Counterpoint

‘Counterpoint’ is an occasional feature presenting discussion of a topic that is currently under debate in quality of care circles. We invite readers to submit Letters to the Editor adding their opinion to the topic.

Getting more from private health care in poor countries: a missed opportunity

In ‘Privately funded quality health care in India: a sustainable and equitable model’, Samandari et al. [1] describe ‘a successful model through which high-quality, equitable health care can be provided in a developing country’. The L. V. Prasad Eye Institute (LVPEI) provides excellent quality care with a significant focus on treating those who are unable to pay. It is able to finance itself and these subsidies in one of the world’s poorest countries, while remaining financially solvent and still expanding its volume and scope.

LVPEI is a privately owned, not-for-profit institution, which provides services ranging from screening and acute outpatient care in rural communities to highly sophisticated inpatient treatment in state-of-the-art clinical facilities. This is an inspiring tale. What can institutions like this contribute to India’s health care system? What can we learn from LVPEI and places like it in developing countries?

India still ranks among the world’s lowest income countries, with a per capita income of approximately $440 in 2000. Soon after India’s independence from British rule, its government put forward an ambitious proposal for a national health service that would provide tax-financed comprehensive health care for the population. Although this strategy was never adequately funded or implemented, the Indian government continues to focus almost entirely on the role of the public sector in health care financing and delivery. India’s government spends in the region of 1–1.5% of national income on health, a modest amount in comparison even with other poor countries.

Partly because of the limited government funding it received, India’s real health care system developed quite differently from what was envisioned in those early optimistic days. India has one of the more highly privatized health care systems in terms of both finance and delivery among low-income countries. Recent estimates suggest that about 75% of total spending is direct household payment for care. For outpatient treatment, the figure is even higher, perhaps over 90%. For inpatient care, the government plays a larger role in funding and delivery. About two-thirds of all hospital beds are in government institutions, but the numbers of private hospital beds are growing rapidly.

How is non-government health care delivery organized in India? There are four main sub-sectors. First, there are the formal, medically qualified, private for-profit providers: hospitals at various levels as well as individuals and groups of GPs and specialists. Second, there is the formal, medically qualified not-for-profit sector. This also comprises hospitals at various levels of specialization, as well as outpatient facilities and community-based programs. LVPEI is in this sub-sector. Third, there are formal providers qualified in Indian and other, non-allopathic systems of medicine. (Note: The term ‘allopathy’ is used in India to refer to the dominant ‘Western’ scientific tradition in medicine.) These systems also include hospitals and outpatient providers of various kinds, but who have received formal training and licensure. Finally, there is a ‘less than fully qualified’ private sector, which ranges from partially qualified and experienced practitioners of allopathic medicine to practitioners who have little or no formal training. These providers deliver mainly acute outpatient treatment and drugs.

India’s not-for-profit sector is also quite diverse. It includes large tertiary hospitals providing mainly elite care on a fee-for-service basis and charitable institutions like LVPEI, which address social needs while maintaining clinical excellence. It also includes institutions that focus entirely on the most basic needs of the poor and rural population.

Many of these not-for-profit institutions, including LVPEI, make an immense and important contribution to India’s health and health care. But while there are no reliable figures measuring their contribution, they probably account in total for less than 5% of patient care in the country. In addition, they tend to be more concentrated in India’s more advanced states and often in the more advanced parts of those states.

This description suggests that leading not-for-profit institutions like LVPEI should not primarily be seen as models for wholesale replication, but rather as laboratories of innovation. That is, in India and many other places like it, institutions such as LVPEI offer the best opportunity to develop and test appropriate solutions to many problems faced in delivering good quality care to those in need in low-income countries.

As Samandari et al. [1] describe, LVPEI has found innovative answers to a number of important questions. It has found practical ways to integrate quality monitoring and quality standards, both clinical and patient-care quality concerns, into a large medical institution in India. LVPEI has also maintained high quality care in an environment of limited funding, through close attention to costs and efficiency within a quality boundary. While eschewing government and international organization funding, LVPEI has found ways to raise funds for its operations from patient fees while still
maintaining a 1:1 ratio of paying and subsidized patients; a high degree of cross-subsidization. It has developed new strategies of rural outreach and planned efforts to shift care patterns to less resource-intensive approaches. It also maintains important education and training activities. In all of these areas and perhaps more, LVPEI has much to contribute to improving health care in India.

How well does India (and other countries with similar institutions) learn from these experiences? Not well enough, in my experience. And that is the ‘missed opportunity’ of the title of this opinion. The innovators in private not-for-profit health care in India, like LVPEI, are unlikely to ever be numerous enough to meet a major share of India’s immense health needs. But they can be the proving grounds for new approaches and the educators for the larger universe of health care providers. Unfortunately, there often remains a barrier of mistrust and disinterest between public and private health care that limits taking full advantage of this important resource.

What should be done? There is an urgent need for new initiatives of public–private collaboration in India and other developing countries, especially between the government and the private not-for-profit sector. For this to happen, both partners, public and private, must come together in a spirit of collaboration and problem solving for the health system, much like what we expect from administrators and managers in a hospital seeking to improve quality. More collaboration could be developed in three areas: (1) partnerships for problem-solving at both the policy and practice levels; (2) collaboration on documenting successful innovation and dissemination of lessons learned; (3) joint efforts at education and training of administrators and clinicians.

The first of these, partnerships for policy and practice, has the widest potential scope. Not-for-profit innovators like LVPEI are often the pioneers in developing appropriate methods of integrating modern health care into resource-poor environments. Visionary thinkers in government will seek them out and invite their collaboration in solving strategic problems as well as in delivering services to hard-to-reach populations. India has many examples of successful collaboration of this type, but much more could be done. For the other areas, both government and non-government providers would benefit immensely from more and better information about good practices and from joint development of human resources.

Governments in all countries are increasingly finding that they cannot afford to ignore innovation emerging from outside the organizations of the state. In poor countries, the cost of these missed opportunities is particularly striking. In India, the private health sector is large and diverse. Some of its experience deserves emulation and replication. Other aspects are best controlled or suppressed. A serious effort to tell the difference and use what is useful would have great benefits.

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References