14.74 Foundations of Development Policy

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Low Demand for Preventive Care

Conclusion

Health

Esther Duflo

14.74

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Introduction

- Today, we will talk about health from the point of view of social scientists: We will not talk about the efficacy of one treatment or another, but about health services and health behavior.
- We will start by discussing, in detail, health and health care in one specific region, to identify what seem to be the key problems.
- Motivated by this evidence, we will then discuss the research that has tried to address these key issues:
 - Fixing supply.
 - Demand for preventive health: low demand, high sensitivity to prices.
 - Why this low demand? What can be done to improve it?

Some Striking Facts about Health. Udaipur, Rajasthan, India

The Udaipur Health Project

- A five-year collaboration with Seva Mandir, a local NGO active for over 50 years in Udaipur, Rajasthan.
- Seva Mandir was interested in overhauling the work of their health unit, and contacted my colleague Abhijit Banerjee and me to see whether we would be interested in working with them on it.
- We had no idea what the problems were on the ground, so we decided to start with a year-long survey of health status, health services and health behavior in Udaipur.
 - We would then analyze the data and hold a consultation in Udaipur with representatives from everyone working in the health sector in the area (doctors, NGOs, government officials) to decide on promising interventions.
 - ► We would then test those ideas in several randomized evaluations and meet again to discuss the results.

Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

The Udaipur Health and Well Being Survey

This survey took place in 2002-2003. It covered:

- ▶ 100 villages;
- 1,000 households: long household interviews, some measures of health status;
- ▶ 451 "modern," private facilities; and
- ▶ 123 public facilities, visited every week.

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Some Striking Facts about Health. Udaipur, Rajasthan, India

The Survey: Interview

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Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

The Survey: Measuring Height

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Some Striking Facts about Health. Udaipur, Rajasthan, India

Some Striking Facts

- Health status is poor.
- Patterns of demand for health care.
- Patterns of supply of health care.

Some Striking Facts about Health. Udaipur, Rajasthan, India

Health Status Is Poor

- Diseases Data
- Nutritional status:
 - Height and weight: 88% of women, and 93% of men, have Body Max Index below 21 (average=18).
 - Respiratory problems: peak flow meter on average 316 ml per expiration (anything below 350 is symptoms of respiratory difficulties).
 - ▶ Anemia: 56% of women, and 51% of men are anemic.
 - An India-wide phenomenon: Despite growth in income, even for the poor, calorie consumption is worsening, and child nutritional status is not improving.

 Why Is Demand Low?

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Some Striking Facts about Health. Udaipur, Rajasthan, India

An Ocean of Disease



Low Demand for Preventive Care

Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

Fraction of Households Consuming Less Calories than Recommended



Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

Patterns of Demand for Health Care

- High share of budget is devoted to health, even by the poor
 Figure
- On average, household visits are provided once every two months.
- Most health visits are to private "doctors." Figure
- In contrast to curative care, preventive care is very limited.
 E.g.,
 - ► Full immunization rate: less than 2% at baseline.

 Why Is Demand Low?

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Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

Share of Budget Devoted to Health



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 Why Is Demand Low?

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Some Striking Facts about Health. Udaipur, Rajasthan, India

Share of Visits to Different Facilities



Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

Pattern of Supply of Health Care: The Private Sector

- ► The Private Sector:
 - Completely un-regulated, terrible quality. Qualifications
 - Treatments that emphasize antibiotics and drips, not tests.
 Treatments

Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

Qualifications of Private "Doctors"



Low Demand for Preventive Care

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Some Striking Facts about Health. Udaipur, Rajasthan, India

Treatment in Private Facilities



Conclusion

Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

Pattern of Supply of Health Care: The Public Sector

- The public sector:
- On paper, the "ideal" system for a developing country.
 - A 3-tiered system of public health facilities:
 - One sub-center for 3,000 people (3,600 in our data), close (within 2 km in Udaipur), a nurse provides preventive care and referral, free treatment;
 - One primary health center for 50,000 people (48,000 in our data); and
 - Community health centers and district hospitals for bad cases.
- In practice:
 - Dismal physical state of facilities. Picture
 - Absenteeism: 54% absence rate (weekly measures over a year), not only Udaipur. Picture
 - Treatments: less antibiotics but no more tests.
 - Multiple missions for the nurses:
 - Undo their credibility (e.g., sterilization campaigns).
 - Leads them to completely give up on discharging any of these duties.

Low Demand for Preventive Care

Some Striking Facts about Health. Udaipur, Rajasthan, India

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Some Striking Facts about Health. Udaipur, Rajasthan, India

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Conclusion

Some Striking Facts about Health. Udaipur, Rajasthan, India

The Interactions between Supply and Demand

- People are less likely to use public facilities when nurses are often absent.
- Two possible explanations:
 - Patients are discouraged by high absence rate.
 - Nurses are discouraged by low demand.
- Both of these phenomena could be present simultaneously.

Conclusion

Fixing Supply?

Fixing Supply?

- At the national level, response to the state of public health is to pour more money in the system. Under National Rural Health Mission, health budget will increase form 0.9% of GDP to 2% of GDP.
- At the local level, during the consultations that follow the analysis, Udaipur's district Dollector (the head of the administration, equivalent to a "préfet") proposed that nurses should be in their center at least one day a week (no meeting, no field visits).

Conclusion

Fixing Supply?

Monitoring Nurses

- District administration and Seva Mandir partnered to test a monitoring system in to ensure their presence on that day (Monday) in 33 centers (randomly chosen in the districts).
 - Seva Mandir distributes a date and time stamp to nurses.
 - Nurses stamp on Mondays to indicate that they were present, indicate if she has a motive to be absent.
 - Seva Mandir collects the register and gives them to the government.
 - The government announced sanctions for very delinquent nurses.
- A research team (J-PAL and Vidhya Bhawan, a local university) performed regular unnanounced checks (on Mondays and other days).

Conclusion

Fixing Supply?

Results of the Nurse Monitoring Program



Conclusion

Fixing Supply?

Results

- Early on, large impact: Nurses are sensitive to incentives.
- However, as time goes on, attendance declines in monitored group (and increases in the other group).
- At the end, attendance on Monday is higher in the non-monitored group.
- What happened?
 - Key is the nurse register indicating reason for absences.
 - Absence became "exempted days" (and "broken machines").

Conclusion

Fixing Supply?

From Absences to Exemptions



Conclusion

Fixing Supply?

Political Commitment to a Monitoring System is Key

- Contrast between these results and results on teacher incentives (where absence went down from 40% to 20% and stayed down):
 - An example of the difficulty to scale up.
 - Seva Mandir was committed to implementing the system for teachers.
 - But the public health system was not committed to implementing it, despite commitment at the top.
 - Among all contradicting demands, nurses try to figure out what is really important and what is not. In the treatment groups, they learned that the commitment to Monday presence was not a real priority.

Fixing Supply?

Demand for Health and Political Commitment

- How could the bureaucracy get away with not implementing its own rules?
- One possible answer: No political will because there is no demand for incremental changes in public health care.
- One symptom: Even during the six months where attendance was higher in treatment group, usage of the facility remained very low:
 - On average, 0.74 clients seen in treatment facility when facility is open.
 - On average 0.81, clients seen in control facility when facility is open.
- It is possible that a system imposed from the top without any grassroot demand cannot be sustained.

Conclusion

Fixing Supply?

Power to the People: Improvement in Health through Grassroot Mobilization

- An interesting contrast is provided by an experiment in Uganda.
- Problems are very similar (e.g., absence rate in health center: 47%)
- Instead of a top down approach, they involved the community in monitoring the providers.
- Intervention started with a household survey to collect data on experience with public health facilities.
- Then, community organizations facilitated three meetings: a community meeting, a meeting at the health center, and an interface meeting.
- The outcome of these meetings was an action plan on how to improve the situation, and how the community members would monitor the facilities.

 Why Is Demand Low?

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Conclusion

Fixing Supply?

Power to the People: Results

Results: • Figure

- Community became more involved in monitoring health workers.
- Health workers were more present.
- ▶ Health utilization improved in some respects.
- Health outcomes improved.

Conclusion

Fixing Supply?

Community-Level Monitoring in Uganda: Results



Why This Lack of Demand?

There could be two reasons for lack of increase in the use of public facilities even when they are improved:

- ▶ Villagers do not trust that changes will persist (rightly).
- The underlying demand for care provided in public facilities (preventive/no antibiotics) is relatively low (compared to care provided by private doctors).
- To investigate the second reason, we look at the effect of an improvement in supply on the take-up of preventive care.

Conclusion

Low Demand for Preventive Care

The Effect of Improvement in Supply: Immunization Camps

- High rates of absenteeism in sub-centers may explain the low rate of immunization in Udaipur.
- Seva Mandir teamed-up with the government to organize immunization camps.
 - Seva Mandir hires a male nurse (on a motorcycle). The nurse picks the vaccines from the government facilities. They then held an immunization camp in the village.
 - Monthly, always at the same date.
 - Very regular (95% of the planned camps took place).
 - Announced by a local health worker who also tries to sensitize women to the need of getting children immunized.

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Low Demand for Preventive Care



- Improvement in immunization rates
 - Fraction of children fully immunized increased. Figure
- However, increase was larger for first immunization; mothers less likely to come back for the following shots. Figure
- 88% of children do not remain immunized despite very low cost.
- Note that results from Uganda intervention were similar: increase in the first immunization received, but

Low Demand for Preventive Care

Conclusion

Low Demand for Preventive Care

Fraction of Children Fully Immunized



Conclusion

Low Demand for Preventive Care

Fraction of Children Receiving a Given Number of Shots


Conclusion

Low Demand for Preventive Care

Preventive Care: The Demand Problem

- Low utilization of cheap health saving medical interventions
 - In India: Only a quarter of mothers breast-fed the child within an hour of birth and the average extent of exclusive breastfeeding was only 2 months (WHO recommends breastfeeding within an hour of birth, and to exclusively breastfeed for 6 months).
 - Fraction of children receiving deworming medicine dropped from 78% to 59% when parents had to sign a form.
- Very high price-elasticity for those services, both for positive prices, and negative prices.
 - Positive prices (even small) discourage use: Figure
 - Bed-nets (Kenya, Uganda, Madagascar)
 - Deworming (Kenya)
 - Chlorine (Kenya, Zambia)
 - Small rewards greatly encourage use:
 - Immunization (India, several African countries) Details
 - Learning HIV-Aids Status (Malawi) Details

Conclusion

Low Demand for Preventive Care

Positive Prices Discourage Use: Deworming



Conclusion

Low Demand for Preventive Care

Positive Prices Discourage Use: Bednets



Conclusion

Low Demand for Preventive Care

Positive Prices Discourage Use: Chlorine



Conclusion

Low Demand for Preventive Care

The Impact of Small Incentives on Immunization

- In some immunized camps, Seva Mandir offered one kilogram of lentils to mothers who took their children to be immunization, and a set of plates for completed immunization.
- A very small reward would not convince people who are strongly against immunization.
- Large impact on full immunization, especially on getting more than one of the needed shots.

Low Demand for Preventive Care

Conclusion

Low Demand for Preventive Care

Fraction of Children Fully Immunized



Low Demand for Preventive Care

Conclusion

Low Demand for Preventive Care

Fraction of Children Receiving Different Number of Immunizations



 Why Is Demand Low?

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Conclusion

Low Demand for Preventive Care

Spillovers to Other Villages



Conclusion

Low Demand for Preventive Care

The Impacts of Small Incentives on Learning HIV-Aids Status

- A study by Rebecca Thornton (Malawi)
- Voluntary Counselling and Testing (VCT) is seen as a cornerstone in the fight against HIV (Mozambique: 55% of all HIV-Aids expenditures were for VCT.
- Yet, few people know their status: It is often assumed that psychological and social barriers are very strong.
- As part of a survey, over 2,812 respondents were tested for HIV-AIDS.
- A few weeks later, they could pick up their results if they wanted to (in a tent set up in the village).

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Experimental Design

Two elements were randomized:

- At the end of the interview, respondents drew a bottlecap with a number, with an indication of a small thank you voucher (between 0 and 3 dollars) for picking up their tests.
- ► The location of the tent was also randomized within the village (► close or ► far).
- Results suggest that fear or stigma may not explain the low take up rate of VCT.

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Conclusion

Low Demand for Preventive Care

Close...

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Low Demand for Preventive Care

 Why Is Demand Low?

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Low Demand for Preventive Care



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Conclusion

Low Demand for Preventive Care

Impact of Incentive: Percentage Learning Results



Conclusion

Low Demand for Preventive Care

Impact of Distance and Incentive: Percentage Learning Results



Conclusion

Why Is Demand Low?

Why Is the Demand for Preventive Care So Sensitive to Prices?

- The high sensitivity to (even small) prices on the demand for financial care is surprising. In a standard model of investment in health, the individual compares the costs and the benefits. Given the very high returns of those investment in terms of health, the demand should be high.
- There could be fear, or lack of trust: But in that case small changes in prices should not have any effect (e.g. immunization, HIV-test).
- Two explanations have been proposed:
 - 1. Time inconsistent preferences.
 - 2. The perceived benefits of those actions is low (even if the real benefits are high): Parents are largely indifferent between immunizing their children or not immunizing them.

Conclusion

Time Inconsistent Preferences

Time Inconsistent Preferences

- Today, cost of immunizing the child is time taken, child discomfort, potential side effects.
- Benefits are in the future (at some unknown time).
- Human beings think of the present and the future differently (O'Donoghue and Rabin, Laibson).
 - In the present, we are impulsive: Costs incurred today appear very large relative to benefits.
 - In the future, we are more rational: Costs to be incurred next month appear small relative to benefits.
 - We have a tendency to postpone small costs to a future period.
 - But when the future comes, it is now the present, and the costs again seem large.

Conclusion

Time Inconsistent Preferences

Time Inconsistent Preferences and Preventive Care

- This could explain why getting an immunization is always postponed until next month while people are willing to spend large sums of money on a dubious curative care treatment for the same disease for their child.
- In this case, a small benefit that offset the small cost and is obtained today (e.g. a bag of lentils) can convince parents to take the step today.
- In most developed countries, there is a compulsory schedule of immunization: it plays the same role.
- In this world, subsidy, incentives, making some behavior compulsory, can be justified for two reasons:
 - Externalities: They convince us to undertake behavior that have positive spillovers on others.
 - "Internalities": They help us undertake behavior that are optimal from our own point of view.

Conclusion

Time Inconsistent Preferences

The Role of Commitment Devices

- If time inconsistency is the main problem, there can be other ways to help individuals in taking the right steps:
 - "Nudging," in the words of Richard Thaler and Cass Sunstein: Marketing techniques used to stir individuals to a choice that would be right from their rational's self point of view (e.g. "good" default choices).
 - Helping them to commit in advance to behave in a certain way in the future: commitment devices.

Time Inconsistent Preferences

Smoking: The Role of Commitment Devices

- Smoking is a public health epidemic in developing countries.
- Self-aware individuals with time inconsistent preferences may want to commit to stop smoking.
- A microcredit bank in the Philippines proposed the CARES program, a commitment contract to smokers:
 - They open a (interest free) savings account.
 - They make regular deposits in the account.
 - After 6 months, they have to pass a surprise smoking test.
 - If they fail the test, they forfeit their money.
- No one would take this product if they were not looking to force themselves to stop smoking.
- The CARES program was evaluated by Dean Karlan and Jon Zinman.

Conclusion

Time Inconsistent Preferences

The Impact of the CARES Program

- CARES randomly offered to 781 out of 2000 smokers (randomly selected). 83 out of 781 (11%) accepted to take up the program.
- After 6 months, everyone performs a smoking test.
- Smoking cessation rates:
 - ▶ 11% in the treatment group (*all* those offered CARES)
 - ▶ 8% in the control group
- 29 out of 83 who took CARES stopped smoking (35%). But note that we cannot compare those who took up CARES and those who did not: Those who took-up may be those who are the most (or the least!) likely to stop smoking.
- Impact of being offered CARES: 3 percentage points.
- If we assume that being offered CARES has no effect on those who do not take it up, these extra 3% are due to the 11% of people who took up the program. Effect of the program: 0.03 0.11: 30%.

Perceived Benefits: Learning about Health

The Perception of Benefits

- ► Thus, there is evidence that time inconsistency plays a role.
- However, constantly postponing preventive care, if we are fully aware of its benefits, requires to be both time inconsistent and very naive.
- Maybe the low demand and the high sensitivity to prices for preventive care, and the high demand and high willingness to pay for curative care comes from the fact that we tend to:
 - Underestimate the benefits of preventive care.
 - Overestimate the benefits of curative care.
- Learning about health is difficult:
 - For curative care: Since most diseases are self-limiting, any cure is going to appear effective. When a "doctor" gives one shot of antibiotic against the flu, we may think he cured the flu, and we will go back to this doctor.
 - For preventive care: It prevents a disease from happening, so the disease is not observed: no immediate link is drawn between immunization and not getting sick.

Low Demand for Preventive Care

 Conclusion

Perceived Benefits: Learning about Health

Learning about Preventive Health

- 1. Well targeted information is useful, general incantations are not.
- 2. Education as a health policy.
- 3. We can learn by doing, and we can learn from others.

Perceived Benefits: Learning about Health

HIV-AIDS Prevention: Risk Avoidance or Risk Reduction

- In the effort to prevent HIV-AIDs, the youth are considered to be a "window of opportunity." Youth were targets of prevention efforts in many countries that have been relatively successful at curbing the spread of HIV-AIDs (e.g. Uganda)
- Government response in Kenya: HIV-AIDS education in school
 - As in many countries, the curriculum is a product of a consensus: UNICEF, churches.
 - Based on ABCD Message (Abstain, Be Faithful, use a Condom... or you Die).
 - Public health discourse: choice beween emphasizing risk avoidance (promote the message that AIDs is everywhere, abstinence is the only 100% safe behavior) vs risk reduction (avoid the most risky situation).
 - ABCD is a risk avoidance message.

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Risk Avoidance or Risk Reduction: An Evaluation in Kenya

- Collaborative project: Government of Kenya, ICS (an NGO), and E. Duflo, P. Dupas, M. Kremer, S. Sinei.
- The curriculum is, in principle, in place everywhere, but teachers do not teach it (fear of stigma, lack of comfort, etc.).
- Government has a few trainers for teachers, but program is being phased in progressively: evaluation possible.
- ICS organized training by Government Trainers of 3 teachers in 183 schools, randomly selected out of 370, in official curriculum. ICS follows with health clubs.

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Risk Avoidance or Risk Reduction: An Evaluation in Kenya

- In 35 trained schools, and 36 untrained schools, ICS organized an extra program, centered on risk reduction: the "Sugar Daddy" program.
 - Many adolescents girls have relationships with older adults ("Sugar Daddies").
 - Cross generational sex is associated with transmission of epidemics: Rate of infection of girls age 15 to 19 is 5 times that of boys.
 - Intervention showed rate of infection of older men, younger men, younger women.
 - And showed a UNICEF video against sugar daddies "Sarah, the Trap".

Conclusion

Perceived Benefits: Learning about Health

Results: Teacher Training

- To get an objective measure of changes in sexual behavior, get information on pregnancy of girls who were in grades 6-8 at baseline (2003). Reveals abstinence, condom use. Desirable information in and of itself.
- Teacher training
 - Trained teachers more likely to have discussed HIV-AIDS in class
 - Not much impact in self reported knowledge.
 - Not much impact in self reported behavior (sexual activity; condom use).
 - No effect on pregnancy rates after 3 years, and after 5 years.
 Figure
 - Similar results found for HIV-AIDs prevention in Mexico, Tanzania.
 - Michael Kremer and Edward Miguel: Same (lack of) effects of information campaign on deworming (wear shoes, don't swim in lake)

Low Demand for Preventive Care

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Fraction of Girls Who Started Childbearing



Girls pregnant or having Girls pregnant or having a child after 3 years a child after 5 years

Conclusion

Perceived Benefits: Learning about Health

Results: Sugar Daddy

- Decrease in sexual activity with older partners; increase with younger partners, but condom protected.
- Large decrease in pregnancy rate, especially with older partners.
 - Results
 - Pregnancy rates after one year dropped by 30% (from 5.4% to 3.7%).
 - Pregnancy rates with older partners dropped by 67% (from 2.4% to 0.79%).

Low Demand for Preventive Care

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Fraction of Girls Who Started Childbearing



Perceived Benefits: Learning about Health

Education as a Health Policy: One Example

- In half the trained schools, and half the untrained schools, ICS provided school uniforms in grade 6 (in 2003) and grade 8 (in 2005).
- ▶ For girls, dropout declined from 18% to 12%.
- Fraction of girls who became pregnant or had a child by 2005 declined from 14.4% to 10.6%.
- Fraction of girls who became pregnant or had a child by 2007 declined from 30.7% to 26.1%.

Low Demand for Preventive Care

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Fraction of Girls Who Started Childbearing



Girls pregnant or Girls pregnant or having a child after 3 having a child after 5 years years Perceived Benefits: Learning about Health

Learning by Doing and Learning from Others

- Role of habits: Trying a health behavior may encourage one to continue.
- Role of norms, culture, social learning: Seeing others adopt a health behavior may encourage further adoption.
- Pascaline Dupas: experiment with bednets in Kenya
 - Worked with 644 households (sampled from parents' list) in western Kenya.
 - Distributed voucher for reduction in the price of a bednet at local stores: Price varied from 0 to 250 Ksh , or \$3.80) (full price is approximately \$5).
 - One year later, offer a voucher to all the households, for 100 Ksh.

Conclusion

Perceived Benefits: Learning about Health

Learning by Doing and Learning from Others: Results

- More likely to purchase at first follow up if net is cheaper.
 Figure
- As likely to use bednet in beginning at first follow-up when free. Figure
- More likely to buy a second one if they received the first one for free. Figure
- It is really an experience effect: effect smaller for chlorine.
- Social learning: More likely to buy at second follow-up if they know more people who got it for free. Figure
- Social learning on health (but going in the other direction) was also found by M. Kremer and E. Miguel on deworming.

Low Demand for Preventive Care

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Fraction of Households Who Buy the First Net



Low Demand for Preventive Care

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Fraction of Households Who Use the First Net, if Purchased



Low Demand for Preventive Care

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Fraction of Households Who Buy the Second Net and Chlorine


Some Striking Facts Fixing Supply?

Low Demand for Preventive Care

Why Is Demand Low?

Conclusion

Perceived Benefits: Learning about Health

Fraction of Households Who Buy the Second Net



Policy Implications

Conclusion: Policy Implications

- The market will not naturally lead to an outcome where preventive care is delivered, or demanded.
- We cannot just rely on communities to ensure that preventive care is delivered.
- The quality of care depends on the underlying demand:
 - Emergence of a dangerous private sector if there is no trust in Government (to regulate, or to deliver).
 - Good quality care must be a politically salient issue to guarantee the quality of the public sector.
- A publicly funded, publicly provided (or regulated) effort to encourage behavioral change is essential.

Low Demand for Preventive Care

Conclusion

Policy Implications

How Can Behavioral Change Be Facilitated?

- ▶ In the short run, prices are important. We should use them.
 - Full subsidy of good quality preventive care and health products: the emphasis on "sustainability" often heard may be missplaced. CostBenefit
 - Incentives (or compulsion) for preventive behavior work.
 - Use cross-subsidy of health behavior. E.g. distribution of bednets in measles camps (WHO, UNICEF) and in maternity clinics (TamTam, PSI).

▶ We need to find effective ways to communicate information:

- Credibility is essential. Governments often waste it on ancillary goals. For example, sterilization campaign in India has ruined the credibility of the nurses.
- Focus on information that can be acted upon (e.g. Sugar Daddy vs Total Abstinence)
- Exploit the mass media (done in rich countries): e.g. in Brazil and India, TV and soap opera associated with reduction in fertility.

Low Demand for Preventive Care

Conclusion 000

Policy Implications

Is the "Sustainable" Approach Cost-Effective?



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