

Money for Nothing: The Dire Straits of Medical Practice in Delhi, India

Jishnu Das and Jeffrey Hammer

Academic and policy discussions about health care increasingly view the quality of care as a crucial determinant of health outcomes. Policy levers to address quality disparities in health care must cover a variety of underlying causes. If geographic variations in practice quality reflect differences in provider competence, the solution lies in geographic incentives for doctors, greater movement of patients, or both. If variations result from differing provider effort, stronger performance incentives are needed.

In a new paper, Das and Hammer explore differences in doctor competence and incentives to explain variations in the quality of care in India. A companion paper was published in 2005 in the *Journal of Development Economics*. Both papers rely on interviews with 205 doctors using hypothetical medical conditions as well as records of what actually happened, and on measures of effort that reflect what doctors do when they show up for work (abstracting from the number of hours they work). Doctors in the public sector are often absent, though less so in urban than rural areas.

The authors find that provider competence and effort both play a role in the quality of care. The data indicate that what doctors actually do is very different from what they know they should do. This gap reflects the cost of effort relative to reward and illustrates a response to incentives: doctors paid for each service they provide are closer to their “knowledge frontier” than those paid fixed salaries. Furthermore, effort and competence are complements, not substitutes. More competent doctors spend more time with patients, ask more questions, and do more examinations. Less competent practitioners deliver worse care because of the direct effects of lower competence and the indirect effects of lower effort.

The new paper explains that the differences between what doctors know and what they do reveal disparities across institutional settings and geographic locations. Private sector practitioners do more or less what is expected of them by patients. Poorer patients receive low-quality advice and spend a fair amount of money for nothing—on low-value advice and unnecessary drugs. Wealthier patients get better advice, both because they see more competent providers and because their providers put in more effort. But wealthier patients also spend a fair amount of money for nothing, on unnecessary drugs.

Public sector practitioners spend less time and effort on patients and do less than they know they should. But this public-private disparity masks variations in the public sector. Public providers in smaller clinics and dispensaries substantially underperform public providers in hospitals; the latter are comparable to private practitioners.

Unfortunately, poor people do not really use public hospitals. Over a two-year period about 55 percent of medical visits by members of low- and middle-income households were to private doctors. Just 31 percent were to clinics and dispensaries—and only 13 percent to public hospitals. The public sector spends more than 80 percent of the government’s health budget on salaries for doctors and heavy subsidies to educate them. This is another form of money for nothing: substantial public spending on cursory, poorly delivered health care.

The concentration of more competent providers in richer neighborhoods, combined with the low use of public hospitals, implies that poor urban residents are particularly underserved—for several reasons:

- The private practitioners they visit have low competence.
- They receive worse medical care both due to the direct effects of lower competence and the indirect effects of lower effort.
- Weaker incentives in the public sector offset the protective effects of higher competence.

Thus the poor receive low-quality care from the private sector because doctors do not know much—and low-quality care from the public sector because doctors do not do much. Poor households are better off visiting less-qualified private practitioners than more qualified public doctors.

The findings of Das and Hammer suggest that weak medical services, at least for poor people, are more a function of a lack of incentives for public providers than a lack of competence among private providers. This would tend to indicate that solutions are more likely to come from improving information for consumers and reducing the demand for extensive inappropriate treatment. The authors suggest changing the incentives of public providers rather than increasing provider competence through training.

Jishnu Das and Jeffrey Hammer. Forthcoming. "Money for Nothing: The Dire Straits of Medical Practice in Delhi, India." Journal of Development Economics.