Discussion of: "The VIP Effect in Medicine: How Patients' Insider Knowledge, Social Ties, and Organizational Rank Shape Clinical Decisions"

Gong, Xiang, Zhang & Zhang (2026)

Discussant: Zincy Wei
Northwestern University

ABFER 13th Annual Conference
May 21, 2026

Overview

- **A compelling paper on a fundamental question in health economics**
  - Who receives efficient care, and why?
  - Three channels of privilege: insider knowledge, social ties, organizational rank

Overview

- **A compelling paper on a fundamental question in health economics**
  - Who receives efficient care, and why?
  - Three channels of privilege: insider knowledge, social ties, organizational rank
- **Clean Identification via ZMDP Policy Reform**
  - Eliminates 15% drug markup in public hospitals, reshaping physician incentives
  - Does not affect patient-physician matching: a valid quasi-experiment
  - 100% insurance claims from Changsha, 2010–2018

Overview

- **A compelling paper on a fundamental question in health economics**
  - Who receives efficient care, and why?
  - Three channels of privilege: insider knowledge, social ties, organizational rank
- **Clean Identification via ZMDP Policy Reform**
  - Eliminates 15% drug markup in public hospitals, reshaping physician incentives
  - Does not affect patient-physician matching: a valid quasi-experiment
  - 100% insurance claims from Changsha, 2010–2018
- **Main Finding: Privilege Shields Patients from Inefficient Care**
  - Non-insiders: large cost increases (28.9%), no health improvement
  - Insider knowledge and social ties each contribute comparably
  - Organizational rank: a more limited incremental role

Overview

- **A compelling paper on a fundamental question in health economics**
  - Who receives efficient care, and why?
  - Three channels of privilege: insider knowledge, social ties, organizational rank
- **Clean Identification via ZMDP Policy Reform**
  - Eliminates 15% drug markup in public hospitals, reshaping physician incentives
  - Does not affect patient-physician matching: a valid quasi-experiment
  - 100% insurance claims from Changsha, 2010–2018
- **Main Finding: Privilege Shields Patients from Inefficient Care**
  - Non-insiders: large cost increases (28.9%), no health improvement
  - Insider knowledge and social ties each contribute comparably
  - Organizational rank: a more limited incremental role
- **A high-quality paper. My comments are meant to sharpen the contribution.**

Take a Step Back: What Does "Privilege" Buy You?

- **The paper decomposes privilege into three channels via sequential comparisons:**
  - Insider Knowledge: non-insiders vs. different-hospital insiders
  - Social Ties: different-hospital vs. same-hospital insiders
  - Organizational Rank: same-hospital low-rank vs. high-rank

Take a Step Back: What Does "Privilege" Buy You?

- **The paper decomposes privilege into three channels via sequential comparisons:**
  - Insider Knowledge: non-insiders vs. different-hospital insiders
  - Social Ties: different-hospital vs. same-hospital insiders
  - Organizational Rank: same-hospital low-rank vs. high-rank
- **But what exactly does each channel deliver?**
  - Knowledge $\rightarrow$ patient skepticism: insider patients resist over-treatment
  - Social ties $\rightarrow$ physician altruism: doctors act in the patient's interest
  - Rank $\rightarrow$ physician effort: more precise diagnosis signal σ_I^2

Take a Step Back: What Does "Privilege" Buy You?

- **The paper decomposes privilege into three channels via sequential comparisons:**
  - Insider Knowledge: non-insiders vs. different-hospital insiders
  - Social Ties: different-hospital vs. same-hospital insiders
  - Organizational Rank: same-hospital low-rank vs. high-rank
- **But what exactly does each channel deliver?**
  - Knowledge $\rightarrow$ patient skepticism: insider patients resist over-treatment
  - Social ties $\rightarrow$ physician altruism: doctors act in the patient's interest
  - Rank $\rightarrow$ physician effort: more precise diagnosis signal σ_i^2
- **Are these channels truly separable?**
  - Same-hospital insiders have *both* knowledge *and* ties – the comparison isolates the *marginal* effect of ties, conditional on knowledge
  - Question: Does medical knowledge outside one's own hospital transfer fully? Or is there institution-specific knowledge that different-hospital insiders still lack?

Is "Insider Knowledge" Really Knowledge?

- **The paper proxies insider knowledge through healthcare employment**
  - Plausible: healthcare workers understand clinical protocols, drug markups, and physician incentives
  - But the measure conflates multiple distinct types of knowledge:

Is "Insider Knowledge" Really Knowledge?

- **The paper proxies insider knowledge through healthcare employment**
  - Plausible: healthcare workers understand clinical protocols, drug markups, and physician incentives
  - But the measure conflates multiple distinct types of knowledge:
- **Three distinct components are bundled together:**
  - General medical knowledge: understanding treatment options and efficacy
  - Institutional knowledge: knowing how hospital reimbursement works and what doctors respond to
  - Navigational knowledge: knowing how to advocate, seek second opinions, and access better care

Is "Insider Knowledge" Really Knowledge?

- **The paper proxies insider knowledge through healthcare employment**
  - Plausible: healthcare workers understand clinical protocols, drug markups, and physician incentives
  - But the measure conflates multiple distinct types of knowledge:
- **Three distinct components are bundled together:**
  - General medical knowledge: understanding treatment options and efficacy
  - Institutional knowledge: knowing how hospital reimbursement works and what doctors respond to
  - Navigational knowledge: knowing how to advocate, seek second opinions, and access better care
- **Policy implications differ substantially across these:**
  - Medical knowledge $\rightarrow$ patient education programs
  - Institutional knowledge $\rightarrow$ transparency reforms
  - Navigational knowledge $\rightarrow$ patient advocates or care coordinators
  - Can the data help distinguish these? E.g., does specialty match between the patient's field and condition matter?

Who Is the Benchmark? The Welfare Interpretation

- **The paper implicitly treats same-hospital high-rank insiders as receiving "first-best" care**
  - Non-insiders receive excessive surgeries, excessive costs, and no better outcomes
  - This frames the problem as non-insiders being *over-treated*

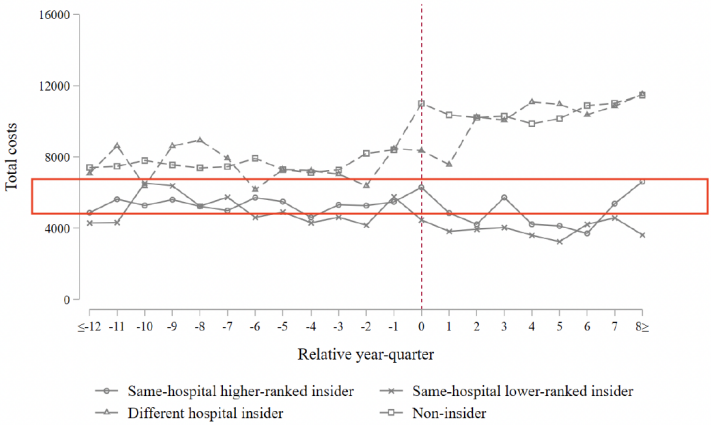
Who Is the Benchmark? The Welfare Interpretation

- **The paper implicitly treats same-hospital high-rank insiders as receiving "first-best" care**
  - Non-insiders receive excessive surgeries, excessive costs, and no better outcomes
  - This frames the problem as non-insiders being *over-treated*
- **But consider an alternative interpretation:**
  - What if high-rank insiders are *under-treated* relative to the first-best?
  - The paper shows that high-rank patients' care is essentially *unaffected* by ZMDP (Figure B3) – but is this level of care efficient?

Who Is the Benchmark? The Welfare Interpretation

- **The paper implicitly treats same-hospital high-rank insiders as receiving "first-best" care**
  - Non-insiders receive excessive surgeries, excessive costs, and no better outcomes
  - This frames the problem as non-insiders being *over-treated*
- **But consider an alternative interpretation:**
  - What if high-rank insiders are *under-treated* relative to the first-best?
  - The paper shows that high-rank patients' care is essentially *unaffected* by ZMDP (Figure B3) – but is this level of care efficient?
- **A test that could help:**
  - Compare health outcomes of insider vs. non-insider patients, *conditional on the same diagnosis severity*
  - If insiders have better long-run outcomes, this supports the over-treatment of non-insiders
  - If insiders have similar or worse outcomes, the benchmark may not be first-best
  - Longer-run outcomes (90-day/1-year) would strengthen the welfare claim

Evidence: Learning from Experience



(e) Total costs

The Model: Does the Binary Structure Miss the Action?

- **The model's key assumption: non-insiders are fully passive**
  - Insiders: Bayesian, skeptical, face obedience constraint $\rightarrow$ limits physician distortion
  - Non-insiders: follow recommendations without updating $\rightarrow$ maximal distortion
  - This binary generates clean predictions, but the data suggest a richer story

The Model: Does the Binary Structure Miss the Action?

- **The model's key assumption: non-insiders are fully passive**
  - Insiders: Bayesian, skeptical, face obedience constraint $\rightarrow$ limits physician distortion
  - Non-insiders: follow recommendations without updating $\rightarrow$ maximal distortion
  - This binary generates clean predictions, but the data suggest a richer story
- **Table B7 reveals a continuous sophistication gradient**
  - Non-insiders with repeated hospitalizations *converge* toward different-hospital insiders
  - Cost gap shrinks from 1,123 CNY to 206 CNY with experience
  - This is learning – patients move along a sophistication continuum, not across a binary threshold

The Model: Does the Binary Structure Miss the Action?

- **The model's key assumption: non-insiders are fully passive**
  - Insiders: Bayesian, skeptical, face obedience constraint → limits physician distortion
  - Non-insiders: follow recommendations without updating → maximal distortion
  - This binary generates clean predictions, but the data suggest a richer story
- **Table B7 reveals a continuous sophistication gradient**
  - Non-insiders with repeated hospitalizations *converge* toward different-hospital insiders
  - Cost gap shrinks from 1,123 CNY to 206 CNY with experience
  - This is learning – patients move along a sophistication continuum, not across a binary threshold
- **What would a continuous-type model buy you?**
  - Predicts *how much* experience is needed to close the gap – directly policy-relevant
  - Connects to the education heterogeneity: more educated non-insiders may already be "partially sophisticated"
  - Testable implication: physician distortion should decline monotonically in patient education/experience, not jump discretely at the insider boundary

Evidence: Convergence with Repeated Visits

Table B7: Mechanisms: Public Hospitals, Two-Group Comparisons with Individual Fixed Effects

	(1)	(2)	(3)	(4)	(5)
		No. of services			Costs
	Unique drugs	Surgeries	Diagnostic tests	Imaging tests	Total costs
	Panel A. Non-insider vs. Different hospital insider				
Non-insider*ZMDP	-3.15***	0.09	3.33**	2.11	206.03
	(0.38)	(0.09)	(1.28)	(3.31)	(523.52)
Observations	62,119	62,119	62,119	62,119	62,119
Mean of Y (Pre-ZMDP)	10.01	0.219	21.01	13.02	6705
	Panel B. Different hospital insider vs. Same hospital insider				
Diff hospital*ZMDP	-1.42**	0.24	3.77**	5.23	1,287.54**
	(0.68)	(0.18)	(1.72)	(4.14)	(585.91)
Observations	1,691	1,691	1,691	1,691	1,691
Mean of Y (Pre-ZMDP)	7.886	0.264	19.43	11.66	5368
	Panel C. Same hospital lower-ranked insider vs. Same hospital higher-ranked insider				
Same hospital-low rank*ZMDP	-0.61	0.01	-0.70	-1.44	-601.60
	(1.05)	(0.09)	(1.45)	(1.15)	(722.48)
Observations	927	927	927	927	927
Mean of Y (Pre-ZMDP)	6.814	0.146	18.67	8.623	4442

Broader Thoughts: External Validity and Information Design

- **The mechanisms are universal, but the magnitudes depend on institutional context**
  - US: physician-patients receive different care (Johnson & Rehavi 2016)
  - China amplifiers: fee-for-service + drug markup, public hospital dominance, rank culture
  - The rank ordering (knowledge $\approx$ ties $\gg$ rank) is the portable finding; the 28.9% magnitude is context-specific

Broader Thoughts: External Validity and Information Design

- **The mechanisms are universal, but the magnitudes depend on institutional context**
  - US: physician-patients receive different care (Johnson & Rehavi 2016)
  - China amplifiers: fee-for-service + drug markup, public hospital dominance, rank culture
  - The rank ordering (knowledge $\approx$ ties $\gg$ rank) is the portable finding; the 28.9% magnitude is context-specific
- **A shared insight from the information design literature**
  - This paper shows that **patient type** constrains physician distortion
  - Complementary work on source credibility (Wei 2026) shows that **patient trust** determines information uptake
  - Takeaway: Both imply that the receiver's characteristics are a first-order determinant of healthcare efficiency

Policy Implications: What the Data Already Tell Us

- **The repeated-hospitalization result (Table B7) is itself a policy finding**
  - Non-insiders who return close the knowledge gap (cost diff: 1,123 $\rightarrow$ 206 CNY)
  - But social ties gap *persists* (890 $\rightarrow$ 1,288 CNY) – ties cannot be "learned"
  - Implication: knowledge-based interventions can work; tie-based ones require structural reform

Policy Implications: What the Data Already Tell Us

- **The repeated-hospitalization result (Table B7) is itself a policy finding**
  - Non-insiders who return close the knowledge gap (cost diff: 1,123 $\rightarrow$ 206 CNY)
  - But social ties gap *persists* (890 $\rightarrow$ 1,288 CNY) – ties cannot be "learned"
  - Implication: knowledge-based interventions can work; tie-based ones require structural reform
- **A concrete, testable policy lever from this finding:**
  - If one hospitalization teaches patients enough to close the knowledge gap, can we *simulate* that experience upfront?
  - Structured pre-admission briefings: "here is what your doctor's incentives look like, here is what insiders typically receive for your condition"
  - This directly targets institutional knowledge – the component the data show is learnable

Minor Quibbles

- **Orthopedics as the primary setting**
  - Chosen for high physician discretion – plausible
  - But orthopedic patients skew older and female: does the insider effect generalize to conditions with different demographic profiles
  - Appendix robustness across other diseases is reassuring, but the magnitudes vary

Minor Quibbles

- **Orthopedics as the primary setting**
  - Chosen for high physician discretion – plausible
  - But orthopedic patients skew older and female: does the insider effect generalize to conditions with different demographic profiles
  - Appendix robustness across other diseases is reassuring, but the magnitudes vary
- **Social ties measure relies on same-hospital employment**
  - Two physicians at the same large Tier-3 hospital may have very weak ties
  - Department-level or co-authorship-based tie measures (if available) could sharpen identification

Summary of Comments

- **A compelling paper with clean identification and important findings**

Summary of Comments

- **A compelling paper with clean identification and important findings**
- **Main suggestions:**
  - Decompose "insider knowledge" into medical, institutional, and navigational components if data allow
  - Establish welfare interpretation more firmly with longer-run health outcomes
  - The repeated-hospitalization convergence empirically motivates a continuous-type model and directly suggests a policy intervention (pre-admission briefings)

Summary of Comments

- **A compelling paper with clean identification and important findings**
- **Main suggestions:**
  - Decompose "insider knowledge" into medical, institutional, and navigational components if data allow
  - Establish welfare interpretation more firmly with longer-run health outcomes
  - The repeated-hospitalization convergence empirically motivates a continuous-type model and directly suggests a policy intervention (pre-admission briefings)
- **Broader significance:**
  - Clear policy target: raising the floor of patient sophistication through structured information interventions
  - The sequential decomposition of privilege channels is a methodological contribution applicable well beyond this setting

Thank You

Zincy Wei
Northwestern University
zixin.wei@kellogg.northwestern.edu