Quality and Accountability in Health: Audit Evidence From Primary Care Providers

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Abstract

Private primary care providers routinely account for more than 50 percent of first-contacts in low-income settings, rising to 80 percent in countries like India. The majority of these providers operate in single provider clinics with little regulatory oversight or government subsidies. No patients have health insurance beyond the free care that they can access in the public sector. These key features offer a unique opportunity to evaluate the relative benefits (or lack thereof) of a market model of primary care provision, relative to provision through the public sector. We report results from audit studies, where *standardized patients* presented to primary care providers in a representative sample of rural public and private providers in the Indian state of Madhya Pradesh. Across all audit studies, public providers spent less time with patients, completed fewer items on a checklist of essential history and examination items, and were either no different or worse in their treatment and diagnostic accuracy. In one dramatic example, public providers in their *private* practice were 32 percentage points more likely to provide the correct treatment for unstable angina relative to in their public practice. Our results, that customer accountability in an unregulated, unsubsidized and uninsured private market results in better primary care relative to the administrative accountability in the public sector, is further supported by a strong positive correlation between the prices charged to the standardized patients and the quality of care received. These results suggest a trade-off between poor administrative accountability in the public sector and market failures arising from (potentially) misplaced quality judgments on the part of patients in the private sector. However, hedonic pricing in the private market also suggests that financial constraints may prevent the poor from accessing higher quality care.

Extended Abstract

Private primary care providers routinely account for more than 50 percent of first-contacts in low-income settings, and in countries like India, close to 80 percent of primary care visits are to such providers. The majority of these providers operate in single provider clinics with little regulatory oversight or government subsidies. No patients have health insurance beyond the free care that they can access in the public sector. These key features offer a unique opportunity to evaluate the relative benefits (or lack thereof) of a market model of primary care provision, relative to provision through the public sector.

We report results from 2 related audit studies, where *standardized patients*—people recruited from the local community trained to present consistent cases of illnesses to multiple health providers—presented to primary care providers in a representative sample of rural public and private providers in the Indian state of Madhya Pradesh. The use of standardized patients allows us to accurately summarize the extent of over and under-treatment, the primary dangers of markets for credence goods, such as health. The particular choice of illnesses—unstable angina, asthma, and childhood dysentery—also allows us to assess care for very different conditions with clear primary care guidelines. Finally, the sample of private providers consists both of primary care providers without any formal medical training—the majority of providers in rural India—and fully trained medical personnel in the public and private sectors.

The audit studies differed primarily in our approach towards the public sector. In the first audit study, the standardized patient sought care from the provider in the public clinic, regardless of their qualification. In 63 percent of cases, this provider was not the doctor but another medically untrained clinic functionary. In the second audit studies, standardized patients sought care *only* if the doctor was available, waiting outside the village till they were notified of the doctors' presence. During this audit, we also identified the private clinics of the public doctors and standardized patients sought care from both the public and private settings of the same doctor.

Across both audit studies, public providers spent less time with patients and completed fewer items on a checklist of essential history and examination item, which aid correct treatment and help rule out differential diagnosis. Public providers were also less likely to give the correct treatment for asthma and unstable angina and were no less likely to provide unnecessary or harmful treatments overall. In one dramatic example, public providers in their *private* practice were 32 percentage points more likely to provide the correct treatment for unstable angina relative to in their public practice. Our results that customer accountability in an unregulated and unsubsidized private market results in better primary care relative to the administrative accountability in the public sector is further supported by a strong positive correlation between the prices charged to the standardized patients and the quality of care received.

These results suggest a trade-off between poor administrative accountability in the public sector and market failures arising from (potentially) misplaced quality judgments on the part of patients in the private sector. At the same time, hedonic pricing in the market for care implies that poor people may be systematically less likely to access high quality care. How to provide subsidies to households to access better quality care without reducing market incentives to provide such care remains a key policy question.