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Balancing Market and Government Failure in Service Delivery

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Executive Summary

Making good policy requires a clear understanding of the constraints under which such policy operates. While we are familiar with maximization of an objective subject to a budget constraint, there are other constraints with which real-life policy must contend. Most importantly, governments differ in their capability to implement policies and these differentials should be factored into choices between them in the first place. The same market failure that motivates an intervention could well have different optimal responses depending on what kinds of policies a government find more or less challenging.

In fact, whether or not to intervene at all should be part of the calculation. When considering a policy intervention, the welfare loss of a market failure, the degree to which an intervention can help poorer people (if that is considered as something separate from market failure) and the ability of government to carry out the intervention (including the loss of welfare of collecting the taxes to finance it) should all be quantified as well as possible and weighed accordingly. This takes some degree of honesty on the part of government to admit the possibility that things will not necessarily go as planned. Well written laws are not worth much if they can't be enforced.

Social sector interventions related to health, education and social protection are good examples of where this balancing or weighing of alternatives are likely to change perspectives on appropriate policies. On the one hand, there are a wide range of market failures they address, from true public goods to subtle, hard-to-identify market failures and from interventions such as subsidies that are more or less beneficial to the poor. On the other hand, there are a wide range of policies that differ substantially in the degree of complexity required for their implementation. Unfortunately, many social sector policies are particularly difficult due to two common characteristics: transaction intensiveness and discretion.

"Transaction intensiveness" refers to the fact that many policies require many person-to-person interactions. School teachers in the tens of thousands have to deal with millions of children on a day to day basis. Further, they must employ "discretion" if they are to do a good job: they must tailor their activities to the needs and abilities of their students. Similarly in health care (to be distinguished from public health): each patient (many transactions) obviously needs a different treatment (discretion). Many antipoverty programs need to screen beneficiaries to determine eligibility – again, many transactions with a lot of discretion and with requisite updating as circumstances change. Both of these characteristics lead to opportunities for bribery since the more places a decision needs to be made, such as providing a service at all, the more that the services can be disrupted without the bribe. Less extreme, simply the monitoring and supervision of providers to do a good job requires more resources when there are millions of transactions requiring independent judgment.

One thing a market is good for is to have the individual be able to hold a provider accountable for adequate service. While pedagogical theories may be beyond the ability of parents to judge or while clinical knowledge is beyond patients, certainly absenteeism is less of an issue (if a doctor does not show up for work s/he does not get paid; if a teacher doesn't, it is easy to observe). For this type of service, then, an administrative system may not work as well as a market.

In the area of health, these principles can be applied with some force. When market failures, the degree to which alternative policies affect poor people and the relative difficulty of implementing different policies related to health are all taken together, much of the conventional wisdom concerning health policy is shown to be questionable. In particular, the commonly advocated policy of providing free primary curative care does not fare as well as ensuring basic preventive public health interventions such as sanitation and water supply on the one hand, and finding a way to insure against expensive, catastrophic, hospital-based care on the other.

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I believe that improved services in health, education and the transfer of purchasing power to the poorest people of Pakistan are of great importance to their welfare. As a long standing 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 well-being. We've 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, too. 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 done for this conference in a context that is useful for policy makers. What do we recommend policy makers 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 policy making 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 policy making can mix and match solutions depending on the nature of the two sets of constraints.

The standard approach to policy – Market failure

How would an ordinary analysis of alternative policies in any sector proceed on the basis of conventional, neo-classical, 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, non-excludability and non-rivalry such that private markets simply cannot exist; externalities; 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 well-being that corresponds to anyone's conception of "fairness"[1]. Many of these have clear policy implications such as anti-trust or price controls for monopoly. Once the particular problems of a sector are 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 are possible. We might then try to measure the externalities associated with the sector – an exercise that is rarely done. We might then 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-enough informed to judge differences in pedagogical technique[2]? Are we concerned that poor children would not be able to attend school and thus education is 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 mandatory years of school may be sufficient for the first. A rule requiring Pakistani history may be sufficient for the second[3]. If the goal is poverty alleviation, then education has to prove its efficacy against all other anti-poverty 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.

Market failure and government failure

[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 be more traditionally utilitarian in approach, supplemented by the very strong assumptions that people can be compared and that all have diminishing marginal utility of consumption.

[2] This is a commonly mentioned but certainly 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 with making decisions. However, the market failures associated with "asymmetric information" emerge from the exploitation of the lack of information of consumers by producers. 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 in their LEAPS (Learning and Educational Achievement in Punjab Schools) project, www.leapsproject.org, shows cheap, rural private schools faring better than public schools on this dimension.

> '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 whole heartedly seek that ideal. Such authorities are liable alike to ignorance, to sectional pressure and to personal corruption by private interest'. A.C. Pigou, 1920

With his book, The Economics of Welfare, published in 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.

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 that the government can go awry.[4] Put another way, we don't have a standard view of the "technology" of policy making. What contributes to better or worse implementation of a policy?[5] How bad does implementation have to go wrong before we decide it's not worth the trouble? Or, if there is a theoretically "best" way to intervene – say insist 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, maybe we 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[6]. In reaction to the interventionism that the one-sided interpretation encouraged, there

[4] There have been some attempts at cataloguing "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 as in USAID's (as one example) concern for "implementation science" (USAID, 2011).
[6] Bator (1957) is the best example.

was a backlash by the "Public Choice" literature[7] which simply returned to the point that government officials are people, too, and respond to incentives just as private agents do. In this view of the world, it is virtually impossible to expect anything like a "public interest" to be pursued by government and that politics infects even seemingly technical interventions.

But it is not all that useful to be at either extreme. The "Public Choice" literature leans towards 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 towards "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 "the market can do no right and the government can do no wrong so the latter should take the economic high ground and plan most everything". Nehruvian socialism of this sort has left an impoverishing legacy in South Asia, the thinking of the first post WWII 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, 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 has 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. Keeping them, though, means we should keep spending by, and the reach of, government 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 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.

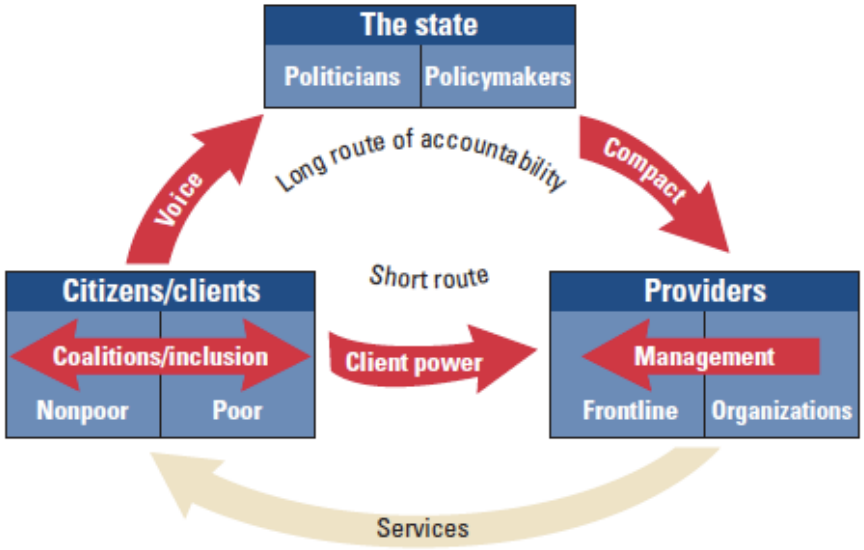
For primary education, we may be convinced that the market failures listed above are severe. The problem then becomes whether it is better[8] to run a school system publicly or to encourage private providers. This could go either way. Rich countries have found a variety of means of educating all of their 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 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. There is often suspicion of private

[7] Best represented by Buchanan (1967, 1986), Buchanan and Tullock (1962), Olsen (1965)
[8] "Better" means cheaper, higher quality or wider coverage.

education. 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 of the necessity of public provision suspect.

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 Development report of 2004 "Making services work for poor people". That report puts accountability at the center of the problem. The essence of the argument is captured in the following diagram:



Essentially, we are interested in getting the right services at an appropriate level of quality to the public, as represented by the arrow at the bottom. Places in which accountability is, or should be, exercised are shown as red arrows. For simplicity, we'll just talk about 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 buys a kilo of *atta*, she requests it from the store keeper, the storekeeper gives her the bag and she gives the storekeeper the money. But that's not the end of it. If it is not the kind or quality of atta she asked for, she might not go through with the transaction. If she wasn't allowed to inspect the atta before purchasing it, she might discover stones or other impurities when she gets it home. She might complain to the storekeeper. If the storekeeper doesn't accept a return of the bag and the money, the customer may threaten to never come back to this store or threaten to tell her friends she's been cheated (or just complain that she's not happy with the quality). In a competitive market, the storekeeper has every incentive to satisfy the customer – if the quality isn't good enough (for the price charged), if the customer doesn't come back 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 may fail. First, the state may not fully understand what it is the public (clients, citizens) want, in our case this may be the right kind of atta to provide in ration shops. Second, high level government officials may not have complete control over the person who is directly providing the service, in our case, the ration shop owner. For government services to work well, the same degree of concern with satisfying the client must be maintained as would be true in a competitive market.

The first step, which is called "voice" in the WDR but which most people think of as "politics" has been the subject of most analyses of political economy. It was the main focus of the "public choice" literature. This deals with the ability of government to represent or aggregate preferences of the population. The literature is vast but one aspect needs emphasizing in the social sectors. This is the influence of unions or professional organizations among teachers and medical providers, primarily doctors.

It is a long standing observation in the education literature that far too many resources are spent on wages and too little on other inputs to education such as pedagogical materials. Numerous reports by international consultants recommend a reallocation of resources to rectify this imbalance. These reports are naïve in that they assume the spending pattern is "exogenous" or, directly under the control of the policy maker reading the recommendations[9]. Of course, this is untrue and the current "imbalance" of spending is an accurate reflection of 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 India's Madhya Pradesh, a reform was initiated to use 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 on salaries (and perhaps buildings), 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 providers of medical care 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.

Implementation of the compact

The second of the steps necessary for maintaining accountability in public provision is labeled "compact" in the diagram. It refers to the fact that even if policy makers have their hearts in the right

[9] Filmer and Pritchett, 1999.

place and really want to educate children or improve the health of the public instead of merely employing professionals, they may not have complete control over their staff. The secretary of education does not teach children, he or she oversees hiring, makes decisions about curriculum, manages transfers and the like. 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 staff accomplish these tasks requires either a great deal of trust or a substantial amount of monitoring of performance. While it is not necessary to formally solve such a problem, it is well worth it to keep in mind the difficulties involved.[10]

Education and health (as well as transfer programs) are particularly difficult because of the degree of discretion and "transaction intensiveness" of staff operations[11]. Teachers are (in the best of worlds) expected to judge the educational needs of the students, plan how to meet those needs and be conscientious in applying those plans so that children learn. While this is rarely done, it is a reason that a college education is claimed to be a requirement for teachers. Obviously, for curative care, each patient has different symptoms and the provider is expected to discover the appropriate treatment for each one. This requires, in both cases, a lot of discretion over what gets done each day. For transfer programs, field workers are supposed to be able to identify people who are eligible to receive benefits from a program and this requires finding out quite a bit 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.[12]

Policies that are both discretionary and transaction intensive are very expensive to successfully implement because of the amount of monitoring that is necessary to ensure good performance. Some actions are easily observable, such as whether a doctor or a teacher has shown up for work at a hospital

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

[11] WDR 2004

[12] 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. For transfer programs, filling out survey forms, while transaction intensive, is not necessarily discretionary unless, of course, the assessors are supposed to use judgment concerning the veracity of the survey responses.

or school or if the person assessing eligibility for transfer programs has, in fact, visited a family. Others are much harder to assess such as how conscientiously their effort has been applied in each case. Some of these can be monitored through a hierarchical administrative structure through, for example, random checks on staff attendance or re-interviews of families applying to transfer programs. Some cannot be monitored without a great deal of extra expense. To check whether a diagnosis by a doctor was correct would require close supervision possible in hospitals but would not be possible 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 of 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, is not going to provide much guidance. Particularly in the case of externalities, this should be a source of embarrassment since such information is virtually the only justification for many of the policies we implement. Research on the relative difficulty of implementation is in its infancy

Striking the balance

The right balance to strike between the market and the government failures is similar to finding the right "second best" solution when there are failures in multiple markets simultaneously. 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 that pollution measurement and control was impossible, then the appropriate policy could look quite odd from a market by market perspective: the right answer may 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 policy maker's administrative or political resources to work well, it may be better to go for a "second best" of support of private education. The ideal of a perfectly well run public system may not match realities.

An example from health

How does this balancing act work in practice? Just to illustrate, we can take a look at the health sector. Several main market failures are associated with the health sector. 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 since they can come from any neighbor's land. Mosquito control is, therefor non-excludable and non-rival. There, logically, cannot be private provision so if it is to exist at all it has to be by government[13]. It is not simply that we might *want* the service to be publicly

[13] Government may not be necessary in all cases. Ostrom (198_) shows that collective action at local level can be accomplished without state intervention.

provided but that its very existence *requires* it be publicly provided. So, swamp drainage simply does not get done 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 get infected. The best example is probably tuberculosis prevention (including secondary prevention of treatment).

Infectious diseases – whether spread by pests or by humans – also heavily and disproportionately affect the poor. In India, their National Family Health Surveys find that tuberculosis is seven times more prevalent in the poorest decile of wealth in the country, malaria four times and blindness (as representative of a chronic illness such as cataract or diabetes) is only one-and-a-half times as prevalent among the poor. Therefore, to the extent that 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 a phenomenon of "asymmetric information" associated with curative care. Doctors, by their very nature, know some things more about your illness than you do –that's why you go to one. It is possible that they can exploit this information imbalance to talk you into things you don't 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 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, rich country and poor. 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 there can be over-billing of an insurer that the latter cannot check without incurring large costs. While the problems of the U.S. health care 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[14]. However, policies that can protect people from financial ruin from health expenses differ substantially in the difficulty of implementation.

Against these market failures, we can assess the nature of their policy solutions: 1) preventive and promotive activities 2) primary health curative care and 3) hospital based curative care. The boundaries between the three are blurry and somewhat arbitrary. However, the first category includes population based, traditional (in the Western sense) public health interventions such as ensuring safe water, improving sanitation (including the reduction of open defecation) and controlling disease-spreading

[14] Narayan (2005)

pests. These are often not done in 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 bit 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, expensive materials and equipment. It can include expensive drug therapy that doesn't 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 show a bizarre under-investment in sanitation (particularly in rapidly growing cities), vaccination, pest control and programs to combat infectious disease.[15] They address massive market failures[16]. They disproportionately affect and are essential to the well-being of the poor. Further, while research is thin, these 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 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 to have a public insurance program is the big question.

Running hospitals solves the insurance problem simply by providing care at subsidized prices, possibly zero. However, as they are currently run, few poor people get 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

[15] Current political unrest, undoubtedly, makes some of these difficult to achieve.
[16] Recent demonstrations of the external effects of sanitation are given in Spears (2012) and Hammer and Spears (2012).

against fraud. Even Canada, often touted as a model for other countries to follow, has rates of overcharging as high as 15 to 20%. When initiated in India, their 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 of the incentives of providers to carry out the program as originally intended is required. 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 get care at hospitals and that people will be treated only if properly referred? Without the referral, 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 government's hands since 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 the decision of which of the two modalities is easier to implement has to be made. Here there are strong but opposing forces: major market and government failures simultaneously.

When we approach primary health care, 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, while the number of relevant studies is small, we find that the quality care in public primary care units is often very low, primarily due to a lack of conscientious effort[17]. It is also unpredictable due to high absentee rates of medical personnel[18].

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

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 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 complaints of citizens are able to influence doctor behavior. Usually the most a village can expect is a transfer of a doctor to some other village.
4. Large differences in social status of providers and patients
5. Substantial opportunity costs of time from having a private practice.

[17] Das, et al, (2008), Das and Gertler (2008), Das and Hammer (2005, 2007)
[18] Chaudhury et al (2006). Chaudhury and Hammer (2004)

Given these incentives, it is a tribute to those public servants who show up at all. But given the difficulty of implementing universal health care 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 Rahim Yar Khan district in the Punjab is instructive. There, organizing travelling doctors to visit three or so clinics per week – at a higher salary – seems to be 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 incentives, at least for attendance, to be in line with peoples' 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 hospitals (and clean water) are running is one major choice governments face. And, no, we may not have money for all three.

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 the ability of government to make good on its promises to the people, such money has been and will continue to be ill-spent. Government should learn to pick its targets carefully – understanding what the alternatives to public provision are and honestly assessing its own capacity to improve upon the status quo. All else is simply posturing.

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