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Brokerage in commercialised healthcare systems: A conceptual framework and empirical evidence from Uttar Pradesh

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ABSTRACT

In many contexts there are a range of individuals and organisations offering healthcare services that differ widely in cost, quality and outcomes. This complexity is exacerbated by processes of healthcare commercialisation. Yet reliable information on healthcare provision is often limited, and progress to and through the healthcare system may depend on knowledge drawn from prior experiences, social networks and the providers themselves. It is in these contexts that healthcare brokerage emerges and third-party actors facilitate access to healthcare.

This article presents a novel framework for studying brokerage of access to healthcare, and empirical evidence on healthcare brokerage in urban slums in Lucknow, Uttar Pradesh. The framework comprises six areas of interest that have been derived from sociological and political science literature on brokerage. A framework approach was used to group observational and interview data into six framework charts (one for each area of interest) to facilitate close thematic analysis.

A cadre of women in Lucknow's urban slums performed healthcare brokerage by encouraging use of particular healthcare services, organising travel, and mediating communications and fee negotiations with providers. The women emphasised their personal role in facilitating access to care and encouraged dependency on their services by withholding information from users. They received commission payments from healthcare programmes, and sometimes from users and hospitals as well, but were blamed for issues beyond their control. Disruption to their ability to facilitate low-cost healthcare meant some women lost their positions as brokers, while others adapted by leveraging old and new relationships with hospital managers.

Brokerage analysis reveals how people capitalise on the complexity of healthcare systems by positioning themselves as intermediaries. Commercialised healthcare systems offer a fertile environment for such behaviours, which can undermine attainment of healthcare entitlements and exacerbate inequities in healthcare access.

1. Introduction

People seeking access to healthcare often have to negotiate a complex and opaque landscape of service provision in which it is difficult to find reliable information on the cost and quality of healthcare and its alternatives, as well as its necessity and outcomes (Arrow, 1963; Gabe et al., 2015). There are informational, social, financial and other practical barriers that prevent people from 'appearing' at places of care, and the people who do reach places of care then face assessment on whether care should be offered or sought elsewhere (Dixon-Woods et al., 2006). It is a situation that has been aptly described as navigating a 'healthcare maze' (Collyer et al., 2015).

This article focuses on the phenomenon of healthcare brokerage: intermediation of access to healthcare by 'third-party' actors who are external to healthcare providers and the immediate families of prospective users. The concept of brokerage has broad applicability in the healthcare sector yet its use has largely been limited to that of a descriptor for studying transnational healthcare arrangements, where companies and travel agents are described as brokering arrangements for 'medical tourists' (Deepa et al., 2013; Snyder et al., 2011). Other authors have used brokerage to describe knowledge transfer (Long et al., 2013), and the pressures of life at the interface between value systems in health, such as the nurse-led 'culture brokerage' between biomedicine and communities (Barbee, 1987; Jezewski, 1990), and community worker brokerage between governments and communities (Nading, 2013). A related body of work uses Michael Lipsky's (1980) concept of 'street-level bureaucrats' to analyse the motivations and pressures for workers at the frontline of healthcare systems (Erasmus, 2014).

This paper presents a novel framework for analysis of healthcare

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brokerage, and empirical evidence on healthcare brokerage in urban slums in Lucknow, Uttar Pradesh. The paper highlights healthcare commercialisation as an enabling factor for emergence of brokerage in the healthcare sector. Section three discusses insights that can be drawn from sociological and political science literature on brokerage, and identifies six areas of interest that provide particular insights into the phenomenon of healthcare brokerage and offer a framework for brokerage analysis. Section four introduces empirical research conducted in Lucknow, Uttar Pradesh, by outlining the setting and the methods used to generate and analyse data. The fifth section is structured using the six areas of interest for brokerage analysis and presents original findings on the strategies, rewards and pressures associated with healthcare brokerage. The paper concludes with discussion on the implications of brokerage for our understanding of healthcare and its provision, and suggests possible future applications of a brokerage framework in the study of healthcare.

2. Brokerage and healthcare commercialisation

Brokerage is a well-recognised phenomenon in economic literature, in which it is frequently analysed as a form of agency in which a 'principal' tasks an 'agent' to act on their behalf (Myerson, 1982; Sappington, 1991). The term is commonly used to describe intermediating actors in marketplaces, and professional 'broker' firms thrive in service sectors characterised by complex systems of information and unpredictable changes, for example finance (Frye, 2000), insurance (Karaca-Mandic et al., 2013), and real estate (Searle, 2014). The companies match clients with one another, facilitate purchases and arrange exchanges, and in return receive fees or commissions based on the size of transaction.

The healthcare sector shares the characteristic complexity and uncertainty of other service sectors in which brokerage behaviours arise. There is detailed information on health issues, medical conditions and treatments (Gabe et al., 2015); substantial difficulties for obtaining reliable information on predicated healthcare costs (Arrow, 1963) and quality of care (Hanefeld et al., 2017), and an array of organisations and actors involved in the processes of providing care. Progress through this 'healthcare maze' requires significant personal resources and some prospective healthcare users can draw on their prior healthcare experiences and on information from online sources and social networks, however many people lack the necessary resources, particularly those people who are from poor and other socially excluded groups (Willis et al., 2016). The need for support when accessing care has been recognised in some healthcare systems by the inclusion of 'gatekeeper' roles for health professionals to guide healthcare users and their decision-making, although gatekeepers are also able to perform exclusionary (Collyer et al., 2017) and abusive practices (Nandraj, 2015).

Healthcare commercialisation processes exacerbate complexity in healthcare systems. These processes involve the expansion of healthcare markets and increased emphasis on models of provision involving cash income and private profit (Mackintosh and Koivusalo, 2005). Commercialisation has led to growing pluralism of public and private services in many healthcare systems (Bloom et al., 2013; Bloom and Standing, 2001). It undermines attainment of healthcare entitlements as prospective users are expected to perform roles as consumers of healthcare, exercising rational choice in a marketplace of providers (Tritter et al., 2011). While there is some evidence to indicate that socially and economically privileged groups in high-income settings are able to effectively exercise choice of healthcare provider (Willis et al., 2016), for other groups user 'choice' is a more restricted concept (Gabe et al., 2015). Brokers offer a way to navigate the complex landscape of varying providers, services, costs and quality in order to attain healthcare entitlements.

3. Social science approaches to studying brokerage

There is extensive sociological and political science literature on brokerage behaviours and this body of work can inform the study of brokerage in the healthcare sector, where similar detailed examination of individual agency amongst brokers is lacking. Six key areas from sociological and political science literature are highlighted in turn below: the nature of brokerage activities; social relations between brokers and other groups; benefits to each group participating in brokerage; attempts by brokers to consolidate their position; personal costs of engaging in brokerage activities; and ways in which brokers react to changes in their context.

3.1. The nature of brokerage activities

Sociological analyses of networks have used varying interpretations of brokerage, ranging from the arrangement of 'transactions' (Marsden, 1982) to the influencing of 'interactions' more broadly (Obstfeld et al., 2014). They include catalytic *tertius iungens* behaviours that promote closer interaction between actors, and 'middle-man' *tertius gaudens* arrangements that facilitate exchange while maintaining existing divisions (Obstfeld, 2005). Studies of political brokerage pay particular attention to the nature of brokerage activities in systems of patronage and clientelism (Lemarchand and Legg, 1972). Political 'fixers' – usually politicians or activists working on their behalf – control access to certain resources, which can then be leveraged in return for payments and votes. In many cases the resources themselves are publicly owned, for example subsidised food or electricity (Harriss-White, 2003; Jha et al., 2007), but are characterised by the presence of opaque eligibility criteria, convoluted administrative processes, over-burdened service providers and corrupt officials (Auyero, 2012).

3.2. Social relations between brokers and other groups

Brokerage behaviours develop amongst groups characterised by local cohesion (strong within-group ties) and wider fragmentation (absent or weak between-group ties) (Burt, 1992; Granovetter, 1973), but also within groups with strong ties where there remains scope for new forms of collaboration (Obstfeld, 2005). The extent to which third-party actors can intermediate is determined by the strength of their relationships with the other actors (Gould and Fernandez, 1989), and so they foster good relationships with potential clients and may downplay certain relationships to avoid perceptions of bias towards one group or another (Stovel and Shaw, 2012). The brokers may operate alone, or may work as part of wider 'problem-solving networks' comprising a range of actors with varying strengths of ties and varying degrees of control over resources (Auyero, 2000).

3.3. Benefits to each group that participates in brokerage

In network analyses of brokerage, significant attention has been devoted to the personal benefits generated by intermediaries through brokerage activities, such as the commission payments they earn from facilitating transactions (Marsden, 1982). For political brokers, such benefits may extend beyond income to include votes and other forms of political support (Lemarchand and Legg, 1972), while brokerage of information within organisations may enable an intermediary to improve their professional reputation and accelerate career progression (Burt, 2004). There are wider potential benefits for engaging in brokerage as persons with knowledge of administrative and management procedures help prospective service users to negotiate bureaucracies (Corbridge et al., 2005; Harriss-White, 2003), even assisting service users in bypassing administrative systems or negotiating a reduction in fees. Meanwhile brokerage of information within organisations can improve communication and facilitate innovation (Burt, 2004).