Deal with the Devil: The Successes and Limitations of Bureaucratic Reform in India

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Motivation

• Bureaucrat absenteeism is a problem in much of the developing world

• Question: Can we institute reforms to provide greater monitoring and incentives to bureaucrats to do a task? Will it lead to other distortions in work?
  
  – Test within the public health sector in India
Pilot Reform

• In 2010, the National Rural Health Mission (NRHM) of the Government of Karnataka (GoK) decided to try to improve enforcement of their actual leave policies
  – All staff only present 43% of the time; doctors: 36%
  – Conceived project and developed system before the researchers got involved

• In 140 out of 322 PHCs (across 5 districts), they introduced a biometric device to capture thumbprint at start and end of the day
  – Note: Two and a half million individuals live in the catchment area of the 140 PHCs
What we do

- Conduct random checks to test for whether attendance improved
- Test whether health improves, and if so, why?
- Collect data with different stakeholders within government system to better understand the reform process
Does Attendance Improve

Doctors

Control: 0.309  
Treatment: 0.3229

Nurse, Lab, Pharm

Control: 0.401  
Treatment: 0.4735

Legend:  
Blue: Control  
Red: Treatment
Does Health Improve?

• In the treatment areas, we find a 26 percent decline in the probability of being born below 2500 grams

• Basic antenatal care already high, but improve along margins that are low to begin with (e.g. iron tablets)
Change in Health Care Usage

• Delivery by trained doctor **increased** despite no change in attendance
  – Deliveries in PHCs and home births fell
  – Shift to deliveries to the large public hospitals and to the private hospitals
Potential Reasons for Shift

• **Better triage?** If spend more time giving advice to patients, may better triage high risk cases to bigger hospitals?

• **Salience of Absence?** Those in the catchment areas are more likely to think that the attendance of the PHC staff is lower than those in the control areas.
Potential Reasons for Shift

- **Corruption?** monitoring imposes a cost--do staff compensate themselves in other ways?
  - Delivery costs increase
  - Knowledge of state entitlements falls significantly, and receipt of them falls as well
Sustainable?

- Government designed program:
  1. Delays and problems in monitoring; only happened due to the persistence of research team
  2. Enforcement of contract was not actually done
     - Part of this due to the fact that it is quite complex to actual cut a leave day
       - Show cause notice allowing appeal and then working one’s way through the doctor, sub-district health officer, Director of Health and Family Welfare, Director to the Accounting General office, etc
     - If you ask government officials, they are reluctant to enforce contracts in practice because of greater human resource constraints: **staff discord** and **vacancies**
Staff discord

• Look at 12 measures of workplace satisfaction: treatment staff unhappier
  – For example, treatment doctors and nurses more likely to be unhappy with location of health center and weekly holidays given
  – Treatment doctors believe that the system upends their authority within the PHC

• More vacancies for nurses, lab tech, pharm
Expectations low throughout system

• Sub-district health officers:
  – expect doctors to be present 1/2 the time
  – Attendance does not enter their ranking of staff

• Local governments (GPs):
  – Higher attendance of doctors in areas with more “in the know” GPs
  – However, observe treatment effect for doctors only in areas with inactive GPS
  – Suggestive that GPs are okay with a certain level of attendance from doctors, but attendance likely won’t rise above that level
Implications

• Monitoring and incentives can improve health
• However, other forms of corruption do increase
• Even in case where it is “government’s idea,” implementation is problematic and unsustainable in current form
  – Monitoring only occurred with help!
  – Contract enforcement did not occur
• Some of this due to:
  – Institutional complexities to implement
  – Human resource concerns that may be somewhat valid
Implications

• What are we enforcing?
  – Expect doctors to be present 7 days a week
  – Expect staff to stay in rural locations (doctor attendance is only 15% in the most rural location)
  – Etc.

• Can we think about structuring work requirements and contracts differently?
  – Staff only present X percent of time
  – Rotations to rural areas
  – And, so forth.....