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Balancing Market and Government Failure in Service Delivery

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Abstract

Whether to provide services by the public or the private sector has been at the center of debates within governments and those in the international aid industry for decades. Unfortunately, this debate has often been cast in terms of absolutes with the private sector either as savior or demon. Casting the issue in this light simply can't be correct. It cannot be the case that either is appropriate for every service and with every government regardless of its capability to the exclusion of the other. In every case, policy makers need to ask "how can the government improve the well-being of citizens with the constraints and tools at hand?" Those constraints include the ability to implement and monitor policy.

This paper outlines how limitations of the market can be matched to appropriate interventions by government as it actually performs, not as it is hoped to perform. This matching will, by necessity, vary with country circumstance. While pure public goods must be provided by government regardless of its weaknesses and pure private goods should generally be left to the market, most serious policies operate in between. The balance of the limitations of the sectors needs careful analysis. The welfare costs of private market failure are rarely measured and the difficulties of implementing different policies are rarely discussed let alone quantified. Policies that are sensitive to deviations from perfect implementation should be avoided in preference to those that are more robust to circumstances. Further, every policy will generate interest groups that will constrain future decisions through political pressure.

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1. Introduction

I am honored to have been asked to give the introductory lecture to this conference on service delivery in Pakistan. I believe that improved

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services in health and education, and the transfer of purchasing power to the poorest people of Pakistan are of great importance to their welfare. As a longstanding observer of Pakistan, South Asia, and the poorest countries of the world generally, this is a goal I have deeply at heart.

However, I think we have become intellectually lazy in searching for the means to achieve better wellbeing. We have looked for simple solutions, usually of the variety "spend more money on things in which I (as a health, education, or social protection expert) take a particular interest." We have also become prone to wishful thinking that almost anything that is intended to improve welfare magically does so.

My argument here is that the design and implementation of effective policies in these sectors requires us to face hard realities of the constraints under which governments operate. These constraints are not solely—and I would argue, not primarily—limited funds. The government is further hampered by endemic problems of governance when the stage of implementation is reached. Ignoring this fact of life has led to enormous sums of wasted money.

The term "governance," too, has been used with a certain degree of laziness. This essay argues that there are concrete, if difficult, choices that specific kinds of limitations to public performance force us to make—choices that make it necessary to think strategically about the type of spending that is most important. From a more practical point of view, no government has complete control over income, health status, or education. What governments can do is facilitate improvements in all three, recognizing that their ultimate drivers are individual peoples' millions of actions.

This essay seeks to put the research carried out for this conference in a context that is useful for policymakers. What do we recommend policymakers do to favorably influence these millions of actions? The answers will differ both from sector to sector and from government to government. The essay reviews, briefly, the standard approach from public economics on policymaking, focusing on resource and market behavior constraints. It then augments the standard arguments for government intervention with concern for the administrative and, to some extent, the political constraints that governments face, and takes some tentative steps to show how appropriate policymaking can mix and match solutions, depending on the nature of the two sets of constraints.

2. The Standard Approach to Policy: Market Failure

How would an ordinary analysis of alternative policies in any sector proceed on the basis of conventional, neoclassical public economics? The first step, of course, is to list the primary market failures that characterize the sector. The litany of such failures are familiar to any student of economics and include natural monopoly; the characteristics of a pure public good, that is, nonexcludability and nonrivalry such that private markets simply cannot exist; externalities; and failure of coordination due to transaction costs or asymmetric information. In addition, we all have (or profess to have) a concern for the poorest in society given that a completely amoral market mechanism may not result in a distribution of income and wellbeing that corresponds to anyone's conception of "fairness."[1] Many of these have clear policy implications such as antitrust or price controls for monopoly. Once the particular problems of a sector have been identified, it is then assumed that a perfectly efficient, fair-minded, and knowledgeable government simply steps in to fix whichever of these canonical problems seems to prevail.

The discipline of listing the specific problems of a particular market is valuable but rarely done with a critical eye. One thing that economists have done is to train sector specialists to invoke the words "market failure," which allows them to stop economic analyses right there as if that was all economics had to offer. In fact, that is where analysis should start. If the identification of specific areas of market imperfection was taken seriously, the direction of appropriate interventions could be clearer. In health and education, the fact that there are large private sectors rules out the possibility that these are "public goods" since no such markets would be possible. We might then try to measure the externalities associated with the sector—an exercise that is rarely done. We might also try to think through the most direct mechanisms to improve the functioning of the market before we assume that the government takes on the responsibility of direct provision.

Within education, are we concerned with achieving basic literacy and numeracy so that a modern labor force is available to employers? Are we concerned that children become better citizens and thus have civic engagement in the curriculum? Are we worried that parents are not well-

[1] There are exceptions to this, such as Nozick's (1977) notion that, as long as the "rules of the game" are fair, the particular distribution of income as an outcome is also fair. Here, we will take a more traditionally utilitarian approach, supplemented by the very strong assumptions that people can be compared and that all have a diminishing marginal utility of consumption.

enough informed to judge differences in pedagogical technique?[2] Are we concerned that poor children would not be able to attend school and education is thus really one of many poverty alleviation schemes? In any of these cases, we should ask if public provision is the best way of solving the problem. A subsidy to private education or, perhaps, merely a minimum number of mandatory years of schooling may be sufficient for the first. A rule requiring that Pakistani history be taught may be sufficient for the second.[3] If the goal is poverty alleviation, then education has to prove its efficacy against all other antipoverty schemes, and, in any case, does not really require public provision. A more thoroughgoing inquiry into the real goals of policy in the sector may lead to major changes in the appropriate instruments to be used.

3. Market Failure and Government Failure

> 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).

With his book, *The Economics of Welfare* (1920), Pigou introduced the concept of externalities—the workhorse of policy-oriented economists to this day. Not only did he identify the nature of externalities where one person's actions, primarily the production of a good or service, positively or negatively affect someone else through means not mediated by the market, he also identified the appropriate corrective mechanism: a subsidy or tax (respectively) to be put on those actions. This is the origin of the term "Pigouvian taxes" for negative externalities, applied most often to the example of pollution.

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[2] This is a commonly cited but entirely wrong application of the concept "asymmetric information" whereby a consumer (a parent) is simply not well informed, or at least not informed enough, to convince an educational expert that parents can be trusted to make decisions concerning their child's schooling. However, the market failures associated with "asymmetric information" emerge when producers exploit consumers' lack of information. In education, there may be some concern over this with regard to technical education post-secondary. It is unlikely that primary education has any such problem. See footnote 3.

[3] It is not clear that public schools have an advantage on this score. The extensive studies of Andrabi, Das, and Khwaja (2006) in their Learning and Educational Achievement in Punjab Schools (LEAPS) project (www.leapsproject.org) shows that cheap, rural private schools fare better than public schools in this dimension.

However, rather than unreservedly advocating his (admittedly brilliant) idea, he immediately saw its limitations. Putting words in his mouth that he most certainly did not use, his point is "Hey! I invented this idea—both the problem and the solution—and I think it is a really good one. But let's not go overboard here. You don't really think that actual governments are going to use these tools for the public good, do you? Governments have problems at least as bad."

The real, practical, problem that governments face is how to improve welfare given that **both** "unfettered private enterprise" (the market) **and** "public authority" (the government) have their shortcomings. While we have developed the vocabulary of market failures, we do not know enough about all the ways in which the government can go awry.[4] Put another way, we do not have a standard view of the "technology" of policymaking. What contributes to better or worse implementation of a policy?[5] How badly wrong does implementation have to go before we decide it is not worth the trouble? Or, if there is a theoretically "best" way to intervene—say, insisting on marginal cost pricing for monopolists—but it is too hard to implement without vested interests (the monopolist, presumably) capturing the regulator or too expensive to collect information about the costs of production, it might be better if the government just takes over production itself. Or, if that is even harder to implement, perhaps we simply have to live with a regulated monopolist who makes more profit than the ideal policy would allow. In Pakistan, electricity generation went through a period with adequate, but excessively expensive, capacity. Now, capacity is woefully inadequate. Whether paying too much for reliable energy or paying too little for a creaky grid is the worse outcome is certainly debatable. It is just this sort of debate that needs clarity.

Much of public economics took Pigou's diagnosis of markets on board but forgot his caution about government (see Bator, 1958). In reaction to the interventionism that the one-sided interpretation encouraged, there was a backlash by the "public choice" literature, which simply returned to the point that government officials were people too and responded to incentives just as private agents did (see especially Buchanan, 1967, 1986; Buchanan & Tullock, 1962; Olsen, 1965). In this view of the world, it is virtually impossible to expect anything like a "public interest"

[4] There have been some attempts to catalogue "government failures" but these have not become standard in the literature. See Stern (1989) or Besley (2000) for such attempts.

[5] This, too, has been the subject of recent work; the United States Agency for International Development (USAID)'s concern for "implementation science" (2011) is one example.

to be pursued by the government and politics infects even seemingly technical interventions.

But it is not all that useful to be at either extreme. The "public choice" literature leans toward conclusions such as "the market can do no wrong (and the government can do no right) so stick to laissez-faire policies." The standard public economics literature leans toward "markets do very particular wrongs and the government is wise and capable enough to fix them, so let the latter do what it deems necessary." Of course, more extreme but common in the modern history of South Asia, is the idea that "the market can do no right and the government can do no wrong, so the latter should take the economic high ground and plan almost everything." Nehruvian socialism of this sort has left an impoverishing legacy in South Asia and in the thinking of the first postwar generation of development economists and the rest of the developing world that subscribed to it.

Of course, we should be seeking the middle path. Thinking through policy alternatives with both failings in mind can take several forms. One is that, within a particular set of policy problems, some address market failures with very large welfare consequences and we should focus attention on the relative difficulty of implementing alternative approaches to correcting them. Sometimes the best and most practical things to do may seem odd or indirect only because the "optimal" policies are too hard.

An example is in the choice of basic tax collection. Pakistan, among many poor countries, still levies substantial import and export duties even though we know these are particularly inefficient. However, they are also easy to collect, particularly if there are only a few major ports or railheads. Broader-based taxes require a larger, widespread and, arguably, more easily corruptible tax system that is simply too hard to administer and monitor. The consequence may be to rely on trade taxes. Retaining them, though, means we should keep government spending and reach limited since all expenditure comes at a very high marginal welfare cost of the revenues they require. So, weighing the value of intervention against the difficulty of administration can help choose priorities for policy.

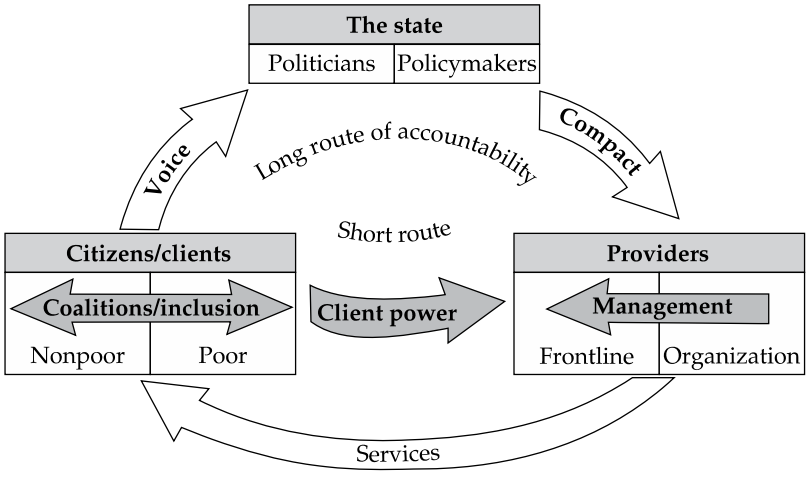
However, a second consequence of comparing market and government failures points to those administrative (or political) reforms that will yield the greatest benefits. In the tax example, the substantial damage that trade taxes impose means we should work steadily on improving other means of raising revenue—those that are currently too hard to do.

For primary education, we may be convinced that the market failures listed above are severe. The problem then becomes whether it is better[6] to run a school system publicly or to encourage private providers. This could go either way. Rich countries have found various means of educating all their citizens. If it is really hard or premature to put a complete, universal public system in place, a system of vouchers to private schools (even if staffed by teachers of dubious qualifications) may be better than waiting until a universal public school system is ready. If even vouchers are too difficult to administer, then at least bureaucratic barriers to private schools need to be lifted—private education is often treated with suspicion. Again, the best study of the reality of private and public schools is the LEAPS project. In this case, the pedagogical advantages and the lower costs of the private sector make many of our assumptions concerning the necessity of public provision, suspect.

4. Dissecting Government Failures to Help Strike the Proper Balance: The Role of Accountability

One way of getting a handle on government failure is suggested by the World Bank's (2004) *World Development Report*, which puts accountability at the center of the problem. The essence of the argument is captured in Figure 1 below.

Figure 1: The route to accountability



Essentially, we are interested in channeling the right services at an appropriate level of quality to the public, as represented by the arrow at

[6] "Better" means cheaper, higher quality, or wider coverage.

the bottom. Places in which accountability is, or should be, exercised are shown as shaded arrows. For simplicity, we will focus on accountability between the main players: citizens, providers, and the state. As a starting point, we can look at how a market usually deals with the problem of accountability. This is illustrated as "client power."

A market transaction is a little more complicated than it seems. When a person wants to buy a kilo of *atta* (flour), she asks the storekeeper for it, the storekeeper gives her the bag, and she gives the storekeeper the money. But the matter does not necessarily end there. If the customer finds that the *atta* is not the kind or quality for which she has asked, she might not go through with the transaction. If she is not allowed to inspect the *atta* before purchasing it and discovers that it contains stones or other impurities when she gets home, she might complain to the storekeeper and want to return the purchase. If the storekeeper does not agree to refund her money, the customer may threaten to never come back to the store or to tell her friends she has been cheated (or just complain that she is not happy with the quality). In a competitive market, the storekeeper has every incentive to satisfy the customer—if the quality is not good enough (for the price charged), if the customer does not return or tells her friends not to patronize the store—the storekeeper risks losing business, income, and the support of his family. He is clearly accountable to the customer.

For any number of reasons, such as market failures or poverty alleviation, the state may interpose itself between buyer and seller. This is fine as long as that same degree of accountability is maintained. The difficulty is that there are now two places where that accountability might fail. First, the state may not fully understand what it is the public (clients, citizens) wants—in the case above, this might be the right kind of *atta* to stock in ration shops. Second, high-level government officials may not have complete control over the direct service provider—in this case, the ration shop owner. For government services to work well, they must maintain the same degree of concern with satisfying the client as would be true in a competitive market.

4.1. "Voice" or "Politics"

The first step, which the *World Development Report* has called "voice" but which most people think of as "politics," is the subject of most analyses of political economy; it was also the main focus of the "public choice" literature. It deals with a government's ability to represent or aggregate the preferences of the population. The literature is vast but one

aspect needs emphasizing in the social sectors, that is, the influence of unions or professional organizations among teachers and medical providers, primarily doctors.

A long-standing observation in the education literature is that far too many resources are spent on wages and too few on other inputs to education, such as pedagogical materials. Numerous reports by international consultants recommend that resources be reallocated to rectify this imbalance. These reports are naïve in that they assume the spending pattern is "exogenous" or directly under the control of the policymaker reading the recommendations (Filmer & Pritchett, 1999). Of course, this is untrue and the current "imbalance" of spending accurately reflects the relative bargaining power of Pigou's "private interests."

One result, reported in the LEAPS study, is that public teachers are paid several times more—even adjusting for qualifications—than private school teachers in the Punjab. Fixing this may not be easy. In Indian Madhya Pradesh, a reform was initiated to employ para-teachers in the schools at wages almost exactly one fifth of standard government pay. Performance was unaffected and costs fell. However, the para-teachers sued on the grounds that they were doing the same job as government workers and were, therefore, entitled to the same remuneration. They won in the courts, again raising the wage bill to unsustainable levels.

Doctors, of course, hold an even more influential place in society and politics than teachers. Similar criticisms have been leveled at the health sector as those in education: too much is spent on salaries (and perhaps buildings) and not enough on materials. Again, this is not a coincidence as one would expect politically influential people to apply pressure to maintain wages. While public salaries for doctors and other medical care providers are not usually as high as incomes in the private sector, many have jobs in both and the public salary is a much-appreciated floor on income. Without understanding the political economy of the allocation process, obvious constraints to more "rational" allocations are sometimes missed.

4.2. Implementation of the Compact

The second step necessary for maintaining accountability in public provision is labeled "compact" in the diagram. It refers to the fact that, even if policymakers have their hearts in the right place and really want to educate children or improve public health instead of merely employing professionals, they may not have complete control over their staff. The secretary of education does not teach children; rather he or she oversees

hiring, makes decisions about curricula, manages transfers and so on. The proper incentives have to be put into place to make sure the direct provider—the individual teacher—puts in the appropriate effort and applies the requisite skills to get students to learn.

The need to delegate responsibilities to providers is the crux of the problem. Difficulty in delegating responsibilities to others is frequently framed as a "principal–agent" problem. The "principal" (in this case, the minister or secretary) wants particular tasks accomplished but can only do them through "agents" (in this case teachers, doctors or field workers for transfer programs). Making sure that staff members accomplish these tasks requires either a great deal of trust or a substantial amount of performance monitoring. While it is not necessary to formally solve such a problem, it is well worth keeping in mind the difficulties involved.[7]

Education and health (as well as transfer programs) are particularly difficult because of the degree of discretion and "transaction intensiveness" of staff operations (World Bank, 2004). Teachers are, in the best of worlds, expected to judge students' educational needs, plan how to meet those needs, and conscientiously apply those plans so that children learn. While this is rarely done, it is one reason that a college education is claimed to be a requirement for teachers. Obviously, in curative care, each patient has different symptoms and the provider is expected to determine the appropriate treatment for each one. Both cases require considerable discretion over what gets done each day. In transfer programs, field workers are supposed to be able to identify people eligible for benefits under a particular program, which requires finding out a fair amount about the applicants' circumstances. "Transaction intensiveness" refers to the fact that there are numerous individual interactions between providers and clients: many students and teachers, many patients and doctors, many poor people and assessors of eligibility.[8]

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[7] "Voice" or politics can also be considered a "principal–agent" problem with citizens being the principals and officials being the agents. Similarly, the direct purchases of services in private markets—"client power"—can also be considered as such. We concentrate on the "compact" side of the triangle because it is most directly concerned with the administrative difficulties of implementing well-meaning policies.

[8] The two characteristics do not always go together. Curative care is both highly discretionary and transaction-intensive. Immunization programs, however, are certainly transaction-intensive but since every child receives the identical service (a few drops in the mouth or a shot in the arm), there is no particular scope for discretion. Similarly, taking attendance at school is transaction-intensive but not discretionary, as is actual teaching. With transfer programs, filling out survey forms, while transaction-intensive, is not necessarily discretionary unless, of course, the assessors are supposed to use their judgment concerning the veracity of the survey responses.

Policies that are both discretionary and transaction-intensive are very expensive to implement successfully because of the amount of monitoring that is necessary to ensure good performance. Some actions are easily observable, such as whether a doctor or teacher has shown up for work at a hospital or school or if the person assessing eligibility for transfer programs has, in fact, visited a prospective beneficiary family. Other actions are much harder to assess, such as how conscientiously a service provider has applied effort in each case. Some of these can be monitored through a hierarchical administrative structure, for example, by carrying out random checks on staff attendance or re-interviewing families who have applied to transfer programs. Some cannot be monitored without incurring considerable extra expense. To check whether a diagnosis by a doctor was correct would require close supervision, which may be possible in hospitals but not in remote clinics.

The trick is to compare the degree of difficulty of implementing the policy itself to the improvement in service that the policy would make if implemented perfectly. Given our current, minimal state of knowledge of both the welfare effects of various market failures and the relative difficulty of implementing alternative policies, we are usually left with pure judgment calls based on instinct or ideology. This should be a fertile area for research in Pakistan since the only literature available is from rich countries, which is not going to provide much guidance. Particularly in the case of externalities, this should be a source of embarrassment because such information is virtually the only justification for many of the policies we implement. Research on the relative difficulty of implementation is still in its infancy.

4.3. Striking the Balance

The right balance to strike between market and government failures is similar to finding the right "second-best" solution when there are simultaneous failures in multiple markets. Fixing one problem but not the other could make things worse. So, if there is a polluting monopolist, solving the monopoly problem will increase production. If production is accompanied by increased pollution, the welfare impact is ambiguous—more production of the good that a monopolist would generally restrict but increased pollution. If there was some reason that both problems could not be solved at the same time, say, if pollution measurement and control was impossible, then the appropriate policy could look quite odd from a market-by-market perspective: the right answer might be to do nothing.

If the problem is that some government policies are difficult to implement, appropriate decisions may seem peculiar, at least in the short run. Universal public education certainly avoids any failure of the market but if it demands too much of a policymaker's administrative or political resources to work well, it may be better to opt for a "second-best" by supporting private education. The ideal of a perfectly well run public system might not match realities.

5. An Example from Healthcare

How does this balancing act work in practice? To illustrate, we can take a look at the health sector, which is associated with several main market failures. First, many problems with health consequences are in the nature of pure public goods. Getting rid of mosquitoes is one—no one has an incentive to rid their land of mosquitoes because they can come from any neighbor's land. Mosquito control is, therefore, nonexcludable and nonrival. Logically, there cannot be private provision, so if it is to exist at all, it has to be by the government[9]. It is not simply that we might *want* the service to be publicly provided but that its very existence *requires* that it be publicly provided. Thus, swamp drainage is simply not undertaken by private markets.

Second, many health problems have large externalities. The very term "communicable disease" implies that one person's illness directly affects the probability that someone else will be infected. The best example is probably tuberculosis prevention (including secondary prevention or treatment). Infectious diseases, whether spread by pests or by humans, affect the poor heavily and disproportionately. India's National Family Health Surveys find that tuberculosis is seven times more prevalent in the poorest decile of wealth in the country, while malaria is four times and blindness (as representative of a chronic illness such as cataracts or diabetes) only one-and-a-half times as prevalent among the poor. Therefore, to the extent that a policy is to be redistributive, this also argues for attention to the control of infectious disease. The comparison with chronic disease is such that any reallocation from infectious to chronic illness is distinctly anti-poor.

The third kind of market failure associated with health is related to the phenomenon of "asymmetric information" associated with curative care. Doctors, by nature, know more about your illness than you do—that is why you go to one. It is possible that they might exploit this information

[9] The government may not be necessary in all cases. Ostrom (1990) shows that collective action at the local level can be accomplished without state intervention.

imbalance to talk you into things you do not need. In rich countries, this phenomenon is known as "supplier-induced demand" and its existence is somewhat controversial. A consequence would be "too much" care and is most likely in contexts where there is "third-party payment," meaning where an insurance company pays the bills, not the patient.

The fourth kind of market failure is also indicative of "asymmetric information" but its existence is less controversial. Private insurance markets for health fail everywhere, in rich countries and poor alike. This is because of both "adverse selection" (people who expect to be ill will disproportionately demand insurance, driving up the cost and driving out the healthiest buyers, leading to even higher costs and the possible unraveling of the whole market) as well as a form of "moral hazard" where an insurer can be over-billed and cannot check this without incurring large costs.

While the problems of the US healthcare system are widely known, every rich country has problems with the insurance function of the health system, even if it is wholly public. The consequence of insurance market failure is the existence of many people who are uncovered and, therefore, exposed to fear of catastrophic financial loss in the case of expensive illness. Many surveys of poor people show the fear of falling into irreversible poverty, including bonded labor, resulting from large health expenses in hospitals (Narayan, Patel, Schafft, Rademacher, & Koch-Schulte, 2000).

However, policies that can protect people from financial ruin induced by health expenses differ substantially in the difficulty of implementation. Against these market failures, we can assess the nature of their policy solutions: (i) preventive and promotive activities, (ii) primary health curative care, and (iii) hospital-based curative care. The boundaries between the three are blurred and somewhat arbitrary. However, the first category includes population-based, traditional (in the Western sense) public health interventions such as ensuring safe water supply, improving sanitation (including the reduction of open defecation), and controlling disease-spreading pests. These are often not done by a health ministry and do not require knowledge of, or even interest in, health per se. Also in this category are health education and immunization, which do involve people who are health-oriented but not necessarily particularly well trained.

The second category, primary curative care, has been variously defined (from "take this pill" to social revolution) and universally touted as something poor countries should emphasize. Here, all it means is patient-initiated (you go someplace when you feel sick), relatively cheap care that

can be given at a small clinic but does need someone with medical knowledge, usually a doctor.

The third category is a little more complicated but comes down to comparing public insurance to public hospital care for relatively expensive care. The care that is covered usually requires a capable medical doctor, and expensive materials and equipment. It can include expensive drug therapy that does not really require a hospital—the main characteristics are that it is both very effective and expensive.

Of course, we would like all three categories of care to be available to people and within reach of the poor. However, "being available" and "being provided by the public sector" are not the same thing. To improve welfare taking all constraints into account may mean making harsh choices.

As described, it is impossible to avoid the conclusion that basic public health remains a top priority. So much so that even a cursory examination of budgets in Pakistan indicates a bizarre underinvestment in sanitation (particularly in rapidly growing cities), vaccination, pest control, and programs to combat infectious disease.[10] Public health policies address massive market failures;[11] they disproportionately affect and are essential to the wellbeing of the poor. Further, while research is thin, they are not the most complicated policies to implement. Immunization campaigns have been effective in Pakistan, though currently running into difficult political problems, among many other countries. Water supply and sanitation infrastructure, while requiring periodic maintenance, do not require day-to-day supervision and monitoring. One-off investments, while less valuable than well-maintained investments, are still valuable and relatively easy to implement. For pure public health, the market failure is clear, the benefits to the poor are clear and (arguably) there are tried and true policies that are well within a government's capacity to implement. Everything seems to argue strongly for finishing the 19th century public health agenda.

Also difficult to avoid is the need to address very large, "catastrophic" expenses that usually involve hospital care. But whether to handle this problem by running public hospitals or having a public insurance program is the big question.

[10] Current political unrest, undoubtedly, makes some of these difficult to achieve.

[11] Recent demonstrations of the external effects of sanitation are given in Spears (2012) and Hammer and Spears (2013).

Running hospitals solves the insurance problem simply by providing care at subsidized prices, possibly zero. However, as they are currently run, few poor people are treated at hospital and often hospitals are used for services that are more readily and more cheaply available at smaller clinics. On the other hand, the monitoring and supervision of a public insurance program requires massive efforts to protect against fraud. Even Canada, often touted as a model for other countries to follow, has rates that overcharge by as much as 15 to 20 percent. When initiated in India, the insurance scheme ran out of money in one third of all districts in the first year of operation. While the insurance route is likely to be the long-run solution to the problem of catastrophic care, the decision whether to run public hospitals or run an insurance program is not an easy one.

Here is where a detailed analysis is needed of providers' incentives to carry out the program as originally intended. Is the government in any position to check on potentially fraudulent claims? Is it in any position to reform its current operations so that poor people can obtain care at hospitals and so that people will be treated only if properly referred? Without referrals, too many people will crowd the halls of heavily subsidized facilities—as happens now. Neither direct provision nor administering an insurance program is easy. Which is more likely to yield to policy reform needs to be sorted out. However, there is no doubt that one of the two options or a combination has to be in the government's hands because the market failure associated with insurance is so very large.

For hospitals versus insurance, the market failure is clear, the benefits to the poor depend entirely on how the policy is implemented (and the track record is not good), and one must decide which of the two modalities is easier to implement. Here, there are strong but opposing forces: major market and government failures simultaneously.

When we approach primary healthcare, which has been proposed as the solution to poor countries' health needs since the Alma Ata conference in 1977, things become much murkier. It is unclear what the market failure is. We know that the quality of care provided by private practitioners is low. However, it is also cheap so it is hard to say where the failure lies. However, despite the small number of relevant studies, we find that the quality of care in public primary care units is often very low, primarily due to a lack of conscientious effort (Das, Hammer, & Leonard, 2008; Das & Gertler, 2008; Das & Hammer, 2005, 2007). It is also unpredictable due to high absentee rates among medical personnel (Chaudhury, Hammer, Kremer, Muralidharan, & Rogers, 2006; Chaudhury & Hammer, 2004).

The government failures associated with maintaining a transaction-intensive and discretionary service such as medical care are enormous. Their source is not difficult to find. Public employment usually entails the following:

1. Providers on salary: Being conscientious or even present does not influence payment, advancement, or any other compensation. We are left to providers to be committed to their jobs but with no way of guaranteeing that commitment.
2. Lack of supervision: It is very hard to monitor a huge network of facilities, often in remote locations.
3. Lack of accountability mechanisms such that citizens' complaints are unable to influence doctor behavior. Usually, the most a village can expect is for a doctor to be transferred to some other village.
4. Large differences in the social status of providers and patients.
5. Substantial opportunity costs of time from having a private practice.

Given these incentives, it is a tribute to those public servants who show up at all. But given the difficulty of implementing universal healthcare for inexpensive treatment, it is unclear how high a priority primary care should be among all competing uses of public funds.

The above argument assumes that government capabilities are given and unchanging. The second use of the comparison of market and government failure points to high-priority areas of reform within the public sector. That can change the balance.

In Pakistan, the experience of Rahimyar Khan district in the Punjab is instructive. There, organizing travelling doctors to visit three or so clinics per week—at a higher salary—seems promising. Whether this is sustainable is yet to be seen. An alternative would be to allow villages to pay for the doctor if and when s/he shows up. This keeps the incentive, at least for attendance, in line with people's wishes—payment is a good mechanism for promoting accountability. Again, the modalities of provision need to be explored.

In contrast to hospitals, however, the balancing act of fixing a market failure and risking a government failure is not as clear. If the public pulls back, the private sector can make up some of the difference. If the public sector pulls back from either of the other major health sector policies—catastrophic care and pure public goods—there will be no private

response to fill the gap. Whether it is easier to fix the incentive problem in publicly provided medical care or to make sure that hospitals (and clean water) run is one major choice governments face. And, no, we may not have money for all three.

6. Conclusion

In summary, it is not sufficient to say that we are going to address social sector problems by spending more money. Without carefully examining a government's ability to make good on its promises to the people, such money has been and will continue to be ill spent. Governments should learn to pick their targets carefully, understanding what the alternatives to public provision are and honestly assessing their own capacity to improve the status quo. All else is simply posturing.

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