Discussant comments on

Breaking Out of the Pocket: Do Health Interventions Work? Which and in What Sense?

Peter Boone and Simon Johnson

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- Easy to motivate why this is such an important topic
- It would be hard to exaggerate the importance of early life health
  - Cognitive development
  - Educational attainment
  - Labor market opportunities
  - Marriage and fertility
  - Health of the next generation (and intergenerational transmission of poverty)

- Boone and Johnson (B&J) give us much to think about
- I will focus on three threads in their argument on the work that will be necessary if we are to establish “robust sustainable delivery mechanisms” for health services

- The first is what gives rise to their clever title "Out of the pocket." They write of a "change in the map of poverty":

  It is … reasonable to expect that countries previously known as "poor" will be host to regions of high income … and other, smaller, pockets of extreme poverty.

- It would be helpful to see some evidence on this

  - Do we know that this is a new phenomenon? Some of the mechanisms that give rise to pockets have been present for a very long time – migration patterns, oppression by a dominant group

  - Do we know the pockets are going to be "smaller" than the regions of higher income?

  - Does it matter? I don't think that anything they've written here depends on there being 'pockets' of poverty within a country, rather than there being poverty. High child mortality and low rates of literacy would seem to be enough. If the pockets are important to the story, it would be helpful to have more in the paper about why that is the case.

The second thread requires that, among all the reasons that pockets of poverty may exist,

Our qualitative assessment from practical experience is that pockets of poverty exist primarily because they are neglected by the elites with power and by the groups that have effective voice. It is neglect, rather than a sinister conspiracy of oppression, that means relatively isolated people do not have access to decent health care or education. [Here comes the punchline…] As a result, it is possible for outsiders to offer such services without generating adverse political reaction or the development of some other means of oppression.

READ: Aid in the form of health care services and education delivery will be well received.

There are many reasons to question whether that would be the case. A "sinister conspiracy of oppression" is only one of many reasons why outside intervention may be ineffective.

The third thread is an assertion that

The key to delivery is to build private services that largely bypass the public sector. If designed appropriately, these should be sustainable.

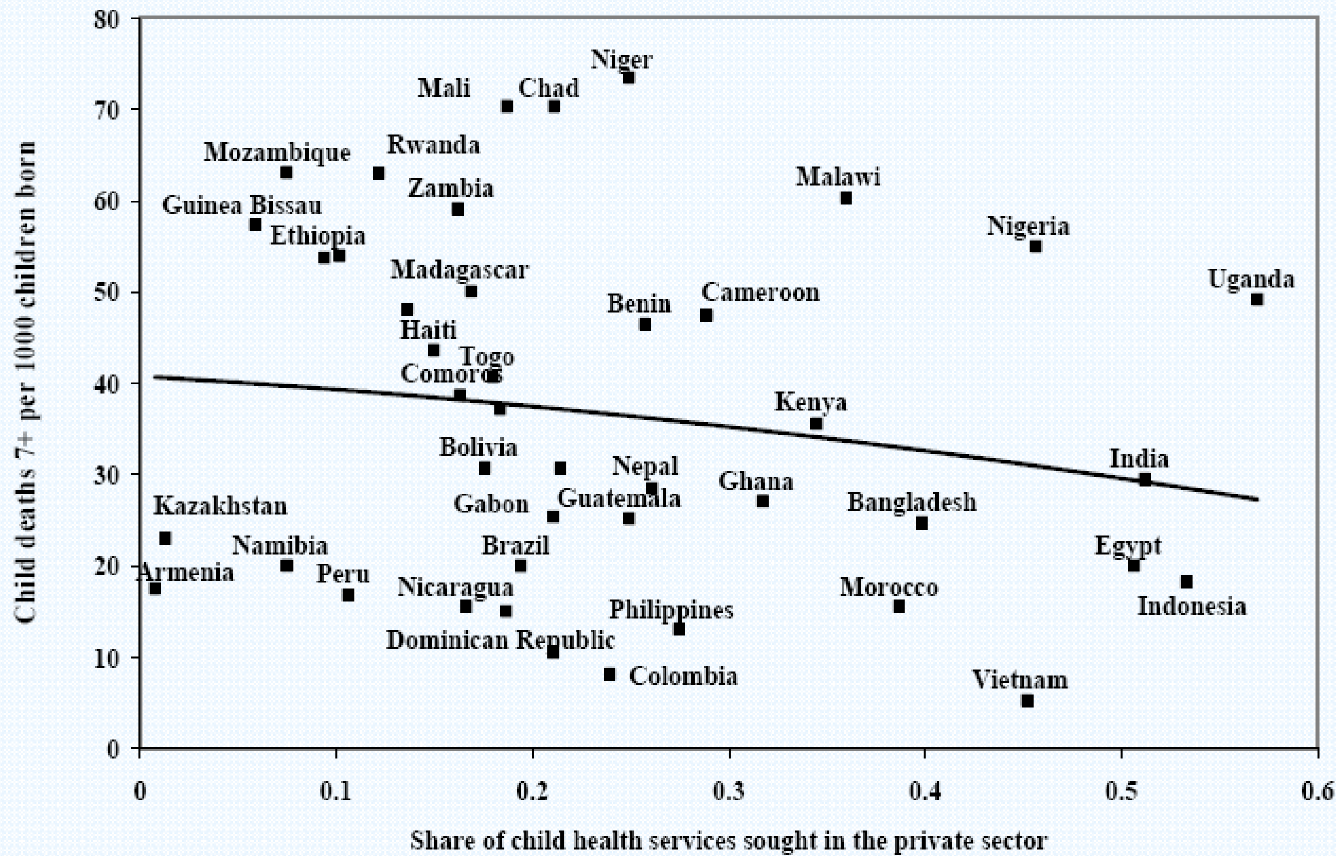
Evidence on the relative merits of private versus public delivery is of first order importance. I don’t see that B&J have made a strong case for private delivery.

B&J: *"The public sector today provides inadequate services, suffers from corruption, and better serves wealthier political elites than the poor."*

This reminds me of stories of privatization of transport in the UK under Thatcher.

- B&J use Figure 5 – which plots post-neonatal child mortality rates against the share of the private sector in child health services – to make the case that there are "multiple routes to low child death"

FIGURE 5
The Relation between Post-neonatal Child Mortality and the Share of Child Health Services Sought in the Private Sector In 45 Low Income Countries



- It is hard to interpret Figure 5 without knowledge of the size of each country's health sector
- A growing body of evidence suggests that the private sector does poorly in those countries where the public sector does poorly in providing health care

- Papers by Das and Hammer
  - "Strained Mercy"
  - "Which Doctor?"

- What do providers know? (competence)
- What do providers do? (practice)

- To go after these questions, D&H collected qualitative-quantitative data on 200+ medical care providers (both public and private providers) in 7 neighborhoods in Delhi

- 300 families in seven neighborhoods of Delhi were visited weekly for 18 months
- Long list of health care providers was collected
- In addition, a census of providers was undertaken within a 15 minute walk of the household's neighborhood
- A stratified sample of providers visited, and those available, was chosen, and interviewed.

- Vignettes were used to elicit information on what providers *knew*. Interviewers sat for whole days to see what health care providers actually *did*.

- Bottom line:
  - D&H find errors of *omission*: public doctors exert less energy
  - And errors of *commission:* private doctors behave as their patients expect, which results in overuse of antibiotics, increased expenditures

- Punchline from these papers: in those places where public services can't be provided well, private services often cannot be relied upon to step in and "get things right"

Can we find a way around this Catch-22 in health care delivery – that if the public sector can't provide it effectively, it can't provide the oversight necessary for private sector delivery?

This sort of (Das and Hammer) qualitative-quantitative data collection can help us understand what works and why it works or why it doesn't.

- B&J end on a positive note

  The advent of testing and experimentation with packages [of interventions] may mean we will soon (within 20 years?) learn the best routes to rapidly end pockets of poverty

I am less sanguine here – to the extent that there are pockets, it seems likely that they exist for very different reasons in different places, and that these differences may require individual learning, place by place – which may make place specific qualitative-quantitative research the more effective research tool