Stakeholders in the Indian Healthcare Sector

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INTRODUCTION

This special issue of Vikalpa was conceptualized to extend the scholarship on stakeholders in healthcare, specifically in the Indian context. Healthcare is a complex system. Multiple stakeholders pursue diverse interests, and this complexity is enhanced in the emerging economies context, where resource constraints are significant (Nicolini et al., 2008).

The Indian healthcare sector is changing rapidly. Especially, with the government announcing Ayushman Bharat and Pradhan Mantri Jan Arogya Yojana (PM-JAY) schemes to make healthcare affordable as well as the increasing use of technology in the way information is accessed, stored and shared (Angell et al., 2019; Gupta et al., 2020; Prinja et al., 2017). These aspects, amongst several others, such as changing demographics, enhancement of medical technologies, regulatory changes such as dissolution of Indian Medical Council (IMC), have transformed the complex relationships amongst stakeholders in the Indian healthcare sector. These rapid and substantial changes require an in-depth inquiry into the changing roles of stakeholders, and this formed the motivation for the special issue.

Understandably, one special issue would be inadequate to capture the complexity related to the multiple stakeholders in the Indian healthcare sector; nevertheless, this issue provides a starting point for developing these discussions further. We summarize the contribution of the articles published in this special issue and present a discussion about how the articles address the conversation around the stakeholders in the Indian healthcare sector.

These studies address issues related to diverse stakeholders and provide insights that help in enhancing our understanding of the sector dynamics. We also suggest directions for future research that can help move the conversation forward.
CHANGING DYNAMICS IN THE INDIAN HEALTHCARE SYSTEM

As evidenced by the actions taken by the government in dealing with the current pandemic, alignment between various stakeholders, including local communities, scientific community across various disciplines, public healthcare, private healthcare, regulatory authorities, executive and even legal authorities, is crucial for dealing with epidemics. In the past two decades, even before the pandemic arrived the Indian healthcare sector has seen several changes that can potentially alter the dynamics between the stakeholders drastically. Initiation of the National Rural Health Mission (NRHM) in 2005–2006, aimed at an architectural transformation in the healthcare sector, especially in the rural areas, by increasing the participation of the community in the healthcare delivery process through the involvement of Panchayati Raj Institutions (PRI) and creating a vast workforce of Accredited Social Health Activist, commonly termed as ASHA workers (Husain, 2011). Thus, the NRHM transformed the role of the community from a mere consumer of the healthcare services to an important stakeholder that can determine the design and implementation of the services locally (Husain, 2011).

A major secular trend that has emerged is the corporatization and privatization of the healthcare sector, with several large corporate hospital chains forming more than 60% of the bed capacity across the country (Srinivasan & Chandwani, 2014). Most of these chains focus on the provision of tertiary healthcare in urban areas. These aspects have also transformed the architecture of the healthcare sector in India, for example, increasing the role of the business community, investors and financiers and managers in shaping the healthcare services in India, increasing the cost of healthcare and changing the role of doctors from owner-entrepreneurs to employees (Srinivasan & Chandwani, 2014). With increasing privatization (more than 80%) and a corresponding decrease in the role of the public sector in healthcare, the government’s role has also transformed from that of a regulator and financier to that of a provider through the public sector to that of a regulator and financier (Bali & Ramesh, 2021). In 2018, the Government of India launched the Pradhan Mantri-Jan Arogya Yojana (PM-JAY), a welfare scheme that extended health insurance to 110 million of India’s poorest families (Angell et al., 2019; Gupta et al., 2020). World’s largest health insurance programme, the PM-JAY increases the complexity of the healthcare system tremendously as it juxtaposes public and private healthcare organizations with health insurance providers and third-party administrators (TPAs) (Bali & Ramesh, 2021). The regulations brought in by the government, such as Clinical Establishment Act and PM-JAY, also entail that more and more hospitals pursue accreditation from the National Accreditation Board for Hospitals (NABH).

The majority of Indians have to incur out of pocket (OOP) expenditure for availing medical treatments, both in the public and private healthcare facilities. Mostly, OOP in public sector hospitals is related to the non-availability of medications or diagnostic kits (Ellis et al., 2000). Apart from the PM-JAY, there are several state and private mechanisms for financing healthcare in India, including state-sponsored healthcare schemes (such as Kalaignar in Tamil Nadu); Central Government Health Scheme (CGHS), Employees State Insurance Scheme (ESIS), other employer managed welfare schemes for employees; and insurance coverage provided by public and private healthcare insurance companies (Angell et al., 2019; Gupta et al., 2020; Prinja et al., 2017). Despite these initiatives, the penetration of health insurance in India remains below 20% (Singh, 2016). However, the healthcare insurance sector is expected to grow rapidly with the government’s focus on healthcare financing rather than healthcare provision. Further, the current pandemic has highlighted the need for health insurance coverage.

Another trend observed in the healthcare delivery across the countries, and also in the Indian context, is the increasing role of Information Technology (IT) such as electronic medical records (EMR), empowering the peripheral and community healthcare workers, connecting patients through online patient support groups, making healthcare information available online, and so on. IT has influenced not only healthcare delivery but also impacted healthcare seeking behaviours of the patients and caregivers. Thus, IT and the firms working in the intersection of IT and healthcare have become significant stakeholders in the healthcare system in India.

The above discussion gives a glimpse of India’s rapidly transforming healthcare system and the related complexity of the stakeholders involved. The next section highlights how the articles in this special issue highlight specific issues related to certain stakeholders.
STAKEHOLDERS DISCUSSED IN THIS SPECIAL ISSUE

Two articles in this issue address the role of technology in transforming the traditional healthcare delivery system by influencing stakeholders’ behaviour. Panda and Mohapatra (2021) conduct a literature review on the online healthcare space in India to identify the relevant stakeholders and their related dynamics along different lifecycle phases. Specifically, the authors highlight the role of different stakeholders, including IT developers and managers, doctors, nurses, patients and caregivers in various stages of the lifecycle of the open health connect (OHC) platform from inception onwards (Young, 2013). They highlight the role of technical aspects such as the appropriate design of the interface, user-friendly GUI and technical support, and informational aspects such as credibility of information in managing an OHC platform. The insights derived have implications for enabling proper information flow during the current pandemic. Indeed, panic and wrong information have been major deterrents for the governments in providing authentic information to the citizens that can enable appropriate behaviour changes for controlling the pandemic.

Mishra (2021) examines why patients connect with their doctors on Facebook. The author adopts a critical lens to conduct an in-depth examination of the phenomenon rather than taking the usual techno-utopian lens (Lupton, 2013). Apart from the need to interact with their doctors, the patients connect with the doctors for multiple reasons, including accessing health information, seeking social support from patient community members and assessing physicians. Through these narratives, Mishra (2021) highlights how accessing the physicians’ Facebook profile allows for neoliberal practices and subjectivities, extending the Foucauldian concept of neoliberal governmentality to the digital health space.

Understanding the dynamics of IT in healthcare delivery and healthcare-seeking would be very important for the growing importance of digital health and telemedicine. These studies, specifically, become more relevant as telemedicine has become mainstream—post-COVID. The Government of India boosted digital health by formalizing the new telemedicine guidelines in March 2020 (IANS, 2020). Though technology is increasingly penetrating the healthcare space in India, especially during this pandemic, the majority of the population still accesses healthcare in the traditional manner.

While the Facebook posts and Google reviews form important parameters for selecting the doctors (Mishra, 2021), a vast majority of the patients and their caregivers rely on recommendations from family, friends or acquaintances to select hospitals and doctors. Indeed word-of-mouth (WOM) marketing remains a major determinant of the choice of facility or physician while seeking healthcare (Dobele & Lindgreen, 2011). In their article, Mishra and Sinha (2021) attempt to explore antecedents of physician’s recommendation by the patients. Specifically, they examine whether and how the physician’s communication skills influence WOM marketing by the patients. Invoking the social interaction theory, they posit that patients build impressions about physicians during face-to-face physician–patient interactions (Lockie et al., 2015). Adopting a quantitative approach, they surveyed 626 patients to highlight that effective communication by the doctor indeed led to favourable recommendations. Emphasizing the pathway of this relationship, they found that the above relationship was mediated through patient satisfaction and perceived influence.

A major change in the Indian healthcare sector is the emergence of health insurance firms. The increasing cost of healthcare and the government focus on affordability have catalysed the growth of the health insurance sector, which has crossed US $6.06 billion in FY 2020. Though the premium paid has been growing at a healthy growth of about 14% year on year, the cost of the treatment has also been rising steadily. These circumstances pose a significant challenge for the private insurance firms as they need to balance two opposing requirements to maintain profitability: provide quality service, which requires ensuring the best possible coverage to their clients while keeping the premiums low to survive the competition. Kumar and Duggirala (2021) draw from the tenets of the literature on resource-based view of the firm (Barney, 1995; Rumelt, 1991) and on competitive strategy (Porter, 1985) to highlight the critical success factors for the firms in this highly competitive sector. Adopting a grounded theory approach, they conduct in-depth interviews with experts from healthcare and health insurance to describe five strategic choices available for the health insurance firms to thrive and gain a competitive advantage. The insights from the article present the way forward for the burgeoning
health insurance sector in India, especially for private sector firms.

As discussed in the introduction, the Indian healthcare system has become highly privatized and corporatized, with the market or commercial logic playing an important role in determining the stakeholders’ behaviours. However, with health being a socially sensitive subject, the government is attempting to ensure quality, affordability and accessibility through regulations such as Clinical Establishments (Registration and Regulation) Act 2010, PM-JAY and the national medical commission (NMC). However, can market dynamics, albeit controlled and regulated, provide access to healthcare for everyone? Or is there some specific population that is crowded out?

Pingali and Das (2021) highlight how the market mechanisms, operating on the commercial logic, crowds out the rare diseases from the pursuit of searching for newer modalities of treatment through R&D and also for providing cure or care for these illnesses. They discuss that because of low volumes, market-driven stakeholders avoid investing their resources for these illnesses as the economic viability of such endeavours is questionable. Even if investments are made, the extremely low volumes result in increased cost per patient, acting as another significant barrier to access. Further, governments across the world attempt to allocate resources towards more prevalent illnesses that affect the population, resulting in crowding out of the rare or less prominent diseases. More often than not, the patients have approached the courts to gain access to the treatments. In most cases, the courts have mandated the governments to provide for treatment. Pingali and Das (2021) propose that while India has taken a progressive step in formulating a policy, National Policy for Rare Diseases 2020, to support patients suffering from rare diseases, the policy is largely silent on resource and fund allocation. They suggest several measures to enhance funding available for research and development and delivery of healthcare for rare diseases in the Indian context.

The next section presents some of the directions for future research emerging from the articles included in the issue.

DIRECTIONS FOR FUTURE RESEARCH

While this issue covers specific aspects related to some of the stakeholders in the healthcare sector in India, the articles introduce several avenues for future research. Articles in this issue range from presenting the patient as stakeholders using technology and also assessing doctors, to the health insurance sector, and the government’s role in rare diseases. There are several other stakeholders in the ecosystem where alignment can be a challenge. Future researcher can focus on different stakeholders, such as public and private sector hospitals, TPAs, NGOs and CBOs, and so on, to expand the understanding between them. In the issue, all the articles highlight how to align these stakeholders for the betterment of healthcare delivery. Alignment can be a challenge in dyadic relationships between two stakeholders for example, community level workers and those in the formal system. The impact of NRHM and the increasing use of technology in healthcare creates close connections between the informal actors at community level and the formal systems. The response to the current pandemic, where behavioural modifications were crucial, highlighted the gap between formal and informal systems including lack of trust and coordination between the two. Future researchers can analyse what are the factors that support or impede the relationship between these related but diverse stakeholders. For example, there have been several ‘success studies’ of managing the COVID pandemic through a collaborative effort between formal and informal systems for instance in Dharavi, Mumbai.

The importance of technology in the healthcare system is increasing rapidly and there has been an acceleration due to the current pandemic. However, many of these technologies are at a nascent stage in India, for example, telemedicine (Chandwani & Dwivedi, 2015) and Internet access for health information (Chandwani & Kulkarni, 2016). There has been a sudden surge in the use of platforms for delivering healthcare as well as for accessing health information. The platforms include both formal platforms such as those designed and implemented by governments and healthcare organizations as well as informal patient groups. The increasing use of IT to access healthcare information and services poses several questions worth exploring. How does patient behaviour vary across platforms such as Facebook, WhatsApp or OHCs? Do they derive different benefits from these platforms? If so, what are the features of the respective platform that prompt certain behaviours? To extend Mishra (2021), what are the specific aspects of the physician’s online presence that determine the choice of a particular physician or hospital. Further, as indicated by Mishra and Sinha (2021) doctor–patient communication plays an important role in WOM referrals. How is this altered
in the online platforms, specifically, what aspects of doctor–patient communication in the online media influence patients’ perception about the physicians.

Notably, the use and adoption of IT in healthcare is contextual and varies from culture to culture (Miscione, 2007). There are substantial geographical and regional and rural–urban variations in the Indian context that can influence the patients’/caregivers’ behaviours. Future studies can explore the influence of such cultural aspects in determining the adoption of in the Indian healthcare system. Involvement of communities in the delivery of healthcare has been emphasized repeatedly, especially so in the current pandemic. Examining the role of IT in the rural areas of India can highlight how we can optimally use IT for enhancing healthcare delivery in rural and vulnerable areas.

Further, the studies included in this issue have looked at the phenomenon from patients’ and/or caregivers’ perspective. Future researchers should explore how physicians or healthcare institutions perceive the phenomenon. Prior research (Chandwani & Kulkarni, 2016) have critically examined the issue of doctors’ perceptions about Internet-informed patients in the Indian context. While their research highlighted the scepticism amongst physicians about dealing with such patients, the current pandemic may have changed the perceptions about the use of IT by patients in general and for accessing health information in particular. Future researchers could examine the perceptions of physicians about the adoption of IT by patients, especially focusing on this particular behaviour as the pandemic subsides. Is the focus on telemedicine going to stay as strong after the pandemic? Or do the physicians (and also the patients) revert to the conventional way of delivering (and seeking) healthcare.

Apart from the implications for individuals—patients, caregivers and physicians that are discussed above—the proposed technological changes in the Indian healthcare system can, potentially, alter the ecosystem of the stakeholders significantly. The Government of India is planning to initiate the NHS (National Health Stack), which would bring all the major stakeholders such as insurers, hospitals, government, TPAs, technology-based start-ups, and so on, on to a single platform. The NHS would thus become a platform where diverse stakeholders will form a collective. Literature suggests that as one moves from an individual to the collective level, several other factors that were not relevant for individual-level analysis become relevant, for example, social dynamics between individuals, intersection between communities, interfaces between formal and informal systems, and so on (Chandwani & Kumar 2018; Hitt et al., 2007). Future researchers can investigate how the collectives of stakeholders relate to each other in situations such as that facilitated by the NHS. How does the collective shape the business models related to healthcare delivery organizations? How does the availability of data to these different stakeholders alter their business strategies such as innovative product design, for example, do the insurance companies make use of data to modify their premiums or to screen out hospitals for empanelment? Extending the work by Kumar and Duggirala (2021), future researchers can conduct studies using different methodologies to explore the strategies adopted by the health insurance firms in India (Ahlin et al., 2016).

In other words, the rapidly changing current dynamics in the Indian healthcare sector, can potentially, significantly alter the stakeholders’ behaviours. These range from individual level (for example, patient/caregiver/physicians) to dyadic levels (doctor-patient, government–private sector, etc.) to collective and systems level (for example incorporation of NHS at the national level). While the present issue examines few questions pertaining to specific stakeholders, it kindles several interesting questions for future research.

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