Conditional Cash Transfer Schemes and Global Health: *strengths and challenges*

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Objectives:

To argue that conditionality works above and beyond simple cash transfers

... but we need to use conditionality more effectively.

Greater health sector involvement is critical to the next stage of CCTS development.

Services go unused by those who most need them ...

↓ costs	↑ benefits
opportunity costs travel costs co-payments disdain	wellbeing knowledge self-esteem social participation

... a financial incentive scheme is one solution to that problem

Cash transfers enable poor households to better manage risk and vulnerability and contribute to pro-poor growth

…by safety-netting risk taking

…by sterilising shocks

…by promoting positive social norms

…and supporting human capital development

Conditionality works: simulated data

Mexico:
pure income transfer associated with an increase in schooling of about 20% of the conditioned-programme[1]

Africa:
cash transfer without conditionality would not lead to any substantial increase in school attendance[2]

Brazil:
parental choices around children's schooling and labour in a non-conditional scheme were almost unchanged from those where the scheme did not exist[3]

1. Todd P, Wolpin K. Using a Social Experiment to Validate a Dynamic Behavioral Model of Child Schooling and Fertility: Assessing the Impact of a School Subsidy Program in Mexico. 2003. Penn Institute for Economic Research. PIER Working Paper No. 03-022.

2. Kakwani N, Soares F, Son H. Conditional cash transfers in African countries. 2005. International Policy Centre for Inclusive Growth

3. Bourgignon F, Ferreira FHG, Leite PG. Conditional Cash Transfers, Schooling and Child Labor : Micro-Simulating Bolsa Escola. 2007. DELTA (Ecole normale supérieure). DELTA Working Papers 2003-07.

Conditionality: observational data

Mexico: unmonitored children 21% less likely to continue to secondary school than children from monitored households[1]

Ecuador: households believing the CTS to be non-conditional showed no increase in school attendance, compared to 7-13% increase in other households[2]

Cambodia: school enrolment only increases for children to whom conditionality is applied, but not their siblings[3]

Zambia: in pilots of unconditional schemes, school attendance does not increase except in the scheme where soft conditions are applied [4]

1. de Brauw A, Hoddinott J. Must conditional cash transfer programs be conditioned to be effective? 2008. International Food Policy Research Institute.

2. Schady N, Araujo M. Cash Transfers, conditions and school enrollment in Ecuador. Economia 2009; 8(2):43-70.

3. Filmer D, Schady N. Who Benefits? Scholarships, school enrollments and work of recipients and their siblings. 2009. Unpublished manuscript, The World Bank, Washington D.C -07.

4. Tembo G, Freeland N. Social Cash Transfers in Zambia: what is their impact? 2009. International Policy Centre for Inclusive Growth. One Pager, no. 91.

Nevertheless, some CCTS effects are weak or inconsistent ...

Colombia

7% relative reduction in stunting for children under 2; no impact on the nutritional status of children older than 24 months, or on the weight of newborns in rural areas.

Attanasio O et al. The short-term impact of a conditional cash subsidy on child health and nutrition in Colombia, December 2005. *The Institute of Fiscal Studies.*

Brazil

No effect on height-for-age measures impact on weight-for-age for children and even a negative younger than 7 years.

Morris SS et al. Conditional cash transfers are associated with a small reduction in the rate of weight gain of preschool children in northeast Brazil. *J Nutr.* 2004;134 (9):2336-2341.

Mexico

Children aged 12 to 36 months after 1 year of exposure to the Mexico program (in September 1999) were 0.96 cm taller than children from control areas. However, it did not affect their probability of being stunted.

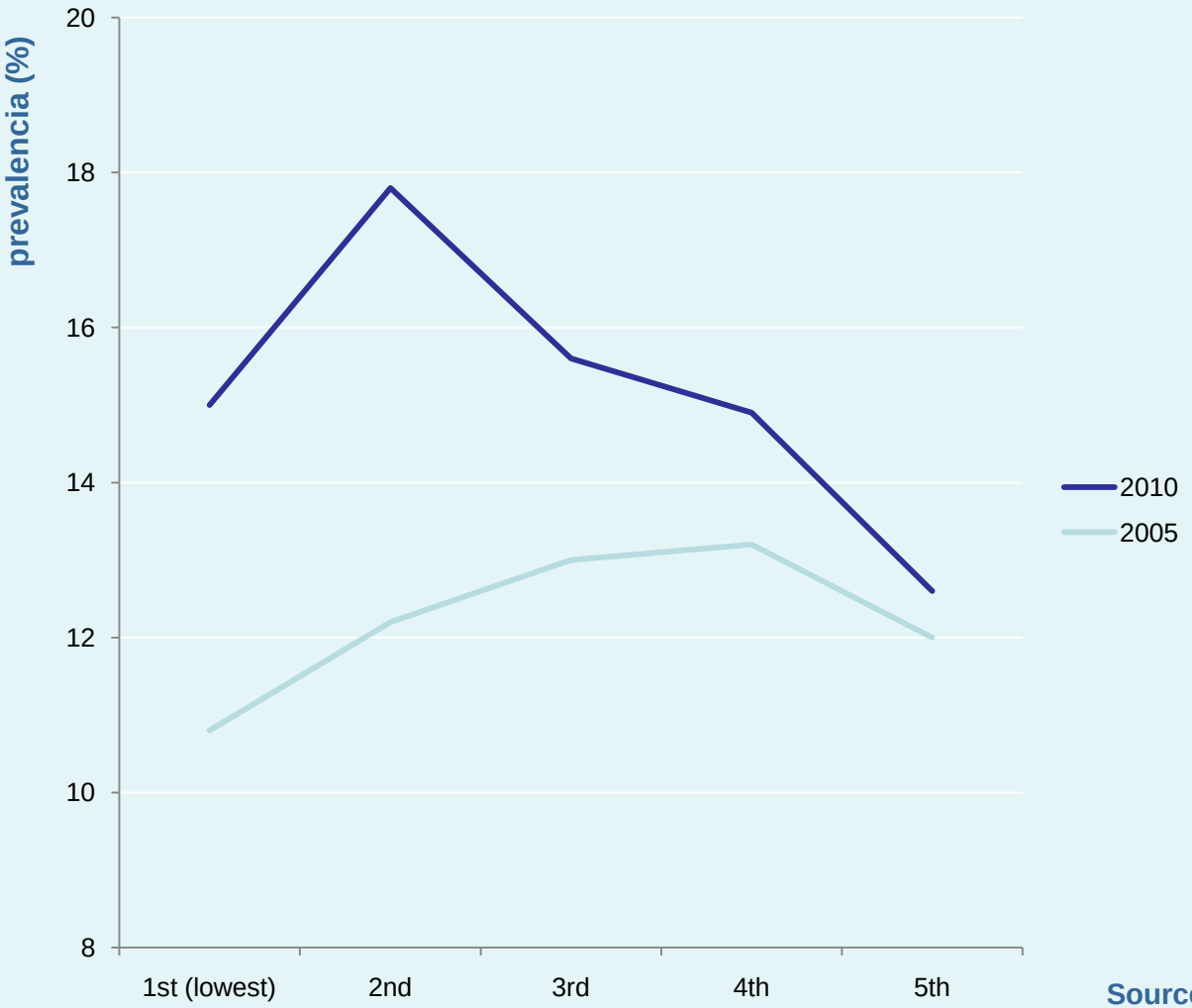
Gertler P et al. Do conditional cash transfers improve child health? evidence from PROGRESA's control randomized experiment. *Am Econ Rev.* 2004;94(2):336-341.

Nicaragua

Net mean improvement of the height-for-age z-score by 0.17) and the proportion of underweight children aged 0 to 5 years (a net impact of 6 percentage points after 2 years).

Maluccio JA et al. Impact evaluation of a conditional cash transfer program: the Nicaraguan *Red de Proteccion Social*. Washington, DC: *International Food Policy Research Institute; 2004.*

Obesity affects poor Colombian women more often



Sources: ENDS 2005, 2010

... and CCTS are partly driving the problem

	Control	Treatment	*Diff. across groups*
Baseline	**25.40** (25.13, 25.66)	**25.11** (24.83, 25.39)	**-0.29**
Follow-up	**26.05** (25.78, 26.33)	**26.11** (25.81, 26.42)	**0.06**
Difference over time	**0.66**	**1.01**	**0.35**

Crude BMI (95% CI) **and double-difference**

	Control	Treatment	*Diff. across groups*
Baseline	**14.4** (12.2, 16.6)	**10.5** (8.2, 12.8)	**-3.9**
Follow-up	**17.1** (14.8, 19.5)	**17.1** (14.3, 19.9)	**-0.0**
Difference over time	**2.7**	**6.6**	**3.9**

Crude prevalence (%) of obesity (95% CI) **and double-difference**

The Colombian CCTS is associated with abnormal weight gain in women and girls

	Women			Girls			Boys		
	β/OR	SE	p	β/OR	SE	p	β/OR	SE	p
BMI / BMIZ	**0.31**	0.12	0.01	**0.14**	0.06	0.03	**0.18**	0.05	<0.001
Odds of overweight or obesity	**1.10**	0.09	0.24	**2.36**	0.60	<0.001	**1.03**	0.20	0.87
Odds of obesity	**1.35**	0.17	0.02	**0.59**	0.35	0.37	**1.53**	0.74	0.38

Forde I, Chandola T, Marmot MG, Attanasio O, Cash transfers to poor women in Colombia are associated with increasing BMI and obesity (2011).

Women in Colombia's CCTS attend seminars more often ...

	Control	Treatment	*Diff. across groups*
Baseline	**0.93** (0.88, 0.99)	**0.95** (0.88, 1.01)	**0.01**
Follow-up	**0.84** (0.77, 0.90)	**2.23** (2.10, 2.36)	**1.39**
Difference over time	**-0.10**	**1.28**	**1.38**

Crude reported seminar attendance (95% CI) **and double-difference**

. . . but do not gain any healthcare knowledge as a result

	Control	Treatment	*Diff. across groups*
Baseline	**2.25** (2.21, 2.29)	**2.33** (2.28, 2.38)	**0.08**
Follow-up	**2.35** (2.31, 2.39)	**2.31** (2.25, 2.36)	**-0.05**
Difference over time	**0.10**	**-0.02**	**-0.13**

Crude healthcare knowledge score (95% CI) **and double-difference**

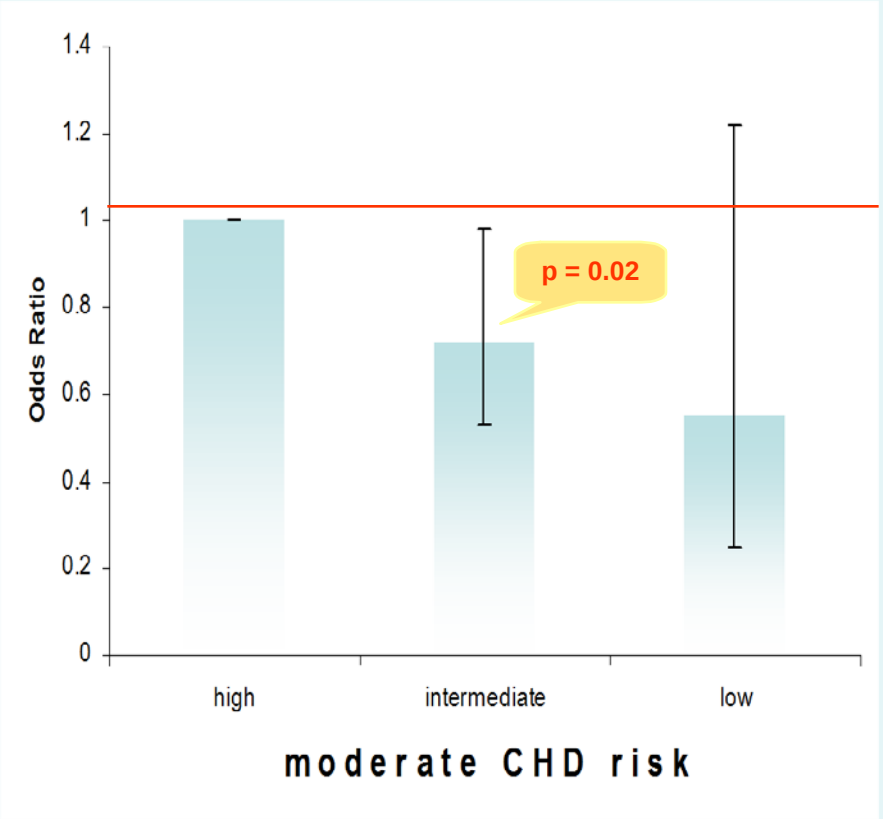
Other factors determine knowledge gain:

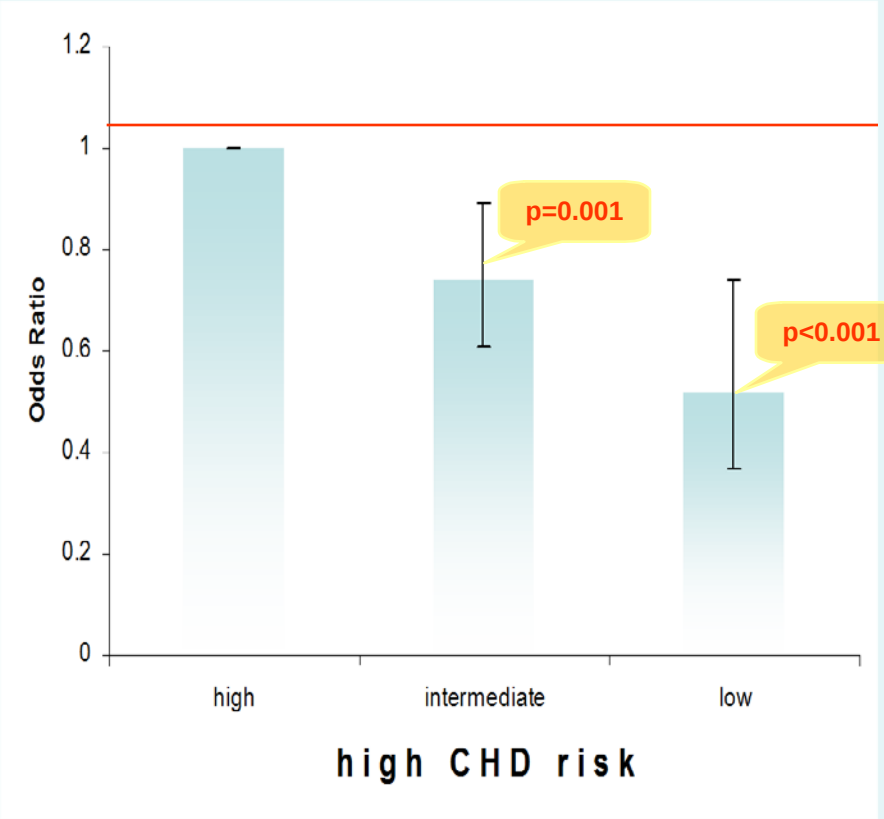
	β	S.E.	p
programme effect	**-0.15**	0.10	0.16
primary education complete	**0.27**	0.04	<0.001
secondary education complete	**0.60**	0.09	<0.001
further education	**0.57**	0.17	<0.001
literate	**0.38**	0.06	<0.001
number of children	**0.02**	0.01	0.04
age	**-0.01**	0.00	<0.001

Forde I, Chandola T, Marmot MG, Attanasio O, **Mandated attendance at parenting workshops improves women's healthcare knowledge but may widen health inequities in low and middle income countries** *J Epidemiol Community Health* 2010; doi:10.1136/jech.2010.120477.63).

Recall of CHD risk by employment grade:

odds ratios (95% CI), adj. age, sex and cognitive score





Forde I et al. Socioeconomic and ethnic differences in use of lipid-lowering drugs after deregulation of simvastatin in the UK: The Whitehall II prospective cohort study. *Atherosclerosis* Volume 215, Issue 1 , Pages 223-228, March 2011

Those most at risk and with the worst outcomes have the poorest personal health awareness

Possible drivers:

Those of lower socioeconomic position

…are frustrated in their attempts to engage with personal health information[1,2]

…are less willing to engage with personal health information[3,4]

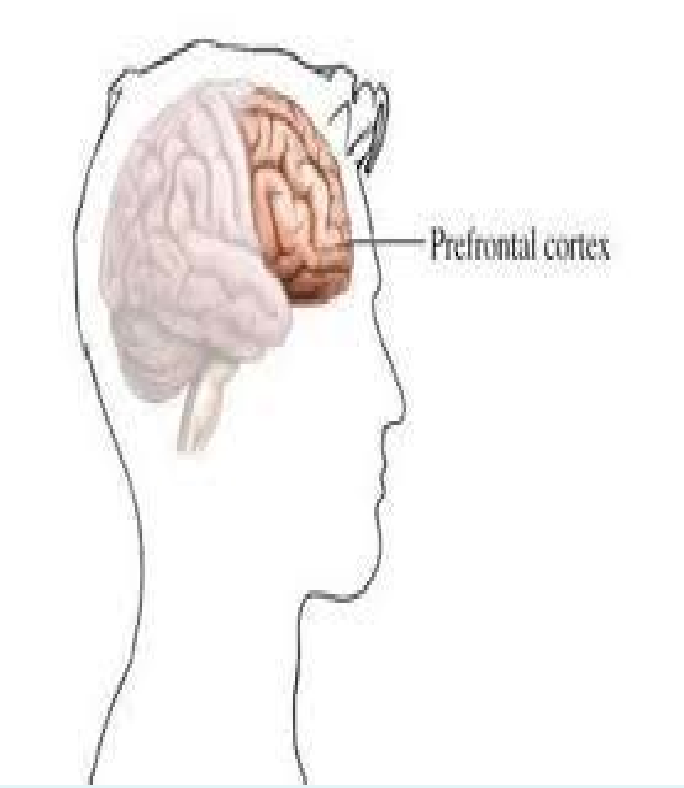
1. Schouten BC, Meeuwesen L. Cultural differences in medical communication: a review of the literature. Pt Educ Couns 2006; 64(1-3):21-34.

2. Willems S et al. Socio-economic status of the patient and doctor-patient communication: does it make a difference? Pt Educ Couns 2005; 56(2):139-146.

3. Wardle J, Steptoe A. Socioeconomic differences in attitudes and beliefs about healthy lifestyles. J Epi Cmty Health 2003; 57(6):440-443.

4. Lindbladh E, Hampus Lyttkens C. Polarization in the reaction to health-risk information: a question of social position? Risk Analysis 2003; 23(4):841-855.

An impulsive cognitive style is more common in lower socioeconomic groups and may limit knowledge gain

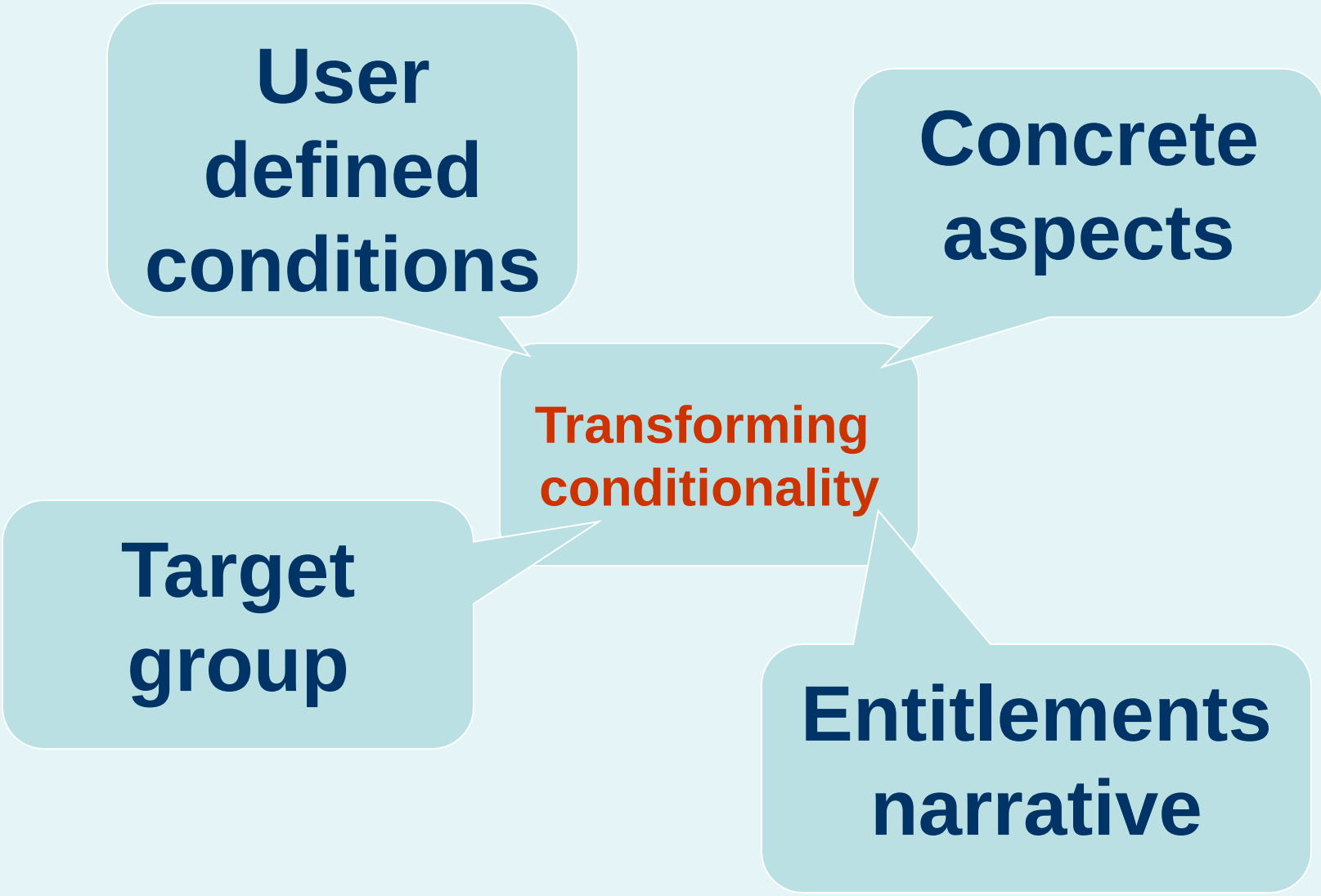


Early socioeconomic disadvantage predicts later adult impairments in several cognitive functions and forms of impulsive decision-making.

Kaplan, G. A., et al. Childhood socioeconomic position and cognitive function in adulthood. *International Journal of Epidemiology, 30*, 256-263 (2001).

Adults from lower parental educational backgrounds exhibit reduced functional connections between the prefrontal cortex and a region implicated in impulse-control.

Gianaros et al., Parental education predicts corticostriatal functionality in adulthood. *Cerebral Cortex*; 21(4):896-910 (2010).


User defined conditions
Concrete aspects
Transforming conditionality
Target group
Entitlements narrative

The conditions:

replace with entitlements?

	Conditionality	Entitlements
Problem	Low service uptake exists because of a variety of barriers – lack of information, hidden costs, derogatory staff etc.	Low service uptake exists because of a single barrier – lack of information.
Solution	Offer a financial reward conditional upon taking up the service.	Publicize, enforce and enshrine the entitlement.
Possible Consequences	Response may be easier to predict Response may be more equitable	Transfers resources *and* power Response may be more sustainable Service quality improvement

There are strong arguments in favour of the health sector becoming more involved in cash transfer schemes.

- cash transfers beneficially impact a range of health outcomes and wider determinants of health
- cash transfers have potentially significant impacts on access to health systems and
- there are aspects of scheme design implementation that the health sector is well placed to assist

Risks of greater health sector involvement

- uncertainty regarding ethics or desirability of conditionality;
- disinterest in wider determinants of health;
- fear of ‘mission creep’;
- dislike of the overt politicisation typical of CCTS;
- aversion to simple solutions.

We should support colleagues in the welfare sector by:

- **advocating cash transfer schemes as a concrete policy option** in pursuit of health, health equity and action on the social determinants of health

- **building partnerships and become an active stakeholder** alongside colleagues from development, welfare and education sectors, offering technical advice and support around the design, funding, implementation and evaluation of cash transfer schemes, where requested

- **assisting in the mobilization of resources** to support cash transfer schemes in partnership with national and international partners, within the UN system and elsewhere.

THANK YOU

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