us but for the well being of humanity. Please believe us! Your belief in us has immense power. And that faith has the power to change the system. This makes miracles possible. There is a saying 'Faith moves mountains'. Let not some defects in the services change track of your faith. Just because your wishes did not get fulfilled you don't do anything to God, just like that don't tarnish the glory of this sacred institution." To which Khan adds: "Let us respect doctors, with it humanity will uplift." (Lingegowda 2017, 434)

The novel's narrative arch covers two key transformations: the metamorphosis of the protagonist from simple, naive village boy to renowned, savvy metropolitan clinician and that of the Chairman from money-minded exploiter of the medical community to true champion of medical authority. While these conversions seem straightforward, they are also profoundly ambiguous. Practising in a corporate facility extends the power and skills of the protagonist but leaves him disillusioned and in search of the soul of his profession. The Chairman is blamed for tarnishing the profession's reputation but is also depicted as the sole person capable of restoring it. These ambiguities mirror how both patients and

doctors often view corporate hospitals as the apex of hospital care in India and at the same time as its most profound perversion. Similarly, the clinicians at Vishvam Hospitals had ambivalent feelings about their practice there and their relationship with the business administrators. They felt that their predicament was accurately described by Lingegowda's novel, which they suggested I should read to learn more about their situation.

In this chapter, I discuss the medical authority of doctors and its relationship with the "corporate culture" introduced by the administration in publicly listed hospital groups. I show how doctors invoked an ideal of medical authority based on selfless commitment to oppose what they perceived to be the corrosive influence of business administrators on medical practice. I argue that this conflict does not indicate a decline of physicians' professional autonomy but instead points to the centrality of medical authority to corporate healthcare delivery.

In the late 2010s, the medical community was in an uproar due to a series of assaults on doctors by dissatisfied patient parties (Shepherd 2019) and the introduction of Medical Establishment Bills in several states aimed at regulating medical practice more tightly (Phadke 2016; Srinivasan 2013; Vasan et al. 2017). At Vishvam Hospitals, doctors also felt unsettled and dissatisfied, arguing that their professional authority was under attack as patients increasingly questioned their clinical judgement, for which they blamed the undue influence of business-minded administrators on their practice. Indeed, the clinicians were deeply upset about the Chairman's decision to turn the hospital group into a publicly listed company a couple of years earlier. Going public, they suggested, was a betrayal of the original vision of lowering treatment costs to make specialised care available to all people and had put them at the mercy of hospital administrators who were answerable to investors and shareholders and lacked proper understanding of medical care. Such complaints were not unique to Vishvam Hospitals but were voiced by practitioners throughout the country who identified "corporate culture" as a chief culprit for medical corruption and a decline of professional standards (see Chapter 1)

The perceived crisis of medical authority is closely connected to the variable alignments of medical care and financial profit described in the previous chapters. Doctors played a crucial role in adapting treatment to the available financial resources of patients, thereby wielding vast power in deciding how to reconcile treatment plans with profitability. However, this critical function came with risks as patients and administrators could

question the clinicians' decisions if the outcome was not satisfactory, especially when doctors deviated from standardised treatment protocols.

Some doctors argued along these lines, but they generally blamed the management and corporate culture for undermining their authority. This was surprising because they also suggested that the management did not interfere with their clinical decisions and thus did not undermine their autonomy to make decisions in their field of expertise. Instead of interference with their clinical judgement, they primarily opposed the business culture of the management centred on the abstract numbers of revenue, expenditures and throughput, which they felt was inimical to their business practice based on personal relations and an ideology of disinterested service.

In contrast to the perceived money-mindedness of corporate culture, the doctors proposed an ideal of medical authority rooted in what I term "devotional commitment" (see Cohen 2013, 319), the wholehearted submission to a higher authority framed in analogy to the deference of devotees to their deity (Bharadwaj 2016a, 237–39). According to the clinicians, such sacralisation of medical authority was not intended to serve the vanity of doctors. Instead, practitioners and patients described it as a necessary condition for successful treatment as faith and unquestioned trust were required for the divine process of healing to occur. Intriguingly, such commitment not only structured the ideal patient-doctor relationship but also framed how nurses and clinicians described their attachment to the Chairman, whom they considered their "role model" or "leader". By committing themselves to him and his vision of a "charitable" hospital serving the rich and poor equally, they hoped to restore the essence of medical practice as disinterested service and reclaim the form of the corporate hospital for the medical profession. However, the risk of disenchantment is inherent to any form of worship (Bharadwaj 2016a, 238). Many doctors and nurses felt betrayed by the Chairman as he appeared to abandon his vision for personal and corporate gain, leaving the medical community at the hospital disoriented and disillusioned.

Debates about corporatisation in medical sociology have focused on the question of how the rise of investor-owned hospitals and other corporate actors in healthcare delivery has impacted the professional dominance of doctors, which is based on autonomy and control over their work in the medical field (Freidson 1970a; 1970b). Scholars have argued that forms of corporate control, alongside technological developments and the challenges to authority posed by the women's and consumer health movements

(Haug 1988), have significantly undermined physicians' control over their area of expertise (McKinlay and Stoeckle 1988; Stoeckle 1988), while others have suggested that their professional dominance remains intact despite these changes (Freidson 1984). A related debate concerns the question of whether professionalism limits the influence of market forces (Freidson 2001) or, to the contrary, has facilitated the commercialisation and corporatisation of medicine by creating protected markets that could easily be exploited by corporations and other commercial entities (Light 1986; 2010; Navarro 1976; Waitzkin 2000). These debates highlight how the involvement of corporate administrators as well as the pressures from consumers and institutional buyers have created an "international crisis of professionalism" (Light 2010, 270), in which the trust in the medical profession to apply scientific and technical information and skills in the best interest of patients has been shaken.

However, the concern with autonomy arises from the situation in the United States, where the medical profession succeeded in establishing unprecedented control over professional and commercial matters, which resulted in an intense backlash (Light 2004; Starr 1982). The situation is markedly different in India and in many other post-colonial societies where the professional organisation of doctors was weakened by internal divisions and dependence on the government (R. Jeffery 1988, chap. 5). Therefore, it is no coincidence that the clinicians at Vishvam Hospitals primarily pinned their hopes on the Chairman to represent and protect their interests because traditionally, well-connected elite doctors rather than professional associations have exerted a key influence on health policy (R. Jeffery 1988, 187–88; V. Krishnan 2015). In addition, the corporatisation literature does not provide insights into the specific ways in which the debates on professional dominance unfold in the South Asian context, where doctors and patients invoked an ideal of medical authority to oppose a corrosive and alienating corporate culture.

The model of authority invoked has much in common with what the South Asian historian Pamela Price terms the "lordly" type of leadership in the subcontinent, which is characterised by the ethical rule and benevolent protection an "ideal/moral patron offers his clients", in analogy to a "god/goddess, a prime agent, ruling the cosmos as a monarch, imbued with the endless possibilities of cosmic energy" (Price and Ruud 2010, xxv). According to Price, such lordly leadership may appear in various forms: the glamorous and generous mode of "monarchs", the spiritual guidance and knowledge of "gurus" (see Copeman and Ikegame 2012), or the disinterested service of "social workers". I suggest

that the ideal of the "doctor-god" draws on such lordly types of leadership. It equally describes a benevolent form of patronage whereby doctors selflessly extend protection and support to patients committed to them in unquestioned trust.

By invoking the notion of the "doctor-god", I do not intend to make a culturalist argument that doctors are venerated as gods, or like gods, in the Indian context. Instead, the point I want to make is that an ideal of medical authority framed in religious terms structured the doctor-patient relationship and the relation between the medical community and the Chairman at Vishvam Hospitals. This point helps analyse the relationship between medical authority, the corporate form of the hospital, and the Chairman beyond conflicts about professional autonomy. The doctors at Vishvam Hospitals did not simply seek to protect their work from interference by the administration. They also actively sought to attach themselves to the Chairman. To them, the Chairman embodied the ideal of medical authority as benevolent patronage, a doctor-god handing out charitable gifts and receiving unquestioned adoration. By committing themselves to the Chairman and his vision, the doctors hoped to use the form of the corporate hospital to realise their vision of a medical community held together by personalised commitments instead of impersonal business transactions. However, many were left disappointed, feeling that the Chairman had betrayed them and his vision by allowing business administrators to run the company and excluding them from his inner circle. Despite such disillusionments, they remained committed to him and appealed to his authority to advance their interests.

Paternalism and Devotional Commitment

The consultation room was a small, windowless room dominated by a wooden desk in the middle with a computer, printer, telephone, and a pile of patient files on it, with the doctor's chair on one side and chairs for the patient and their attenders on the other side. Next to the wall were a bed with curtains and a washbasin with soap to clean hands before and after investigations. Professional insignia – various medical diplomas pinned to the wall and a shelf with medical books and awards – supplemented the sparse furnishing. In addition, there were several displays of Hindu gods and goddesses: wooden and golden Ganesha statues and, on a separate cupboard functioning as an altar, two oil lamps and a picture of the four-armed Saraswati holding a book, a rosary, a water pot, and a *veena* decorated by a fresh flower garland. The room had two doors, a front door for the patients and a back door for the doctor. This arrangement had the advantage that clinicians could

slip away unseen when they needed a break, without being surrounded by the sizeable group of patients with their families waiting outside and impatiently trying to squeeze in as soon as the front door opened. The back door was also a security feature, allowing the doctor to escape if violent confrontation with patients occurred, as several doctors pointed out to me.

Dr Deepak had just entered through this door, ready to start his outpatient consultations for the day. Dr Deepak was a surgeon in his forties who possessed the boyish charm and jovial sense of humour of somebody who preferred focusing on the pleasurable aspects of life instead of dwelling on its vicissitudes. I was seated in one corner of the room and allowed to attend the consultations, without the patient and their attenders objecting to my presence or being asked for their permission. While observing the steady stream of patients entering and leaving the office, I was impressed by how Dr Deepak swiftly adapted his communication style, switching from calmly and professionally informing patient parties about their condition to telling jokes if they seemed gloomy and coming up with comforting words if they seemed anxious. In general, consultations only lasted a couple of minutes, during which few questions were asked. Instead, Dr Deepak looked at the reports, briefly inquired about the medical condition and history, sometimes followed by an examination, and then informed the patients about the procedures and medications required. In general, he addressed encouragements directly to the patients, reminding them to stay positive and wholeheartedly committed to the treatment, in which case there would be nothing to worry about. Details about the condition and the proposed treatment were usually only said to the patient's relatives, and Dr Deepak switched to speaking about the patient in the third person in these instances.

In one instance, an elderly couple with a younger man, probably their son, entered the consultation room. Dr Deepak jovially greeted them and told them that most of the reports were normal. Seeing the worries of the elderly patient, he exclaimed: "You should be happy sir, why are you not happy?!" The only problem he saw concerned the kidney. Turning to the son, he said quietly: "Why his kidney function has come down, I don't know. That is why I'm sending him to a nephrologist. With this report, I don't want to touch, even if he is normal, please get him back once in a year. Must!" The son nodded in agreement, and Dr Deepak turned again to the elderly patient: "All the best, sir. Don't worry. You will be fine. Happy men will always be fine, don't worry" – "I'm old …", the

patient started. “You’re experienced, not old”, Dr Deepak interrupted. “Ok, sir”, the patient replied, and they both laughed. After they left, the next patient party quickly moved into the room, an elderly patient with two younger men, dressed in white shirts and *dhoti*, carrying a large file with reports from various institutions. Dr Deepak looked through the file and asked them some questions about the medical history in Hindi before telling them that they needed to do some further tests in the basement before they would continue with the surgery. One of the younger men objected that nobody had mentioned surgery before, to which Dr Deepak replied that they first needed to do the test, and then they would decide whether surgery was necessary or not. He then turned to me and told me in English: “Did you notice one thing? I have taken the decision for him, you have understood? Because these people will not be able to come up with a decision. This is the problem of our socioeconomic condition.” He then turned to the patient party again and told them which room they needed to visit for the blood test. “Thik hai?!”, he cheerfully concluded while closing the file and, when they did not object, ushered them out of the room.

After the patients had left, he further elaborated on his remark: “In India, practice is such … You must have seen many of the decisions I took on behalf of them. It is probably because of a lack of education. And naturally, they are in a [government-funded health] scheme. They need not pay a single paisa. They are surrendered to you. You take a decision. It is a moral faith. When the faith goes, then only the beating [patient-initiated violence] happens.” Poor patients had to trust the doctors because they did not have the knowledge to challenge their decisions. Patients’ dependency was accentuated when they did not pay for their treatment out of pocket but relied on charitable support or a government scheme for below-poverty-line patients. This situation reminded Dr Deepak of his previous position in the hospital of a famous guru where patients would get specialised treatment for free. “That also happened at [the guru’s hospital]. A person comes from Nepal or Bihar. Whether I’m going to remove his stone, whether I’m going to remove his kidney, whether I’m repairing his kidney, he’s not at all bothered. He will come and let me do whatever I want. He will have one faith: ‘For devotion’s name I have come here, they will do good to me.’” Such faith in and blind submission to doctors’ medical authority was there because monetary considerations did not dilute the commitment of these patients. In contrast, people who had to pay for their treatment and were able to do so wanted to decide for themselves what course the treatment should take: “If he is some

person who is paying, he will come: 'Tomorrow you will only operate, why are you not operating tomorrow, why are you not doing that, why are you putting a hole?!' Because people have done so much research, they will tell: 'Don't go from here, go there only.' They demand, they demand!"

Many doctors shared the sense that affluent patients, who could afford to choose among the plethora of private providers, were often unreasonably demanding and that they often visited them with minor afflictions that did not necessitate a specialist's attention. In contrast, treating poor patients was more satisfying because these patients came with serious problems and accepted doctors' recommendations in good faith. For example, a medical oncologist told me: "Poor patients kind of trust the doctor better. Educated ones always go around doctor shopping. They go and take four or five more opinions before coming back for treatment. Poor patients would say: 'Whatever you say, I'm fine with it.'" In a similar vein, a senior cardiologist told me over a cup of coffee that he preferred to treat poor patients rather than rich ones because their "social systems" made them more likely to accept the doctor's judgement and they did not ask too many questions. Notably, such statements referred to general convictions rather than actual practice, given that I observed the very same cardiologist attending to patients from the upper socioeconomic strata in his "executive" OPD. In these consultations, he visibly enjoyed engaging with patients who came from the same social class and spoke the same language, listening patiently to their concerns and readily discussing various treatment options.

The complaints about demanding rich patients and the satisfaction of exercising unchallenged authority over poor patients are easy targets to call out for their paternalism and classist assumptions about the poor. Indeed, some doctors did exactly that and criticised such conceptions of medical authority as parochial. For example, Dr Anthony denounced the "god complex" among Indian doctors: "In India, physicians are bred to think they are just a couple of notches below god themselves. Especially more so for people who haven't stepped out of the country. Whereas it is much more equitable [in the UK], where you see yourself as part of a much larger system or field. Here health care is like that. It is very much physician-driven. Decisions are driven by them. That's the way it is structured. To some extent, it works for this system. But that comes with this god complex." Although Dr Anthony deplored a system in which patients "are almost expected to be grateful that somebody has looked at them and spoken to them politely, which

should be the minimum they get", he nevertheless agreed that in the "physician-driven" healthcare arrangements in India, doctors needed to make decisions on behalf of their patients, especially the poor. "Now, with health care in India becoming more adversarial, patient versus doctor, we all tend to think more defensively. The ones who suffer in this are the poor who require us to exercise our clinical judgement to say when it is appropriate to do a test, is it appropriate for this disease to do this surgery or not, to take medicines, to define the threshold when you have to intervene." Indian health care is "physician-driven" because doctors need to tailor treatments to the specific situation of patients who have limited resources at their disposal (see Chapter 3). When patients mistrust the motives of doctors and challenge their clinical judgement, doctors tend to stick to standard protocols, leading to unnecessary expenditures and ill-suited therapies.

In this framing, there are two kinds of medical paternalism at work. One is based on a parochial understanding of professional authority and is potentially dangerous because it forecloses the questioning and critique necessary to check the power of clinicians. The other is beneficial and necessary because it allows doctors to make decisions in the best interest of vulnerable patients without adequate knowledge and with very limited resources. In contrast to Dr Anthony, who wanted to distinguish between these two forms, other doctors believed that these forms were indistinguishable.

Such medical paternalism is not unique to India and can therefore not simply be explained by the country's "hierarchical social structure" (Nichter 1983, 964; see Dumont 1991). In her ethnography of the cancer ward in Botswana, Julie Livingston similarly describes ambiguous forms of medical paternalism as doctors made treatment decisions without informing patients about their prognosis. Livingston (2012, 166) points out that paternalism is inherent to all medical practice as "any medical system is built on the premise that patients cannot fully care for themselves." However, it has a special significance in a place like Botswana, which not only has a long and dreadful history of paternalism in colonial medicine and postcolonial global health, but where it also functions as a necessary tool "to distribute scarce resources in the face of ever-growing demand" (Livingston 2012, 168). At Vishvam Hospitals, doctors also used their authority to adapt treatment to available resources (or to increase revenue), but the triage mechanism was different because most patients were self-paying. Instead of using their authority to distribute limited resources available for all patients, doctors used their power to adjust

treatment to the highly unequally distributed resources of individual patients in the context of a for-profit institution where profitability always needed to be taken into account.

While this situation favoured a physician-driven system in which doctors wielded extensive powers to adjust treatments to resources, doctors also ascribed a therapeutic function to their authority, which required the unquestioned submission of patients. In one particularly striking instance, I was invited to attend such a spectacle of therapeutic power by a senior consultant treating a girl of around twelve years, on whom he had performed complicated surgery to correct a malformation of her jaws. For the post-operative consultation, he assembled his whole doctoral team and me to witness how he would "shock" the patient out of her defective way of speaking, which had resulted from growing up with the deformity, in order to allow her to learn how to pronounce correctly with her tongue and jaw now in corrected positions. When the girl and her father were called into the room, the consultant just stared at her earnestly in silence for two or three minutes, which made the girl viscerally uncomfortable, while her father – neatly dressed in a shirt and cotton trousers but visibly from the lower socioeconomic strata – smiled insecurely. After the heavy silence, the consultant suddenly shouted at the girl telling her to recite the alphabet, harshly correcting her when she stumbled or made a mistake. After some rounds of recitation, he seemed satisfied with the result and swiftly changed the tone, kindly reminding the girl to remember the lesson and keep on practising. Then, she would have a bright future ahead of her. The father and the girl, now beaming, profusely thanked the doctor for his help. Other doctors might have criticised this "ethical scene" (Cohen 2010), demanding the patient to wholeheartedly commit herself to the therapeutic power of the doctor, as a primary example of the prevalent "god complex" among Indian physicians and an instance of outdated pedagogy. However, while they might disagree with the method chosen, they nevertheless agreed that patients needed to devote themselves entirely to a treatment plan and could not question the doctor's judgment without harming the prospects of healing.

Such devotional commitment allowed the doctors, ideally, to serve the patients to the best of their knowledge and ability. In this process, the outcome of treatment was never entirely in their hands but ultimately up to god (Bharadwaj 2006; 2016a). However, just as the patient's devotional commitment prepared the ground for a successful outcome, so did the doctor's selfless worship of the patient. "We are all very god-fearing", Dr Deepak explained, "We feel that we are connected to god. We see god in the patient.

You do your work properly; god is listening to you […]. [The guru] used to say: 'Look to god in your work, you see god there, god is next to you, you don't come to me.' That is why when somebody says: 'This is a Vajpayee [government-funded health scheme] patient', it will never come into my picture at all. You're treating a god there." A senior consultant in gastroenterology put it as follows: "There is a saying by one of the most outstanding saints of our times [Ramakrishna]: 'Every jiva is shiva.' Service of *jiva* [individual living being] is worship of *shiva* [god]. That is the fundamental of Hinduism, that is the way of life, *advaita,* as we say. Everything is united. If you have a humanistic approach, you don't have to go to a temple or church to do anything. This is one thing that has to seep into us. Religion is one thing, having a spiritual thing, you don't have to do some mystic stuff, but it is just the way you live your life. Whatever we are engaging with, it is worship."

Strikingly, not only doctors described their service to the patients as worship, but also the patients framed their relationship with the doctor in devotional terms, stressing the need to follow the doctor's order devotedly and having faith in their judgement. For example, a pharmaceutical consultant in his late fifties receiving treatment for multiple myeloma argued that the relationship of a patient to a doctor ideally corresponded to that of a disciple to a teacher or that of a child to the parents: "It's like a *guru shishya* [teacher-disciple relationship] in India. If you believe in a doctor, in your guru, if you believe in him like your parents, then there is no stopping in treatment. [My doctor] will look after me." Such devotional commitment was necessary because patients would otherwise harm themselves through doubt and negative thinking. This erosion of trust had happened in the West, the consultant suggested, where the emphasis on autonomy and information-sharing had dissolved trust in doctors: "In America, there are so many self-help groups coming up. They are going on, giving their experience, go on telling: 'For me, loose motion [diarrhoea] was there, when I took so and so.' So mentally, I will become blocked. I start thinking, when will my loose motion start." Too much information and questioning the doctor's judgment undermined the faith and peace of mind necessary for healing. Instead, a long-term personal relationship and trust were indispensable: "For 5.5 years I'm seeing [my doctor], I know him very well, he knows me well. When you see your patient, you see your doctor, you feel that: 'Now I'm OK.' That gives you positive [feelings]. When you generate positive [feelings], this cancer, everything, runs away. Mentally it stabilizes you."

If entrusting oneself to the medical authority of doctors was vital for the success of the treatment process, too much information could undermine the faith necessary to turn suffering into healing (see D. Banerjee 2020, chap. 1). Thus, a patient undergoing a complicated cardiac surgery recalled how he submitted himself to doctoral judgement: "[The doctor] told me it is a high-risk surgery: 'I have to tell you both sides. Everything is on god." I said: 'Ok fine. Whatever decision you take, I have to follow.' There is nothing on my part. Knowing many things doesn't help me." In another instance, an attender reprimanded the doctor for telling the patient, his mother, about the risk of the surgery, jeopardizing her faith in a positive outcome: "[My mother] is worried, she knows. The doctor spoke out, actually. I don't know. He is a very senior person, and my mum is very smart. When he was telling me the risk for the surgery, she could understand. She could sense it." Even though the doctor was speaking in English, which the patient did not understand, she could sense the gravity in his voice. According to the son, this was dangerous because it could lead to negative thoughts and doubt: "The most important thing for a patient is to be very positive. It helps with the outcome. If they are negative with the surgery – 'I cannot withstand, I cannot do, something will happen to me' – the successful percentage will definitely come down. If they are confident, it helps. What way it helps, I don't know, but it helps." During interviews, some attenders were not comfortable speaking in the presence of patients because they did not want the patients to know about their condition, in order not to hurt the prospects of healing. Similarly, patients often knew less about their medical condition, treatment, and financial matters than their attenders, which is why the attenders were generally in charge of answering questions (Venkat 2017, 98; see Brada 2013).

Apart from the careful management of information to foster the faith necessary for healing, the importance of strictly following the doctor's orders was frequently mentioned (see Whitmarsh 2009). In one instance, Sumitra and I talked to an elderly farmer from North Karnataka who was treated for cancer in the intestine under a state government insurance scheme for below-poverty-line people. His son accompanied him, and another patient present in the ward also joined the conversation. The patient was a vegetarian, and the son told about the difficulty of following the doctor's dietary advice: "The doctor suggested to eat eggs, but he does not like to eat, but now he has to eat eggs. Because after surgery, the doctor said he needs to heal the wounds also. Doctors told him to eat daily six eggs. He is a vegetarian, so it is very difficult to eat eggs. But daily three he is

eating, not eating yellow only white he is eating." The other patient joined in: "Eat one yellow and three white, you have to eat because you need the energy." The elderly patient objected: "I am old. Why I want energy?" The other patient replied, "You have to cure and heal the wound." The elderly patient said: "Yes, because of that, I am eating with difficulty." This interaction revealed that the idea of helpless and devoted poor patients mobilised by the doctors was a self-serving fiction. The patient did not understand the doctor's order as an absolute command to be followed blindly but rather as a template to be adapted, replacing the instruction of six whole eggs with the more appropriate course of three egg whites per day. At the same time, the patient did not question the prescribed treatment, and the encouragement to follow the doctor's instructions highlighted how such obedience was considered essential for successful treatment. Indeed, the need to devotedly follow the doctor's orders was frequently mentioned by patients, their attenders, or even strangers, suggesting that this was a socially validated way of showing care and facilitating a positive treatment outcome.

In a commentary on South Asian tissues economies, Lawrence Cohen (2013) has proposed the notion of "commitment" or the "given over" to break away from the anthropological focus on the gift and its structure of inevitable return. According to Cohen, the notion of commitment "gestures both toward autonomy (as in the liberal gesture of individuation 'I commit to you') and heteronomy (as in the figure of psychiatric commitment: 'she was committed to the institution'), as well as toward a range of giving-over in which we cannot easily write either of autonomy or heteronomy (as in the fact of religious commitment, where the motions of grace are notoriously contestable across, for example, both Christian and Hindu paradigms of devotion)" (Cohen 2013, 319). Adapting this notion for the present analysis, the devotional commitment to medical authority analysed in this section can be conceptualised as a genre of an ethical scene through which patients and doctors recognise themselves as "good" patients and "ethical" doctors. While these commitments should not simply be dismissed as pernicious forms of paternalism, they should not be romanticised either. In some instances, patients' failure to commit themselves to medical authority could be used to blame and shame, for example when relatives and hospital staff blamed a woman for causing her critical condition, which led to her admission to the intensive care unit, because she had not told the doctors of her post-birth infection, presumably due to gendered taboos, and instead visited temples for help. In other instances, the commitment kept patients tormented by anxiety as they feared

that doctors withheld vital information from them. For example, we found a patient in a desperate panic. The doctor had ordered him to do a test outside the hospital without informing him about the reason, making him fear the worst as he believed that they wanted to get rid of him because he was a hopeless case.

Medical Authority under Attack

For better or worse, the doctors at Vishvam Hospitals agreed that the doctor-patient relationship was changing and the model of selflessness and devotional commitment was no longer functioning correctly. The clinicians viewed patients' lack of trust in the medical profession as the most visible sign of this crisis of faith and bitterly lamented the fact that the "educated" patients no longer trusted their expertise, while the "uneducated" resorted to violence when an outcome did not match their expectation. Few doctors reported having experienced violence themselves, but stories circulated widely in the hospital about mob gatherings and physical clashes between doctors and patients. In general, most practitioners felt that such incidents were on the rise, and newspaper reports about such attacks led to widespread agitation and strikes by doctors in the country (see Ghosh 2018; Kar 2017; Nagpal 2017).

Doctors generally identified "corporate culture" as the chief culprit for their tarnished reputation and perceived loss of status. For example, a senior consultant expressed the sentiments of many when he decried the money-mindedness of the corporate administrators: "If the corporate people have it, they will remove everybody and move in extremely money-minded people. […] The purpose of these administrators is to corrupt the doctors so that they, not consciously but subconsciously, become indifferent to the cost for the patients. They will only think, can I do this investigation, can I do that. Ultimately, patients are considered clients, not patients. Client actually removes the connotation of suffering. You are only there as a business relationship. The day the word client was used in the medical profession was the day the medical profession died." The pressures of corporate management not only led to overtreatment and unethical practices, the business culture that came with it also corrupted the doctor-patient relationship because it replaced a moral bond with a purely monetary relation. Some (upper-class) patients expressed similar feelings, complaining that the emotional bond with doctors was jeopardised by the pervasive money-mindedness brought about by the corporate structures. After nostalgically remembering his family physician who knew him since he was a

little boy and with whom he could discuss everything, including domestic matters, an elderly cancer patient told me: “Today it is changed, because of corporate involvement. When it is corporate involvement, money becomes stringent. It becomes like a business rather than an emotional relation.”

To learn more about the changes introduced by the corporatisation of hospital care, I went to see Dr Nijesh, whom one of his colleagues recommended I should speak to if I wanted to learn about the vicissitudes of corporate practice. A balding, athletic surgeon in his late thirties or early forties, Dr Nijesh immediately made clear that he was not someone to mince his words. “I’m completely open to you. I don’t want to talk flowery things in my life. How the director speaks, I know. The Chairman himself is a big orator. I’m not like that.” Explicitly contrasting his candidness with the Janus-faced character of official corporate parlance, he laid out his experiences of working at Vishvam Hospitals in short, restless sentences. These experiences highlighted the difficulties of establishing a reputation and a firm patient basis as a young specialist without long-standing connections in Bengaluru.

When Dr Nijesh began working at the hospital, he joined an existing department, helping his colleagues with surgical reconstruction. He soon realised that he was taken advantage of because he was not properly remunerated for his work and could not build his own pool of patients because he managed other surgeons’ cases. After the department had split up, he struggled to establish a thriving department of his own. He held particular grievances against the hospital administration because he felt they judged doctors only by their financial success and did not provide any support or protection for building up their practice. He related an incident where he sought the help of the administration in dealing with a patient: “One lady had asked me: ‘My surgery you did, and it is even worse than before.’ I had all things photographed, documents I had written. She was not going from my OPD for half an hour: ‘I want my money back.’ That’s when I called the management. They said: ‘You only talk.’ No one should be commanding doctors like that!” Dr Nijesh compared the administration to a queen bee, reaping the benefits of the labour of doctors who toiled away like drones to generate profit for the hospital, while nobody protected them when they got into troubles with patients. These troubles involved being sued or physically attacked by the patient party, as in a series of violent attacks on doctors, which just had resulted in a country-wide doctor strike last week. These struggles and lack of recognition made my interlocutor question his decision to become a doctor: “Why

should you give 17 years of your life for studying this profession when at the age of 40 you need to think whether you will survive or not?"

Having reached this conclusion, Dr Nijesh jumped up and invited me to join him and his colleagues and friends to have lunch in the doctors' room. The doctors' room was a simply furnished chamber with a large table, a newspaper stand, a sofa and two bunk beds for the clinicians to rest. Located next to the Medical Intensive Care Unit, the room was usually occupied by the anaesthetists waiting to be called before surgeries and some surgeons seeking rest or to have lunch in peace, safely hidden from the patients and their demands. In the doctor's room, I was introduced to the anaesthetist, Dr Suri, a man in his fifties with silvery hair and a prominent moustache, who appeared very earnest at first sight but could suddenly break into a broad grin revealing a roguish sense of humour. Unlike Dr Nijesh, who had only joined a few years ago, Dr Suri had been at the hospital almost from the beginning and, as an anaesthetist, was familiar with all its secrets. They invited me to join them for lunch, and between bites of banana chips and *upma* I inquired about their experience of working in the hospital. Like Dr Nijesh, Dr Suri was upset by the doublespeak practised by the Chairman and his management, who claimed to have revolutionised hospital care to the benefit of the poor but were just concerned with profits: "The same caesarean section is done at 40'000 outside. Why will we charge 1.5 lakhs? […] If you want to have more profit, that is a different story. But you should not claim that you're doing charity, you're doing it cheaply." In addition, the administration did not speak truthfully about their motives, and they questioned doctors although they did not know how to take care of patients. "I sit with the patient," Dr Suri said. "The administrative staff sits in the corporate office. They don't see the patients. […] They will ask: 'Why didn't you do [more procedures].' If you sit and interact with the patient, you don't feel like doing that." Putting pressure on doctors, the management undermined the doctor's position and placed their interactions with patients under the mandate of profit calculations.

In some ways, the resentment towards the corporate management they believed threatened their professional status was felt particularly strongly by doctors like Dr Suri and Dr Nijesh. Like Dr Lingegowda, who had written the novel *Pan-Pan Doctor,* whom they knew and whose book they recommended to me, Dr Suri and Dr Nijesh had grown up in provincial towns in Karnataka or neighbouring states, did not attend the country's flagship medical colleges, and had never gone abroad for work or training like some of

their colleagues in the hospital who hailed from more elite backgrounds. They had managed to secure a place in the exclusive circle of doctors working in a metropolitan, renowned super-speciality centre, but still, a sense of inferiority seemed to linger. Consequently, they were susceptible to and upset about the challenge to their professional standing by the ilk of Mr Thomas and business people in the administration, whom they believed to be morally and socially inferior to them. Thus, they did not fail to mention that Mr Thomas was only a physiotherapist by training rather than a proper doctor.

Despite such internal differentiations within the medical community, the clinicians at Vishvam Hospitals unequivocally shared the opinion that the increasing power of the administration had affected their practice for the worse. Thus, even one of the most senior cardiac surgeons, who was a member of the founding team, nervously laughed when I asked him about the changes in their practice over the years, before elaborating:

> See, the world is changing. When we were together, we didn't have the corporate culture. The corporate culture is a little different from how we started. [...] We can't run it anymore, [the organisation] has become so huge. It's diversified, not only in this city, there are different hospitals, outside the city, outside the country. So there has to be a professional contribution on the management side, which is called corporate. They look at us and the patients as coming between their work and the bottom line. They don't see the doctors, the nurses, the allied forces, the patients as a necessary component for that bottom line. They're looking at that bottom line, and they're looking at you as bringing in to make that bottom line work. They're looking at it from a different angle. They don't have the humane approach to a patient. I mustn't say that loudly because they will jump at me, but it is their attitude. And once that sets in, the focus shifts.

Like the senior cardiac surgeon, doctors believed that the administration did not correctly understand their work because they only dealt with numbers rather than with actual patients. However, how exactly was the approach of the administration focusing on the "bottom line" different from the "humane approach" of the doctors?

Notwithstanding the complaints about the administration's interference, doctors stated that the management did not actively intervene in their practice. "We hear that outside they have pressure to get revenue generation," Dr Suri said. "Here, they don't really [put pressure]. Last few years, they have been calling and telling the revenue is low and all these things, but they don't really bug." Especially since the company had gone public, revenue was a constant concern for the administration, which kept a close eye on the data from each department. However, the management did not set targets for increasing revenue as other corporate hospital chains were reported to do (Kay 2015), which physicians positively highlighted. Instead of intervening in clinical decisions, the administrators exerted their influence more subtly, by refusing to fill positions or invest in

departments they deemed to be “underperforming”, for example. Most doctors did not oppose such intervention in principle, as they accepted that their practice needed to run profitably, but they objected to the bureaucratic control exercised through such decisions. “The system becomes inefficient,” a senior cardiac surgeon told me with cold fury. “A broken computer cannot be replaced for several months because of rings and rings and rings [of bureaucracy]. [The managers] say: ‘Why do you need? We have given you last year, you don’t have the budget.’ […] If you’re a public limited company, all these are necessary evils.”

Instead of demanding a specific revenue, doctors suggested that managerial influence and the pressure of operating in a publicly listed company were mostly felt through cost-cutting and lacking investments, which they attributed to the fact that the management’s decisions were primarily orientated towards the next financial report rather than improving long-term clinical outcomes. Dr Anthony highlighted this problem when discussing the role of Mr Thomas, the Chief Operating Officer: “Mr Thomas is kind of answerable to shareholders, to those who got financial incentives. […] The way they would judge his success or failure is very much limited to money. How much you’re bringing in versus what your cost of running is. His yardsticks are set on very short-term goals.” A senior cardiologist concurred: “The clinical facilities need to be upgraded. If you’re answerable to the funding public, there are some things that you deliberately cannot do that really need to be done. For example, there are so many things that can be done to cut down on hospital infections, number of staff, good quality material, good quality labs.” Investing in high-quality equipment and upgraded facilities did not reflect positively in the quarterly financial reports for shareholders. Consequently, such things tended to get delayed, although they were indispensable for treatment quality in the long run.

Apart from lacking investments due to a narrow business mindset unfamiliar with clinical realities, doctors blamed the management for intentionally creating divisions within the medical community through an unfair incentive system. Consultants received only part of their salary as a fixed sum. The other part was based on the number of procedures they conducted. Procedures performed on patients covered by a government insurance scheme were omitted because the hospital management argued that these patients did not generate enough revenue. In addition, medicines and consumables were not incentivised either, because the medical community had resisted it. According to Mr Thomas, such incentives were necessary so that doctors had “their skin in the game”;

otherwise, they would come at 10 am and leave at 3 pm. Physicians fiercely disputed this interpretation, arguing that the incentive scheme was a convenient way for the management to reduce the fixed costs and save money by paying them lower salaries. In addition, they argued that the system was highly intransparent because the amount paid differed for every speciality and that they did not receive accurate reports about what was their due. More importantly, they perceived it to be unfair because it did not truthfully reflect the work they were doing and favoured those doctors who happened to practice in a high-revenue generating specialisation. "The pharmacy might make more money than doctors", Dr Suri explained, "but you cannot run the pharmacy without the doctors. The administrative people divide like this. They say the pharmacy has done [well], this department has not done [well]. Have you seen an Indian meal? An Indian *thali* will have salt, pickle, curry, everything. To make a good meal you need everything, even a small quantity of salt is needed. You cannot tell salt is not required. Everybody's presence is important. They should not differentiate like that. Dr Nijesh here. He goes and does surgeries in the cardiac [hospital]. It is not recognised, it is not documented, it is not paid, nobody takes into account he has done that job. What they ask is what is your revenue. That is not right."

Undermining collaboration between and within departments that is vital for good treatment processes was not simply incidental, the doctors suggested. Instead, it amounted to a deliberate attack on the professional unity of the medical community by the administrators who wanted to have control. "From a corporate and administrative point of view," Dr Anthony pointed out, "administrators don't like [units that work together] because physicians are already a powerful group and if you put them together and they speak with one voice, it is very difficult to make them do what they want. Generally speaking, what they want is generally good for the patients and the overall long-term good of the hospital, which may not always translate into good revenue or a good bottom line. Over the past 4–5 years, they have tried to undermine that and make it more consultants competing with each other. So that everybody is going to the administrator for adjudication or favour, which transfers power in a sense. […] I don't think this is an unconscious decision or strategy." From the doctors' perspective, the managers attacked the unity of doctors because they wanted to have free reign to structure the hospital business in line with maximising profits for the investors and shareholders. Such interventions

also ran counter to the patients' interests because the doctors were the primary guardians of treatment quality.

In voicing their critique of administrative interference, doctors raised valid concerns about the effects of corporatisation on medical practice, which introduced financial pressures to optimise numbers to satisfy shareholders while it came with inadequate incentives for long-term investments to improve clinical outcomes. However, the equation of patients' with doctors' interest was too easy, given that the physicians, too, had commercial interests in a fee-for-service system. Even without corporate involvement, patients, could therefore never be sure whether doctors were advising them "surgically on the right ground" or because they wanted "to send [their] kids to college", as Dr Anthony put it. In opposing "corporate culture" and the "money-mindedness" that came with it, doctors did not question that services were offered for a monetary reward or that healthcare providers needed to make a financial profit. Therefore, they did not simply oppose the commercial aspects of medical practice (cf. Freidson 2001). Instead, they attempted to shape their commercial and medical interactions with patients on their own terms, without interacting with a management business culture that they felt was alien to the medical field (see Light 2000).

Hence, many of the consultants' grievances concerned the fact that the administration did not involve them in business decisions properly and did not share the profits fairly with them. Importantly, they felt that the administrative people did not understand medicine as a business properly. Dr Simon told me: "The administrator is not medically equipped to understand how to make money. […] They think you cannot actually make money by entrusting the doctor and improving the care. They think we are spending too much money, [that] we should do it by force and by fast economics." Managers did not know how to make money out of offering good healthcare services because they did not understand medicine and approached the medical field as any other business. Dr Nijesh put it in this way: "The market-driven strategy by MBAs who are sitting in that post is going to be very disastrous for the medical field. If it is a mercenary field, it is absolutely fine. But in medicine, you have to deal with emotions. You have to deal with patients, with families. There is a lot of permutation, complications in getting patient fit and discharged." A senior cardiologist made a similar point: "What has been happening is that the actual running of the hospital is in the hands of general managers, who have some kind of business qualification. But almost no one with any kind of medical background

which would combine effective patient care with good business to the hospital." Because the business administrators lacked a proper understanding of medicine, they could not truly grasp its commercial aspects.

As the doctors saw it, the administrators viewed the medical business as a mere numbers game in which doctors were important, but replaceable actors and patients only figured as a depersonalised quantity. In contrast, doctors viewed their interactions as deeply personalised and characterised by various commitments. "In the business of medicine," Dr Anthony explained, "the final point of sale is when you sit across the table with the physician. That is when the patient decides if I want to be here, elsewhere, if I trust him. The rest of the infrastructure becomes very secondary to that interaction. It is very different from other businesses in that sense." Not only did the business managers not understand this personalised relationship of trust, they actively wanted to undo it: "That is what the management says: 'We don't want patients coming for doctor x, we want them to come for Vishvam Hospitals where a Vishvam doctor will treat them. […] [But] your interaction is very different, on a one to one basis. There is literally no other enterprise like this where you have repeated one to one interactions with individuals, and you think you can anonymise the person you interact with. It's nothing like that." Doctors, therefore, opposed the administration because they felt its interference undermined their personalised relationship with their patients.

The grievance of the doctors with the corporate management was not simply that they were pushed to generate more revenue but that the administration did not offer enough support and protection and did not allow them to operate their practice according to their terms. Indeed, some complaints concerned how the administration forbade doctors to run their own practice outside the hospital. "Previously I used to go outside operate also", Dr Deepak said, "then hospital told me [to stop doing that]. Previously they also have told me, but it was not strict because everybody was going. I used to get patients from there. But the hospital said some day I shouldn't do. From there, I had good referrals." These disagreements are a consequence of the diverging interests of individual practitioners and the hospital as an institution. More importantly, they result from competing business cultures. According to Talcott Parsons (1954, 34–49), what distinguishes the doctor from the businessman is that the first operates within an institutional pattern of disinterestedness, in contrast to the context of self-interest in which the latter functions (see Light 2000, 209–11). The problem of doctors operating in the institutional setting of

a corporate hospital was, however, not that it pushed an essentially altruistic profession towards self-interestedness but that it made it more difficult for them to maintain the perception of disinterestedness that was important for their dealings with patients. Corporate practice, therefore, created the conundrum for clinicians that it provided professional opportunities, both medically and financially, to doctors but at the same time threatened to undermine the professional standing that allowed them to exploit these opportunities (Light and Levine 1988, 19).

The Corporation of Devotees

After lunch in the doctors' room, Dr Suri invited me to come along to the endoscopy room to have some mangos for dessert. When we arrived, we were greeted by the two attending nurses, who led us to an adjoining room where a large bowl of freshly cut mangos waited for us. I felt uncomfortable because the low moaning of patients undergoing the painful procedure was audible from where we were sitting. Dr Suri, in contrast, was clearly in his element and thoroughly enjoyed the scene. He leaned back in his chair and indulged in mango slices while answering phone calls. Meanwhile, the two nurses kept looking around the corner and beaming at us, excited by the presence of Dr Suri and a foreigner. Dr Suri hung up the phone and turned to me again. "This man is coming for twelve years. We operated him twelve years back. He doesn't go [visit the hospital] without calling. I told him: 'It's okay.' He just said, 'No Sir, I just want to check [with you].' That goodwill is not there [anymore]." As we got up to leave, one nurse inquired whether we wanted some coffee, biscuit, chocolate, or dry fruits. Dr Suri smiled and proudly pointed out to me: "She asks to give so many things!" The nurse, equally pleased, replied: "They are taking care of us, we have to care [for them]. If they are not taking care, we will disobey. They're taking care, we have to take extra care." Before parting, Dr Suri told me: "I have a close bonding with the people there in the [cardiac] building. It's like a family. We know each and every person there. […] I know from the lowermost to the topmost people. I used to interact with the big man."

The bond between patients and doctors was not the only commitment characterising medical practice in the hospital. Equally important were the commitments connecting doctors with their colleagues and the broader medical community of nurses and technicians. As in the doctor-patient relationship, physicians generally described these

commitments in terms of hierarchical relationships of dependency modelled after idealised familial relations. “Doctors are the breadwinners”, Dr Nijesh stated, “not only for their families but the families inside: the sisters, the sweepers, everyone who cannot earn. If we don’t earn, these people don’t get money. If we’re screwed, they are screwed more.” In this view, the doctor who convinced a patient to undergo treatment earned money not only for themselves but also for the hospital and its employees. In turn, the doctor could expect unwavering loyalty and unquestioned acceptance of their judgements. As the cheeky comment of the nurse in the endoscopy room reveals, the relationship also mandated that doctors commit themselves to look after the well-being of their staff by being generous and caring to them. If such commitments were not upheld, the staff had the moral permission to disrespect the doctor’s authority by ignoring orders or working slovenly. However, when the commitments were honoured and the different parts of the medical community worked together in unity, great things could be achieved. “It’s all like one big family,” Dr Anthony said. “You have your tensions within family, but there is also a central unity of purpose. And I think you achieve greater things like that.”

At the very heart of the medical family characterised by mutual commitments was the Chairman of the hospital, the “big man”, as Dr Suri called him. The people of the hospital derived considerable satisfaction from working in close proximity to a man of national and international renown and reputation. The long-standing administrative and nursing staff, in particular, had a deep sense of loyalty to the Chairman. “The Chairman’s heart is good”, one nurse told me, “he is a holy man.” The staff had been in close contact with him in the early days when the hospital was still a tiny facility, and most people thought he was highly charismatic and had the talent to win over people’s hearts. The Chairman himself was said to put great emphasis on loyalty and dedication. Thus, a senior manager joked that the Chairman was like “Don Corleone”, the Godfather in Francis Ford Coppola’s film trilogy, valuing loyalty and dedication above everything else.

Not only nurses and administrators but also physicians felt a deep sense of loyalty towards the Chairman. “Sir [the Chairman] is definitely an influence. He’s truly a visionary”, a breast oncologist said, “his outlook on health care is completely different. If you meet him, he’s a very charismatic person, a great motivator. He was one of the biggest reasons to join the hospital.” Other surgeons referred to the Chairman as their “role model”, and an anaesthetist pointed out: “We look at him as our leader. He can take any decision.” In particular, many doctors fondly recalled how the Chairman had personally

taken the effort to contact them and show them the hospital premises, laying out the plans for further development in detail. For instance, a senior pulmonologist recalled the first meeting with the Chairman as follows: "I got a call from the Chairman. […] When I met him, he took me to the roof and pointed out the different parts of the campus: 'This is gonna come here, and that's gonna come there.' I was thoroughly impressed with his vision. Practically everything he told me came up. He's a very persuasive speaker. I didn't look back, and from day one, I enjoyed it." Being involved in the Chairman's visions inspired a profound sense of attachment. One of the cardiac surgeons who had helped establish the hospital described his quasi-religious attachment to the Chairman's vision: "He is a visionary, and I have the passion and the energy to work, to fulfil his vision. Initially, I thought, when we started: 'Is this a normal thinking man who says we do so many [things] or is it someone else?' Because we can't see that. But he could see!" The surgeon first experienced a moment of doubt when confronted with the Chairman's grand plans to revolutionise hospital care and make it accessible to the poor, doubting the Chairman's sanity and veracity. However, once his doubts had been replaced by faith, he made it his life's mission to implement the Chairman's plans.

The principal reason why the Chairman inspired such loyalty and devotion among the physicians and staff appeared to be that he exemplified the archetype of the doctor-god. They hardly ever failed to mention the Chairman's charisma and command over patients and the wider public and that he was revered like a god among patients from Bangladesh and West Bengal. "They don't want to see us. They want to see him", a cardiac surgeon explained. "He sees 80 to 100 patients a day. The majority are Bangladeshi. They just want to meet him, talk to him. He touches them, and they are happy. After that, what happens, they are not bothered. They know we [the other cardiac surgeons] operate this or that, but under his care in his hospital. They don't keep the Prime Minister of Bangladesh's photo at home. They keep his photo in the majority of the houses. Even if they don't have heart diseases, they pray to him. If not to get better, not to give them heart disease. He's revered like a god there in Bangladesh and West Bengal." The slight that their reputation was no match for the admiration patients fostered for the Chairman was compensated by the fact that they were connected with him and the reverence afforded to him served as an example of the devotional attachment doctors still could evoke despite the challenges to their quasi-sacred authority.

Such devotion and the Chairman's visionary capacities to conjure up a model of making treatment accessible to the poor allowed the doctors to see their mundane everyday activities in light of the noble purpose of curing the needy. Indeed, many doctors harboured nostalgic feelings for the selfless commitment and undiluted care they believed was delivered in mission hospitals like Christian Medical College Vellore or healthcare institutions sponsored by gurus like Sathya Sai Baba. In these institutions, a patient was not just seen as "a person to be dealt with clinically", but as "a person to be helped", as Dr. Simon put it. In addition, they were driven by a higher sense of purpose which made all the difference. "Having a sense of purpose drives you to achieve much more than you would do otherwise", Dr Anthony put it. "Humanity wants to be part of something greater than their own lives, a higher sense of purpose, and the organisation you work in provides that." Indeed, working at Vishvam Hospitals under the leadership of the Chairman allowed the doctors to combine the best of both worlds. On the one hand, practising at Vishvam Hospitals came with sophisticated medical equipment, prestige, and salaries comparable to other private hospital groups. On the other hand, the Chairman's presence made sure that Vishvam Hospitals was a corporate hospital with a difference and assured doctors that they were not just part of a for-profit enterprise but were working for the higher purpose of helping the needy, following the prevalent humanitarian self-understanding of the medical profession as serving humanity. "The day the Chairman leaves Vishvam Hospitals", a senior gastroenterologist said, "it will just be one corporate hospital that is looking at revenue, revenue, revenue. He is what makes the difference in the whole system. That's why I call him visionary."

By providing a sense of purpose and inspiring dedication and loyalty among the medical community, the Chairman's presence curbed the back-biting and competition that characterised many hospital departments, the doctors claimed. "There are very few changes. The core team has remained the same", a cardiac surgeon said. "We have an excellent relationship with colleagues. The Chairman made that it was a level playing ground. No backbiting, you took my patients, I took your patients." Another cardiac surgeon and founding member of the hospital stressed the same: "Basically cardiac surgeons are very egoistic fellows, very arrogant and egoistic. But when we started, [the Chairman] gave me a free hand to run the surgical services. I didn't mind somebody coming up. I encouraged teamwork. When you have that team spirit, you do it for the welfare of the community, not for your well-being. That is why there are twenty cardiac surgeons under

one roof; otherwise, they'd be fighting with one another." Committing themselves to the Chairman and his mission was, in this sense, not an end in itself for the doctors. Instead, it allowed them to return to the true nature of their profession, which consisted of a selfless commitment to healing, and thus to overcome all the detrimental aspects of "corporate culture" and its money-mindedness.

This understanding came with the paradox that the Chairman was an exemplar of the benevolent doctor-god as well as an exponent of the corporate world that the doctors blamed for tarnishing their profession. Indeed, the physicians were acutely aware that the Chairman was not only a skilled surgeon but also a shrewd businessman. "The Chairman got a very clear business head in addition to being a very skilled cardiac surgeon", Dr Anthony said. "You don't get to run a fifteen crore organisation [otherwise] […]. He's always looking at twenty years from now, but not many people will know what he is looking at." Being a shrewd businessman was thus very much part of the Chairman's visionary quality that made him so appealing to the doctors. Therefore, the seeming paradox was the very reason why the Chairman was so revered, because he was able to transcend domains and incorporate them. He was a gifted surgeon and leader to the medical community, asserting his authority by giving treatments for free or at a discounted price to the poor in ways directly recognisable to the clinicians. At the same time, he ran a publicly listed corporation and gave lectures at international business schools. "The Chairman would be there operating till 12 am," a consultant said admiringly. "He doesn't have to, but he is there. He is a fantastic surgeon. He is a multi-billionaire, he could stay home, but he is there. There is definitely a business side, but there is a big soft side also." By combining business and social service as a compassionate doctor, the Chairman promised to bring the corporate world under the fold of medical authority, using it to strengthen the role of doctors instead of undermining it.

The Chairman's Betrayal

Devotional commitment to a higher cause comes with the risk of disenchantment. In Indian IVF clinics, Aditya Bharadwaj (2016a, 238) observed that the cultural framing in which doctors were viewed and revered as "life-giving, sustaining gods" could lead patients to feel betrayed and angry if their commitment to the doctor-god did not produce the desired results. These moments of recognition were, according to Bharadwaj (2016a, 238), "not dissimilar from the momentary disenchantment, and even alienation,

experienced by devotees when their deities fail them." At Vishvam Hospitals, where the doctor-patient relationship and the relation between the hospital community and the Chairman were modelled after the commitment of devotees to their deity, the clinicians and nurses similarly experienced bouts of disillusionment and anger directed at the Chairman. In particular, since the hospital had turned into a publicly listed company, the admiration and loyalty towards the Chairman had partially given way to a sense of abandonment and resentment.

A senior nurse, who had worked for the hospital since the early days, fondly recalled in conversation how the Chairman used to make sure that everything was performed according to the highest standards. "He was very particular about patient safety. Those times he came for rounds, it used to be perfect. He was very strict. We think it was a small thing, but he would not leave us. Even this he would not allow", she said and pointed towards an electrocardiograph machine, "if [remains of] gels were there, he would not accept, the correct reading won't come. He used to catch us every time they had to clean. So much it was. […] Because of him only actually I stayed here. Because that motivation was there, it was all personal, very few staff, very personal. […] Always he corrected, sometimes he shouted, but the next day made sure that we were okay. […] He would make sure everybody reaches home safe, like that it used to be here. Now we cannot even see him like it is. That was the starting time." When I inquired whether it was more difficult now to do her work without the Chairman's benevolent attention, she replied: " Nobody is there. If you're invested, you continue your work. But nobody tries to motivate. […] There is nobody like him. […] We will all not be there for long." Without the personal supervision and care of the Chairman, the staff felt left alone and considered looking for work elsewhere.

Apart from administrative and nursing staff, the doctors also harboured smouldering resentment and a sense of betrayal. Most of the doctors I spoke to felt that the original vision they had signed up to when joining had changed without them being consulted. When I told one of the consultants about my conversation with the nurse discussed above, he told me that many doctors felt the same way: "This is similar to what I hear across the board from people who have worked with him since the beginning. We all feel that we have been used. It is not what things were in the beginning. In a sense, people were brought in on a dream or a vision. When you see that vision or dream changing, you feel

disillusioned." The betrayal of the vision was deeply personal because the Chairman incorporated the organisation as a whole, which is why he received all the credit for what happened – and the blame. "I feel it is the attitude of a person, how you respect your colleagues, how much you care for them", a consultant explained. "Some people respect a lot, even if you give small help, they remember their whole life. *S*ince it is an individual, everything runs on him. In Fortis, it runs on the CEO. They cannot take decisions. But here it is one to one*."* Having established the centrality of the Chairman for the organisation, he continued: "He never had gratitude, he's self-interested only. He's a shrewd businessman. In one interview, he'll tell since I'm paying my doctors, they're with me. Very next moment he meets his doctors, [he will tell] no, we cannot run like this."

To understand how the vision had changed and why the hospital community felt betrayed, I went to see the Chairman. Unlike with the other doctors, it was impossible to simply walk into the Chairman's office and arrange a meeting with the secretary. Instead, the receptionist had to call the secretary first, who led me to the waiting room on the first floor next to the operation theatres. In the anterior room, four secretaries were typing on their computers or making phone calls. They were speaking in hushed voices, and the solemn atmosphere contrasted markedly with the bustling atmosphere in public waiting areas of the hospital, underlining the importance and the sanctity of the person I was about to meet. In the adjoining room, I could see patient groups waiting to see the Chairman. While I was awaiting my turn, a nurse brought a patient party to see the Chairman. One of the secretaries took up the phone angrily and called the head nurse who had sent the patient, telling them that they could not just send people without prior approval. Clearly, the Chairman needed to be sheltered from constant and undue demands.

After some time, I was led into the Chairman's office and made to sit on the sofa near the entrance. On the other side of the room, the Chairman, a handsome man in his sixties, sat behind his spacious desk, dressed in his surgical garment. He was listening to a delegation from South-East Asia who heaped praise on him and expressed their enthusiasm for a collaboration to spread his fame in their part of the world. While he was still occupied, I had the opportunity to muster the large, sun-lit room. On the desk, in front of the Chairman, there was an iPad beside a heart model and a lotus-shaped bowl with sweets and lollipops. There were several pictures and paintings on the wall behind: a famous Hindu art depiction of children playing and dancing behind a blue baby Krishna,

a picture from Shri Satya Sai Baba with the print “there is only one language – the language of the heart”, and a quote by Margaret Mead “Never doubt that a small group of people can change the world. Indeed, it is the only thing that has.” In addition, there was a large photograph of his father-in-law, who had sponsored the building of the cardiac hospital, as well as other family pictures, pictures of Mother Theresa and a statue of Gandhi. The conversation with the group from South-East Asia was drawing to a close, and one of the women inquired whether she could have one of the lollipops from the bowl. Indeed, several patients had also mentioned the bowl of sweets, and one Bangladeshi woman told me that she asked to have a second lollipop to bring home as a *prasada* for her family.

When I was called to the desk, the Chairman mustered me intently and inquired about me and my research. I nervously told him that I was conducting a sociological study of Vishvam Hospitals. I explained that I would be highly interested in asking him some questions about his model of building a successful business with a charitable orientation and his vision of making hospital care affordable for all independently of their ability to pay. The Chairman was not particularly impressed and told me that I should choose a topic with “tangible impact”; otherwise, I would be wasting my time. He then lay out a topic close to his heart and which merited sustained attention. He spoke in a solemn voice, carefully choosing his words and making it clear that he did not expect to be interrupted by questions.

The Chairman told me that the healthcare industry was “in this mess” because there was too much variation in how doctors treated their patients. Different doctors would prescribe different treatments for patients with similar conditions. Patients, therefore, made many enquiries about which doctors to see and whom to trust. In contrast, when taking a plane, nobody enquired who the pilot was. This trust was there because there was a standardised way and due protocol how to fly a plane. In case of an accident, a black box made it possible to reconstruct the mistakes made and correct them. Doctors, however, were told that they could use the methods they deemed appropriate. The treatment process was documented on paper in the doctor’s handwriting that nobody could decipher and was not time-stamped. Hence, there was insufficient standardisation and accountability. Digitalising the hospital processes provided the solution to these problems because it would make sure that every doctor's action was adequately documented and tracked. To this end, they were developing a digital health platform. In addition to making

treatment safer, this platform would also make them more accessible because it would allow doctors to monitor and instruct patients remotely. For example, there were 17 million diabetic patients in the country and 600 diabetologists. Policymakers would suggest training more diabetologists, which would take 14 years. However, using their online diabetic services, the existing number of diabetologists could see all diabetic patients in the country because patients only needed to see the diabetologist once a year, which could be done online. In this way, digitalisation would fundamentally redo the way health care is delivered.

The vision of a digitalised hospital the Chairman outlined, and frequently discussed in recent media reports, differed from his earlier vision of a charitable, low-cost hospital (see Chapter 1). On the one hand, the emphasis on affordability, which had been at the heart of his original plans, was notably absent from his elaborations. While digitalisation may streamline processes and thus save costs for the organisation, the example of online diabetes consultations underlined that such digitalisation strategies were primarily geared towards the more affluent sections of the population, who were considered able to do the self-monitoring necessary for successful online consultations. On the other hand, and more importantly, in his plans for a digital hospital, the Chairman emphasised accountability and control by highlighting how digital tools allowed for increased standardisation by imposing limits on the ability of doctors to use their clinical reasoning. In other words, he primarily viewed it as a managerial tool to coordinate and oversee doctors rather than a means to enhance their freedom to make decisions. This point was underlined in a brief phone conversation I had with one of the Chairman's sons, who served as a strategist in the group and was about to leave for the US to do an MBA. He stressed how they had reached a limit how they could improve outcomes and cost efficiency through centralisation and supply chain efficiency, which is why they turned towards digitalisation strategies. He added that their digital health platform would become a business in itself as it could be sold to other providers and might eventually even become more important than the core business of healthcare delivery.

These points were not lost on some of the doctors. Commenting on the comparison with the aviation industry, Dr Anthony pointed out that the analogy did not work. "It doesn't work like that. For one, the pilots in this setup do not want that. When you fly in a plane, the pilot does not personally escort you to the seat and fly you. It's different." Emphasising the crucial role of the doctor in establishing a relationship with the patient,

Dr Anthony stressed the impossibility of replacing the trust in the individual doctor with trust in a corporate brand. He also pointed out that the Chairman had for some time lobbied to reduce doctors' remuneration and lower the educational requirements for receiving an MBBS to create a larger pool of available physicians. This lobbying work had given the Chairman and Vishvam Hospitals a bad name in the medical community as someone who sought to undermine doctors' authority. "[The Chairman] is one of the most respected physicians in public circles", Dr Anthony said. "He is quite respected in Karnataka but not as much as outside. There is a lot of unhappiness with Vishvam Hospitals as being perceived to be a predatory organisation and not very supportive of the physician and healthcare community. […] It has been in the news that the government has come up with a new bill, which regulates medicine differently, where they are allowing paramedical people to take courses and become mid-level bridge physicians. [The Chairman] is supportive of that. There is a lot of disgruntlement in the medical community that somebody who is perceived as a medical community leader is supporting that." Instead of defending the doctors' interests, the Chairman used his influence to lower the standards of medical education to ensure a ready supply of cheap practitioners for the expansion of the corporate group.

The vision of streamlining medical practice through digitalisation was not problematic because it differed from earlier visions of lowering costs to make treatment accessible to the poor and needy. Indeed, the Chairman had always been able to reformulate visions according to the needs of the hour and to galvanise the medical community and the broader public anew. Indeed, some doctors were genuinely excited about the plans for digitalising the hospital and expected them to improve their practice. Instead, the doctors resented that they felt increasingly excluded from the inner circle around the Chairman and marginalised in the corporation. In the beginning, they had believed that they would, as a group of doctors, develop the hospital and wield influence through their direct relationship with the Chairman. As the organisation grew and the Chairman decided to turn it into a public limited company, they increasingly realised that they were not involved in decisions about the hospital's direction. Instead, the business administrators seemed to play an increasingly important role.

Some attributed this to how the Chairman himself lost control over the company as he was now increasingly dependent upon investors and shareholders. "A single hospital can be run at your whims and fancies and visions", a consultant told me, "but if you are

a group with investors irrespective of what your vision, in the long run, is, you need to adhere to their requirements and demands for meeting minimum turnover. If you look at it now, the requirement for minimum turnover far exceeds what would have been the turnover had the Chairman's original vision been in place." Along similar lines, a senior consultant argued: "Earlier it was a little freer. You would do what you want, and then you just went and met the Chairman and told him that you want some help. You didn't have to worry about the implications as a public limited company. Some things are now tied because you've gone public. You have to worry about everything being transparent." As the company had grown and gone public, the hospital group could no longer be governed like a small family firm with informal processes and personal interactions. Instead, it had to rely on business administrators and formal approvals. This meant that the Chairman had not incorporated the business world into his vision as the doctors had hoped but had come under the control of the despised corporate culture.

In contrast, others argued that the Chairman was still very much in control but that he had betrayed his ties with the medical community and instead had demonstrated that his true allegiance was to the business world. "The organisation is very much run by the Chairman and the family only by their vision where they want to be", a senior consultant said. "I might be completely wrong with this, but the plan was to start the hospital, develop a certain brand name so that you could get your numbers going. With a certain brand name and image, expand the hospital business until you eventually you go public." In this view, the Chairman's vision had always been a smokescreen to hide his true intention of developing a business and accumulate wealth. When I asked another senior consultant why he thought the Chairman decided to go public, the doctor replied: "Because he has four children! […] If he decided to be truly doing like that [implement the vision of low-cost care], he could have done amazing things. Now whatever we do or say, we're limited. But he has children. He must have thought he must leave them all multimillionaires." By turning the corporation into a public limited company, the Chairman had shown that his vision had been limited from the start to himself and his close family and had never included the broader family of the hospital employees devoted to him. When I asked a senior cardiologist who had worked in the hospital since the beginning whether the doctors had a say in decisions about the course of the company, the cardiologist reacted angrily: "No doctor has control. It is run by a private man. It's a private organisation. The Chairman and his family are the owners. They run this hospital. If some

doctor feels he has control in this hospital, he's delusional. We're employees. We work for our livelihoods, we enjoy our work, and we go home."

Such recognitions created a sense of disorientation among the doctors who no longer felt a proper vision guiding their work. "If people are dissatisfied," a consultant said, "they will stop themselves [and think:] 'that is not part of my job.' They don't stand up for the organisation. The minute you have this non-belongingness feeling, it affects everybody; it becomes disjointed. The vision is absent or has deteriorated." Among others, the insight that the Chairman's actions were not what they seemed led to the conclusion that the emperor had no clothes. "It is a big exercise [the Chairman] has done", Dr Suri said. "He has created a big aura, in a sense, big man, big these things. That is creation. And now whatever he tells, they listen, whether it is stupidity, whatever it is."

At the same time, such disillusionments came with the possibility of new enchantments. According to Bharadwaj (2016a, 239), disenchantment with the doctor-god is often only temporary as the "devotee/patient returns to the source with renewed supplication" in the absence of any real alternatives. Similarly, the doctors still wanted to believe in the Chairman, and their complaints about his betrayal of the vision often contained the hope of reconciliation. For example, after a lengthy interview about the problems plaguing Vishvam Hospitals, Dr Anthony expressed the hope that his remarks and my research could restore the vision lost. "Actually, the idea of Vishvam Hospitals is fantastic. What we are trying to achieve, the purported aim. We lost our way. If, through this process, you're able to make them do a course correction, that will be a huge plus. If, as an organisation, we remain and manage to rejuvenate ourselves, that will have a huge positive impact for thousands or millions of people." Even if the vision could not be restored, others consoled themselves that the Chairman was one of them and they were tied to him as a family: "Many people have left because they cannot accept. [You may ask:] 'Why are you here?' At least here, I can speak to him or shout at him, or I can get shouted at. In Fortis and all, nobody even cares for you. He's part of us, one of our family members. You can get upset with him. But you need to accept your role."

Conclusion

In this chapter, I have described how an ideal of medical authority based on selfless and devotional commitment was central to healthcare delivery at Vishvam Hospitals. Doctors

invoked this ideal to oppose the influence of business administrators, which they felt introduced a depersonalised business culture based on numbers and financial analysis that was alien to their personalised interactions with patients. I have argued that this opposition to "corporate culture" was not a rejection of the commercial aspects of for-profit healthcare delivery, nor simply a consequence of administrators' pervasive interference with clinical decisions. Instead, clinicians felt that administrators did not offer enough support and protection for them to run their practice on their terms. In doctors' understanding, the presence of the administration made it difficult for them to maintain the perception of disinterestedness that was critical to their interactions with patients.

The ideal of unquestioned commitment to the doctor's judgment also structured the patient-doctor relationship. Doctors argued that patients needed to surrender themselves to their authority because faith and unquestioned trust were necessary for treatment to succeed. Patients equally invoked the ideal of devotional commitment by suggesting that they needed to fully entrust themselves to the doctors without any doubts. That is not to say that patients blindly followed clinicians' orders in practice. Instead, they invoked the ideal to remind doctors of their duty towards them and used it to question doctors' decisions if they felt that clinicians acted not with their interests in mind but were primarily motivated by commercial concerns. The notion of the "doctor-god" is paternalistic. At the same time, it calls attention to the centrality of medical authority in a situation where clinicians played a crucial role in aligning medical care and commercial profits.

The appeal to medical authority highlights that corporate hospitals create a dilemma for patients visiting them and doctors working for them. Clinicians and patients are both suspicious of corporate management, which they consider to be focused exclusively on financial gain and thus to have a corrosive effect on good medical care. At the same time, they depend on them for work opportunities or healthcare services as alternatives for specialised care are limited and corporate providers are believed to set treatment standards in the country, alongside flagship institutions in the governmental and non-profit sector (Baru 2016, 136–37).

The presence of the Chairman and his vision for Vishvam Hospitals seemed to provide a solution to this dilemma by combining the form of the corporate hospital with a "charitable" orientation that allowed doctors to maintain an ethical self-understanding and practice with minimal corporate interference. The doctors at Vishvam Hospitals hoped that by attaching themselves to the Chairman and committing to his vision, they

would bring about an ideal of a medical community knitted together by selfless commitments. This vision was partially rooted in nostalgic imaginations of the past that obscure how commercial motives had always been present in health care due to the predominance of private practice (Baru 1998).

Over the years, many doctors, nurses, and hospital staff who had devoted themselves to the Chairman have felt abandoned and betrayed. In moments of disillusionment, they concluded that the vision had only served to obscure the way Vishvam Hospitals was a corporate hospital like any other, dominated by managers serving the interests of investors and shareholders. The scope of the Chairman's interests seemed to be limited to himself and his core family, and the Chairman appeared to side with corporate management instead of championing the concerns of the medical community. However, the doctors remained committed to the vision and the Chairman despite such disillusionment and hoped for reconciliation and a reinvigoration of the original vision.

5 Making Up Patients

17 May is World Hypertension Day. On this day in 2019, the entrance of Vishvam Hospitals was decorated with red, heart-shaped balloons. In the lobby area, young nurses and technicians wearing red T-shirts with the tagline "#checkyourpressure" were standing around billboards with colourful posters. They were laughing and joking with each other while two DJs were playing soft tunes. The arrangement reminded me of the entertainment and product launch events in shopping malls on busy Sunday afternoons. However, the headlines of the hand-drawn posters were medical in content: "Pathophysiology of Hypertension"; "Effects of Untreated Hypertension"; "How to Prevent Hypertension"; "Sitting Is New Smoking"; "Maintain Your BP, Be a Super-Hero". After some time, the music stopped, and a group of consultants working at Vishvam Hospitals entered the stage. The initial speaker, a nephrologist, began by outlining some alarming numbers about the "silent killer" hypertension. About 1.2 billion people worldwide were diagnosed with hypertension as per WHO data, 75 per cent of whom lived in low- and middle-income countries. In India, 20–30 per cent of the general population were believed to be affected by it, but very few were diagnosed. These numbers were followed by an urgent appeal to regularly check one's blood pressure.

> If you're aged above 40 years, make sure to check your blood pressure. The good thing about hypertension is, it is very easy to diagnose. You don't need a sophisticated lab. Hardly it will cost. The only problem is that we need to have the urge or will to check our blood pressure. We should not presume, 'I'm fine, I don't have any blood pressure.' The symptoms appear very, very, very late in the course of illness, only when there is serious organ damage. One humble request is, at least once in six months, you check your pressure. Make sure that you convey this message to your dear ones, your friends, your neighbours so that this message is taught. The whole intention of celebrating this World Health Hypertension Day is to spread awareness. It is something easily treatable, easily detectable. The only thing is, don't wait until you become symptomatic.

This appeal was followed by similar speeches. An obstetrician warned about the dangers of hypertension for pregnant women. A paediatric neurologist pointed out that hypertension also affects children and gave practical tips on motivating teenagers to exercise and eat healthily. During these speeches, a sizeable crowd of about a hundred

people gathered in the lobby area and applauded and cheered after each appeal to prevent the disease through regular testing and a healthy lifestyle. The audience also eagerly used the opportunity to ask questions about the symptoms and treatment methods for hypertension and share personal experiences of trying to control blood pressure. When I asked some people why they were listening, a retired engineer told me that he was concerned about the disease and tried to reduce sugar and salt in his food and do regular exercise. He was also interested in joining the queue and getting his blood pressure checked at the small screening station next to the podium where two nurses were doing the measuring and handing small slips with the results to the participants. The members of the marketing team who organised the event told me that it was part of a broader effort in the context of the global "May Measure Month" awareness campaign, during which marketing also sponsored a marathon and conducted various medical camps in which they screened between 8'000 and 10'000 people in Bengaluru.

Such "awareness-raising" events formed the core activities of the marketing and corporate social responsibility (CSR) teams at Vishvam Hospitals. Marketing and CSR officials used awareness-raising as an umbrella term to describe campaigns aimed at educating lay people and general practitioners about health risks, focusing on non-communicable diseases. Preventive messages were at the heart of these activities, which also included discussions about treatment options. Critically, awareness-raising was not only about the dissemination of knowledge but involved calls to action by reminding audiences to be vigilant and do regular health check-ups, often in combination with an offer to do a medical screening. This concern with awareness-raising and prevention was not specific to Vishvam Hospitals but is common among Indian hospital providers, who put preventive messages at the centre of their public relations and marketing activities (see, for example, *The Hindu* 2016; Roychowdhury 2016).

The focus on prevention is surprising because scholars have highlighted how corporate hospitals primarily concentrate on specialised treatments and surgical interventions that are lucrative for them while neglecting primary and preventive care, with detrimental effects for public health (Chakravarthi 2013, 173; see Hodges 2016, 162). In this chapter, I address this puzzle by discussing the role prevention and primary care play in the medical business of corporate hospital care. I show how marketing employs campaigns and activities with a preventive focus to attract patients to the hospital, and I discuss how CSR uses outreach programmes to forge ties to government agencies

and technology partners. These endeavours are selective and closely tied to the business interests of the hospital. At the same time, they are effective tools to market the hospital because practitioners and the general public agree that prevention and primary care are direly needed to address India's changing disease landscape.

In recent years, doctors and public health experts have raised the alarm about the rise of non-communicable diseases in India, touching on fears about the effects of socio-economic and lifestyle changes due to globalisation and economic growth (D. Banerjee 2020, 15–16; see Caduff and Van Hollen 2019; Solomon 2016). Corporate providers tap into these fears and public health concerns by mobilising international prevention discourses for their specific ends. In particular, they organise medical screening camps in various locations to monitor the health status of participants and test them for health risks. Such camps are very common and are organised by medical providers as well as charities, religious organisations, and political parties. They have a long history in public health campaigns and are generally viewed favourably as a way to provide free treatment to the general population, despite the dark legacy of sterilisation camps during the Emergency period (Copeman 2009, 18–21).

Medical anthropologists and sociologists have analysed medical screening as part of a shift towards "surveillance medicine" (D. Armstrong 1995), where interventions increasingly target health risks instead of symptomatic conditions, thereby effectively blurring the line between health and illness (Timmermans and Buchbinder 2010; see Rose 2007). Scholars have identified pharmaceutical research and marketing as central drivers of the reconfiguration of disease categories in terms of risk factors (Dumit 2012; Greene 2007). For example, Joseph Dumit (2012, 17) argues that pharmaceutical companies generate "surplus health" by using data from clinical trials to identify smaller and smaller health risks to sell more medications. In this pharmaceutical model of surplus creation, standardised screening tests and checklists replace the expertise of doctors as patients are screened for risks of potential illness and then put on medication to mitigate these risks (Dumit 2012, 12–15).

In this chapter, I discuss how the use of medical screening at Vishvam Hospitals contrasts with this model of surplus creation and how it produces a surplus for the hospital. The marketing team organised screening camps to identify health risks in order to attract patients to the hospital. At the same time, screening rarely identified undetected health risks because the tests were often very rudimentary to save costs and because it

was targeted at affluent patient populations that already closely monitored their health status. Therefore, screening alone was not sufficient to convince patients to come to the hospital for further treatment and tests. Instead, screening provided an opportunity for physicians to have face-to-face interactions with potential patients and make a case why they should choose Vishvam Hospitals for further treatment. Therefore, the hospital's model of screening for a surplus depended on the personalised interaction with physicians rather than simply on numbers and standardised risk thresholds.

Apart from attracting patients to the hospital, preventive activities were also important for the hospital's image, to establish a reputation as a provider that offers a public service and cares for people's well-being beyond narrow commercial interests. This legitimising function of prevention was particularly important for marketing, as patients generally viewed marketing activities with scepticism as a symbol of unwanted commercialisation in healthcare delivery. Prevention allowed marketing officials to focus on the medical care provided by the hospital and frame their activities as a form of information-sharing, helping people stay healthy, and thus permitted them to market the hospital without provoking negative reactions.

Prevention and awareness-raising also played a central role in the activities of the corporate social responsibility team, but its mode of operation was very different from that of marketing. Marketing professionals did not follow a consistent approach in pursuing their goals. Instead, they emphasised the importance of learning by trial and error and using whatever strategy proved effective in practice. In contrast to these expedient practices of marketing, CSR officials prided themselves on adhering to a strict methodology and scientific assessments in designing and implementing programmes seeking to address the poor and neglected healthcare needs. However, I shall show how the systematic approach pursued by CSR failed to make a lasting impact on the people targeted by these programmes and primarily served as a way to collaborate with technology companies to test medical equipment.

In the first section of the chapter, I discuss the activities of the marketing team and the role prevention plays in advertising the hospital. The second section provides an ethnographic description of a medical screening camp and presents an analysis of how screening attracts patients to the hospital. In the final section, I show how a primary care programme organised by CSR used telemedicine-enabled equipment in an outreach clinic.

The equipment deterred people from visiting the clinic, but its use served to test the technology and forge ties with the technology company providing the equipment. I conclude by highlighting how the standardised approach employed by CSR did not provide a more consistent experience of care than the variable use of screening in medical camps organised by marketing.

The Preventive Angle

The marketing office was located in a remote corner of the basement in the multi-speciality building of Vishvam Hospitals. Compared to the lavish offices of the hospital directors and the simple but comfortable doctor rooms, the office was cramped and poorly furnished. Daylight came in through cracked small windows directly under the ceiling. A plastic clock showed the wrong time, and mould covered the corners where an old air-conditioner noisily struggled to cool the moist summer air. Long desks with computers, various publicity materials, loose papers and backpacks were placed next to the walls of the small room. Above the desks, there were folders containing memoranda of understanding with various insurance providers, corporations, and government agencies regulating what kind of services available in the hospital were covered by the insurance plans of these institutions. A pin board displayed a note from the Steel Authority of India accepting an invitation to conduct a health awareness campaign at one of the company's factories, an agenda with the World Health Days published by the World Health Organisation, and a list of patient contacts with a note that the last person they tried to call had "abused & disconnected." The note had presumably been posted by the two young women who sat next to the entrance and made phone calls trying to convince their interlocutors to go ahead with a treatment at the hospital. In addition to the women, a group of ten men in their twenties and thirties were present in the room. Some worked on their computers while others engaged in heated discussions or friendly banter interrupted by frantic activity when the marketing head called them into his small separated office, decorated with his awards and a large map of India, or sent them off to some activity with a "challo" or "let's go, boys." Amid the bristling activity, I was sitting on a chair in one corner waiting for a meeting with a senior marketing official, for the moment ignored by the group of young marketing professionals who seemed unsure who I was and how I should be approached.

“I’ve never been a good student”, Nashit, a senior marketing executive, told me after he had inquired about my project. “It is practically we learned, never by books. When I did my MBA, I never did my theories. We learned marketing once we got into the field. Nobody told us how to do that.” There was professional pride in the way Nashit contrasted his hands-on experience to my bookish background, but also a certain defensiveness. Indeed, although the marketing team was essential to the hospital's operations, the other professional groups within the organisation tended to look down upon it. To many of the doctors, marketing people were unsophisticated folks who had to be tolerated as a necessary but unwelcome addition to the practice of medicine. Administrators involved in the hospital's day-to-day operations considered them lazy and not doing any proper work. Some members of the marketing team themselves shared this perception. “It is a very challenging job actually”, said one of Nashit’s colleagues who had worked in the administration before. “In the administration, I used to deal with patients directly; there were no targets. At that time, I used to think: ‘Ah, marketing is nothing. Simply they are roaming around, and they don’t do anything. Patients are coming like that.’ When I entered marketing, I came to know what are the challenges they face.” Hidden away in their unassuming office, marketing people did not seem to have much to do with the steadily increasing number of patients coming to Vishvam Hospitals. However, they maintained that they played a crucial role in attracting the patients and that it was hard work.

Marketing did not seem like proper work because it primarily consisted of the intangible labour of forging and maintaining relationships. Marketing people needed to establish ties with doctors, hospitals, companies, and the media to attract patients to the hospital and manage its image. The strength of these relationships often made the difference between success and failure in a contested market. “Health care in India is a pull product”, Nashit explained. “Everywhere it is a pull product, but mostly here. There is so much competition.” The competition he referred to concerned the market for specialised surgeries most of all. Nashit proudly remembered how he was able to convince four patients to go ahead with a liver transplant at the hospital – “convert” them as he called it – that was one of the most lucrative procedures for hospitals. Nashit focussed on employees of large companies who were referred by the medical officers of these corporations when they needed treatment. The medical officers would ask various hospitals to quote their prices before making a decision. At this stage, the skills of the marketing person were crucial, Nashit explained: “Now your influence is shown here, how confident you are to

take that case. You are quoting 24 lakhs, another hospital is 22 lakhs, still another 21 lakhs. Now the real marketing person has to show his capability to convert for that 24 lakhs. So all the four patients I have done is for 24 lakhs." When I inquired how he had been able to convince clients to undergo the procedure at Vishvam Hospitals, Nashit stressed that maintaining relationships with the referring doctors through regular visits, personal communication, and updates was crucial. Such updates included reports about the progress of the referred patients, testimonials about critical cases handled in the hospital, and new services and specialities offered. In addition, there were the rhetorical skills required to convince the interlocutor, acquired through years of practice. Critically, there were no rules on how to succeed in marketing: "Sales and marketing is all about convincing people in front of you. It takes a long time. It is not just the theory you have learned about marketing. Practically you have to get into the field, dirty your hands, that's when you come to know, and there is proper learning." Other marketing professionals similarly stressed the importance of going into the "field" and learning by "trial and error methods". It was only by being exposed to practices on the ground level and analysing what worked and what did not that marketing skills were acquired.

While the methods adopted were variable, the goals were clearly defined. Thus, every manager and executive had specific monthly targets regarding revenue or the inflow of new outpatients, with a certain percentage of the salary linked to the performance. To judge the performance and the success of marketing activities, one executive produced daily reports for the marketing team showing how revenue and patient numbers for each department were trending against the targets set for the month. The data for this analysis was taken from the hospital information system, where all patient data and treatments were registered. In addition, a referral tracking team was tasked with finding out how patients found their way to the hospital. To this end, an executive would visit newly admitted patients daily to ask them how they had learned about the hospital and who had referred them. This information was critical for the relational work of the marketing officials, who then contacted the referring doctors and companies to deepen the relationship and ensure that they would continue to refer patients to the hospital. On these rounds, executives would be careful never to mention that they worked for marketing. Instead, they suggested that they were doing a survey for the "support team", given that most patients were not willing to talk to marketing officials, as one executive explained to me.

The practice of keeping marketing activities hidden from patients highlights that the marketing officials were aware that patients and doctors viewed their work with scepticism. This scepticism was rooted in the sense that marketing people did not care whether patients received effective medical treatment but were only concerned with their commercial targets and thus would resort to any means necessary to reach them. Nashit's reference to the necessity of "dirty[ing] your hands" in marketing was ambiguous in this respect because it not only stressed the importance of hands-on experience but also suggested a certain illicitness of learning the tricks of the trade from sales practice. He also mentioned that convincing people in marketing involved a certain amount of "lying": "We started selling health check-ups in the park. How did we start selling health check-ups? Even we didn't know what are health check-ups. We started lying; there is that." Most notoriously, such questionable marketing practices concerned the sharing of a percentage of the revenue generated from a particular patient with the doctor who had referred the patient to the hospital. Doctors and journalists condemned these "cut" practices as a form of corruption, undermining medical ethics and jeopardising patient safety (Gadre and Sardeshpande 2017; Kalra 2014). The marketing people at Vishvam Hospitals staunchly denied giving such "kickbacks" because it was against Vishvam Hospitals' official policy and the Chairman's conviction. However, it remained unclear how marketing people could successfully convince doctors to refer patients to the hospital when competitors offered such financial rewards.

The tarnished reputation of marketing in health care created a problem for the marketing professionals because it complicated their task of forging relationships and creating a positive image for the hospital when public opinion considered marketing as a sign of problematic commercialisation in corporate hospital care. The marketing team focused on "awareness-raising" and "prevention" to deal with this problem. When I asked the head of marketing at Vishvam Hospitals, Mr Latif, what was the focus of marketing at Vishvam Hospitals, he stated that their key aim was "to bring in awareness and a preventive approach": "We take a preventive angle where we say that prevention is better than cure. Get yourself screened so that you don't get diagnosed at a later stage. That is the communicative drive that we do. Mainly when we do campaigns, sixty per cent of our efforts to the community is in getting awareness for preventive actions." Preventive activities included medical screening camps for non-communicable diseases such as cancer, heart conditions, and diabetes organised in companies, residential areas, and public locations

and through “door-to-door surveys” in which medical workers visited people at their homes to screen their health. Campaigns and advertisements also predominantly focused on preventive messages, listing risks and warning signs for certain diseases and giving advice on preventing them and staying healthy. Consultants also spread these messages by discussing preventive health topics at public events or medical education sessions with general practitioners.

Such “awareness-raising” sessions were an excellent way to market the specialists at Vishvam Hospitals because they allowed circumventing restrictions on the advertising of doctors and their services imposed by the ethical codex of the Medical Council of India (Bharadwaj 2000, 66). These restrictions forbade doctors to market themselves and their services but allowed them to speak or write with their names about “matters of public health”.[11] Marketing professionals supported such exposure by fostering ties to journalists and doing press briefings to ensure that their doctors would be included with a statement when journalists wrote a story on a medical subject. They also paid local TV stations for half-hour sessions, in which one of the doctors could discuss a health topic. Moreover, preventive messages resonated with the intended public. For example, videos of doctors discussing preventive measures against various diseases were most popular among the more than four million subscribers to the official Vishvam Hospitals Facebook channel, garnering tens of thousands or in some instances even hundreds of thousands of views, thousands of likes, and hundreds of comments.

[11] The Indian Medical Council (Professional Conduct, Etiquette and Ethics) Regulations, 2002, state:

6.1.1 Soliciting of patients directly or indirectly, by a physician, by a group of physicians or by institutions or organisations is unethical. A physician shall not make use of him / her (or his / her name) as subject of any form or manner of advertising or publicity through any mode either alone or in conjunction with others which is of such a character as to invite attention to him or to his professional position, skill, qualification, achievements, attainments, specialities, appointments, associations, affiliations or honours and/or of such character as would ordinarily result in his self aggrandizement.

7.11 A physician should not contribute to the lay press articles and give interviews regarding diseases and treatments which may have the effect of advertising himself or soliciting practices; but is open to write to the lay press under his own name on matters of public health, hygienic living or to deliver public lectures, give talks on the radio/TV/internet chat for the same purpose and send announcement of the same to lay press. (Medical Council of India 2002)

Awareness-raising and prevention put the focus on doctors and the medical care provided by the hospital, demonstrating that they served the public interest by preventing diseases and helping people stay healthy. At the same time, prevention legitimised marketing itself because it provided an opportunity to frame marketing activities as the dissemination of information for the benefit of the general population, seemingly without any commercial interest involved. William Mazzarella (2003, 91–98) has argued that advertising for family planning and other developmental issues legitimised the Indian advertising industry as a public service that mobilised aspirations and desires to achieve a common good. I argue that prevention played a similar role for the marketing officials at Vishvam Hospitals because it allowed them to justify the medical business of the hospital and their own role in it as being concerned with health as a public good and not just revenue. Thus, marketing officials claimed that doing preventive screenings showed that they did not think "only commercially" but wanted to help people. Other team members rejected my question of how the focus on prevention served their commercial ends by suggesting that their activities were not only about business and that they had a responsibility to promote prevention instead of only treatment.

Screening for a Surplus

Medical screening camps formed the core of the marketing team's preventive activities. There were three types of camps: "corporate camps" took place in companies to screen the company's employees, "public camps" were open to the general public and were conducted in locations such as residential areas, schools, event halls, and parks, and "government camps" were organised jointly with government authorities in district centres and town halls with a focus on people eligible for government-funded health insurance schemes. During my field research, I attended five such camps.

One of these camps organised by the marketing team took place in "New Town", a newly constructed gated residential area in the suburbs of Bengaluru not far from Vishvam Hospitals. Located close to the large offices of the IT industry, the residential area was built for well-to-do professionals with their families and retired parents. The area was still under construction but already featured a group of 15-storied apartment blocks, a broad avenue lined with palm trees, and an artificial lake, surreally tidy islands in the chaotic surroundings of dusty construction sites, patches of agricultural land, and smouldering waste dumps. The health camp was set up in a covered parking space between the

high-rising apartment buildings next to the community centre, several small shops, and a pharmacy. When I arrived, around twenty older people were seated on plastic chairs while children were chasing around screaming and laughing. A senior cardiologist from Vishvam Hospitals had just finished his talk about the symptoms, treatment, and prevention of cardiac diseases and was now escorted back to his car by a marketing team member. On the stage, the president of the New Town Apartment Owners' Association, who had invited the marketing team to arrange the health camp, was asking the people to get themselves screened at the camp.

The camp consisted of a sequence of stations attended by students from a local nursing college who were completing an unpaid internship at Vishvam Hospitals. At the first post, participants were greeted by a range of publicity materials advertising health check-up packages and other services offered by Vishvam Hospitals, and they had to register themselves for the camp with their name, age, gender, and phone number. A nurse noted down their height and weight at the second station before another nurse measured their blood pressure and blood sugar levels at the third and fourth stations. The participants went to the last station with a slip of their measurement readings to consult with a doctor. While they were waiting for their consultation, a marketing official tried to convince them to sign up for a Vishvam Hospitals "privilege card" programme, which offered a free health check-up and discounts on treatments in exchange for an annual fee. The camp was very well attended, and around 70 older adults, sometimes accompanied by their (step-)daughters and sons and grandchildren, were queuing to get screened. In the background, children danced to songs being played at high volumes or shouted English children's songs into the microphones, while now and then, one of the older residents took to the stage and intoned a sentimental ballad. The whole setting resembled a neighbourhood get-together as much as a medical activity. Indeed, this was the point. As the president of the Apartment Owner Association told me, he arranged for the camp because he felt that there was a lack of neighbourly activities and because he wanted to show that the association cared for its members.

The doctor consultation was the main attraction of the camp, and the participants, mainly women and men in their sixties and seventies, sometimes accompanied by younger relatives, patiently waited for their turn. The lack of privacy – as the consultations were conducted in the open where the neighbours, the marketing people, and I could overhear them – seemed not to deter them. The doctor was a resident in the cardiology department

in her late twenties dressed not in her doctor garments but a simple Salwar Kameez. She first controlled the heartbeat of the camp participants with a stethoscope and then gave health advice and answered questions variously in English, Hindi, or Kannada for a couple of minutes. She was clearly in her element giving attention and advice, encouragingly shaking her head, making jokes to lighten the mood, or providing comfort with a caring gesture. A typical consultation session started with the doctor telling the participant whether their blood pressure, blood sugar level, and weight were normal. She then inquired whether they took any medications, whether they had diabetics in their family, and whether they ate healthily and did regular exercise. Most consultations were concluded by the doctor giving basic health advice. She reminded the participants to take regular walks, avoid salty, oily, and fried food, eat more green-leaf vegetables and less rice and chapatis, drink more water, and take nutritional supplements. The key message of these instructions was to stay healthy by abandoning bad habits and frequently doing health check-ups to detect signs of disease early.

The participants were not surprised by these instructions. They clearly knew about the importance of exercise and a healthy diet, took dietary supplements, and regularly monitored their health. In fact, rather than needing further health advice, they seemed overwhelmed by the abundance of it. One woman was slightly upset when the doctor implied that she might be able to get off her thyroid medication someday, objecting that she had recently done a check-up in Mumbai, where she had been told that she had to continue her medication until she died. Most of the participants had done a health check-up within the last year and knew about the normal ranges for blood sugar levels, weight, and blood pressure. Although there did not seem to be a particular need for doing the tests, most of the participants visibly enjoyed the consultation sessions, in which the doctor kindly reprimanded them for not taking care of themselves and urged them to exercise and eat healthily. One elderly man jokingly objected to her, scolding him that he was not doing sufficient exercise, by exclaiming: “it is not sufficient! I’m doing all this exercise; in spite of that, I’m not getting normal BP [blood pressure].” – “That’s what I’m saying.” – “You’re saying so many things!” This bantering continued for some time before he thanked her for the good advice she gave to him “like a daughter.” Some participants appeared to feel uncomfortable during the consultations, especially some of the women she said were overweight. However, most women and men expressed their gratitude that the doctor told them to take better care of themselves. By berating them for their negligence as a

family member would do and giving them straightforward advice, she made them feel cared for and looked after.

During the twelve consultations I followed in this particular camp, the doctor suggested three times that the concerned party seek further treatment at Vishvam Hospitals. To a middle-aged woman who suffered from a hole in the heart, the physician suggested that she should do an echocardiography test once a year at Vishvam Hospitals to see if the hole was getting bigger. In another conversation, the doctor encouraged a corpulent woman in her forties to undergo a nerve conduction test because the woman said that she had suffered from numbness in one part of her body for a few days. Finally, a chubby couple who accompanied an older woman with a walking stick and thick glasses told the doctor that their old mother(-in-law) was getting very forgetful of late and sometimes barely recognised them. The doctor suggested that it could be "age-related schizophrenia" and advised them to see the psychiatrist at Vishvam Hospitals. When I later asked her why she had suggested a psychiatric disorder rather than a neurodegenerative condition, she told me that she always sent people to the psychiatrist first, especially when they were old, and that the psychiatrist would then refer them to the neurologist if necessary. This instance baffled me because invoking a mental illness after a short conversation seemed audacious to me. In general, the doctor's primary concern was not to establish a definitive diagnosis but to provide an impetus to seek out further tests and medical advice. Intriguingly, the actual screening played an incidental role in all these cases as the physician suggested further tests based on the symptoms the participants reported rather than on the readings provided by the tests.

Whether or not the tests showed abnormal results, the focal point of the health camps was always the concluding consultation with the physician. Screening on its own was not sufficient to make referrals because the populations targeted by marketing through health camps were already very well monitored, and screening, therefore, was unlikely to reveal previously undetected health risks. Apart from upper-class residential areas like New Town, marketing focused on organising health camps in corporations with employees who had a good salary and were generally covered by health insurance. These companies usually organised yearly check-ups for their employees. The people screened in these companies were usually young professionals with little health risks, as members of the marketing team confirmed to me. In contrast, the people screened in upper-class residential areas like the elderly residents of New Town were often drawn from groups

with increased morbidity, but they already closely monitored their health and had excellent access to an (over)supply of medical services. Instead of screening people without access to healthcare amenities, the camps organised by marketing generally focused on wealthy groups that could already select from an abundance of medical services and were targeted by other healthcare providers as well. In these contexts, screening alone had little chance of convincing people to seek out further treatment at the hospital.

Besides, the diagnostic tools used in these camps were generally simple and thus only provided rudimentary information about participants' health status. Most health camps organised by the marketing team encompassed only a few basic tests using a scale, a blood pressure gauge, and a blood sugar monitor. More sophisticated tests were only administered in large camps or when the invitation to conduct the camp included a request for a specific test. Marketing executives explained that the advantage of health camps was that they were cheap, which allowed camps to be conducted profitably even when they only resulted in a few patients coming to the hospital.[12] To maintain this advantage, they subjected all instruments employed to rigorous cost-benefit analysis and sought to keep them to the bare minimum.

These observations underline that screening camps organised by marketing did little to detect unidentified health risks, which raises the question of what kind of surplus medical screening generated for the hospital. In Joseph Dumit's (2012, 8) analysis, *surplus health* marks the shift from an "individual health model" to a "mass health model." In the older paradigm, people experienced symptoms and went to see a doctor who made a diagnosis and prescribed a treatment to cure the illness. In the new "mass health model",

[12] Apart from the machinery, cost minimisation also extended to the personnel employed. Health camps organised by marketing relied on doctors in training or general physicians who were supported by poorly paid nursing students. In this way, marketing was able to keep the cost for organising a camp to roughly 20'000 Rupees. Marketing officials claimed that around ten per cent of the total number of people screened would go ahead with a procedure at the hospital. This "conversion rate" seems overly optimistic as the success rate was considerably lower (around 5 percent) in the examples a marketing official showed me in the internal referral tracking system. Based on the few cases I was shown, a typical example would be a camp with a total of 50 participants, out of whom 2 or 3 would come to the hospital for treatment generating a total revenue of 1 or 2 lakhs.

people need not have any symptoms or experience of being ill. Instead, doctors use checklists and screening tests to detect risk thresholds indicated by clinical trials and prescribe medications that do not cure but only mitigate risks of falling ill (Dumit 2012, 105–36).

The practices of medical screening in Indian health camps do not fit into such a neat paradigm shift. Medical screening camps promised to detect signs of latent diseases in people who might not feel ill at all. However, the tests were so basic that they generally could not diagnose a condition or a specific health risk. Instead, they served as a general impetus to conduct further tests and treatment at the hospital, which is how the hospital earned money. Significantly, the role of the physician in these interactions was not limited to applying checklists and guidelines. Because the tests were rudimentary and the people screened already closely monitored their health, the test results alone were not sufficient to propel people to come to the hospital and undergo treatment. Instead, screening offered the physicians an opportunity to engage with the participants in order to connect with them and convince them to visit the hospital for further treatment. Generating a surplus for the hospital through screening thus depended on the mediation done by physicians.

Engaging the Medical-Industrial Complex

The fact that awareness-raising and medical screening were primary tools for marketing at Vishvam Hospitals led to considerable overlap between the activities of the marketing team and those of the corporate social responsibility (CSR) team, whose programmes similarly focused on the early detection of disease, prevention through education, and the dissemination of knowledge about health risks. In line with the Chairman's vision of making health care accessible and affordable to all, Vishvam Hospitals has from the beginning promoted social initiatives and outreach programmes, such as establishing an insurance scheme for farmers, initiating a telemedicine programme, running primary care facilities, and organising medical screening camps focusing on non-communicable diseases. In 2014, these programmes were formalised under a CSR committee after the enactment of the Companies (Corporate Social Responsibility Policy) Rules, 2014, which mandated

that companies exceeding a particular size[13] spend at least 2 per cent of their average net profits on CSR activities. At the end of my field research period in summer 2019, the Companies (Amendment) Act, 2019 introduced penalties, including imprisonment if the requirements were not met, which many industry representatives criticised as draconian (Vasini et al. 2019).

Dr Sangya, an energetic woman in her late forties or early fifties, was the head of the CSR team at Vishvam Hospitals. A medical doctor by training, she had also obtained a Master's and a PhD degree in the social sciences. When I asked her what distinguished CSR from earlier efforts at Vishvam Hospitals, she pointed out that CSR, in contrast to prior "informal" initiatives, was done in a "programme mode" where the needs for and outcomes of specific interventions were systematically assessed. Dr Sangya took pride in how the programmes she designed and implemented were subject to vigorous scientific assessments and had a measurable impact. She emphasised that CSR was not simply about doing acts of benevolence using whatever tool seemed handy. It was about providing data to justify the means chosen to achieve a defined outcome and to convincingly prove the impact of CSR activities to regulatory authorities and an interested public.

The scientific approach set CSR apart from marketing, Dr Sangya pointed out. When I inquired what distinguished the screening camps conducted by the CSR team from those of the marketing team, she argued that the key distinction was that CSR used "a very objective, research-oriented outlook to screening." Marketing was conducting "opportunistic screening" by setting up camps where it was lucrative to recruit new patients for the hospital. In doing so, the marketing team did not have any interest in systematically assessing health risks in the populations screened. The CSR team, in contrast, focused on poor and vulnerable groups, which were not commercially interesting for the hospital. Camps organised by CSR used more sophisticated screening technologies such as mammography machines, mobile echocardiography devices, and a digital platform to register patient data. Most importantly, the CSR professionals conducted "population-based

[13] The Companies Rules, 2014, to the Companies Act, 2013, specified that companies with a net worth of Rs 500 crore (around 70 millions USD) or more, a turnover of Rs. 1000 crore (around 140 millions USD) or more, or a net profit of Rs. 5 crore (around 700'000 USD) or more during the preceding financial year came under this provision (Nangia 2021).

screening" following a stringent methodology to systematically assess disease patterns and health risks among vulnerable groups. If marketing was about hands-on experience and mastering the informal tricks of the trade, CSR was characterised by advanced technologies and a rigorous methodology.

To understand how CSR programmes worked in practice, I visited a primary care facility on the outskirts of Bengaluru. Apart from medical screening and educational programmes, such outreach clinics were among the key CSR activities of Vishvam Hospitals. These facilities were called e-health centres because they employed telemedicine-enabled technologies to offer primary healthcare services to disadvantaged groups. The clinic I visited was one of around seven outreach facilities all over the country (the number of clinics kept fluctuating as some centres were closed and new ones opened). The facility in Bengaluru, which was presented to me as the flagship facility of the programme, had been running for about ten months when I visited it in early December 2018. It was established through a collaboration between the CSR team of Vishvam Hospitals, which provided the medical personnel necessary to run the clinic, an American technology conglomerate that supplied the medical equipment and communication technologies, and the local municipal body, which provided and maintained the building and supplied it with electricity and water.

The clinic was located on the outskirts of an industrial area that had grown by leaps and bounds in the last two decades. A simple but neat white building, it was set on a small dirt road a couple of steps away from the main road running through the centre of what had been a small village with a couple of shops, a primary school, a mosque, and some temples. The old village was still discernible but would soon vanish as numerous construction sites engulfed it in thick dust clouds. In the clinic, I was greeted by a nurse and Dr Arjun, a young self-assured doctor with a MBBS degree, who showed me the premises. In addition to a lobby area with a nursing station where the patients were registered, the clinic included a telemedicine room where patients were examined and a consultation room with a desk for Dr Arjun. Dr Arjun was present in the clinic once or twice a week. On the other days, he attended to his practice and consulted patients at a corporate hospital and attended to the people coming to the e-health centre via telemedicine.

Compared to the bustling atmosphere of other clinics I had visited, the centre seemed abandoned as no patient was present this Friday morning. The lack of healthcare

seekers allowed Dr Arjun to show me the sophisticated equipment in the clinic, which was among the best that could be found in India, as he assured me. The system included a 360-degree camera with zoom function, microphone, and loudspeakers, a one-click scanner to upload documents, a telemedicine-enabled multi-purpose scope to examine and photograph various body parts, and several digital diagnostic tools such as a heart rate monitor and a urine analysis system. All the readings were automatically uploaded to an electronic medical record system. On this platform, the medical history and diagnosis could be noted through voice commands calibrated to accent and voice.

During the demonstration of these technologies, a patient had arrived, a middle-aged man with bare feet and yellow stains on his cotton trousers. The man, who mentioned that he did welding work, brought an electrocardiograph, which Dr Arjun examined, concluding that the heart functioning was normal. He then prescribed some medication for heartburn because the man complained of stomach aches. A second consultation followed, with two women, one of whom reported intense pain in her leg. The women laughed embarrassedly when Dr Arjun scolded them for not taking care of themselves after noticing in the system that they had already visited him five months back and he had prescribed calcium and advised a thyroid function test, which they had not done. He sent them away with the same prescription and asked them to do the test. A third patient complained of giddiness and received a prescription for an electrolyte solution. According to Dr Arjun, most of the patients he attended to in the centre were daily labourers who worked on the nearby construction sites. The consultations and tests, however, were open to anybody and completely free. If further tests were needed, the clinic had an agreement with a diagnostic centre where referred patients would get a discount. For further treatment, he would refer patients either to the nearest government health centre or, if a complicated intervention was required, to Vishvam Hospitals to get treatment under the government-funded health insurance scheme if they had a below-poverty-line card.

Although consultations were free, the services of the clinic did not attract many patients. When I asked Dr Arjun about patient numbers, he showed me the statistics of the consultations available on the health platform. In ten months of operations, Dr Arjun had conducted a little more than 1400 consultations, of which seventeen had been during the last week. These numbers were not impressive given that specialists at Vishvam Hospitals attended to up to 60 patients on a single day. When I asked Dr Arjun why more

people did not come to the clinic, he suggested that people were not comfortable using the telemedicine services, which was demonstrated by the fact that many more people came when he was present than when he was not. Ironically, the sophisticated telemedicine technology employed at the clinic deterred the targeted population from using the services rather than allowing more consultations to take place.

The limited success of the e-health clinic was not lost on the senior CSR officials. Before I could make a second visit to the clinic in May 2019, this "flagship" clinic had already been closed after little more than a year of operation. When I asked Dr Sangya about the closure, she explained that the numbers were insufficient to justify its continuation. Besides, Dr Arjun had left the programme. When I suggested to Dr Sangya that the technology was the reason why the clinic did not attract patients, she rejected the proposition, even though she was aware that telemedicine consultations were not popular with most people: "it's not about technology here. It is about the acceptance of technology. What I feel is that people have to accept technology. Why do they seek a physical interface with a doctor? In fact, the devices are much more accurate than what a normal general practitioner would be using in his set-up." Instead of considering the use of telemedicine as a potential problem, Dr Sangya attributed the lack of interest in the clinic to the fact that the area did not lack primary healthcare services, which also meant that the clinic could safely be closed and moved to a different site. Indeed, this was the normal life cycle for Vishvam Hospitals' CSR programmes, which were not intended to be permanent solutions but had to be constantly adapted to the changing nature of the problems they addressed. CSR programmes were inherently mobile and iterative. "We're constantly searching and trying to reiterate. Iterations are the norm in every CSR programme", as Dr Sangya pointed out.

As iterative solutions, CSR programmes were periodically redeployed to new sites. Thus, the telemedicine-enabled technologies were now being used in a programme with government district hospitals in which specialists from Vishvam Hospitals could consult patients via telemedicine if the district hospital lacked the required expertise. According to Dr Sangya, this was a "win-win situation" for all parties involved because the district hospitals had a way to offer specialist consultations while the CSR team saved the cost of running a centre of their own. The CSR team had learned from the e-health clinic experience that such collaborations between technology companies, government bodies, and Vishvam Hospitals were the way forward because they allowed all partners to "leverage

each other's strength" to maximise the impact. This was an odd conclusion given that telemedicine consultation was not what the population targeted by the programme demanded, nor was the short-lived intervention likely to have had a substantial impact on the health and well-being of the people in the area. The mismatch between the curative needs of the local population and the sophisticated technologies employed raises the question of why telemedicine-enabled devices developed by a US-based technology conglomerate were used in this primary healthcare set-up where there seemed to be no need for these technologies and where they actually prevented people from using the services.

When I asked Dr Sangya why technology companies were interested in deploying their devices in a CSR programme, she answered that these companies were possibly looking for future commercial applications: "there are quite a few companies who would like to evaluate the value of a technology through CSR, and then maybe push it in a commercial way to governments. […] So they would do CSR and look to a B2G [business to government] collaboration, wherein the government takes up their technology." The point that technology companies participated in CSR programmes to demonstrate their technologies in an actual healthcare delivery setting so that they could later sell them to governments was supported by the promotional materials and case studies published by these corporations. For example, the multi-national conglomerate that collaborated with Vishvam Hospitals in running the e-health clinics published a report about the programme that stated:

> By September 2014, the six established eHCs [e-health clinics] had recorded over 48,000 patient visits – underlining the capacity of the programme to help large numbers of people over a short period of time. The eHC has quickly emerged as a successful example of a public-private partnership, and [the company] is actively working with the government, NGOs and local communities to enable smooth implementation and acceptance of eHCs in order to address pressing issues of access to health care.

By testing their technologies through a CSR programme, these companies were able to show that they were solving problems afflicting disadvantaged sections of the population. Moreover, they were demonstrating to potential customers that their solutions worked in real-world situations. This was important for marketing their services to governments in need of healthcare solutions that worked for many people, including those from lower socioeconomic strata. The same people, that is, who were targeted in these CSR programmes.

In turn, collaborating with such technology companies in CSR programmes allowed Vishvam Hospitals to access new technologies and test solutions offered by these companies. Thus, Dr Sangya pointed out that these programmes provided a "testing ground" to see which technologies worked in practice and gave Vishvam Hospitals a "first-mover advantage" by granting privileged access to novel equipment.[14] Collaborations with technology companies in CSR programmes also opened doors for formal business relationships. For example, Vishvam Hospitals entered into a memorandum of understanding with the American conglomerate to use its telemedicine solutions for all its hospitals, not only for the e-health clinics.

In sum, CSR provided Vishvam Hospitals with an opportunity to maintain and expand its network with government agencies and technologies companies by closely collaborating with them in programmes addressing the needs of the vulnerable and underprivileged, with reputational benefits for all partners involved. On the one hand, these collaborations were valuable for publicity purposes because each partnership or programme launch was announced in public events and widely reported by the media. The programmes demonstrated that Vishvam Hospitals was a provider that acted responsibly and addressed public health concerns beyond its narrow commercial interest. At the same time, they showcased the advanced equipment and technologies used, helping market the hospital as a provider offering cutting-edge services. On the other hand, the collaborations were tied to business agreements because they allowed testing technologies in real-world situations, thereby granting early access to novel equipment that could be used in other areas of the hospital's operations. In this context, the systematic assessment of the CSR programmes' impact provided data about the effectiveness of the technologies employed, which was an important motive for companies to enter into collaboration and at the same time allowed Vishvam Hospitals to demonstrate the good work that was being done.

[14] For such testing purposes, Vishvam Hospitals also maintained a start-up incubator where start-ups were invited to test their technologies. This arrangement secured the hospital early access to new technologies. In addition, it also helped accrue status and prestige by fostering a brand image as a research-oriented and innovative company. Similarly to CSR, which was intended to operate independently of profit interests, the incubator was set up under the umbrella of a non-profit foundation. The person in charge explained to me that this was to dispel potential doubts on the part of investors that the focus of the company might be diluted by such research activities.

The use of sophisticated technologies and systematic data generation in CSR programmes primarily served the purpose of fostering ties with partners in the medical-industrial complex and was not suited to the curative needs of the people addressed by these programmes. Instead of advanced technologies, people primarily required long-term and stable healthcare provision, which the mobile and fleeting CSR programmes did not provide (see Dolan and Rajak 2016). This mismatch was not necessarily due to bad faith on the part of the actors involved. Dr Sangya and her colleagues spoke passionately about using the most sophisticated technologies to solve the health problems of the poor, and they seemed genuinely convinced that their evidence-based approach had a tangible impact. Nevertheless, the programmes were designed to suit the interests of Vishvam Hospitals and its partners, while the people addressed by these programmes did not have a say in them. The focus on mobile technologies made sense for the CSR team and its partners because they could rapidly be moved between sites and made it possible to treat many people and test technologies that had the potential to be applied elsewhere. However, the programmes only provided a selective and fleeting experience of care and thus did not meet the healthcare needs of the people they targeted.

Conclusion

In this chapter, I have analysed the role of marketing and corporate social responsibility in the medical business of Vishvam Hospitals. I have highlighted the prominent role of prevention and awareness-raising in marketing the hospital. Prevention was an effective way to spread marketing messages because it tapped into fears about the rise of non-communicable diseases in India and mobilised the prestige of prevention as a cornerstone of public health to advertise hospital services without raising suspicions about the commercial motives involved. In addition, medical screening provided an effective way of attracting patients to the hospital.

I have highlighted that the use of medical screening by Vishvam Hospitals does not neatly correspond to a mass health model according to which standardised thresholds indicate health risks and replace the doctor's judgement as the basis of treatment. Medical screening in the camps organised by marketing rarely detected unknown health risks because the tests were rudimentary and the people screened already closely monitored their health. In most instances, the screening tests conducted by Vishvam Hospitals just added a few new numbers to other numbers from previous health check-ups. Screening alone

was therefore not sufficient to get patients to opt for Vishvam Hospitals for further treatment. Instead, the success of a medical screening camp depended on participants' interaction with the physician who interpreted the numbers for them and needed to make a convincing case that Vishvam Hospitals was the best option for future tests and treatment.

The analysis of medical screening camps also shows the expedient approach of marketing. As I have pointed out, marketing professionals emphasised that their work depended on hands-on experience and using whatever strategy proved effective. Thus, the screening camps organised by marketing did not use the most sophisticated tests available, even though such tests would indicate more health risks. Instead, marketing relied on rudimentary screening devices to minimise costs, hoping that these tests would pick up some abnormal readings and, even if they did not, that the camp participants would engage with the medical and marketing personnel present and remember the hospital next time they were ill. Such pragmatic ways of arriving at a desired result using sparse resources are often designated by the Hindi word "jugaad" and celebrated as an ideal of entrepreneurship (Ahuja et al. 2012; Prabhu and Jain 2015), but such practices are also associated with the stigma of not doing things in a proper or straight fashion (C. Jeffery 2010, 204–5). This was also the case for marketing at Vishvam Hospitals, which played a central role in attracting patients to the hospital and managing its image but was hidden away in the facility's basement and rarely appeared in public events.

The corporate social responsibility team instead carried out this public role. The CSR officials systematically planned and evaluated their programmes to document the impact of their activities. In addition, they employed advanced medical equipment and technologies. The example of the e-health clinic shows that the use of these technologies and the systematic data collection did not improve health care for the people visiting the clinic. Instead, they allowed Vishvam Hospitals and its partners in the medical-industrial complex to validate these technologies and promote them as effective solutions. This discussion highlights that neither the variable use of screening in marketing nor the standardised approach of CSR provided a consistent form of care. Nonetheless, the two approaches were complementary and worked in tandem to market the hospital.

Conclusion: The Workings of Profitable Medicine

In this thesis, I have addressed the question of how financial profit and medical benefit, as the two intertwined aspects of profitable medicine, relate to each other. My answer throughout the dissertation has been that therapeutic benefit and commercial gain are variably negotiated: actors vary standards and norms to adjust treatments and prices to patients' specific situations, with contingent and uneven outcomes. Standardised variability makes medicine profitable in Indian corporate hospitals.

I have used Vishvam Hospitals as case to analyse the workings of profitable medicine in corporate hospital care. Vishvam Hospitals promised a solution to a central problem concerning the medical business of Indian corporate hospitals: how to deliver specialised treatment profitably to diverse patient groups with unequal resources at their disposal. This problem was not specific to Vishvam Hospitals but points to a general tension in Indian corporate hospital care. As I discussed in Chapter 1, the first corporate hospitals promised an exclusive form of care for the affluent based on a claim of offering "world-class" hospital care using internationally trained specialists and the latest medical equipment. At the same time, corporate hospitals raised capital to expand the scale of their operations and capture increasing market segments in specialised hospital services to attract large patient numbers and benefit from economies of scale. In the fragmented Indian healthcare sector characterised by a deep rural/urban divide and limited health insurance coverage, expansion plans aimed at broadening the clientele basis created tensions with the claim of exclusivity and superior standards of care used to justify the higher costs of corporate providers compared to not-for-profit and public hospitals.

Vishvam Hospitals' representatives claimed to have resolved this tension by using standardised processes and cross-subsidisation to lower the price of treatments and make specialised hospital services available to broad sections of the population. I have shown that there is no evidence that Vishvam Hospitals succeeded in radically lowering treatment costs. Instead, I found that the prices charged for treatments were comparable to other corporate providers and that the hospital's employees did not experience its mode

of operation to differ substantially from that of its competitors. Moreover, other providers have similarly claimed to achieve efficiency gains through standardisation and technological innovation and suggested that they grant discounts to make treatment affordable to people from all sections of society.

The sweeping claims about a revolutionary model of delivering standardised care were at odds with the variable practices I observed in my research. Instead of uniform rules and standardised processes, administrators and doctors made decisions variably on a case-by-case basis. Patients with similar conditions ended up paying different prices and receiving different treatments depending on their socioeconomic circumstances.

I have proposed the concept of *standardised variability* to capture this situation. The notion highlights that *variability* characterises the practices of corporate hospital providers whereby actors vary standards and norms to produce profitable medicine. These practices did not follow consistent rules and produced uneven and contingent results and are thus at odds with the view of corporate hospitals as standardising and rationalising healthcare delivery. By highlighting such variability, I do not suggest that the hospital's practices were arbitrary or lacked organisation. Instead, variability was *standardised* in the sense that it emerged as a norm in the hospital, came with its own rules, and established certain regularities. Thus, administrators and clinicians not only drew on existing standards set down in pricing tables and protocols to vary prices and treatments. They also sought to align variability with their interpretation of the socioeconomic situation of patients. Such alignments were inconsistent and remained variable, however, so that patients appealed to the authority of the Chairman and the clinicians to receive care and treatment.

By making these points, I do not suggest that standardised variability is a deficient way of delivering care compared with the seemingly properly standardised provision of health care found elsewhere. I have argued that the variability characterising Indian corporate hospitals is not a consequence of lacking biomedical resources and thus differs from the improvised practices other ethnographers studying hospital care in the Global South have observed (Livingston 2012; Street 2014; Zaman 2005). I discussed in Chapter 3 how clinicians have sophisticated biomedical tools at their disposal but vary treatment protocols to adapt them to patients' specific socioeconomic situation because some can afford to follow standard protocols while others cannot. To some extent, such variability is part of any clinical practice as the medical gaze can never be completely standardised,

and clinicians need to tailor treatments to specific biosocial conditions to make them useful for patients (Fox 2000; Fox and Swazey 1974). However, the need to vary treatments is heightened in Indian health care where available protocols do not adequately reflect the socioeconomic conditions of care and disease and where the unequal distribution of resources is largely unmitigated by health insurance coverage. In this situation, varying treatments may provide viable solutions but raises suspicions about the commercial motives driving such variability.

I discussed how the business practices at Vishvam Hospitals responded to this situation characterised by unequal distribution of resources and mistrust towards commercial providers in Chapter 2. I analysed how varying prices through discounts allowed the hospital management to flexibly react to fluctuations in patient numbers and to make optimal use of the hospital's capacities. Variable pricing thus optimised profitability in a situation where patients depended on unreliable funding sources and provided a competitive edge over other providers. At the same time, offering discounts helped establish and maintain the reputation as a provider not exclusively concerned with maximising revenue and willing to help patients who are struggling financially. Offering discounts created a symbolic surplus because it demonstrated that the hospital did not simply enforce bureaucratic rules but took account of a patient's specific situation, thereby personalising the interaction. While discounts reduced the financial burden for some patients, they depended on specific constellations of interests and therefore constituted an unpredictable and selective way of varying treatment prices as patients had no right to demand treatment at a certain price.

I further explored the intertwining of economic and symbolic surplus in the medical business of Vishvam Hospitals in Chapter 5 by discussing how the marketing and the corporate social responsibility (CSR) teams used specific approaches to attract patients and manage the hospital's image. Marketing used medical screening and preventive activities expediently to market services and doctors, trying out various methods to see what worked without committing to a consistent approach. In contrast, CSR officials systematically planned their programmes to generate data records demonstrating the impact of their activities and showcasing sophisticated technologies. The CSR programmes thus demonstrated both the "world-class" care and the philanthropic orientation of the hospital, generating positive publicity while simultaneously helping forge ties to government

agencies and industry partners. However, the experience of care in these CSR programmes was no less variable than in medical camps organised by the marketing team, showing that the standardised, research-oriented approach of CSR did not produce more consistent results for people addressed by these programmes than the expedient practices of marketing.

I have argued that medical authority assumes heightened significance in healthcare context characterised by standardised variability. In Chapter 1, I discussed how the charismatic authority of the Chairman was at the heart of Vishvam Hospitals' much-publicised model. While organisational analyses and business case studies focused on purported efficiency gains through standardised treatment processes and technological innovation, I traced how the model depended on the Chairman's charisma, which was derived from and manifested in the variable practice of offering surgeries for free or at a subsidised price. Other corporate hospitals are similarly associated with charismatic doctors who serve as the public faces of these companies and distinguish them as a brand (Ketan and Ghosh 2006; Marathe et al. 2020). These superstar doctors connect specific instances of charitable help and spectacular surgeries to the hospital's image in close collaboration with the media. The arrival of corporate hospitals, therefore, has not replaced the charismatic authority of doctors with corporate brands. Instead, these doctors define the image of corporate hospitals, and their charisma is established through these institutions.

Doctors also play a critical role in the everyday workings of corporate hospital care. In Chapter 4, I discussed how an ideal of medical authority defined by unquestioned trust and devotional commitment was at the heart of doctor-patient relationships at Vishvam Hospitals. Doctors maintained that this ideal was a necessary condition for successful treatment, while patients invoked it to receive care and support in a situation where they felt they could not rely on rules and standards to receive adequate treatment. Doctors, in turn, sought to attach themselves to the charismatic persona of the Chairman because they felt threatened by the growth of the corporate administration, which they did not trust to protect their interests and establish fair rules of remuneration. These appeals to medical and charismatic authority were not simply a "cultural" phenomenon but a pragmatic response to healthcare arrangements where rules were unevenly applied.

By arguing that therapeutic benefit and commercial profit are variably negotiated in corporate hospital care, and by highlighting the central role of medical authority in this process, I seek to add further nuance to existing accounts of commercialised healthcare

delivery. Researchers studying for-profit hospital care have used the concepts of rationalisation and commercialisation to account for the growth of private hospital chains. In the Weberian framework of rationalisation, commercial hospital organisations introduce bureaucratic rules and novel accounting techniques that narrow the scope for clinicians to exercise their clinical judgement and limit their professional autonomy (see, for example, Hafferty and Light 1995; Ritzer and Walczak 1988; Starr 1982). My findings highlight that such rationalisation is not an inevitable consequence of corporate involvement in healthcare delivery. Instead of an "iron cage" (Weber 2001, 123) of rationalised healthcare delivery where rigid bureaucratic rules and merciless profit-maximisation leave little room for attending to patients' specific circumstances, I found a system where administrators and doctors pay close attention to the particularities of patients and adjust their practices accordingly to make profits.

Similarly, analyses of commercialisation in health care suggest that commercial prerogatives increasingly dictate clinical practice through the proliferation of standards that contribute to the expansion of markets through the ever-increasing application of procedures and technologies (see, for example, Clarke et al. 2010; Kaufman 2015; Waitzkin 2000). While these commercial imperatives are also at work in Indian corporate hospitals, my analysis emphasises that the medical business of corporate hospitals does not operate according to a consistent commercial logic. Instead, the commercial prerogatives operate through variable alignments of medical care and financial gain.

The argument that standardised variability produces profitable medicine in Indian corporate hospitals has implications for the question of whether corporate hospitals deliver care equitably to patients. On the one hand, my analysis highlights that corporate hospitals offer inconsistent experiences of treatment and care with uneven outcomes. The treatment patients received at Vishvam Hospitals depended on their socioeconomic circumstances. In addition, patients could not rely on established processes to deliver consistent results and required financial and social resources to navigate the variable provision of care. These care arrangements did little to mitigate existing inequalities and, at times, exacerbated them. On the other hand, the variability I observed was not a ruthless strategy that maximised financial profits at all costs without regard to the consequences for patients, as some critical commentators have suggested (see, for example, Gadre and Shukla 2016; Kay 2015; Nandraj 2012). Instead, it describes an expedient practice by which doctors and administrators responded variably to circumstances to provide medical

care profitably. The shortcomings of these care practices were a consequence of their selectivity and specificity rather than a result of systematic disregard for patients' well-being.

In sum, Vishvam Hospitals did not provide a revolutionary healthcare delivery model that could be replicated elsewhere. Nor did it remedy the inequities of Indian health care by offering equal treatment to all patients irrespective of their financial resources. Instead, its mode of operation was similar to that of other corporate hospital providers. These hospitals are part of a broader healthcare landscape characterised by a deep rural-urban divide and unequal distribution of resources in a system where healthcare expenses are predominantly paid out of pocket. Corporate providers react to this situation by tailoring the care they offer to the financial resources available to generate financial profits (Hodges 2016). In so doing, they focus on specialised procedures that are financially lucrative instead of providing comprehensive care addressing the curative needs of the whole population. Corporate hospitals, therefore, offer no solution to the problems plaguing Indian health care, and they deepen them by providing selective care, but they are not their principal cause.

This dissertation has offered an analysis of the everyday workings of corporate hospital care and unpacked its variable practices and their broader implications. Further research could expand the focus beyond the corporate hospital and explore how these institutions are embedded in the broader politics of health in India. Lawrence Cohen (2011, 43) has suggested that corporate hospitals are part of a "medical-political complex" that links political factions, business people, and hospital providers in shifting alliances. Exponents of corporate hospitals are closely connected to state authorities and industry leaders and are important power brokers involved in determining the course of health policy (V. Krishnan 2015). This influence has recently become more evident during the Covid-19 pandemic, in which the Chairman of Vishvam Hospitals and other hospital and healthcare industry exponents have assumed critical roles as task force members coordinating the response to the pandemic (*Bangalore Mirror* 2021; N. Sharma 2021). The aftermath of the pandemic and the expansion of state-sponsored health insurance coverage under the Ayushman Bharat initiative open up an arena in which various state and non-state actors will renegotiate the rules of healthcare delivery, with potentially far-reaching effects. Analysing this nexus at this critical juncture would expand the analysis

of commercialised healthcare delivery and provide insights into how notions of commerce and public good are reworked, allowing to critically assess the distinction between public and commercial healthcare services that is often too easily drawn.

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