

Understanding Government Failure in Public Health Services

High absenteeism, low quality in clinical care, low satisfaction levels with care and rampant corruption plague public health services in India. This has led to mistrust of the system and the rapid growth of private services. This paper develops an analytical framework to understand the status of healthcare in India. Drawing on a model of public sector accountability, it argues that a weak voice and low accountability is the key binding constraint to effective delivery.

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It is a well recognised fact that the system of public delivery of health services in India today is in crisis.¹ Recent analyses show that high absenteeism, low quality in clinical care, low satisfaction levels with care (clinical and with regards to courtesy and amenities) and rampant corruption plague the system [Chaudhury et al 2006a,b; Das and Hammer 2007].² This has led to mistrust of the system, a rapid increase in use of the private sector and its attendant problems: high out of pocket expenditures that take a serious toll on families³ and quality of care that is highly variable (from much worse to much better than in public facilities).

No progress can be made without first admitting the problem. However, resolving the problem requires the understanding its root causes. This paper aims to develop an analytical framework within which to understand the status of healthcare in India. Drawing on a model of public sector accountability, it argues that a weak voice and low accountability between public sector employees and citizens in the healthcare sector is the key binding constraint to effective delivery.

This paper is structured as follows: Section I begins with some prefatory remarks setting the context for discussion of health, healthcare and health policy in India; Section II draws on standard economic analysis to articulate key problems in the healthcare sector; Section III adds the perspective offered by the understandings of public sector accountability using the framework developed by the *World Development Report* on service delivery (WDR 2004)⁴ and through this analysis the causes of "government failure" in health services and Section IV concludes the paper.

I Background and Basic Context

Before addressing issues related to the health sector in India, there are a few basic characteristics of health that we feel need to be made clear as background.

First, a distinction must be made between health status versus publicly provided health services. An individual's health is determined by multiple factors which may fall outside the purview of health policy altogether. This includes income (whose

direct effect is felt through nutrition) and education (whose direct effect is through knowledge of nutrition, basic hygiene and so on). Because of these multi-sectoral determinants, achieving better health requires strategies that range well beyond health policies proper and involve a wide range of service providers – from engineers, teachers, designers of roads and traffic flow as well as medical workers.

Second, there is a lot of variation even for health policies that are normally within the purview of health ministries. The basic distinction is between public health versus publicly provided healthcare. Public interventions range from public health engineering such as swamp drainage and spraying for mosquitoes, water supply and sanitation, to active promotion of preventive healthcare measures such as immunisation, inexpensive curative care and hospital-based care. The range of service providers is varied – from engineers to medical workers of all kinds: village health workers to specialised medical doctors.

The third distinction is between publicly provided healthcare and all healthcare. Healthcare in India is *overwhelmingly* private. Most recent estimates are that 85 per cent of all visits for healthcare are to private practitioners, even for the poorest.⁵ The quality of these services is varied. When provision or financing of healthcare is discussed as a public policy, it is essential to know what the consequences of changes in public provision may have on total provision of health services including the much larger private sector. This impact also varies substantially by location and public policy at all levels of government.

The fourth and final is a distinction that cannot be emphasised enough: between providers paid by salary versus payments for services rendered. The general principle in a publicly financed health systems management (including when medical staff are civil servants) is that "money must follow the patient" and is the practice of *every* rich country.⁶ Decision-making as to which provider is chosen, at least at the level of primary care, is done by the patient and not by the government. The provider is paid by the number of patients they attract (either by visit or through "capitation" systems in which patients sign up for specific providers or fees for specific services) and not via salary. The solution that the richer countries converged on was not simply a

matter of chance or historical circumstance. Many western European countries nationalised health provision and did pay input-based budgets and salaries to doctors in the 1960s and 1970s. By the late 1980s, dissatisfaction with these systems led them to switch to activity-based payment systems for hospitals and return to performance-based incentives for primary care physicians which encouraged better treatment (clinically and courteously). It was through bad experience with payments via input-based budgets – equipment and personnel – that these systems have come to pay for services instead [Scheiber et al 1991].

The Indian system of paying doctors and other healthcare providers with salaries is an anomaly that stands in the way of any meaningful improvement in publicly provided healthcare.⁷ Therefore, when reform in the healthcare sector is discussed, it must be in the context of how providers get paid and whether the responsible government has the ability to link pay to performance.

With these core principles as background, we take a closer look at major categories of health policy. We then analyse them under a series of realistic assumptions for guiding government policy.

Defining Broad Categories of Health Services

Health services cover a wide range of activities, some whose provision must be guaranteed by the public sector, some of which are open to a wider set of options. We classify publicly provided health services into two main categories:

- (1) *Traditional public health* which can be further classified as:
 - (a) *Population based public health interventions*: These include large-scale activities like vector (pest) control (e.g. draining swamps and spraying for mosquitoes), water supply and urban sanitation. An important activity in this group is the systematic collection and dissemination of information about the population's health status. These range from quick-response surveillance activities as well as regular and routine collection of information on health status to research its causes.
 - (b) *Preventive and promotive public health interventions*: These include periodic services such as person-to-person information, education and communication (IEC) activities, immunisations and monitoring of child nutrition. These can be and often are carried out by paramedics, nurses, specialised health educators and related professionals.
- (2) *Curative services* which can also be further classified as:
 - (a) *Ambulatory care*: This includes routine, relatively cheap services alongside a large, if heterogeneous in quality, private sector. This also includes some "secondary prevention" activities, like identifying tuberculosis.
 - (b) *Hospital care*: For "catastrophic" (financially) illness.

II Case for Government Intervention: Identifying Market Failures

The conventional way that economists approach public policy is to identify the specific systematic reasons why an unfettered free and competitive market will not allocate resources efficiently. These are called "market failures", which in principle justify government intervention and usually imply a particular set of appropriate interventions. Implicit in this approach is that if such

Figure 1: The Poor Suffer Disproportionately from Infectious Disease

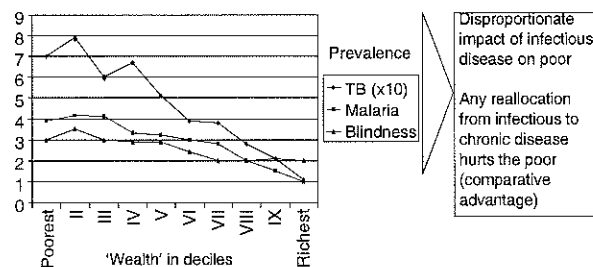
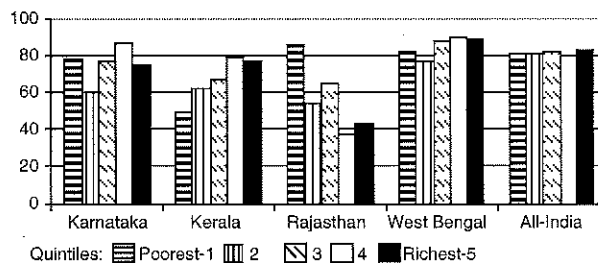


Figure 2: Share of the Private Sector in Number of Visits for Primary Care Services – Rural Areas



a market failure is discovered, government should step in.

The two clear, characteristic and universal⁸ market failures in health are the large externalities associated with communicable disease control and the universal failure of insurance markets due to asymmetric information. These affect each of our four categories of health services to different degrees. Based on this, we discuss how setting priorities in health do indeed vary by each category.

Population-based public health interventions: These interventions address communicable diseases and some are as close to pure public goods as we ever see in the real world. As mentioned above, large-scale vector control and the systemic collection and analysis of data are the best examples. Mass media campaigns fit this category as well. All of these interventions rank high on efficiency grounds alone.

Preventive and promotive public health interventions: Activities in this category address communicable diseases such as immunisations, health education and other preventive or promotive activities.⁹ We separate this category from the population-based interventions because of the difference in the nature of policy measures and personnel needed. These activities confer external benefits – the more children immunised, the fewer other children are likely to get diseases though the main protective benefits accrue to the immunised child.

Communicable disease control addressed by both these public health interventions involves externalities in the form of potential spillovers and should be a high priority for public engagement on efficiency grounds alone. Crucially, communicable disease control ranks highly on *equity* grounds as well. Figure 1 shows the prevalence of three ailments across income groups in India based on the National Family Health Service (NFHS): malaria, tuberculosis and blindness.¹⁰ While poor people suffer from almost all illnesses more than rich people do, it is the *disproportionate* prevalence that is relevant for determining who benefits from policy.

Indeed, any reallocation of resources from communicable disease to non-communicable disease within a given budget hurts the poor. Even though it is the case that poor people may suffer from non-communicable disease more than they do from communicable disease, it is the relative prevalence *across income groups* that drives this crucial result.¹¹ Figure 1 illustrates this point.

Curative Services – Ambulatory Care

There is a large private sector for curative services in India so it cannot be a “public good” in the standard economic sense. The estimates for the size of the private sector vary substantially (depending on definition by cost or visits, by data source and by assumptions made by various researchers) but the best estimates from the 52nd round of the National Sample Survey (NSS) show a very high proportion of people visiting private providers. Figure 2 highlights the fact that in primary care, the use of the private sector is dominant among the poor as much as the rich in both states as well as the all-India case.

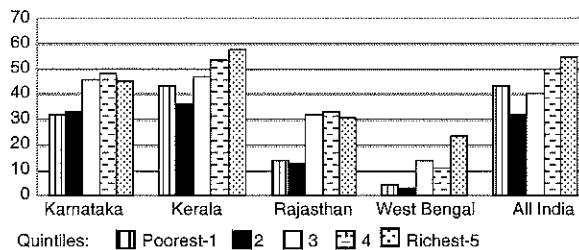
The market failures associated with relatively inexpensive, routine care are generally quite subtle. One important one is the phenomenon of “supplier induced demand” in which the asymmetry of information – doctors know more than patients about their illness – leads the latter to give more care than is needed or desired by patients if they understood as much as the doctor. The importance of this as a market failure is controversial in the developed world. In most places in the developing world, it is almost certainly an unimportant factor since the manifestation is too much care in places where the main concern is too small.

However, in India, at least in urban areas, there is a distinct tendency to over-medicate in the private sector mainly due to the ignorance and lack of knowledge of what constitutes proper care on the part of the patient. Whether this reflects a market failure or not is debatable [Das and Hammer 2005]. On the other hand, there is substantial evidence of over-medication (ibid, Phadke 1998) (and sometimes outright harmful treatment) in the private sector as well as a wide consensus that a significant fraction of this is supplier-induced. So, the problem must be taken more seriously in India than elsewhere. Even with this evidence, though, the welfare loss due to the efficiency-related market failures in the primary care sector is very difficult to pin down. In rural areas where the practitioner, even if unqualified, may be part of the community having to live with the consequences of actions could limit truly dangerous practices that the provider knows to be dangerous.¹² The problem could be much worse in urban areas with a weaker sense of responsibility since the “community” is hard to define. In any case, the welfare loss of market failure is likely to be limited by the fact that at least there is a market in the absence of government action.

On equity grounds, a stronger case can be made for public support for ambulatory care. A priori, medical care has a high income elasticity and is not a natural candidate for a general subsidy. However, if poor people can be accurately distinguished from other people, then services can be disproportionately given to them. Ambulatory care may also be a case of “specific egalitarianism” as expressed by people wanting to achieve the Millennium Development Goals (MDGs).¹³ But the case is not clear.

Curative services – hospital care: While given short shrift (what

Figure 3: Share of the Private Sector in Hospital in Patient Days – Rural Areas



does this mean?) in the international public health community since the Alma Ata conference in 1977, hospital care may be a reasonably efficient way to address the second characteristic market failure in the health sector: the systematic breakdown of the health insurance market.

In the absence of insurance, almost everyone is exposed to catastrophic loss of income if treatment is sought for expensive-to-treat illnesses. But no one sells assets to pay for ambulatory care – it is only hospital bills that poor people express fear of. Since public health insurance programmes are notoriously difficult to administer, public support for hospital care may be justified on efficiency grounds as a “second best” solution. Universal public insurance often turns out to be too difficult to manage since while universality solves the adverse selection problem, the other two problems plague government schemes just as much as private schemes. Figure 3 shows that use of private hospitals is, in fact, lower for everyone than for ambulatory care as illustrated in figure 2 above. Further, while Rajasthan showed higher use of primary facilities as income rose, private inpatient care is more prevalent among the relatively better off everywhere. It is just not possible for individuals to pay for expensive services that require hospitalisation.

Referral systems that encourage the use of hospitals only when necessary are difficult to design but can increase the efficiency of health expenditures generally. A practical solution could include capped fees in public hospitals. Optimal pricing for insurance is to have a small deductible and a cap on patient’s expenditure up to a maximum corresponding to “adequate” treatment and full payment by patients for expenditures beyond that maximum [Zeckhauser 1970]. Publicly provided hospital services is a reasonable, second best, option.¹⁴ Hospitalised Indians on an average spend 58 per cent of their total annual expenditure. Over 40 per cent of hospitalised Indians borrow heavily or sell assets to cover expenses. Over 25 per cent of hospitalised Indians fall below poverty line because of hospital expenses.¹⁵ This financial burden does not arise from the kinds of health problems treatable at ambulatory care facilities.

On equity grounds, again, if poor people can be identified, they can be provided with services. However, as we discuss below, the use of public hospitals rises substantially with income as is true in virtually every developing country in the world [Castro-Leal et al 2000]. As a result, we defer this discussion to the next section which outlines constraints on government in making health services progressive.

To summarise this section, there are two key characteristic market failures of the health sector. The first is the large externalities associated with communicable disease control whereby too little is spent on genuinely “public” goods. The second is

the inherent failures of the insurance market which leaves almost everyone exposed to catastrophic loss of income.

III Can Government Fix Market Failures? Understanding Government Failure

The implicit assumption of the standard, public economics, approach is that once a market failure is identified, the obvious solution is for government to step in and fix it. But as anyone familiar with developing countries in general and India more specifically knows, governments have their own sets of constraints and problems in carrying out their responsibilities crucial amongst which is the failure of accountability.¹⁶

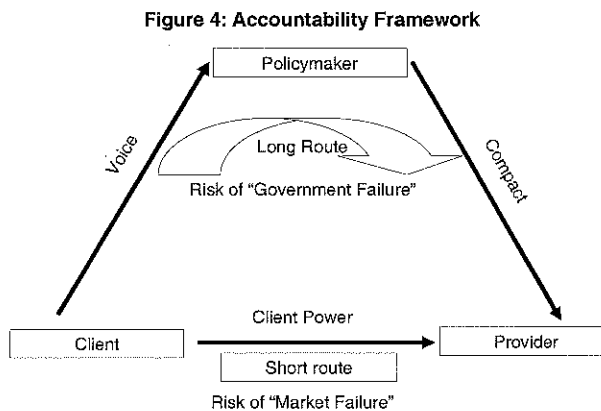
There are many formulations and understandings of the nature of accountability relationships that abound in public policy literature [Goetz and Gaventa 2001; Goetz and Jenkins 2004; Newell and Bellour 2002]. In this section, we aim to understand these relationships through the framework developed in the WDR 2004 to analyse this accountability relationship and how it applies to the health sector. Our argument emphasises the connection between accountability and incentives that are implicit in institutional arrangements.

One piece of the logic of the market is that a market transaction has implicit in it a natural process of accountability of the provider of a good or a service. A customer goes to a seller, asks for what s/he wants, decides whether what the seller has is worth the money being asked for it, trades money for the item, consumes it, decides whether it was worth the money after all, if it was not then might complain to the seller and either gets mollified somehow or refuses to come back again or threatens to tell friends not to patronise this seller. The essence of the transaction is that the seller is completely accountable to the desires and preferences of the buyer and has every incentive to make sure that those desires are met.

When the government decides to step in and act as an intermediary between the buyer (a patient or people at risk of disease) and the seller (the health worker) it has to make sure that the provider has the same or better incentive to satisfy client demand. For a government, this means that two steps are necessary for providers to satisfy consumers.

First, the government (the policymaker) has to have a clear understanding of what the citizenry wants – in particular, the poor. Second, the policymaker must be able to transmit these demands to the actual provider of services and to make sure that the incentives for these providers are aligned with the ultimate preferences or well-being, of the citizens. The minister of health does not personally give vaccinations. S/he sets up rules, personnel policies, issues directives, payment and management systems, etc, to have these vaccinations done. The vaccinations themselves are given by real people with real constraints and preferences of their own. The trick is to ensure that the incentives to the provider continue to reflect citizens' interests.

This two-step process and its comparison with the direct transaction through a market was the essence of the WDR 2004 approach to accountability. It is illustrated in Figure 4. In this picture, lines of accountability are illustrated for the two ways to make sure that services are delivered. Services, of course, go from provider to clients/citizens. But the accountability mechanisms to ensure these services get delivered can go in one of two



ways: directly to the provider as in a market or through the state (the policymaker in the diagram). We call these the “short route” and the “long route” of accountability, respectively.

Failures of service delivery are seen as failures of accountability. Market failures in this picture are the problems or risks with the “short route” of accountability. Government failures are problems with the “long route”. There are two classes of government failures. The first is those associated with the policymaker not succeeding in hearing or taking cognisance of what people want. We call this “voice” in the diagram though we could equally well call it “politics”. It does not work well if policymakers – elected officials or the higher levels of the administrative bureaucracy – are not accountable to the citizens.

The second assumes that politicians (policymakers) want to transmit the wishes of the people to the providers of services. The accountability of providers to policymakers is called the “compact” in the diagram.¹⁷ When working properly, the compact creates incentives such that the providers implement the wishes of the policymakers, who, in turn, accurately reflect the wishes of their constituents. Government failures associated with the compact are due to policymakers not being able to create these incentives and the provider again fails to satisfy clients/citizens wishes.

This framework helps us do two things. First, it helps set priorities for government interventions. If both the market and the government are subject to their respective failures, we have to weigh the advantages of one versus the other – given that neither is perfect. If the market failure is not “too bad” and the difficulty in correcting it is, then that activity would be a low priority for intervention (say, changing people’s eating habits to eat more green vegetables). Where market failures seriously outweigh government failures it indicates a high priority policy as in draining swamps to eradicate malaria. In this case a genuine public good (in which there is a total failure of the market) will outweigh even serious problems of public delivery because there is simply no alternative.

The need for this “balancing act” was well expressed by A C Pigou, the originator of the idea of corrective taxes to deal with market failures. Pigou argues that “It is not sufficient to contrast the imperfect adjustments of unfettered private enterprise with the best adjustment that economists in their studies can imagine, for we cannot expect that any public authority will attain, or will even wholeheartedly seek that ideal. Such authorities are liable alike to ignorance, to sectional pressure and to personal

corruption by private interest" [Pigou 1920]. Pigou was thus a bit sceptical of the ability to implement his ideas and identified both voice (sectional pressure) and compact (corruption by private interest) as obstacles.

Second, it helps to identify where the government services are going wrong and pinpoints where changes need to be made. We can then decide whether it is easier to fix the market failure or the government failure. Improving policies where the government is clearly the appropriate route means assuring accountability along both legs of the long route. The short route is the default, private market, option but as we shall see later, it can also be used as a policy instrument by government to take advantage of the client's ability to monitor the provider if it is better than the government's own systems.

The 'Voice' in Health Policy

For a variety of reasons, health often loses out to other demands on public resources. This has implications both for the overall health budget as well as for the composition of expenditures within that budget. The problem of generating sufficient overall resources has been addressed by several commentators but one main issue has been that while education, for example, has gained acceptance as an important factor in the overall development of the country, health has not [Keifer and Khemani 2003]. Therefore, there is more willingness on the part of elites to support education and other "development" expenditures than there is for health.

Health has frequently been termed a "merit" good, i.e., is deserving of more funding than is justified even by efficiency and equity arguments. However, the status of "merit" good is determined by the political process, particularly in a democracy. Many commentators have noted that India spends much less of its government budget on health than many other countries in the region and at comparable levels of income. This does not bear the markings of a "merit good". Outsiders cannot tell governments that certain goods are "merit" goods – that is something that the society as a whole has consensus on and is expressed through political mechanisms.

Within the sector, political concerns may go quite far in explaining the actual allocation of funds. The factors determining the political incentives are not always the same as those that determine the economic or health priorities across different policy options. We now look at how this applies to our health categories:

Traditional Public Health

This is one area where there is a clear conflict in the allocation of resources to preventive/promotive public health activities, whether population based or face-to-face. While this is essential from a technical (equity and externalities) point of view, it is quite difficult to garner political support. For example, if mosquitoes have been successfully handled by the government and people do not fall sick as much, it is not clear that people will recognise the absence of illness as a result of a government policy. Therefore, it is harder for politicians to take credit for successfully adopting public health measures whereas they can be at the official opening of a physical facility. The WDR 2004 argues that "health status" is much harder to take credit for than clearly observable inputs, like buildings.¹⁸

Curative Ambulatory Care

Curative care is individual specific and can be attributed by the client to a specific government service. However, because the private sector is so large and is used more by the relatively well-off than the poor (as in Figure 2) there is always an alternative to the public sector and a systematic reason for there being less pressure to improve the functioning of the latter. Studies find that substitution with the private sector mitigates the net increase of medical care consumption from public provision [Filmer et al 2000].

Curative Hospital Care

Hospitals tend to be prioritised for two reasons. Firstly, large facilities are more prominent than small ones. Political figures can take more credit for opening hospitals than for opening primary healthcare centres or sub-centres. Secondly, it is much easier to take credit for the construction of facilities than for its successful functioning [World Bank 2003]. The former is visible and can be accompanied by a single visit from the politician of the area, the latter is harder to attribute to any one person since it is part of a system and depends on lots of different actors on a continual basis.

This failure in "voice" results in a misallocation of resources whereby too little is spent on genuinely public goods such as communicable disease control by traditional public health measures like vector control, sanitation, hygiene education and so on. While exact estimates are hard to find due to differences in definition, the best guess is that 5 per cent of public money goes to traditional public health activities while, until very recent efforts, almost nothing has gone to disease surveillance – despite the fact that reallocation away from infectious disease control towards non-communicable disease control hurts the poor.

As discussed, government commitment to helping the poor with the use of the health budget is dubious. Beyond the fact that so little money is spent on combating infectious disease generally, the beneficiaries of healthcare are disproportionately among the better off groups in society. Figure 3 shows the distribution of beneficiaries of healthcare subsidies primarily¹⁹ based on the 52nd round of the NSS data. This figure shows that the large majority of the curative healthcare budget benefits the top 40 per cent of the population with the top 20 per cent receiving more than 35 per cent alone. This is difficult to reconcile with a health policy justified on the basis of its benefits to poor people.

Therefore, it is hard to "break into" the voice leg of accountability, particularly for outsiders since this is so intimately bound up with politics. However, there is one service that governments can provide by which it may actually improve its own performance. This is in the regular, large-scale and multi-purpose collection of data – a true public good. The "multi-purpose" nature of data collection can help determine causal factors related to government policies and health. We defer discussion of this to the "compact" section.

Relevant, reliable and regular flows of data that highlights differences in health inputs and expenditures as well as health status at a small enough geographical level for someone to feel responsible for improving these indicators can serve two important purposes. First, information is power and it may generate political pressures for improved policymaking. Second, it fulfils a basic

democratic right – people are entitled to know what is spent in their name and with what effect.²⁰

The 'Compact' in Health Policy

The above discussion raises some doubts concerning the political support that health receives from the national and state governments which currently determine the size and composition of health budgets. However, even where money is being spent, evidence suggests that it is not being spent well. If peoples' behaviour is anything to go by, the health sector is being "privatised" by people voting with their feet. We highlight three important points:

– The public share of institutional deliveries of babies fell from 57.3 to 48.2 per cent between 1992 and 1998 (NFHS I, II).

– The public share of all deliveries fell between 1998 and 2001 (RCH I, II) as the private sector's share rose from 9.4 to 21.5 per cent.

– Pay commission raises of 1997 makes this unlikely to be due to lack of money – health ministries are very labour-intensive.

This indicates that the ability of governments to monitor and to enforce the compact is weak. Here, the key constraint is whether the provider is accountable to the policymaker (and, through them, to people) for providing good services. Even if the policymakers are sincerely attempting to act for the good of the people (i.e., strong voice), the difficulty lies in making sure that providers implement the intended policies.

Every policy option brings with it its own set of administrative and managerial problems. We discuss them here in terms of our categories of health with one caveat – there is very little empirical evidence on the relative difficulty in implementing policies. The following brings whatever empirical evidence there is to the subject but is necessarily supplemented by anecdote and common sense.

Population-based Public Health Interventions

Most policies that fall under this category are "one-shot" or occasionally engineering interventions requiring little management except for short periods. Draining swamps need maintenance but the main construction is relatively straightforward and easy to monitor. As policies go, these are likely to be the easiest for government to implement.

There are exceptions, particularly when the wrong problem is addressed. An example is the Central Rural Sanitation Programme in the 1980s, to construct latrines in every village. In Maharashtra, between 1997 and 2000, 1.7 million toilets were constructed by the government. Many of these structures were used for reasons other than for latrines – 53 per cent by the government's own estimates.²¹ In this case, the problem was not the absence of infrastructure; it was the lack of understanding of the relationship between sanitation and health. So, while it was easy to implement construction, this was not sufficient to get health effects [Ahmad et al 2005]. Rather it needed to be complemented with health education.

A crucial service is the generation and dissemination of data concerning the inputs, outputs (services delivered) and outcomes (changes in health status and protection against catastrophic financial loss) within the health system. This information has little monetary value to anyone outside of government or academia²² so it will not be collected in the private sector. The information

serves not only to enhance "voice", but also to determine which public policies are most effective in improving health via statistical analysis. Further, if collected regularly enough and representative of small enough areas, it can help hold providers accountable for results.

Referring back to Pigou's argument on the balancing act, the "balance" of market and government failures, in this context government intervention: (1) fixes serious market failures, (2) are highly disproportionately pro-poor, and (3) should, in most circumstances, be relatively easy to implement via the compact – either by government departments or direct, easy to monitor, contracts. Yet, it is not being undertaken due to lack of voice.

Preventive/Promotive Public Health Interventions

Peoples' behaviour is a key factor to health. This includes hygienic practices of all sorts, making sure children are immunised, boiling of water, breastfeeding, and all factors associated with non-communicable "lifestyle" related diseases. As in the population-based interventions, some of these are relatively easy to implement. Immunisation campaigns – the most recent successful example being the pulse polio campaign²³ – seem to work quite well. It is a commonplace that India can deal with famines but not with day to day malnutrition. It is easy to mobilise and monitor specific, well-defined policies with measurable outcomes. It is much harder to run systems on a continuous basis.

As far as our inquiry about "balancing" market and government failure is concerned, preventive/promotive activities: (1) address serious market failures, particularly when directed at communicable disease control, (2) for the same reason, are services that cater disproportionately to the poor but, (3) in contrast to pure public goods of population-based interventions, do face more difficulties in the "compact", in making sure the services are provided adequately. Monitoring of provider behaviour is not easy. The potential effect of healthier behaviour is clear as is the role that government needs to play to encourage it. How to change behaviour is a bit harder and is likely very context-specific – pointing to the possibility that government performance may be improved by local decision-making.

For both of our above-mentioned categories of traditional public health, it is important to note that the fact that government needs to fund and guarantee the provision of a service, does not mean it has to do the actual provision of it with civil servants – contracting out the service could work as well.

Curative Care

The essential problem of curative care is that the public part of the Indian healthcare system violates a basic premise of healthcare finance. That is – money must follow the patient. With one exception, no developed country pays public money to primary care providers with salaries. And while India may be a special case in many regards, this is one area where the logic that guides this policy in the rest of the world applies with full force to India. This is why rich countries (with far greater technical control mechanisms), as discussed earlier, always allow choice among patients and rules where payments follow patients.

Organising, monitoring and managing a dispersed set of facilities on a daily basis in rural areas is not easy. The difficulty is underscored by the common phenomenon of people bypassing

free public care to spend money in the private sector. Why is it hard to give these services away for free? We approach this by asking: what is it that people find when they go to a rural, public, primary health centre (PHC)?

(1) *Vacancies in posts leading to inadequate staff:* A recent study in India finds that the unweighted average of vacancies to be 18 per cent among doctors, 15 per cent among nurses and 30 per cent among paramedics [Chaudhury et al 2006b].

(2) *Absenteeism among medical care providers:* Figure 6 shows the results of a large-scale study of surprise visits to health facilities in all the major states. As the figure highlights, the average level of absenteeism for the country is very high. There are legitimate reasons for being away from posts such as leave or official duty. However, the numbers claimed for being on leave are much higher than are allowed by the rules. The study also found that absenteeism was worst in the smaller sub-centres (for staff that were not supposed to be on home visits), followed by the primary care centres and best for the few community health centres (small hospitals) in the sample.

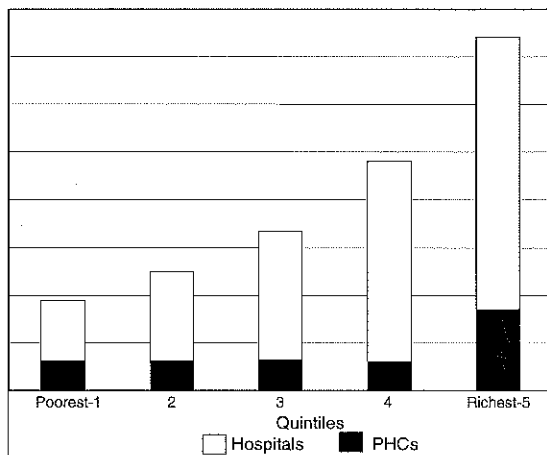
Since salaries are paid *regardless* of absences, the total cost of maintaining a PHC system includes both those costs that are legitimately necessary to keep facilities running, but also those costs that are received by providers in the form of “rent”, that is, payments that do not lead to increased services. The modification of the distributional benefits in the figure below takes into account the full costs of the PHC system inclusive of these rents.

Vacancies and absenteeism reflect that too few healthcare providers are at their posts when patients demand healthcare. Timing exacerbates this problem – public facilities are open only when patients have to work. This may seem to be a separate problem from those that are determined by provider behaviour, but can be traced to a similar source.

(3) *Inadequate competence of staff:* A recent study on the quality of medical care in Delhi found that competence levels of a public sector MBBS doctor in a PHC were so poor that there was as high as a 50:50 chance of the doctor recommending a positively harmful therapy [Das and Hammer 2005]. Moreover, the study undertook a comparative analysis of competence levels of doctors in Delhi with a national random sample of doctors in Tanzania and in Indonesia of the equivalent of MBBS doctors and found that the typical MBBS doctor in a PHC (not hospitals) in Delhi is less qualified than the typical provider in Tanzania, and substantially, less competent than doctors in Indonesia, and that even hospital-based public sector MBBS doctors only about reach the Tanzanian level – and are still below that of Indonesia.

(4) *Inadequate effort applied by staff:* The study referred to above also examined, through observations, the effort doctors put in their actual clinical practice. The striking thing was that, while the private, non-MBBS providers were not very competent in practice, they did what they knew, while the public MBBS doctors did not. In the hypothetical vignettes used to measure competence, about 30 per cent of public sector doctors asked the right questions – but less than 10 per cent did so in observed practice. In contrast, private non-MBBS doctors knew to ask the right question only 20 per cent of the time, but achieved that same level in practice. This low effort becomes even more striking when the public doctors in PHCs in poorer neighbourhoods in the study are examined – there both competence and effort was below even that of non-MBBS doctors – and both were much worse than in rich neighbourhoods. The contrast with the

Figure 5: Subsidies for Curative Care Help the Rich
Distribution of healthcare subsidies, 1995-96



Source: Mahal et al (2002) and Chaudhury et al (2006a).

private sector is instructive: since private doctors are directly accountable to the patient, they put in effort, although they tend to over-prescribe medicines that are ineffective (at best) simply to please the client (see the box).

(5) *Discourteous behaviour:* Many surveys show that patients are treated much more courteously in private clinics (even if they are staffed by the same public sector workers in their off-duty hours).

(6) *Illegal payments:* Transparency International's report in 2005 measured the monetary values of payments people were required to pay to receive different free public services. Of the seven services covered by the study, healthcare accounted for the largest single share of money payment – at 27 per cent it was ahead of police and judicial services.

Indeed, all of the problems of delivering healthcare – particularly primary care – are the results of bad incentives – a particularly bad compact. People may be bypassing public facilities for private for all of the above reasons. But why does this apply to the public

Box: Health Insurance Markets Always Fail

This is the reason why almost all rich countries have found it necessary to have government assume the insurance function. The following three inherent features of healthcare are responsible for this market failure:

(1) *Adverse selection:* When insurance purchases are voluntary, the sickest people will buy policies, driving the price up for everyone else and driving the healthier among them out of the market. This further raises costs, prices and the tendency for healthy people to stop buying coverage – a process that can lead to an unravelling of the entire market.

(2) *Inadequate monitoring:* The adverse selection problem is exacerbated by the difficulty of a “third party” – i.e., the insurance company – to observe whether treatments given are necessary and, since it is free to the consumer and profitable for the provider to increase the intensity of treatment, costs rise faster still.

(3) *Moral hazard:* Whereby the very existence of the insurance leads people to take fewer precautions to prevent illness than they would if they had to bear the cost of the treatment. An example would be not exercising to reduce blood pressure when (costly) medicines to control the problem are available and covered by insurance. This adds to overall costs but is probably less of a problem than the adverse selection and monitoring problems.

and not the private sector? Why might public doctors not be as conscientious as private? One clear explanation is that their pay does not depend in any way on their being conscientious. Their performance has little, if anything, to do with their remuneration. When private providers do not show up in their clinics, they do not get paid. When a public provider misses their clinic opening hours, they get their salary, at the public's expense, anyway. If you are paid by salary; not monitored by supervisors; cannot be fired or have pay reduced under any circumstances; have lucrative alternative work in the private sector – what would you do?

Summarising the “balance” of market and government failure, ambulatory care: (1) is subject to some market failure as manifested in the tendency to over-prescribe drugs or otherwise over-treat patients, (2) has the potential of being a way of redistributing resources to the poor since rural areas are, indeed, poorer than urban. However, as currently run is not serving this purpose very well, and (3) appears to be very difficult to run properly under the set of incentives providers currently face.

Curative Services – Hospital Care

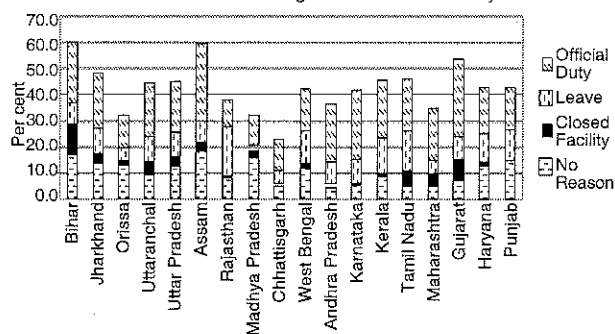
Although hospital services are run in the same way as PHCs, enforcing the compact – at least in terms of attendance – is somewhat easier for the following reasons. First, in a hospital setting, peer monitoring (several people on staff observing other provider's behaviour), often leads to better attendance [Chaudhury et al 2006a] than in smaller facilities. This is particularly true for more junior staff when the senior medical officers are present. Peer monitoring and consultation may also help in the less-easily-observable aspects of medicine such as clinical practice. In addition, it is easier to manage personnel in larger facilities than in dispersed networks. Secondly, a major determinant of attendance is living nearby and hospitals, for obvious reasons, tend to be in towns and cities where upper class people (like physicians) would prefer to live. Thirdly, research in Andhra Pradesh has shown that doctors tend to like to work in settings where they have colleagues to work with as well as equipment and opportunities to use their skills and education. Thus larger facilities and in particular hospitals can rely on better internal motivation from staff to ensure better performance.

Although, as in ambulatory care, there are serious problems based on an incentive system that relies on salaries though in the case of hospitals, this is the organisational equivalent of fixed annual budgets independent of performance.

Summarising the “balance” of market and government failures in the context of hospital care: (1) hospitals are a plausible “second best” solution in the absence of a functioning universal health insurance programme. Such systems are extraordinarily difficult to manage and while it is the likely form of the Indian healthcare system of the (far) future, universal insurance is an unlikely option. Therefore, hospitals ameliorate the serious market failure of insurance and can, potentially, provide protection against financially catastrophic loss to everyone – rich and poor, (2) on equity grounds hospitals are failing the poor miserably with the vast majority of subsidies going to urban residents, and (3) subject to the basic problem of payments to providers in the form of salaries but with some advantages over ambulatory care.

In this section we have argued that there are two kinds of government failures that have contributed to the current failures of the healthcare system in India. These are failures in voice and

Figure 6: High Average Level of Absenteeism in India
Reasons of Absence among Healthcare Providers by State



compact. Failures in voice have resulted in a misallocation of resources with relatively little being spent on genuinely public goods on the one hand, and the top 20 per cent of the population receiving a majority of benefits from healthcare subsidies for curative services. Failures in the compact are most evident in ambulatory care services where problems of vacancies, absenteeism and corruption are rampant. Fixing government failures requires identifying the level of government where voice and compact is strongest for the given service.

IV Conclusion

In this paper we have argued that the current crisis faced by the public healthcare system can largely be attributed to the failure of accountability. It is important to note that the government has recognised the importance of accountability as the key to resolving the current crisis. Efforts to address this are best articulated in the National Rural Health Mission (NRHM) that attempts to strengthen voice by empowering local governments to manage and control public health services. However, while these efforts can strengthen voice they fail to address the issue of incentives that determine provider behaviour. It is only when both legs of the accountability chain are intact – that policymakers hear and represent the wishes of people – particularly, in rural areas where the majority of the poor or near poor live – and that the policymakers successfully transmit these wishes, through the provision of proper incentives to providers that any significant improvements will be made in the healthcare system in India. [PP]

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Notes

- 1 Public discussion in academia, government reports and in newspapers is rife with discussions of crisis. See Sen (2005), Sainath (2006), G Das (2006) among many others.
- 2 Transparency International (2005), www.transparency.org
- 3 At least one quarter of hospitalised Indians fall below poverty line because of hospital expenses.
- 4 ‘Making Services Work’, World Bank (2003).
- 5 Preliminary analysis of NSS 60th round, 2004.
- 6 The very few exceptions are, themselves, very illuminating. For example, Swedish doctors are employees of local governments.
- 7 The anomaly is with respect to rich countries with at least vaguely

well-functioning healthcare systems. The vast majority of poor countries do pay providers with salaries. This may go a long way in explaining the absence of any connection, across countries, between increased health expenditures and improved health [Filmer and Pritchett 2001; Filmer et al 2000].

- 8 So universal, in fact, that they are not noticed in rich countries – people take them for granted because they have already been addressed.
- 9 Although prevention may be directed at non-communicable disease as well.
- 10 *The Hindu*, Thursday, May 4, 2006.
- 11 This is a critical and often misunderstood point. The elementary arithmetic for why this is true is presented in World Bank (1998). The hypothesis could even be put forth that in public information campaigns, particularly where the germ theory of disease is not completely understood, the risk of sending confusing messages on lifestyle, diet, etc, could undercut the effect of combating communicable disease. In this case even public goods may be low priority if their impact on the effectiveness on pro-poor public good is strong enough. This is an empirical (and untested) question.
- 12 Dulleck and Kerschbamer (2006) specify conditions under which “credence goods” like medicine where the customer has to have some trust (credence) in the seller will lead to larger or smaller welfare losses from market failure.
- 13 For discussion of a moral question related to treating people as means of achieving favourable statistics while overriding their own preferences as ends in themselves, see ‘Ends and Means in Public Healthcare’, [Hammer and Berman 1995].
- 14 If the incentive problem discussed in the next section is solved.
- 15 From NRHM mission document.
- 16 It is a well-researched fact that the continued deterioration of india’s public sector can be attributed to the failure of accountability mechanisms in government. See for instance, N C Saxena (2004).
- 17 We refrain from calling it a “contract” though it has many of the same features, because it can take a number of forms that are less explicit agreements.
- 18 There can certainly be exceptions to this general observation depending on the awareness of citizens on the causes of disease and how observable are changes in its prevalence. A good example is that Italian fascists gained enormous political support from successfully eradicating malaria.
- 19 The “primarily” part is due to the analysis of Mahal et al based on the usage of different health units. Their calculation of the total cost of PHCs was arbitrarily cut by 40 per cent since the per-visit costs were so high they felt it unrealistic to call this a “benefit”. This figure incorporates “rents” to providers based on absentee rates in Chaudhury et al (2006a) and discussed later.
- 20 There are some risks to this and such data should emphasise the changes in health status or health expenditures that a local area experiences. When district level human development indices were first (meaning levels were reported but not changes) introduced in Maharashtra, for example, government was besieged by low scoring areas as a way of lobbying for more money. This accountability should go both ways, however. In the second year – if such information were available – it might be that the state government could turn around and ask: how come the extra money we gave you last year did not lead to any improvement? (interview with former district collector, Thane).
- 21 There are cases where the latrine superstructure (built without a pit underneath it), was converted into a puja room since it was the only concrete, “pucca” structure in the village (Water and Sanitation Programme (2003)).
- 22 Funds for this kind of research in academia are severely limited and the incentives for collecting data and publishing within India academia are weak, indeed. But that is another story.
- 23 We are deliberately avoiding the controversy over whether the polio campaign interfered with other, perhaps, more important epidemiologically, immunisations. The contrast does reinforce the point, though – time bound, clearly defined, and therefore, easy to monitor interventions are easier to make sure get done by a statewide programme while more complex tasks are more difficult to ensure.

References

Ahmad, J K, S Devarajan, S Khemani and S Shah (2005): ‘Decentralisation and Service Delivery’, *World Bank Policy Research Working Paper*, No 3603.

- Berman, P, and J Hammer (1995): ‘Ends and Means in Public Health Policy in Developing Countries’, *Health Policy*, Vol 32 (1-3), pp 29-45.
- Castro-Leal, F J, J Dayton, L Demery and K Mehra (2000): ‘Public Spending on Healthcare in Africa: Do the Poor Benefit?’ *Bulletin of the World Health Organisation*.
- Chaudhury, N, J Hammer, M Kremer, K Muralidharan and H F Rogers (2006a): ‘Missing in Action: Teacher and Health Worker Absence in Developing Countries’, *Journal of Economic Perspective*, Vol 20, No 1, pp 91-116.
- (2006b): ‘Is There a Doctor in the House?’, forthcoming.
- Das, G (2006): ‘The Best of Times and the Worst of Times’, *Times of India*, April 22.
- Das, J and J Hammer (2004a): ‘Which Doctor? Combining Vignettes and Item Response to Measure Doctor Quality’, *Policy Research Working Paper Series*, No 3301, The World Bank.
- (2004b): ‘Strained Mercy: Quality of Medical Care in Delhi’, *Economic and Political Weekly*, February 28.
- (2007): ‘Money for Nothing: The Dire Straits of Medical Practice in Delhi, India’, *Journal of Development Economics*, Volume 83, No 1, May.
- Dulleck, U and R Kerschbamer (2006): ‘On Doctors, Mechanics, and Computer Specialists: The Economics of Credence Goods’, *Journal of Economic Literature*, Vol XLIV, pp 5-42.
- Filmer, D, S J Hammer and H L Pritchett (2000): ‘Weak Links in the Chain: A Diagnosis of Health Policy in Poor Countries’, *The World Bank Research Observer*, Vol 15, No 2, pp 47-66.
- Filmer, D and H L Pritchett (2001): ‘Estimating Wealth Effects without Expenditure of Data – Or Tears: An Application to Enrolments in States of India’, *Demography*.
- Goetz, A M and J Gaventa (2001): ‘Bringing Client Voice and Client Focus in Service Delivery’, *IDS Working Paper No 138*, www.ids.ac.uk.
- Goetz and Jenkins (2004): ‘Accountability’ in Adam Kuper and Jessica Kuper (eds), *The Social Science Encyclopedia*, Routledge, New York.
- Keifer, P and S Khemani (2003): ‘Democracy, Public Expenditures and the Poor’, *The World Bank Policy Research Working Paper Series*, 3164.
- Mahal, A, J Singh, F Afridi, V Lamba, A Gumber and V Selvaraju (2002): *Who Benefits from Public Sector Health Spending in India*, National Council for Applied Economic Research, New Delhi.
- Mehta, P B (2003): *The Burden of Democracy*, Penguin, New Delhi.
- Newell, P and S Bellour (2002): ‘Mapping Accountability: Origins, Context and Implications for Development’, *IDS Working Paper No 168*, www.ids.ac.uk
- Phadke, A (1998): *Drug Supply and Use: Towards a Rational Policy in India*, Sage Publications, New Delhi.
- Pigou, Arthur C (1920): *The Economics of Welfare*, Macmillan and Co, London.
- Sainath, P (2006): ‘The Health of Nations: Seeking a Way Forward’, *The Hindu*, January 4.
- Saxena, N C (2004): ‘Improving Delivery of Programmes through Administrative Reforms in India’, www.nac.nic.in and cited in P B Mehta, *The Burden of Democracy*, Penguin, Delhi, 2003.
- Scheiber, G J, J P Poullier and L M Greenwald (1991): ‘Healthcare Systems in Twenty-four Countries’, *Health Affairs*, Fall, pp 23-38.
- Sen, A (2005): ‘India’s Poor Need a Radical Package’, *The Hindu*, January 9.
- Shetty, D (2006): ‘Year 2010 – India, World’s Largest Mass Healthcare Provider’, www.hsph.harvard.edu/pgda/Shetty_Presentation1.ppt
- Tobin, J (1970): ‘On Limiting the Domain of Inequality’, *Journal of Law and Economics*, October, pp 263-77
- World Bank (2003): *World Development Report 2004: Making Services Work for Poor People*, The World Bank, Washington DC.
- Zeckhauser, R (1970): ‘Medical Insurance: A Case Study of the Tradeoff between Risk Spreading and Appropriate Incentives’, *Journal of Economic Theory*, Vol 2, pp 10-26.

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