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A Comprehensive Study of International Trade and Laws with Special Reference to CSR Of Healthcare Industry in India

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Abstract

Over the past 20 years, international trade in healthcare goods and services has increased under the GATS. Increasing income levels, cross-border mobility, foreign investments, the use of advanced communication, information technologies, and demographic shifts have all contributed to its growing reach; India is a major participant in this process. Currently, India's healthcare sector is growing at a 20% yearly rate. The government's expenditures on healthcare are relatively small. Despite this, Corporate Social Responsibility is a major force in promoting health and education in India. This is because the Companies Act was amended to require that any corporate houses that have made money for three consecutive years donate 2% of their average net profit to CSR initiatives. Despite spending a lot less on healthcare, CSR spending has a significantly greater influence on society. Corporate House's utilisation of CSR funding to improve public health systems and facilities will benefit society as a whole. Because they are more knowledgeable about the subject, corporate entities like healthcare facilities, pharmaceutical companies, and health insurance companies will have a greater impact when they use CSR funds to engage in social activities.

It is commendable that certain initiatives, like safety standards in healthcare, are helping the less fortunate members of society receive better medical care. In other words, corporations that invest in Corporate Social Responsibility initiatives are granted tax exemptions by the government, which will increase public goodwill and support their marketing initiatives. In particular, healthcare providers have made social accountability in their mission. Crises like the COVID-19 pandemic, however, had an impact on a number of healthcare-related operations, including CSR and its oversight. However, the healthcare industry lacks theory-driven CSR research, and monitoring calls for a methodical comprehension of the procedures. As a result, the goal of this study was to examine the CSR practices and initiatives that healthcare providers have put in place in India as an example, as well as the impact of the pandemic on these initiatives on the globe. (2) Methods: The

sample of participants was selected according to their group membership, organization type (public, private, or non-profit), and field of care (general, psychiatric, or recovery). Initially, nine of the 18 healthcare providers who were recruited took part in the interview process. Their enterprises have between 900 and 73,000 people and generate between EUR 110 million and EUR 6 billion in revenue annually. (3) Findings: Because of crises, CSR-related activities were delayed. The need to digitize processes quickly was evident. Regular and accurate communication was found to be crucial for maintaining high levels of employee satisfaction, motivation, and well-being. A change in focus and new hygiene regulations offset environmental efforts. A lot of research participants said they hoped that new structures, procedures, and methods (such as digital meetings and faster, more inclusive communication) would be preserved and expanded upon after the pandemic. (4) Inferences: In addition to being difficult, the pandemic has presented chances to forge new paths and apply the lessons learned to get through upcoming economic or health crises.

Keywords: Corporate Social Performance; Indian Healthcare Market; International Trade; International Laws; CSR; Healthcare Services; Modes of services; COVID-19

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I. Introduction

Since the World Trade Organization (WTO) was established in 1995 and the services sector was added, the health industry has expanded quickly. In 2012, this industry is expected to have earned $13.31 trillion in revenue, of which approximately $2.67 trillion (20.06 per cent) came from emerging nations. It was anticipated to expand by 17% annually in 2015. The Indian health sector, which was estimated to be worth $65 billion in 2012, was extremely dispersed and controlled by private companies. According to estimates, India's healthcare industry was reached $100 billion by 2015 and grow by 20% annually. By 2025, it is anticipated that the sector will reach $290 billion. The need for specialized, high-quality healthcare services will only grow. A number of factors, including rising life expectancy, rising incomes, and increased public awareness of health insurance, have contributed to the remarkable evolution of the healthcare sector over the past four years, according to the Investment Commission of India, which has seen an additional 12% annual growth. Despite this, Corporate Social Responsibility is a major force in promoting health and education in India. This is because the Companies Act was amended time to time, to require that any corporate houses that have made money for three consecutive years allocate 2% of their profits to CSR initiatives.

Despite spending a lot less on healthcare, CSR spending has a significantly greater influence on society. Corporate House's utilization of CSR funding to improve public health systems and facilities will benefit society as a whole. Because they are more knowledgeable about the topic, corporate entities like healthcare institutions, pharmaceutical corporations, and health insurance companies will have a stronger influence when they employ CSR funding to engage in social activities. Some of the initiatives, like safety standards in healthcare, are commendable because they improve healthcare for the underprivileged in society. In other words, corporations that invest in Corporate Social Responsibility (CSR) initiatives are granted tax exemptions by the government, which will increase public goodwill and support their marketing initiatives. The expansion of the private healthcare sector is being aided by the growing demand from the middle class in India's major cities. The primary and secondary healthcare sectors will expand as a result of initiatives by the federal and state governments. For the medical community and other associated service providers, the growing demand for healthcare services would present both significant opportunities and challenges. From April 2000 to March 2013, $1597.33 million in foreign direct investment (FDI) was invested in hospitals and diagnostic facilities. Over the same period, FDI inflows into medical and surgical appliances were $604.47 million. The pharmaceutical and drug industries also brought in $10,318.17 million in foreign direct investment at the same time.

By 2015, the hospital services industry was anticipated to be valued at $81.2 billion. In 2013 was seen Indian healthcare providers spend $1.01 billion on IT goods and services. Boosts in pharmaceutical outsourced and increased investments by global corporations are predicted to propel the Indian pharmaceutical industry's growth into double digits shortly. It is anticipated that emerging industries like bio-generics and pharmaceutical packaging would propel the pharmaceutical industry's expansion. According to a Gartner estimate, the rapidly expanding healthcare services market must make up the approximately 2.8 million hospital beds that were currently needed by 2014 in order to catch up to the global average of three beds per 1000 people.

The market is now controlled by unorganised sector companies, and this trend is expected to continue in the foreseeable future. With over 80% of the market, private sector investment will play a major role in the growth of the hospital industry. In India, almost 80% of healthcare is provided by the private sector. According to estimates, the private sector employs 80% of all certified physicians, 75% of dispensaries, and 60% of hospitals. There is very little evidence that the majority of Indians are covered by health insurance. Even if the number of health insurance plans has increased in recent years, the vast majority of people still lack coverage. The market for health insurance has expanded due to the rising income levels of the middle class and the resulting lifestyle-related disorders. Patients primarily travel to India for organ transplants and the treatment of orthopedics, cardiac, and oncological issues from Africa, the CIS, the Gulf, and South Asia. It was recorded that the medical tourism business was grown at a rate of 27% per year, from $1.9 billion in 2011 to $3.9 billion in 2015 and onwards. Compared to South East Asian nations, Western Europe, and North America, the cost of medical care is far lower in India. This market is probably going to expand by more than 20% shortly. The treatment skills at several speciality hospitals are similar to those in the Western world, and the facilities have been updated.

According to Das K. Pradip, & Kumar Ankit(2022),"Transforming India into a center for international commercial arbitration challenges and opportunities" stated that international commerce is the foundation of the economy and that the likelihood of commercial disputes has increased due to its quick growth. Commercial disputes that are not promptly settled will negatively affect the company and ultimately the economy. About 4 crore cases remain unsolved in India's packed courts, and the country's courts are not known for promptly resolving conflicts. Arbitration can be a powerful remedy for this illness. One way to quickly and quietly resolve conflicts is through arbitration. The Indian government is working to make India a center for international arbitration. In order to make India a center for international arbitration, the Arbitration and Conciliation Act of 1996 was passed in order to conform the UNCITRAL model law.

In particular, healthcare providers have made social accountability their mission. Crises like the COVID-19 pandemic, however, had an impact on a number of healthcare-related operations, including CSR and its oversight. However, the healthcare industry lacks theory-driven CSR research, and monitoring calls for a methodical comprehension of the procedures. Thus, the goal of this study was to examine the CSR actions and practices that healthcare professionals have adopted in India in post pandemic era as an example, as well as the impact of the COVID-19 pandemic on these efforts on the globe. (2) Methods: Initially, nine of the 18 healthcare providers who were recruited took part in the interview process. Their enterprises have between 900 and 73,000 people and generate about EUR 110 million and EUR 6 billion in revenue annually. (3) Findings: During times of crises, CSR-related activities were delayed. Digitalisation of processes had to happen quickly. The maintenance of high levels of employee satisfaction, motivation, and well-being was found to depend on regular and accurate communication. Priorities changed, and new hygiene regulations offset environmental efforts.

A lot of research participants said they hoped that new structures, procedures, and methods (such as digital meetings and faster, more inclusive communication) would be preserved and expanded upon after the pandemic. (4) Inferences: In addition to being difficult, the pandemic has presented

chances to forge new paths and apply the lessons learned to get through upcoming economic or health crises.

II. Significance of Indian Healthcare Sector

Even after independence, inadequate colonial-era health infrastructure remained to influence Indian health policy. The Indian states gave health and welfare very little room. The political economics of India's healthcare reform have been defined by the extensive privatization and the predominance of the private and unorganized sectors in healthcare delivery, even for the most impoverished. In India, the private sector provides 80% of healthcare services.

According to Chanda (2008), the private sector employs an estimated 80% of all certified physicians, 75% of dispensaries, and 60% of hospitals. Since independence, neither the federal government nor the states have prioritized the health sector. Public spending on health has only recently increased over the historical average of 0.9% of GDP, which was lower than the majority of other nations worldwide (Sen and Dreze, 2002, p. 202).

About 15% of India's overall health spending goes toward public spending; the average for sub-Saharan Africa was 40%, and for high-income European nations, it is over 75% (Sen and Dreze, 2002, p. 204). India spends relatively little on healthcare compared to many other nations. India spends significantly less on health care than other developing market countries and less than half of what is spent worldwide. Spending on health care was determined by the low per capita income. Table-1, provides information about the Indian healthcare situation.

Comparing India to many other nations, Table-1, shows that private health spending is large and public health spending is low. Compared to many other nations, India has incredibly low healthcare spending per capita. For instance, India's health spending per capita was $40, whereas China's, Brazil's, and the US's were $108, $606, and $7285, respectively. Additionally, it falls well short of the $802 average per capita worldwide. In India, there is a clear disparity between rural and urban health status indicators. The disparity between urban and rural areas is significant and growing. Children in rural areas typically see significantly greater gaps. In the healthcare industry, discrimination against women is widespread.

There's a big difference between the states that perform well and the others. Within states with higher performance, districts also differ significantly. Health outcomes seem to be better in urban regions than in rural ones. An estimated 190 million people lived in slums in the year 2011, and the number was still growing till the year 2020. This population group has very poor access to healthcare, especially in rural slums. In addition, India's hospital bed density was remained at 0.9 per 1000 people since 2005, falling well short of the 3.511 per 1000 patients as per WHO recommendations.

Table1:Health Expenditure: Comparison Between Select Nations

Country	*% to GDP*		*Health Expenditure : Compositional distributed*			
			Public Expenditure		*Private Expenditure*	
	2010	***2020***	***2010***	***2020***	***2010***	***2020***
India	4.9	5.9	26.7	30.9	74.9	69.9
Brazil	7.8	9.0	40.6	45.8	59.9	54.9
UK	7.9	9.8	79.8	82.9	21.9	17.7
China	4.8	5.8	38.9	56.8	61.8	44.5
USA	13.7	17.9	43.9	47.9	57.7	52.8
Global	5.9	6.9	55.7	61.8	45.7	38.7
South East Asia Region	3.8	4.6	32.8	36.9	68.9	63.9

Source of Data: ***WHO, World Health Statistics, 2020***

In addition, the quantity of healthcare facilities is insufficient. For instance, as of March 2009, India had 4510 community health centers, 23,391 primary healthcare centers, and 145,894 sub-centers.

Only a small number of blood banks exist; in January 2011, there were 2445. The establishment of additional medical schools and paramedical training facilities is necessary even in post pandemic era. Even though, 289 colleges offered BDS courses, while 314 medical colleges were present. This is severely insufficient. Inadequate infrastructure leads to inadequate training of nurses and midwives. India is one of the major participants in the global trade of health services, notwithstanding these shortcomings see the figure-1, as authors have mentioned here.

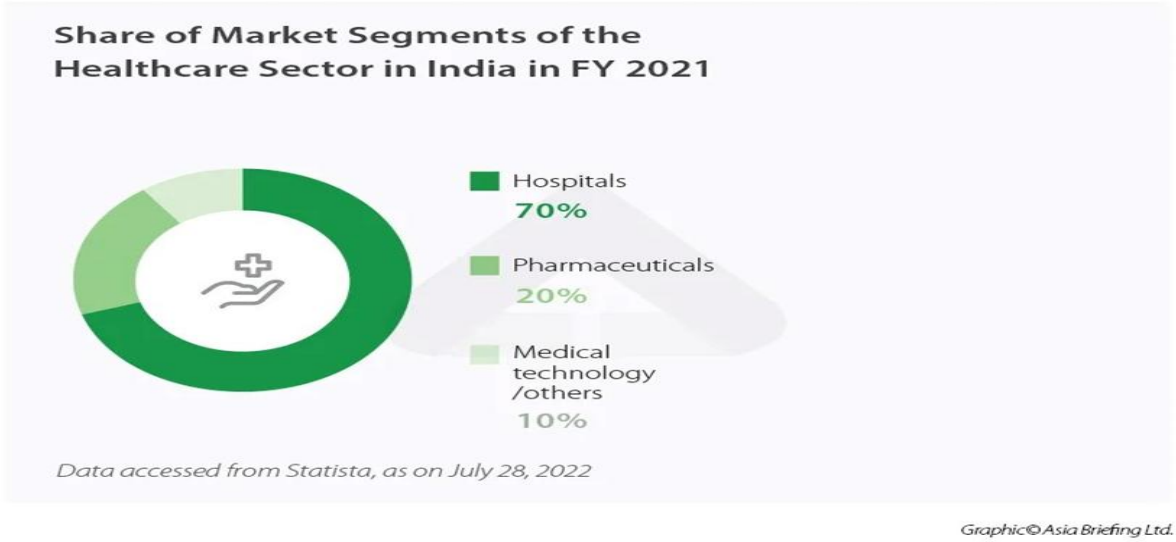

Figure 1: Shares of Market Segments of Healthcare Sectors in India (Financial Year 2021-2022), *Source of Data*: authors calculations, *data taken from WHO, World Health Statistics, 2021-22*

Table 2. Features of the companies that are taking part in the research

Participants data	*Headcounts data*		*Belonging to a corporate profit and non-profit group*	
		Yearly Revenue (EUR) Average		**Organizations**
I.	13,550	1.3billions	Not initiated	Profit
II.	16,100	873 millions	Yes initiated	Non-profit
III.	73,100	6.1billions	Yes initiated	Profit
IV.	30,100	1.633billions	Yes initiated	Non-profit
V.	2610	184 millions	Yes initiated	Non-profit
VI.	1810	111 millions	Yes initiated	Profit
VII.	3210	201 millions	Yes initiated	Non-profit
VIII.	910	951millions	Yes initiated	Non-profit
IX.	4100	401 millions	Yes initiated	Profit

Source of Data: Authors calculation

In Table-2, authors have discussed that the nine participating companies employ between 900 and 73,000 people. Annual revenue for the largest enterprise is EUR 6 billion, while the smallest participating healthcare provider makes EUR 110 million. Just one hospital does not belong to a group, whereas eight interviewees stated that they are a part of a corporate group. The findings indicate that five survey participants claimed to work for a non-profit group, whereas four said they

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were employed by a profit company. See the figure-2,indicated in this concern

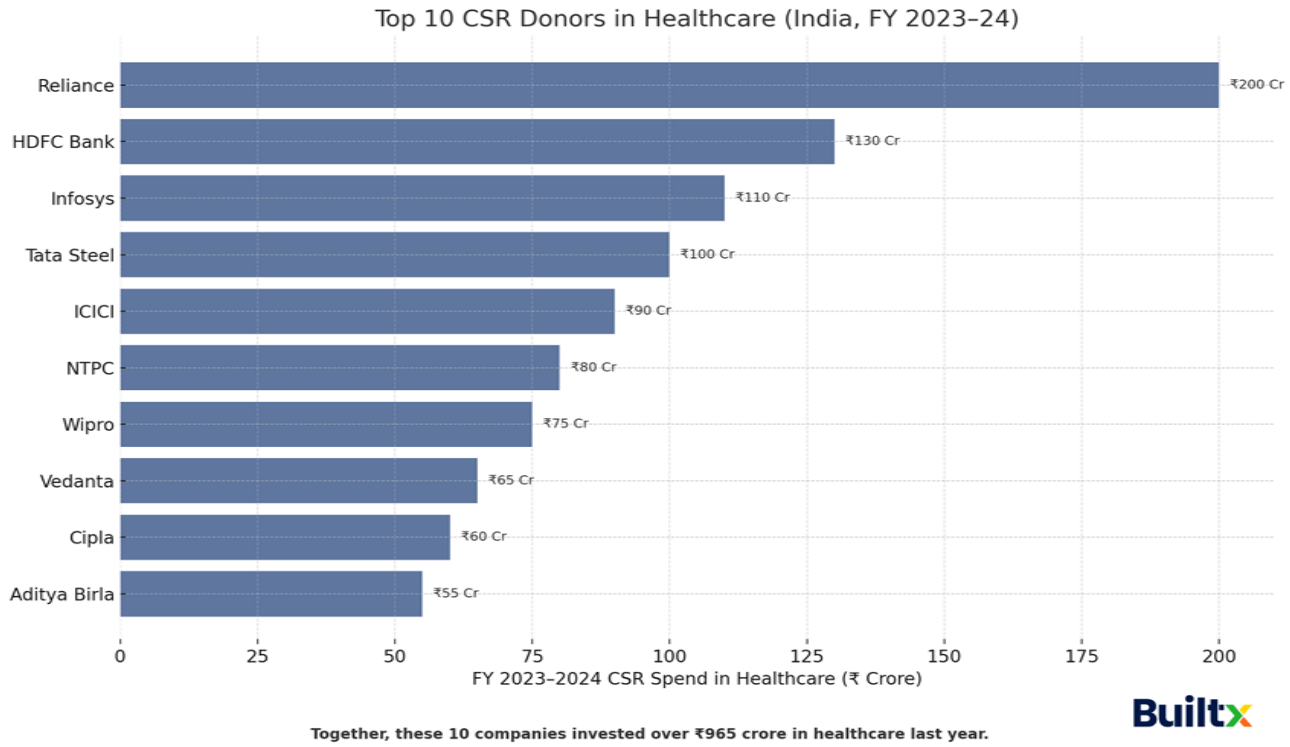

Figure 2: Top 10 Healthcare CSR Donor Companies in India (Financial Year 2023-2024)

Source of Data; https://www.builtxsdc.com/blog/top-10-csr-donors-in-healthcare-sector-india-2025-ngo-funding-guide

III. International Trade and Laws in Healthcare Sector

Trade in health services is governed by the General Agreement on Trade in Services (GATS) of the World Trade Organisation (WTO). There were about 120 governments that negotiated the GATS. The WTO's formation in 1995 marked the implementation of the GATS. Its goal was to facilitate trade in services in order to increase productivity and economic expansion. In order to do this, it permits nations to tie themselves to lowering trade barriers. The provider-consumer exchange of services is perceived as occurring across a short distance, in contrast to the transaction in products. However, as technology has developed, services like health, education, and finance have been available globally.

Often, many modes are used to supply or trade services. With very few exceptions, technology makes cross-border supply (mode 1) possible for practically all services. Mode 4 (i.e., demander-located services) differs from mode 3 in that the former is concerned with the nation of origin of the person providing the service, whereas the latter is more focused on the local formation of foreign legal entities.

Table 3: Four Modes of Services Supply

Mode	*Defined by*	*Explained with*	*Examples*
1.	Supply of Cross border	While the supplier and the customer stay in separate countries, the service crosses the border.	selling translation services by fax or online from nation A to nation B.
2.	Abroad Consumption	The customer enters the provider's jurisdiction over the border and uses the services there as well.	When visiting country B, a tourist from country A purchases hotel accommodations (tourism services).
3.	Commercization	Crossing the border, the provider creates a business presence in the area of consuming.	A Bank from nation A opening a branch locally in country B.
4.	Natural persons Presence	labor that is temporarily moved to the consumer's territory. It may be an intra-corporate transferee or something else entirely.	*The hiring of an engineer from nation A in nation B.*

Source of data: **Herman, Lior(2009),'Assessing International Trade in Healthcare Services,'ECIPE, Brussels.**

Conditional and unconditional rules are the two types of rules found in the GATS. The conditional norms are only applicable to a particular service sector if a nation has legally and expressly committed to preserving a certain level of trade openness in that sector. Just because a nation has signed the GATS does not mean that the unconditional rules do not apply to its whole service sector. Two are significant among the many unconditional norms that govern any service trading. First and foremost, members are prohibited from treating suppliers from other nations unfairly. The Most Favored Nation (MFN) conduct clause requires a nation to provide service providers from all nations with the same terms and benefits. A nation cannot, for instance, limit entry into the insurance sector to US insurance companies while barring German competitors. The nations must also continue to be open and honest about their trading policies. It is specifically nations responsibility to notify the Council for Trade in Services and other members of any new or amended rules and regulations that could significantly impact on the globaltrade in services regulated by their particular GATS obligations. The GATS gives each nation the freedom to choose which industries and sub-sectors within those industries to adhere to the conditional standards, which are stricter than the unconditional rules. In a given service area, this enables nations to determine the level of trade openness they want to preserve. The number and kind of sectors or sub-sectors that each country has committed to, as well as the level of trade openness that each country has promised to maintain in those sectors, differ. .

IV. Trade Limitations in Healthcare Sector

However, the relationship between sector-specific and horizontal commitments is not always clear-cut, and two sections may include contradicting items. Modes 1 and 2 (cross-border commerce and consumption of health services overseas) impose relatively few restrictions on health services, and they are primarily sector-specific. Their main worry is the non-portability of insurance benefits. Non-eligibility of foreign suppliers for subsidies and restrictions on the availability of foreign exchange are examples of horizontal limitations, which apply to all scheduled sectors that may become relevant for health services.

Other obstacles not listed in schedules may have limiting effects comparable to those of these limits. These include the failure to recognize foreign qualifications, licenses, or standards. For instance, public health insurance might decline to pay for treatment overseas if the quality of the services provided is inferior to that of domestic providers. Under GATS, challenging such practices can be challenging. To give them recognition, the Members could, however, agree. They are not, however, required to adopt a liberal stance.

The largest percentage of partial or restricted commitments has been attracted by modes 3 (commercial presence) and, more specifically, mode 4 (presence of natural beings). While a comparatively large number of the limits intended for mode 3 are sector-specific, the majority of those proposed for mode 4 are horizontal. Some nations, mostly industrialized, have reserved the authority to limit the commercial incorporation of overseas healthcare providers by restricting their mode 3 obligations to natural people. Frequent market access constraints outlined in mode 4 are quantitative, primarily limiting the number of foreign workers or preventing access to anyone who isn't a specialized physician, etc. Training and requirements for language are typical national treatment limits under Mode 4.

In addition, the Economic Needs Test (ENT) has been commonly used under modes 3 and 4, for medical and dental services as well as hospital services. The pertinent criteria that underpin these assessments, such as population density, age distribution, mortality rates, and the quantity of existing facilities, have not always been mentioned by Members. The primary criteria that ENT should be founded on were specified by GATS. For instance, the demographic criterion should be succinctly explained if it is the basis for the power to create a facility. The advanced nations have, however, more frequently employed the undefined criterion. Due to their potential for discretionary use, these entries might resemble a scenario where no commitment is present. A sizable portion of mode 4 obligations is restricted to trainees or transferees. Their importance mostly hinges on a foreign supplier's capacity to create a business presence under Mode 3. Given the current investment patterns, this is typically more challenging for medical personnel exporters in developing nations than for those in developed nations. It may also prove elusive in those sizable portions of the health sector where private business ownership is either not permitted or not economically appealing.

In a few instances, restrictions on the types of legal incorporation and foreign equity participation have been scheduled as market access constraints (Article XVI) for mode 3. These limitations, which are mostly found in the horizontal portions of the relevant schedules, may be meant to promote the transfer of technology, expertise, and skills. Additionally, several members have limited horizontal national treatment while retaining the authority to mandate that foreign-owned facilities train their citizens. Both the horizontal and sectoral divisions contain comparatively frequent references to national legislation. It is challenging to find restrictive, discriminatory elements in these situations. National laws that negatively impact market participation, including those about licensing or training, do not in and of themselves necessitate scheduling. As with the telecommunications sector, the health sector surprisingly lacks advanced commitments that call for deregulation starting at a specific later time.

V. India’s Present Status in Global Healthcare Market

Mode 4, places limitations on international service providers but does not specifically prohibit the economic participation of foreign companies. Additionally, the federal government and the state share responsibilities. But there isn't a uniform system of accreditation. India does not have national treatment limits or market access for medical and dental services, hospital services, or services rendered by midwives, nurses, physiotherapists, and paramedical staff under mode 2.

Mode 1, allows for the provision of services on a provider-to-provider basis without any restrictions on national treatment or market access, as long as the transaction is between reputable medical

institutions and covers areas such as research or second opinions to aid in diagnosis. Mode 3, allows market access solely through incorporation, with a foreign equity cap of 74%, provided that (i) the newest treatment technology is introduced and (ii) FIPB approval is obtained if foreign investors have previously collaborated in that particular Indian service sector.

When it comes to national treatment under mode 3, publicly sponsored services might exclusively be accessible to Indian nationals or might be provided to non-Indian citizens at a discounted rate. All horizontal commitments about entrance visas are unbound in mode 4. Mode 1, services grew rapidly in India between 2000 and 2015. In 2000, there were 30,551 workers in IT-related health services; by 2015, that number had increased to 242,500. During that time, the amount of money received from these services climbed from $264 million to $4,072 million (approximately).

Patients in Bangladesh, Nepal, Bhutan, and Myanmar can now receive telemedicine services from the Apollo group's Apollo Gleneagles facilities in Kolkata, including consultation, diagnosis, telepathology, and teleradiology. According to Table 4, the increase was more than 15 times. Through a $5,429 million Pan-African e-Network Project, India is providing telemedicine and teleeducation services by connecting with 53 African Union member nations via fibre optic and satellite networks. Therefore, in this regard, 12 super-speciality hospitals and five renowned Indian universities are participating in the Pan-African e-Network project, which offers telemedicine and tele-education services.

India is a key service provider in mode 1, with its infrastructure and skilled workforce base. The Apollo Group of Hospitals uses telemedicine and teleradiology services to serve patients in Bangladesh, Nepal, Bhutan, Myanmar, and Kazakhstan. They also collaborate with Healthcare Services of America for medical coding and billing, medical record documentation, and insurance claims processing.

Table 4:India's earnings in healthcare services from mode 1, trade (in millions of dollars)

Segments Services	2010-2011	2020-2021(times increases)
Centers of Customerinteractions	65	2,260 (39.54)
Transcription of Medical	33	805(27.68)
Financialandaccounting services	55	379(8.45)
Medicalbillingandcollection	5	80(26.10)
Insuranceclaims processing	14	35(2.61)
Pre-pressanddigital pre-media	46	205(5.43)
GIS Systems	-	50 (new)
Learning in Distance mode	65	160(3.56)
HRservices	-	115 (new)
Services of Litigationsupport	5	29(9.18)
Grand Total	288	4,072 (16.00)

Data Source: (**authors calculations)** Estimates of business process outsourcing (BPO) industry revenue by service type are provided by the Electronic & Computer Export Promotion Council (ESC).

The advent of the internet era has led to a recent surge in the outsourcing of healthcare services. By 2010, almost 60% of healthcare organizations in the United States had outsourced more than 50% of their IT activities. In 2010-2011, the medical outsourcing market was valued at more than $19 billion. In India, over 180 businesses were providing medical transcription services, with an average yearly income of $250 million. Considering the ageing populations in the US and Europe, the expanding regulatory emphasis on digitizing medical records and documentation, and other considerations, this is probably going to rise significantly shortly.

Roughly 60% of the US medical transcription business is outsourced from clinics and hospitals, with 10% of that outsourcing going to nations like the Philippines and India. Around $200 million, or 2% of the US industry, is India's portion, according to the Indian Medical Transcription Industry Association.

Outsourcing medical billing services includes accounting, producing reports for hospitals, diagnostic service organizations, and physician practices, as well as charging insurance companies, doctors, and patients. For high-quality medical billing services, India is emerging as the top location. Currently, the medical billing outsourcing market is valued at approximately $1 billion. India is regarded by American businesses as the most desirable location. Today, it serves as the world's "back office." Operators will provide comprehensive health tourism packages that include necessary medical procedures, lodging, airfare, and trips to well-known tourist locations. They also bargain for medical expense coverage from insurance carriers. The amount of money spent on healthcare infrastructure has increased recently. The private sector, which has access to cutting-edge technology, has thrived. Leading corporate hospitals in India, like Apollo, Medanta, Fortis, Wockhardt, Max, and the Manipal Group, have stepped in to offer top-notch medical services and cutting-edge technology. India is expanding its medical tourism options with the opening of numerous new private speciality hospitals and integrated health cities in major cities. Over the past five years, the healthcare and life sciences sectors have seen over $2 billion in investments from private equity funds. Additionally, hospitals and diagnostic centers received $1,030.05 million in foreign direct investment (FDI) between 2010 and 2020, accounting for 0.78 per cent of all FDI received by India, totaling $32,837 million in 2020. By the end of 2020, hospitals and diagnostic centers had received FDI equity inflows totaling $1,395.82 million, which had been steadily rising.

Indian hospitals are subject to a permissive foreign investment policy, and there are few significant regulatory barriers for foreign companies looking to enter the industry. Despite the lenient regulatory environment, it seems that foreign investment in Indian hospitals is still relatively low overall. One estimate states that barely 10% of the Indian health market has been touched by international investors. The hospital sector in India is expected to see a significant increase in foreign investment in the near future due to plans for significant growth by both current and potential corporate participants. These include the establishment of new hospitals across the nation, the expansion of current operations, and massive cities with integrated health services and super speciality or multispecialty hospitals.

The United States, the United Kingdom, Australia, and Singapore are expected to be the primary sources of foreign direct investment in this sector. Additionally, it is acknowledged that significant expenditures can only be made through corporate hospitals and that doing so would require time. In order to obtain capital through private equity, foreign institutional investment, and external borrowing, reputation and brand value are crucial.

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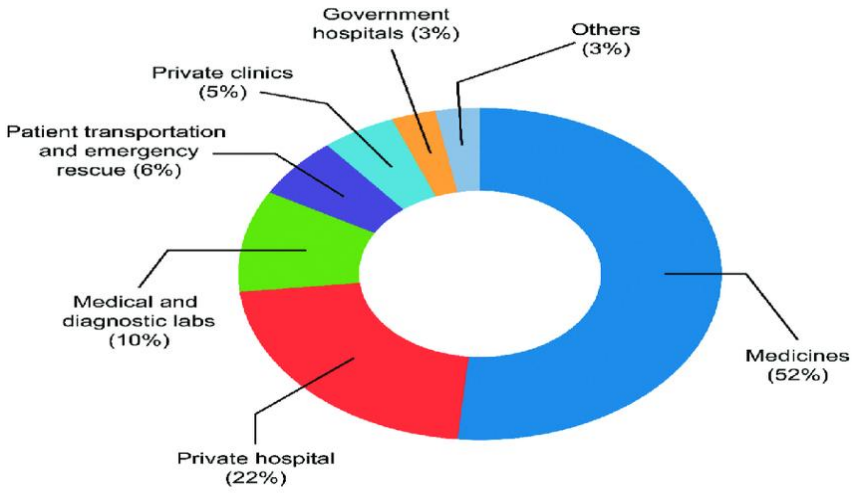
Figure-3: Size of India's healthcare Market (2008-2020) with projection for 2022-2023 (US$ Billion) WHO

Source of Data: (**authors calculations**)

There are a number of internal and external barriers that contribute to the low level of foreign investment in Indian hospitals. Among these are the following facts: there are many competing investment destinations, there are few international participants, and foreign companies that want to enter independently and sustain joint ventures face challenges. Additionally, hospital projects have a lengthy gestation time, and investors might not be prepared to commit to such a long-term investment. More significantly, there are a number of domestic factors that negatively impact the returns on investment in hospitals in India, including low health insurance penetration, medical trainer, high initial establishment costs, provider restrictions, the high cost of importing medical devices, and unclear policies. A liberal foreign investment policy alone is insufficient to ensure significant foreign engagement in the hospital sector, as demonstrated by the Indian experience.



Source: Household Health Expenditures in India (2013-14), December 2016, Ministry of Health and Family Welfare; PRS.

Figure-4: Household Health Expenditures in India

Source of Data: (**authors calculations**)

The authors' discussed regarding the household healthcare expenditures in India by the Indian government is addressed in Figure 4. In their article "Implementation of Equity and Access in Indian Healthcare Sector: Current Scenario and Way Forward," by Canna Ghia and Gautam Rambhad (2023), stated that, the data available shows that 78% of people are insured by public insurance companies, making up 37.2% of the population. Out-of-pocket (OOP) prices are high, and the public sector covers roughly thirty per cent of all medical expenses. The government has implemented a number of new health policies and programs, increased the healthcare budget by 137% in 2021, increased vaccination campaigns, increased medical device manufacturing, special training packages, and AI/ML-based standard treatment workflow systems to guarantee appropriate treatment and clinical decision-making. These initiatives are all part of the government's efforts to improve healthcare funding, equity, and access. The type and goal of the investment will have a significant impact on how imports under mode 3 are perceived. Many people worry that foreign businesses will primarily cater to wealthy domestic or international clients, which would present issues with access to healthcare for all. Furthermore, foreign establishments that ostensibly pay greater salaries than the public or private sectors in the country may redirect limited human resources to treat wealthy clients at the expense of the underprivileged and the goal of universal access to healthcare. The government considers this internal brain drain to be a waste of tax dollars. Certain actions must be taken by the government to lessen these risks. If the markets are divided, leaks will occur more frequently.

Conclusion

GATS seek to foster economic growth and efficiency to establish a favorable environment for trade in services on a global scale. Participating nations are able to tie themselves to reducing trade barriers. As a result, despite very little liberalization, the healthcare industry has grown in India in post pandemic era. With increased physician fees, expensive new technologies, and advanced hospital facilities in the industrialized world, the cost of medical care has increased significantly. This made it possible for emerging nations to establish infrastructure that would improve commerce in all four modalities. The GATS gives participating nations the freedom to choose which subsector they want to adhere to the conditional regulations. Additionally, it gives them the freedom to choose how much trade openness they want to keep in sectors that they are dedicated to implement in this concern.

One can see that the number of sectors that members are involved in tends to be positively correlated with their economic development level. Hospital services, midwife and nursing services, and medical and dental services are the most dedicated of the four subsectors. Overall, the trend shows that many nations have chosen to liberalize capital-intensive and skill-intensive industries because they are more economically appealing than labor-intensive ones. Mode 3 commitments are more lenient in order to address the lack of human and physical capital and improve efficiency through foreign direct investment and skill supply in healthcare sector. However, in mode 4, where the movement of medical staff is involved, trade conditions are more limited. None of the participating members in mode 4 has fully committed to national treatment and market access in a global way.

Other approaches generally have very restrictive commitments that are subject to constraints. The developing nations have committed to greater market access in the medical and dental services sectors, but they have made fewer promises in other areas. Due to a variety of domestic market laws and regulations, the commitments are not equally significant across all industries and modalities. In particular, the purpose of healthcare providers is social responsibility. But catastrophes like the COVID-19 pandemic affected CSR and its tracking, among other operations in the healthcare industry in India. In the healthcare industry, there is a dearth of theory-driven CSR research, and process understanding is necessary for monitoring. As a result of this study was to examined the

CSR practices and initiatives that healthcare providers have put in place in India as an example, as well as the impact of the pandemic and these initiatives on the globe. The sample of participants was selected according to their group membership, organization type (public, private, or non-profit), and field of care (general, psychiatric, or recovery). Initially, nine of the 18 healthcare providers who were recruited took part in the interview process. Their enterprises have between 900 and 73,000 people and generate between EUR 110 million and EUR 6 billion in revenue annually. Because of crises, CSR-related activities were delayed in this concern.

Processes have to be digitalized quickly. It was out that maintaining high levels of employee happiness, motivation, and well-being required frequent and accurate communication. New hygiene standards and a change in emphasis offset environmental efforts. Many research participants expressed the expectation that newly formed structures, procedures, and methods (such as digital meetings and faster, more inclusive communication) will be retained and further developed after the CIVID-19 pandemic. Although the pandemic has presented difficulties, it has also presented chances to forge a new course and apply the lessons learned to get through upcoming medical or financial crises. Despite this, Corporate Social Responsibility is a major force in promoting health and education in India. This is because the Companies Act was amended to require that any corporate houses that have made money for three consecutive years allocate 2% of their profits to CSR initiatives. Despite spending a lot less on healthcare, CSR spending has a significantly greater social impact. Corporate House's utilisation of CSR funding to improve public health systems and facilities will benefit society as a whole. Because they are more knowledgeable about the topic, corporate entities like healthcare institutions, pharmaceutical companies, and health insurance companies will have a stronger influence when they employ CSR funding to engage in social activities specially in India. It is commendable that certain initiatives, like safety standards in Indian healthcare, are helping the less fortunate members of society receive better medical care.

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