missioning role, and the development of a market in primary care threatens their constitutional integrity. As long as primary care was almost entirely provided by practices owned by general practitioners operating to a national NHS contract, the conflict of interest inherent in having the commissioning function run by bodies dominated by NHS general practitioners was manageable, justifiable, and arguably a strength. The development of a market in primary care provision requires that ultimate responsibility for local commissioning should be undertaken by a body entirely separate from all providers. Despite an apparent backtracking by policy makers about the need to remove provider functions from primary care trusts, it is hard to justify them having a continuing provider role in what is clearly a primary care market.

However, the reintroduction of general practitioner budget holding (in the guise of practice based commissioning) appears to contradict this since it is intended to increase general practitioners' engagement in the purchasing of services, facilitate a further shift of care from acute to community settings, and provide a demand management counterweight to the power of the new, more autonomous foundation hospitals.[7] Primary care trusts have to determine which practices can take devolved purchasing responsibility—and ensure that all practices are engaged in some commissioning by the end of 2006.[5] Primary care trusts also have to find resources for new forms of management, information, and analytical support for local practice based commissioning.

A more pluralist yet still publicly financed health system calls for stronger market development, management, and regulation. While some elements of these functions will fall to national bodies regulating healthcare standards, patient safety, and levels of access to and choice of care, a local body (with a more appropriate name) is still needed to act as both the local "brain" in the system and its "conscience." As brain it needs to determine public health priorities, overall resource allocation, and service design across primary and secondary care; as its conscience it needs to assure service quality, manage and oversee contracting on behalf of practice based commissioners, govern conflicts of interest, secure public involvement, and assure probity in the use of public funds.

Recently, it has been argued that non-NHS bodies should be eligible to become commissioners of NHS care.[8] In a publicly funded system, however, it seems reasonable to assert that the brain and conscience should be a public body, particularly in a mixed economy of providers. That is not to say that elements of commissioning cannot be contracted out to actuaries, contracting specialists, and disease management plans, and that some commissioning could be delegated to private providers of primary care, but rather that ultimate accountability for use of public funds should remain with a public body.

So do PCTs have a future role? The answer is unequivocally yes in relation to the need for stronger strategic purchasers and governors of local health systems as detailed commissioning decisions pass to practices and perhaps in time to their private sector competitors as well. But, as the primary care system becomes increasingly diverse, they should no longer be service providers. This leaves unresolved the question of where current community health services such as community nursing and public health will be relocated, a conundrum that would seem to be yet another unintended consequence of a policy shift towards a more plural primary care market.

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The private health sector in India

Is burgeoning, but at the cost of public health care

Foreigners in increasing numbers are now coming to India for private health care. They come from the Middle East, Africa, Pakistan, and Bangladesh, for complex paediatric cardiac surgery or liver transplants—procedures that are not done in their home countries. They also come from the United Kingdom, Europe, and North America for quick, efficient, and cheap coronary bypasses or orthopaedic procedures. A shoulder operation in the UK would cost £10 000 ($17 460; €14 560) done privately or entail several months' wait under the NHS. In India, the same operation can be done for £1700 and within 10 days of a first email contact.[1]

The recent remarkable growth of the private health sector in India has come at a time when public spending on health care at 0.9% of gross domestic product (GDP) is among the lowest in the world and ahead of only five countries—Burundi, Myanmar, Pakistan,

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Sudan, and Cambodia. This proportion has fallen from an already low 1.3% of GDP in 1991 when the neoliberal economic reforms began.[2]

Yet India ranks among the top 20 of the world's countries in its private spending, at 4.2% of GDP. Employers pay for 9% of spending on private care, health insurance 5-10%, and 82% is from personal funds. As a result, more than 40% of all patients admitted to hospital have to borrow money or sell assets,[3] including inherited property and farmland, to cover expenses, and 25% of farmers are driven below the poverty line by the costs of their medical care.

Despite the suspicions of the people who use the service that many private providers of health care perform unnecessary diagnostic tests and surgical procedures, Indians are choosing the private sector in overwhelming numbers. This is because the public alternative is so much worse, with interminable waits in dirty surroundings with hordes of other patients. Many medicines and tests are not available in the public sector, so patients have to go to private shops and laboratories. Each harassed doctor may have to see more than 100 patients in a single outpatient session. Some of these doctors advise patients, legally or illegally, to "meet them privately" if they want more personalised care. In a recent survey carried out by Transparency International, 30% of patients in government hospitals claimed that they had had to pay bribes or use influence to jump queues for treatment and for outpatient appointments with senior doctors, and to get clean bed sheets and better food in hospital.[4]

This was not always so. When India became independent of British rule in 1947 the private health sector provided only 5-10% of total patient care. Today it accounts for 82% of outpatient visits, 58% of inpatient expenditure, and 40% of births in institutions.[5] Spending on health has not been a priority for successive governments, and they have encouraged the growth of the private sector. They have subsidised the private sector by releasing prime building land at low rates (as long as a quarter of patients are treated free—a condition that is rarely met), by exemptions from taxes and duties for importing drugs and high tech medical equipment, and through concessions to doctors setting up private practices and nursing homes. Moreover, when medical staff trained in public institutions for fees of about 500 rupees ($11; £6; €9) a month move to work in private health care this represents indirect support for the private sector of some 4000m-5000m rupees per year. They leave not only for better salaries but also for better working conditions—the same reasons why they leave India to work abroad.

Until about 20 years ago the private sector comprised solo practitioners and small hospitals and nursing homes. Many of the services provided were of exemplary quality, especially those hospitals run by charitable trusts and religious foundations. As the practice of medicine has become more driven by technology, however, smaller organisations have become less able to compete in the private healthcare business. Large corporations, such as drug and information technology companies, and wealthy individuals—often from the Indian diaspora (commonly called non-resident Indians)—have started providing health care to make money. They now dominate the upper end of the market, with five star hospitals manned by foreign trained doctors who provide services at prices that only foreigners and the richest Indians can afford. These hospitals are largely unregulated, with no standardisation of quality or costs.[6] Their success may be gauged by their large profits and ability to raise funds through foreign investments.

The medical system is failing its own people. Yet the government of India has stated: "To capitalize on the comparative cost advantage enjoyed by domestic health facilities in the secondary and tertiary sector, the policy will encourage the supply of services to patients of foreign origin on payment."[2] Medical tourism to India is expected to become a billion dollar business by 2012[7] and is starting to change the financing and regulation of certain private hospitals by encouraging private health insurance and international accreditation.

The private health sector in India has made some impressive strides but has done so at the cost of the public sector. To regulate it may be, however, just another opportunity for bureaucratic delays and corruption. A better solution might be to impose greater social accountability on private providers, making a certain proportion of private services available to the poor.

The first priority must be to increase public expenditure on health care. The government's common minimum programme promises an increase in the spending on health care from 0.9% to 2-3% of GDP in five years with a health insurance scheme for poor families.[8] In the past two years, although expenditure on health has increased in absolute terms, the proportion of GDP it represents has declined.

In India, each year tuberculosis kills half a million people[9] and diarrhoeal diseases more than 600 000. It is time for the government to pay more attention to improving the health of Indians rather than to enticing foreigners from affluent countries with offers of low cost operations and convalescent visits to the Taj Mahal.

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