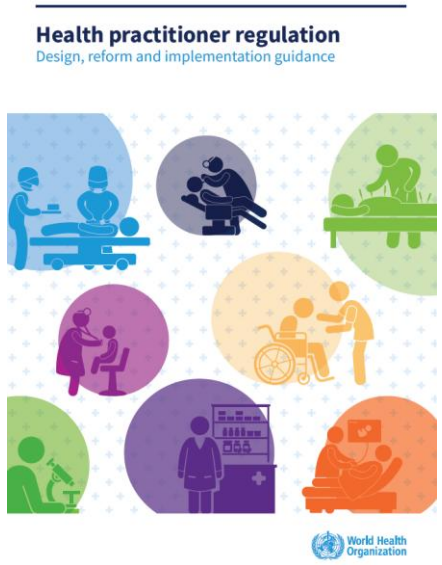

Beyond Credentials: What Evidence Tells Us About Medical Competence And Health Practitioner Regulation

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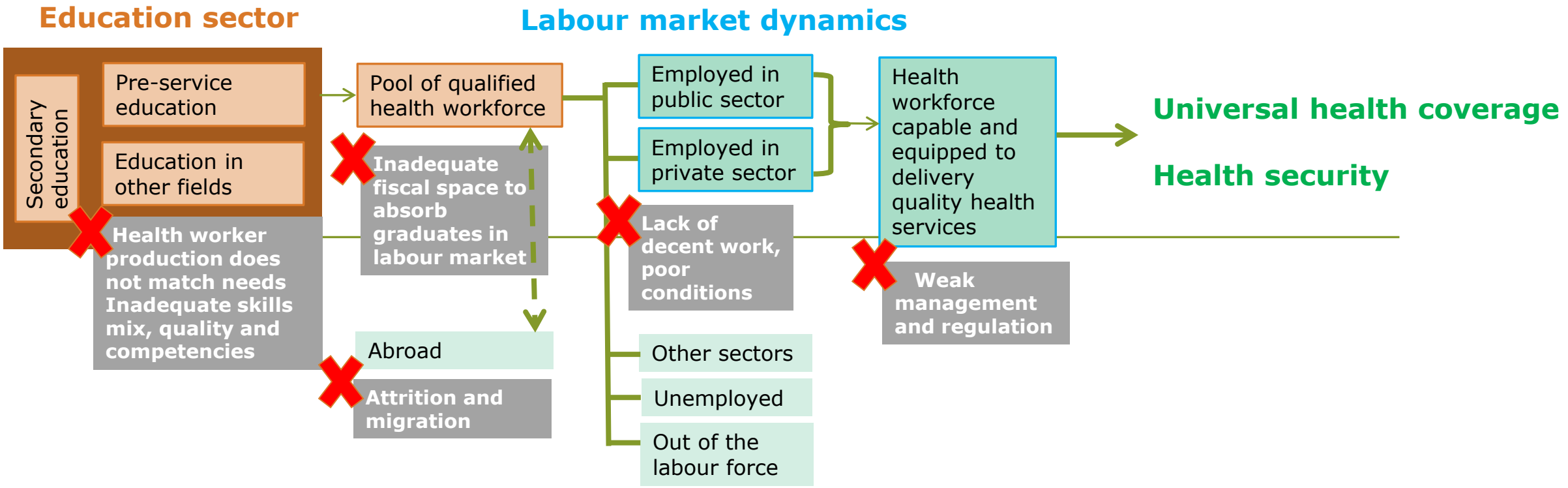
Georgetown University & NBER
28th Annual AMCOA Conference
25 AUGUST 2026

Understanding health labour market failures



Policies on production

- Infrastructure, materials, faculty
- Transformative education models
- Student selection and enrolment

Policies to address inflows and outflows

- Investing in decent employment
- Managed migration
- Attract unemployed health workers

Policies to address maldistribution and inefficiencies

- Improve productivity and performance
- Improve skills mix composition
- Retain health workers in underserved areas
- Gender sensitive policies for equity

Policies to regulate the public and private sector

- Regulate dual practice -Improve quality of training -Enhance service delivery

The regulatory-practice gap

Many regulations on the books, but *practice* can fall short

Why?

Partly because these gaps have not been carefully highlighted till now, allowing regulators to build the case for better resourced offices

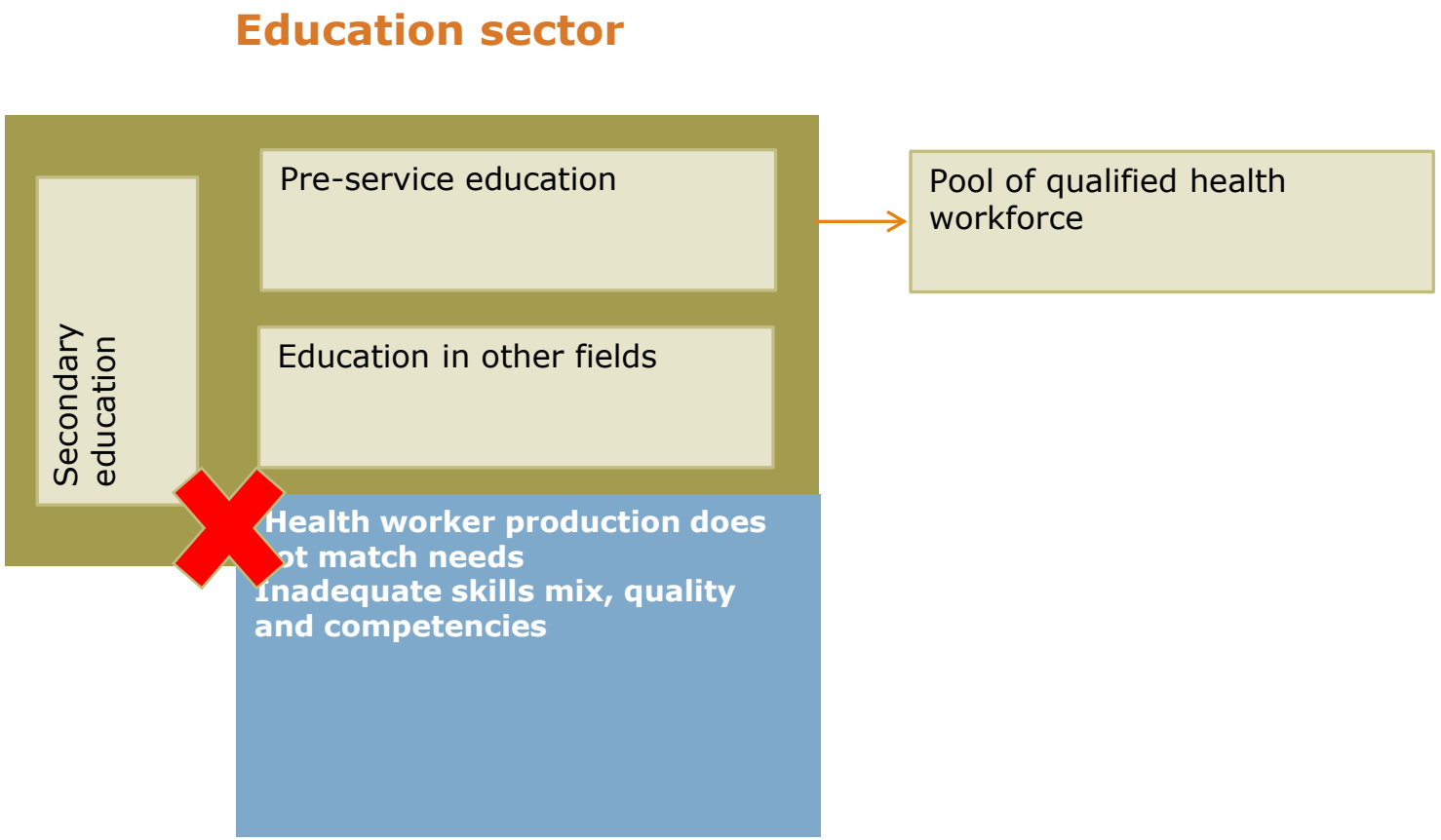
- Regulatory offices are often dramatically understaffed and under-resourced

Note: The argument that even if regulatory offices are better staffed and resourced, we will not see improvements is incorrect

- In fact, when they are better staffed and have sufficient resources to perform their functions, we see substantial improvements
- First *Randomized Controlled Study* of regulations from Kenya (See WHO Guidance, Page 22)

Demonstrate empirically some of the consequences of the regulatory-practice gap

Zoom in on the Education Sector



Zoom in on the Education Sector

Table 2.

Health practitioner regulation – functions

Core functions (centred on licensing schemes)
1. Setting and enforcing education standards 2. Informing the public about health practitioners who meet minimum standards through a registry 3. Assuring the competence of practitioners entering practice 4. Setting standards for ethical, personal and professional conduct 5. Monitoring compliance with practice standards and continued competence 6. Investigating noncompliance with standards and taking necessary action

The studies

Used clinical vignettes designed, tested and validated in India and Tanzania to measure the clinical knowledge of healthcare practitioners in Sub-Saharan African countries and in India

Visited 16,127 healthcare practitioners in 11 SSA countries over 10 years

Visited 1,451 healthcare practitioners across 19 states (1,519 villages) over 3 years in India

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Research Article

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The medical competence of health care providers in sub-Saharan Africa: Evidence from 16 127 providers across 11 countries

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Two Indias: The structure of primary health care markets in rural Indian villages with implications for policy

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The Results (1)

Sub-Saharan Africa (SSA): The mean provider correctly diagnosed 60% and correctly managed 35%

- 15% of the sample could treat no more than 1 in 5 vignettes correctly
- 5% of the sample could treat 3 in 5 vignettes correctly

India: Among the lowest performing 20%: 71.9% correctly diagnosed TB, 50.9% correctly diagnosed pre-eclampsia and 70.7% correctly managed childhood diarrhea with ORS

- Among the top 20%, these fractions were 97.4%, 95.4% and 96.2%

Note: India cannot be compared to SSA because the cases were different

The Results (1)

In both samples, all types of healthcare workers who were actually providing care to patients were included in the vignettes

- In SSA countries, this included nurses who were the most frequent staff providing care
- In India this included informal providers (without formal medical training) who were the most prevalent among all types of providers in the sample

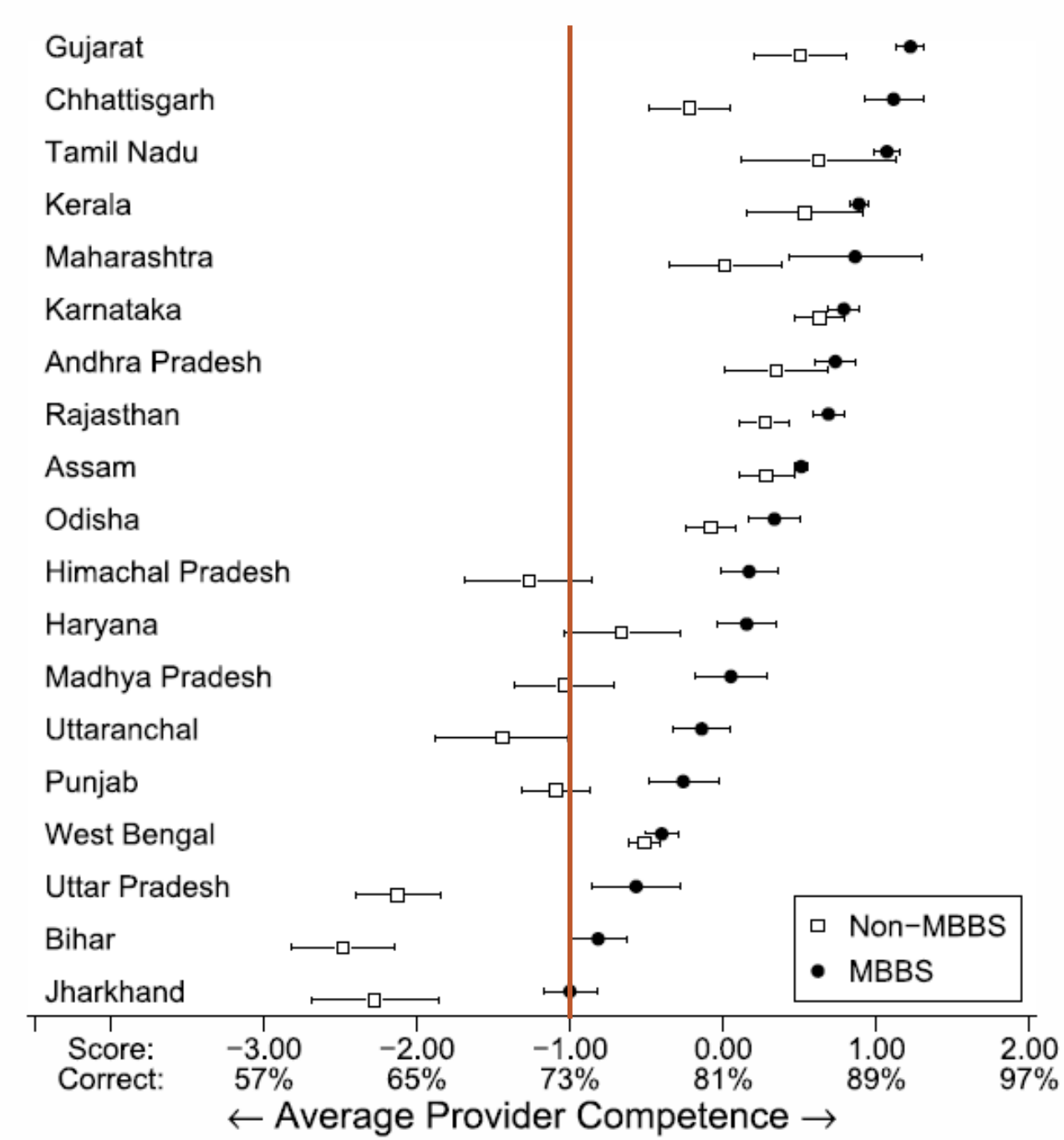
Question: Could it be that the wide variation we observe is because of differences by professional qualifications?

Results (2)

Medical knowledge is *variable* and *unpredictable*

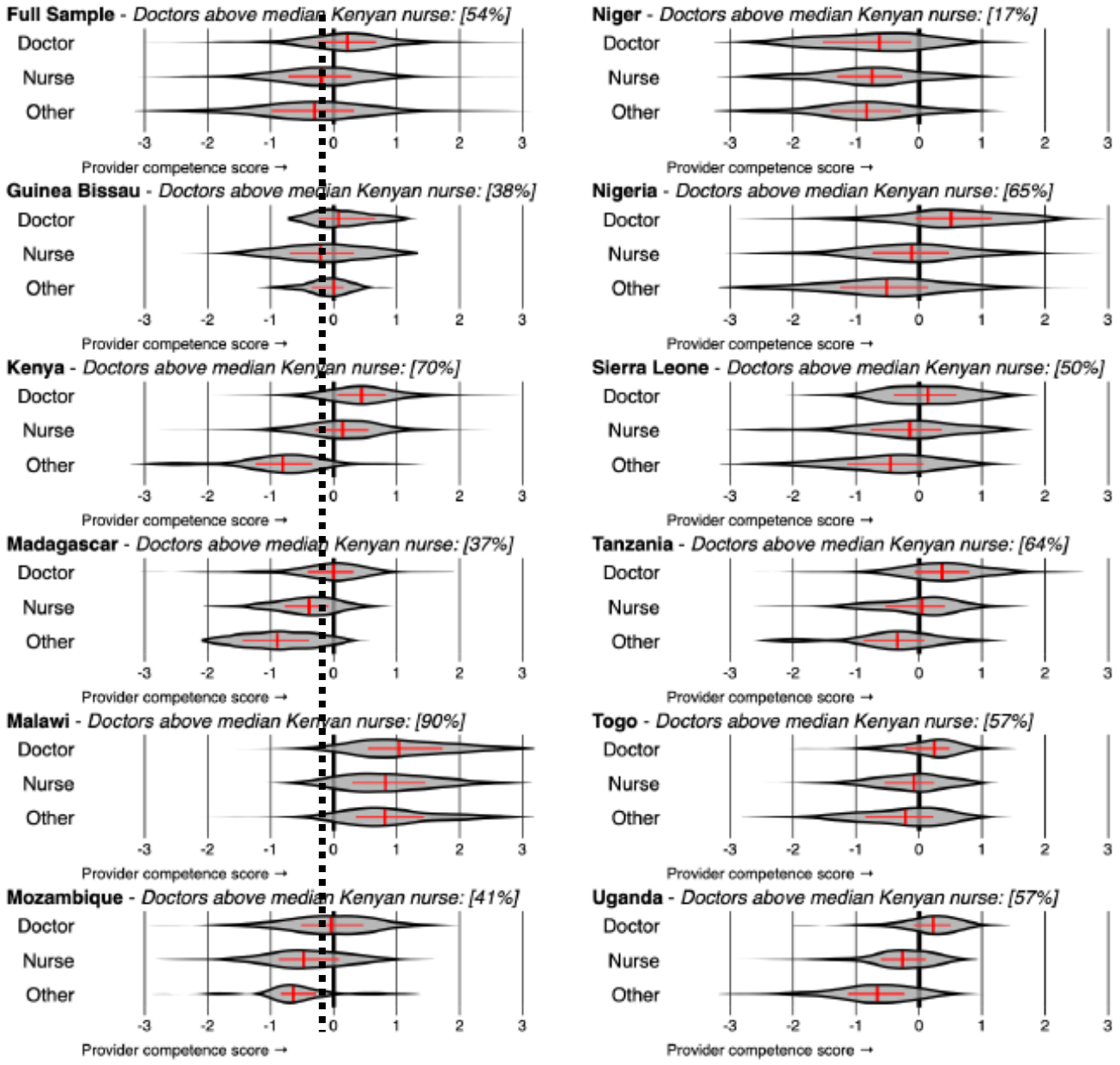
For MBBS and non-MBBS providers, there is massive variation in provider's knowledge

Using all known information on the provider—seniority, competence, training etc.—we can never predict more than 10% of the variation in competence that we observe in the data



Results (3)

The results are very similar in multiple Sub-Saharan African countries

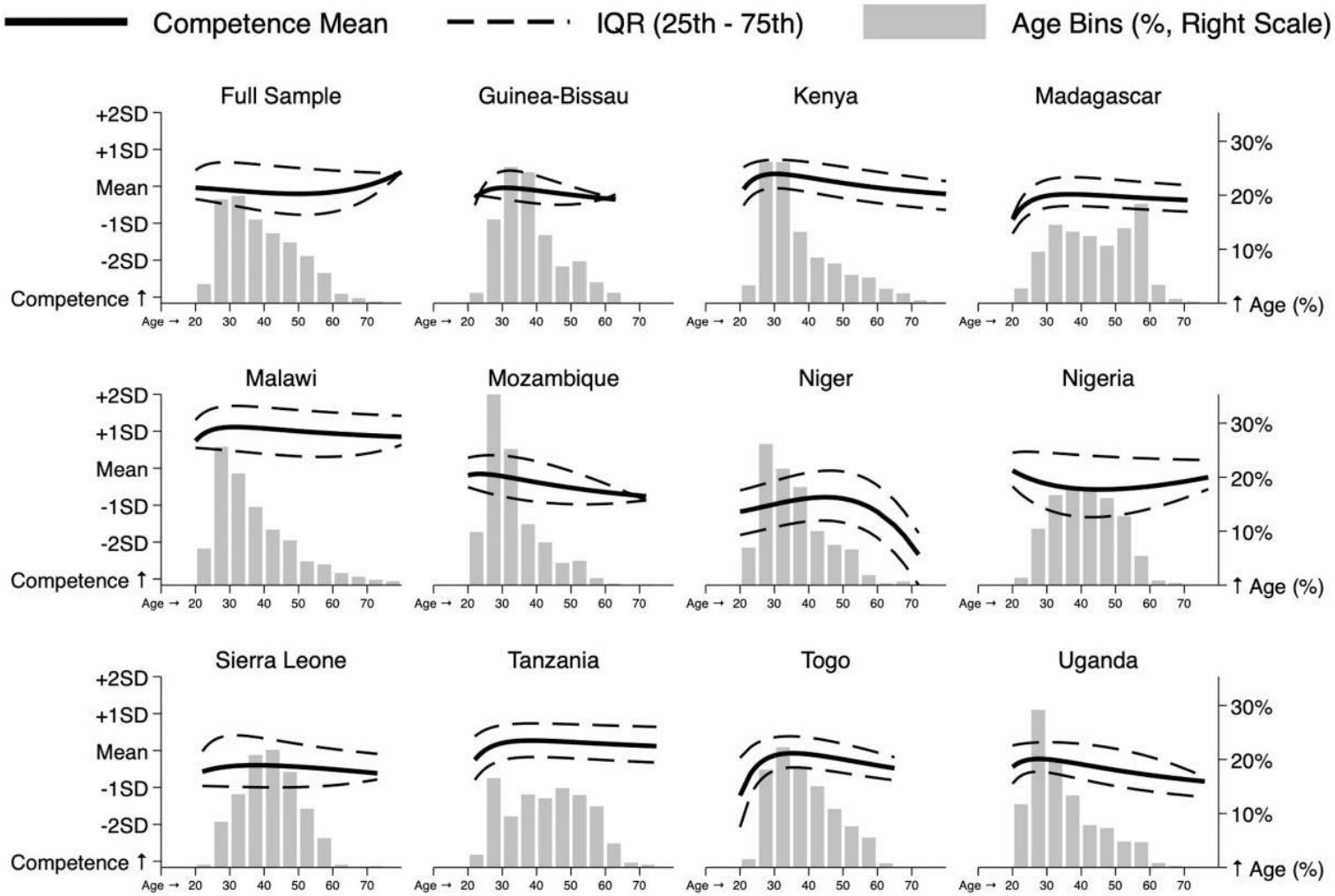


Results (4)

These results include all healthcare providers: Results could be very different by age

- On the one hand, experience may improve medical knowledge
- On the other hand, training may have improved

In general, we see little to no change in medical knowledge with age



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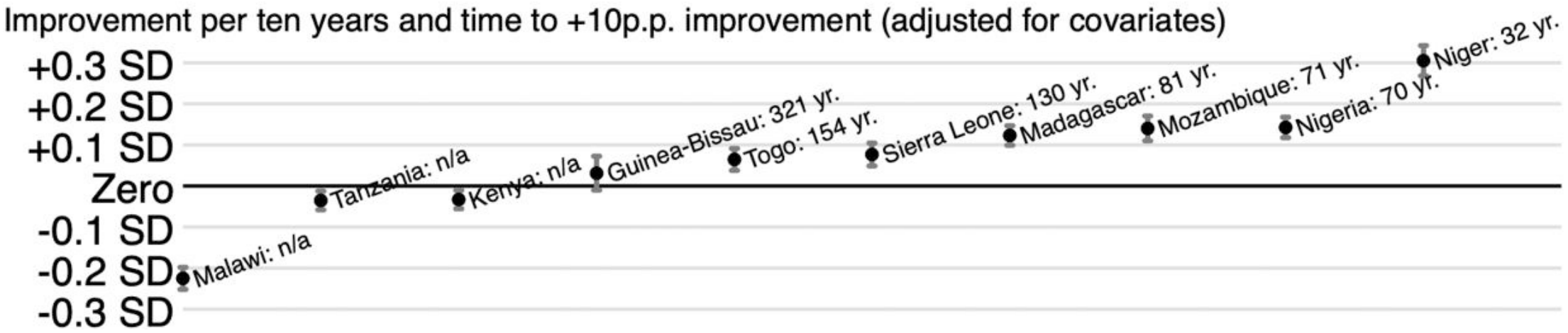

Concluding Thoughts

The regulation of medical education is a core function of regulators in every country with clear legal requirements for entry into the profession

Yet, because of the regulatory-practice gap providers with very poor medical knowledge are practicing in every country in our sample

In fact, *qualifications*, which is usually considered to be a marker of medical knowledge is not a good predictor at all

In general, Qualifications ≠ Competence in these samples

Finally, we do not find improvements in competence with age, suggesting that the quality of medical education has not improved over time

Understanding how the regulation of medical education can be improved is one of the most urgent problems facing regulators in these countries today