

Tim Phillips [00:00:00]:

Welcome to VoxTalk's Economics, recorded live at the PSE CEPR Policy Forum at the Paris School of Economics. My name is Tim Phillips.

Tim Phillips [00:00:17]:

In this episode, a massive investment in universal healthcare may not be universal in its impact. In lower middle income countries, women have worse health than men, and policymakers in many of those countries have tried and failed to close the gap. In India, still one of the five worst countries in the world for the health and survival of women, the recent introduction of massive health insurance programs should give women and men equal access to healthcare. So is that happening? Pascaline Dupas of Stanford University has studied the impact of one of these programmes with her co author, Radhika Jain of UCL. And Pascaline joins me now. Pascaline, I've spoken to you before, but it's great to meet you for the first time.

Pascaline Dupas [00:01:04]:

Same here. Thanks for having me.

Tim Phillips [00:01:06]:

We think of this after the work of Amartya Sen, I think, as a story of missing women, women who should be alive but are not. So how many of these missing women are we talking about in lower middle income countries, India in particular, because of health inequality.

Pascaline Dupas [00:01:22]:

So it's actually hard to know what share of the missing women are missing due to health inequality. The way you can back out how many missing women there are is by comparing sex ratios and having a sense of how many should be there. So the latest estimate for India from 2018 is about 63 million missing women in India alone. So for the whole world, it's probably going to be at least twice that. But it's very hard to know how they could be missing. A bunch of it may be sex, selective abortion, but there's a lot of these missing women that start to be missing in adult age, and so health inequalities may be a very good explanation for that. And that's what we try to look into with my co author, Radhika Jain.

Tim Phillips [00:02:03]:

What is causing this? Is it because women and girls have more illness and injuries? Or is it because when they are sick, they're less likely to receive equal treatment?

Pascaline Dupas [00:02:14]:

So what we're able to look at is the extent to which they receive treatment and we definitely see a deficit there. To actually know if they are disproportionately sick and what causes that. It could be due to poor treatment, poor nutrition. It's much harder because if somebody doesn't get care in the first place, you just don't have much data on them at all. And so the paucity of data on these topics is what prevents very clear senses for policymakers of what drives all these issues and what progress can be made. And so that's why we take advantage of this new data set that we have access to, to really make progress on that.

Tim Phillips [00:02:48]:

If women and men have the same health problems, what's behind the difference in the care that they're receiving then? Do we know that?

Pascaline Dupas [00:02:56]:

Yeah. So what seems to be going on at households are not willing to spend as much to take care of the health of the women than the men. And that could be driven by a number of factors. It could be standard economic model that the returns to female health are lower than the returns to male health. And in the context of India, this may be because women have a very low rate of participation in the labor market. It could be also in the context of India that women are not the ones who take care of their parents in old age. It's a son who is responsible. So it's not as bad for me if my daughter doesn't survive as if my son doesn't survive. It could also be just pure taste based discrimination, as we call it in economics. People may just not value women as much as men. But also in the context of healthcare, there could be some what we call female specific barriers or costs. And I guess in the case of India, that maybe well, to go to the hospital, which may not be that close, I think to take public transportation, maybe it's tricky for women to travel on their own because of gender norms. Or maybe it is very costly for the household if the woman travels to the hospital and waits in line for 2 hours because during that time she's not taking care of the chores in the household that she's expected to take care of.

Tim Phillips [00:04:09]:

To look deeper into this, you investigated the impact of a government health insurance program that was introduced in Rajasthan in India. So what is this program? How does it work?

Pascaline Dupas [00:04:19]:

So it's a very ambitious program that's now been essentially mirrored by a national program. And the similar programs have been going on in many states in India that essentially covers the poor. So every household with a below poverty line card is eligible to receive, in principle, free hospital care, typically secondary tertiary care. So not primary care, which is already free in smaller public health facilities, but secondary tertiary care. And so you're supposed to be able to

go and be admitted and receive services. And then the hospitals on the back end directly bill the insurer or the Government for the services that they've provided.

Tim Phillips [00:04:55]:

And so in theory, this closes the gender gap because it reduces the cost of getting treatment.

Pascaline Dupas [00:05:01]:

Yes, the main reason why you see these gaps and access to care to start with is that households are not willing to pay for women as much as for men. When the cost becomes zero, then these main barriers to women care should be going down. But if you have these other costs. That I've talked about before related to the transportation costs, if you don't subsidize transportation, then you won't get necessarily complete equality and access to care even when the cost at the hospital is free. Or if there are these other differences in willingness to let the person forego whatever activities they are doing otherwise.

Tim Phillips [00:05:32]:

So at the outset, the baseline, how big was this gender gap in Rajasthan that these treatments that become free might close the gap on?

Pascaline Dupas [00:05:42]:

So we actually don't know that. Again, just because you don't know who should be getting care, you don't know what you can see. But I can tell you that under the scheme, which is we have access to claims data from hospitals and so the way we started working on this issue of gender access is just the first tabulation what we did was what's the share of the patients or the claims in these data sets that are for female patients? And it was very low. It was very far from 50% or 48%, which is a share of women in the state of Rajasthan. So these very big gaps are there. Even under the scheme which is really striking. And so, for example, for chronic kidney conditions, we find that only 28% of the patients are female. And for things like cardiology, also anything related to heart, it's also very low.

Tim Phillips [00:06:27]:

So in this story, the first thing you find out is that what seems like free treatment actually, when it's being delivered, turns out not to be free in many cases. What happened?

Pascaline Dupas [00:06:36]:

Yeah. So one of the hypotheses we had was that maybe the scheme is not implemented exactly as it should be, and in particular, hospitals may still be requesting some out of pocket payments

from patients. Especially for type of services that the hospitals think are more expensive to provide than the scheme is reimbursing them for. So the way we looked at that was doing audit surveys with patients. So you would get access to these claims data from the hospitals on a regular basis and we were able to call patients who had been seen very recently and ask them what they were seen for. But also whether they had to pay anything out of pockets. And we found that actually a good chunk of patients are charged out of pockets and more so in private hospitals than in public hospitals and the amounts were quite large. And so that means that it's not actually free even at the hospital. And then on top of that, there are these transport costs that in any case were not covered. So, yes, the program does not bring the cost down to zero at all. And so that explains part of the remaining gender gaps.

Tim Phillips [00:07:33]:

And as you say, we have these travel costs, but the scheme expanded so that travel time to hospitals presumably was going down. Did that start to close the gender gap?

Pascaline Dupas [00:07:45]:

Actually, if you really try to think about the extent to which a program that reduces the monetary cost and/or reduces the transport cost by increasing the availability of hospitals in the scheme, whether it's going to reduce a gender gap, it's a bit tricky because it could very well be that the marginal beneficiaries of the scheme are still the men. So think of household that live so far away that no one goes for care absent any scheme. And then the scheme is introduced at a hospital that's still 25 km away. Maybe at that distance, now the household is going to be willing to take the guy, but not the woman. So you may find that actually, for households, this scheme increases the ability to get care for men only and not for women. For some of the household that we're already getting care for men now, the further reduction in costs may bring them to also bring women over. But overall, there is no obvious ways through which this scheme should systematically reduce the gender gap. It may well, and it does increase the access to care for women. So more women get care thanks to the scheme, thanks to the reduction in the transport cost from more hospitals becoming empaneled, as we call it, but also more men. On average, we see that men are still the ones that disproportionately benefit. Okay, so the program is actually quite expensive and it's wonderful when you see governments spend money on the poorest in their state. But we do estimate that males are disproportionately benefiting from this spending. And all the increases in the scope of the scheme seem to be disproportionately benefiting men as well.

Tim Phillips [00:09:09]:

It's so interesting because when you don't think about it carefully, you think, of course that will help close the gap. When you do think it carefully, you look at the data, you find out that the opposite is happening. So is really the thing that needs to be fixed here the gender norms?

Pascaline Dupas [00:09:27]:

Yes, for sure. Now, that's easier said than done. Norms are very, very sticky. India is known for a number of very strongly gendered facts, including very low female labor force participation. And just this morning we had a presentation in the conference about high rates of intimate partner violence. So I'm not claiming that I have a magic bullet to change norms anytime soon. In the paper, we're able to look at one way through which norms have been slightly moving in India, which is this political reservations for women that have been studied extensively in the literature. And people have shown that it can move things a little bit, it takes time, it requires having multiple episodes of having a local leader with a female. So these reservations are for local government.

Tim Phillips [00:10:12]:

So to explain this, in local governments, in villages, some of those places in local administrations are reserved for women.

Pascaline Dupas [00:10:20]:

Exactly. So there are some local councils and the head of that council has to be a woman every once in a while. And in the Rajasthan, at least, the way it's done is that every election cycle it's random whether or not you need to have a woman or not. And so we can exploit that variation in exposure to female leadership, just as the previous literature has done, to look at whether that changes things. And we do see a little bit of movement. So we do see that in the Gram panchayats, where there's been more instances of female leaders, there's slightly lower gender gap for certain age groups, but not for all age groups to start with, and it's not huge. It's not that this helps close the gap completely far from that, it just slightly reduces a gender gap. So it's an indication that by working on the gender attitudes, you can make some progress, but much more needs to be done. And then there are still some groups that we see do not seem to benefit from that, in particular the elderly women.

Tim Phillips [00:11:14]:

This is interesting. We know from data, previous data, don't we, that elderly women in India are particularly affected by this problem of health discrimination. Does this policy do anything to help them?

Pascaline Dupas [00:11:28]:

So the health insurance policy itself does increase the access, but the reservations policy does not further help reduce the gap for that age group. So what we see for the younger women, we don't see at all for the older women and it's a very interesting question as to why. Our conjecture, and it's really a conjecture, because we don't know for sure, is that the ways through

which a local governing body, when you have a woman at the head, is able to make progress on these gender aspects in healthcare is by encouraging the local health workers to push women and push households to get more care. But those local health workers are very focused on women of childbearing age, and so that's a way you can reach young women and their children potentially. But the mother in laws are not included in that, and so they are the mothers, so they are not benefiting, as far as we can see.

[Voiceover] [00:12:22]:

In September 2022, we covered another example of how policies that seem as if they are genderblind are not in practice. We spoke to Abi Adams-Prassl about how workplace violence has different consequences for both attacker and victim, if that victim is female. Listen to the episode Violence Against Women at Work.

Tim Phillips [00:12:44]:

So we have a very difficult problem here. We know that reducing the costs in itself does not close the gap and may even widen the gap. We know that changing norms and institutions has some impact on that, but it's very difficult and takes a very long time. Is there anything that we can do to say this intervention should not be gender neutral, should focus on women that might close the gap some more? Is there any way that policy can do it that way?

Pascaline Dupas [00:13:16]:

Subsidizing the care, making it free is necessary, but we find that it's not sufficient. So you can go further than that. You can actually pay. You could have an incentive scheme and pay households more. Like if a woman shows up at the hospital, she gets extra payment. There's already some of that. There's a subsidy for delivering at the hospital. But to Radhika and I the main takeaway that you need not only the subsidies and potentially the financial incentives, you also need to work on other norms. And so purely gender neutral policies only go that far. And you need to specifically address the barrier that women face in order to really make progress on that. So it's not to say that subsidizing is not good. We definitely see that women are better off with it than without. But the gap with men is not going to decrease much unless we focus specifically on women's needs.

Tim Phillips [00:14:02]:

It's a very interesting lesson in how well intentioned policy doesn't always achieve the goals that are set out for it.

Pascaline Dupas [00:14:08]:

That's right.

Tim Phillips [00:14:09]:

Thank you, Pascaline.

Pascaline Dupas [00:14:11]:

Thank you very much.

Tim Phillips [00:14:21]:

The paper is called; Women Left Behind: Gender Disparities in the Utilization of Government Health Insurance in India. And the authors, of course, are Pascaline Dupas and Radhika Jain.

[Voiceover] [00:14:36]:

This has been a VoxTalk recorded at the Paris School of Economics CEPR Policy Forum, 2023. If you like what you hear, subscribe, you can find us wherever you get your podcasts. And you can listen to clips of past and future episodes when you follow us on Instagram at VoxTalks Economics.