IMPACTS OF MEDICAL AND WELLNESS TOURISM CENTERS ON THE
COMMUNITIES AROUND THEM: CASE STUDIES IN DELHI AND KERALA

By

PURBA RUDRA

A Dissertation submitted to the

Graduate School-New Brunswick

Rutgers, The State University of New Jersey

in partial fulfillment of the requirements

for the degree of

Doctor of Philosophy

Graduate Program in Geography

written under the direction of

Briavel Holcomb

and approved by

______________________________________________

______________________________________________

______________________________________________

______________________________________________

New Brunswick, New Jersey

October 2011
ABSTRACT OF THE DISSERTATION

IMPACTS OF MEDICAL AND WELLNESS TOURISM CENTERS ON THE COMMUNITIES AROUND THEM; CASE STUDIES IN DELHI AND KERALA

By PURBA RUDRA

Dissertation Director: Briavel Holcomb

Over the past decade or so the movement of patients and wellness seekers across borders, over long distances, has increased and India has been the destination of choice for many. This is private sector led growth, but the government has provided support in terms of subsidies and its promotion. With the alignment of governmental support and other enabling circumstances, many new centers—both corporate hospitals and Ayurvedic wellness centers—have opened in India. The case studies for this research were centers in Delhi, for medical tourism, and Kerala, for wellness tourism.

This study involved assessing the impacts of these centers on the local communities around them, in terms of medical, economic, and infrastructural consequences. Another question was whether these centers formed enclaves, of varying degrees, where the impacts were focused, or were there significant benefits for these communities from the centers being there.

The flow of benefits to the locals, in terms of access to healthcare and other economic and infrastructural impacts was limited, more so around the wellness tourism centers. Many, living close to these centers, could not afford the facilities because of the expense involved. All the medical tourism centers in the study were built on land given at concessional rates, with the promise that the hospitals would reserve a certain percentage
of their outpatient and inpatient capacities for people below poverty level. Most of these hospitals have failed to follow that. In terms of other benefits, some local businesses and the accommodation sector have benefitted from these centers being located in their neighborhoods.
Acknowledgements

A lot of people have been instrumental in the completion of this project. First of all, I would like to thank all my interviewees and people I met during my fieldwork who were very generous with their time and inputs. I would like to thank my friends Soma and Mamuni for all their help during my fieldwork in Delhi and Jaya and Namrata for accommodating me in their house and in their busy schedules. Thanks also to Sreeja, Harish, Nazar Chetta, Sara chechi, Amjada, Chikkoo, George and Vijayamma for making me feel at home in Kerala.

I would specially like to thank my advisor, Briavel Holcomb, for her continuous support and encouragement and extreme patience. From the project formulation to its completion, she was there, ready with very insightful feedback and to bring me back on track whenever I wavered. I am really thankful to Robin Leichenko and Tom Rudel for their helpful suggestions and encouraging me through the whole process. I was really fortunate to have David Gladstone on my committee. His experience of having worked in India and his knowledge about my field sites were extremely useful. I would also like to thank Lyna Wiggins and Dona Schneider who made important contributions in the project formulation stage.

A special thanks to the whole Geography community at Rutgers, including the faculty, the wonderful support staff, Mike, Betty Ann, Elaine, Theresa and Michelle and an amazing group of colleagues who made the whole PhD experience exciting and memorable.
During my stay here at Rutgers I met some really wonderful people. Life here would not have been the same without them. Shambhavi, Kasturi, Nelun, Alexis, Vijay, Sushmita and Kshitij made the whole dissertation writing phase more bearable with constant support and help with reading through drafts. I can’t thank them enough! Thanks a lot to all my amazing friends; Za, Mona, Rosana, Vitor, Anindya, Darakshan, Deepak, Aatish, Irene, Aude, Debby, Catherine and Ishani,. My Parents and my brother, Atri, for encouraging me, helping me keep my focus and just being there!
Table of contents

Abstract of the dissertation .................................................................ii
Acknowledgements ..............................................................................iv
Table of contents .................................................................................vi
List of tables ........................................................................................x
List of illustrations ...............................................................................xi
List of acronyms ..................................................................................xiii

Chapter 1: Introduction
I. Introduction ........................................................................................1
II. Research questions ...........................................................................3
III. Importance of the study ....................................................................3
IV. Structure of the Dissertation .............................................................4

Chapter 2: The growth of medical and wellness tourism in India: a background
I. Globalization of healthcare ...............................................................6
II. Medical and wellness tourism: concept and growth .............................8
III. Healthcare in India ...........................................................................11
IV. Medical and wellness tourism in India ..............................................14
V. Impacts of medical and wellness tourism ..........................................18
VI. “Enclaving” in medical and wellness tourism ....................................18

Chapter 3: Research design
I. Medical tourism sites ........................................................................24
II. Wellness tourism sites .....................................................................26
III. Data collection ................................................................................28
A. Interview procedure ................................................................. 28

IV. Limitations .................................................................................. 30

Chapter 4: Medical and wellness tourism centers in Delhi and Kerala

I. Medical tourism centers .............................................................. 33

A. A brief history of the hospitals .................................................. 33
   1. Indraprastha Apollo hospital ............................................... 33
   2. Max Super Specialty Hospital (The Devki Devi foundation unit) 34
   3. Fortis-Flight Lt. Rajan Dhall (Fortis FLRD) Hospital .............. 38
   4. Fortis-Escorts Heart Institute .............................................. 41

B. Accreditation and insurance ..................................................... 44

C. Marketing and publicity ............................................................ 47

D. The patient profile ................................................................. 50
   1. A Medical tourism boom? .................................................... 50
   2. The numbers ...................................................................... 52
   3. Country/Region of origin .................................................... 53
   4. The reasons for selecting India as their destination .............. 55

E. Location ..................................................................................... 57

II. Wellness/Ayurveda tourism centers ......................................... 60

A. Typology .................................................................................... 62

B. Location .................................................................................... 63

C. The study sample ...................................................................... 68
   1. Somatheeram Ayurveda Resort ........................................... 69
   2. Kairali Ayurvedic Health Resort .......................................... 70
D. Patient/tourist profile

Chapter 5 Impact of medical tourism centers on the communities around them

I. Medical impacts

II. Attitude towards international and domestic patients

III. Economic impacts

IV. Infrastructure and other local issues

V. Impact on leisure tourism

Chapter 6 Impact of wellness tourism centers on the communities around them

I. Economic impacts

II. Impacts on Infrastructure

III. Healthcare

IV. Conclusion

Chapter 7 Comparison of medical and wellness tourism centers

I. Location

II. Patient demographics

III. Treatments

IV. Economic impacts

A. Employment

B. Other economic benefits

V. Impact on local property

VI. Conclusion
Chapter 8: Conclusion

I. Wellness tourism centers ................................................................. 136
II. Medical tourism centers ................................................................. 141
III. Conclusion .................................................................................. 142
IV. Future research ........................................................................... 144
References ......................................................................................... 146

Appendix 4.1 Green leaf and Olive leaf certification .......................... 153
Appendix 5.1(a) Fortis healthcare limited, audited financial results for year ending March 31, 2010 .......................................................... 157
Appendix 5.1(b) Financial report from the annual report for Fortis Healthcare Ltd ...... 158
Appendix 5.1(c) Apollo hospitals enterprise limited. Audited financial results of quarter ending 31st March 2010 .................................................. 159

Appendix 6.1 Kerala high court judgement Kairali; Ayurvedic Health Resort Vs. The commercial tax officer(WC &LT) and the State of Kerala ...... 160
Appendix 6.2 Kerala high court judgement; Somatheeram Ayurvedic Beach Resort Vs. The sub inspector of police, taxi drivers and others ................. 164
Appendix 6.3 Sales advertisement for a place in the vicinity of Somatheeram ........ 167
Curriculum Vitae .............................................................................. 168
List of tables:

Table 2.1 Cost comparison for various treatments across countries.........................15

Table 4.1 Land allotments made to the hospitals.................................................34

Table 4.2 International insurance and medical assistance partnerships...............46

Table 4.3 Proportion of patients/tourists as per their place of origin in

Kairali (2006-07)..........................................................72

Table 5.1 Specialties availed by most medical tourists.................................77
List of illustrations:

Figure 2.1: Medical tourism and globalization of healthcare services.......................7
Figure 2.2 Health and wellness tourism...............................................................8
Figure 4.1 Location of field sites.................................................................32
Figure 4.2(a) Max Super Specialty hospital (Devki Devi wing) before the renaming.....37
Figure 4.2(b) Max Super Specialty hospital (Devki Devi wing) after the renaming......37
Figure 4.3 Regions of origin of international patients in Indraprastha Apollo hospital...54
Figure 4.4 Urban villages and neighborhoods in the vicinity of the hospitals..........58
Figure 4.5 The tourism product; a list of facilities in a center on the north cliff, Varkala61
Figure 4.6(a) View on the way to an ayurvedic resort........................................65
Figure 4.6(b) View inside a resort........................................................................65
Figure 4.6(c) View from a resort...........................................................................65
Figure 4.7 Ayurvedic massage centers in popular tourist destinations in Kerala......67
Figure 4.8 Chowara beach and the Arabian sea from Somatheeram resort..........69
Figure 4.9 On the way to Kairali resort; the view on the ground and from the top....71
Figure 5.1(a) The board at the entrance to Escorts reads concessional instead of free....90
Figure 5.1(b) The board in front of the preventive cardiology building..................90
Figure 5.2 Small informal businesses around the hospitals...............................105
Figure 5.3 Autorickshaws make a line outside Fortis...........................................106
Figure 5.4 A sign outside pocket B1 warning non residents against parking inside...108
Figure 6.1(a)&(b) Resort boundary walls.........................................................112
Figure 6.2 Paddy fields on the way to Kairali......................................................113
Figure 6.3(a) Taxi near Somatheeram..............................................................116
Figure 6.3(b) shops outside Somatheeram ..............................................................116

Figure 6.3(c) People selling food and handicraft at the beach ..........................116

Figure 8.1 Fishing boats on Chowara beach, just outside the cove ....................137
# List of Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AYUSH</td>
<td>Ayurveda Yoga Unani Siddha and Homeopathy</td>
</tr>
<tr>
<td>BPL</td>
<td>Below Poverty Level</td>
</tr>
<tr>
<td>DDA</td>
<td>Delhi Development Authority (an autonomous body which reports directly to the Ministry of Urban Development, Government of India)</td>
</tr>
<tr>
<td>IPD</td>
<td>In Patient Department</td>
</tr>
<tr>
<td>ISM</td>
<td>Indian System of Medicine</td>
</tr>
<tr>
<td>JCI</td>
<td>Joint Commission International</td>
</tr>
<tr>
<td>MCD</td>
<td>Municipal Corporation of Delhi</td>
</tr>
<tr>
<td>NCR</td>
<td>National Capital Region</td>
</tr>
<tr>
<td>NRI</td>
<td>Non Resident Indian</td>
</tr>
<tr>
<td>O&amp;M</td>
<td>Operation and Management</td>
</tr>
<tr>
<td>OPD</td>
<td>Out Patient Department</td>
</tr>
<tr>
<td>PIL</td>
<td>Public Interest Litigation</td>
</tr>
<tr>
<td>RWA</td>
<td>Resident Welfare Association</td>
</tr>
</tbody>
</table>
Chapter 1

Introduction

I. Introduction

Since the beginning of this millennium there has been a rapid increase in the number of medical tourists heading from richer countries towards the developing world for hi-tech treatments and for wholesome body and mind rejuvenation experiences.\(^1\) India is fast emerging as one of the preferred destinations for this increasingly visible section of medical and wellness tourists (Bookman, 2007). The implementation of neoliberal policies in the health sector and improvements in the transport, information and communication infrastructure have given a huge impetus to the movement of patients/tourists to India for availing both its modern and traditional health facilities. The amalgamation of age-old traditions of healing and modern day medical practices is creating a deep niche for the Indian brand of medical tourism. The Ministries of Tourism (MoT) and Health and Family Welfare (MoHFW), including the department of AYUSH which is responsible for the development of the Indian systems of medicine, at the national and state levels have worked to bring tourism and healthcare together into a more or less mutually beneficial form of medical and wellness tourism.

---

\(^1\) Some individual country estimates are available, but consistent numbers for the global market have been difficult to come by. A report by Tourism Research and Marketing (TRAM), put the numbers in 2005 at 19 million and the total value at $20 billion. According to a McKinsey report by Ehrbeck et. al., contrary to conventional wisdom the size of the medical tourism market is much smaller. They put the number at a meager 60,000-85,000, using a much stricter guideline to define a medical tourism. In their study they include only people traveling explicitly for medical treatment. They exclude patients who receive care on an emergency basis, wellness tourist and expatriates getting healthcare in the country of residence. They have also excluded patients who travel largely contiguous geographies to the closest available care.
The increased promotion and modernization of the health sector, and the opening up of it, allowing foreign investment in hospitals and pharmaceuticals, have given the necessary impetus for the corporate health sector to take off. This is while the government spending on healthcare in India stays at a woefully low figure of less than 1% of the GDP (Ministry of Health and Family Welfare, 2005).

On the other hand the worldwide trend of going back to nature, against synthetic and symptomatic treatment has led to the growth, or rather revival, of the traditional holistic methods of medicine like Ayurveda. It has found takers from around the world. It is the wellness part of the system that is gaining more popularity among tourists, even though, apart from the preventive care, the system has excellent curative treatments as well.

This boom in the medical and wellness tourism sectors have led to the growth in the number of centers providing such amenities. This has been more prominent since the beginning of this century. Most of these centers are very high end in terms of facilities and infrastructure. The same is not always true about the communities around them - their economic status that is. The larger process of globalization of healthcare, with ample support from the government, has manifested itself in the proliferation of world class facilities, but that comes at a price; a price that many, even living right across from these centers, can’t afford to pay. While ignoring local people without access so close by, some of these centers are going out of their way to woo the foreign patients.²

² In her account, The state of the heart, of her partners tryst with a corporate hospital, Escorts, in Delhi, Maggie Ann Grace mentions one incidence when, in the process checking out options for treatment, for someone who would not be covered by insurance. She gets in touch with Escorts hospital and then with Dr. Trehan, a very famous Cardiologist, who was instrumental in starting Escorts hospital. Dr. Trehan is a really busy person but in response to the email he actually calls her up in the US, from India, to take the process forward. One wonders if he would do the same for an Indian patient as well.
II. Research questions

In this study I attempt to assess the impact of medical and wellness tourism centers on the communities around them in terms of the involvement of the community and the flow of benefits.

I seek to assess the degree of permeability the medical/wellness centers have relative to the communities in which they are located. For that I would look at whether they are physically shielded from the surroundings and what economic and healthcare benefits are to be had for the locals from the center being there. Economic benefits would include both direct benefits like employment in the centers and indirect ones like a boost to local businesses and increased economic opportunities for them and other multiplier effects. In terms of healthcare impacts I assess the locals’ access to the healthcare services of these centers.

I also compared the two, the medical and wellness tourism centers, to see which one has a higher level of enclaving and, if there is a difference, what kind of enclaves these centers form. Whether differences exist across all factors- physical barricading, economic and healthcare benefits - or is there a mix with one center doing better on one count but not on the others?

The site and sample selection and methods to go about answering these questions are discussed in the next chapter.

III. Importance of the study

The government of India has envisaged turning India into a global healthcare destination but this vision seems to exclude the very people among whom these world
class healthcare facilities are set (Marcelo, 2003). The vision for a world healthcare
destination comes at a time when a significant population does not have access to good
healthcare and while the government investment in the healthcare sector is very low it is
giving perks to the private sector in an effort to make profit. The government of Delhi
experimented with some public private partnerships with the corporate hospitals to bring
more people into the ambit of hi-tech tertiary care, but those experiments mostly seemed
to have failed with these hospitals not keeping up their side of the promise of providing
free treatment in return for concessional lands. These centers hold potential for benefiting
the community in which they are located and being more integrated with them.

This study will explore the impact of selected medical and wellness tourism
centers on the communities around them, to see the extent to which communities are
benefitting from the hospitals and wellness resorts. These benefits are not restricted to
access to healthcare in these centers so the study also looks at other economic multiplier
effects that they might have. It will also try to analyze if the government is justified in
subsidizing the private healthcare sector.

IV. Structure of the dissertation

Beyond this introductory chapter, this dissertation is organized in 7 more
chapters. Chapter 2, “The growth of medical and wellness tourism in India: a
background,” explores the literature on the globalization of health care and the growth of
medical and wellness tourism. It also delves into the literature on tourism enclaves, in
trying to place this research, of enclaving in medical and wellness tourism.
Chapter 3, on Research design, discusses the design of the project. It explains the reasons for selecting the research strategy of a case study and then details the process of selecting the cases and the actual process of fieldwork and data collection.

Chapter 4, “Medical and wellness tourism centers in Delhi and Kerala,” describes the centers in more detail. It introduces the cases, both the medical and wellness centers. That chapter describes the history of the centers and their location and patient profiles.

Chapter 5, “Impact of medical tourism centers on the communities around them,” is one of the three main analysis chapters which detail the impact of the centers on the communities around them. This chapter focuses on the impact of medical tourism centers in Delhi. It describes the economic, health, infrastructural and other impacts. From looking at these aspects this chapter also tries to see the level of enclaving that these centers have.

Chapter 6, “Impact of wellness tourism centers on the communities around them,” describes the impacts of Ayurvedic resorts on the communities around them. Like the previous chapter this also looks at the economic, health and infrastructural impacts, among other things. Encalving is also looked at for these centers based on the impacts and level of integration with the community.

Although direct comparisons are not valid, chapter 7, “Comparison of medical and wellness tourism centers” tries to look at impacts on similar aspects across the centers. It also compares the level of enclaving of these centers.

Chapter 8 The concluding chapter sums up the research findings, provides some suggestions and also lists some possibilities for future research.
Chapter 2

The growth of medical and wellness tourism in India; A background

I. Globalization of healthcare

In recent times there has been an increase in the global access to “medical knowledge, technology and management expertise” (Schroth & Khawaja 2007), and this globalization has affected the spatial configuration of healthcare delivery, leading to changes in the movement of patients, health professionals, infrastructure and information across borders (Marchal and Kegels, 2003, Collins, 2003). Chanda, frames these movements in the form of trade in health services, within the General Agreement on Trade in Services (GATS) framework (Chanda, 2002, 2006). Under GATS, the four modes of trade in services include, cross border supply, consumption abroad, commercial presence and movement of people, the last three being by way of cross border movement of consumers, capital and professionals. These modes are also inter-linked, in that the growth in one affects the growth in some of the others. For example, an increase in the establishment of healthcare infrastructure might lead to more patients and more professionals (positive linkages). Building on Chanda’s application of GATS to healthcare, tourism is included to highlight the intersection of healthcare and tourism services, in the form of medical tourism (Figure 2.1). So, within the larger context of globalizing healthcare, medical tourism, that is consumption of healthcare abroad, has really taken off in some countries, and this movement of patients to countries providing
medical services has not been restricted just to modern medicine but has also extended to traditional systems of medicine.

**Figure 2.1: Medical tourism and the globalization of healthcare services**

Based partly on Chanda’s articles on Trade in Health Services and Inter-modal linkages in services trade.
II. Medical and wellness tourism: concept and growth

Carrera and Bridges, after an extensive review of the literature on health and medical tourism, in their 2006 paper, have defined medical tourism as “the organized travel outside one’s natural healthcare jurisdiction for the enhancement or restoration of the individual’s health through medical intervention” and health tourism as “the organized travel outside one’s local environment for the maintenance or restoration of the individual’s wellbeing in mind and body.” Health tourism typically includes alternative medicine and spa treatments (Medical Tourism Association). Although, health and wellness tourism is used interchangeably by some, wellness tourism is considered a subset of Health tourism and one differentiation some use is that medical activities play an important role in health tourism whereas the medical and cure dimension is not used in most parts of wellness tourism (Smith & Puckzo, 2009). Mueller and Lanz Kauffman (2001), also stress the differentiation based on the cure and prevention angle, in their illustration:

Figure 2.2 health and wellness tourism
While talking about a philosophical framework for thinking about wellness tourism Steiner and Reisinger point out “how wellness tourism might balance and integrate lives unsettled and fractured by runaway time, frantic busyness, disconnection from the natural world and other people, loss of spirituality, and longing for a sense of place in an alien, impersonal and out-of-control world.” Some of this is reflected in Langford’s reflection on Ayurveda (an ancient Indian system of medicine), in today’s world, as well. She points out that

For, the promises of twentieth century Ayurveda extend from calming the overexcited dosa to easing the excessiveness of industrial lifestyles and from curing illness to healing modernity itself. To fulfill such promises, practitioners employ potent neo-orientalisms, promoting Ayurveda as spiritually attuned, anti-materialist, and non-violent, in contrast to biomedicine. Its therapies are advertised as antidotes for the severe and toxic side effects of both modern lifestyles and modern pharmaceuticals…. (2002:17)

Although medical tourism has become a buzz word only recently, the idea of traveling for health is a concept that is very old. Greeks travelled to the healing center at Epidaurus, where Asklepius, the god of healing, advised people in their dreams about remedies to their illnesses and Romans went to thermal baths to cure joint pains (Bookman, 2007:4, Reisman, 2010:1). There are many such examples of people traveling to seek cure for their ailments.

The recent growth, in the last decade or so, has been slightly different in that the tourists are travelling farther away than they did earlier, going to poorer countries and going for high tech and invasive medical procedures (Bookman, 2007). Woodman, in his book, Patients without borders (2008, 2nd ed.), lists the destinations with the various treatments available for the health traveler. He also highlights which destinations are primary and which ones are secondary when it comes to the various treatments. Among
the countries listed are Brazil, Costa Rica, Czech Republic, Hungary, India, Israel, Jordan, Korea, Malaysia, Mexico, New Zealand, Panama, Philippines, Singapore, South Africa, Taiwan, Thailand, Turkey and UAE. Thailand was a primary destination for almost all the treatments listed, including cardiovascular, cosmetic & plastic surgery, dentistry, fertility and reproductive, neurology and spine, orthopedic(all), total hip replacement, Birmingham hip resurfacing, oncology, stem cell research, sex change, weight treatment (Bariatric) treatments. Singapore and India also offer almost all these treatments but are secondary destinations for cosmetic and dental treatments.

Merging medical expertise and tourism became government policy in India when finance minister Jaswant Singh, in his 2003 budget speech, called for India to become a “global health destination” (Marcelo,R. 2003). Since then India has been taking rapid strides towards proving itself to be one. The Ministry of Tourism and the Ministry of Health and Family Welfare have taken steps to promote both the traditional Indian system of medicine as well as the modern ones to the international tourist; and the private sector has emerged as a very important player in the scheme of things.

Among other things, the increased trade in Indian health services has led to a rise in the number of patients traveling to India to avail themselves of the medical facilities. It has not only led to inter-sectoral linkages but also to a lot of inter-modal linkages, that is linkages between the various modes of trade in health services. The Foreign Direct Investment in the health care sector, such as the establishment of joint ventures and foreign owned multi-specialty or specialized hospitals, have also played a small role in facilitating exports of health services through consumption abroad by providing facilities and world class hospitals for medical tourism and tele-health exports. There also has been
an increase in the movement of health professionals across borders and across sectors. As in the IT sector, returning health care professionals have indirectly helped in this process by facilitating such investment flows through diaspora networks and contacts, by helping promote medical tourism through network externalities, reputation effects, upgraded skills and knowledge, and portability of health insurance (due in part to recognition of their qualifications by foreign health insurance providers) (Chanda, R. 2006)

III. Healthcare in India

The history of post Independence India’s health system can be categorized into three distinct phases. The first phase, 1947 (the year of independence)-1983, the health policy was assumed to be based on two principles: first that no one should be denied care due to lack of ability to pay and that it was the responsibility of the state to provide health care to people. The second phase was between 1983 and 2002. 1983 saw the country’s first national health policy that expressed the need to encourage private initiative in health care service delivery. Concurrently the access to publicly funded primary health care was expanded. The need to utilize private sector resources for addressing public health goals has been further emphasized in the current phase, since the new National Health Policy of 2002 (Chanda, 2006).

The public health investment in the country over the years has been low, and as a percentage of GDP has declined from 1.3 percent in 1990 to .84 percent in 2004-05. The total health expenditure as a percentage of the GDP was 4.25% in 2004-05, out of which only around 20% was government expenditure and the bulk, around 78% was private expenditure. The remaining 2% was external flows (Bhat 1999; MoHFW 2005; Bajpai
et.al 2004). Coinciding with the decreasing public investment, the emergence of lifestyle related non-communicable diseases and an effective demand for modern health services is the steady corporatization of medical care (National Commission on Macroeconomics and Health, 2005). In no small measure is this development also the result of the neo-liberalization-privatization process that India has been witnessing since the early 1990s. Seeing the scope for profit, several non-resident Indians (NRIs) and industrial/pharmaceutical companies are also investing money in setting up super-specialty hospitals such as Medinova, Mediciti, Wockhardt, Escorts etc. Between August 1991 and August 1997, the Foreign Investment Promotion Board (FIPB) approved foreign direct investment (FDI) proposals worth US$100 million in the Indian health care sector (Purohit, 2001; Berman 1998). The foreign investment policy in the hospital sector in India is quite liberal. Since January 2000, FDI is permitted up to 100% under the automatic route in hospitals in India. A controlling stake is also permitted in hospitals for foreign investors (Chanda, 2007). Despite the liberal regulatory environment, Chanda notes that FDI presence in hospitals in India is still limited; only three hospitals qualify as FDI hospitals and the rest are FDI approved only on paper. She also adds that most of the recent capital inflow has been through private equity funds and Initial public Offers (IPOs), and while this trend is expected to continue, at present, the predominant method of financing hospitals is domestic borrowing.

The National Health Policy of 2002 was also meant to widen the reach of the Indian System of Medicine and Homeopathy or ISM&H (MoHFW, 2002). The potential of ISM has been recognized since the last 50 years but it was only in the last decade of the last century that it received government attention in the form of the creation of an
independent department of ISM&H in 1995, which was later rechristened as the department of Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) (Sinha, 2002). India has a vast reservoir of practitioners in the Indian System of Medicine and Homeopathy who have undergone training in their own disciplines. The possibility of using such practitioners in the implementation of State/Central government public health programs, in order to increase the reach of basic health care in the country, was addressed in the National Health Plan-2002. There were 691,470 Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) practitioners registered in India as of 1 January 2002. Committees set up by the government have highlighted the competitive advantage of ISM doctors due to their easy accessibility to the people, especially in the rural areas (MoHFW 2002). There is a need to integrate ISM in the health care delivery system. Of late, some coordination between the two systems of medicine has been attempted by the central government and clinics of Ayurveda, Unani and Homeopathy have been set up at some allopathic hospitals and dispensaries (NCMH, 2005). Though the policy objective was to increase the reach of the Indian systems of medicine to the public at large, Ayurveda and Yoga have also become big draws for tourists. This has come about at a time when there has been a trend, more so in the developed countries, of “going back to nature”. Ayurveda, which literally translates as the “Science of life”, is a holistic science that evolved through the ages in ancient India some 5000 years ago, advocating a way of life in combination with diagnosing and curing ailments in harmony with nature. Ayurveda, as the legend has it, was created by Brahma, the creator of the universe, and the knowledge was then transmitted through the generations in an oral tradition. Recorded knowledge came much later. “Suhsruta” and “Charak Samhita” are considered
to be very important texts in Ayurveda (Varier, 2005:5). Varier warns that many still treat Ayurveda as divine just because it is Vedic and that dissuades many from adopting a critical approach to the subject but he also points out that the international importance and scientific value of Ayurveda are becoming clearer (2005: xiii). The growing dissatisfaction with western medicine in terms of long term side effects has led to a growing demand for less harmful therapies and a holistic approach to health, which is why Ayurveda is growing in popularity (Sinha, 2002). Ayurveda holds that specific disease conditions are symptoms of an underlying imbalance. It does not neglect the relief of these symptoms, but its main focus is on the bigger picture of restoring balance (Varier, 2005; Pushpanath et.al). Ayurveda emphasizes prevention of disease, rejuvenation of the system and longevity of life and it’s the rejuvenation and de-stressing therapies that have found most favor among tourists. As mentioned earlier, traveling for health has a very long history. The use of waters at mineral spas and hot spring has been popular since Roman times, and the “taking to the waters” of the elites of seventeenth century Europe provided one of the foundations for the modern pleasure resort complex (Hudson, 2002). The concept of spa tourism has considerably broadened to include resorts that are not based on hot springs but instead focus on other natural resource attributes (ibid.). The alternative medicinal system of Ayurveda has lent itself very easily to this kind of a set up.

IV. Medical and wellness tourism in India.

Given the favorable conditions both, the private sector in tertiary health care and Ayurveda, a traditional Indian system of medicine, in the tourism sector, have grown
rapidly. The numbers have been difficult to come by and most numbers include both medical and wellness tourism. A study by Federation of Indian Chambers of Commerce and Industry (FICCI) and Evaluserve says that India’s share in the global medical tourism is touching 2.4% and the number of medical tourist is projected to reach one million by 2012. In the same study they project the industry to be a $1 billion industry by 2010, something that was projected by a Confederation of Indian Industries (CII McKinsey study way back in 2002. ³ Associated Chambers of Commerce and Industry in India (ASSOCHAM), in 2009, projected that the medical tourism industry will grow at an annual rate of 30% in a six year period.

Some of the reasons that have fueled this growth are the cost benefit, shorter waiting time, high tech facilities, skilled professionals and government support. The costs of procedures are sometimes as low as one tenth the prices in the west. ASSOCHAM provides a chart comparing the prices across countries:

**Table 2.1 Cost comparison for various treatments across countries ($)**

<table>
<thead>
<tr>
<th>Medical treatment</th>
<th>USA</th>
<th>UK</th>
<th>Thailand</th>
<th>India</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bone marrow transplant</td>
<td>more than 200,000</td>
<td>up to 200,000</td>
<td>up to 62,500</td>
<td>round 20,000</td>
</tr>
<tr>
<td>Bypass surgery</td>
<td>15,000-20,000</td>
<td>around 20,000</td>
<td>14,250</td>
<td>4000-6000</td>
</tr>
<tr>
<td>Knee surgery</td>
<td>16000-17000</td>
<td>15,000</td>
<td>7000</td>
<td>1000</td>
</tr>
<tr>
<td>Liver transplant</td>
<td>300,000</td>
<td>250,000</td>
<td>750,000</td>
<td>4000</td>
</tr>
</tbody>
</table>

Source: ASSOCHAM website.⁴

In some places like the UK and Canada the waiting time could be very long for “the ones that are not institutionally seen as priority surgery” (Connell, 2006). The medical tourism infrastructure, even if they are located in developing countries, compare

---

³ Press Trust of India (PTI) source used in an Economic Times article, April 11, 2010. There is not data available to show whether the industry reached the projected figure in 2010 or not.

⁴ The price comparison chart together with some data on growth was provided here: [http://www.assocham.org/prels/printnews.php?id=2055](http://www.assocham.org/prels/printnews.php?id=2055)
well to the ones in the West. The phrase “first world healthcare at third world price” has been used widely to show the double advantage that these facilities are providing (Turner, 2007). As Connell points out relative affordability of international flights and favorable exchange rates are also enabling reasons for some.

The government has also played an important role in promoting the growth of medical and wellness tourism in India. Both the National and State governments are taking steps in that direction. The “Incredible India” campaign included special sites on Ayurveda and yoga. A few years back the Ministry of Tourism issued a comprehensive brochure on Medical tourism in India (MoT website).

Further, the Indian Government has also started issuing medical or M-visas specifically for medical tourists, since 2005. The initial validity is one year or the period of treatment, whichever is less. It can be extended with the support of valid medical documents. Unlike the tourists travelling under the tourist visa, which is for a maximum of six months, the medical tourists have to register themselves at the Foreigners Regional Registration offices within 14 days. The medical attendants are also given a special MX visa (Ministry of Tourism).

The government has also extended the Marketing Development Assistance (MDA) to accredited hospitals, under which financial support to approved medical and wellness tourism centers will be given for participation in approved Medical/tourism fairs, medical conferences, wellness conferences, wellness fairs and its allied road shows.6

---

5 The Incredible India campaign was a major campaign to promote Indian tourism worldwide
6 This was mentioned in a Tourism Ministry circular: revised guidelines for Marketing Development Assistance (MDA) Scheme for medical tourism/wellness tourism provider. [http://www.tourism.gov.in/writereaddata/Uploaded/Guideline/020920110632343.pdf](http://www.tourism.gov.in/writereaddata/Uploaded/Guideline/020920110632343.pdf)
For making the choice easier for the tourists, the Ministry of Tourism, Government of India has started issuing Green leaf and Olive leaf certifications\(^7\), which, even though not compulsory, give credibility to those centers that have the certification, especially when a lot of inexperienced and wrong intentioned people have started opening up Ayurvedic centers anticipating good returns. In some destinations a lot of these centers do not follow the true traditions of Ayurveda and just function as massage parlors behind the name of which illegal sex tourism takes place. This has also made people apprehensive about a wrong image of Ayurveda being promoted among visitors from other countries. In India the corporate private sector has already received considerable subsidies in the form of land and reduced import duties for medical equipment. Increasing returns from medical tourism will only further legitimize their demands and put pressure on the government to subsidize them even more (Singh, 2008; Sengupta and Nundy, 2005). Shetty, while quoting Dr. Thomas, an orthopedic surgeon from a hospital in Delhi, wrote that the hospitals designed to attract medical tourists have been built “by lobbying the government for cheap land to build hospital, cheap loans to finance expenditure, and tax breaks” (2010:672). In a country where the poorest are taxed on every item they buy, the concessions handed out to the rich are simply obscene.” Singh adds that “it is a myth that the revenues earned by these corporates will partly revert back to finance the public sector…… so why should developing countries be subsidizing the healthcare of developed countries?”

\(^7\) The ministry of tourism, Kerala, classifies government approved Ayurvedic centers into Green leaf and Olive leaf based on certain criteria. Green leaf is olive leaf requirements plus some more, like high standard of building and furnishing and separate hall for yoga/meditation, among other things. The complete certification requirement is attached in appendix 4.1.
V. Impacts of medical and wellness tourism:

To briefly summarize, some of the advantages to India from medical tourism include, among other things, foreign exchange earnings, reverse brain drain, domestic research and development, and improvement in the physical infrastructure (Bookman, 2007). Apart from some of the negative impacts mentioned in the previous section there are some more negative impacts of medical tourism. Reddy and Qadeer (2010) mention some of those as shift of subsidies to the private sector, extremely low inputs in the public sector health care and a movement of professionals from the public sector to the private sector. They also point out that as medical tourism caters to the diseases of the rich “the services these institutions promote are not necessarily in accord with the epidemiological priorities in the country.” (2010: 74)

VI. “Enclaving” in medical and wellness tourism

Medical tourism, in its present form, being a relatively recent phenomenon, has an expanding body of literature on its impacts, but most of the impacts that are talked about are on a larger regional/national level, and at the system’s level. The local impacts of these centers on the people living around them have received little attention. The impact of wellness tourism in India has been even less studied. Despite being in the healthcare sector these are profit making ventures and do draw upon the local economy. This study tries to fill in that gap in the literature. I explore what these centers “give back” to the locality in which they situate and document some negative consequences.
I have approached that gap using the concept of enclaves, to see the extent to which the centers are integrated into the local community and if they form enclaves or not. Following from that, what forms do the integration or “enclaving” take and how does that differ between medical and wellness tourism? The literature on enclaving in tourism has been more for resorts, parks and safaris in Africa and cruises and island tourism destinations. Although there is existing literature on ‘enclaving’ in resorts there are none related to Ayurveda tourism. Because of their medical treatment aspect it needs to be seen if these centers have impacts similar to other tourist enclaves or not.

Sometimes it is difficult to separate out the impact of specific centers in popular tourist areas but they tend to keep most of the benefits within their “enclaves” and the tourists themselves tend to remain in their “tourist bubbles” “experiencing the novelty of the macro environment of a strange place from the security of a familiar microenvironment” (Jaakson, 2003). There is always a distance maintained from the locals. “For critics, resorts exemplify stark disparities between western elites, able to enjoy leisure and conspicuous consumption in exotic locations, and local workforce, which must behave with neocolonial servility towards white guests in compound-like settings from which they would otherwise be excluded” (King, 2001:175).

The term enclave, however, is a fuzzy concept which is used at a variety of scales from a single hotel in an area otherwise lacking tourism developments, to a concentration of tourism developments within a country. Even resorts are varied “ranging from vast integrated developments to boutique eco-resorts” (ibid.). It is also sometimes used to describe destination region. And somewhere between single resort properties and urban destinations is what King calls the “resort zone” (2001:176). In this study both resorts
and enclave have been used for a single resort property. Resorts, regardless of scale, cannot be entirely self-contained or self-sufficient. The tourists come from elsewhere and they usually use airports and other transportation facilities outside of the resort and the resorts usually rely upon external supplies of water and electricity. Thus, differences are in degree rather than in kind. Nevertheless, because integrated resorts provide most of the facilities that tourists need, they may retain a large proportion of visitor spending. In fact, resort managers may do all that they can to encourage visitors to remain within the resort, since their temporary departure to other locations may mean a loss of potential spending.

One of the most important features of enclavic space is the continual maintenance of a clear boundary which demarcates which activities may occur and who may be admitted. Often, for instance, locals not employed in the enclave are barred, and roaming sellers are denied the opportunity of approaching tourists to sell their wares or services by constructing walls and fences and posting guards at the entrance. Thus, tourists are cut off from social contact with the local people and are “shielded from potentially offensive sights, sounds, and smells” (Edensor, 2000:329). Mac Cannell, as quoted by King, describes it as places that squeeze “the local people out of every role except the menial positions that they have always occupied” (King, 2001:175). It discourages the development of links with the local economy and, if the resort is owned by external investors, leakages may be high. In his study on the tourism industry in the Okavango Delta in Botswana, Joseph Mbaiwa points out that “the foreign domination and ownership of tourism facilities has led to the repatriation of tourism revenue, domination of management positions by expatriates, lower salaries for citizen workers and a general failure by tourism to significantly contribute to rural poverty alleviation” (2005:157).
Resorts are often poorly integrated into the local economy (Edensor, 2000; Wall, 1996; Hernandez, 1996; Freitag 1994) but there are also some that are not so isolated. Smabrook et.al. (1992:65) put forth a helpful typology for the range of integration of resorts with the local community as self-contained enclaves, semi-insular/interactive enclaves and integrated domestic-international resorts. The first one being highly restrictive luxury enclave resorts, the semi-insular ones having controlled access through small concessions on the fringe of the resort away from the beaches and hotels and the third kind characterized by a competitive participation of the formal and informal sectors (Sambrook et. al. 1992)

As the magnitude of local economic linkages is a critical determinant of the extent to which tourism promotes local economic development this study has important policy implications. If inputs are derived locally, more money is retained within the local economy and local economic impacts are enhanced even if the numbers of tourists and their expenditures remain the same.

According to the global Code of Ethics for tourism adopted by the United Nation World Tourism Organization General assembly in 1999 “the local population should be associated with tourism activities and share equitably in the economic, social and cultural benefits they generate and particularly in the creation of direct and indirect jobs resulting from them” (Singh, 2008). Through employment, tourism provides the opportunity for direct and indirect linkages with the local community. Efforts to maximize the economic benefits derived from tourism in destination areas have centered on increasing the number of tourists, increasing the tourists’ length of stay, and increasing tourists’ overall expenditures. A complementary way to enhance the benefits of tourism is to expand the
backward economic linkages such as by sourcing materials locally as much as possible. There is a need to investigate and strengthen economic linkages between tourism areas and their hinterlands (Telfer and Wall, 1996).
Chapter 3
Research Design

While talking about the relevance of various research strategies Yin (2003:7) says that the exploratory “what” questions can be answered by any of the strategies, which include, among others, archival research, survey and case studies. He adds that the “how” and “why” questions are likely to favor the use of case studies. As this study involved exploring what the impacts of these centers on the communities around them were and looking at how the centers were linked to the local community and its economy, if at all, the case study method was chosen. Multiple-case design was selected instead of a single case design. From the preliminary research none of the centers seemed unique and as Yin put it, for multiple case design “a major insight is to consider multiple cases as one would consider multiple experiments-that is, to follow the “replication” logic (2003:47), multiple cases were selected with the view to test if the predicted replicability of results was a reality or not. Stake mentions that case studies seem to be a poor basis for generalization but when cases are studied at lengths certain responses might come up again and again and certain generalizations can be drawn. He adds that with more observation the generalization gets modified and refined (Stake, 1995:7). With multiple cases I was hoping to find some common responses based on which certain generalizations could be made. Helpful insights could have been drawn if Ayurvedic hospitals and government hospitals were included in the cases, to see if there were contrasting results, but because of time and resource constraints that could not be done.
To explore these questions in the selected case studies, semi-structured interviews were done. The fieldwork was carried out between August 2007 and August 2008 and a total of 108 interviews were conducted. As I had not had an opportunity to do pre-dissertation travel, most of 2007 was spent planning the proposed research and getting a firmer grip on the state of medical and Ayurvedic wellness tourism in the chosen sites. I had also not finalized my cases. I wanted to do a reconnaissance of some of the possible centers and get some initial inputs to design my interviews better, to be more informed to carry on an effective conversation.

The time spent in Kerala was two and a half months and in Delhi it was about 6 months, spread between two trips. The initial sample selection for Delhi did not change but the one for Kerala was cut short given the time and resource restraints.

I. Medical tourism sites

Numbers for medical tourism are very hard to come by even at the national level, let alone at a regional level, but even though the exact number of medical tourists heading towards Delhi is not known it is one of the top destinations within India. Also, being part of the Golden triangle of Delhi-Jaipur-Agra, a very popular tourist circuit, it offers a chance to observe how much medical and leisure tourism intersected.

Four hospitals catering to medical tourists were selected. Although there are a few public hospitals that also cater to some international patients, the numbers/proportion are small and they do not explicitly aspire to get medical tourists. The selected centers are private hospitals. In this study they all happen to be corporate hospitals and they explicitly seek medical tourists. Some of the hospitals are in the study sample just
because of this reason, even though the proportion of medical tourists to total patients is still low. Some of these hospitals are relatively new and do not have a lot of international patients just yet but have that explicit vision to attract international patients.

In the *Incredible India* website (and their medical tourism microsite) Delhi and Mumbai have the most centers listed for medical tourism. Even the medical travel agents’ websites have a lot of Delhi hospitals listed on them. Delhi was also home to a few hospitals owned by the relatively recent entrant, Fortis healthcare, now a big player in the hospital scene. Initially they were restricted to the National Capital Region (NCR)\(^8\) but now they are slowly spreading all over India. Delhi is also home to Indraprastha Apollo Hospital, the first hospital in India to get international accreditation from the Joint Commission International (JCI) and a pioneer of sorts in medical tourism in India. Choosing from the most frequently occurring names on government and medical tourism websites, Indraprastha Apollo Hospital, Max Super Specialty Hospital (the Devki Devi foundation unit), Fortis Escorts heart Hospital and Fortis, Flt Lt. Rajan Dhall Hospital were selected for the study. The ‘community’ around these hospitals were the neighborhoods, or colonies as some of them are called in India, right next to these hospitals and included in most cases urban villages and middle and upper middle income neighborhoods, some affluent neighborhoods and also businesses, some of which were part of these neighborhoods while some were independent of them; that is, they were not on the property of these neighborhoods. The history and other details about the centers are discussed in the next chapter. One thing to note, which I have discussed later also, is that the management of Flt Lt. Rajan Dhall hospital did not agree to let me do research.

---

\(^8\) The National Capital Region includes the National Capital territory of Delhi and some of the contiguous urban areas from the states of Haryana, Uttar Pradesh, Uttarakhand and Rajasthan.
within their premises, but I did get the reaction of residents around. Actually their refusal made me more curious, especially given the fact that I had told them I would not approach patients, if that was an issue, and that I only wanted to meet some representative of the management.

II. Wellness tourism sites

Ayurveda tourism was selected for the wellness part of the study. Although Ayurveda has very good curative treatments as well, I have focused on the wellness side of it, which eventually also dictated the selection of the sample. The initial sample was drawn from the list of tourism ministry certified Ayurvedic centers. After going to Kerala I also realized that there were a whole range of Ayurvedic centers starting from hospitals to small Ayurvedic massage centers in popular destinations. The typology is discussed in more detail in the next chapter. Because I was looking at wellness I decided to leave out Ayurvedic hospitals. Kottakkal Arya Vaidya Sala is one of the most popular destinations for Ayurvedic patients, including foreign patients, but they did not agree to let me conduct interviews in their premises. That initial list was meant to include two centers each from the districts of Kottayam, Thiruvananthapuram, Ernakulam, Idukki and Palakkad, because they had the highest concentration of Ayurvedic centers in that list. The second leg of selection was based on a typology, in trying to select representatives for Ayurvedic resorts, resorts and hotels with Ayurvedic centers in them, and small Ayurvedic massage centers. But I realized that doing justice to covering so many centers in less than three months time would not have been possible, which is why I decided to concentrate on Ayurvedic resorts. I did travel around Kerala to get a sense of the
different kinds of Ayurvedic centers. I spoke to some of the management representatives to get an impression of the supply side of it and finally decided to focus the study on two Ayurvedic resorts: Somatheeram Ayurveda Resort and Kairali Ayurvedic Health Resort. The reason for selecting this over one Ayurvedic resort and one resort with Ayurvedic center is that the proportion of tourists taking Ayurvedic therapies was more in the Ayurvedic resort and one of the reasons for tourists selecting that resort was Ayurveda. The final selections also represented slightly different kinds of centers. Somatheeram, the first Ayurvedic resort was one located very close to a popular tourists destination and was bound to have some impact from the general tourism to the area while Kairali was away from any major tourist destination and was pretty much the only resort in the locality, unlike Somatheeram which was surrounded by many more resorts and hotels.

The other centers that I also briefly visited were Ayurvedic resorts of Rajah Healthy Acre Ayurveda Hospital and rejuvenation center in Palakkad district, Athreya Ayurvedic Center in Thiruvananthapuram district, Sahayadri Ayurveda division-Peermade Development Society, the River Retreat Heritage Ayurvedic Resort in Thrissur, Keraleeya Ayurveda Samajam Hospital, Resorts with Ayurvedic centers at Spice Village in Idukki district, Coconut Lagoon ayurveda and Marma Treatment Center in Thiruvananthapuram and hotels with Ayurvedic centers at Trident Hilton and the Taj Spa at Taj Malabar, both in Ernakulam district. I also selected some small Ayurvedic massage parlors spread all over popular tourist destinations like the Kovalam beach and Varkala beach in Thiruvananthpuram district and in Thekkady close to the Periyar Tiger Reserve and the lake in the Idukki district.
III. Data collection:

The major source of information was interviews with the management representatives of the centers and residents and business owners in the neighborhood. Apart from that, an analysis of the content of the websites, brochures, and photographs has also been used, as a source of information.

The website and brochures have been used not only as a source of information about the centers but also to look at their brand building exercise, the selection of words and pictures and links, especially given that, for most of these centers, their website is a very important first point of contact with prospective customers. All six centers had active websites but I did not have brochures for all of them. I did get brochures for most of the Ayurvedic centers, even the ones that were not in the final sample, but for the medical tourism centers I got the brochure only from Apollo Hospital. The centers that are included in the study gave their brochures on their own account. In some of the Ayurvedic centers I asked for the brochure myself.

A. Interview procedure

In my sample, I wanted to get representatives from the management of the centers, residents of the neighborhoods, covering the different neighborhoods, if there were more than one immediate ones, business owners, government representative and representatives of the education institutes. I contacted the centers in advance to get permission and set up appointments for the interview. Some interactions were initiated through email before heading out to the field but the response to emails wasn’t very good so most of it happened through phone or by directly approaching them in person. With
the businesses I went up to them, explained my work and asked for an appointment if they were willing to talk about it. I consciously picked property dealers, because the impact on the accommodation sector seems to have been big and also pharmacists because their business was directly linked with the hospital. The other businesses were not selected based on any particular criteria in mind. For interviewing residents, in some neighborhoods, I approached the Resident Welfare Associations (RWA), for permission. This also gave more credibility; specially given how unsafe Delhi is and how suspicious people could have gotten if I walked unannounced to their place. I carried a letter from my advisor briefly explaining the reason for me being there and also as a proof of from where I was coming. I made photocopies of it. I also included a copy of my school identification card on that. In one of the pockets in Sarita Vihar I approached the president of the RWA and he wrote on the photocopy that I have taken permission to do my research. He then signed it and put a stamp on that paper. The residents seemed more at ease after seeing that. As I met people some of them also introduced me to others in the neighborhood and I also spent time in the common/commercial centers where locals would drop by. This happened in Vasant Kunj where the RWA member wasn’t very comfortable letting me walk around in the neighborhood knocking on doors. For some neighborhoods I started by interviewing people I knew through friends and family and then went ahead from there. In Kerala, in the beginning, I simply went to people’s houses to talk. Many were just outside their houses so it felt less intrusive. The questions were mostly about their perception about how the presence of the center in that locality had impacted them, and if there had been benefits that have come about as a result of the hospitals being located there.
I also met some faculty in the Ayurveda College in Kerala and a medical college in Delhi, some government representatives and industry representatives, like the official at Confederation of Indian Industries. Because medical and wellness tourism have taken off relatively recently there were a lot of things I did not know about them or did not find in the existing literature, so these interviews, even though were not directly related to the local impacts were important nonetheless to improve my understanding of the two sectors.

IV. Limitations

There were various limitations in the research which meant I had to restrict some of what I would have liked to do. Resource restrictions meant I could not spend a lot of time in Kerala doing a more extensive study. Another handicap in Kerala was the language. Malayalam is the language most widely spoken there and I do not speak Malayalam. I mostly got around without too much of a problem but it also meant that my sample was restricted only to those who either spoke Hindi or English. I did find quite a few respondents but it definitely was a limitation. Even with people who spoke English, some of them spoke barely enough to communicate so it was difficult to have a good conversation. Those interviews ended up being more of “yes/no” responses rather than interviews. I did not have enough resources to hire a translator so I had to make do with what I could, keeping this limitation in mind. Having said that, I did get enough responses that spoke to my research questions. There is also scope to do more comparative work including resorts with Ayurvedic centers and Ayurvedic hospitals.
Given the time I could not manage to visit so many centers and had to focus on Ayurvedic resorts.

For medical tourism centers, I could not get the management side perspective in one of the hospitals, Fortis Flt Lt. Rajan Dhall. Despite that the responses from the locals added to the narrative, but it would have been advantageous to get the management’s point of view as well.
Chapter 4

Medical and wellness tourism centers in Delhi and Kerala

Both medical and wellness tourism are developing at the same time, despite the seemingly contrasting nature of the two practices in terms of being modern vs. traditional, instant-synthetic-symptomatic treatment vs. long standing-back to nature-root cause treatment. This contrast, in many ways, showcases the present dilemma of a rapidly developing India deeply rooted in traditions.

The national capital of Delhi is one of the leading destinations for medical tourism in India, and the southern state of Kerala leads in Ayurveda-wellness tourism.

Figure 4.1 Location of field sites

Base map source: United Nations, Cartographic section (Department of field support).
I. Medical tourism centers

The growth in Medical tourism in India has mostly been led by the corporate hospitals. Apollo Hospitals, Fortis Healthcare, and Max Healthcare are all proactively promoting medical tourism. While the Apollo group of hospitals and Fortis Healthcare are among the leading hospital chains in India, Max healthcare’s network of hospitals is mostly in Delhi and the National Capital Region (NCR). This research is mostly concentrated in and around the Indraprastha Apollo Hospital and the Max Super Specialty Hospital (a unit of the Devki Devi foundation) and, to a lesser extent, around Fortis Flight Lt. Rajan Dhall Hospital, Escorts Heart Institute and Research Center (EHIRC), or as it is known now, Fortis-Escorts Heart Institute.

A. A brief history of the hospitals

1. Indraprastha Apollo Hospital

The Apollo group of hospitals was founded more than 25 years back by Dr. Prathap C. Reddy, who is said to have pioneered corporate healthcare in India. The Chennai Hospital was the first to be established in 1983 followed by the Indraprastha Apollo Hospital in Delhi, more than a decade later in 1996.\(^9\) Indraprastha Apollo has now become a very important destination in India for medical tourists from around the world.

In 1986, the Delhi administration invited proposals to establish a multi super specialty hospital on a ‘no profit no loss’ basis. Land was leased out to Apollo Hospitals after two years, on a token payment of INR 1 (~$ .02) a year, to set up the Indraprastha Apollo Hospital. Set up in the spirit of a Public-Private Partnership, the hospital is a joint

\(^9\) Part of this information was obtained from the website of the Apollo Hospitals Group.
venture with the Delhi government.\(^\text{10}\) By the terms of the agreement, the government provided 15 acres of land and INR 16 Crores (~$3.6 million at the current exchange rate of around INR 45 to $1) for the building construction. In return, Apollo Hospital agreed to reserve at least one third of its 600 beds capacity for poor in-patients and to provide free consultancy to 40% of its out-patients (Thomas and Krishnan, 2010).

2. Max Super Specialty Hospital (The Devki Devi foundation unit)

Max Healthcare is another big name in the corporate health sector in the National Capital Region of Delhi. Max Super Specialty Hospital in Saket, Delhi is its leading tertiary care center. The 278 bed capacity east wing of this hospital is a unit of the Devki Devi foundation.\(^\text{11}\) This land was given to the trust at concessional rates to build a hospital with 25% inpatient and 40% outpatient slots being reserved for poor people for free treatment (Public Accounts Committee, 2005, table 4.1)

<table>
<thead>
<tr>
<th>Name of the society (Hospital)</th>
<th>Area (Sq. Mtr.)</th>
<th>Date of allotment (mm/dd/yy)</th>
<th>Price INR(USD) @~INR45= USD 1</th>
<th>Price per Sq. Mtr. (USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flt. Lt. Rajan Dhall Ch. Trust (Fortis Flt. Lt. Rajan Dhall hospital)</td>
<td>7446</td>
<td>08/29/83</td>
<td>15,640($352)</td>
<td>0.05</td>
</tr>
<tr>
<td>Escorts Heart Institute and Research Center (Fortis Escorts Heart Institute)</td>
<td>7,932</td>
<td>05/03/90</td>
<td>1,600,000($36000)</td>
<td>4.54</td>
</tr>
<tr>
<td>Devki Devi foundation(Max Super Specialty Hospital, East wing)</td>
<td>12,300</td>
<td>02/06/96</td>
<td>24,314,640($547072)</td>
<td>44.48</td>
</tr>
</tbody>
</table>

Source: From the response to the Right to Information (RTI) filed with D.D.A Institutional Land branch, by the PI, under the RTI Act, DDA website (institutional land allotment)

\(^{10}\) Inputs from the interview with the management representative of Indraprastha Apollo Hospital.

\(^{11}\) From the interview with the Max representative. The most recent information on the capacity (number of beds) of the Max Healthcare Hospitals was taken from their website [www.maxhealthcare.in](http://www.maxhealthcare.in)
Max Healthcare now holds the operation and management (O&M) contract for the hospital. Max Healthcare also bought the plot adjacent to the Max-Devki-Devi Hospital through an auction of the site by the Delhi Development Authority (DDA) and added the 191 bed capacity west wing to the Super Specialty hospital. The Devki Devi Foundation wing, which functions as the cardiac wing, started operations in December 2004, while the newer multi super specialty wing started in May 2006.

Devki Devi Foundation is not the only charitable trust with which Max Healthcare has entered into a management contract. It also drew up a contract with the Balaji Medical and Diagnostic Research Center in Patparganj, Delhi. Max has been on a contract with the Devki Devi Foundation from the very beginning; so, like Fortis Flight Lt Rajan Dhall Hospital, it might have financed the construction of the building as well. Without any documents to prove this, it is a guess at best, but given the trend towards expanding their presence and seeing some documents for Fortis FLRD, it seems plausible.

Another intriguing phenomena seems to be taking place; over time, the charitable trust seems to be getting increasingly hidden from the public view as ‘brand Max’ is taking over instead, which also raises questions about the nature of the O&M contracts. It is a possibility that the management views Max as a better-selling brand and highlight it

---

12 From the interview with the Max representative.
13 Management representative of Max Super Specialty Hospital.
14 See my discussion on Fortis Flight Lt Rajan Dhall hospital.
15 While interviewing the representative from Fortis-Escorts he talked about the brand equity of Escorts being higher than that of Fortis. This was at the time of take over though; Fortis has since grown to be a very big player in the corporate healthcare scenario. My point here is that these healthcare providers are very serious about building their brand image; and healthcare is talked of in business terms.
to increase ‘business’. It is, however, equally possible that this is done in order to play down the fact that these are hospitals owned by charitable trusts. Without any input from the management, the purported reasons for this change are based on my conjectures, but the change is curious, nonetheless. The Super Specialty unit of the Devki Devi Foundation was called the Max Devki Devi Heart and Vascular Institute. (It was so even at the time of fieldwork, in 2008). The East wing building had that name on the outside but at some point in time after that it has been renamed as the Max Healthcare Super Specialty hospital with ‘A unit of the Devki Devi Foundation’ written in a much smaller font\(^\text{16}\) (Fig. 4.2 a & b) and has both the Max Healthcare\(^\text{17}\) and Max India logos (of which Max Healthcare is a subsidiary) unlike in the other Max hospitals (with the exception of Max Balaji Hospital) which only have the Max healthcare logo. The inner reception area still has the earlier name, though it is not very visible on the outside now. This was also done in the Max Balaji Medical and Diagnostic Research Center in Patparganj, which has been renamed as Max Super Specialty Hospital with a small font running the text: A unit of the Balaji Medical and Diagnostic Research Center.

\(^{16}\) While doing fieldwork I had seen Max Devki Devi Heart and Vascular Institute written on the east wing of the hospital building. While going through their website recently the updated pictures had the new name on the building. A search done for Max Balaji hospital also showed a similar result.

\(^{17}\) The Max representative, who has been with Max healthcare from before this particular hospital started its operations, mentioned that the logo was inspired by Michelangelo’s ‘The creation of Adam’ painting on the ceiling of the Sistine chapel, symbolic of breathing life into man. This is not there in the recorded interview or in the notes but this is something that one doesn’t forget easily!

source: Max healthcare logo from Max healthcare website: \url{http://www.maxhealthcare.in/}
“The creation of Adam” from Wikimedia commons.
Another curious fact came to my notice while going through a draft of this dissertation. Both these pictures are exactly the same (as can be seen from the people in front of the building), which means that the logo was probably 'photoshopped' into the picture. There are other pictures online which have the new logo also, so possibly the person updating the picture in the hospital website did not have a recent picture and used the older picture and put the new logo in.
3. Fortis-Flight Lt. Rajan Dhall (Fortis FLRD) Hospital

The Fortis Healthcare Limited was incorporated, under the 1956 Companies Act, in 1996 and has already opened up a chain of hospitals in India (Fortis Healthcare Limited. 2006). The extension of the chain has come about by building new hospitals and, by acquiring other hospitals, as well as through operation and management contracts with other hospitals, some of which happen to be held by charitable trusts. Fortis, technically, does not own the hospitals for which they own O&M contracts; however, they are listed as Fortis hospitals on their website, and nothing is mentioned about the trust (except as being part of the name) or the trust’s missions, if they had one to begin with. While, in the recent past, the acquisition of the Wockhardt chain of hospitals has made Fortis’ intention of increasing its presence beyond just the NCR very clear. The bid to acquire stakes in the Singapore Parkway Holdings points towards its ambition for an increased global presence. Fortis did not go through with the acquisition and bowed out of the race in July 2010 (The Hindu Business Line, July 2010). The CEO of Fortis Healthcare made that clear when he declared that the acquisition of Parkway Holding was the beginning of his global ambition and that other international buy-outs were being considered (Thomas, T.K., 2010). Fortis has also been promoted by Ranbaxy, a leading Indian Pharmaceutical company. The CEOs of Fortis Healthcare, Max Healthcare, and Ranbaxy all belong to the same extended family.

The 200 bed capacity Fortis-FLRD hospital stands on a land owned by the Flight Lieutenant Rajan Dhall Charitable Trust in Vasant Kunj, which again was given by the

---

19 I keep going back to what the websites portray because from talking to management representatives in all the hospitals their websites seem to be a really important first point of contact with a lot of their prospective patients (medical tourists).
DDA at a concessional rate (Table 4.1). As mentioned in the chapter on research design, the management of Fortis FLRD hospital did not agree to an interview but interviews with residents and businesses in its vicinity were done, so this account is incomplete. The Max and Fortis groups have taken over management contracts of quite a few trust and charity hospitals in the National Capital Region, all of which had received land at concessional rates from the Delhi government and a lease agreement which included a promise to reserve 25% of inpatients and 40% outpatient care for poor people for free. Although in the case of the Flt Lt. Rajan Dhall Charitable Trust, which owns the Fortis FLRD hospital, according to a report by the Public Accounts Committee (2005), the Ministry of Urban Development, DDA had failed to incorporate this condition in the allotment letter. Apart from the hospitals under study, Max healthcare has an O&M contract with Balaji Medical and Diagnostic Research Center and Fortis Healthcare; other than Fortis, FLRD also has an O&M contract with R.B. Seth Jessa Ram hospital. Both Jessa Ram hospital and Balaji Medical and Diagnostic Research Center were charitable societies that were given land at a concessional rate.

According to the draft Red Herring Prospectus20 that Fortis Healthcare Limited filed with Securities and Exchange Board of India (SEBI), Fortis FLRD, a hospital they operate through their subsidiary, Oscar Bio-Tech Private Limited (OBPL), under a

---

20 “A company making a public issue of securities has to file a Draft Red Herring Prospectus (DRHP) with capital market regulator, Securities and Exchange Board of India, or SEBI, through an eligible merchant banker prior to the filing of prospectus with the Registrar of Companies (RoCs).

DRHP provides all necessary information an investor ought to know about the company in order to make an informed decision. It contains details about the company, its promoter, the project, financial details, objects of raising money, terms of the issues, risks involved with investing, use of proceeds from the offering, among others. However, the document does not provide information about the price or size of the offering.” From Economic Times, June 2011, ET in the classroom: Draft Herring Prospectus. http://articles.economictimes.indiatimes.com/2011-06-14/news/29657110_1_offer-document-merchant-banker-draft-red-herring-prospectus
perpetual operation and management (O&M) contract, started operations in 2006. They have spent approximately INR 350 million (~ $7.5 million) for the improvement of the hospital building and pre-operative expenses. Under the O&M contract they have the right to receive a significant portion of the hospital’s total profits, if any, but are not responsible for the losses. Their responsibility includes building, managing, maintaining, and running the hospital as well as arranging funds. They have also invested approximately INR 470.17 million (~ $10.5 million) in medical and other equipment and other infrastructure for the hospital. They retain the title for the equipment. These payments for the hospital were financed through short-term debt obligations and were arranged for the account of the society that owns the hospital.

In 2006, DDA terminated the lease alleging that the society did not use the property in accordance with the terms specified in the lease, leaving the property vacant for a number of years. According to the terms of allotment, within two years of taking possession of the lands given at concessional rates, building plans have to be approved by DDA and the construction completed. An extension for completion of construction can be given, according to the guidelines issued from time to time by the DDA, up to a period of 15 years (10 years for plots up to 500 Sq. Mtrs.) (Comptroller and Auditor General of India, 2004). Following the termination of the lease, the society filed a suit in the Delhi High court, which gave a stay order restraining DDA from recovering physical possession of the property. The matter has been in courts since then. Recently, Fortis FLRD came under scrutiny again when the issue was debated in the Delhi Government Assembly. Responding to a question by the Bharatiya Janata Party (BJP) Member of Legislative Assembly, Satprakash Rana, Health Minister Kiran Walia said that the
hospital was, at that time, given an honorary registration, as the case was still in court. She stated that the matter will be looked into and the required steps taken when the registration came up for renewal (Express News Service, March, 2010). The situation appears to be in status quo since 2006. Earlier this year, the hospital was also given a show cause notice by the Health Minister for functioning without a completion certificate from the Municipal Corporation of Delhi (MCD) (Bhalla, J.S. 2010). Under section 346 of the Delhi Municipal Corporation (DMC) Act of 1957, it is mandatory to obtain a completion certificate for buildings before they can be occupied and/or used (SPA-ENVIS). Moreover, their application with the Delhi Jal Board (the water board) is still pending (Bhalla, J.S. 2010). As of the end of 2010, the water requirement for the hospital was being met by a daily supply of water tankers. Despite all this, ironically, according to their website, the hospital is recognized by the National Accreditation Board of Hospitals and Healthcare Providers (NABH).

4. Fortis-Escorts Heart Institute

The Nanda family-run Escorts group’s Escorts Heart Institute and Research Center (EHIRC) was registered as a charitable society in 1981. The organization was allotted prime land at subsidized rates together with other tax benefits and exemptions (Delhi High Court, 2009(b); Table 4.1). Leading cardiologist, Dr. Naresh Trehan played an important role in founding EHIRC, which became operational in 1988.\(^{21}\) It went on to

\(^{21}\) There seems to be a mismatch between the year of allotment of the land and the year when the hospital became operational. The hospital became functional in 1988 but the year of allotment and possession mentioned in the RTI response puts the date to 1990. Yet another document on the DDA, institutional land website, the list of institutional land allotted by the DDA lists the year of allotment as 1994. I realized this after I had left the field site and I haven’t been able to clear out the confusion from sources. This information matches on both the documents for Escorts-Fortis and Max Super Specialty (Unit of Devki Devi foundation)
become one of the leading cardiology hospitals in the country. In 2005, Fortis Healthcare Limited bought 90% stakes in EHIRC. (The Hindu Business line, 2005; The Financial Express, 2005) The remaining 10% was held by Dr. Trehan, who, if sources are to be believed, later sold it as an out-of-court settlement and moved to Apollo Hospital when he ran into disagreements with the management. (Hindustan Times, 2007) This acquisition has had its fair share of controversy and the matter still remains unresolved in the courts.

From Fortis Healthcare Limited.’s Draft Red Herring Prospectus submitted to Securities and Exchange Board of India (SEBI):

‘EHIRCL’s predecessor was a charitable society and subsequently merged with a non-charitable society in the nature of a joint stock company, which was thereafter incorporated as a company with limited liability under Part IX of the Companies Act. The validity of the initial merger of the societies and the subsequent incorporation as a company are now being challenged in the Delhi High Court. The Delhi Development Authority (the ‘DDA’), the owner of the land on which the EHIRC hospital is located, has treated both the initial merger of the societies and the subsequent conversion to a company as prohibited transfers of property under the terms of its lease of the land and, accordingly, has terminated the lease deeds and allotment letters in respect of the land on which the EHIRC hospital is located by its order dated October 6, 2005 (the ‘DDA Order’).’

In response to that, EHIRCL filed an Original Miscellaneous Petition (OMP) and a civil suit in the Delhi High Court:

‘seeking both a declaration that the DDA Order is illegal and a permanent injunction restraining the DDA from dispossessing EHIRCL without due process of law. The High Court has granted a stay restraining DDA from recovering physical possession of property in both the OMP and the civil suit, and the stay is still in operation.’

Anil Nanda, brother of Rajan Nanda, the CEO of Escorts group of companies, filed a civil suit in the Delhi High court:

‘for a declaration and permanent injunction against EHIRCL, among others, in the Delhi High Court seeking, inter alia, (a) to void the amalgamation of EHIRCL’s predecessors, Delhi Society and Chandigarh Society, and the subsequent
incorporation of the amalgamated society as a limited company (i.e., EHIRCL) and, by implication, void the Escorts hospitals acquisition and (b) to restrain Escorts Limited from transferring or creating any third party rights with respect to its shares in EHIRCL. The High Court has ordered the parties to maintain the status quo as of September 30, 2005.’

The matter has been in the courts since. In January 2009, the High Court stayed the conversion of the charitable trust into a private company. Earlier, in 2008, a single bench order had dismissed Anil Nanda’s plea challenging the conversion of EHIRC from a trust hospital to a private company. Anil Nanda challenged that order and his plea was admitted by a division bench of Justice Mukul Mudgal and Justice Manmohan. The order of the single bench was put aside and the suit was restored to its original position and the interim order of 2005 was restored as well (Delhi High Court, 2009 (a)). Earlier, Fortis was not involved in the court battle directly: It was named as a party in the case in 2007. In September 2009, Anil Nanda submitted an amendment application, which was accepted by the high court, seeking to declare Fortis’ Initial Public Offer (IPO) as illegal, as the EHIRC acquisition was still disputed. Fortis healthcare entered the capital market in 2007 and raised INR 500 Cr. (~$110 million) through the IPO (Express Healthcare, 2007). Following this development, Fortis became directly involved in the suit and is now contesting it as a defendant (Delhi High Court, 2009(b)).

In their annual budget meeting in June 2009, the DDA regularized the sale of EHIRC to Fortis. This was apparently done as a policy matter (Times of India, 2009). At this point, it is unclear how it will affect the case in the court. No mention of this development was made in the court judgment in the amendment admission hearing in September 2009. The regularization, if it happens, will set a bad precedent and might have an adverse impact on tertiary care delivery, as more hospitals, who have acquired
lands on concessional rates, might want to follow this path, wanting to wring themselves out of the agreement of free treatment for the poor.

B. Accreditation and insurance:

All these hospitals have pushed for accreditation, since it is seen as a trust building exercise which ultimately facilitates an increased patient inflow. Indraprastha Apollo hospital was the first hospital in India to get a Joint Commission International (JCI) accreditation. JCI is a US based accreditation agency that provides accreditation for hospitals, ambulatory care facilities, clinical laboratories, care continuum services, medical transport organizations, primary care services, as well as certification for disease or condition specific care. In 2010 Fortis-Escorts also received a JCI accreditation. Hospitals vary on their views regarding the impact of having an international accreditation on the inflow of international patients. Avantika, the representative at Apollo, viewed JCI accreditation as having been a definite draw for more patients from the developed countries; she observed that that the demography of the patients had transformed since they got the accreditation in 2005. Max does not have JCI and Fortis-Escorts acquired a JCI accreditation only in 2010. Representatives from both hospitals differed in their views about the perceived effectiveness of JCI. Akash, from Fortis-Escorts, was of the opinion that, based on the experience of other hospitals, JCI proved to be an effective means of attracting patients from developed countries. However, Abhinav, the Max representative, stated that he had not been able to validate that statement. He emphasized that hospitals with JCI, “put out these

22 This is based on her interview response. This is a pseudonym. All interviewee names in this dissertation are pseudonyms.
numbers on the board”, but there was no way of proving if these were a result of having a JCI accreditation. Delving further into the question he pointed out, “Would JCI help me into the medical market at the retail level? No. JCI will help me get into the US and the European market maybe at a corporate level. Is any corporate aligned to any of the JCI hospitals across the world? No. So that’s in a way the pros and the cons.” Having said so, he added that their core team has gone through the JCI practicum in Chicago and is equipped to seek accreditation when they so desire. He noted that they were not pursuing it aggressively at that point not only due to the cost but because they “believe that the application of JCI in our cultural settings is very different and we don’t want to go in for an accreditation just to hang a medal on the wall.”

All these hospitals, other than Indraprastha Apollo, have the National Accreditation Board for Hospitals and Healthcare providers (NABH) accreditation. NABH is a constituent board of the Quality Council of India set up to establish and operate accreditation program for healthcare organizations.

As Mattoo and Rathindran (2005) had pointed out in their World Bank Policy Research Working Paper, one of the reasons why insurers in countries with expensive healthcare deny coverage for non-emergency treatments abroad, despite the fact that there are significant economic gains to be made, is the insurer’s concern about quality of overseas providers and malpractice law. The accreditation has, to some extent, eased the concern about quality; it has given credibility to the services provided by these centers and has made tie ups with insurance companies abroad easier. Most of these hospitals now have connections with an ever increasing number of leading international insurance
and medical assistance companies (Table 4.2). These tie ups are mostly with health insurance companies. Apollo, for example, does not have agreements with travel insurance companies, in covering medical emergencies while traveling, but the travel insurers usually find local partners to negotiate with them.

Some of these companies have also ventured in insurance themselves; Apollo with Apollo DKV and Max with Max New York Life Insurance.

**Table 4.2 International Insurance and medical assistance partnerships**

<table>
<thead>
<tr>
<th>Hospital network</th>
<th>Companies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apollo Hospitals</td>
<td>Blue Cross Blue Shield, CIGNA, AIG International Group, ALICO(American Life Insurance Co), International SOS, Van Breda International, Seven Corners Inc, Asia Medical assistance, Asia Rescue &amp; Medical Services, GMC Services, Emergency Assistance Japan, International Claims Service</td>
</tr>
<tr>
<td>Fortis Hospitals</td>
<td>Aetna, BUPA, CIGNA International, GMC Services, HTH Worldwide, Van Breda International, Seven Corners Inc., Tokio Marine &amp; Nichido Fire Insurance Co, Ltd., International SOS Services(India), Asia Rescue and Medical Services(ARMS), AIG Life Insurance Company, Europe Assistance India Pvt. Ltd., Asia Medical Assistance, East West Rescue, Alfa Evacuation and Medical Services Limited,</td>
</tr>
</tbody>
</table>

Source: interviews with hospital management representatives and hospital websites (last accessed Sept. 2010)

The increasing number of tie ups with international insurance and medical

---

23 This information has been changing with time. There have been additions to the list since the fieldwork was conducted in 2008. The list was updated from going through the websites of the hospitals.

24 This came up while discussing the insurance tie ups of Apollo. This is probably how it works for patients (who fell ill while traveling) in the other two hospitals as well.
assistance providers is expected to further facilitate the movement of more medical tourists from the countries where these companies have their client base.

C. Marketing and Publicity

Other than getting proof of quality, through accreditations, these hospitals are also using other means to spread the “good word” around. Underlining the importance of marketing and publicity, Akash, from Escorts, noted that they have started promoting themselves, “because today the time has come that unless you are good and you don’t shout about it there are less of listeners that are available.”

The three major sources of publicizing available to these hospitals are medical facilitators or the medical value travel agents, word of mouth, and their official websites, which are quite extensive in terms of information content.

This new breed of travel agents, the medical facilitators, has been a direct result of the growth in medical tourism. These facilitators serve as a conduit between the hospitals and the patients passing along information about the hospitals, the doctors and tariffs, etc. to the prospective patients who are “shopping around” for options, mostly on the internet. The medical facilitation back office that I visited was of a company which received all of its queries through the internet. People come across medical tourism information on their website and then contact them. Representatives at the back office inform the prospective patients about the options and serve as a nodal point of queries between patients and the hospitals; they also arrange for travel and accommodation plans for patients or their “attendings” who want to travel after the surgery. It is not clear how much profit they gather in the process. The representative at Apollo cited some patients as mentioning that
the facilitators charge $100-$200 for facilitating the entire process.

At this point, it is also not clear what expertise most of these agents possess in selecting hospitals and doctors. The woman I spoke to is a registered nurse in the US and got associated with this company, based in India, when she was in India as a medical tourist herself. She now travels to India twice a year, in April and September, and facilitates the flow of patients; she even accompanies some of them during their travel to India. She also visits hospitals and doctors in India and reports back to the management on whether they could be added to their future list of hospitals and doctors.

There seems to be a nested network to reach out to people. They use the reach of network of others to augment their own online presence. This particular facilitator also has links with a person in California who has a website of his own and deals with discounted prescription medication and forwards queries about surgeries that are directed to his website to this medical facilitator, so they have, what they call, “Dr. Scott cases.”

This particular link in the medical tourism chain needs to be studied more closely to see how the facilitators operate and what their credentials are; more so, because their importance is only going to increase with hospitals also looking to them with the view to increase their reach for prospective patients. Talking about the problems of the present state and his vision for the future, Akash, the Fortis-Escorts representative said:

‘Unfortunately there are so many loopholes in the system that everyday there are 30 odd so-called facilitators who mushroom up, but at the end of the day no one shows up, because you should also understand that it is just not like a travel business. There are a lot of things that are there. What we call as pick up and drop off. I mean you pick up a particular patient from the doorstep of his or her house and then you drop the same patient at his or her doorstep….. I mean there are a lot of things that are attached to this. I mean you can add yoga; maybe, you can add spas, because the post operative care is something that is really important and crucial. So there are a lot of steps that are being taken, and I presume that in another 3-4-5 years down the line

25 Or the cases that were forwarded to them by Dr. Scott (A pseudonym)
there will be some seamless integration which will happen, and that’s how the industry will see a sea change in the way people perceive about (sic) India and about (sic) its medical facilities.’

It’s not only the medical facilitators who use the internet to reach patients. Hospitals themselves have very active websites which are quite exhaustive in terms of the information they carry. The information can mostly be categorized into one of the two-- basic information about the hospital, doctors, facilities, etc, and information to prove their excellence. They also have a separate link for international patients. Fortis-Escorts has a person dedicated to handling queries that come through their website, with a response time of 24-48 hours. This is probably true of the other hospitals as well. For Apollo, most of the queries seem to come through their website. The Middle East being an important source of patients, Apollo has a separate section on their website that is in Arabic. Most of them also carry pictures of smiling doctors, doctors bonding with their patients, or of luxurious hospital buildings and state of the art equipment. It is quite evident from just going through their websites that they use it as a tool to reach out and attract prospective patients.

Despite the extensive reach of the internet and the presence of intermediaries in the form of medical facilitators, all the hospital management representatives felt that word of mouth was the most important tool to get more patients. “Ultimately 99% is word of mouth publicity. If you are a happy and delighted patient/customer, you will go tell 10 different people,” added the Fortis-Escorts representative.

The other modes of getting word around are participation in various health expos and through the promotions done by the government of India, both by the Ministry of Tourism and Ministry of Health. The names of some of these hospitals figure in
government information brochures and web pages on medical tourism.

At this point, this relatively nascent industry is trying to iron out the glitches to make cross border healthcare delivery an “easy ride”.

D. The patient profile

1. A Medical tourism boom?

All the management representatives I spoke to agreed that the media has hyped up the extent of medical tourism a bit, but they were also unanimous in their view that the future of this sector in India is big. Their level of expectation was varied though. As Avantika, from Apollo, put it, “If you say that yes, media is covering a lot about medical tourism, I think this is not the right time. We are still catching up, but it will take another 3-4 years, 4 years at least, when people will be really aware that there is a place like India where you can get cheaper, you know, procedures done or surgeries done that are at par with international standards.” Akash seemed more optimistic and enthusiastic about the growth prospect and added that “one thing I am absolutely sure (about) is that maybe 5 years, 10 years down the line this healthcare industry will become far bigger than what the IT industry has earned its name for.” Abhinav, from Max, was also suspicious of the numbers that were being thrown around in the media and felt that those numbers had to include wellness tourists going to Kerala as well and not that many are “Serious

---

26 The patient is another link in the medical tourism chain that I did not get ample chance to look into directly. I did not have much direct interactions with them because the hospitals, understandably, were not keen on letting me do that. At Apollo I came close to getting an opportunity but that fell through in the end. She had said that I might get a chance to meet some African patients. The Arabic patients, she said, do not like interference. Some American patients were coming but that was only after I was to leave Delhi and there was no surety if they would be willing to talk to begin with.
patients”. A source in the Confederation of Indian Industries\(^{27}\) pointed out that leisure tourism and medical value travel are two very different aspects that need to be distinguished. When asked about media reports promoting medical tourism as a package that combines world class treatment with a visit to, say, the Taj Mahal, he said that it varied with individuals and that “obviously if you are coming and you were opened up after 10 days you would not probably (travel for leisure)…..if you want to get your teeth changed then you would maybe want to go to Taj (Mahal).” Many in the medical tourism fraternity frown on the term medical tourism because they feel that the term tourism conjures up an image of a relaxing vacation, which is not the case with medical tourism. They prefer to call it medical value travel, even though by definition medical tourists are the same people. This, I believe, comes from people’s bias towards what the term tourist means; it is almost always a vacationer traveling for leisure. Avantika pointed out that perhaps eventually there will be a time when, ‘they will add medical plus tourism together,’ but right now they are mostly high-end surgery patients. Unlike the hospital’s reaction, a travel agent dealing with medical tourism or a medical facilitator, as they are known, had a very different view of the nexus between traveling for medical procedures and leisure tourism. Their clients more often than not combined the two. The reason for this difference in views probably was that this particular medical facilitator seemed to have a lot of clients coming in for ophthalmological, orthodontic, or other cosmetic surgeries that were minimally invasive and had quick recovery periods, while the hospitals reported about ‘more serious’ surgeries that restricted traveling in the post

\(^{27}\) CII is a non-government, not-for-profit, industry led and industry managed organization’ which works towards creating and sustaining ‘an environment conducive to the growth of industry in India, partnering industry and government alike through advisory and consultative processes.’
operative stage.\textsuperscript{28} Indraprastha Apollo happened to be on the list of this medical facilitator.

2. The numbers

In terms of numbers, Apollo hospital leads the field. At any given time about 1/8th of their patients are from beyond the Indian borders. On the day of the interview, there were around 65 international patients admitted in the hospital. Going strictly by the definition of a medical tourist this might not be an undercount, but it is important to point out that for bookkeeping purposes, only inpatients figure in her list of international patients; this is because outpatients coming for what are called day care procedures are not in the list of international patients. So, people from the various embassies or leisure tourists who have fallen ill on their trip, seeking treatment/consultation in the OPD would not make it to her list. Another very important demographic section that gets excluded from the list are the Non Resident Indians (NRIs)\textsuperscript{29}. Only those NRIs who come through foreign insurance companies like CIGNA, Aetna, and Seven Corners in the US, BUPA in the UK, or Van Breda from Belgium, etc are counted as international patients. NRIs just ‘coming in, walking in’ are not counted as such. The international patients in all contribute about 25\% to 30\% of the hospital’s revenues.\textsuperscript{30}

Max and Fortis-Escorts have a much smaller proportion of patients from overseas. The proportion is 8-9\% at best at Max (Devki Devi unit). At the time of the interview, the

\textsuperscript{28} Medical facilitators was a link in the medical tourism chain that I did not get ample opportunity to explore. I only had direct contact with one company that had it’s office in Delhi.
\textsuperscript{29} Non Resident Indians, as the name suggests, is ‘An Indian citizen who is ordinarily residing outside India and holds an Indian Passport’ \url{http://www.mha.nic.in/pdfs/oci-chart.pdf} (November 2010)
\textsuperscript{30} These approximate figures on number of patients and revenue were provided by the Apollo representative during the interview.
numbers were approximately 700 in the last ten months. No approximate figures were provided for Fortis-Escorts, but Akash conceded that the proportion was small and that the ‘quantum of business is not as much maybe the way the media has exposed'. He also pointed out that Fortis-Escorts being a single super specialty hospital (cardiology), they do not get as many patients as some of the other hospitals.

3. Country/Region of origin

Quite unlike the pictures splashed in the media, international patients are not predominantly white Caucasians. On the contrary, patients from the US, Canada, and European countries still form a small proportion of the total international patients. Though all these hospitals follow a similar trend, as far as their international patients’ home countries is concerned, there are differences in proportions across the hospitals. Apollo, from having been around longer and also having the international accreditation, has a larger proportion of patients coming from developed countries, as compared to the other hospitals. It remains to be seen if the JCI accreditation that Fortis-Escorts received early in 2010 makes a difference in the demography of their patients.

The South Asian Association for Regional Cooperation (SAARC) countries forms the single largest source of patients in all the hospitals. SAARC includes the countries of Afghanistan, Pakistan, India, Bhutan, Nepal, Bangladesh, Sri Lanka, and Maldives. In Apollo hospital, among the SAARC countries, Afghanistan, Bangladesh and Nepal form a big segment. Apollo has an information center in Nepal and they get patients through them. A lot of Bangladeshis prefer to go to Kolkata in the eastern state of West Bengal that borders Bangladesh, as it is much closer and they also have a common language,
while Sri Lankans prefer going to Chennai in southern India as that is closer to them.\(^{31}\) About patients from Afghanistan she said ‘but (people from) Afghanistan, where will they go? They find it better here you know......and they can converse and there are a lot of Afghans here in Delhi so Afghans (come here).’ A Federation of Indian Chamber of Commerce and Industries (FICCI)-Ernst and Young report gives a break up of the countries from where most of Apollo’s patients come from (figure 4.3).

**Figure 4.3**

![Regions of origin of international patients at Indraprastha Apollo hospital](image)

Source: FICCI-Ernst & Young 2006

This pie chart looks very different for the other two hospitals.\(^ {32}\) At Max hospital 70-75\% of their international patients come from SAARC countries while at Fortis-Escorts that number is as high as around 90\%, mostly from Pakistan and Bangladesh. For Max this

---

\(^{31}\) Apollo has hospitals in Kolkata and Chennai also. Apollo also has a hospital in Bangladesh, which is a franchisee(from the interview)

\(^{32}\) The exact numbers are not available. The hospitals only gave approximations for their international patient numbers
proportion, around 2004-05 (when the hospital became operational), was upwards of 90% but that has been changing with time as newer ‘markets’ have opened up. At the time of the interview in 2008, he pointed out that, "The newer markets that have opened recently and by recently I mean last one year time frame is, one, Middle East with a lot of patients coming in from Oman, Iraq, and the likes and the African markets." Middle East and African, mostly East African, countries form the next most important and growing source of patients in these hospitals. For Apollo the proportion fluctuates some months, because even though they have patients from all over the Middle East including Saudi Arabia, UAE, Oman, and Yemen, their patients from Iraq tend to come in groups of more than 25 patients at times. In those months the proportion of Middle Eastern patients shoots up. For Apollo the next important source is the US followed by Europe (Except UK) and then the UK. A lot of the Europeans tend to be the ones who fall sick while travelling and are covered by their health or travel insurance companies.

4. The reasons for selecting India as their destination

The hospitals concur with most of the reasons that are mentioned in the literature as far as the reasons for patients selecting India as the destination of choice is concerned.\(^{33}\) The conversations do point to a slightly different stress on the relative importance of some of those. When asked to list reasons, cost benefit almost always is the first response together with world class, state of the art hospital infrastructure. This is mostly talked of in relation to patients from the developed countries, pointing to big savings that the patients from those countries can make by opting to have their surgeries

\(^{33}\) Check my earlier discussion in the literature review section on medical and wellness tourism in India (section IV).
in India instead of their home countries, and as is the case with Apollo, approximately
95% of the patients coming from developed countries to this hospital come because they
cannot afford it back home as they are un/under insured.\textsuperscript{34} Although a majority of the
patients coming from developed countries might have that for a reason, patients from
developed countries form a very small percentage in the total international patient pool in
these hospitals. A lot of their patients come from countries where these facilities are not
available at all. So, the cost does become a factor in the choice given that they would not
choose the US or Europe over India. The reason is not because it is expensive in their
home countries, but because the infrastructure does not exist there. These hospitals also
have “tie ups” with the government of some of these countries in the Middle East and
East Africa.\textsuperscript{35}

In some of the Middle Eastern countries though, the absence of the physical
infrastructure is not the reason for patients seeking out healthcare elsewhere. As in the
other hospitals, Max also has a fair number of patients coming from the Middle East
including, among others, from Oman, but the reason for these patients coming to India is
more of a human resource issue. Abhinav, from Max, pointed out that the health setup in
Oman is very good. ‘They have the infrastructure, but they do not have the people.’

Middle Eastern countries, in the recent times, have also been forced to reconsider
their choices because of the changed geopolitical situation, after 9/11 and the US invasion
of Iraq. ‘Most Arab countries have voiced during their visits that for them to go to US or
Europe is becoming increasingly difficult. They don’t get visas, they are scrutinized more,

\textsuperscript{34} This is an approximate number, mostly to bring out the fact that it is a big majority of people from
developed countries.
\textsuperscript{35} They did not specify which countries.
they are ill treated, and therefore they are more culturally aligned to come to the south part of Asia. 

E. Location

All the hospitals under study were located in close proximity to residential neighborhoods and also had one or more urban villages in the vicinity; Sarai Jullena, close to Escorts-Fortis, Khirki village and Hauz Rani close of Max Devki Devi Heart and Vascular Institute (Super Specialty Hospital), Madanpur Khadar and Jasola close to Apollo Hospital and Kishangarh and Masoodpur close to Fortis Flt. Lt. Rajan Dhall Hospital (Fig. 4.2). These areas, being marked for institutional use, also have other hospitals close by. Max Super Specialty Hospital shares a boundary with G.M Modi Hospital, and the Holy Family Hospital is across the road from Escorts-Fortis. Both of these hospitals are registered charitable trusts and have been around for much longer than the newer corporate hospitals.

A bit of a history of the urban villages is important to understand the existence of these pockets of highly cramped, unplanned areas located within the planned parts of the city and also to comprehend the impact of these hospitals on the neighborhood.

A sizable portion of the present day planned pockets of urban Delhi has grown on agricultural land that was acquired from villagers. The area around the village ‘abadi’ (habitation) section used to be circumscribed by a ‘Lal Dora’ (literally meaning red thread) for revenue collection purposes. Over the years the agricultural land around the lal dora areas was lost to the rapidly urbanizing city of Delhi, leaving behind very closely

36 The Max representative mentioned this while talking about why patients choose India over other countries.
laid out ‘abadi’ areas within the lal dora, with narrow lanes and bylanes and without much open space or civic amenities (Expert committee on Lal Dora, 2007).

**Figure 4.4 Urban villages and neighborhoods in the vicinity of the hospitals**

Map source: Google maps

As per the Delhi Master Plan 1961 and the subsequent ones, the villages lying within the ‘urbanizable’ area were designated as urban villages. Large scale acquisitions took place when the government embarked on the path of a planned development for Delhi. Since the 1960s, under various master plans, a total of 135 villages have been
urbanized (Economic Survey of Delhi, 2007-08). The official compensation rates for the agricultural lands were much lower than the amount for which the lands were later auctioned. Yet, very little was invested in improving problems of congestion, poor layout or, more importantly, the most basic civic amenities like water supply, sewerage, solid waste management systems etc. (Expert committee on Lal Dora, 2007)

The layout was poor to begin with, but with precious little being put into planning the future growth of these villages, the increasing population and increasing land values led to more congestion and illegal constructions, making the situation worse. The rural villages that fell within the urbanizable limits, as per the Master Plan of Delhi, were declared urban under Section 507 of the Delhi Municipal Corporation (DMC) Act of 1957, through a notification issued by the Government of the National Capital Territory (NCT) Delhi. Once a village ‘became urban’ the provisions of the Master Plan/Zonal Plan/Relevant Area Development Plan/Building by-laws became applicable to them. This clarification was issued by the Union Ministry of Urban Development in their letter dated 03/23/01 (Expert Committee on Lal Dora, 2007). The delay in the issue of notification declaring them as urban and acquisition of land for meeting the needs of the village communities resulted in unplanned growth around the villages. No plans were made to accommodate the future growth in the village population. Rather than keeping a buffer for that, new colonies were planned around the villages. ‘Building control regulations were neither prescribed in the Master Plan nor made effective in urban villages.’37 This lack of clarity led people to assume that since these regulations were not applicable in the village ‘abadi’ area it was not in the case of urban villages as well. With the agricultural

---

37 The Expert committee on Lal Dora and Extended Lal Dora quoted from the Tejinder Khanna Committee Report.
land, the major source of livelihood for most villagers, having been taken away, and coupled with the lack of skills for alternate employment, they had to rely on their only remaining asset, the landed property. Some opened up shops, small industrial units and godowns/small warehouses while others rented out their property or sold it (ibid.). With the notification from the Municipal Corporation of Delhi (MCD) to urbanize the villages the land use was to change from rural to residential but it clearly turned into a mixed land use area, some of which were unauthorized and illegal.

Apart from the urban villages and residential areas, these neighborhoods have also seen an increase in the planned development of commercial centers. Construction of the district centers in Jasola and Saket, close to Apollo and Max respectively are cases in point. The Saket district center, a block away from Max Super Specialty hospital has one of the most expensive malls in Delhi, which became functional only recently. A shopping mall has also been built in Vasant Kunj, close to Fortis FLRD.

II. Wellness/Ayurveda tourism centers

Kerala, with its long history of practicing Ayurveda, is one of the leading destinations for tourists seeking Ayurvedic treatment and therapies in India. With time, the popularity of Ayurveda has spilled beyond just patients seeking cures to tourists seeking relaxation. Though it gained wider popularity among international tourists through Ayurveda tourism, it was mostly a particular aspect, the Ayurvedic oil massages, which caught people’s fascination and in the process became commercialized.³⁸

³⁸ As a Kerala Institute of Tourism and Travel Studies (KITTS) faculty put it, in his interview, “The real thing (Ayurveda) is not given. Except for some places….what is being done as a part of Ayurveda
The whole gamut of Ayurveda providers has gone beyond just Ayurvedic ‘vaidyashalas’ or hospitals and clinics to centers providing services for people ranging from those in need of serious treatment to casual experimenters who just want to get an introduction to Ayurvedic healing. This has also meant that in quite a few places Ayurveda is just a part of the package, just another addition to Kerala’s unique selling points. As can be seen in Fig. 4.5 in the following page, Ayurveda is just an item in the list of facilities that the resorts/hotels offer together with houseboat rides, elephant rides, internet and taxi services, among other things. Centers highlight different aspects from this list depending on their target group.

Fig 4.5: the tourism product; a list of facilities in a center on the north cliff, Varkala

While the Ayurvedic resorts would lay stress on Ayurvedic treatment, in other centers, like the one in the picture, it is just another service that is offered.

tourism is different; selling totally modified packages. Selling only what is saleable’
A. Typology

Based on the scale of their operation and whether they are meant for treatment or rejuvenation, for tourists or locals, the Ayurveda centers could be, very broadly, divided into four categories:

- Ayurvedic hospitals,
- Ayurvedic resorts,
- Resorts/hotels with Ayurvedic centers
- Small Ayurvedic massage centers

This research mainly focuses on Ayurvedic resorts and to a lesser extent on resorts/hotels with Ayurvedic centers and small Ayurvedic massage centers. This in no way means that Ayurvedic hospitals do not get international patients. One of the best known Ayurvedic centers/hospitals, Arya Vaidyasala Kotakkal in Malappuram district, for example, has many international patients and also patients from other parts of India. Although this kind is not as widespread as the other ones in terms of non-locals accessing it.

Some in the business were a bit uncomfortable initially with my using the term wellness/rejuvenation for the therapies they offered. They stressed the fact, in their interviews, that a majority of the tourists/patients visited their centers for treatments rather than for rejuvenation/wellness. After explaining my usage of the term, the

---

39 While waiting to meet the management for permission I went to the cafeteria to get some food and got talking to a few patients/patient attendings who shared my table/waited in line with me to get a table and all of them seemed very pleased with the place. I did not finally get the permission to conduct my research within the premises but he did give some information about numbers. They had about 3500 inpatients in 2006 and a little more than a third of them were foreigners.
proportion for wellness went up. For the sake of clarity, all de-stress, de-toxification, relaxation, and other preventive care therapies are the ones for which I have used the terms wellness or rejuvenation. While therapies for people seeking curative treatments for, say arthritis/other joint problems, Psoriasis, or other specific ailments are the ones for which I have used the term treatment or medical.

Most of the tourists in resorts and hotels having Ayurveda facilities mainly went for wellness/rejuvenation therapies, and only a small proportion got any treatments done. Most Ayurvedic treatments require anywhere between a week to more than a month and people on a vacation in Kerala do not usually have that much time. Added to that is the fact that the treatments involve restrictions on diet and movement. But these centers also play an important role, as the attending doctor in one of the centers in a hotel pointed out. He felt that these kinds of centers are good for spreading the word about Ayurveda, because they include some customers who were in Kerala as tourists but did not have any prior knowledge of Ayurveda. They get to know about this system of medicine and then go back and talk to friends about it. This, he pointed out, is not the case with Ayurvedic resorts where people visiting already know/have heard about Ayurveda.

B. Location

None of the Ayurvedic resorts were located right in the middle of any major tourist destinations. The centers very close to or in those destinations were mostly resorts or hotels that also had an Ayurvedic center within their premises, so Ayurveda was only a

---

40 This inference is based on talking to management representatives of hotels and resorts providing Ayurveda, namely Spice Village, Coconut Lagoon, Taj Malabar among others.
small part of the whole package. Within Ayurvedic resorts, in terms of distance, there were mostly two kinds, one that tended to be located slightly further from the major tourist centers, while others were located away from major tourist centers and the hustle and bustle that comes with it. The resorts like Kairali and Rajah Healthy Acres are located at some distance from any major tourist destinations while the likes of Somatheeram are close to one, in this case, less than five miles (from Kovalam beach); yet, they avoid the majority of the crowd that usually is a part of any major tourist destination.  

The Ayurvedic resorts and resorts with Ayurvedic centers were either located in picturesque locations, next to or overlooking the sea or rivers, on mountain sides, in quiet village settings. When such centers were close to a town or located in surroundings that weren't picturesque, as was sometimes the case with resorts with Ayurvedic centers, they tried to recreate natural surroundings within the premises, so even if they were very close to the heart of the town, once the tourists entered the resort, the immediate, external context was shut off.

The importance of location was evident when the person at Kairali, while talking about why they are not very keen on marketing Kairali to Keralites, said “the foreigners and NRIs come for this nature and all. They find it more beautiful than say for a Keralite. For a person from Kerala it’s the same in their backyard.”

---

41 This observation is based not just on the centers that were part of the sample but also from noting the location of many other centers(all three kinds) while traveling around Kerala.
Figure 4.6 (a): View on the way to an Ayurvedic resort

Fig. 4.6 (b): View inside a resort

Fig. 4.6 (c): View from a resort

Figure (a) is on the way to Kairali Ayurvedic Health Resort, Palakkad district (b) Inside Kairali Ayurvedic Health Resort (this picture was taken from their brochure) and (c) Looking out from Sahyadri Ayurveda Hospital and Resort premises in Idukki district.
A look at the brochures also yields an interesting observation that adds to the previous reflection on the importance of location. It would not be too far fetched to infer from them that the resorts are not only selling Ayurveda but a whole experience of escape from daily routine and from the crowd, and being close to nature. The covers of some of the brochures mention “divine destinations where nature nurtures your well-being” “the ultimate getaway”, “the place breathes peace”, “the gateway to serenity”, etc. The possible reason could be that the resorts are, in some senses, destinations in themselves and hence have to make a case for the destination as well, while the smaller centers, which are already located in major tourist destinations, don’t have to. The tourists are in those places already and these centers just offer an additional attraction, Ayurvedic massages. These smaller centers usually just list the treatments/massages with their address and contact information on simple brochures, along with, in most cases, the name of the attending Ayurvedic doctor. While the mention of a doctor or the center being government approved adds credence to what is on offer, most of these centers also use the word "traditional" to describe the treatment, (which it is), as it tends to add a sense of history to the service while also adding to the sense of it being something unique to the history of the place, which it is not, since historically it has been practiced in a lot of other places in India.

For the smaller massage centers the location matters only to the extent of being in a location frequented by tourists; the immediate surrounding does not matter as much. A lot of these were one time walk-in centers, where tourists did not have to go multiple times for any therapy, and these involved different kinds of massages but no internal medication. They were present in almost all important tourist destinations.
Clockwise from top left: A center on a street in Fort Kochi, one along the road to Periyar lake/Tiger Sanctuary in Thekkady, multiple centers along the north cliff in Varkala and multiple centers along Kovalam beach.

Among other places, these centers were located along the beachfront, like in Kovalam or on the North Cliff in Varkala (overlooking Arabian sea), or along the main thoroughfares, for instance, on the road to the Tiger sanctuary/Periyar lake in Thekkady, close to the bird sanctuary along Vembanad lake in Kumarakom, Fort Kochi, or dotted around in cities like Ernakulam (Kochi/Cochin).\(^{42}\)

\(^{42}\) These are the places I visited and more probable than not is the chance of having such centers in other destinations popular among international tourists as well.
C. The study sample:

This research was concentrated in and around Somatheeram Ayurveda Resort and Kairali Ayurvedic Health Resort. The fieldwork also included talking to people in and around other Ayurveda resorts, resorts and hotels with Ayurvedic centers, and small Ayurvedic massage centers in prominent tourist destinations like Kovalam beach, Varkala in Thiruvananthapuram district, and Thekkady/Kumily (close to Periyar lake and tiger sanctuary) in Idukki district. The goal of these interviews, however, was to gain a better understanding of Ayurveda tourism rather than measure the impact of such centers in particular. In the case of some centers, I spoke only to the management. Some of these resorts were very close to the selected centers, while others were located further away. For most of these latter centers, extensive interviews were not conducted with the locals living in surrounding areas, as the given time and resource did not permit that. The idea behind focusing on multiple centers for this study, instead of one, was to get a general view of the situation than an in depth analysis of the one center (even that approach has considerable merit). Being very different in nature in terms of services offered, approach to Ayurveda, location, etc., it was difficult to select one center that could be representative of all. Although this study is not as in depth as it could have been, by spending less than three months in Kerala in multiple locations, I got a chance to interact with a number of locals and found some important pointers which spoke to my objectives for the study, while leaving scope for further interrogation in that direction.
1. Somatheeram, Ayurveda Resort

Somatheeram Ayurveda Resort is a Green Leaf Ayurvedic resort, located in Chowara, about 5 miles south of the famous Kovalam beach, in the southernmost district of Thiruvananthapuram (Trivandrum). It was started by the Matthew brothers, Polly and Baby, in 1985. As Mohan, from Somatheeram, pointed out, earlier the brothers were “like the middlemen linking patients to Ayurvedic centers, and then they thought of opening one themselves, and that was the first Ayurvedic resort in India”. The two brothers have split the business; the Somatheeram Ayurveda Resort (Somatheeram from now on) and Manalatheeram are a part of the Somatheeram Ayurveda Group and are located on either side of Somatheeram Ayurvedic Health Resort, now a part of Somatheeram Ayurvedic Hospital and Yoga Center Private Limited.

Somatheeram is located on a cliff overlooking the Arabian Sea and the Chowara beach (Figure 4.6).

**Figure 4.8 Chowara beach and the Arabian Sea from the Somatheeram resort**

![Chowara beach and the Arabian Sea from the Somatheeram resort](image)

Source: Somatheeram Ayurveda Resort’s brochure.

Although the Chowara beach is a public beach, a part of the beach between

---

43 Interview with the management representative and Somatheeram website. ([http://somatheeram.in/php/showContent.php?linkid=4&partid=1](http://somatheeram.in/php/showContent.php?linkid=4&partid=1))

44 Interview with the management representative.
Somatheeram and Manalatheeram is in a cove, making it enclosed, more so during high tide, and it almost seems like an exclusive location. The place around was dotted with big and small resorts of the Ayurvedic kind and otherwise, like Dr. Franklin’s Institute’s God’s Own Country Resort (God’s Own Country being the tourism tagline for Kerala) and Ideal Ayurvedic Resort along the same road leading to the beach. There were numerous other hotels and resorts along other small roads leading up to the beach from the Poovar-Vizhinjam road.45

I haven’t looked into the possible impact of the proposed international seaport in Vizhinjam about 2 miles north of the location (The Hindu, 2010). Container ships passing by might not form the most idyllic of scenes for Ayurvedic resorts, although it would probably affect the resorts along the beach that are closer to it, if at all.

2. Kairali Ayurvedic Health Resort

Kairali Ayurvedic Health Resort is a Green Leaf Ayurvedic resort spread over 50 acres in Ollassery, Kodumbu in the Palakkad district.46 It became operational in 1998.47

45 Once while walking from Kovalam beach to Chowara, a distance of around 5 miles, I noticed closely the numerous billboards along the main road. They were mostly of resorts, some of which were Ayurvedic. Some resorts had it every few kilometers mentioning the distance from that spot. As I got closer to Chowara, every so often there were roads leading towards the beach and along those roads were more resorts and hotels. Being covered with coconut trees one could not tell that from afar, if not for the hoardings.

46 From their website
47 As mentioned in the interview.
The Kairali Group has two more resorts one of which provides Ayurvedic treatments as well. Apart from these resorts they have a number of day spas around the country and spas in resorts in other countries that are franchises of Kairali.⁴⁸

**Fig. 4.9 On the way to Kairali Resort; view on the ground and from the top**

Source: The top view was taken from google maps’ satellite view. The red placemark is the resort and the yellow line is the way in from the Palakkad-Chittur rd.

For the most part, the final mile leading up to the resort is through paddy fields, but once inside the resort, the canopy of trees creates a different environment and the fields aren’t quite visible.

D. Patient/tourist profile

Most of the centers either did not have collated information on the patients’ country of origin or were unwilling to share data. Kairali provided the requested numbers for 2006-07 (Table 4.3). For Somatheeram, the only information I could get was the name of the countries from where most of the patients/tourists arrived there.

⁴⁸ From the interview with the management representative of Kairali and their website: [http://www.kairali.com/Centers.asp](http://www.kairali.com/Centers.asp)
Across the board, Europeans were most numerous and a majority of the tourists were females. Both centers reported a relatively low proportion of Indians among their clientele, especially in the peak season, which is roughly between November and March. Indians have not been the target of their marketing either, because they're of the opinion that Ayurveda is not as novel to them as it is to foreigners. As Mohan said, “There are filthy rich people in Western European countries”. The person in charge of the Ayurveda center in a resort, Spice village, while talking about the predominance of European tourists, pointed out, “Europeans don’t know about the system or are new to it so they show more interest as compared to Indians.” Both centers did plan on targeting Indians for the off season with good package deals. From the point of view of treatment, the monsoon season is considered to be the best time, but it is marked by very heavy downpours, as Kerala is among the first to face the on coming South West monsoons, and that hampers other tourist activities.\footnote{Most of the Ayurvedic doctors in the Ayurvedic centers, across the spectrum, said that the monsoon season was the best time for Ayurvedic treatments.}

**Table 4.3: Proportion of patients/tourists as per their place of origin in Kairali(2006-07)**

<table>
<thead>
<tr>
<th>Country/Region</th>
<th>% Tourists</th>
<th>Region totals</th>
<th>% Tourists</th>
</tr>
</thead>
<tbody>
<tr>
<td>India</td>
<td>24.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>USA</td>
<td>14.7</td>
<td>Top Americas total</td>
<td>14.7</td>
</tr>
<tr>
<td>UK</td>
<td>10.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Germany</td>
<td>9.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td>4.4</td>
<td>Top European total</td>
<td>28.9</td>
</tr>
<tr>
<td>Italy</td>
<td>4.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UAE</td>
<td>5.6</td>
<td>Top Asian total*</td>
<td>8.3</td>
</tr>
<tr>
<td>Japan</td>
<td>2.7</td>
<td>Africa</td>
<td>2.5</td>
</tr>
<tr>
<td>other countries</td>
<td>20.9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Kairali

* excludes Indians
A total of 487 tourists visited Kairali between 2006 and 2007. Among international tourists Europeans formed more than a third (38%) of the clientele of Kairali. In the interview Abhilash pointed out that foreigners and NRIs form almost 90% of the total and that a big portion of the tourists from USA and the UK are NRIs. He added that in this particular year the numbers look slightly different because a large group of Indians visited after having won a gift voucher for a holiday in Kairali. That group stayed there for 2-3 days but not for Ayurveda.

The exact numbers were not available for Somatheeram but as he mentioned in the interview, their tourists/patients are mainly from Germany, Italy, UK and Russia. There was an increase in the last two years (before the interview) in tourists from Russia, and he attributed that to attending an international fair in Russia. The importance of Europeans, especially the Germans, can be gauged from the fact that their brochures list the prices in Euros and that they are bilingual (in English and German). They have about 3000 patients in a year out of which 2000-2300 visit during the peak season.

Somatheeram has been around for much longer and has built quite a reputation for itself. They also actively engage in promotion. They attend a number of international travel fairs and expos, and a lot of their clients come through travel agents. More than 60% are through agents and only about 40% are direct clients. This picture seems different for Kairali, which gets a lot of its customers through the internet. Somatheeram

---

50 The data from Kairali was in the form a bar graph with the percentages written on each bar. It was only later that I realized that one bar, with a sizable number (10.7%) did not have the name of the country on it and hence I added it to the other countries. If it was an European country the proportion for Europeans would become more than 50%. I could not contact them later to check the data. Also, the whole continent of Africa was clubbed together as one country!

51 It would be interesting to see data from other years. That group apparently took up two cottages, so that doesn’t seem like a number that would alter the whole picture by a lot, which also leads me to wonder if there is not a conscious effort to overplay the picture of a mostly foreign-hardly Indian clientele.
is also trying to utilize the internet more because getting customers through that channel would mean that they can bypass agents, and hence, not have to pay commission. Both Somatheeram and Kairali have websites in multiple languages. While the Kairali website can be accessed in English, French, Spanish, Portuguese, Italian, and German, that of Somatheeram has all of these (except Portuguese) and additionally makes it available in Swedish, Norwegian, Polish, Japanese and Russian. The list for Somatheeram has increased in the last few months. Last checked, it was not available in Swedish, Norwegian and Polish. It is quite likely that they attended a travel show or had a promotional event in the Scandinavian countries and Poland. They regularly attend travel marts and expos. As he mentioned in the interview, they go every year to ITB, Berlin and World Travel Market London (WTM London). They have also been to ones in Italy, Spain, Russia, and France.\textsuperscript{52} Apart from efforts to reach out to prospective tourists, to cater to the ones already visiting regularly, they also have German, French, Italian, and Russian translators.

The Internet is a major source of information about these centers, but sometimes, it also acts as a supplemental source to other traditional methods after the traditional methods have acted as points of first contact/introduction. A couple of Taiwanese tourists at an Ayurvedic resort, a resort in the district of Kottayam, had read about Ayurveda in Kerala in a travel magazine and then had gone online to find more details and to decide on the actual destination. The internet also has problems, as a tourist in another resort

\textsuperscript{52} All the information about numbers and country of origin is based on the interview with the management. Kairali did have data in their record which they shared. Apart from the resorts attending travel show the Ministry of Tourism has also been actively promoting Kerala tourism, including Ayurveda in various travel marts around the world. At the marketing division of the Directorate of Tourism, Kerala, they mentioned ITB, WTM and the Arabian travel mart. They have also been organizing road shows in Milan, Rome, Sydney, Zurich and Melbourne.
pointed out. She said that it all looked very different on the website and that she was disappointed with what she actually saw. All in all, this mode of information dissemination seems all set to play an even greater role in the future.

Kerala is an important player in the Indian tourism market, and Ayurveda has added a lot of value to the tourism experience in the state. A lot of people have taken the opportunity to benefit from it. As a result, Ayurvedic centers have proliferated throughout the state in the last decade or so. The hinterland for these centers seems to be expanding into new countries with time, and as the information gets around, this trend is likely to increase even more. With the expanding markets and increased profits for owners, what needs to be seen is how much of the profit from these centers and in what form the profit gets channeled to the locals.
Chapter 5

Impact of medical tourism centers on the communities around them

Most of the literature on impacts of medical tourism focuses on large scale impacts, but there are some impacts that are very local, and some that cut across scales. In this chapter I discuss the local medical, economic and infrastructural impacts of medical tourism centers.

I. Medical impacts:

With the opening up of the corporate tertiary care hospitals, like the ones in this study, quality tertiary care has expanded. Most of these hospitals are single or multi super specialty hospitals and have treatments, infrastructure, and equipment on par with hospitals in the West. Akash, the Escorts representative mentioned:

…..infrastructure, as I said, was a bigger problem(earlier)….equipment and the kind of technological innovations, whatever earlier that the doctor used to think that happens abroad but never used to happen in India, but now definitely the trends are changing. The same 64 slice CT or a 1.5 Tesla MRI machine which you are using in US, the same equipment is gonna be used here.

Escort and Max Devki Devi hospitals specialize more in cardiovascular care while the other two are multi specialty hospitals. In his guide book for medical tourists Josef Woodman lists the typical treatments for the medical tourist in Delhi and they include cardiovascular, orthopedic, cosmetic, dental, vision and weight loss (Bariatric) treatments. Table 5.1 gives an idea of the range of treatments that international patients use in these hospitals.
The growth of these hospitals has also made these treatments available to locals and Indians from other states. Being super specialized tertiary hospitals the spatial catchment for patients is pretty large. At Escorts almost 60% of patients are from outside Delhi.  

Table 5.1 Specialties availed by most medical tourists

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Specialties/services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indraprastha Apollo hospital</td>
<td>Cardiac Surgeries, total knee/hip surgery replacements, Birmingham hip resurfacing procedure, liver, multi-organ and cord blood transplants, coronary angioplasty, abdominal and thoracic aneurysm open and endovascular repairs, carotid endarterectomies, Distal tibial bypasses for limb salvage, endovenous laser treatment of varicose veins, Stereotactic radiotherapy and radiosurgery, cosmetic surgery, Bariatric surgery-laparoscopic, Laparoscopic hernia repair, Laproscopic adrenalectomy</td>
</tr>
<tr>
<td>Max Super Specialty hospitals (unit of Devki Devi foundation)</td>
<td>Cardiology, Cardiothoracic and vascular surgery, Oncology-cancer care, Minimal access, metabolic and bariatric surgery, nuclear medicine, diagnostic,</td>
</tr>
<tr>
<td>Fortis Fl. Lt. Rajan Dhall hospital</td>
<td>Total Knee Replacement (TKR), Coronary Artery Bypass Graft, Kidney Transplant, Arthroscopic surgery, Fertility treatment(IVF), Microdiscectomy, Liposuction, Hip resurfacing, Weight loss surgery, cancer treatment</td>
</tr>
<tr>
<td>Fortis Escorts heart institute</td>
<td>Cardiac bypass surgery, minimally invasive surgery, Interventional cardiology, Non-invasive cardiology, pediatric cardiac surgery, Multi-specialty care for cardiac patients</td>
</tr>
</tbody>
</table>

Source: the international patient page on the hospital websites and interviews.  

97 Based on the interview with the management representative.

98 Some of the websites listed the facilities/procedures while some (Fortis) listed top ten procedures (for international patients) and while some listed general specialties others listed specific treatments.
In many cases, though, it is more the doctor than the hospital that bring in the patients. When Dr. Trehan, a cardiologist who was instrumental in starting Escorts, moved to Apollo, many of his patients came with him.

These hospitals have also become landmarks because of the name they have earned in terms of quality care. A resident of Vasant Kunj who lived close to Fortis hospital said that “If we have to guide them with a landmark we tell them we are near Fortis and everybody knows it.” A similar sentiment was echoed by Kumar, the owner of a guest house close to Escorts hospital, when he said “The reputation of this place has increased because of Escorts opening here, Jullena’s (reputation)\textsuperscript{99}, Okhla’s…. People come from outside and they get to know that there is a place called Jullena as well. Before Escorts people did not know this place at all.”

While these hospitals have brought world-class healthcare, literally to their doorsteps, it hasn’t quite crossed the threshold of some of the houses, so to speak. The world class healthcare, in reality, has been a bit elusive for some, even living right across from these hospitals.

There does seem to be a deliberate attempt to make some of these hospitals look expensive, which also ends up making them look more exclusive. I had a chance encounter with an architect whose firm was hired by one of the hospital chains under study, in which she mentioned that one of the visions of the hospital management was for the design to look “high end”. She also felt that Apollo hospital looked more like a hotel than a hospital. I observed something similar in one of my hospital visits. Fortis Flt. Lt. Rajan Dhall hospital had a doorman at the entrance door with an ethnic Indian head gear, something seen on doormen in some high end hotels and restaurants in India. The

\textsuperscript{99} Here he is referring to the urban village of Sarai Jullena, across the road from Escorts.
headgear of the doorman at the Trident Hilton hotel in Kochi, Kerala, was similar. While talking to one of the residents of Sarita Vihar, a neighborhood close to Apollo, I mentioned the headgear and the doorman at Fortis and he said that he had seen that in Apollo as well. Although having security in hospitals is nothing new and is probably required, the kind of image they seem to be trying to project is different. In a newspaper article a senior official at the Tajmahal palace and towers, Mumbai, said “Beard and turban is linked very closely to Indianness. Foreign tourists are easily impressed seeing doorkeepers in ethnic attire, turbans and beards (the Hindu business line as posted by Chopp, C. on fullstopindia)” One is led to wonder if the reason for the doorman’s attire at Fortis was to ‘impress’ foreign tourists and in some way part of the whole Indian hospitality sales pitch.\(^{100}\) One cannot overlook this pandering to foreign tourists in the security apparatus either. My bag was checked while entering Escorts hospital almost every time I went in.\(^{101}\) The experience of a foreign patient was different though. Instead of cross checking names or going through the bag they were saluted (apart from being foreigners it could also be because they were with the hospital staff). Maggi Ann Grace in her book about her partner Howard’s experience in Escorts hospital writes, “there are guards or security officers at every corner, at every elevator door, on every floor. They salute as we pass.”\(^{102}\) Rahul, a resident of Press enclave, located right next to Max hospital, pointed out:

In all hospitals in India the cardinal principle still holds that if there is an accident victim you send him off to the government hospital….our driver was

---

\(^{100}\) I did not get permission to conduct my research within the premises of Fortis hospital so I could not confirm my hunch from the management.

\(^{101}\) In the same hospital, one time, I had to go down to the basement, to the marketing department. I reached for the elevator and the guard standing next to the elevator asked me where I was going and if my name was there on the list (he had a list of names with him).

\(^{102}\) In the book she mentioned that they were the first American patients there and they also had a press conference covering their experience(because they were the first American patients to visit Escorts).
involved in a brawl, not even an accident, he needed emergency medical care. They did some kind of temp stitching up at G M Modi (another hospital right next to Max) and such is the equation, Max was alive, I think, by then, that they sent him off to AIIMS. Nobody even thought of sending him to Max because across the road that’s the relationship. These are glitzy and shiny and for the rich. Not for ordinary folks…it’s impervious.

…it’s a sociological divide. We have our own family doctor in hauz rani village, I’m more comfortable stepping across (the road from Max/Press enclave) to her and speaking to her....Max? first I encounter, I run my car in and there is a uniformed bugger asking me to park somewhere and then I go to the gate another guy with a walkie talkie looking me over, like I am a criminal about to blow up the place. This is not medical care; this is some kind of 5 star hoteliering. Number three inside the portico if the receptionist, who is manicuring her nails, gets the time to look at you…maybe I don’t look a certain type, perhaps I don’t wear the right type of jacket or shave everyday, have my hair combed a certain way, so if I get her to listen then I ask for what ultimately was last week, for my wife’s knees to be checked up for, you know, orthopedic care and we get an appointment on that day for 12th of March. So, last week of February, I go, and I get an appointment for the 12th which is pretty much like the west.

He adds:

I am conscious of the fact that you have your tape recorder on and you are doing an interview...perhaps I’m a bit more angry than I would be, because I want this point to get across, there’s a certain sense of, you know... my roots are very proletarian, so something militates... मुझे इसमे, जैसे हिन्दी मे बोले तो, बू आती है पैसे कमाने की103 (like, in Hindi one would say, it smells of profiteering). I don’t get the feeling of somebody caring. I don’t get the feeling of the white coat and the stethoscope encompassing me saying that come on, settle down, everything will be worked out.

Giving credit where it is due, he points out that,

At the same time I would like to say that a lot of people say like our immediate neighbors, because of whom we went and checked them out…This orthopedic is a very fine orthopedic and to have him right next door he has been a boon for some other neighbor who has got both his knees operated and come back home. So in real medical terms it has reached out.

……I also keep saying there’s something about being taken for a nice song. Yes, admittedly at one time one would have gone to All India Institute of Medical Science(AIIMS) for a similar operation now it’s nearer home, it’s much costlier, you don’t mind the cost either, you have found out that you have the ability to pay that’s why you have gone there but even within that there’s an out and out,

103 He mostly spoke in English, but used some Hindi as well.
you know, cheating, there’s a surface cover of a lot of, oh please go here, here’s this nice covered green file and everything but there at the end of the tunnel you’ll find the same gruff laboratory attendant or the nurse and the attitudes were the same, that’s what they were saying.

ऐसा नहीं है की फायदे नहीं हुए है लेकिन immediate दायरे में जरूरी नहीं.... दूर दूर से लोग आते हैं और इलाज कराते हैं. नाम है की मॅक्स. हैं quality care है definitely (it’s not as if there hasn’t been any benefits but not necessarily in the immediate area… people come from far off places to get treated. The name of Max is well known. Yes, there definitely is quality care.)

Last time I went there to fix my wife’s appointment there were at least some ‘non Max types’ sitting there…some comfort level thing, you know, if you look like an urchin you wouldn’t be said ऐ! अगर urchin हो तब भी तुम्हारा पैर कट सकता है (hey(called out)! Even if you are an urchin you can sever/hurt your leg)….Barista, Crossword¹⁰⁴ nice, but the trappings that come with it are not nice. Went to the receptionist and she said call up so and so to get an appointment. They connected me on the internal and go to that person but that person also later on gave me their number, their mobile, so within that place there are multiple things happening. Not easy turnkey or maybe that’s the way these guys work, to be fair to them.”

Abhinav, the Max representative had a slightly different take on the approachability of the hospital:

Two things that we started with when we came here was that we need to be very clear as to what your positioning is and not segregate yourself out from the world together. When we started we did have that Citibank effect of people not walking in because it looks expensive, but now over a period of time when they have tasted the emergency services and then they say this is not actually that expensive…it worked greatly for us specially being in the region where you have on the back a highly affluent society and in the front…

Many living close to the hospital would disagree with his views on the expense part of it because for them it doesn’t just appear expensive and intimidating but is actually beyond their reach. They find it too exorbitantly priced to even consider going there for a treatment. As was mentioned in the previous chapter, most of these hospitals have both lower income and middle/upper-middle income neighborhoods around them.

¹⁰⁴ well known coffee and book store
For most residents of the urban villages nearby it’s out of reach because they lack insurance or sufficient funds to pay out of pocket. The picture is slightly different in the middle and upper middle income neighborhoods nearby, where many more would go to one of these hospitals, if there is an emergency or even otherwise because they have insurance or have enough money. A property dealer from Khirki village, right next Hauz Rani village and very close to Max hospital, said that hardly 1-2% from his village or Hauz Rani would go to Max for treatment, but more people would go to Max from Saket (the middle/upper middle income neighborhood close by). A shop owner across from Fortis put it succinctly: “see, it’s beneficial for people who have money, middle class people will go if there is an emergency, not otherwise, and the lower class people would not even enter.” Expanding on that view a resident of Sarita Vihar, a mostly middle class or upper middle class residential complex close to Apollo, had this to say:

Hospital being there, very close to the residential area, is very good but as far as Apollo hospital is concerned it’s very costly, very expensive. One would think so many times before going to Apollo for treatment they would prefer to go to doctors or nearby hospitals like Holy Family……most people living here are getting mediclaim benefits from the office then they have no problem, they can claim but for general cough and cold and diarrhea or other problems people will prefer to go to other doctors.

A property dealer in the Janta flats, a low income neighborhood in Sarita Vihar, had a more extreme assessment of the situation:

There’s been no benefit from Apollo being here. The facilities that they were supposed to provide, based on which the government gave (land), of treating poor for free… none of that is there. There’s cheating. They refuse (to take patients in). If you go and say that you are poor, they have made so many criteria for ‘poor’… they ask for recommendations from multiple places. They say if you have a recommendation from some particular place only then would Apollo give you treatment. There’s no use. They make people deposit money first. It’s (free treatment) there only on paper. Only those people go there who have heavy pockets. Common man would go to Holy Family or some such
hospital because one needs courage to even enter that place (Apollo)….even for conditions like diarrhea they start talking in thousands (of rupees)….either big businessmen will go there or patients who are in the last stage (of a disease) then they will go there, even if that means that they have to sell their house off…whether this is in Chennai or here on Mathura road, does not make any difference…it’s the duty of the government also to check if they are providing the facility (they are supposed to).  

A resident of press enclave, close to Max hospital, felt that the blame is not only on the hospitals but also on the government for not being strict on enforcement:

The profit motive has always been there but my thing is what is the government doing? Shouldn’t the government be implementing and taking these people to task? You got it dirt cheap, you better do this! The government is also letting things happen, you know, they are not cracking down on (them)….. Ultimately the have-nots have to rush to AIIMS or Safdarjung (government hospitals).”

A property dealer close to Janta flats mentioned an empty plot in Madanpur Khadar (a village not far from Apollo) with a sign for a hospital that has been around for quite some time. “Come election time,” he said, “the minister will surely put a stone there and then no one will ask anything after that.” He expressed anger with the ineffective, opportunistic and corrupt ministers who make tall promises during election time, only to look the other way after winning. He said that “politics should be given the status of an industry”. A similar sentiment was echoed by a shop owner in Hauz Rani village opposite Max hospital when he said, “In India work gets done only in files…and once a person becomes a minister for 5 years then 5 generations after him can just sit and eat.” Some have little faith in their elected representatives in getting anything done. Some even from within the government do not hold a very good view of the situation. An official from the Ministry of Health and Family Welfare felt that the

---

105 This response has been translated from Hindi. Janta flats is a small pocket of low income DDA housing in Sarita Vihar, very close to the urban village of Madanpur Khadar.
106 Here he means that work is done only on papers and these laws etc. don’t translate into action.
private sector is very manipulative and that many in the government must have minted money (this was while talking about the land given by the Delhi government to Apollo).

I ran into a Max employee at the local phone booth in Hauz Rani and he said that they do treat poor people and that they get referrals from the government hospitals. When I told him that many locals were saying the hospital hasn’t kept its promise, he stressed the fact that free treatment is for people below poverty level and not for lakhpatis (millionaires) and that if they have the proper documents they would be treated. Another employee of Max hanging out in one of the shops in Hauz Rani also defended the hospital saying, “the documents have to be complete. There is an affidavit for free patients that needs to be complete. Only then will it be valid. Not every other patient will be free right?...If I go for treatment then I’ll have to show that I am poor.” The shop owner retorted saying that

“it’s the truth, first get the stamp then only they’ll give free treatment, would not give it without that. It’s just words, no action. The entry is Rs. 600. How will we afford that? We are working people. A person who earns Rs. 3000 how will he do that? They say get it written from the MLA, if you go there, he (MLA) doesn’t have time to meet. Who will go to Max then? Government hospital is good….They got this land for peanuts. Earlier it was called Devki Devi hospital. It had charitable hospital written on it. Max made it Max Devki Devi ..where did the charitable go? Where did the charity go? Charity was all distributed (among them), people took it away. There was a board, they pulled it down….. That’s a hospital for the rich, what will we poor people (do there).”

Abhinav, the representative from Max pointed out that they treat 10% IPD and 25% OPD patients for free and that

---

107 He was probably hinting at the fact that not all in Hauz Rani are from a low income background and that some are pretty well off.
108 This response has been translated from Hindi
109 Translated from Hindi
110 This has been translated from Hindi
We have maximum of our patients from this region. Now what is your demographic of a patient that is coming to you right? 35-40% of my patients are covered by their third party insurance. They wouldn't really worry about where they are. Another 15-20% are covered by their corporates, governments, both central and state. Out of pocket expense is very very limited. Penetration of health insurance, at least in the urban area, is very high and if you are working with any corporate it covers you through an insurance.

He questioned “How many people will be self employed and not be making that kind of money?” It definitely seemed they have a set clientele in mind and he did concede that “if one wants to say that every one off the road is coming to me, not really so.”

The situation is different from Apollo where, according to Avantika, very few domestic patients go through insurance companies. The awareness, she added, is increasing and the corporates, instead of coming with their employees directly, are going through an insurance scheme. “I think around 10-15% is insured; the rest all are cash patients.”

Insurance penetration in India is still pretty low and when hospital access requires a lot of money or insurance, it goes beyond the reach of many people. The estimated health insurance coverage in India is about 11% and the percentage that subscribes to private health insurance is as low as 1.5-2%, the others being employer (including government) funded financing schemes and government insurance companies and community and public health insurance (Bhattacharjya, A.S. and Sapra, P.K. 2008). The entry of private entities in insurance started after the passage of the Insurance Regulatory and Development Authority act in 1999 and is now expected to grow at annual rates above 75% (*ibid.*). Also, there is still a lot of learning to be had for consumers, for whom health insurance is a relatively new thing. A resident of press enclave had this to say:
I’m still to see the tangible evidence of the costs of medical care translating into the kind of medical insurance on offer… ultimately there’s a sleight of hand, in all of them. They’ll either say “wait by the door, you’ll get it later” or “boss you didn’t tell this earlier”...the insurance guy is also covering ass, making sure... what is happening is the consumer and the watchdogs are also very strong and they are getting stronger so it’s equalizing, except right now there are a lot of unknowledgeable people, like us, who are being suckered.

Even with Government financed health schemes, like the Central Government Health Scheme (CGHS), Apollo was initially listed as one of the hospitals that Central Government employees could visit, but was later removed from that list. On asking the reason for the change, Avantika added that “I do not know…probably you know they have selected the second grade hospitals….probably they owe a lot of money to a lot of hospitals.” This appears to have changed in the last year or so because the Apollo website now has this on it: “Indraprastha Apollo hospital is now on the panel of CGHS, DGEHS, Haryana Government, Sikkim Government, ONGC, BHEL, Oil India, Indian Oil Corporation,”112 The hospitals now agree to take CGHS patients, even if the earning from individual cases might be relatively smaller. Apparently the volume of patients makes up for it. Max is also on the list for CGHS patients seeking cardiac care.

One of the many property dealers and a resident of Hauz Rani mentioned that while growing up they used to play cricket on the land where Max hospital stands today., which served as the village fields. “They (the hospital) got the land on concession but our whole village is sad about the fact that they don’t give even 1% discount. They have put a board at the gates that there is concession, but there is no concession.” The acquisition of land by the DDA is an issue I would like to delve into further.113 A very

---

112 Haryana and Sikkim are states in India. ONGC, BHEL, Oil India and Indian Oil Corporation are public sector undertakings
113 In the RTI that I filed under the Right to Information Act, with the Delhi Development Authority, Institutional land branch, one of the questions was about the ownership of the land on which these hospitals
old resident of Kishangarh, the urban village close to Fortis hospital, mentioned that the land was taken from the villagers with very little by way of compensation, and some nearby villages were sold at much higher prices. “There is nothing in Kishangarh,” she said, “the government has looted everything.” A resident of Khirki village also had something similar to say.

They (the government) took it at a very low rate. They took if by force from farmers….The Government can take it for their planning. They can take it for schools, hospitals, colleges, no problem but if you are selling a 25 paise thing for (Rs.)2 lakh square yard that is not fair114….people were not even that educated. They took it by force”

The land was taken from the villagers by force or at very low prices and now “people feel sad that there is such a big hospital here and we can’t get treatment there….for this village the hospital being here or not doesn’t make any difference”115

As was discussed in the previous chapter all these hospitals are on lands that were sold at concessional rates. DDA had allotted land to 65 social/charitable institutions for construction of hospitals and dispensaries at varying concessional rates (Public Accounts Committee, 2005). I spoke with Ajay from Social Jurist, an organization comprised of a group of lawyers and social activists, which filed a petition in the High Court for the enforcement of the free treatment clause in the hospitals that got concessional lands. He mentioned in his interview that conditions regarding free In Patient Department (IPD)

---

114 He doesn’t mean it literally. He used those numbers to put the point across that they got the land from the village residents for cheap and then sold it for a higher price. Here he is talking not just about the land on which the hospital is but in general about acquisition of land that belonged to Khirki village.

115 This was the reaction of a resident of Hauz Rani village, opposite Max hospital. It has been translated from Hindi.
beds varied between these hospitals, starting from none up to 70% for some. According to the recommendation of the Justice Kureshi Committee, constituted in 2000, these conditions were to be made uniform at 10% IPD and 25% OPD, after the court judgment no. WP(C) No. 2866/2002\(^{116}\) (in response to the petition filed by Social Jurist). “Free” was meant to be totally free, but some hospitals have gone to the Supreme Court contesting the inclusion of free medicines. Ajay, being a part of a committee to keep a check on whether the hospitals follow the free treatment clause or not, keeps conducting inspections from time to time. When asked if the hospitals are following the condition he said:

A very negligible percentage they are doing. Their common excuse is that ‘we want to do. We have kept beds vacant also but the patients are not coming and some of the hospitals are trying to say that we have written to the government hospitals but they are not referring to us what we can do?’...and the other thing is that they still don’t seem interested in doing”

Avantika mentioned that they put aside some beds for the poor, in Apollo, but that they do not have discretion in using them. The patient has to prove that he is BPL and that they cannot put someone else on that bed. When asked if this bureaucratic procedure might make it harder for the poor patients, the Apollo representative said, “but at least we are safe...we are safe, I mean nobody can point a finger to us like why did you put a patient in a free bed.”

I also asked Akash, the Escorts representative, about their compliance with free treatment. His response was:

It’s purely an organization in which......yield has to support itself. We are a strong 1600 staff we have got majority of the high level consultants which are there. They are in the very very high salary bracket so we have to sustain that fact....so ... to sustain ourselves we have to maintain and rather upgrade our quality services you know.

\(^{116}\) The judgment can be accessed online on the Delhi high court website.
When asked if that makes it difficult to make arrangements for free beds he said, “there is a requirement and we also do that, so whatever the norms are there we abide by that. I can’t exactly tell you as to how many.” When asked about complying with the lease agreement of free treatment no one mentioned the lack of referrals from government hospitals, which differed from the reason given to advocate Ajay.\textsuperscript{117} They all said that they are doing what is required. One possible reason could be that they felt it wasn’t possible for me to go in and cross check their claims.

The non-compliance of these hospitals was also mentioned in the Public Accounts Committees twelfth report on the DDA land allotments to private hospitals. A resident of the press enclave expressed her discontent with the way these hospitals have gone about acquiring charitable land with a motive for profit making.

They are starting off on a wrong this thing na.? just see! Imagine buying charitable land. Who are you fooling ya? Why can’t you pay the government ya? Why are you scouting for, you know, all these devious ways of making money. You know the façade of doing public service healthcare and all that. I’m not saying medical tourism is bad but it definitely has to be ploughed back to people who don’t have….it’s become very stark, you know across the road. Just across the roads there are two different worlds, what we call two Indias.\textsuperscript{118}

The hospitals are supposed to put up a board which says that free treatment for BPL patients is available in the hospital but in some cases it just becomes a token thing (figure 5.1(a) and (b)) which again calls into question their willingness to deal with poor patients.

\textsuperscript{117} For him the responses also included the ones from hospitals not under study here.
\textsuperscript{118} Here she is referring to the difference between Max hospital on the one side of the road and Hauz Rani and Khirki village on the other side.
Figure 5.1(a): The board at the entrance to Escorts reads concessional instead of free.

Figure 5.1(b) The board in front of the preventive cardiology building

The board is in English and it is highly likely that many BPL patients would not be able to read it and it is also unlikely that they will avail of preventive cardiology, to begin with.

Ajay mentioned a specific case in Escorts where they refused to take a child and then he went to high court. The high court “snubbed them and then they became willing to take back the child.” Akash, from Escorts, mentioned that they arrange regular medical camps for downtrodden people apart from medical camps and free OPDs for the “corporates”.
Ajay also mentioned that now they (the hospitals) are saying, “take money, (almost like) take as much as you want but leave us alone.” Ajay criticized this attitude, saying, “The [problem] is that money will not serve the purpose and that land has a social purpose.” He apparently was the only one opposing this move to take money for the land instead of insisting on free treatment. “The government was also coming with the idea of taking the money (to make up for the concession on land) which would add up to around 500 crore and then they can open an account which will have that corpus money.” The case in Apollo, he said, is slightly different because it was a joint partnership between the state government and Apollo. Even then, there was an independent case going on in the high court to decide if free treatment should include medicines and consumables. In 2009 the Delhi High court imposed a fine on the hospital for failing to comply with the lease agreement (Kumar, P. 2009). This was in response to the PIL filed by the Social Jurist. In the last couple of years the courts have stressed the enforcement of the free treatment clause by private hospitals on concessional lands (Kumar, P. 2009, TNN, 2010, 2011). Ajay also added that the government, following the non compliance by hospitals, has now stopped giving concessional lands to schools and hospitals and all lands are sold through auctions.

A not so local impact has been what some have called a reverse brain drain. Indian doctors have in the past gone to the US and UK causing a drain of trained doctors from India but with medical tourism and growth of corporate hospitals there is now some traffic in the other direction as well. Doctors who had left the country to practice medicine elsewhere have returned to some of these corporate hospitals, some even after spending more than a decade abroad. At Apollo, Avantika said, that about 30% of the
senior consultants are foreign trained and they have more trained in the UK than in the US. She added that foreign experience does count and that it is a plus for the hospital. However, she said that is not the only reason they are coming back. Abhinav related a similar story for Max. He said:

You know medical tourism or medical value travel is resulting in negative brain drain…see, the opportunities for physicians in India was next to nothing. Today with more, bigger hospitals coming into play yes, the opportunities are more. Capacity is more, volume of work is more, the level of technology is also very high so today you can compare most hospitals that exist here to most hospitals that exist anywhere else. Earlier why did they go there? They were seeking better technology, better exposure, better pay... If we can provide everything here why wouldn’t somebody come back, so we do have a lot of doctors come back from UK. Stayed there for 20 years and now wanting to come back. Yes that does happen.

Akash, from Escorts, added:

And now, with the infrastructure coming up, with lots and lots of private investment, the so called corporate hospitalization is happening now. The doctors are coming back to India, because it is much more fruitful for them. It is much more invigorating for them to work for their own people, to work for their own country and then to make name and fame out of this.

When asked about movement of doctors from the public hospitals to corporate hospitals Avantika noted noted that:

They do not do it in their, you know….probably when they have a lot of experience in their… public hospital then only they move out. Either they are in late 50s… not very young ones…they enjoy…..the exposure…they see more patients. They get more….experience.

On asked whether that’s a loss for the public sector because there are so many hospitals, she conceded that there is a kind of a drain. Abhinav also agreed that people prefer corporate hospitals to the government ones. This movement of skilled healthcare
professionals from the public health care to corporate healthcare is causing an internal brain drain (Chanda, 2002, Hazarika, 2010).

II Attitude towards international and domestic patients:

The international patients seem to be treated differently, especially the patients from the western countries, and more so in Apollo where the proportion of patients from the western countries is relatively larger. Here are some interview excerpts from Apollo:\[119\]

A: And when the patients are in ICU or in the OT\[120\] usually we ask the domestic patients (relatives/attendants) to vacate the room and get into or wait in the ICU lobby which we have made for them. But for the international patient especially the western countries we do not ask the patients attendant to leave the room because then just for two days where will he or she you know, go\[121\] …

P: why not even for Middle East and…

A: Because Middle East they have their own…. They come…in bulk, so they can arrange…..So, if suppose one patient has gone for this thing, surgery, we accommodate the attendant in someone else’s room because they are very accommodating but western countries will never share a room with anybody. Because my Iraq patients they come in bulk say 25 patients together, so if two people are going for (treatments)…two ladies can be accommodated in some other room where there are female attendant as well as female patient …but for western patients I will not be able to do that.

P: Does the Jasola district center coming up here affect the hospital in any way? Make it more crowded or noisy?

A: No, because foreign patients will hardly go to Jasola….There are few guest houses that are coming up but very few people, the people whom I call foreigners they go…are not, you know, the ones who would like to stay in

---

\[119\] P is my initial and A is for Avantika.

\[120\] OT is Operating Theater.

\[121\] When patients are given rooms, attendants sometimes stay with them but this is usually not allowed in the ICU but here she means that when the patient is in the ICU the attendant does not have any place to stay for those two days or so, so they let them stay in the ICU.
Jasola. Like if I say Bangladeshi or Iraqis they will go and stay in Jasola, but not the real proper, you know, western country.

Talking about the special provision for OPD, she adds:

A: In OPD consultations also…Suppose I do not want my foreign patients to mix with the domestic patients in the OPD because OPD is full of Indian patients so we make them wait in the Platinum lounge and the doctor himself comes and sees the patient for the consultation….. So we charge extra for that. They are charged 600; 500 + registration fee. 600 there. Here they are charged 1100. 500 extra they have to pay because the doctor has to leave his OPD in between and come, you know, he is answerable to all the patients as to where he is going. For ½ an hour he has to come down and see the patients. So we get a lot of embassy patients lot of consultations, lot of patients who are getting admitted...all the paper works are done in the platinum lounge.....so you can see a lot of things but now the problem is that it is filled with Dr. Trehan’s patients. You can’t even see where the international patients are…they have to stand.122

In other words, there are domestic patients getting a consultation for heart problems (Dr. Trehan is a cardiologist) who, according to Avantika are sitting while the foreign patients in the OPD have to stand. She seemed to suggest that it wouldn’t be as bad if the patients forced to stand were domestic. Ideally no patient should have to stand and wait but privileging international patients for seating at a hospital, even if they are paying more, feels like discrimination of sorts. She had mentioned that they were thinking of putting the international patients in a separate hospital building.

The picture is not very rosy for all international patients though. Durgesh Nandan Jha (2011) wrote about the plight of some of the Iraqi patients who have gone to some of the corporate hospitals in Delhi. The Iraq embassy has received a lot of complaints about overcharging by these corporate hospitals. Prospective patients, when asking about treatment procedures, are misled by the interpreters into thinking that the medical facilities are affordable, but once in the hospital they are overcharged and forced to stay

122 Sometimes it feels like the old Indian adage of “atithi devo bhava” of equating a guest to god is taken a bit too far, to the extent of over privileging them, specially if the guest is from a ‘rich country’.
for longer (Jha, D.N. 2011). A senior official from the Iraqi embassy, Muqdad M. Abbas, was quoted as saying “the mortality rate of patients who come for treatment here is high. Since January, 23 Iraqi patients have died due to medical complications, which is reflective of the poor quality of treatment provided to them” (ibid.) In the same article, another official pointed out that “many private hospitals hire facilitators, mostly Iraqi and Palestinian students, who collect patient details from hospitals and accost them at the airport, persuading them to opt for certain hospitals, but once admitted, the interpreters fail to cooperate (Jha, 2011).”

III. Economic impacts

The government incentives is not only restricted to concessional lands, they have also provided tax breaks to promote the growth of medical tourism (Sengupta, A. 2011; De Arellano, ABR, 2007). Import duties on equipment required for medical tourism have been lowered and the rate of depreciation for life-saving medical equipment has been increased by the Indian Government (Bookman, M.Z. and Bookman, K.R. 2007. pg 72, Reddy, S & Qadeer, I. 2010; Sengupta, A.2011). A quick look at the financial audit of a couple of these companies highlights this point. After looking at the financial audit of Fortis Healthcare Ltd. and Apollo Hospitals Enterprise Ltd., a corporate tax lawyer, pointed out:

---

123 While a friend’s father was admitted in a hospital belonging to one the chains under study, she over heard a translator (for a patient from somewhere in the Middle East) trying to convince the patient to move to another hospital. There was probably some commission involved for the translator/facilitator from the hospital he was pitching for.

124 While trying to figure out Fortis’ financial sheets I could only see that they were paying very little tax. To understand this better I was looking for some explanation. When I approached a journalist for some leads she decided to follow that up and do a story on it. She is the one who got in touch with the lawyer. The article hasn’t happened yet but she said that the information she has is in the public domain and can be
Though computation of taxable income is not available, my observations on the basis of the printed balance sheet are as follows.\textsuperscript{125}

1.) In case of Apollo, Provision for taxation is Rs.5771 on the profit of Rs.22217 for the year ended 31/3/2010. These figures for the year ending 31/3/2009 are Rs.4798 and Rs.17626 respectively. In percentage terms, tax on profit comes to 25.97\% and 27.22\% for the years ending 31/3/2010, 31/3/2009 respectively. Though tax rates for these two years for a company were 33.99\% but it appears that effective tax rate of 25.97\% and 27.22\% which are below 33.99\% may be due to higher amount of depreciation on life saving machines available under Income Tax Act. There may be other reasons also but nothing concrete can be said for want of relevant details and information.

2.) Regarding Fortis, tax expense is Rs.336 on the profits of Rs.7337 for the year ended on 31/03/2010 which comes to 4.57\% which is far below the normal tax rate of 33.99\% and MAT of 15\%+ Surcharge+ Cess. Again, no precise reason can be found out for such an ostensible anomaly due to non-availability of complete facts and figures. There may be several reasons such as higher depreciation rates for life saving machines, weighted deductions if any are available, un absorbed business loss and depreciation as per Income Tax Act and as per books of account.\textsuperscript{126}

Tax is one of the means by which the earnings from these hospitals can be channeled for public use, but the hospitals are not paying the expected tax either.

At a larger level, medical tourism is bringing in foreign exchange. It is projected to be a billion dollar industry by 2012, but at a more local level the hospitals have had some benefits in terms of employment and increased local business and income generation opportunities.

These hospitals employ a lot of people, not just doctors, nurses and other paramedical staff but also managers and other staff to keep the place running. Escorts, for

\textsuperscript{125} Refer appendix 5.1(a) and 5.1(c) for the audited financial documents for Fortis Healthcare Ltd. and Apollo Hospitals Enterprise Ltd. An equivalent document was not available for Max healthcare. Also, this is for the whole company and not individual hospitals, that are under study.

\textsuperscript{126} The financial report in their annual report for 2009-2010 gives a break up of the taxes (appendix 5.1(b)). Minimum Alternative Tax (MAT) credit entitlement and deferred tax credits seem to be the reason for so little by way of taxes. Even without the deferred tax credits the tax amount is less than 20\%. 
example, has an employee size (including doctors) of about 1600.\textsuperscript{127} For most of the skilled jobs the catchment is much larger but some local residents have gotten jobs in the hospitals also, even though it’s a pretty small number. A resident and shop owner in Hauz Rani, near Max, said that from the village, which has a population of 150,000-200,000 about 20-25 people are working in the hospital. Here he is referring to original residents of the village and not hospital employees, who hail from elsewhere, but are staying in the village. He added that about 90\% of the staff is from outside Delhi and they stay in Hauz Rani or within a radius of 5-7 kilometers (~3-4 miles). In some places even local doctors have been employed. The president of the Resident Welfare Association (RWA) of Vasant Kunj pocket B1, right next to Fortis, pointed out that “Some of the doctors living in our pocket are also working there.” These direct employment opportunities have been very limited though. A resident of Kishangarh, the urban village close to Fortis, said that “they (the hospital) are not giving jobs to the kids from Kishangarh…… I don’t know what allergy they have from Kishangarh.”\textsuperscript{128}

Besides direct employment to local residents, some of the biggest gainers have been residents renting out rooms and apartments to the staff working there and also in some cases to attendants who accompany patients. A shop owner in Hauz Rani, while talking about benefits from the hospital, said, “property/house owners have benefited…they make it tall [add floors to the building]. They pay the police some money, otherwise they would not let them build.”\textsuperscript{129}

\textsuperscript{127} Based on the interview with the management representative.
\textsuperscript{128} The response has been translated from Hindi.
\textsuperscript{129} Here he is probably referring to the building restrictions that apply in the urban villages (this has been discussed in the previous chapter)
In all of the urban villages close to these hospitals including Hauz Rani, Khriki village near Max, Madanpur Khadar, Janta flats near Apollo, Kishangarh, Masoodpur near Fortis and Sarai Jullena near Escorts have housed a lot of the nurses, other paramedical staff, and other staff working in these hospitals (refer to maps in chapter 4). Apollo has a hostel for nurses but a lot of them stay outside as well. A property dealer close to Janta flats, near Apollo said:

Nurses stay here (Janta flats). Doctors don’t. Doctors are all on contract basis. Up to six of them stay in one room…. Depending on theirs shifts some stay during the day others during the night. The rent is about Rs. 5000-5500 for two rooms.

In Hauz Rani also the hospital staff from Max live there. A property dealer there said, “the staff lives here. Two two three three people stay together…almost 60% of the staff lives close by.”

This has meant that people with places to rent out have benefited from the hospital being there. There is a difference in opinion as to how much it has affected rental rates and property values. While many think that the property values and rents have increased because of the hospital, some give only partial credit to the hospital for that. A property dealer near Max adds that “we used to get rent earlier (before Max) also and we get them now also but the standard (of the place) has improved….The rent that was 1500 earlier is now 1700/1800.” A shop owner in Hauz Rani pointed out that the rate per square yard has increased by Rs. 3000 in the last 5 years. The increase in property value of the place is also a result of the opening of the Saket district center which includes a huge mall (the Select Citywalk), as well as the extension of the Delhi metro (subway) to the neighborhood and the hospital. All of these changes have come about during the
same time and it’s hard to attribute the property value change to any one factor. A Press enclave resident also confirmed a high increase in property values in the last few years. A resident of Sarai Jullena, near Escorts said, “The benefit to the community from Escorts being here is that the area has become a bit commercial, rents etc. have increased and some people’s poverty has reduced to some extent.” He adds that about only 25-30% of the increase (in rent etc.) can be attributed to Escorts. The rest is more because of the “expensive times in general”. And when people stay in a place it’s not just rent that they would be paying, they would be using other facilities in the locality also, like the grocery store, shops etc.

It is not just hospital staff who take up residence in these localities, but also the attendants who accompany patients and occasionally the patients themselves, especially the ones who have to stay for a longer period of time. Apart from attendants who get a complimentary room in the hospital when a patient is admitted, some patients or attendants either rent a room/apartment close by or stay in a guest house or a hotel, depending on the amount of money they have and how long they have to stay. It’s mostly domestic patients who rent places. Among international patients there are “Afghanis and some other foreigners”.

A property dealer in Janta flats said that “patients come; they come for 1 year, they come for 6 months, they come for one month….people have turned their houses into guest houses. They (patients/attendants) stay in Sarita Vihar and they stay in Janta flats also.” This has happened in Vasant Kunj and Saket as well where people have started renting out rooms in their houses to patients and their attendants. A taxi driver at a taxi

---

130 From the interview with the Apollo representative.
131 From an interview with a resident and shop owner in Sarai Jullena, close to Escorts.
stand near Max said that among international patients (more) Arabs stay. “(They) have attendants. Some don’t stay here (Hauz Rani) because it’s kind of dirty… Saket is 2-3 times more expensive.” Comparing guest houses in Friends colony (an middle/upper middle class neighborhood close to Escorts) and Sarai Jullena, a village resident and shop owner said that “it will depend on the capacity of your pocket as to how much you can afford because there it’s 2000 per day and here it’s 350-400 per day, but (here) they can’t provide so many facilities that they’ll install a geyser, install an AC… The rooms (outside the village) are better, must have carpets and must have luxury beds. Here you would not find that luxury.” Between renting and living in a guest house, another consideration, as the Apollo representative pointed out, is that if one has to live for longer then paying on a daily basis becomes very expensive and then the option of renting a place is much better.

About the renting situation in Hauz Rani a property dealer pointed out:

Nobody rents out on a per day basis, madam…they (patients/attendants) don’t stay for the whole month. There are no guest houses here. In a guest house one would need a bed, one would need TV. Here, there’s just the room. Get your own bed, get your TV, get whatever you feel like!”

Another thing to note was that there are very few (and sometimes no) guest houses in close proximity to hospitals that have opened relatively recently, like Fortis and Max. Many guest houses are close to Apollo and Escorts and even more are close to the well known government hospitals of AIIMS and Safdarjung, which are across the road from each other. A shop owner in Hauz Rani mentioned that “people who come with the patients, it’s a big problem for them because there are no guest houses here. The biggest problem is for people who come for treatments….So many families come. We send some of them to places close to Safdarjung (government hospital) because there are a lot of

132 Translated from Hindi.
guest houses there because Safdarjung (hospital) has been around for long.” Or as a property dealer in Khirki village said, “here instead of staying in a guest house people rent a place or try to stay with relatives in Delhi, from where they can get to the hospital in half an hour to an hour.” There are guest houses and renting options for people with different economic capacity. There are also big hotels close to some of these hospitals, like Crowne Plaza and Inter Continental not very far from Apollo and Escorts and Sheraton located very close to Max.

As mentioned earlier the proportion of international patients and attendants renting a place or staying in guest houses is relatively small. It’s predominantly domestic patients. Also, patients choosing to rent places or live in guest houses are also mostly from the other South Asian countries and the Middle East and some from Africa. For example, in a slightly upscale guest house close to Escorts, both patients and attendants from Escorts and Apollo stay there. The percentage of foreigners is about 10%, but not necessarily from the hospitals. They have tie ups with a lot of companies. Another guest house close by has a large proportion of it’s occupants coming from Escorts or Apollo, as high as 90%. The owner mentioned that

I don’t have a tie up with them in the sense of giving them something (commission). There is no give and take. I have given my name and yes, they can suggest (to the patients) that you can stay here. There is no commission. Here we mostly have Afghans, from Afghanistan, from Bangladesh. There are 2-3 patients from Nigeria, there’s Nepal. There’s foreigners also and Indians also.

The proportion of foreign to Indian guests, he added, was 40 to 60. The whole system of integrating accommodation with the hospital services is being worked out as well. As a shop owner near Escorts pointed out “they (the guest house owners) leave their cards there. They don’t pay commissions but sometimes they leave some gifts at the
reception. Everything is give and take, you see.” In some place it has become more formalized. At Apollo:

Whenever the patients are coming, they give their budget, we send a list of guest houses, they go through it. They’ll visit their websites, if they have one…the guest houses or hotels then they say yes we have, we have selected this and you can make reservations so we do it but at the same time if they want to get into some five star hotel we tell them not to book on the net because the net will not give any discount for an Apollo patient. If they go through us I mean if they tell us we can talk then we get the corporate discount but not if they go straight to the yeah….some people have made mistakes they said that they are charging $250…I said no because you didn’t tell us. If we had done the booking then they would have just (charged you less).

On being asked if these guest houses and hotels get in touch with them or they find out about them she replied that:

Whenever we (are) comfortable like ok this is a good place for western people because (it is) clean and big and understand English and then for the other backward countries we select a different one which is cheaper…..(mostly) within 3 kms. A lot of times it is in the Friend’s colony. We have two 5 star hotel. One is Crowne Plaza and one is Inter Continental.

They don’t do the booking for rented places. For rents they suggest names and ask the patients to see and figure it out themselves. Owners of places leave their cards with the hospital. Guest house and hotel accommodation works in a similar manner at Escorts as well:

So what we do is, there’s one attending is allowed to stay with the patient in the hospital but then we have got tie ups with a couple of hotels nearby or guest houses nearby. I mean we have that accommodation available for each and every, you know, strata…..So we facilitate their stay as well.

While staying in the local neighborhoods the patients and their attendants contribute to the local economy as well. As a resident of Sarai Jullena pointed out “Those who come will stay, they would need soap, they would also need [tooth]paste. For food there’s the canteen but some people don’t like eating inside (the hospital).” A shop owner
felt there was another reason for people to eat outside “The restaurants inside, opened by big companies, are very expensive so in a case where one is spending lakhs and lakhs of rupees a person will try to save wherever he can, that’s why they come outside.”

And the eating places close by cater to them. A resident of Press enclave said that a couple of eating places have been established in Hauz Rani. He also mentioned that among the new shops and businesses opening up in the vicinity, there are few owned by local residents. A property dealer in Khirki village also said that some shops have opened inside the village “but outsiders have done that. The village people have not done much.”

But if there was a demand for something the supply for it also comes up. As Avantika pointed out:

"You know they have come to know. They have come to know that the foreigners they need the SIM cards, so they also try... if they need a cell phone we can let you have a cell phone also outside Saita vihar…. they are very aware of it and even they have...and you know each country has a particular kind of food they would prefer to have. So any Saudi…any Middle East people they would have to have a typical kind of a date so they know that which shop it will be available you know. They are also aware of it.

Chemists (local pharmacies) have also benefited, to varying extent, from the hospitals being there. Most of these hospitals have their own pharmacies and supply of medicines: Apollo is supplied by Apollo pharmacies. For Fortis (including Escorts) there is Fortis health world, and for Max there is a central purchase department in the corporate office that buys for the whole company and then sends the supply to individual hospitals.

When I visited, most of the nearby neighborhoods had quite a few chemists, most of which had opened shop before the hospitals opened. They either served the customers

---

133 One Lakh is a hundred thousand, but here he just means a lot of money.
134 I ate at a couple of eating places inside these hospitals, while more expensive than many places outside it wasn’t prohibitively expensive, but that would also depend on the paying capacity of people.
135 These are from interviews with the various management representatives. From growing up in India I remember hospitals having a lot of chemists (medical stores) outside their premises.
from the other hospitals that were around from earlier (Holy Family close to Escorts and GM Modi close to Max) or the local residents. One of the medical store owners near Escorts said that they have more patients from Holy Family than from Escorts. He added that before the pharmacy opened inside (after Fortis took over) they had more patients from Escorts. Talking about the pharmacy in Fortis a pharmacist close by said that they (Fortis) have their own pharmacy for the inpatients, inside, but if they run out of medicines they get it from him. They have authorized that. Some of them also seem to try to cash in on the name, in some way. There was a pharmacy near Escorts, which was called Eascorts (although they insisted that the name had nothing to do with Escorts). A lot of pharmacies in India have a red cross on their signboards, but this particular pharmacy across from Max had a green one. The board was the same color as the Max logo (as seen in the previous chapter) and it displayed the name ‘Mac pharmacy’. The shop had been shut because of the sealing drive in Delhi and hadn’t yet been unsealed at the time of my visit.

Not only pharmacists but also some doctors with clinics or chambers in these residential areas seem to have made adjustments. It is hard to exactly pinpoint the hospital as a cause, but it is quite possible. A resident of Vasant Kunj pointed out that the local doctors have increased their visitation fees and so has Apollo Clinic, in Vasant Kunj. She added that the registration at Fortis is Rs 500 and Apollo clinic increased it from 350 to 400-450, keeping it just a little cheaper than Fortis.

---

136 Chemists seemed to be more numerous near Escorts/Holy Family and GM Modi/Max. I did not see many near Apollo. There were a couple near Fortis. Here I am talking about chemists right next to the hospitals. All neighborhoods had chemists inside/or in their commercial complexes.

137 In 2006 the Supreme Court had ordered the sealing of unauthorized business establishments in residential areas.
Apart from shops and businesses, small makeshift shops, tea stalls, juice stands, and beetle nut/cigarette stalls had also been set up close to the hospitals. I also came across a makeshift barber shop close to Apollo.

**Figure 5.2 small informal businesses around the hospitals**

Barber shop in front of Apollo

Juice and tea stall next to Escorts

A resident of Vasant Kunj, while talking about the small makeshift tea stall that has opened up in front of the hospital felt that it was at least giving employment to two people. The president however felt that such shops encroached on the green area of the neighborhood and attracted anti-social elements, creating a security issue.\(^{138}\)

The presence of the hospital has also given a little boost to local transport. Auto rickshaws and taxi stands close to the hospital have benefitted some. A taxi driver close

\(^{138}\) Vasant Kunj pocket B1 was almost like a gated community. It not only had a boundary fence around it, something that is very common in neighborhoods in Delhi it also had a guard posted at the gates where they also had an entry register, also something not very uncommon. While most of the concerns of the president of the RWA were very genuine some responses seemed like they would rather not have much outsiders in their neighborhood.
to Max said that 25% of his customers were from the hospital. The international patients admitted in the hospital get transfers from the hospital itself. For Apollo, “From the beginning, the airport transfers, airport pickup, and airport dropping, and also when the patient is recuperating here, that time also from the guest house to the hospital we are bringing to and fro. If it is within 2-3, 3Kms. If they are staying very far we may not send the car but otherwise we do it.” Despite that some would use local transport.

**Figure 5.3 Autorickshaws make a line outside Fortis**

A resident of Vasant Kunj said that “definitely more autos have come (since Fortis opened). They have started charging a lot. You waste 5-10 minutes bargaining (with them) that it’s not right, you know. I think it’s a common problem, so we have to specify that we stay here so we know the rate and you can’t really cheat us.”

IV. Infrastructure and other local issues

The hospitals have also had some impact on the local infrastructure, some beneficial and others not.
A press enclave resident, close to Max hospital said:

One of the main things was the siting of the dustbins and the cleaning of the area around them. Earlier it used to be a permanent public toilet, which it is no longer and a bit of landscaping, which seems to be a little ironic because there’s another hospital next to it which doesn’t seem to have had the effect.

Another press enclave resident added that the road in front of press enclave had improved. For the last ten years there was sewage flowing on the road, despite all the articles that were written and the MLA’s and RWA’s involvement. Now however, after Max and the mall opened there, the road has been concretized. She felt that “there has to be some nexus, you know. It will be too much of a coincidence because you know the residents have been after the authorities for the past 8 years and only now it’s done.” The previous respondent also added that “I wouldn’t give Max the entire credit for it….approach road clearance has happened for a variety of factors; because of the press, because of the Hauz Rani politicians, because of the metro and because of the district center.” The road has improved but the traffic has also become worse. Again, here, it’s a combined effect of other things as well, the result of heavy traffic has been that it has made it difficult for pedestrians to cross the road, a complaint that a resident of Sarai Jullena had as well.

The hospital parking has not only increased traffic on the road, but in some places created a bottleneck for local traffic. The RWA president of Vasant Kunj pocket was complaining about how the residents face problems with the Fortis parking on the road just outside the B1 gates, which blocks the vehicles going in and out of B1. Their repeated requests to the hospital to deal with the issue, she said, had fallen on deaf ears. She added that from what they knew they were supposed to use the basement for parking, but now they are using it for some other purpose and the cars are parked outside. Some
cars had also started parking inside the neighborhood, but they had been clamping down on that (figure 5.4)

**Figure 5.4 A sign outside pocket B1 warning non residents against parking inside**

A sign at the gate to pocket B1 specifies that the parking inside is only for the residents and if the non residents park inside their tires will be deflated.

At Max it was not the parking but something else that was creating a traffic hazard. A press enclave resident pointed out:

The fringe road on the side, I don’t know whether they are involved in it or otherwise, because of the landscaping what I see is because of them there are chaps who cross their cars over from what is essentially the wrong side of the road, at an angle, which is a traffic hazard and they don’t seem to be working towards energetically resolving that.

Another issue that a resident of press enclave pointed out was the incinerator at the back of Max:

I still want to see if there has been an assessment of the incinerator in their back which is on my way to the sports complex, because what looks pretty in the front, on my back route to the sports complex, their back alley is like any other back alley….I wouldn’t say there are skeletons but there definitely seems to a cupboard which seems to be overflowing all the time.
Hospitals generate a lot of hazardous waste and some hospitals use incinerators to burn some of it. Unfortunately this angle was not followed during the fieldwork and I’m not sure what happens with the waste generated in these hospitals and if it is discarded safely or not.

In summary, the hospitals seem to have generated new infrastructural problems in the process of solving old ones.

V. Impact on leisure tourism

The combining of “a tummy tuck with a trip to the Taj Mahal” (Woodside, 2008:232-244) doesn’t seem very widespread. The combination of leisure tourism with treatment varies from patient to patient, depending on what treatment they have come for. Akash said the two haven’t gelled well and from what they have seen people come for health care alone. The response was very different while talking to an employee of a medical travel agent, Life Smile Biosciences, which is based out of Delhi. She said that people don’t only come from serious invasive surgeries but also for dental and eye treatments and that

Most of the people (their clientele) go on tours. When I talk to them, I explain to them that you are only two hours from the Taj Mahal, it will be a waste (not to go there), it’s one of the seven wonders of the world, so that’s what we basically do…..and we advertise it as an all inclusive vacation surgery package, bring your family so if the husband needs Lasik and the wife wants a tummy tuck they can do that, very cheaply and the tours usually run at $600. So that’s your Golden Triangle (Delhi-Agra-Jaipur) and that gives you a day of shopping at Delhi also.

Also, sometimes the patient might not go on a tour but the friends or family accompanying them might. As the Apollo representative said:
If they are long staying patients like the ones who come for transplants and all what will the patient’s attendant do when the patient is here for one month say for two weeks toh (then) he or she is in the transplant unit nobody... cannot stay with the patient so sometimes they say Agra tour or something, which we do not have much facility from our hospital but we know some agents or some tours and travels or we tell the Crowne Plaza people to coordinate with the patient’s attendant but we do not come into the picture because that is not our side of expertise.

The impact of these hospitals on the neighborhoods around them has been a mix. In economic terms there have been benefits for some and no difference for others, but in terms of access to healthcare, it has left a vast swathe of the population untouched.
Chapter 6

Impact of wellness tourism centers on the communities around them

With so many Ayurvedic resorts and centers opening up in Kerala in the last decade or so, there have been some impacts on the local area around them and this chapter is an attempt to look at those. The impacts are broadly discussed under economic, infrastructure and medical impacts.

Going back to the discussion in chapter 4, on location, the Ayurvedic resorts tend to be in very picturesque locations, away from the crowds of big cities and towns. Both the resorts in this study are located in villages. While Somatheeram takes advantage of a sea front location, Kairali does that with the calm and quiet of the paddy fields around it. In both cases, once inside the resort the view of the village is hidden and the only view is either the sea or a canopy of trees, well insulated from other habitation in the vicinity.

The main entrance to Somatheeram was still being built when I visited because it was not long after the resort was split between the two brothers, as discussed in chapter 4. Manalatheeram had a different compound from the beginning, but, because Somatheeram had to be split into two, the Somatheeram Ayurveda Group had to build a new approach/entrance to their part of the resort. On the other side, looking up from Chowara beach towards Somatheeram and Manalatheeram, one could mostly just see a green blanket of coconut trees, on top of a cliff (figure 6.1 (b)). There is the cliff on one side and on the other sides are either concrete walls or woven coconut leaf screen (Figure 6.1(a)), shutting off what is not as soothing a view as the sea and the beach or the coconut
trees inside the resort. At Somatheeram, there is a flight of stairs down the cliff, leading directly to the beach.

**Figure 6.1(a) & (b) Resort boundary walls**

6.1(a) The road between Manalatheeram and Somatheeram Ayurvedic Health Resort, leading to the beach. 6.1(b) Manalatheeram (under the coconut trees on the cliff), from the beach right in front of Somatheeram.

Kairali has open paddy fields around it (figure 6.2), but inside, the dense tree cover essentially covers the view looking out, so the inside of the resort is very different from what is on the outside of it.
Even though the village view is shielded from the inside, the surroundings form a part of their experience. Visitors go through the village while driving in and out. Sometimes “foreigners come out to exercise; jogging, walking…” Akhila, a resident of the village mentioned. The entrance to it is through a very big gate with a guard posted there. With or without gates, the compounds are, in a way, fenced in.

I. Economic impacts

There have been direct and indirect economic fall outs of the resorts being located there. It has given employment to people and also created employment/business opportunities for others.

Abhilash, from Kairali said that they employ 40-50 people. Including guards and all other temporary workers that number is around 60. The employees mostly include

---

139 I have used a pseudonym here. All names mentioned in this chapter are pseudonyms.
140 Boundaries, gates and guards are pretty common in private establishments in India. The structure above the gate seemed like an attempt to replicate the traditional architectural style of buildings in Kerala.
Ayurvedic doctors, therapists, management/administrative employees, house keeping staff, kitchen and gardening staff and guards. They have eight therapists for women and four for men most of whom are from the same district (Palakkad). About house cleaning staff, he said that there are very few who are from around but some of the kitchen and gardening staff are from the nearby village.

One day I walked over to the staff kitchen, which was located across the road from the Kairali compound. While talking to Chandresh, a member of the staff kitchen, he said that most of the employees come from far, some stay inside the resort, some stay there and some outside the village. On one occasion, on the way out from Kairali I got talking to Balmohan, a guard at the gate, who had just gotten off duty. He was from Kerala but not from the district of Palakkad and had rented a place nearby and was just walking home. He had been in the Indian paramilitary. The practice of keeping ex-army and ex-paramilitary personnel as security guards seems like a fairly common practice. The guard, who took me to the Somatheeram office, was also in the army earlier. I had met some in other centers as well.

Authentic Ayurveda doesn’t allow for cross massage. A female therapist does the massage for females and male therapists do it for males. The higher number of female therapists also points to the fact that there is a larger proportion of females taking Ayurvedic therapies.

On asked why there are so many more females (some times the ratio is 1 male to 20 female guests), Abhilash said that it “Maybe because of the security. We strictly follow the authentic ….we don’t have non vegetarian in the restaurant, there is no alcohol, no bar there is no smoking even. We don’t allow that, it’s strictly against Ayurveda. When you follow Ayurveda you need to have a very light diet. Then body energy won’t be behind the food, to digest it….that maybe one of the reasons for ladies to come, because if there is no non veg and there is no alcohol, atmosphere will be peaceful…” On asked about cross massage he said that there is no question of doing cross massages. When I asked if they get requests for it he conceded that they do but added that “we don’t promote that, we don’t want to promote that.”

In one case at Somatheeram a person, after consultation by the doctor, had requested that he be given a ‘good girl’ and when he was told that his therapist will be male he said that he had paid and is willing to pay more. When they insisted, he apparently checked out.

While walking to Kairali one day, I met a couple of young boys outside a house where preparations for some event was going on. They introduced me to a person who worked as a gardener at Kairali. They also added that not many from around there worked in Kairali.
In terms of employment the situation was similar in Somatheeram. Nandika said that a majority of the therapists were from the same district in which the resort was located (Thiruvananthapuram), and some even from Chowara, the village around. Nirav, a local shop owner and resident of the village said that there are very few Somatheeram employees from there. There are some in gardening and house keeping, but not in office work. Many working in the office are from Ernakulam (Kochi/Cochin) or Kodamangala. He added that the villagers are not very educated and less educated people don’t get good jobs, they tend to get cleaning, kitchen and washing jobs. Prasad, a therapist who grew up in the nearby fishing village of Azhimalthura (Adimalathura) said that the hotels don’t bring any work for the village people. He felt that it was because they don’t want children of fishermen to be working there.

Apart from direct employment, some locals benefit in other ways, even though it is only to a limited extent. It is mostly in the form of a boost to some local businesses.

The road outside Somatheeram and Manalatheeram is dotted with textile/clothing and handicraft shops (Figure 6.3(b)), around 15 of them, which cater to the tourists. Most of these have been around for less than 10 years and still others opened very recently. The first shop outside Somatheeram opened about 16 years back. Many clothing shops have tailors who can fit the clothes to the customer’s liking. Their customers are not only from Somatheeram and Manalatheeram but also from other resorts and hotels close by. Some of the shopkeepers complained that the business hadn’t been very good, specially

---

143 Here, by office he meant the management and administrative jobs.
144 He is an Ayurvedic therapist and had approached the resort for a job. They asked for his certificates and bio data, which he provided them with, but he did not get the job. He felt that when they saw his CV and figured out that he was from that fishing village they didn’t want him. This could be a slightly exaggerated claim, given that there are therapists from Chowara working there. I don’t know that about Azhimalthura though. A part of this reaction could also be from the frustration of not getting the job.
that year. Some also felt that because of the treatments and therapies which follow a schedule not many tourists venture out as often and with the stairs at the backside of the resort leading directly to the beach they don’t have to walk through the road where these shops are. Compared to other tourists, people who have come for treatments and therapies tend to stay indoors more.\footnote{While undergoing Ayurvedic treatments and therapies there is restrictions on diet and exercise also. They are not supposed to swim, for example. Sometimes they have multiple massage sessions in a day.}

**Figure 6.3(a) Taxis near Somatheeram**  **Figure 6.3(b) Shops outside Somatheeram**

**Figure 6.3 (c) People selling food and handicraft at the beach**

Figures 6.3(a): a line of taxi cabs (one can tell from the yellow number plate) waiting along the boundary wall of Somatheeram Ayurvedic health resort, right next to Somatheeram Ayurveda Resort.  
Figure 6.3(b) Shops along the road leading to Manalatheeram(on the left) and the beach.  
Figure 6.3(c) In the cove right in front of Somatheeram and manalatheeram. People selling things to the tourists(from the resorts) on the beach.

Because tourists taking therapies also have to follow a light diet, which is made available inside, they don’t eat out much. Mohan, from Somatheeram said that for those undergoing treatment there is a diet chart and a copy of that is with the doctor, one with
the restaurant, one with the kitchen and one with the patient. He also added that “if you saw someone having beer, then he is not undergoing treatment.” On the road, with all the shops, there wasn’t a single restaurant or other eating place. Another thing to note is that most of these shops right outside the resorts were owned by outsiders, not only from outside the village but also from outside the state. Only a couple of shops belonged to locals. Most of the shop owners were from Kashmir, to the north of India, selling Kashmiri handicraft and from the state of Karnataka. They also seemed to have bigger and better shops. Some of the Kashmiri shop owners had been in other tourist places, like Kovalam, before, but came here recently hoping for better business than the over crowded Kovalam beach.

Apart from the shops lining the road, on the beach, right behind Somatheeram there are a few people with makeshift fruit salad and handicraft stalls (figure 6.33(c)). Stalls is probably not the right word here, they usually just sit on the rocky outcrop with a woven and sometimes not even woven coconut palm leaf shade and sometimes tourists stop by or sometimes they go with their wares to the tourists sunbathing on the beach chairs. Poornima, one of the women selling fruit salad to the tourists, said that she lives about 3 miles away from there. She takes the bus to get there and gets the fruits from the city. When I asked her if she managed to sell a lot, she said that some foreigners don’t like it that she keeps the fruit on a cloth while cutting it. She also added that during off season the sea levels are higher and so “no beach, no business.”146 Even for some of the other businesses it is a seasonal affair. While some shops, on the road, are open all year round some are only open for about six months during the peak season. There isn’t a whole lot of business during the off peak season.

146 She said that she had learnt English just from interacting with foreigners.
Taking off from Poornima’s point, about rising sea waters, the beach right behind Somatheeram and Manalatheeram is in a cove and during high tide it sometimes gets disconnected from the rest of the beach. People could still scramble up and down the rocks to get to it but because of being in the cove, despite being a government beach, it is almost like an exclusive beach. There, at the cove, they also have lifeguards and they tend to be from nearby. Mohan added that because they (the local lifeguards) have grown up there they understand the pulse of the sea better than anybody else.

As compared to Somatheeram, Kairali does not seem to have had such an impact locally. There were no shops that had opened to cater to the tourists. There could be a couple of reasons for that. Firstly, Kairali is the only resort/hotel in the area and that means there aren’t enough people to run shops for. As Abhilash had pointed out, during peak time they might have up to 50 guests (at one time) and up to 100 a month and given that Ayurvedic tourists tend to stay for longer than the usual leisure tourist, on a daily basis, there would be lesser chances of more tourists buying things from shops outside. Many big resorts also tend to have a handicraft/souvenir shop inside the premises. Secondly, at the time of the fieldwork, the resort had been around for less than ten years. It is possible that with time more of that happens, but it is not very likely. On asking Madhvan, a resident of the village, whether he foresaw more businesses opening there, he said that that might happen, people are slowly getting to know about this place but because there aren’t a lot of people it wouldn’t be very profitable to set up a shop. The

147 One day I was eating my lunch, sitting on one of the rock outcrops, just outside the cove, and the water was rising and I remember thinking that I should hurry and finish eating or else the rising waters would submerge the beach right in front of the outcrop and I would be stuck on the other side. That is where I also spotted some human feces. Apparently some villagers also use the beach to defecate, something Mohan, from Somatheeram, had also pointed out. They have apparently built 20-30 laterines, in cooperation with the local church because otherwise sometimes “in the morning it wasn’t a very good scene”
small local shop, right next to the resort, does have some customers from Kairali, but they are the staff, not the tourists. A local tea stall close by said that they did not get any business from the resort, not even the workers, because they have their own canteen. A few shops near the bus stop at the junction with the main road, about a mile away, get some customers from the resort. No new shops have opened after the resort opened. Some local shops have had some business from there.

So, in terms of creating employment or business opportunities there have been some benefits but a lot of that has also gone to outsiders. Traditionally being farmers or fishermen, probably not many local villagers had the resources to utilize that opportunity.

The following is not a local impact, but again taxes are a means of channeling money back to the public. This court case in the Kerala high court is particularly revealing.¹⁴⁸

The case of the petitioner (Kairali) is that, notwithstanding the nomenclature of the Company, the petitioner is actually running a 'hospital' and since 'hospital' was brought within the purview of the Kerala Luxury Tax Act, 1976 only w.e.f. 1.4.2008, the petitioner is not liable to be assessed in respect of the previous period.

The respondents have filed a counter affidavit, vehemently rebutting the pleadings raised from the part of the petitioner. With reference to the various documents produced along with counter affidavit as R1(a) to R1(e), it is sought to be substantiated that the petitioner's establishment cannot be regarded as a 'hospital' and that, it is actually a 'luxury retreat centre' with various amenities provided to the inhabitants, who are given accommodation on rent, which varies from Rs.2500/- per day to Rs.10,000/-per day. It is also pointed out that the facilities being provided as the alleged Ayurvedic Hospital is only optional for the inmates, who can avail of the benefit/amenity on payment of the additional amount prescribed in this regard.

Apart from the point made in the affidavit, that the treatment facility is optional, what is also important is the fact that they include a lot of wellness therapies under

¹⁴⁸ The whole judgement can be found in Appendix 6.1.
treatment, which technically they are, but to call it a hospital is stretching it a bit too far. Although Abhilash claimed that about 60% of their clients are there for treatment and the rest are there for wellness therapies, when I asked him what that 60% included, he said weight loss/obesity reduction packages, arthritis and other treatments. While waiting outside the treatment area, I met four women, all of them were there for a weight loss package and one of them said that she had come earlier and that this makes her feel very rejuvenated. It should be noted that the 60% might include a much smaller proportion of patients with serious ailments. Obesity and overweight can be a serious problem but these patients seemed more like wellness tourists. I am not, in any way, denying that they offer good treatment for a lot of different ailments or even for de-stressing and rejuvenation but the setting seems closer to a spa than to a hospital, so trying to avoid paying luxury tax based on this argument seems forced. There have been more court hearings after this and the final decision is not known.

II. Impacts on Infrastructure

While the resorts arrange for the tourists to be picked up and dropped off at the airport, some local transport gets a little benefit. Near Kairali, the three wheeler-auto rickshaws, running on the road leading to the main road, do get some tourists some times. Sometimes they get customers to go till the town of Palakkad also, but for sight seeing the resort arranges for it. Abhilash said that depending on the case, that is, if they do not have any travel restriction because of the treatment, they arrange for tours also. They take them to festivals, tourist places like Malampuzha (dam), the fort (in Palakkad town), Silent Valley and Nelliampathy. He said that there wasn’t any popular package as such.
Near Somatheeram there was a line of taxis waiting on the road, but apparently they don’t get many customers from the resort because the resort has their own cars and that has created friction between the resort and the taxi owners. Somatheeram had approached the court for police protection.\(^{149}\)

According to the petitioner (Somatheeram), it is a private limited Company engaged in the conducting of a Resort. It is also stated that they are providing Ayurveda treatment and Yoga there. It is the case of the petitioner that they have road transport facility for its staff as also the tourists and other persons who come to the Resort. It is the further case of the petitioner that whenever the in-house transport facility is not available for the petitioner, the tourist taxies of the party respondents, who are plying taxies in front of the premises of the petitioner, were made available. But of late, according to the petitioner, the party respondents have started creating unnecessary problems and do not permit the plying of the vehicles of the petitioner and always insist that the vehicles belonging to them should be made use of for the foreigners alone and none of the other persons of the petitioner Company.

In the respondents’ (local police and some taxi drivers) counter affidavit:

It is the case of the party respondents that they were issued with taxi permits by the competent authority. They say that most of the customers of the petitioner are tourists and now the petitioner has acquired 10 private owned cars with the intention to operate as Taxi services. According to the respondents, the ten cars owned by the petitioner's resort are privately owned cars and, therefore, they cannot be operated as taxi service for their customers and staffs.

The cars owned by the resort apparently also charge much more than the taxis outside. While talking to a few taxi drivers, outside of Heritage Travancore, a heritage hotel close to Somatheeram, one of them said that the hotel management discourages tourists from taking taxis from outside, saying that there is no guarantee, by which they mean that they (outside taxis) can’t be trusted.

\(^{149}\) Appendix 6.2 has the whole court judgement.
Although not a lot of locals seem to have benefited in terms of business and employment, what has worked in some residents’ favor is that the property values have gone up and the land sells for a much higher price now and they are also getting rent (from shops etc.). As some of the staff stay inside the resort and some travel in buses, from their homes, there are not many who stay in the village. Some of the shop employees live locally though.

The property value hasn’t increased just because of Somatheeram. A big stretch, along the beach, south of Kovalam and Vizhinjam has seen a tremendous growth of resorts and hotels but being one of the first ones it, in a way, started it. Ideal Ayurvedic resort and Dr. Franklin’s Panchakarma Institute and Research center opened in 1997 along the road leading to Chowara beach, Past Somatheeram. Dr. Franklin’s Institute started their God’s Own Country Resort recently. When I was there for the fieldwork final touches were still being made. Not just this road, but multiple roads leading up to the beach north and south of Somatheeram, have seen a lot of resorts and hotels open up. Being very close to Kovalam beach and having a very good beach of its own (Chowara) has been one of the reasons why it is such a popular destination choice for resorts and hotels. It has led to an agglomeration effect of sorts. Somatheeram’s importance in that can be gauged from a Azhimala property sale advertisement online, which read “the house is appropriate for starting Ayurvedic treatment center as it is very near to the beach, Somatheeram Ayurveda center.”

Kairali has not had any such agglomeration effect. As it is located far from any major tourist attraction, the possibility of agglomeration happening is pretty bleak. While

---

150 A screen capture of the advertisement can be found in Appendix 6.3.
talking to Abhilash he said that no other center has come up and that “Europe is very big, no problem of people coming. We are confident that we are giving them the best.” \(^\text{151}\)

III. Healthcare

Ayurveda has a more niche following so not everybody in the locality will use it. But even if they did, these ‘hospitals’, as Kairali claimed to be, would definitely not be the destination for them. The therapies and treatments available in these resorts are very expensive and they usually do limited kinds of therapies which is why locals would not go there. They could not afford to go there. Unlike most of the other states of India, the use of Ayurveda in Kerala is much more prevalent. Towns have multiple Ayurvedic pharmacies and there are a lot of government Ayurvedic hospitals and centers all over the state. When I asked Madhvan, a resident of the village close to Kairali, if he used Ayurveda he said that he uses Ayurveda only once in a while. He mostly uses ‘English’ medicine and if that doesn’t work, in case of joint pain or some swelling, he uses Ayurveda. He goes to Palakkad, if not to the Ayurvedic store nearby. Some resorts, like Athreya Ayurvedic Resort close to Kottayam and centers like Keraeeya Ayurveda Samajam in Shornur, apart from treating their wellness tourists also have an Out Patient Department (OPD) section for locals. \(^\text{152}\) Samajam, though, is more treatment oriented in general. Nothing of the sort happens in Somatheeram or Kairali.

From visiting various Ayurvedic centers of all different types, I felt that traditional Ayurveda families running an Ayurvedic center rather than businessmen (be it a resort or not) are more likely to have an OPD. The Samajam, run by a trust, are also

\(^{151}\) This was in response to if other centers have opened up after Kairali. He is, most probably, referring to the competition, if other centers open up.

\(^{152}\) I had briefly visited both these places during my fieldwork.
involved in Ayurvedic education. On the website of the Keraleeya Ayurveda Samajam are these words: “Beyond commercialization and competition, Samajam still remains on ethical lines in medical practice.”

All through my fieldwork the question of authenticity and commercialization was a point of discussion. While talking about this issue some of the government hospital practitioners, traditional family practitioners, and people in Ayurvedic education seemed slightly accusatory in their tone and the resorts, while conceding that there are issues of inauthenticity and commercialization of Ayurveda in some centers, had a more defensive tone. There were a lot of, “we know that happens (commercialization of Ayurveda) but we don’t do it” responses. Another side of the response was that most of these centers are just businesses and are in it for making money. They do not follow traditional Ayurveda and a continuation of this trend might destroy Ayurveda. Not following tradition includes cross massage, using soft beds for massages (traditionally the ‘pati’ or the bed on which massage is done is made of wood), shortening the treatment time to a few days or a couple of weeks where it is supposed to be for longer, letting patients go sightseeing or swimming in the sea while the treatments are on, and basically changing the traditional practices to accommodate the tourists’ whims and schedules. Many tourists see it as something meant for relaxation and don’t care much for the traditions anyway. Padmaja, a researcher I met in Kerala, said that she would like a spa-like treatment and would not care much if it was true to tradition or not.

The Ayurveda tourism industry seems to be filling in that demand by making compromises, something that is not seen as a good trend by some. And in this world of dispersed information sources it is hard to control the information. While in Thekkady, near the Periyar tiger reserve, I went into a Ayurvedic massage center. It had a soft ‘pati’

http://www.samajam.org/institution.html
with a rexin cover and the board outside read ‘Recommended by Lonely Planet’. I haven’t checked Lonely Planet to see if that claim is correct, but if it is, it indicates that traditional or not, some tourists just want a nice massage and they are fine with that idea of Ayurveda.

When asked if the Ayurveda students nowadays prefer the tourism sector to the hospitals and clinics, Dr. Akhilesh, a faculty member at the Government Ayurveda college said that it depends on the mentality of the individuals and if someone wants to earn more money then he or she would go to the tourism sector while if they want to be established as a good doctor they would go to the hospitals. He also mentioned that the government is building an Ayurveda hospital of international standards, where the treatment would be the same but the infrastructure would be much better. There they would treat foreign patients and wealthy patients also and will charge them accordingly and then use that money to treat the poor. I saw the site for this hospital in Poojapura in Trivandrum. The construction had already begun. He acknowledged that many centers do not follow traditional Ayurveda and for that very reason the health ministry was passing a legislation to curb unwanted practices in these centers, by putting regulations in place. He was part of the committee that put these regulations together. He also mentioned that the doctors association wanted this legislation to be passed because otherwise unqualified people were doing it. They want to make sure that these centers practice Ayurveda the right way. He also mentioned that for this purpose they had categorized Ayurvedic centers into hospitals, Ayurvedic centers which are not hospitals but where one can go take a treatment and come back, and then the hotels which have Ayurvedic centers (the

154 Just a note; These regulations are different from the olive leaf and green leaf certification given by the tourism ministry.
resorts are included in that). He added that centers in the third category would not be allowed to do serious treatments. It needs to be seen, if that will impact some of these resorts, if they did any of those ‘serious’ treatments to begin with or if it would not matter much because they were mostly doing rejuvenation and massages anyway.

Ayurvedic treatments have a lot of scope in terms of an alternate system of medicine but as some people pointed out that while Ayurveda tourism might be popularizing Ayurveda outside India, it is also important to keep it all within regulations, so that the right kind of word gets around.

IV. Conclusion

In terms of healthcare these resorts have meant no benefit to the locals at all because they are extremely expensive and mostly offer limited kinds of therapies. So, even if someone from nearby wants to get Ayurvedic treatment he or she will go to the nearby Ayurvedic hospital or clinic. While healthcare-wise these centers are not beneficial to local people, there have been some economic benefits from it, in terms of employment opportunities and boost to some businesses around, but they also seem to have been involved in some unfair practices, which seem to show that they want to keep most of the profit from the tourists, to themselves.

There definitely seems to be a larger scope for involving the local community in the process and building more goodwill. If they have genuine concerns about quality they could figure out a way to do that. As at Athreya Ayurvedic Resort, if the tourists want to go to the city they call local auto rickshaws. They have the contact number of some
drivers and they contact them whenever needed. They also know which driver can speak good English, for tourists who do not speak the local language and arrange accordingly. If the resorts are a little more willing to engage with the local community both parties could benefit from the tourists coming to these resorts.
Chapter 7
Comparison of medical and wellness tourism centers

Both western medicine/treatment and the ancient system of Ayurveda have, in the recent decade, seen a big growth happening at the same time, although for the most part independent of each other. They seem to cater to different demographics and, in terms of their impacts, have similar ones in some cases and different in the others. The rationale behind comparing this is not to conclude whether one is better than the other, because they are very different on various levels, but it would still be interesting to see how they compare and see which one has a higher level of “enclaving”.

I. Location

While the medical tourism centers have tended to locate in the bigger cities, mostly in the biggest metropolitan cities, the Ayurvedic centers are found mostly away from big cities and have tended to gravitate towards rural areas, mostly close to some popular tourist destination.

While accessibility and infrastructure and access to super-specialized human resources has been an important factor for medical tourism, one of the bigger draws for wellness tourism has been its location in natural settings, away from the crowded cities. Given that Kerala is a hotspot for Ayurveda and the whole state has an abundant supply of greenery and beautiful locations, it is not very surprising that Ayurveda tourism is so popular there. For Ayurvedic centers, the ambience and the surroundings form an important part of the image that is sold. Although one could argue that the high-tech infrastructure and modern hospital buildings that form the hospital ambience, are also
part of the image that is sold, especially when they want to convince prospective patients that the facilities are at par with that of any developed country.

The Ayurvedic centers are more physically insulated from their surrounding areas as compared to the hospitals. One cannot see from outside what the inside looks like. For hospitals it is easy to see what’s within the boundary walls, but the Ayurvedic resorts are well hidden among the trees and behind the walls. It is a much more private space.

II. Patient demographics

While patients coming for medical tourism mostly come from South Asia, Middle East and Africa a large number of the Ayurvedic wellness tourists are Europeans. The medical tourism centers still predominantly cater to Indians and the proportion of foreigners is much higher in the Ayurvedic centers. Locals getting treatments in the Ayurvedic resorts is almost nil, this is relatively better in the medical tourism centers where at least some, with the capacity to pay or with access to insurance, go to these centers. Ayurveda also has a lot of internal medications for treatment but the resorts predominantly do oil massages and supplement that with internal medication; and oil massages are expensive and very few resorts or centers have an OPD.

The medical tourism centers cater to a much larger number of patients, not only because of their larger capacity (number of beds etc.) but also because the patients’ average length of stay of tends to be shorter. Also, Ayurveda is a very niche market. In the year 2009-10 Indraprastha Apollo had 36,583 inpatient admissions, of which the number of international patients were 5,030 (Economic Times, March 2010). Data for a comparable year is not available, but the annual figure for Somatheeram is about 3000
and that of Kairali is less than a 1000. The average length of stay at Apollo for 2009-10 was less than 5 days while the wellness tourists stay for a week to two weeks and some stay much longer. Also, in the wellness centers treatment is optional. There are also people who do not get any treatment done.

In general, the more the number of patients/tourists the more is the possibility of higher local impacts.

III. Treatments

While the medical tourists mostly come for curative treatments some of the Ayurvedic therapies are mostly preventive therapies for de-stressing and rejuvenation. They are done more for holistic health rather than cure for specific ailments, especially in the resort and hotel setting. Ayurveda as a system of medicine has been very effective in curing ailments such as arthritis, other joint problems, psoriasis, etc. and many patients have gone in for Ayurveda after western medicines failed to bring much relief and found relief in Ayurveda. Although there are a lot of Ayurvedic patients getting treatment for such ailments, most of the resorts, spas/hotels with Ayurvedic centers and small Ayurvedic massage centers do not cater to many such patients, with a few exceptions.

The most popular treatments in the medical tourism sector are cardiovascular, orthopedic, cosmetic, dental, optic and bariatric. Many of these treatments include surgery. Ayurvedic treatments, on the other hand, are mostly non-invasive, including oil massages, internal medication and diet control.

In terms of a system of medicine and also as a leverage point for advertising it to prospective patients, medical and wellness tourism hold up contrasting ideas. Medical
tourism stresses the modern while Ayurvedic wellness tourism stresses traditional and ancient. So, it is ancient wisdom on the one side and the marvels of the jet age on the other, and both seem to have plenty of takers!

IV. Economic impacts

In terms of creating direct and indirect employment, business and other economic opportunities, the impact has been mixed.

A. Employment:

In terms of numbers, the medical tourism centers generate a lot more employment, just by virtue of the difference in the scale of operation; catering to a much larger number of patients and treatments. The exact number is not available for all the centers but as Akash, from Escorts, pointed out, Escorts employs about 1600 people and that number for Kairali is around 60. The proportion of local employment in both cases was small and was mostly restricted to cleaning, security and other less skilled jobs. Another thing that was different between the two was that most of the staff in the medical tourism centers was from outside the state while in the wellness tourism centers they were predominantly in-state and also to a large extent from the same district. One of the reasons for that is Ayurveda is very popular in Kerala and has a lot of Ayurvedic education centers (colleges, therapist training centers etc.) so even the ‘medical’ staff is predominantly in-state. A lot of the nurses in the medical tourism centers, even in Delhi, happen to be from Kerala. Another reason is that Delhi, being a metropolitan area, has a lot of workers from outside the state, in general.
B. Other economic benefits:

Other economic benefits include opening up of new businesses and boosting existing ones. Some new shops have opened close to the medical tourism centers, although it is hard to pinpoint that as the sole reason, because they are located in areas where a lot of other developments are also happening. The shops that have opened also cater to the local residents, unlike in the case of wellness tourism where most of the new shops that have opened are meant only for the tourists. Locals do not have much use for a handicraft store in their village. In both cases, a lot of the newer shops, whether of use to residents or not, are not necessarily owned by locals.

There is some informal sector work as well, be it people roaming around with food/handicrafts on the beach or the makeshift tea stall or juice stand catering to the tourists/patients and the staff or even a makeshift barber shop.

Another effect has been that guest houses have opened up, close to the hospitals, to accommodate patient attendants and even patients in the recuperation stage. Local residents have also started renting out rooms in their houses to patient attendants and also to the hospitals staff. Unlike the areas close to hospitals the neighborhoods around the Ayurvedic resorts do not get a lot of renters. This is not only because there are not a lot of people there but that there is not a patient attendant in most cases. People may be traveling with friends and family, but everybody stays in the resort and also gets some therapies. So, the accommodation sector has not benefited as much close to the Ayurvedic resorts, as have the ones around the hospitals. Most of the staff also do not live in the nearby village. Some stay inside the resort while quite a few of them travel from
home each day because their homes are not very far. And as far as the tourists are concerned, not only does the whole party stay together they also do not venture out much as they have food restrictions and the resort provides food inside. There are not any restaurants or eating places close by. Some resorts have handicraft stores of their own, inside. They also arrange for entertainment, like Kathakali, a traditional dance form or Kalaripayattu, a traditional martial art from Kerala or other programs. The hospitals also have eating places inside but people still eat outside, especially if they are living outside in a guest house, hotel or a rented room.

Some patients and/or their attendants also combine a leisure trip to some tourist place but for the wellness tourists the treatment is a part of a leisure trip. Also, the Ayurvedic resorts would be considered a part of the hospitality industry but the hospitals are not, at least yet. In terms of tours, the Ayurvedic resorts seem to be taking more of it into their own hands than the hospitals who do provide assistance to some medical tourists or their attendants, in the event that they are interested in a tour, but that assistance is mostly limited to pointing them towards tour operators, travel agents or hotels etc. who deal in travel and tourism on a more regular basis. There is also a new link in the chain, the medical travel agents or facilitators, who bridge that gap and arrange for the treatment as well as a leisure trip to go with it.

V. Impact on local property

In both cases the property values have increased but the centers are not the only reason for the increase. While close to the hospitals the rentals have gone up and the accommodation sector has received a boost the area close to the resorts have benefited
because of the growth of tourism in general. The resorts contribution has been very important though. While the impact near the hospitals included more places being rented out and more guest houses opening up, close to the Ayurvedic centers, the impact has been even more Ayurvedic centers and hotels, more so if they are close to some popular tourist destinations. Some resorts are the cause of the agglomeration while others are the result of it.

One difference in the two cases is the land acquisition and sale. While the sale of land in Kerala has been a direct transaction between the seller and the buyer, in Delhi the land has been acquired by the DDA and then been sold/auctioned to hospitals, and the land acquisitions have not always given adequate compensation to the original landowners. Although it’s not known how much Somatheeram or Kairali paid for the land, but it will be a relatively safe guess to say that because they were among the first ones to buy land in those localities, they probably got the land cheaply. Now with the increase in the property values, the newer resorts and hotels would pay much more.

What remains of the village in Delhi, where these hospitals and some of the other more recent developments stand, is the residential part of the village. ‘Development’ has pushed them from all sides into what today are these urban villages. In the beachfront Ayurvedic centers the push has been a linear one, away from the beach. With more of the sea front land being bought by more resort and hotel developers, the beachfront does not have many locals living there. There is a line of hotels and resorts along the beach and the villagers are mostly inside of that beachfront row of hotels.
VI. Conclusion

When it comes to impact on locals, both the medical as well as the wellness tourism centers leave a lot to be desired, but the wellness tourism centers seem to be more insulated from their immediate surroundings, both physically and in terms of flow of benefits. While direct comparisons are not valid, because the scale of operation is different, the facilities they provide are different and they are also different when it comes to one being a niche market and the other being a more widespread system, but despite all that there is more scope for local engagement. It could be less of a bubble.
Chapter 8

Conclusions

I. Wellness tourism centers

In terms of being physically cut off from the surrounding environs the Ayurvedic resorts are ‘enclavic’ spaces. Not only are the resorts physically sealed off with boundary walls and cliffs and gates with security guards, there is also very little interaction between the tourists and the locals. Tourists venturing out into the village, beyond the shops, was not very common. There were a few porous moments, so to speak, like tourists going out for a walk on the main village road, close to Kairali, or stopping by local shops near the bus stand. For many tourists though, they were picked up from the airport and they spent their days inside the resort getting treatment, eating inside and going on tours arranged by the resort management and, in the end, being dropped off at the airport. As the major tourist destination near Somatheeram was relatively close, the tourists could go on their own also; but in Kairali, being away from major tourist destinations, the tours were mostly arranged by the resort. While Kariali visitors went into the village for walks once in a while, visitors in Somatheram could just walk down the steps on the sea facing side of the resort, to go to the beach, again, avoiding the road and the people outside. And despite being in a public space, as the beach was public, they still seemed to be in their own little private space. I did not see a many locals on the beach in the cove. Just beyond the cove, where the beach extended for a long stretch, were a lot of fishing boats, resting on the sand (Figure 8.1). I was told by Mohan, that sometimes, on request, the fishermen take tourists on their boat. Every time I went to the beach I saw the boats in this state. Maybe when they head out or come back from fishing and tourists are out on the beach
they request rides from them. Here the guarding of the beach/cove was not so obvious\textsuperscript{155}, like it was in Varkala beach, another beach in Trivandrum that is very popular with foreign tourists. The small beach with a cliff running along it is almost entirely filled with foreigners and some of the locals were saying that they are not allowed on the beach,

\textbf{Figure 8.1 fishing boats on Chowara beach, just outside the cove}

because that is apparently a security issue. It is a public beach! So, the enclaving is not just physically enclosing it but also minimizing outside interaction wherever possible; and as some of these resorts sell these packages as something to get away from the daily life and the chaos, other than the rejuvenation therapies, that is what the visitors are being provided with. And unlike Kovalam beach, it is the resorts, which off course includes the sea view, that are the destinations rather than the beach itself.

\textsuperscript{155} Although, one day when I was sitting on the rock outcrop on the edge of the cove a lifeguard came and asked me what I was doing there, but the tone seemed genuinely inquisitive. Wearing a salwar Kameez, and with papers and a pen I did not quite fit into the tourist picture and I also did not quite look local.
If the average length of stay is long because they are getting some therapies, they are not going to go and buy handicrafts and clothes every day. It is establishments like restaurants that would benefit from a longer stay of the tourists, some service that is required daily, but with food restrictions while the therapies are on, tourists do not eat outside much. Although this might be working both ways in that there are not any restaurants or small eating joints outside, so tourists do not venture out to eat; but the locals also know that because of the food restrictions there would not be a whole lot of customers, and they cannot run a business based just based on the few that do not get therapies.

One of the reasons why governments promote tourism, apart from the foreign exchange, is that it has multiplier effects and improves the economic opportunities available to the locals. Also, as mentioned in chapter 2, according to the Global code of ethics for tourism adopted by the United Nation, World Tourism Organization General assembly in 1999, “local population should be associated with tourism activities and share equitably in the economic, social and cultural benefits they generate and particularly in the creation of direct and indirect jobs resulting from them” (Singh, 2008). I am not suggesting that they change their therapies because there are concerns about the authenticity of the therapies being given also\textsuperscript{156}, but given that constraint, the resorts could try to work with the locals to find ways to share the benefits. For example, at Somatheeram they sometimes buy eggs and meat locally but if the quality is not good then they do not take it. It is not clear if they do that for fish as well. It is located right next to a fishing village. The concern for quality and regular supply is genuine but given

\textsuperscript{156} Although they do tweak the treatment themselves. They own a houseboat (very popular among tourists in Kerala to spend time on luxurious house boats on the backwaters) and they fix the treatment time according so that they can go to Alleppey and spend the night there.
the fact that the fish that is available in the city is also caught by some fisherman and that the patients mostly eat vegetarian food and less fish is consumed in the resort, they could work out a way to deal with the quality and regularity issue. Maybe they can have multiple suppliers. Kairali has its own vegetable garden and they use that for food and get the rest from the city. The villagers do not grow vegetables. They mostly cultivate paddy and have coconut trees. Kairali has enough coconut trees to fulfill their need for coconut, given that Kerala cuisine uses a lot of coconut in their cooking. They could also try and involve some villagers in growing food for them. Given that the farm sizes are not very big and that the villagers might not want to give up on their traditional crop of paddy, not everybody would be eager. Also, given the location and lesser chances of more resorts opening there, which might push for putting up more shops, they could work something out with the locals, with the given situation in mind. As I had mentioned towards the end of chapter 6, some resorts do work things out with the locals. Athreya resort has the numbers of auto rickshaw drivers and they call them when tourists need a ride to Kottayam city. There are autos plying on the road connecting it to the main Chittoor - Palakkad road and they can also work something out, along the lines of Athreya resort. Somatheeram could also arrange something with the taxi drivers lining up outside the resort. As discussed in chapter 6, Somatheeram has acquired a fleet of 10 cars that are not registered as taxis and that has irked the local taxi drivers, because that also reduces their customer base. When both the parties were called to the police station a demand was raised that the services of the resort cars and the taxis outside be used in a ratio of 1:1 but that request was not acceded (Appendix 6.2). This suggestion of using the taxi services, along with their own cars, is a very pragmatic solution. They could have an
understanding between the taxi drivers about rates etc. The stand that the resort has taken is not only reducing work opportunities for the taxi drivers but also vitiating the environment and creating ill will.

A phone booth owner close to a resort in Kumily/Thekkady, was complaining that they have everything inside, phone and internet. They also have entertainment programs, like Kalariayattu (traditional martial art form of Kerala) performances inside the resort. I had gone to a performance of Kalaripayattu in a local arena in Kumily and that was very close to the resort. In taking the entertainment inside they are maybe catering to tourists who do not like venturing out much, but they could use the presence of the arena close by and encourage the tourists to go there instead. The performance there is also predominantly done for tourists, but by going there they will at least be moving out a little from their bubbles. Sometimes it is hard because the resorts and hotel are trying to provide what the tourists want, but they can make subtle changes and encourage more intermingling.

Most of the suggestions I have, in this case, are more at the individual resort level and not a government policy level, because the states direct investment in these projects is not very high, although they do a lot of promotion and now some Ayurvedic resorts are also eligible to get the Marketing Development Assistance for travel marts and expositions, they are not given as many financial perks as the corporate hospitals. They also do not contribute at all to local healthcare, very few Ayurvedic resorts have an OPD. Not all ailments require expensive oils and if they really claim to be serious about treatments and claim to be a hospital, so that they do not have to pay luxury tax, they can have an OPD or something along the lines of what is there at Athreya Ayurvedic Resort.
and Kereleeya Ayurveda Samajam, where they treat patients from close by also, and because in Kerala there are a fair number of Ayurveda followers some locals might benefit as well.

II. Medical tourism centers:

Although, compared to the wellness center the medical tourism centers seem to be an enclave to a slightly lesser degree there still are a whole lot more possibilities for an improved outward flow of benefits. Being a hospital they cannot really stop anyone from going in but many locals have a “this is too expensive, would not dare go in” kind of a reaction to the place. Some of the hospitals also have a lot of security guards, which ends up making the place seem more inaccessible.

The question about these centers, apart from the economic and health benefits is that they have received a lot of perks and concessions. As has been discussed in various places through the dissertation, these centers have received land concessions along with tax and import duty reductions. The question is, should they continue to receive that or not? All the hospitals in this study had received land from the Delhi Development Authority at concessional rates, to treat a certain percentage of their patients, who are poor, for free, but they have not been following up on that. The Delhi High court has fined Apollo for non-compliance and even the Supreme Court has impressed that the hospitals that received land on concession should follow up on their lease agreement. As Ajay from Social Jurist pointed out, the DDA has stopped giving land on concessions after this experiment failed and now all lands are auctioned. Despite that the lease agreement should be enforced more stringently. As Ajay had also pointed out, the land
had a social purpose and letting the hospitals get away with it would be a loss. It is a good thing that hi-tech tertiary care is available to people but if it cannot be made more widely available the government should not be subsidizing it. And not only that, the hospitals are paying less taxes as well. So they are not treating the poor for free, getting subsidies and not even giving back by way of taxes. They are big corporate chains, profit making ventures and nowadays they have started raising money from the market. The government should rather invest in primary health care.

Another point to be noted is that medical tourism has not explicitly made a whole lot of difference because those guest houses and rental places where the staff live would be occupied even if the international patients were not there. A lot of domestic patients who have come from outside Delhi also use these services. The proportion of international patients living outside is small and the western patients do not live in the guest-houses and rented places.

III. Conclusion

These centers are falling short on what they are supposed to do. In the case of medical tourism centers, although they are legally bound to treat a certain percentage(below poverty level) of patients for free they are not doing so. The government should see to it that this is enforced and given that this mode of public private cooperation did not work, think of other ways to make the advanced healthcare more widely available and also not to lose track of the basic problems with poor primary healthcare and healthcare expenditure in general. The high court has fined Apollo for not following the lease agreement but the amount it was fined was very small. These
hospitals are located on prime land, which they got for very cheap and it is only fair to ask for what is due. Harsher steps need to be taken on hospitals that are not following the lease agreement.

These hospitals are also receiving Marketing Development Assistance to participate in international health fairs and expos; a platform that they can use to get more patients and hence increase their profits. The government should be judicious in doling out money for promoting the private sector to international patients, especially if that is not going to help improve access for domestic patients. It’s not as if the hospitals are going to use the revenues from the international patients to subsidize other patients in need.

In terms alternative means of improving access to health care, one doctor I had spoken with had suggested changing the insurance system from the grassroots. He mentioned the Yeshasvini health insurance scheme, first proposed by Narayan Hrudalaya’s Dr. Devi Shetty. The key players in this scheme are the Yeshaswini health trust and the Government of the state Karnataka, the department of cooperation. A study available on the National Institute for Health and Family Welfare website explains the initiative. This initiative was undertaken to cater to the major health concerns of rural people. It is based on the idea that an independent administrator receives bids from hospitals and in exchange the hospitals offer low rates for certain major operations. Many hospitals running at low occupancy rates also benefit from it. It is a group scheme and only covers surgeries. The scheme is self funded and does not have coverage from any insurance company.
Apart from the hospitals following up on their lease agreements, the state governments could work on a similar scheme with the hospitals as well. This scheme mainly covered rural people but there are plenty of urban poor who could benefit from such a scheme.

Tough situations need creative solutions and that seems to be the need of the hour, but giving a free ride to the private sector definitely should not happen.

IV. Future research:

This study has answered some questions but has also raised some more and left some unanswered. To take this research further a comparative study of Ayurvedic resorts with Ayurvedic hospitals could be done to see how different the impacts are. As mentioned in chapter 6, Government of Kerala is also starting an international standard Ayurvedic hospital in Pujapura where medical tourists would be treated and would be charged higher and that money used to treat people who cannot afford to get the treatment. Following up on that could improve the scope for a better comparative impact assessment.

Also, in the recent past new “Medicities” have come up, a couple of which are in the National Capital Region, in Gurgaon. One of the medi-cities is owned by Fortis. As these medical tourism centers become bigger and possibly more exclusive a study of these centers could add important information on trends and change in the level of impacts or enclivity.

---

157 Some of the big integrated health care facilities that have opened in India recently are being called medicities.
The current research delved more into finding out what the impacts were but did not get to finding the extent of it. Most of the figures in terms of employment and businesses were estimated figures. A more in depth study of individual centers could be done to get data on the real extent of the impact and the numbers could be used to do a multiplier analysis.

Medical tourism is a fast growing industry in India and also in other parts of the world. As the relatively nascent industry figures out the nuances of its workings a lot will change in how the industry works and how things move within the system, the integration of tourism and health and that of health and wellness. There will be more opportunities to study those changes and how those changes impact the current relationship of these centers with the communities around them.
References:


http://www.expresshealthcare.in/200710/coverstory01.shtml (October 2010).

FICCI-Ernst &Young. 2006. *Opportunities in Healthcare ”Destination India”*. Report of a study conducted by Ernst & Young.


Kumar P. Sept. 23, 2009. Apollo fines Rs. 2 lakh for not treating poor patients. *India Today*. 
http://indiatoday.intoday.in/site/story/Apollo+fined+Rs+2+lakh+for+not+treating+poor+patients/1/63079.html (April 2011).


MoT, Government of India, 2006. Incredible India newsletter. Vol. 43


National Institute for Health and Family Welfare. Harvare study; Karnataka Yeshaswini Health insurance Scheme.


Interviews, of management and local residents and businesses, cited (Pseudonyms):

Abhinav, Personal interview
Abhilash, personal interview
Ajay, Personal interview
Akash, Personal Interview
Akhila, Personal interview, Avantika, Personal Interview
Balmohan, Personal interview
Chandresh, Personal interview,
Jayant, Personal interview
Kumar, personal Interview
Madhyan, Personal interview
Mohan, Personal interview
Nandika, Personal interview
Nirav, Personal interview
Poorniam, Personal interview
Rahul, Personal Interview
Appendix 4.1:

Green leaf and Olive leaf certification

Criteria for Olive Leaf Certificate

For obtaining Olive Leaf Certificate, Ayurveda centres should observe the following criteria.

i) Technical Personnel:-

a) The treatments/therapies should be done only under the supervision of a qualified physician with a recognised degree in Ayurveda.

b) There should be at least two numbers of masseurs (one male and one female) having sufficient training from recognised Ayurveda institutions by the Government.

c) Following the Kerala tradition, male will be massaged only by male masseurs and female by female masseurs.

ii) Quality of Medicine and Health programme:-

a) The centre will offer only those programmes, which are approved by the approval committee.

b) The Health programmes offered at the centre should be clearly exhibited. The centre should also exhibit the time taken for normal massage and other treatments. The generally approved time limit for a massage is 45 minutes.

c) The medicine used should be from an approved and reputed firm. These medicines should be labeled and exhibited at the centre.

iii) Equipments: - The Centre should have at least the following equipments.

a) One massage table of minimum size 7 feet x 3 feet in each treatment room, made up of good quality wood/fibre glass.

b) Gas or electric stove.

c) Medicated hot water facility for bathing and other purposes.

d) Facilities for sterilisation.
Every equipments and apparatus should be clean and hygienic.

iv) Facilities: -

a) Minimum two numbers of treatment rooms (one for males and one for females) having minimum size of 100 sq.ft with width not less than 8 feet. The rooms should have sufficient ventilation and it should be with attached bathroom of size not less than 20 sq.ft. The toilets should have proper sanitary fittings and floors and walls should be finished with proper tiles.

b) One consultation room having minimum size of 100 sq.ft with width not less than 8 feet. The room should be equipped with equipments such as BP apparatus, stethoscope, examination couch, weighing machine etc.

c) There should be a separate resting room of minimum size 100 sq.ft with width not less than 8 feet, if the centre is not attached with a hotel/resort/hospital.

d) The general construction of the building should be good. Locality and ambience, including accessibility, should be suitable. Furnishing of rooms should be of good quality. The entire building, including the surrounding premises, should be kept clean and hygienic.

Criteria for Green Leaf Certificate

The basic facilities required for Green Leaf Certificate is the same as Olive Leaf. In addition to the requirements for Olive Leaf, the following additional facilities also are essential to get Green Leaf Certificate.

i) The general construction, architectural features etc of the building should be of very high standard. The furnishing curtains, fittings etc should be with superior quality materials.

ii) There should be adequate parking space in the premises.

iii) The bathroom should have facilities for steam bath.

The following are additional desirable conditions to get Green Leaf Certificate.

i) There should be separate hall for meditation/yoga.
ii) The centres should be at picturesque locations with greenery in abundance and quiet atmosphere.

iii) There should be herbal garden attached to the centre.

**Procedure for Classification**

1. Every person operating an Ayurveda centre in the State and is desirous to get classification from Department of Tourism, Government of Kerala apply for Classification in the prescribed form. The application form will be available at Directorate of Tourism free of cost. All the application duly filled shall be addressed to Director, Department of Tourism, Park View, Thiruvananthapuram – 33.

2. A fee of Rs.2,500/- shall be enclosed with the application form by way of Demand Draft drawn in favour of Director, Department of Tourism, Park View payable at Thiruvananthapuram.

3. Director, Tourism shall unless the approval is refused, issue a classification certificate to the centre on the recommendation of a committee consisting of the following members, after inspection.

   i) Director, Tourism - Convenor
   ii) Director, Indian Systems of Medicine - Member
   iii) Professor Kayachikitsa, Government Ayurveda College, Thiruvananthapuram - Member
   iv) Representative of Ayurveda College Kottakkal - Member
   v) Representative of Indian Association of Tour Operators - Member

   The committee should specify the health programmes, which can be offered by each centre considering their facilities.

4. The period of Classification will be only for three years. After the expiry of the classification period the centre has to apply for re-classification afresh. In case of Ayurveda centres already approved by Department of Tourism under the existing scheme, have to apply for classification afresh if they desire to get classified. Otherwise these approved units will be separately considered as only ‘approved Ayurveda centres’ till the expiry of the period of approval.

5. The Department has prescribed regulatory conditions to be abided by promoters of classified Ayurveda centres. The promoters should furnish the acceptance of these regulatory conditions in the prescribed form and execute an agreement on stamp paper of Rs.50/- on this.

**Incentives to classified Ayurveda centres**

Only the Ayurveda centres, which are classified/approved by Department of Tourism, will be eligible for claiming 10% state investment subsidy or electric tariff concession offered by Department of Tourism, Government of Kerala. Only these centres will be
considered for giving publicity and promotion through print and electronic media by the Department.

Source: Website of the Ministry of Tourism, Kerala.
http://www.keralatourism.org/classificationofAyurvedacenters/AyurvedaClassification.html
<table>
<thead>
<tr>
<th>Particulars</th>
<th>Consolidated</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quarter Ended March 31</td>
<td>Year Ended March 31</td>
<td></td>
</tr>
<tr>
<td>1. Income from Operations</td>
<td>32,590</td>
<td>82,575</td>
<td>52,002</td>
</tr>
<tr>
<td>(A) Operating income</td>
<td>32,590</td>
<td>82,575</td>
<td>52,002</td>
</tr>
<tr>
<td>2. Total income</td>
<td>32,952</td>
<td>83,794</td>
<td>63,069</td>
</tr>
<tr>
<td>(A) Material Consumed</td>
<td>9,061</td>
<td>22,257</td>
<td>16,850</td>
</tr>
<tr>
<td>(B) Other operating expenses</td>
<td>2,232</td>
<td>18,590</td>
<td>14,730</td>
</tr>
<tr>
<td>(C) Net Depreciation &amp; Amortization</td>
<td>2,300</td>
<td>3,584</td>
<td>4,374</td>
</tr>
<tr>
<td>(D) Gross Profit</td>
<td>12,045</td>
<td>22,257</td>
<td>20,815</td>
</tr>
<tr>
<td>(E) Tax expense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Profit (Loss) from Ordinary activities</td>
<td>2,312</td>
<td>7,062</td>
<td>2,171</td>
</tr>
<tr>
<td>(F) Tax expense</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Net Profit (Loss)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(G) Dividend / Losses attributable to shareholders of the Company</td>
<td>2,179</td>
<td>2,082</td>
<td></td>
</tr>
<tr>
<td>5. Diluted Earnings Per Share (EPS) before extraordinary items (in Rs.) for the period, for the year to date and for the previous year (not annualised)</td>
<td>1.02</td>
<td>0.92</td>
<td>0.64</td>
</tr>
<tr>
<td>6. Public shareholders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Percentage of shareholding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Promoters and promoter group shareholding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5.1(b)

Financial report from the annual report for Fortis Healthcare Ltd.

<table>
<thead>
<tr>
<th>CONSOLIDATED PROFIT AND LOSS ACCOUNT FOR THE YEAR ENDED MARCH 31, 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For the Year Ended</strong></td>
</tr>
<tr>
<td><strong>March 31, 2010</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Rs. in lacs</th>
<th>Rs. in lacs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Operating Income</td>
<td>93,794</td>
<td>63,059</td>
</tr>
<tr>
<td>Other Income</td>
<td>4,931</td>
<td>2,835</td>
</tr>
<tr>
<td></td>
<td><strong>98,725</strong></td>
<td><strong>65,894</strong></td>
</tr>
<tr>
<td><strong>EXPENDITURE</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials Consumed</td>
<td>26,267</td>
<td>18,954</td>
</tr>
<tr>
<td>Personnel Expenses</td>
<td>19,900</td>
<td>14,736</td>
</tr>
<tr>
<td>Operating Expenses</td>
<td>24,130</td>
<td>14,329</td>
</tr>
<tr>
<td>Selling, General and Administrative Expenses</td>
<td>9,765</td>
<td>6,449</td>
</tr>
<tr>
<td></td>
<td><strong>79,663</strong></td>
<td><strong>54,469</strong></td>
</tr>
<tr>
<td><strong>Profit before Financial Expenses, Depreciation and Amortisation</strong></td>
<td><strong>19,362</strong></td>
<td><strong>11,425</strong></td>
</tr>
<tr>
<td>Financial Expenses</td>
<td>5,729</td>
<td>4,366</td>
</tr>
<tr>
<td><strong>Profit before Depreciation and Amortisation</strong></td>
<td><strong>13,333</strong></td>
<td><strong>7,059</strong></td>
</tr>
<tr>
<td>Depreciation and Amortisation</td>
<td>6,162</td>
<td>5,050</td>
</tr>
<tr>
<td>Loss: Transferred from Revaluation Reserve</td>
<td>168</td>
<td>176</td>
</tr>
<tr>
<td></td>
<td><strong>13,333</strong></td>
<td><strong>7,059</strong></td>
</tr>
<tr>
<td><strong>Profit before Tax and Prior Period Items</strong></td>
<td><strong>7,339</strong></td>
<td><strong>2,185</strong></td>
</tr>
<tr>
<td>Current Income Tax</td>
<td>1,532.56</td>
<td>308</td>
</tr>
<tr>
<td>Loss: MAT Credit Entitlement</td>
<td>77.53</td>
<td>204</td>
</tr>
<tr>
<td>Deferred Tax Charge/ (Credit)</td>
<td>(1,120)</td>
<td>207</td>
</tr>
<tr>
<td>Fringe Benefit Tax (includes Rs. 0.55 lacs (Previous Year Rs Nil) for earlier years)</td>
<td>1</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td><strong>7,339</strong></td>
<td><strong>2,185</strong></td>
</tr>
<tr>
<td><strong>NetProfit after Tax and before Prior Period and Extra-ordinary Items</strong></td>
<td><strong>7,003</strong></td>
<td><strong>1,774</strong></td>
</tr>
<tr>
<td>Less: Prior Period Items</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>Add: Extraordinary Item</td>
<td>-</td>
<td>640</td>
</tr>
<tr>
<td></td>
<td><strong>7,003</strong></td>
<td><strong>1,774</strong></td>
</tr>
<tr>
<td><strong>NetProfit before Minority Interest and Share in profits/ (losses) of Associate Companies</strong></td>
<td><strong>7,001</strong></td>
<td><strong>2,406</strong></td>
</tr>
<tr>
<td>Less: Profits attributable to Minority Interest</td>
<td>209</td>
<td>274</td>
</tr>
<tr>
<td>Add: Share in current year profits/ (losses) of Associate Companies</td>
<td>156</td>
<td>(50)</td>
</tr>
<tr>
<td></td>
<td><strong>7,001</strong></td>
<td><strong>2,406</strong></td>
</tr>
<tr>
<td><strong>NetProfit attributable to the shareholders</strong></td>
<td><strong>6,948</strong></td>
<td><strong>2,082</strong></td>
</tr>
<tr>
<td>Add: Balance brought forward from previous year</td>
<td>(24,795)</td>
<td>(36,877)</td>
</tr>
<tr>
<td></td>
<td><strong>(17,847)</strong></td>
<td><strong>(24,795)</strong></td>
</tr>
</tbody>
</table>

**Earnings Per Share** [Nominal value of shares Rs. 10 each]

<table>
<thead>
<tr>
<th><strong>Basic</strong></th>
<th><strong>Diluted</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Including prior period and extra-ordinary items</td>
<td><strong>2.61</strong></td>
</tr>
<tr>
<td>Excluding extra-ordinary items</td>
<td><strong>2.61</strong></td>
</tr>
</tbody>
</table>

**Source:**
## Appendix 5.1(c)

**Apollo Hospitals Enterprise Limited**

Regd. Office: No. 19 Bishop Gardens, Raja Annamalapuram, Chennai - 28

Audited Financial Results for the Quarter/Year ended 31st March 2010

<table>
<thead>
<tr>
<th>S.no</th>
<th>Particulars</th>
<th>Quarter Ended (Rs.in Lakhs)</th>
<th>Year Ended (Rs.in Lakhs)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Audited</td>
<td>31.03.2010</td>
</tr>
<tr>
<td>1</td>
<td>(a) Income from Services</td>
<td>48290</td>
<td>39106</td>
</tr>
<tr>
<td></td>
<td>(b) Other Operating Income</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total Income</strong>(a+b)</td>
<td>48290</td>
<td>39106</td>
</tr>
<tr>
<td>2</td>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(a) Increase/Decrease in Stock in trade</td>
<td>328</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>(b) Material consumption</td>
<td>14631</td>
<td>12748</td>
</tr>
<tr>
<td></td>
<td>(c) Purchase of goods</td>
<td>10035</td>
<td>7759</td>
</tr>
<tr>
<td></td>
<td>(d) Employee Cost</td>
<td>7970</td>
<td>6345</td>
</tr>
<tr>
<td></td>
<td>(e) Depreciation</td>
<td>1441</td>
<td>1247</td>
</tr>
<tr>
<td></td>
<td>(f) Other expenditure</td>
<td>1125</td>
<td>1006</td>
</tr>
<tr>
<td></td>
<td>(g) General Administrative Expenses</td>
<td>7745</td>
<td>5024</td>
</tr>
<tr>
<td></td>
<td>(h) Selling and Distribution Expenses</td>
<td>149</td>
<td>871</td>
</tr>
<tr>
<td></td>
<td><strong>Total Expenditure</strong></td>
<td>45444 **</td>
<td>35002 **</td>
</tr>
<tr>
<td>3</td>
<td>Profit from Operations before Other Income, Interest &amp; Exceptional Items [(5 - 2)]</td>
<td>48416</td>
<td>4106</td>
</tr>
<tr>
<td>4</td>
<td>Other Income</td>
<td>555</td>
<td>552</td>
</tr>
<tr>
<td>5</td>
<td>Profit before Interest &amp; Exceptional Items [(5 - 4)]</td>
<td>5401</td>
<td>4686</td>
</tr>
<tr>
<td>6</td>
<td>Interest</td>
<td>1070</td>
<td>996</td>
</tr>
<tr>
<td>7</td>
<td>Profit after Interest but before Exceptional Items [(5 - 6)]</td>
<td>4331</td>
<td>4162</td>
</tr>
<tr>
<td>8</td>
<td>Provision for Taxation</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Current</td>
<td>747</td>
<td>1033</td>
</tr>
<tr>
<td></td>
<td>Previous</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Deferred</td>
<td>684</td>
<td>126</td>
</tr>
<tr>
<td></td>
<td>Fringe Benefit tax</td>
<td>-</td>
<td>69</td>
</tr>
<tr>
<td>9</td>
<td><strong>Net Profit / (Loss) from Ordinary Activities after tax (7+8)</strong></td>
<td>2920</td>
<td>2914</td>
</tr>
<tr>
<td>10</td>
<td>Extraordinary item</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>11</td>
<td><strong>Net Profit / (Loss) for the period (9+10)</strong></td>
<td>2920</td>
<td>2914</td>
</tr>
<tr>
<td>12</td>
<td>Issue equity share capital (Face value Rs.10/- per share)</td>
<td>6178</td>
<td>6024</td>
</tr>
<tr>
<td>13</td>
<td>Reserves excluding Revival Reserves as per balance sheet of previous accounting year</td>
<td>148000</td>
<td>131002</td>
</tr>
<tr>
<td>14</td>
<td><strong>EPS for the period for the year to date and for previous year</strong> Before Extraordinary Item</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Basic</td>
<td>*4.73</td>
<td>4.84</td>
</tr>
<tr>
<td></td>
<td>Diluted</td>
<td>*4.67</td>
<td>4.72</td>
</tr>
<tr>
<td>15</td>
<td><strong>Net Profit / (Loss) for the period (9+10)</strong></td>
<td>2920</td>
<td>2914</td>
</tr>
<tr>
<td>16</td>
<td><strong>Total Number of Shares</strong></td>
<td>35,397,940</td>
<td>35,414,817</td>
</tr>
<tr>
<td></td>
<td>Percentage of Shareholding</td>
<td>58.91%</td>
<td>60.45%</td>
</tr>
</tbody>
</table>

### Promoters and Promoter Group Shareholding

<table>
<thead>
<tr>
<th>a) Pledged/Encumbered</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Shares</td>
<td>12,020,896</td>
<td>10,970,866</td>
<td>12,020,896</td>
<td>10,970,866</td>
</tr>
<tr>
<td>Percentage of shares (as a % of the total shareholding of promoter and promoter group)</td>
<td>42.87%</td>
<td>47.36%</td>
<td>42.87%</td>
<td>47.36%</td>
</tr>
<tr>
<td>Percentage of shares (as a % of the total share capital of the company)</td>
<td>21.09%</td>
<td>18.22%</td>
<td>21.09%</td>
<td>18.22%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b) Non-Encumbered</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of Shares</td>
<td>5,005,833</td>
<td>8,186,109</td>
<td>5,005,833</td>
<td>8,186,109</td>
</tr>
<tr>
<td>Percentage of shares (as a % of the total shareholding of promoter and promoter group)</td>
<td>37.13%</td>
<td>42.64%</td>
<td>37.13%</td>
<td>42.64%</td>
</tr>
<tr>
<td>Percentage of shares (as a % of the total share capital of the company)</td>
<td>12.48%</td>
<td>13.45%</td>
<td>12.48%</td>
<td>13.45%</td>
</tr>
</tbody>
</table>

* Net Annualised

** Includes startup costs of new hospital project commissioned during the quarter

The petitioner has approached this Court with the following reliefs:

(i) To issue of a Writ of Certiorari or other appropriate writ, order or direction, quashing the proceedings for levy of luxury tax on the petitioner hospitals for the period prior to 1.4.2008 as the same is arbitrary, illegal and unconstitutional and violative of Article 265 and Articles 14 and 19 of the Constitution of India.

(ii) To issue a Writ of Mandamus or other appropriate writ, order or direction, direct the 1st respondent to refrain from proceeding levy luxury tax on the petitioner for the period prior to 1.4.2008
(iii) To declare that the petitioner is not liable to pay luxury tax for the period prior to 1.4.2008 which is the date on which statutory coverage was effected in respect of hospitals and Ayurvedic treatment centres;

(iv) To stay all further proceedings pending before the first respondent under the provisions of KTL Act, pending disposal of the W.P.(C).

(v) To grant such other or further reliefs, as this Hon'ble Court may deem fit and proper in the facts and circumstances of the case, including the cost of this proceeding to the petitioner.

2. The case of the petitioner is that, notwithstanding the nomenclature of the Company, the petitioner is actually running a 'hospital' and since 'hospital' was brought within the purview of the Kerala Luxury Tax Act, 1976 only w.e.f. 1.4.2008, the petitioner is not liable to be assessed in respect of the previous period.

3. The sequence of events shows that, the petitioner, when was confronted with the notice issued by the statutory authority, he approached this Court, by filing WP(C) No. 9653 of 2009, which led to Ext.P6 judgment, permitting the petitioner to file objections in response to the notice and to have the matter finalized accordingly. The specific contentions raised by the petitioner with regard to the extent of liability and also as to the point whether any luxury tax can be levied on the petitioner prior to 2008, were also taken note of by this Court, observing that the petitioner could raise the said issues before the concerned authority, who was to consider the same.

4. However, it is brought to light that the departmental authorities happened to pass the assessment orders on the very same date of Ext.P6 judgment i.e. without considering the objections to be filed by the petitioner, which made the petitioner to approach this Court by filing WP(C) 10841 of 2009, leading to Ext.P7 judgment, whereby the impugned order was set aside and the assessing officer was directed to finalize the proceedings only after considering the objections preferred by the petitioner. As a condition precedent, this Court also observed that the petitioner would remit a sum of Rs.5,00,000/- as specified, which is stated as complied with by the petitioner. This Court also directed the petitioner to appear before the first respondent on 30.4.2009. It is submitted by the learned counsel appearing for the petitioner that the petitioner had appeared before the first respondent on the stipulated date and filed his objections as borne by Ext.P8, Ext.P10 and Ext.P13, which are pending consideration.

5. The respondents have filed a counter affidavit, vehemently rebutting the pleadings raised from the part of the petitioner. With reference to the various documents produced along with counter affidavit as R1(a) to R1(e), it is sought to be substantiated that the petitioner's establishment cannot be regarded as a 'hospital' and that, it is actually a 'luxury retreat centre' with various amenities provided to the inhabitants, who are given accommodation on rent, which varies from Rs.2500/ per day to Rs.10,000/- per day. It is also pointed out that the facilities being provided as the alleged Ayurvedic Hospital is only optional' for the inmates, who can avail of the benefit - amenity on payment of the
additional amount prescribed in this regard. It is also pointed out that, subsequent to Ext.P7 judgment, the petitioner had approached the Division Bench of this Court by filing W.A. 952 of 2009, where interference was declined as per judgment dated 21.4.2009.

6. The learned Government Pleader with reference to the specific averments in the courtier affidavit further submits that the petitioner subsequent to the above proceedings, had also approached the Vacation Court, Palakkad by filing a suit along with I.A. 799 of 2009 for an injunction to restrain the statutory authorities from proceeding further under the relevant provisions of the Act. It is stated that said I.A. was dismissed, whereupon I.A. 819 of 2009 was filed for appointment of an Advocate Commissioner, which is stated as pending. The learned Government Pleader also submits that the jurisdiction of Civil Court is expressly barred by virtue of Section 19 of Kerala Tax for Luxuries Act.

8. The learned counsel appearing for the petitioner submits that, suit is actually for a declaration of the status of the petitioner's establishment and hence, it will not come within the purview of the embargo placed under Section 19 of the Act. The learned counsel further submits that attempt in the Writ Petition is only to have a direction to the first respondent to decide maintainability of the assessment with respect to the period prior to 2008 as a preliminary issue.

9. Obviously, this submission made before this Court is a 'new one', in so far as, such prayer is not reflected in the reliefs sought for. The above proposal was not raised before this Court even during the pendency of WP (C) 9653 of 2009, which led to Ext.P6 judgment, whereby the petitioner was permitted to project his case before the statutory authority. Ext.P7 judgment passed subsequently also gives no positive declaration that the said aspect has to be decided as a 'preliminary issue' by the concerned authority. The matter has admittedly become final upon dismissal of W.A 952 of 2009, filed by the petitioner challenging the Ext.P7 verdict.

10. This being the position, there is absolutely no rationale on the part of the petitioner for having approached this Court again, with the reliefs as already extracted herein before i.e. for the declaration and incidental reliefs. It appears that the petitioner has attempted to take this Court for a ride, which cannot be permitted under any circumstances.

11. In the above facts and circumstances, this Court does not find any ground to interfere with the proceedings, particularly when the petitioner has admittedly filed objections in response to the notices issued before the first respondent and in furtherance to direction given by this Court to appear before the said respondent on 30.4.2009. The proceedings pending before the first respondent cannot be permitted to be stalled by filing present Writ Petition and the conduct of the petitioner in this regard is liable to be deprecated. No interference is called for. The Writ Petition is dismissed with cost of Rs.5000/-. It is made clear that the dismissal of the Writ Petition will not stand in the way of the first respondent in considering and deciding the issue in accordance with law and
of course after giving an opportunity of hearing to the petitioner as already directed by this Court.

P. R. RAMACHANDRA MENON, JUDGE

Source: The Judgement Information System(JUDIS) website
http://judis.nic.in/judis_kerala/chejudis.aspx

Disclaimer on the website:
All the contents of this Site are only for general information or use. They do not constitute advice and should not be relied upon in making (or refraining from making) any decision. Government of India, Ministry of Information Technology, National Informatics Centre hereby excludes any warranty, express or implied, as to the quality, accuracy, timeliness, completeness, performance, fitness for a particular purpose of the Site or any of its contents, including (but not limited) to any financial tools contained within the Site. Government of India, Ministry of Information technology, National Informatics Centre will not be liable for any damages(including, without limitation, damages for loss of business projects, or loss of profits) arising in contract, tort or otherwise from the use of or inability to use the Site, or any of its contents, or from any action taken (or refrained from being taken) as a result of using the Site or any such contents. Government of India, Ministry of Information Technology, makes no warranty that the contents of the Site are free from infection by viruses or anything else which has contaminating or destructive properties.

IN THE HIGH COURT OF KERALA AT ERNAKULAM
Appendix 6.2

SOMATHEERAM

IN THE HIGH COURT OF KERALA AT ERNAKULAM

WP(C) No. 4348 of 2008(P)

1. M/S.SOMATHEERAM AYURVEDIC BEACH
   ... Petitioner

   Vs

1. THE SUB INSPECTOR OF POLICE,
   ... Respondent

2. THE CIRCLE INSPECTOR OF POLICE,

3. THE COMMISSIONER OF POLICE,

4. K.VIJAYAN, S/O.KRISHNAN NADAR,

5. BAIJU, S/O.PRABHAKARAN,

6. HARI, S/O.DIVAKARAN,

7. V.SANTHOSH KUMAR, S/O.VASUDEVAN,

8. BINU PRABHAKARAN, S/O.PRABHAKARAN,

9. KUNJUMON, S/O.REGHU,

10. RAJAN, S/O.LAKSHMANAN,

    For Petitioner :SRI.G.SREEKUMAR (CHELUR)

    For Respondent :SRI.AJITH KRISHNAN

The Hon'ble the Chief Justice MR.H.L.DATTU
The Hon'ble MR. Justice K.M.JOSEPH

Dated :15/02/2008
ORDER

H.L. Dattu, C.J. & K.M. Joseph, J.

---------------------------------------------
W.P.(C).No.4348 of 2008-P

---------------------------------------------

Dated, this the 15th day of February, 2008

JUDGMENT

K.M. Joseph, J.

This is a petition for police protection. According to the petitioner, it is a private limited Company engaged in the conducting of a Resort. It is also stated that they are providing Ayurveda treatment and Yoga there. It is the case of the petitioner that they have road transport facility to its staff as also the tourists and other persons who come to the Resort. It is the further case of the petitioner that whenever the in-house transport facility is not available for the petitioner, the tourist taxies of the party respondents, who are plying taxies in front of the premises of the petitioner, were made available. But of late, according to the petitioner, the party respondents have started creating unnecessary problems and does not permit the plying of the vehicles of the petitioner and always insist that the vehicles belonging to them should be made use of for the foreigners alone and none of the other persons of the petitioner Company.

(2) The party respondents have filed a counter affidavit. It is the case of the party respondents that they were issued with taxi permits by the competent authority. They say that most of the customers of the petitioner are tourists and now the petitioner has acquired 10 private owned cars with the intention to operate as Taxi services. According to the respondents, the ten cars owned by the petitioner's resort are privately owned cars and, therefore, they cannot be operated as taxi service for their customers and staffs.

(3) We heard Sri.G.Sreekumar (Chelur), learned counsel appearing for the petitioner and Sri.Ajith Krishnan, learned counsel appearing for the party respondents besides Smt.K.Meera, learned Government Pleader appearing for respondents 1 to 3.
(4) The learned Government Pleader would submit on instructions that the parties were called to the police station and though a demand was raised that the services of the party respondents and the petitioner's vehicles shall be used in the ratio of 1:1, the request was not acceded to and it was agreed by the party respondents that they will not create any law and order problems.

(5) We are of the view that when a complaint is lodged by a party, it is the bounden duty of the police to look into, consider the same and proceed on it in accordance with law.

(6) In the above view of the matter, this writ petition is disposed of directing that if the petitioner files any complaint before respondents 1 and 2 with regard to any commission of any offence by the party respondents, the respondents 1 and 2 shall look into the complaint and act in accordance with law.

Ordered accordingly.

H.L. Dattu, Chief Justice
K.M. Joseph, Judge

Source: The Judgement Information System (JUDIS) website
http://judis.nic.in/judis_kerala/chejudis.aspx

Disclaimer on the website:
All the contents of this Site are only for general information or use. They do not constitute advice and should not be relied upon in making (or refraining from making) any decision. Government of India, Ministry of Information Technology, National Informatics Centre hereby excludes any warranty, express or implied, as to the quality, accuracy, timeliness, completeness, performance, fitness for a particular purpose of the Site or any of its contents, including (but not limited) to any financial tools contained within the Site. Government of India, Ministry of Information Technology, National Informatics Centre will not be liable for any damages (including, without limitation, damages for loss of business projects, or loss of profits) arising in contract, tort or otherwise from the use of or inability to use the Site, or any of its contents, or from any action taken (or refrained from being taken) as a result of using the Site or any such contents. Government of India, Ministry of Information Technology, makes no warranty that the contents of the Site are free from infection by viruses or anything else which has contaminating or destructive properties.

IN THE HIGH COURT OF KERALA AT ERNAKULAM
Appendix 6.3

A screen capture of a sales advertisement, for a place close to Somatheeram.

As accessed in May, 2011.
Curriculum Vitae
Purba Rudra

EDUCATION

2011 PhD, Rutgers University, Department of Geography. Dissertation topic: “Impact of medical and wellness tourism centers on the communities around them: Case studies in Delhi and Kerala.” Advisor: Briavel Holcomb.


2002 M.A., Center for Study of Regional Development (CSRD)-Department of Geography, Jawaharlal Nehru University. Specialization: Regional Development.


PROFESSIONAL EXPERIENCE

2009-2010 Graduate Research Assistant, John J. Heldrich Center for Workforce Development, Edward J Bloustein School of Planning and Public Policy, Rutgers University

2008 Member of the Parliamentary Research Services (PRS) and Indian Institute of Management (Ahmedabad) research team, headed by Prof. Neharika Vohra, on informational needs of parliamentarians. Role: Interviewing members of the Indian parliament.

2007 Teaching Assistant, “Transforming the global environment,” Department of Geography, Rutgers University.

2006 Teaching Assistant, “Transforming the global environment,” Department of Geography, Rutgers University.