Picking your battles: Setting government priorities in health

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Principles of public expenditure

"The important thing for government is not to do things which individuals are doing already, and to do them a little better or a little worse; but to do those things which at present are not done at all"

J.M.Keynes, The End of Laissez-Faire, 1926

I only have two things to say about policy
(Any policy. Ever.)

- Provide public goods before private goods. (Or: fix really bad market failures first.)
- Do things you can do before trying those you can’t. (Or: take constraints on government capabilities seriously.)

In health: a simple argument

- Some health policies address massive market failures and some don't
  - "Real" public health (a la 19th century Europe), particularly sanitation, address genuine public goods and goods with big externalities
  - Public Insurance or Hospitals: health insurance markets fail virtually everywhere at all times but are needed for catastrophic care
  - Primary health care (??? – depends. needs local information)
- Some health policies are particularly important for the poor (infectious disease control again) and some aren't
- Some health policies are hard to implement, some are even harder
- Policy should be strategic and get the most welfare improvement possible (relative to what happens without a policy) per public rupee spent with implementation constraints fully considered

OK, OK maybe it isn't SO simple

In any case…

- Shouldn’t we get a handle on this before we spend a lot more money on, say, universally publicly provided primary care?
- Shouldn’t we know a lot more about the many, varied, determinants of health before we spend large sums on anything?

Apparently not

Policy statements, India 1946 on…

- Bhore committee 1946: Recommended integration of curative and preventive medicine at all levels with seamless referrals. Specific staffing per capita requirements for each level.
- Mudaliar Committee 1962: noted PHC's weren't working but advised spending more on them anyway
- Jungalwalla 1967: A service with a unified approach for all problems
- Singh (1973), Shrivastav (1975), Bajaj(1986), plus four other reports all the same
- Mid-term review 10th plan 2005: Sub center for every 5,000 people, PHC for every 30,000 people etc. etc., Integrated referral chain (virtually identical to Bhore on).
- NRHM mission statement 2005: not much different but does mention water and sanitation (which may not have happened but a new line of health workers did)
- Lancet (January 2011): NOW is the time to implement the Bhore recommendations
- High Level Expert Group (November 2011): "Develop a National Health Package that offers, as part of the entitlement of every citizen, essential health services at different levels of the health care delivery system." Oh, and "**Reorient** health care provision **to focus significantly on primary health care**." **while** we "Ensure equitable access to functional beds for **guaranteeing secondary and tertiary care**." By "increasing HRH density to achieve WHO norms of at least 23 health workers per 10,000 population" (i.e., Bhore if Xerox machines existed in 1946)
- Einstein 1925 (possibly apocryphal, though true): "Insanity is doing the same thing over and over and expecting different results"

So, since it figures so prominently in India's health policy…

…let's start with primary, curative, health care. How is it doing?

Evidence of success of NRHM
Speeches at Delhi School of Economics August 5, 2013

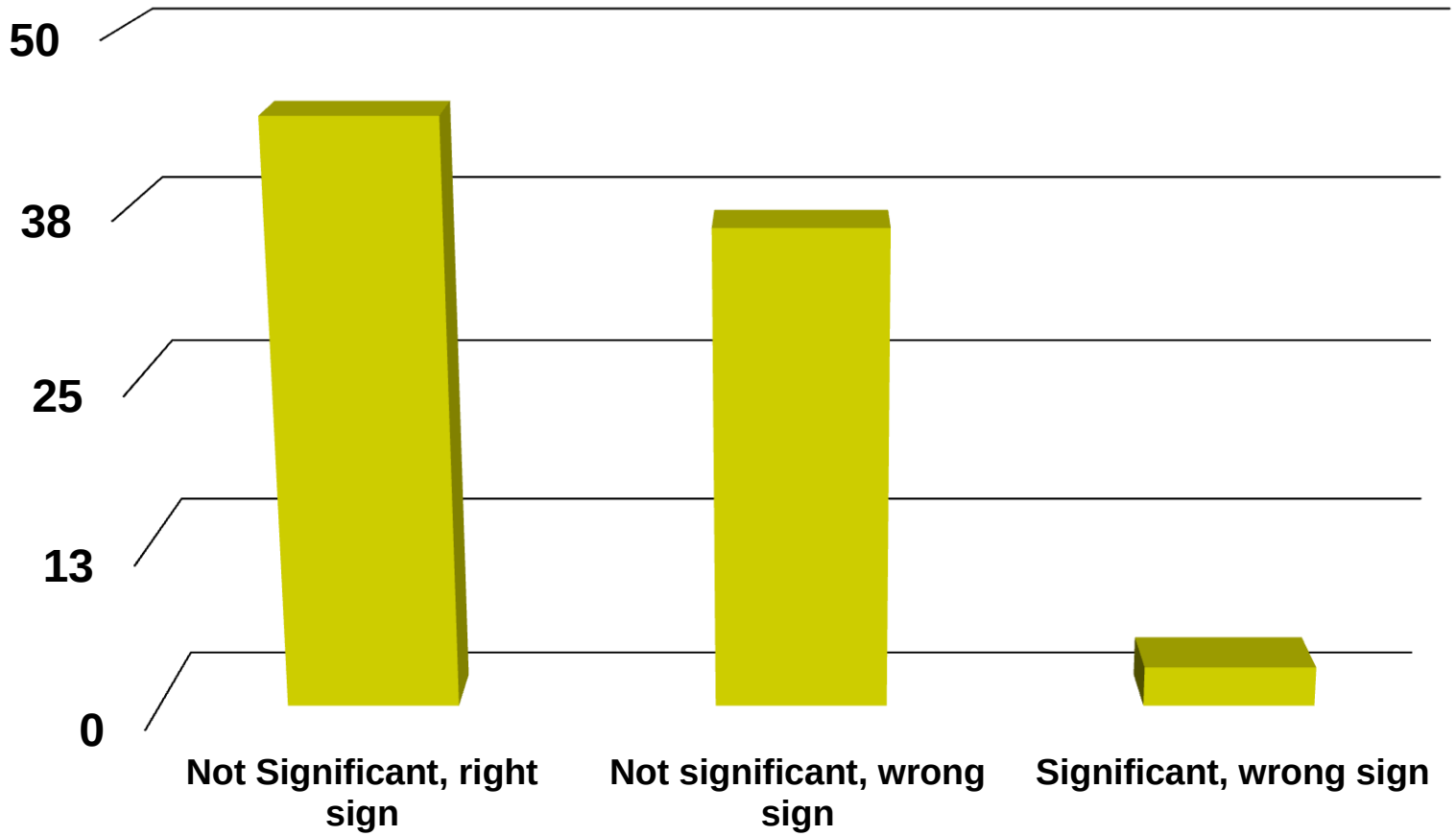
- We spent more money
- We hired more workers
- We increased the capacity of states
  - They spent more money
  - They hired more workers

The purpose of health policy is…

- To employ medical providers?
- To spend money?
- To improve the health and well-being of the people of India?

- There is no one-to-one relationship between spending and getting something for it – the connection has to have empirical support

And the evidence isn’t overwhelming



Distribution of t-tests of the variable “any public facility in village” on rural infant and child mortality. All states, NFHS 1992, 1998 (propensity score matching)

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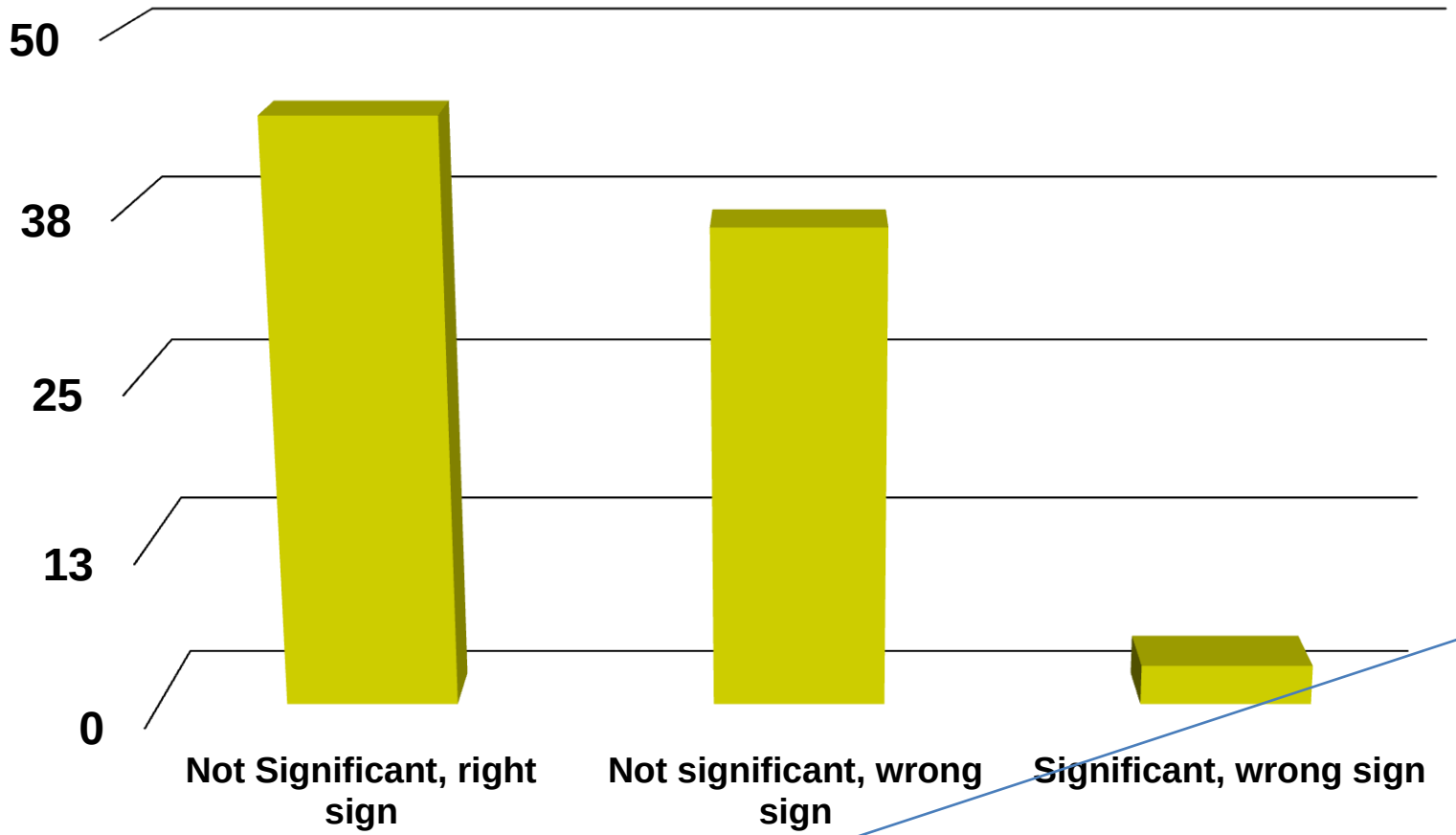


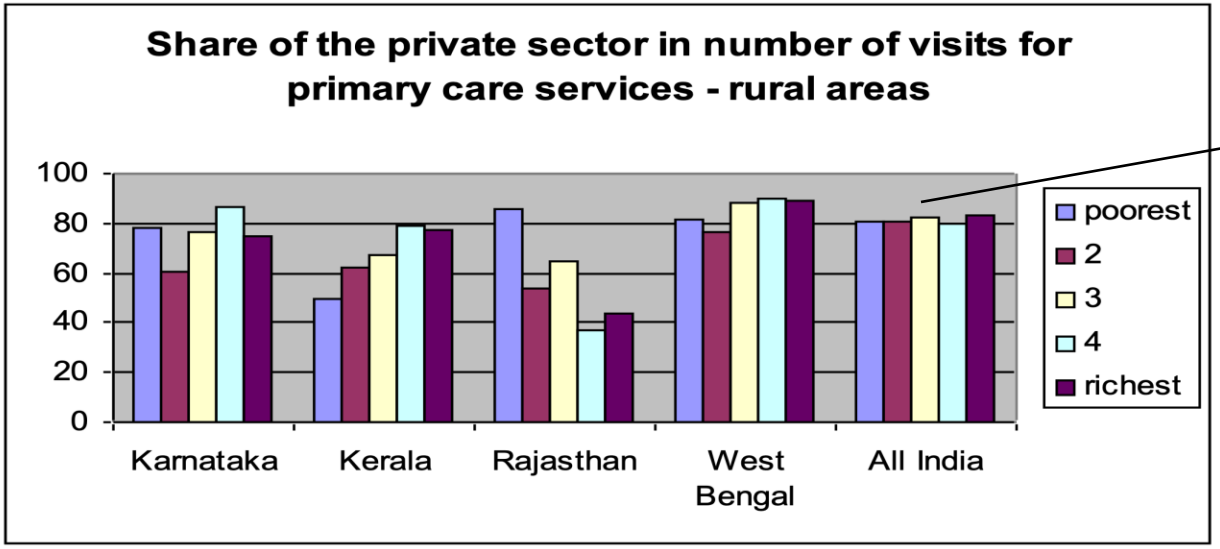
Distribution of t-tests of the variable "any public facility in village" on rural infant and child mortality. All states, NFHS 1992, 1998 (propensity score matching)

How can this be? How can publicly provided medical facilities NOT help?

- Public sector is small relative to market as a whole (of widely varying quality)
  - And there seems to be substantial substitution between the public and private sectors
- And what comes out of the public sector (in comparison to the private) anyway?

Overall usage: public and private sectors in the health sector

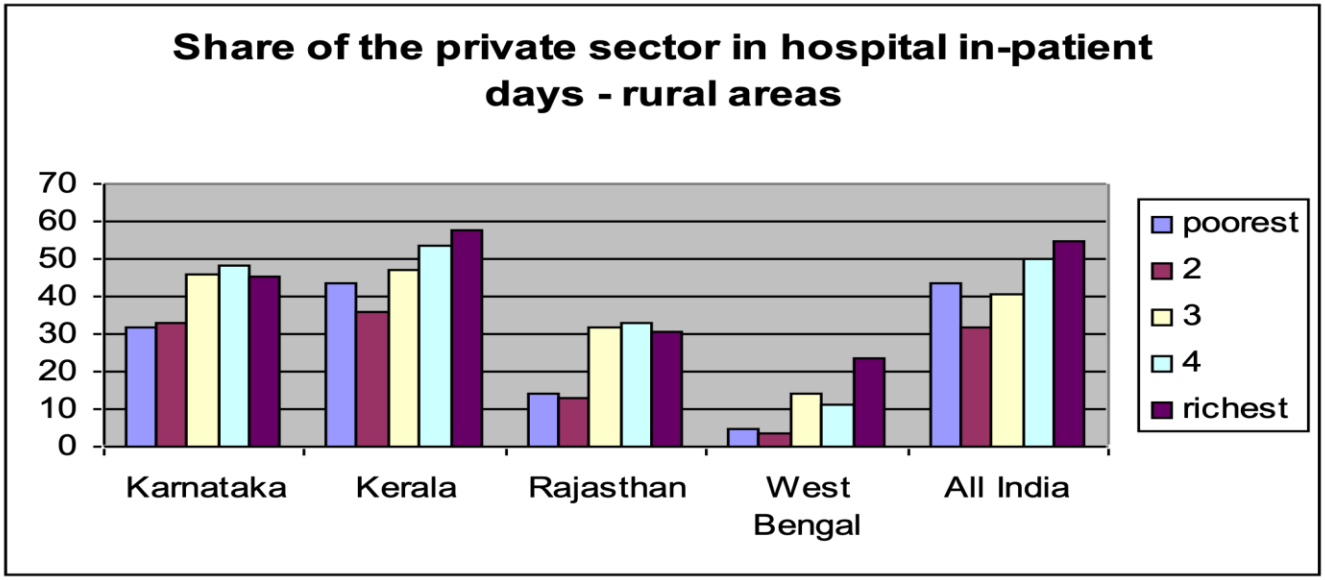
Primary Health Care



Doesn't seem to matter how poor you are. But national average masks some interesting state variations.

Hospitals

Note, first, that this data is for 1995 and second, that the most recent NSS, twenty years later, after NRHM has 80% private at PHC level



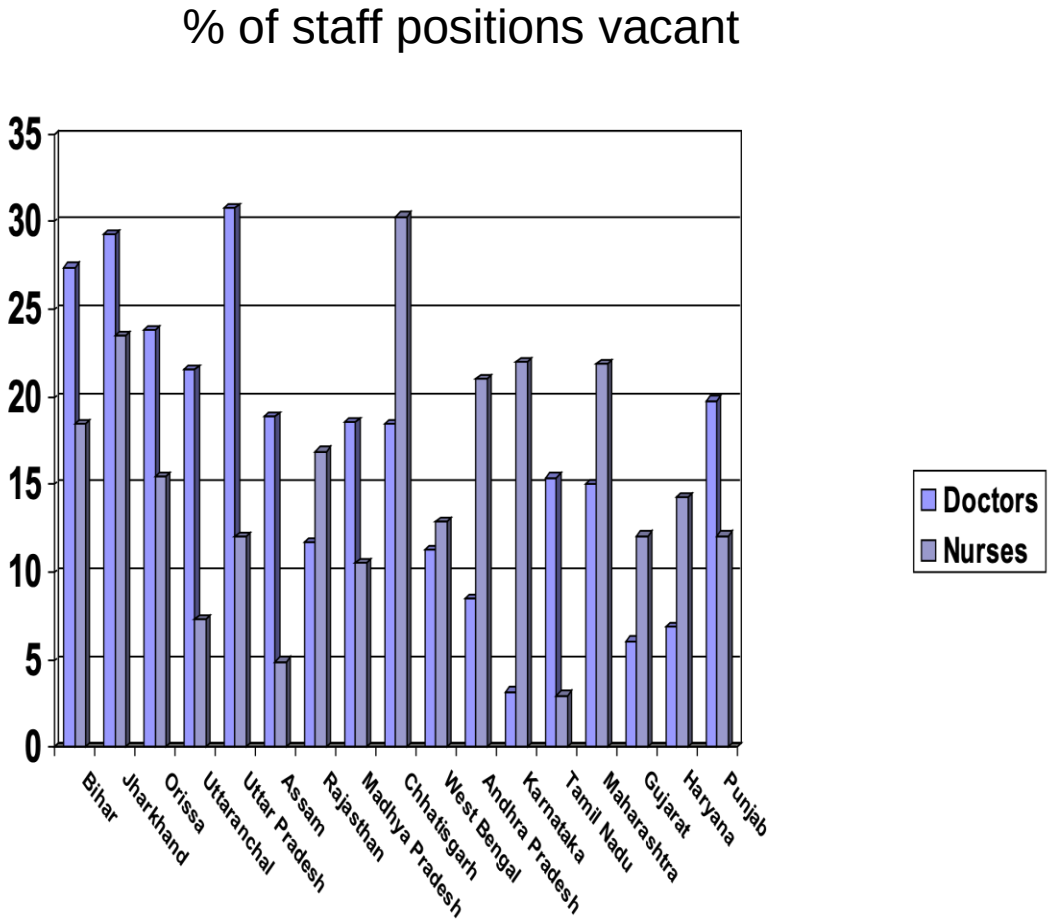
Source: Calculations based on Mahal et al (2001)

Why don’t people use free public care with qualified doctors instead of paying for “variably” qualified ones?

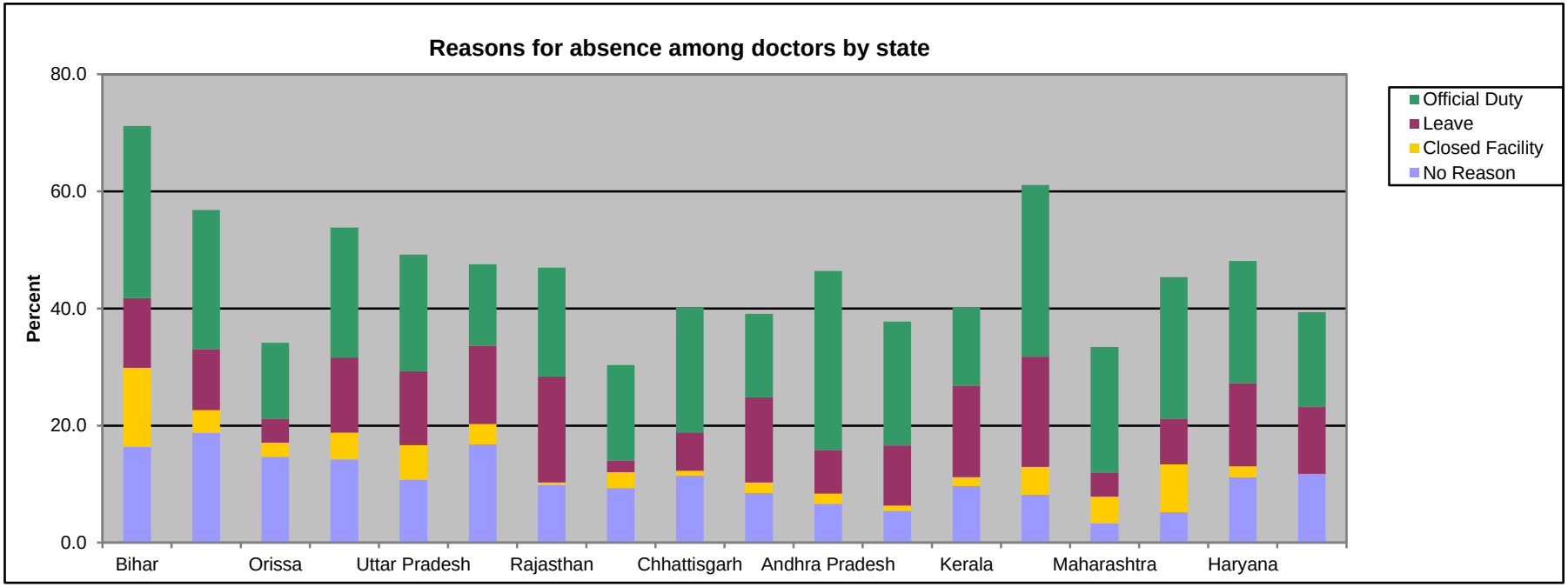
- Hint: It’s not because they don’t know any better
- Let’s ask a different question

PHC's: What do people find when they get there?

- Vacancies

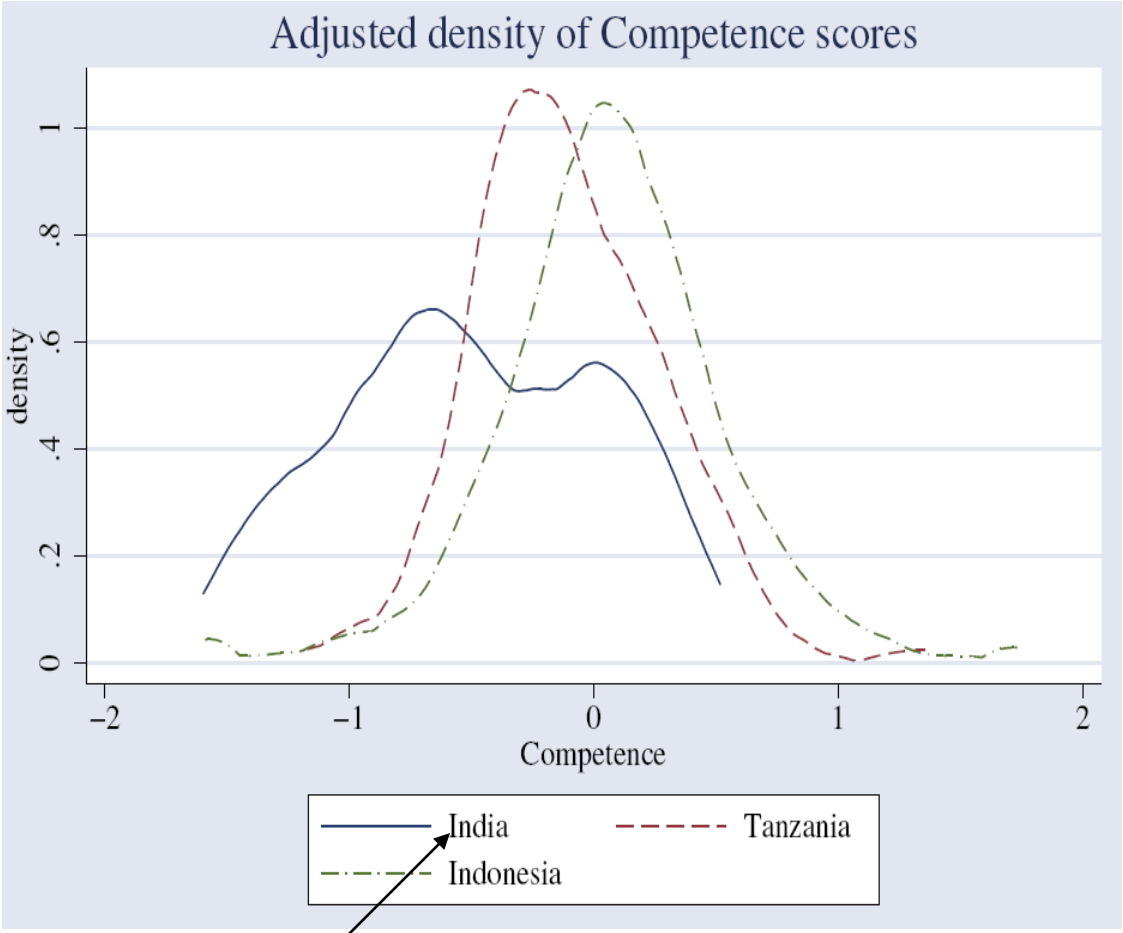


PHC's: Absentee rates



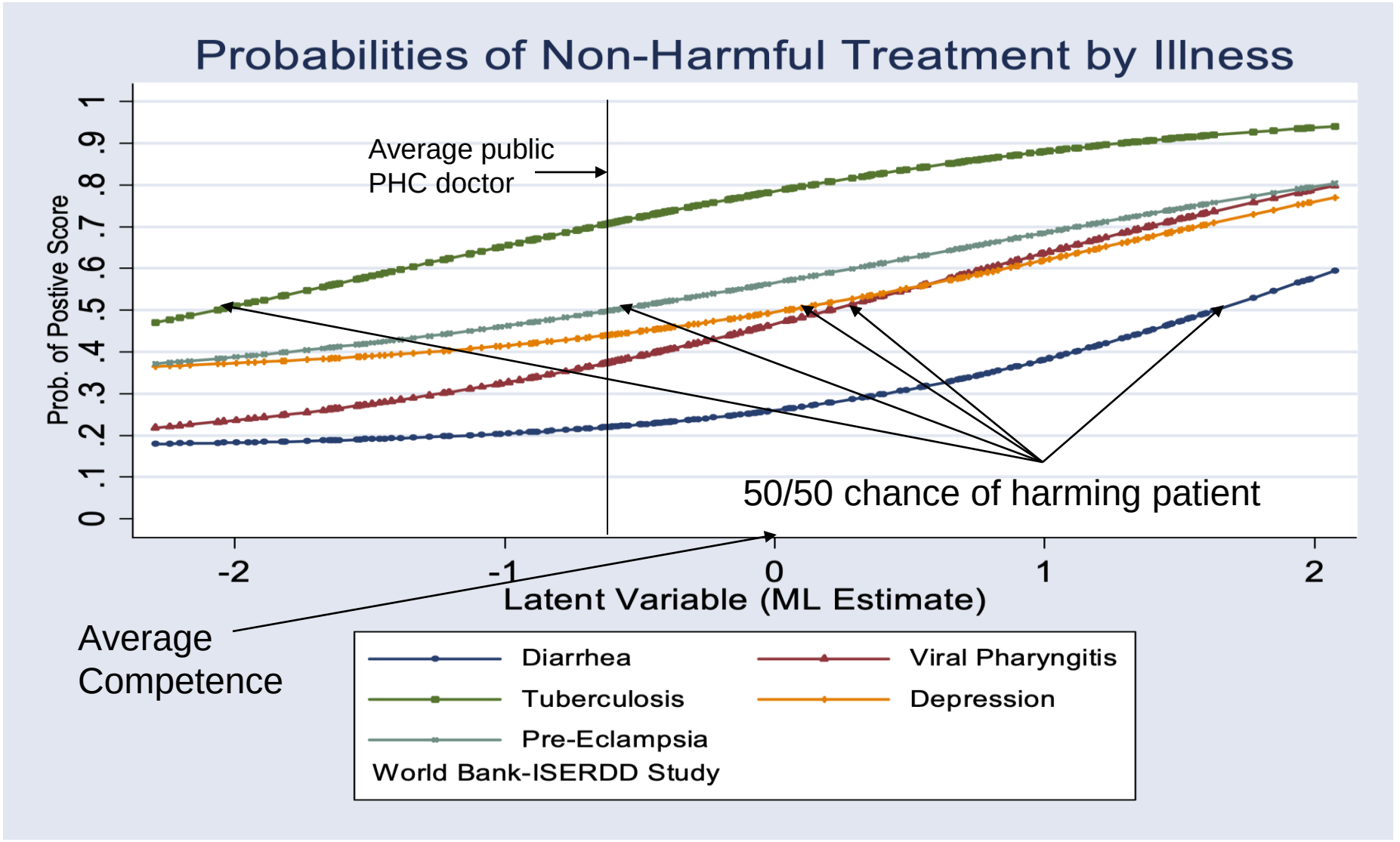
PHC's: What do people find when they get there?

- Vacancies
- Absenteeism
- Low capability

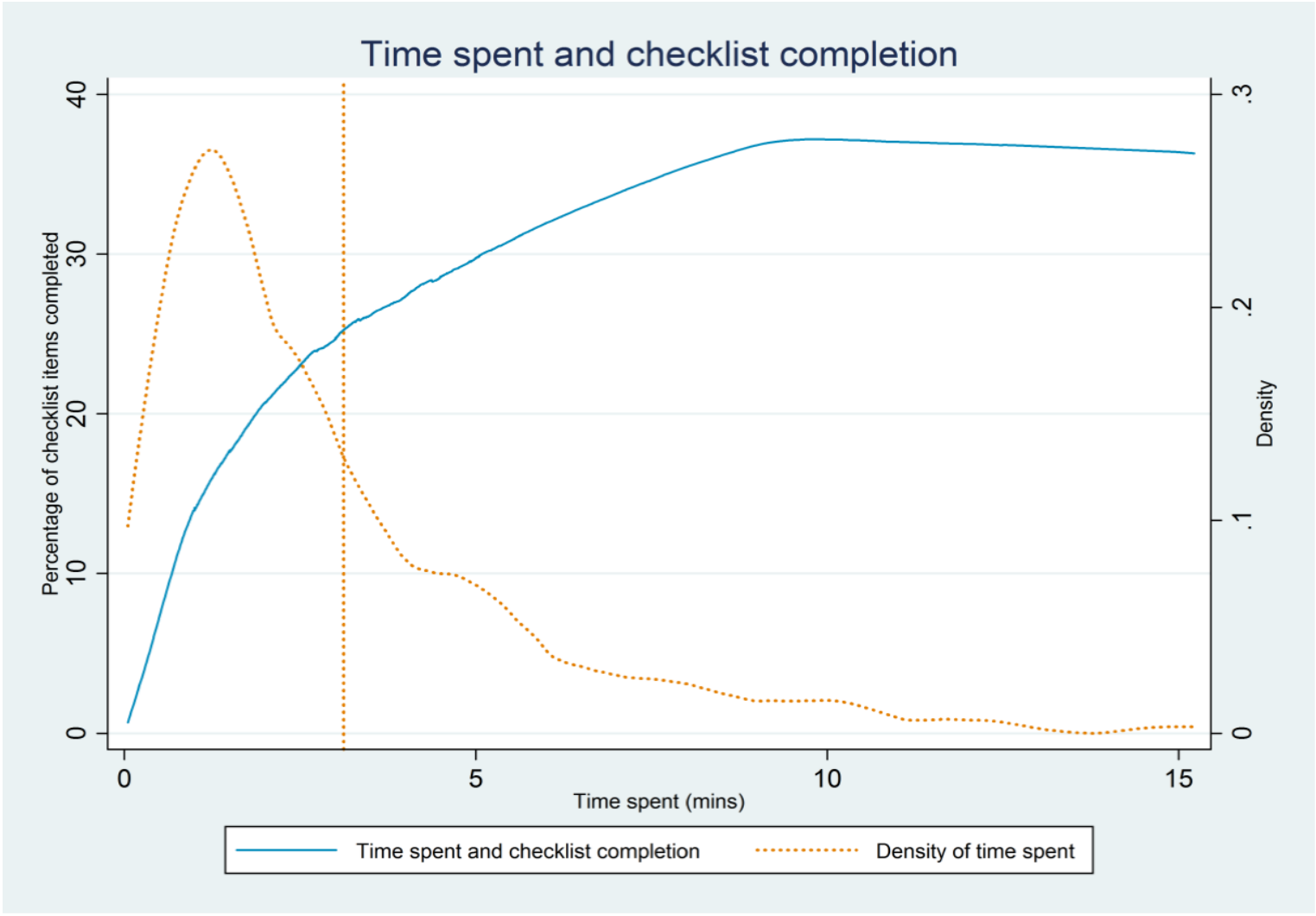


Just Delhi!

What does "low capability" mean?

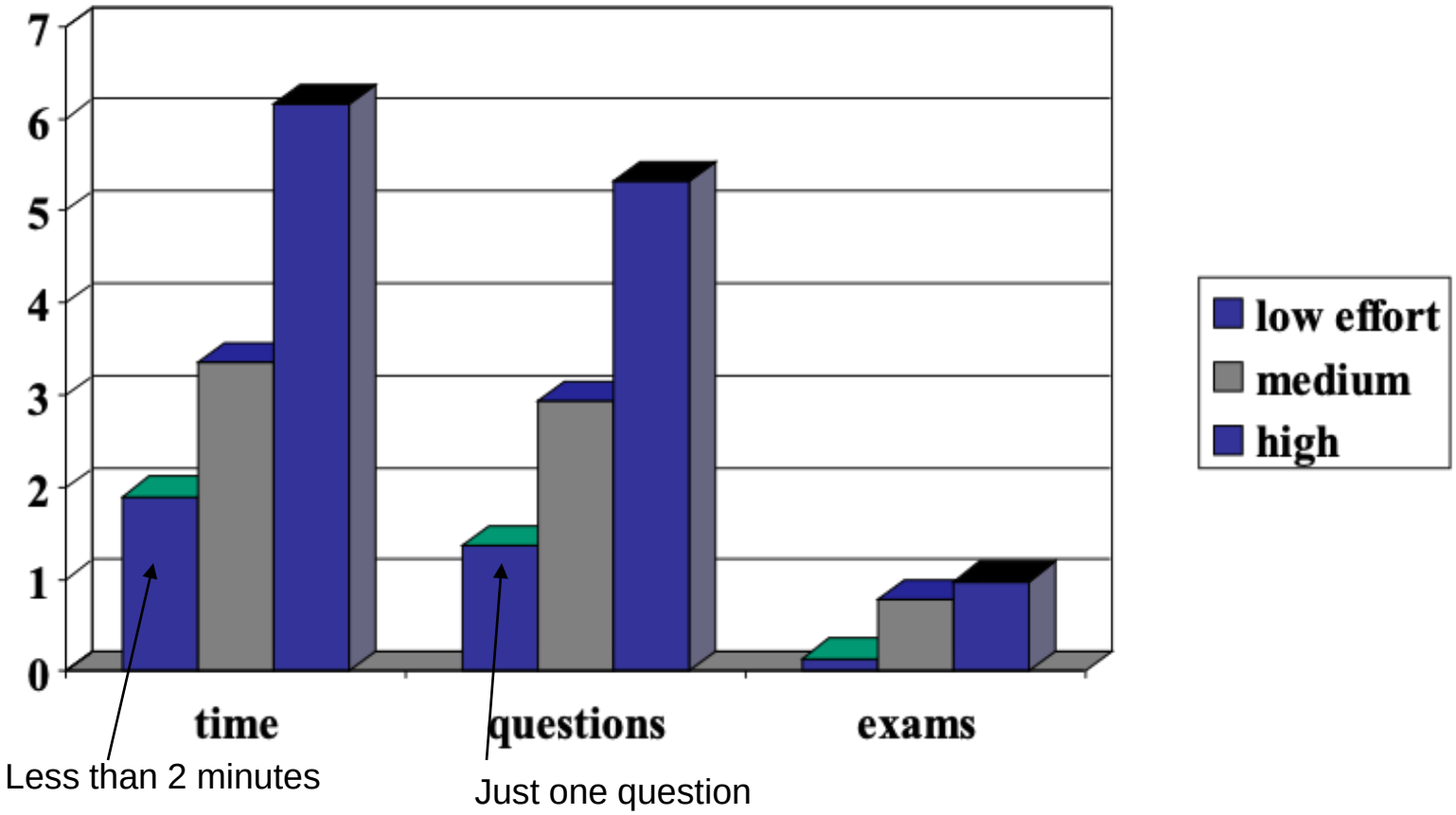


PHC's: what do people find when they get there? Lack of effort

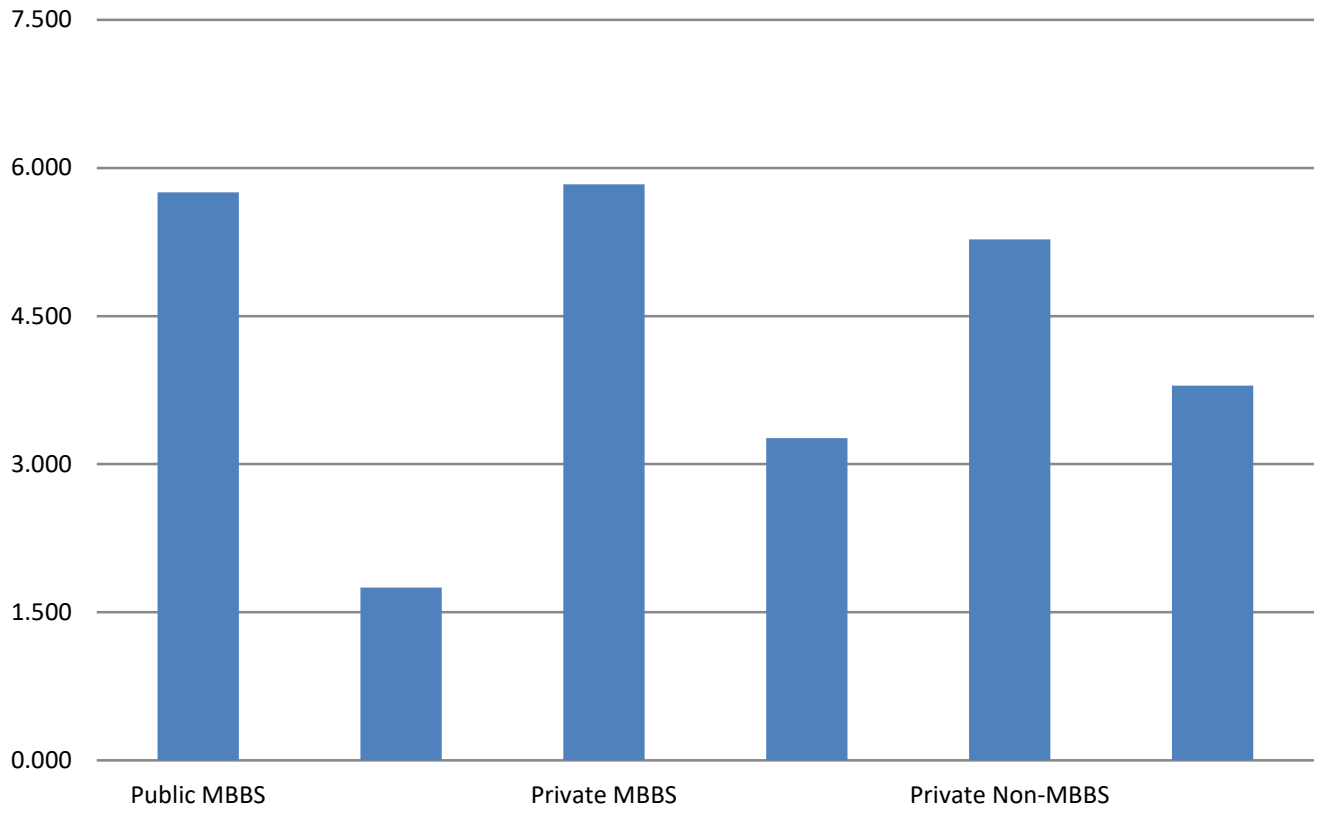


What does “very little effort” mean?

In Delhi, “low effort” interactions are almost completely coincident with those in public Primary Health Care facilities

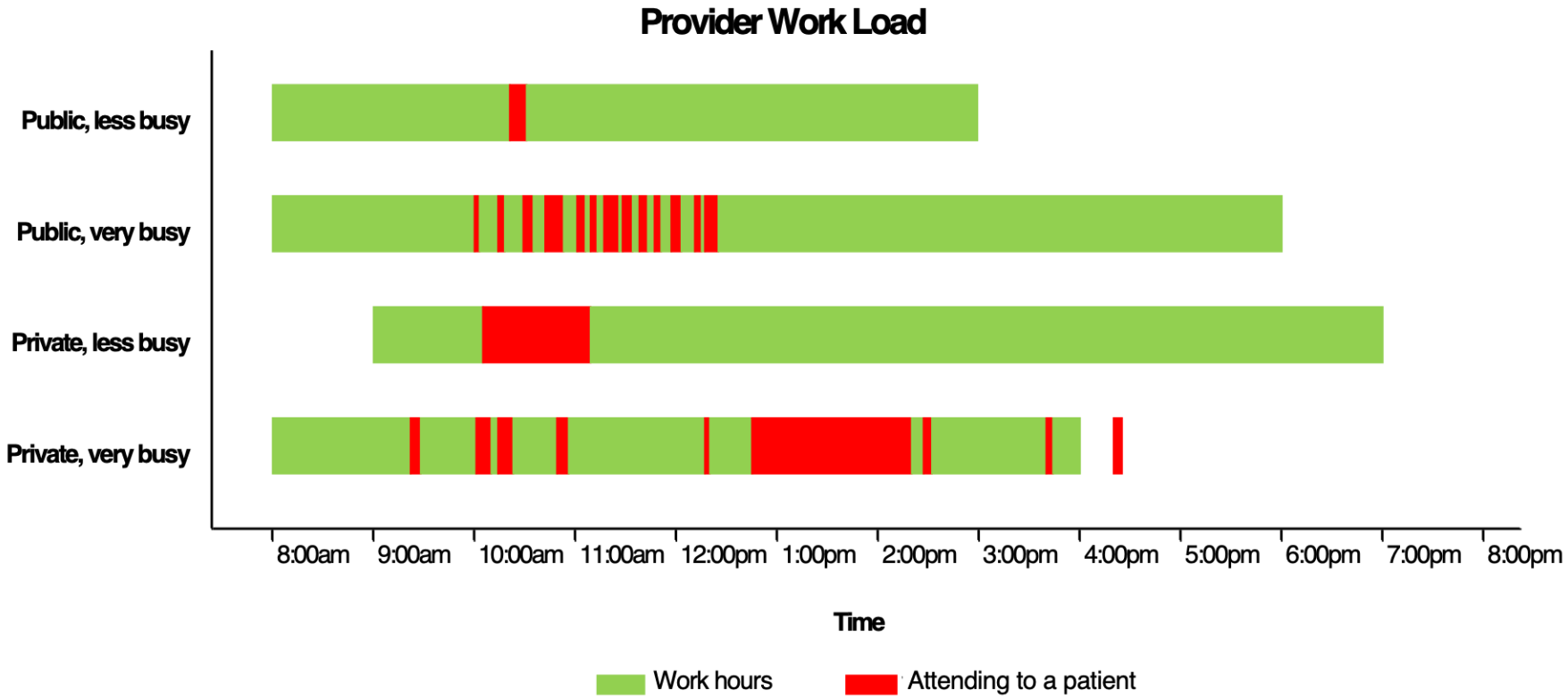


Time spent with patients – Rural MP



…and it's not because they are too busy

Public employees work 39 minutes/day – same as private providers (similar results from Tanzania, Senegal where doctor "shortage" is even more acute)

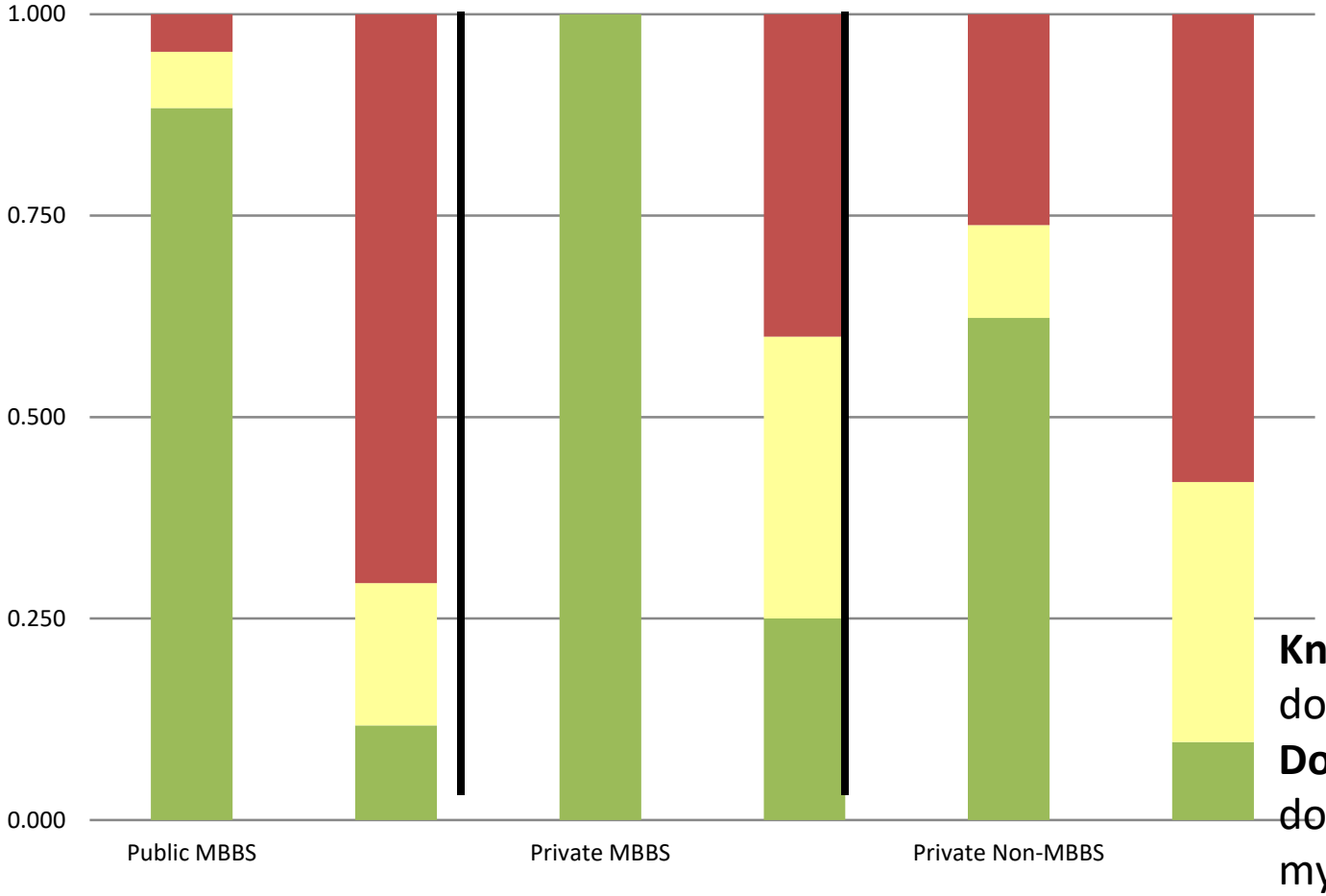


The “know-do” gap in medical care

- Several studies worldwide (and in India) have attempted to measure both what medical providers (ranging from “real” doctors to quacks) know about how to treat problems AND measure what they actually do in practice
- The differences are extreme and very hard to rationalize

The Know-do gap in India

Correct treatment of Unstable Angina



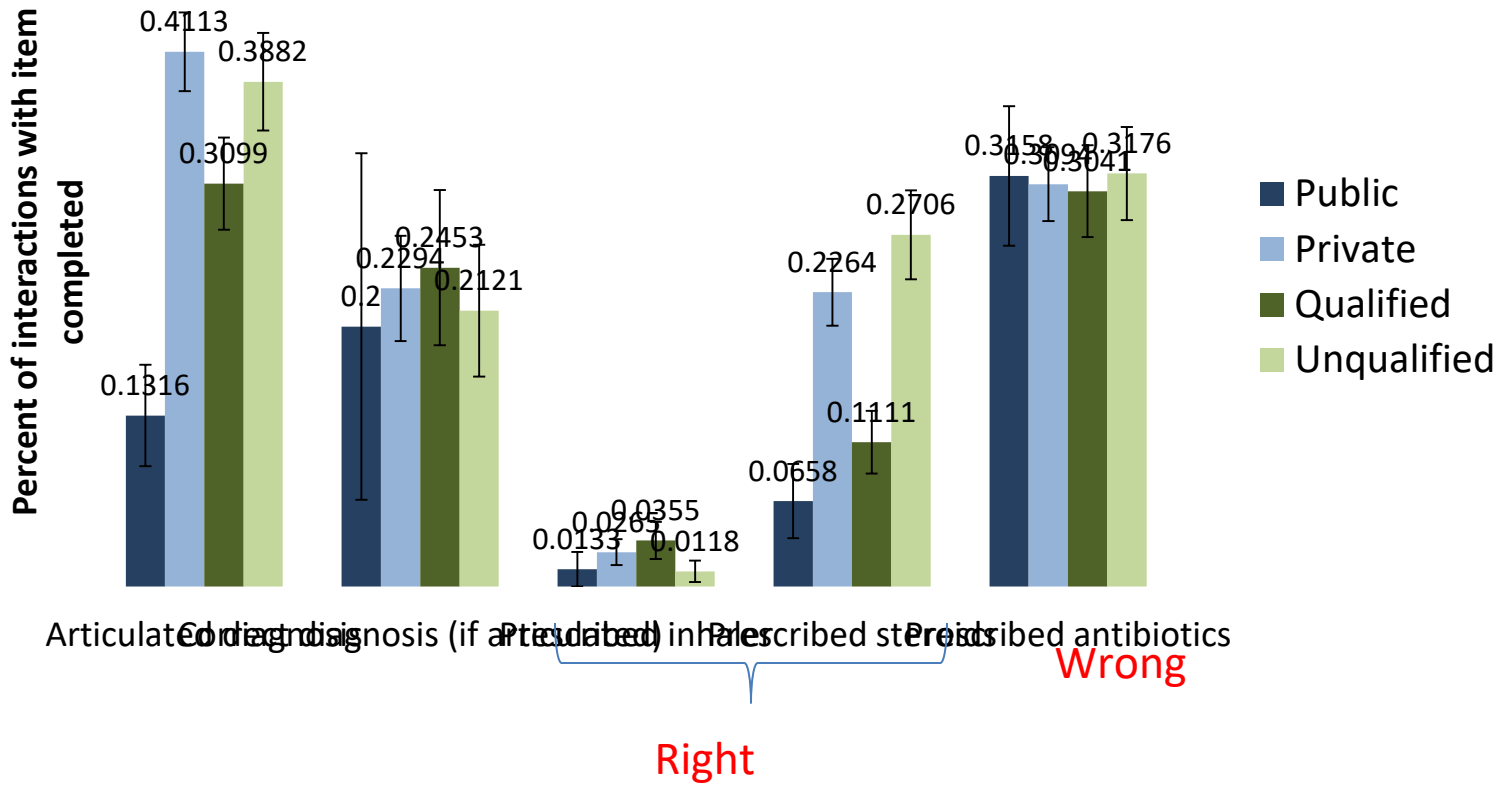
Know: What was done in vignette
Do: What was done for a mystery patient

Public MBBS Private MBBS Non-MBBS

Madhya Pradesh only (Das et al 2015 and another et al, forthcoming)

All of this leads to poor diagnosis and treatment

Asthma In Madhya Pradesh



Source: MAQARI project, Das et al, 2014, 2015

PHC's: What do people find when they get there?

Vacancies

Absenteeism

Low capability

Low effort

Little difference between PHC doctors and "differently trained" providers (except, perhaps, lack of courtesy)

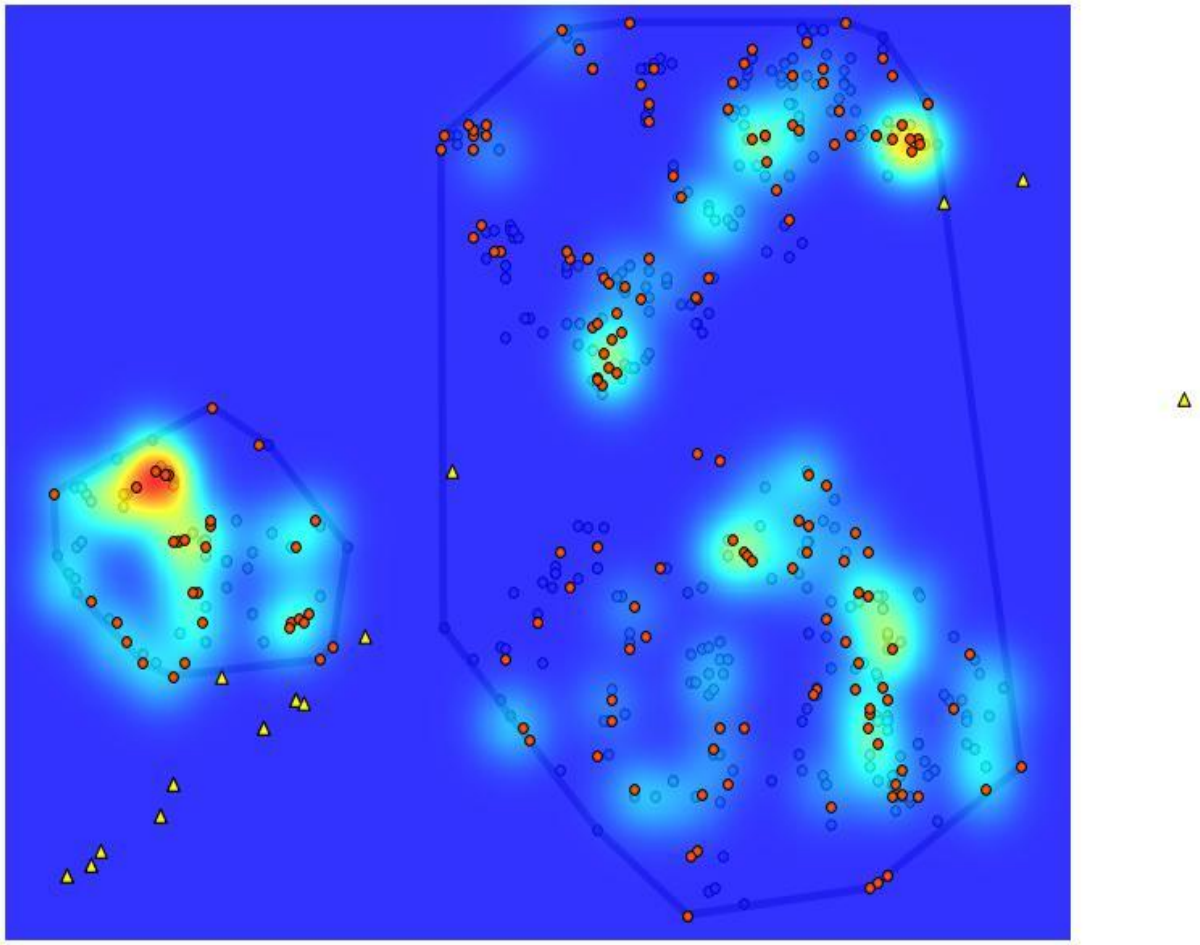
However…

- All is not lost
- Believe it or not – this is an optimistic presentation

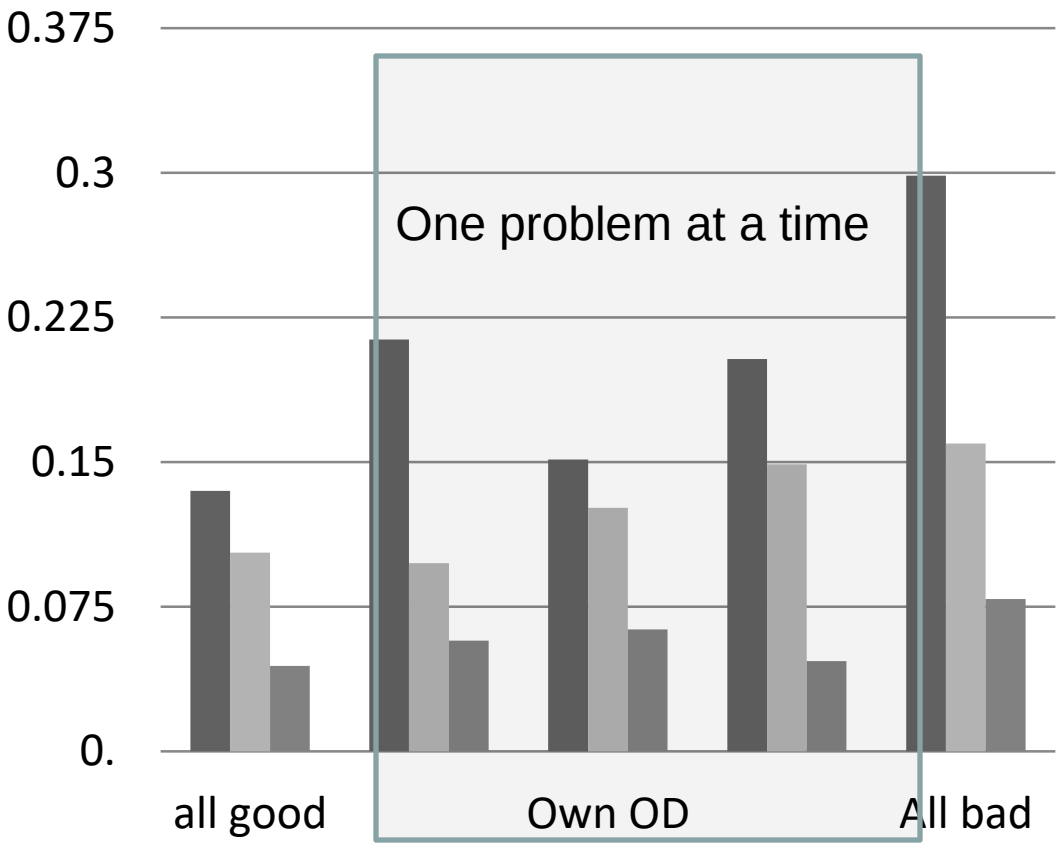
Some things are pretty sure to improve health and help the poor

- Traditional public goods (19th century rich countries)
  - Clean water
  - Sanitation
  - Vector (pest) control
  - Nutrition
- And a few things rich countries never had
  - immunizations

Open defecation in area and cases of diarrhea



Hygienic conditions and diarrhea incidence in Delhi slums

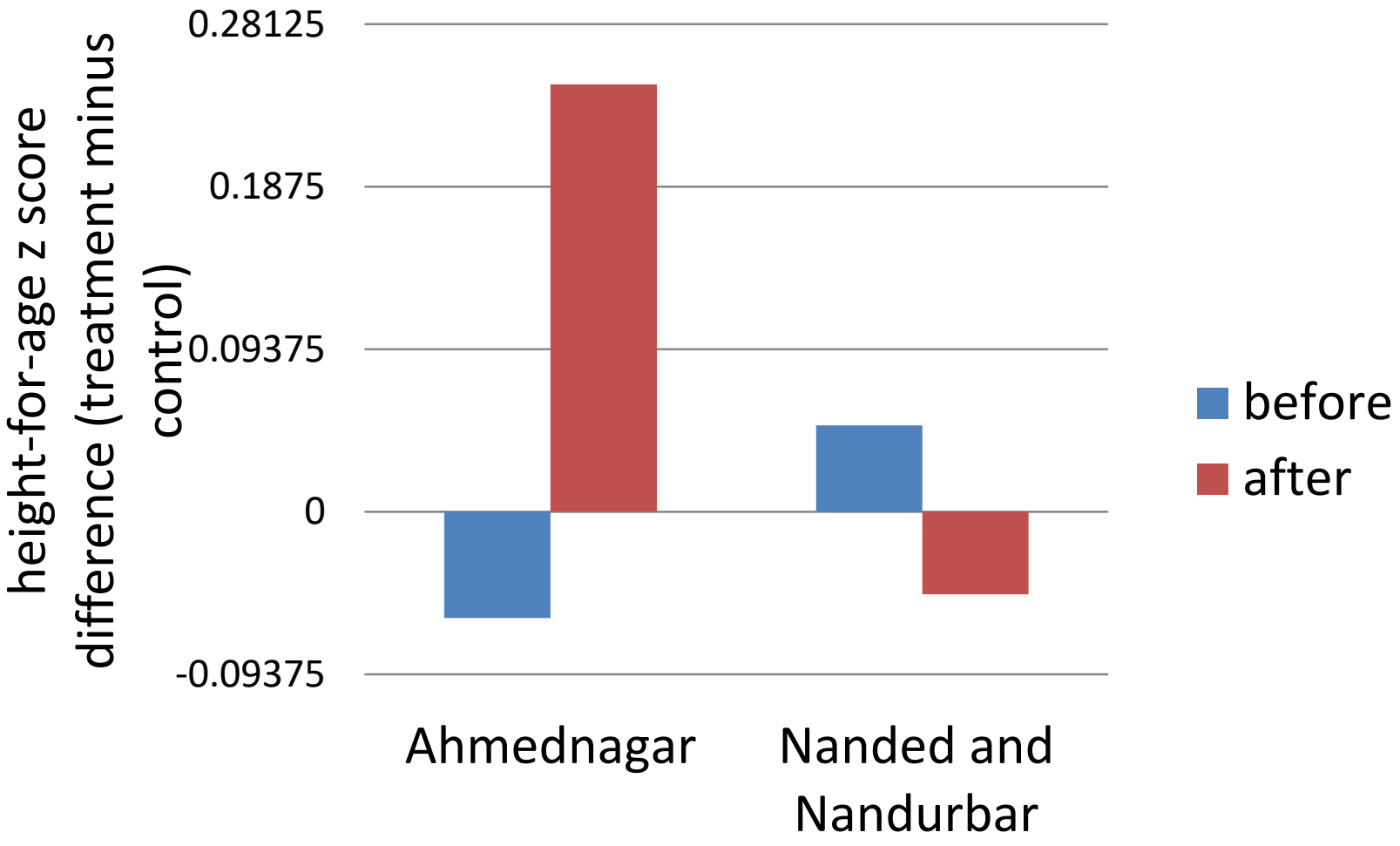


Water: Water enters home from street sometime during year
Own OD: Someone in the family sometimes defecates in open
Neighbor OD: a neighbor household has “Own OD” (GIS ID)

Falsification

- These results do not hold for any other health condition (fever, cough, accidents, childbirth)
- So it's not "poverty that 'wealth' mis-measures" or "constitutionally unhealthy people".
- The sanitation variables only affect water borne disease.

Sanitation campaign: effect on height



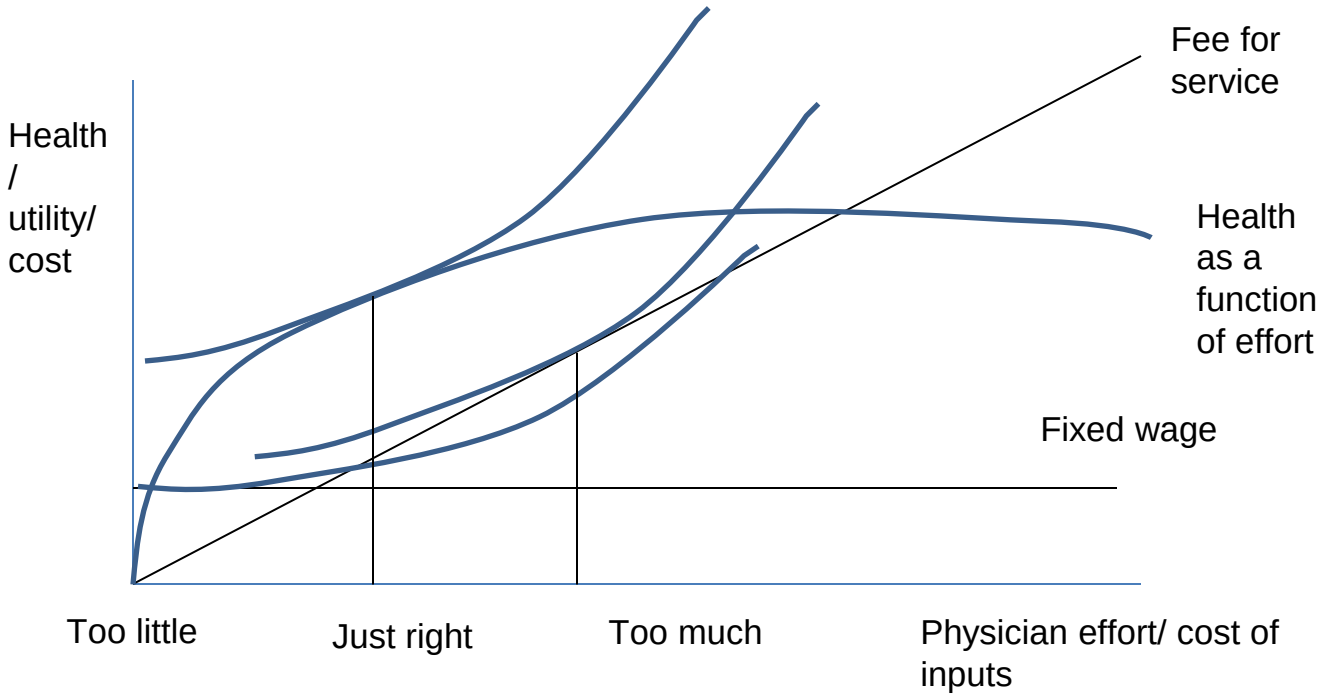
Catastrophic care - fixing market failures

- Insurance markets always fail
- Avoiding catastrophic financial loss a problem for everyone
- Great fear of falling into debt and inescapable poverty from the poor and nearly poor (Problems curable at PHC level won't do this)

So, is public insurance the solution?

- Rich countries (except the U.S.) seem to think so
- But insurance systems – arm's length relation to providers – have lots of regulatory requirements and personnel that are hard to manage
- At issue is: how (and how much) do you pay the provider (and which provider and for what)? And how do you know they are doing what you paid for?

“Effort” determined by form of payment



Hospitals:

- Could public hospitals be a substitute for insurance? (hospitals are kind-of hard to run, insurance is very hard to run)
- Need to know:
  - How well are hospitals working given that the public presence in hospital care, relative to private, is much greater than in primary care? And what does “working well” mean?
  - Do improvements in public hospitals provide competitive pressure for private? On prices? On quality?
- Big problem: how to make services progressive. How to make sure poor people get to hospitals.
- Knowledge hampered by PHC fixation

Summary– Picking your battles

- Population based services (water, etc.) are incredibly important for the health of India, particularly for the poor and are very underfunded
- Hospital care supported by government, directly or by insurance, is essential for dealing with catastrophic risk
- The case for universal, publicly supported, primary curative care is … not obvious

Thank you