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Unfree markets: Socially embedded informal health providers in northern Karnataka, India

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ABSTRACT

The dynamics of informal health markets in marginalised regions are relevant to policy discourse in India, but are poorly understood. We examine how informal health markets operate from the viewpoint of informal providers (those without any government-recognised medical degrees, otherwise known as RMPs) by drawing upon data from a household survey in 2002, a provider census in 2004 and ongoing field observations from a research site in Koppal district, Karnataka, India. We find that despite their illegality, RMPs depend on government and private providers for their training and referral networks. Buffeted by unregulated market pressures, RMPs are driven to provide allopathic commodities regardless of need, but can also be circumspect in their practice. Though motivated by profit, their socially embedded practice at community level at times undermines their ability to ensure payment of fees for their services. In addition, RMPs feel that communities can threaten them via violence or malicious rumours, leading them to seek political favour and social protection from village elites and elected representatives. RMPs operate within negotiated quid pro quo bargains that lead to tenuous reciprocity or fragile trust between them and the communities in which they practise. In the context of this 'unfree' market, some RMPs reported being more embedded in health systems, more responsive to communities and more vulnerable to unregulated market pressures than others. Understanding the heterogeneity, nuanced motivations and the embedded social relations that mark informal providers in the health systems, markets and communities they work in, is critical for health system reforms.

Introduction

The current policy thrust towards universal health care in India (HLEG, 2011) is premised on the participation of adequate numbers of skilled health providers who operate within a unifying regulatory framework. However, qualified providers are unevenly distributed geographically, with remote rural areas and urban slums particularly underserved (Gangolli, Duggal, & Shukla, 2005; NCMH, 2005; Rao, Rao, Shiva Kumar, Chatterjee, & Sundararaman, 2011). Many of the providers who do work in these marginalised regions lack government-recognised medical degrees and are known in India as RMPs (acronym discussed in further detail later). In India, although only registered providers are allowed to practice, poor regulatory enforcement allows RMPs to enterprisingly fill an informal market for curative allopathic treatment. The dynamics of these informal health markets, which shape the behaviour and practice of RMPs as well as the dependence on them in marginalised regions, are relevant to the policy discourse, but are at present poorly understood.

In this paper, we examine how informal health markets operate from the viewpoint of RMPs in northern Karnataka, India. By drawing upon sociological literature on markets and empirical data, we describe the varied motivations, social relations and linkages (with formal health providers and the community) that underpin RMP practice. In doing so, we contribute insights to an emergent literature on the institutional context of informal service provision, which is relevant to the policy discourse in India and to marginalised populations accessing informal health markets the world over.

Literature review

In economics, markets are seen as arenas for the exchange of goods and services in which buyers and sellers participate to maximise their interests. However, economic sociologists like new

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institutional economists argue that markets can also be seen as being contingent on social relations, structures and norms. In addition, economic sociologists find problematic the separation of human behaviour into mutually exclusive spheres, defined as self-interested market relations versus political social relations (Swedberg, 1994). They argue that economic goals can be pursued in conjunction with social goals like sociability, approval, status and power (Granovetter, 1992). Individual economic action is not about self-interest alone, but can also involve reciprocity and redistribution (Mackintosh & Gilson, 2002). Market expressions, therefore, reflect settlements negotiated by human actors who are motivated by multiple goals and influenced by their embedded location in social relations and contexts as defined by broader political economies.

A more nuanced sociological approach to understanding how markets function is critical for health systems in Asia and in other low and middle income contexts. Private health providers are dominant, but the complex dynamics that define their discretion or dependency within the health systems, markets and communities in which they work require further investigation (Kamat, 2001; Kielmann et al., 2005; Krause, 2001; Sheikh & George, 2010). The contradictions and ambiguities of contemporary health markets in unregulated contexts are particularly relevant to informal providers (Bloom, Standing, & Lloyd, 2008; Peters & Bloom, 2012).

Informal providers are increasingly being recognised as major providers in the south Asian region (Ahmed, Hossain, & Chowdhury, 2009; Rashid, Akram, & Standing, 2011). In India, these providers have long been recognised as playing a critical role (Neumann, Bhatia, Andrews, & Murphy, 1971) and historically outnumbered formal providers. The 1881 census recorded 12,620 physicians and surgeons, 582 army hospital medics and 60,678 unqualified practitioners (GOI 1883 cited by Duggal, 2005). Although informal providers represent a network that outnumbers providers with government-recognised degrees in rural areas, their numbers are still insufficient considering the volume of rural health needs. A study in Uttar Pradesh had to cover three times the villages originally planned in order to reach their desired sample of RMPs (Rohde & Viswanathan, 1995: p. 42). Similarly, Ashtekar and Mankad (2001: p. 448) found that 84% of villages in Nashik district, Maharashtra, had no resident private provider – not even an informal one.

In India, the terminology to describe informal allopathic providers or RMPs can be confusing. RMP used to stand for Registered Medical Practitioner. Prior to independence, the colonial government began registering unqualified rural practitioners in 1933, requiring a certificate from a revenue officer attesting to their successful practice for ten years (Rohde & Viswanathan, 1995) or their apprenticeship with other experienced providers (Jeffery, 1988). Today the only doctors qualified to practise allopathy in India, and who are eligible for registration, are those who hold MBBS degrees. Nonetheless, the term RMP persists in India and permission to practise allopathic medicine is not effectively controlled by the state. For example, Ashtekar and Mankad (2001: p. 451) listed 43 different degrees reported by rural medical practitioners in Nashik district, Maharashtra. This is beyond the degrees that the government recognises for medicine: MBBS (Allopathy), BDS (Dentistry), BAMS (Ayurveda), BHMS (Homoeopathy), and BUMS (Unani). In our study, we defined RMPs as private providers who provide allopathic curative care without having any of the degrees for medicine recognised by the Government of India.

Cross and MacGregor (2010) highlight the problematic assumptions around defining informal providers, the context of their biomedical and economic transactions, and their networks with other providers. They argue for a more nuanced understanding of RMP practice. One step in that direction is made by Ingram, Sudhinaraset, Lofthouse, and Montagu (2012), who define informal providers as those who: 1) receive payments from patients rather than institutions, usually in an undocumented fashion, 2) receive little or no officially recognised training, 3) operate outside the purview of regulations, registration or any official oversight, and 4) may be part of professional associations that do not have certification or regulatory authority. Based on this definition, their review found that these providers represented a significant proportion of the health sector varying from half to more than half of all providers in Asia and Africa and generally had high patient loads (Ingram et al., 2012).

Informal providers are increasingly recognised as an important part of health systems in various contexts (Ingram et al., 2012; Konde-Lule et al., 2010; Kruk, Rockers, Varpilah, & Macauley, 2011; Omaswa, 2006; Onwujekwe, Onoka, Uzochukwu, & Hanson, 2011). In the south Asian context, the poor clinical quality of care rendered by informal providers is well established (Ahmed & Hossain, 2007; Chakraborty & Frick, 2002). While training interventions have most frequently been used to address this problem (Ingram et al., 2012), a combination of interventions that change the institutional relationships, incentives and accountabilities of these providers is recommended (Shah, Brieger, & Peters, 2010). Understanding the contextual basis of the institutional relationships that support their knowledge, livelihoods and reputations is critical (Bloom et al., 2011). Following these recent reviews that argue for a more contextualised understanding of informal providers, and those who have described medical pluralism in India (Khare, 1996; Pinto, 2004), we detail the social profile of these providers, including how their practice is embedded in and regulated by their relations with formal health systems, markets and communities in which they work and live.

Methods

Data for this paper is derived from a research site comprising 60 villages in Koppal district, northern Karnataka, India, together with the larger villages and towns to which its inhabitants routinely travel for health care. With just over 1 million people, Koppal district has the worst development indicators within Karnataka (Sen, Iyer, & George, 2008). As a drought-prone agrarian economy, it has high levels of poverty, illiteracy, seasonal migration, and adverse caste and gender hierarchies. Caste hierarchies are based on the notion of ritual purity inherited at birth that restricts intermarriage and inter-dining. The caste system, which traditionally defined occupational groups, remains a powerful determinant of access to resources, as well as discrimination and violence, even if its boundaries can be blurred and contested.

Three data sources are used. *First*, a household survey in 2002 on health care utilisation for self-reported morbidity from a circular systematic random sample of 12.5% (or 1920 of 15,360) households in the project area. *Second*, a private provider census in 2004 in the 60 villages within the project area and surrounding 11 market villages and commercial towns, which collected data on informal providers i.e., RMPs with no degrees or with claims to unrecognised degrees (Box 1), traditional birth attendants, spiritual and traditional healers, provision stores selling tablets, unlicensed medical stores that serve as informal pharmacies, as well as formal providers (i.e., licensed medical stores (pharmacies) and laboratories, private doctors with MBBS, BDS, BAMS, BHMS, BUMS degrees). Among informal providers, this paper focuses on RMPs. *Third*, daily field notes recorded during nine months of ethnographic study on health service provision in 2004, as well as from unstructured observations and interactions with RMPs to this date during training sessions on maternal health care.