First Things First:

The unfinished agenda of public health in India

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NIPFP Conference on “New thinking on health policy”

4 November, 2016

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The unfinished barely started agenda of public health in India

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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
  - Hospitals are a second – best way of dealing with health insurance markets that fail virtually everywhere at all times
  - 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) given money AND implementation constraints

OK, OK maybe it isn’t SO simple

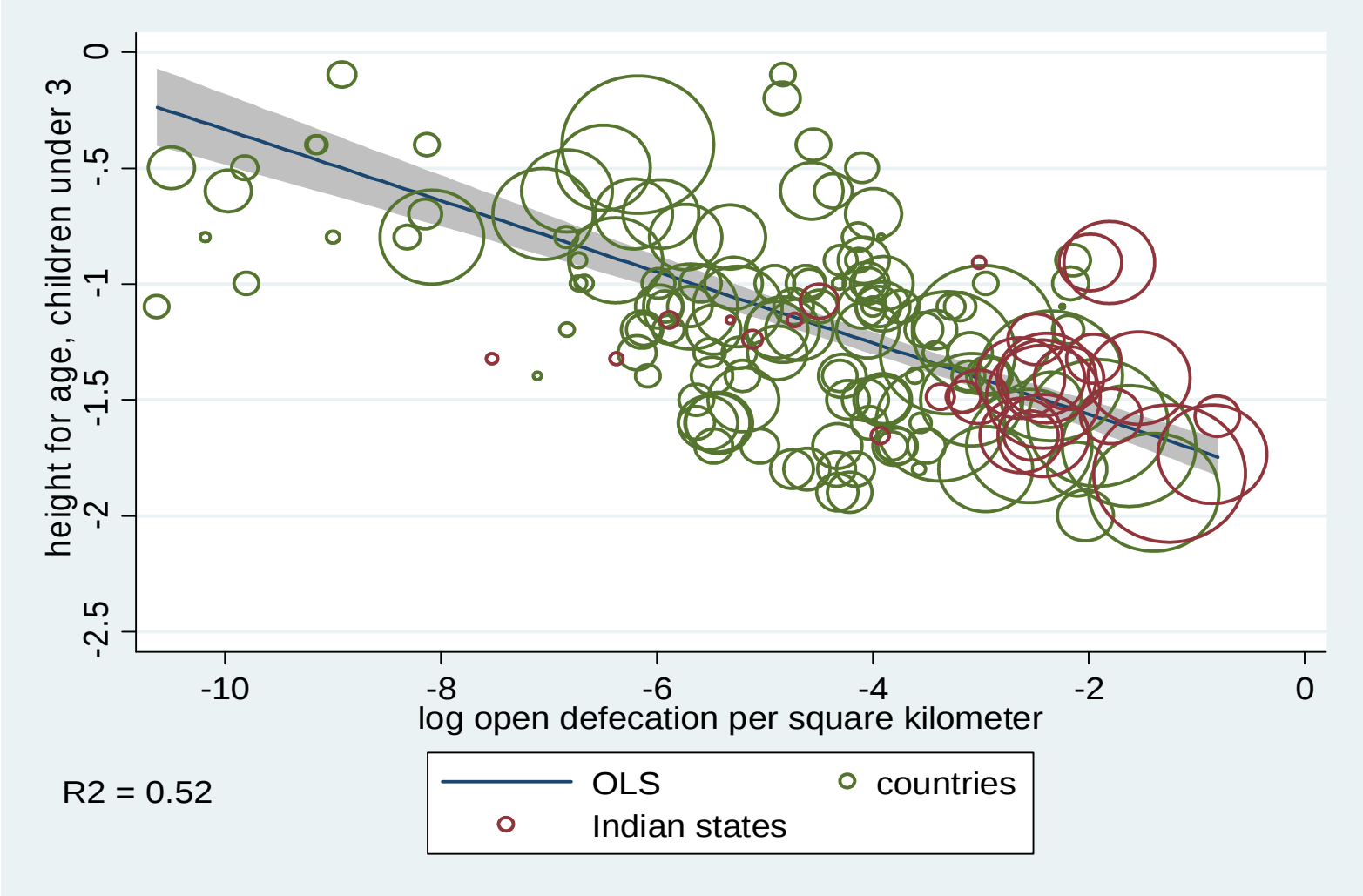
Priorities with limited budgets

- How well do alternative health policies do in promoting health?
- Not easy to discover using available data (we’ll come back to this)
- But lets just look at two kinds of policies head to head

Four studies contrasting sanitation to publicly provided medical care

- Urban
  - Drainage, open defecation and health in Delhi slums
  - Quality of medical care in public primary health facilities in Delhi
- Rural
  - A randomized control trial of the Maharashtra Total Sanitation Campaign
  - Quality of medical care in rural Madhya Pradesh

Context: Indian states in international comparison



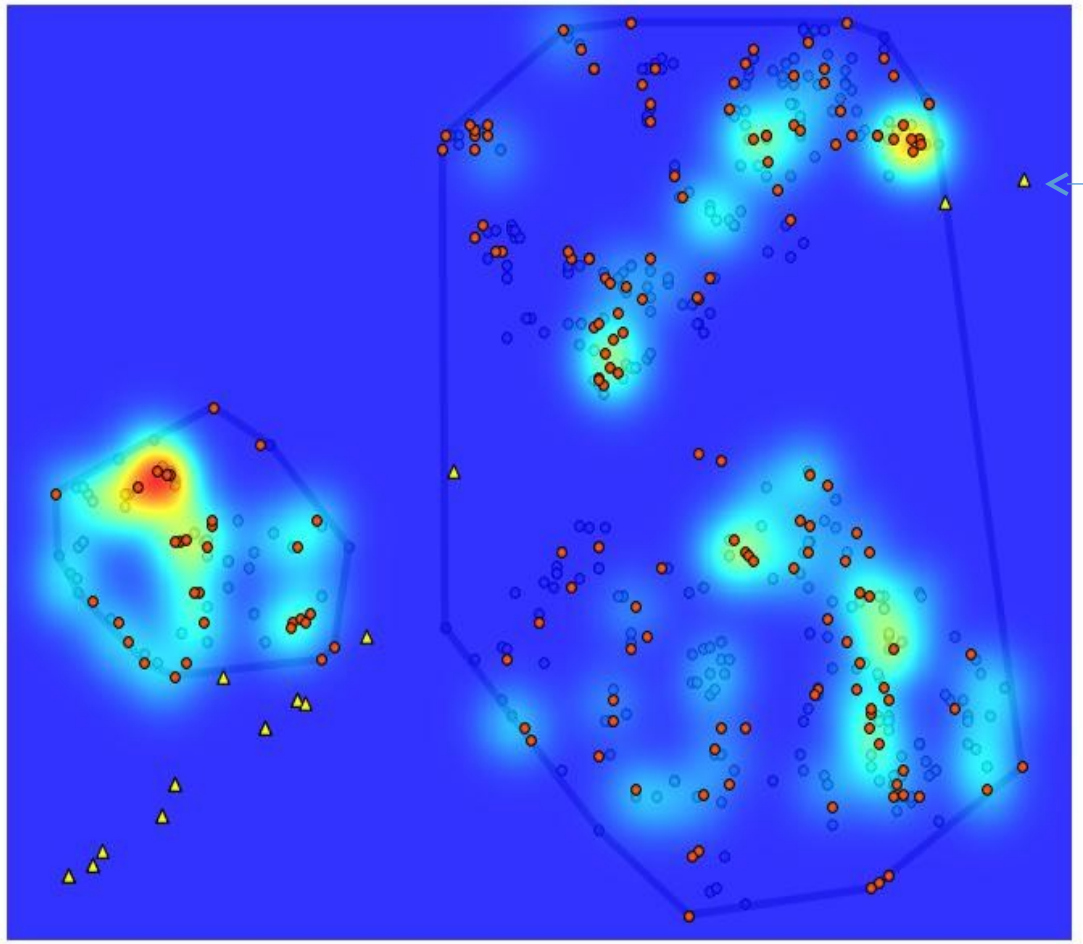
Density of open defecation suggest we take a closer look at cities

- Study of four unrecognized slums in Delhi
- Project by committee
  - Collaboration of political scientists, an anthropologist and a couple of economists
  - Larger project was to find out how the residents got public services even though they weren't really entitled to them
  - My part was much easier – what's hygiene got to do with health?

Open defecation and cases of diarrhea, Noida 8

“Heat” map – background color is derived from weighted average of people who openly defecate

Red dots are households with cases of diarrhea, Open dots are households

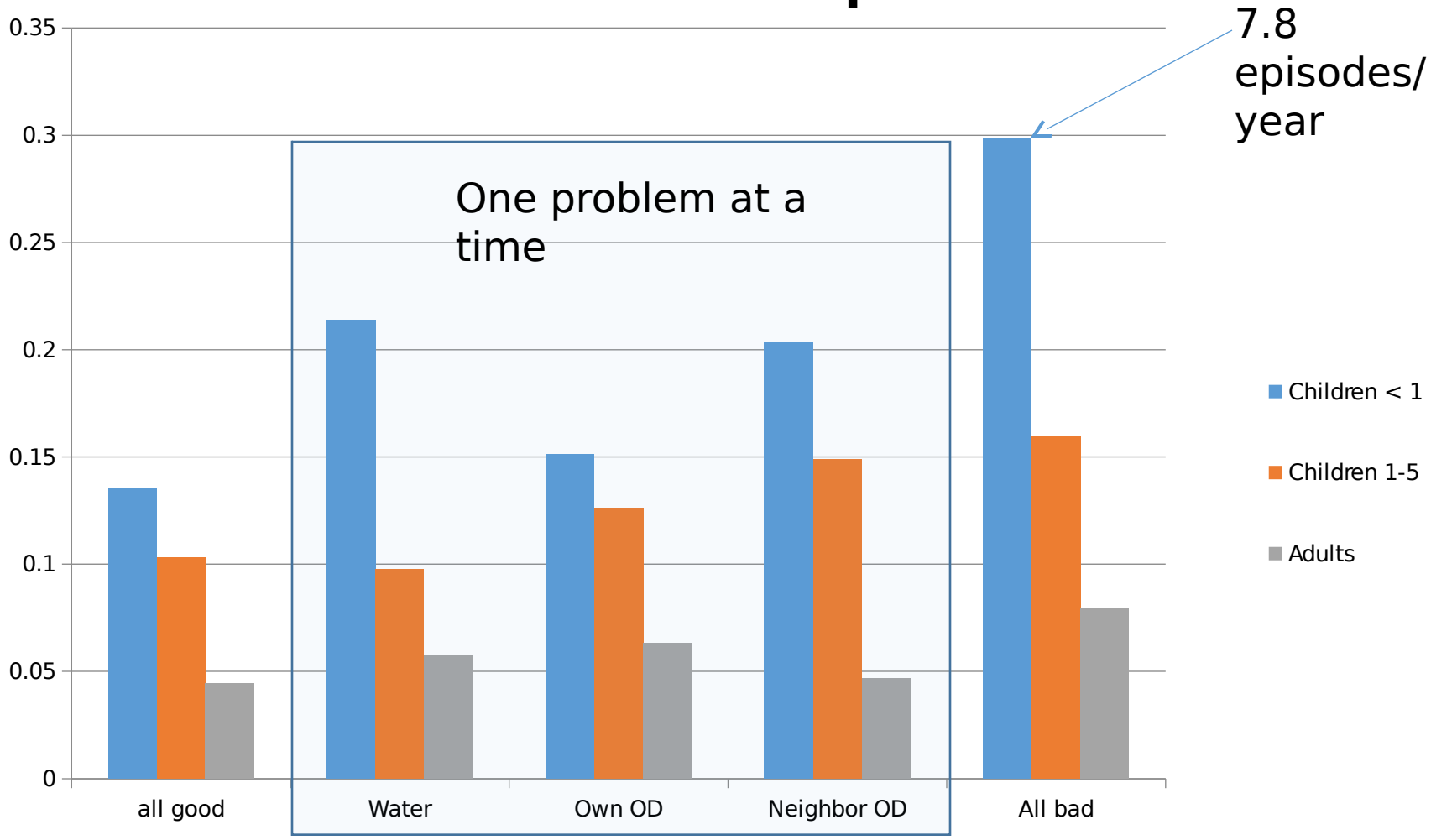


These slipped in from a different diagram

Some descriptive statistics

	Punjabi Basti	Kathputli	Noida 5	Noida 8
N	2024	1297	354	2207
HH's - someone with diarrhea in past 2 weeks	13%	32	36	32
Individuals with diarrhea	2.7%	6.3	7.3	6.6
General caste	59%	16	17	37
SC/ST	24%	25	72	28
OBC	17%	59	11	35
"Wealth“ (not%)	1.68	-0.65	-0.75	-0.84
(Others too complicated to show	but never come	up in any	regressio n	anyway)
Water enters home sometime during year	7.10%	47.6	47.4	55.4
Someone in HH sometimes openly defecates (OD)	6.4%	85.6	48.4	13.4
# of Neighbors<2.5 meters away who OD (not				

Results in pictures: Diarrhea in two week period

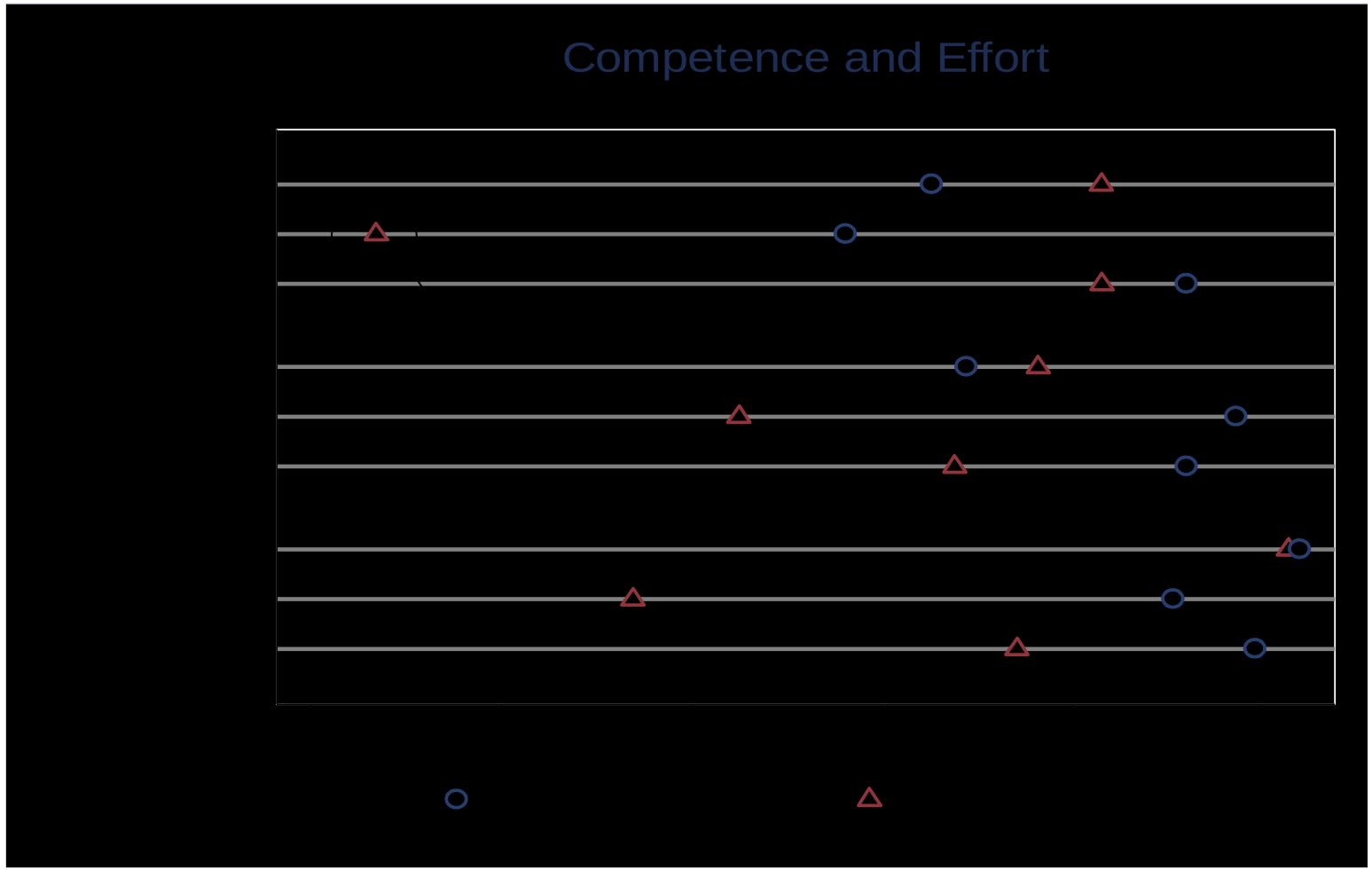


Public money in Delhi

- Why might publicly provided health care not work?

Quackery and crookery for the poor in Delhi

- no matter where they go



Das and Hammer, 2007

What about rural areas?

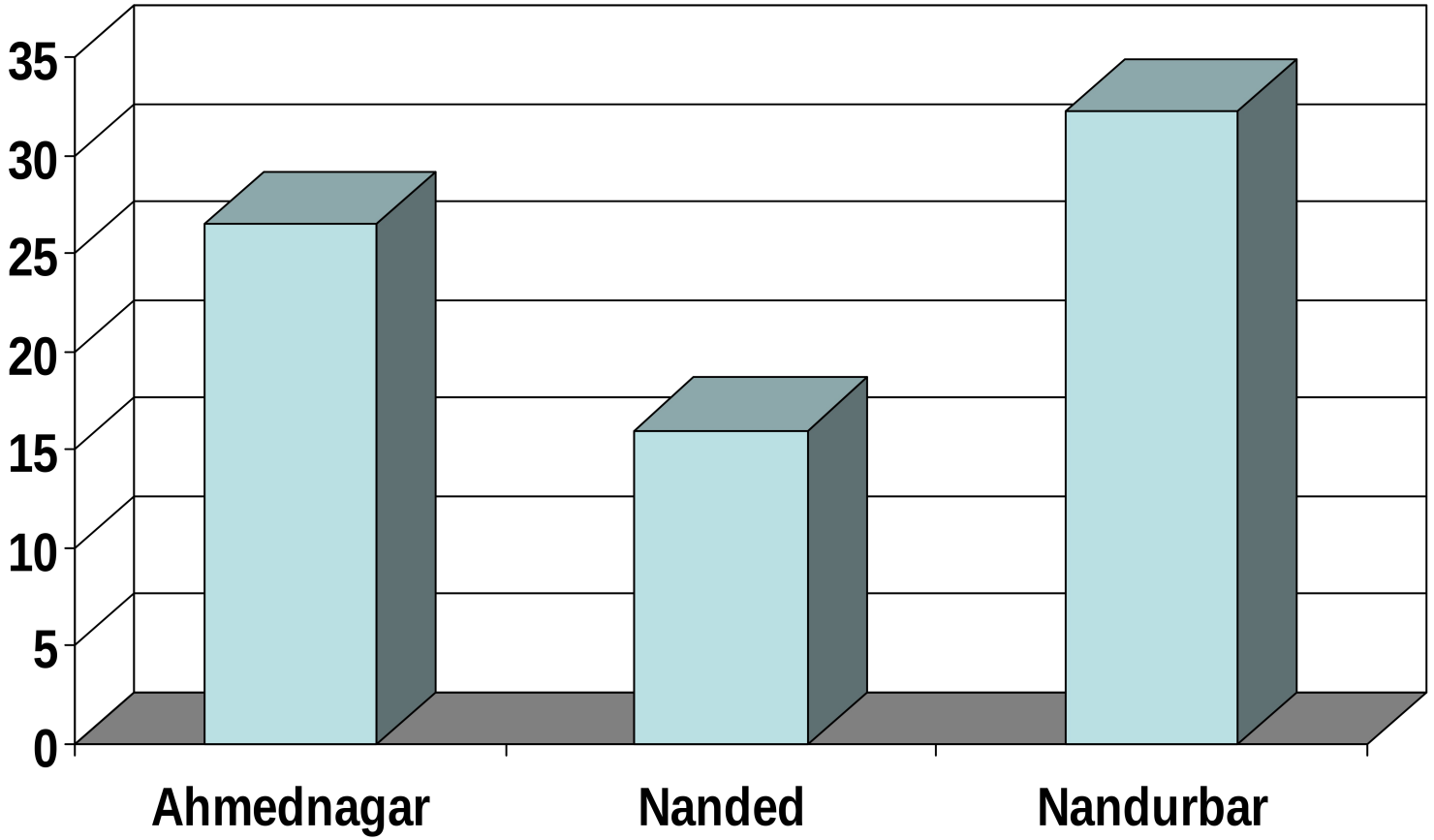
- Surely sanitation isn’t as important
- Surely there is no access to medical care and public medical care is necessary

- Surely someone should measure something before asserting these so confidently

Studying the Total Sanitation Campaign in Maharashtra

- A collaboration between the World Bank and the government of Maharashtra to evaluate a sanitation intervention with an RCT
- What was supposed to happen?
  - Baseline February 2004
  - Intervention: a village-level education effort by the government – to change behavior, not just build latrines. India's Total Sanitation Campaign but a little more intense
  - Midline survey August 2004; final survey August 2005
  - Three districts: Ahmednagar, Nanded, Nanderbar
- What did happen?
  - Well, all the surveys were done
  - But only Ahmendnagar got the intervention – couldn't get officials to do this in the tougher areas

Why behavior change?: Latrine ownership ≠ usage



Percentage of people who defecate in open despite owning toilets in Maharashtra (2004)

Effect on height comparing those that were supposed to be treated in all districts

Hammer and Spears 2016

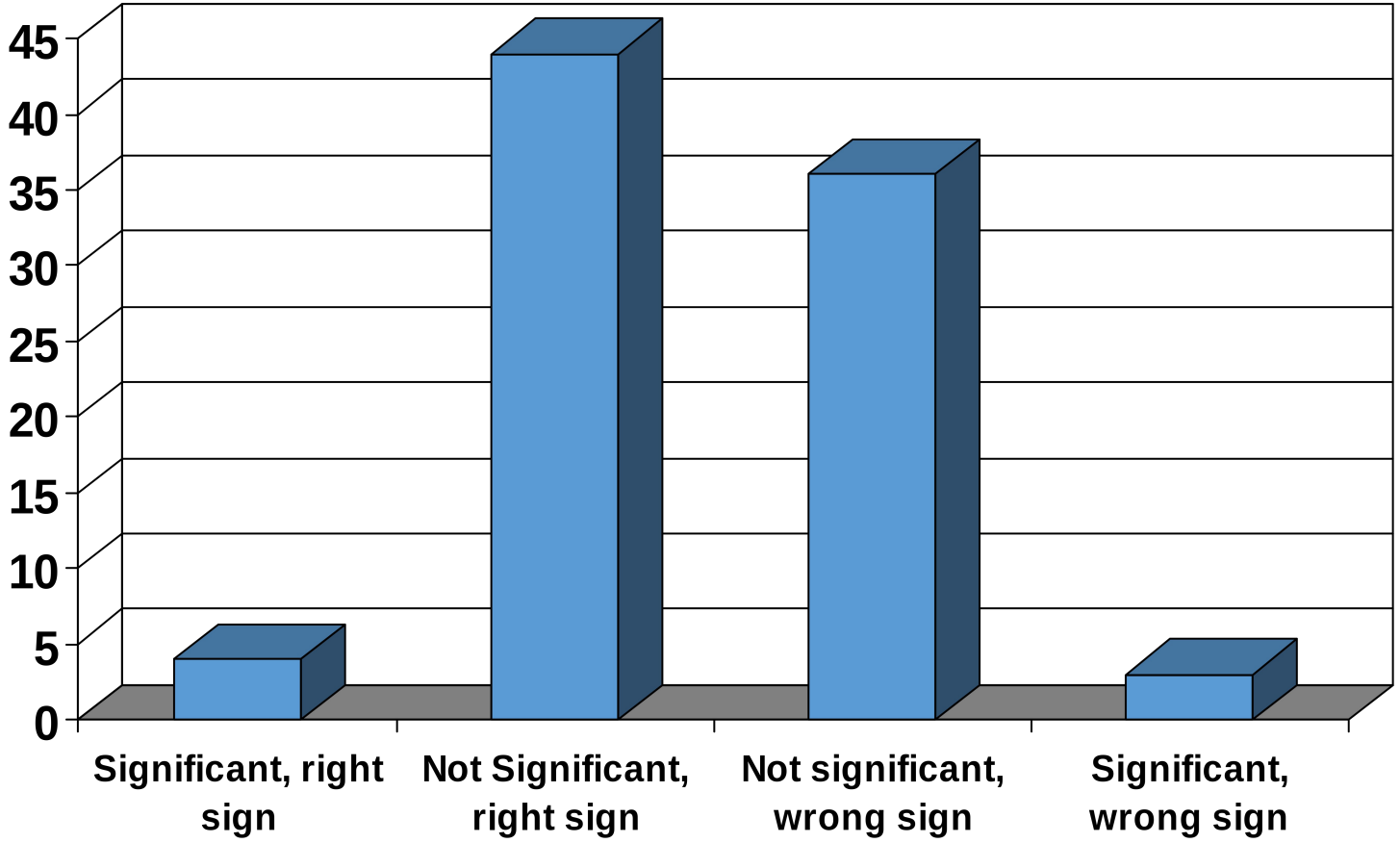
So, this is promising

- It works …
- … but only where it works – where it gets implemented
- Limitations of getting staff to go, and to put in conscientious effort, in difficult areas
- Should not overestimate government’s ability to implement this everywhere
- Swachh Bharat Abhiyan says it is about eliminating open defecation but is only measuring latrine construction – just like CRSP in mid ‘80’s

What about publicly provided primary health care?

- Doesn’t seem to “work” at all

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



Source: Chaudhury, Hammer and Pruthi (2005)

What about <u>publicly provided</u> primary health care?

- Doesn’t seem to “work” at all
- Why?
  - Vacancies
  - Absenteeism
  - Low capability of medical providers
  - Abysmal effort of medical providers
  - **<u>Many</u>** substitute providers of comparable quality care in private sector (even if they are quacks)

qualit
y

Whatever the problem is, it isn't "access"

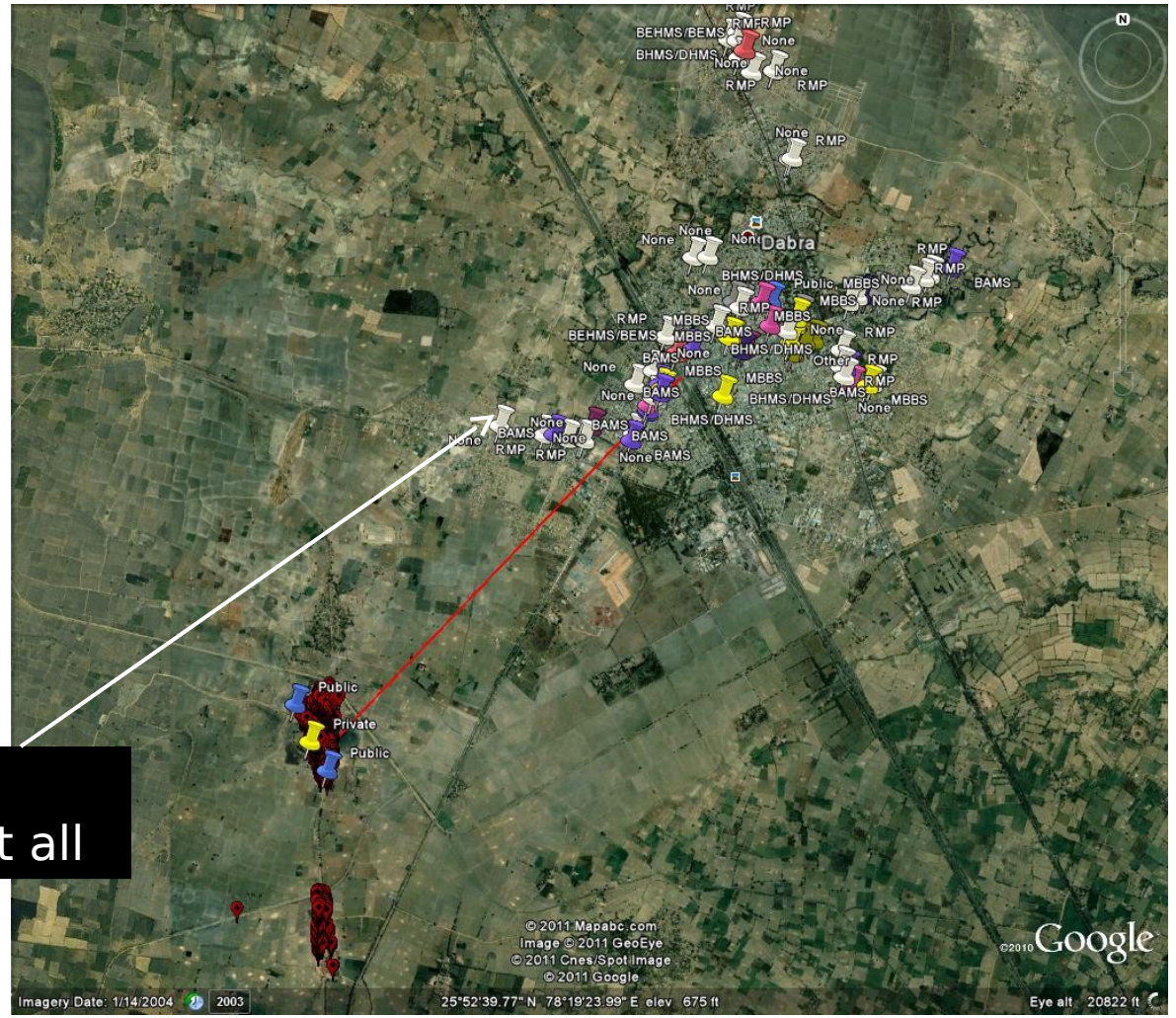
Public providers

Private MBBS

Homeopaths

Ayurvedic / Unani

No degree or qualification at all



Das et al, 2013

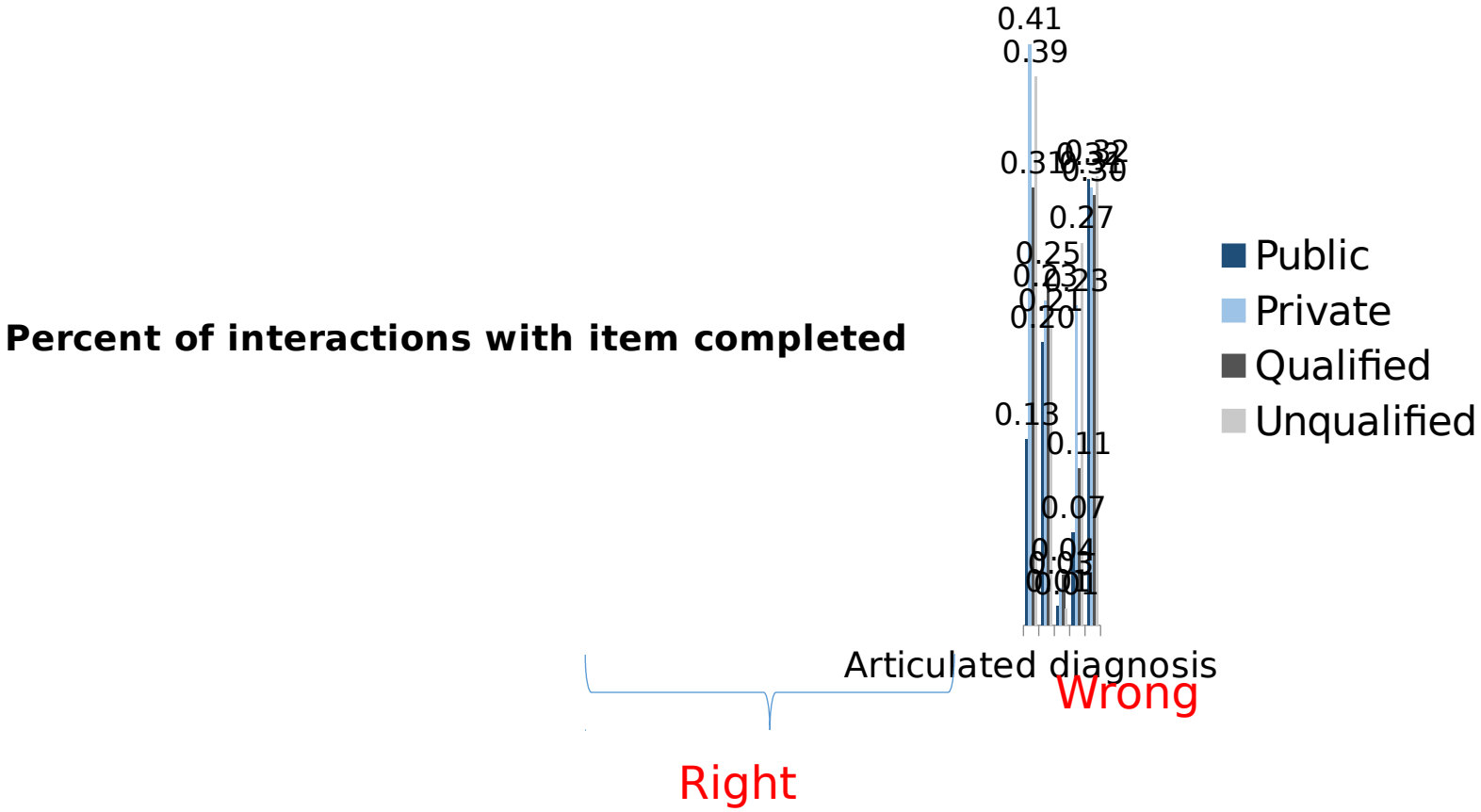
“Aha!” You say.

- You just told us a lot of these people are quacks
- Surely there is a problem of “access” to high quality “real” doctors in the public sector

- OK, let’s measure that

Diagnosis and treatment

Asthma In Madhya Pradesh



Das et al, 2013

So, let’s look at market AND government failures

- Real public health includes real public goods
  - Old-fashioned problems of the 19th century are still amongst us
  - It doesn’t matter how bad government is at doing it, there is no choice. Also common sense (for cities) and some evidence that it might work (in rural areas).
- Primary care has we’re-not-sure-which market failure
  - and the government has a really hard time providing it.
  - Directives from the WHO (or the HLEG) promoting primary health care for all should not be taken on faith. So far, it is all on faith. (Jeff: mention NRHM meeting)

Weighing market and government failures

- Right comparison is with the way policy is actually implemented OR the way it can practically be improved (with explicit, concrete steps for correction)
- Wrong comparison is with policies as we wish they could be implemented

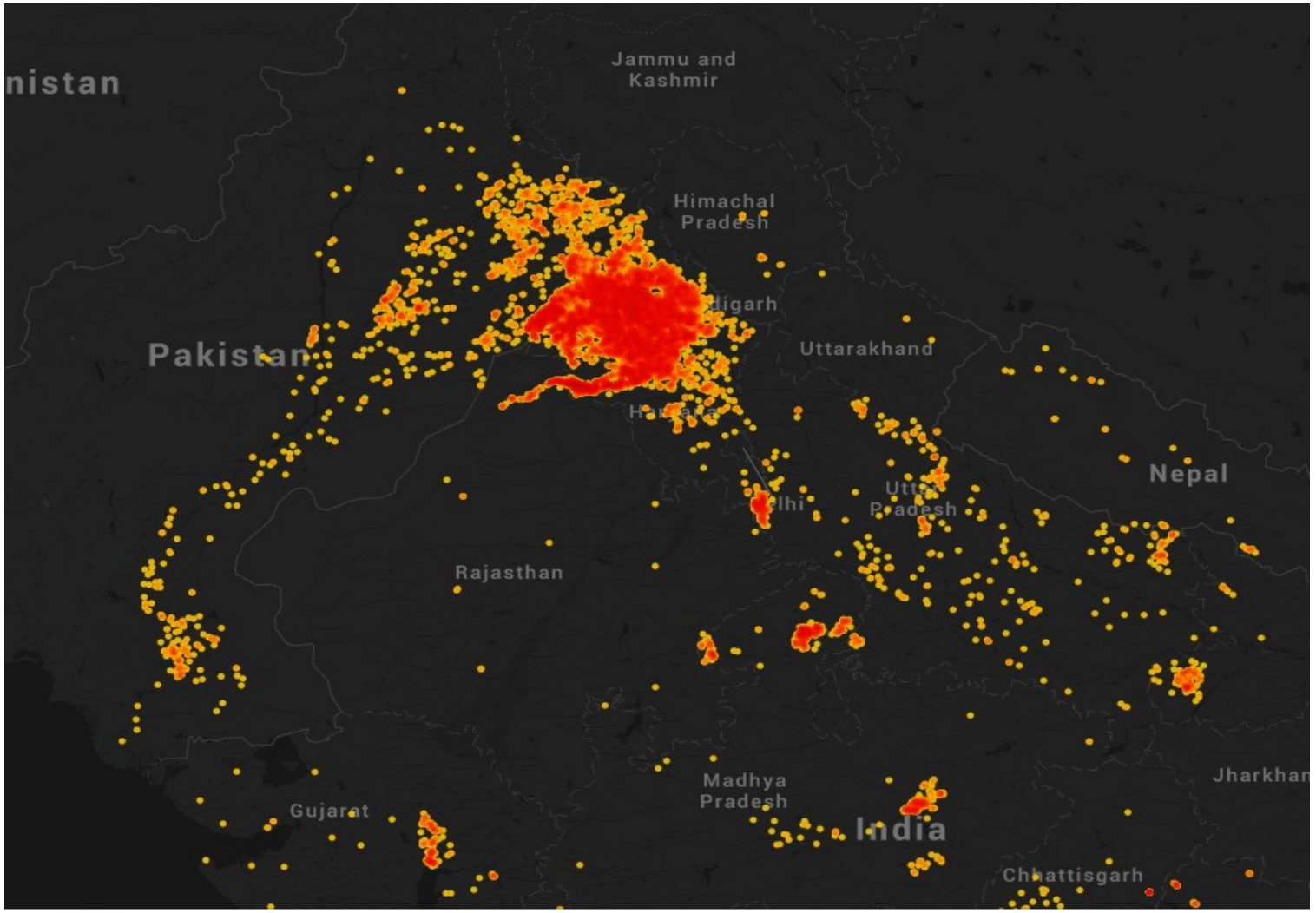
And another thing

- Another genuine public good that is seriously underprovided is data open to the public on public policy inputs and outcomes

Whining plea for better data

- Massive changes in rich world in type, sources and sizes of available data sets
- Organized in ways that are either easy to use or, at least, publicly available
- Much is being organized geographically – a continuously lengthening panel of routinely collected data

Fires in November 2013



Can we start now to develop general use statistics?

- Think through important issues for data collection? (how much of the NFHS will actually be looked at?) And maybe ensure quality?
- Could we request researchers to format data so that it can be absorbed into a larger system?
- Could we request ministries to do the same?
- Maybe we can start learning about the world

Thank you