Conditional Cash Transfers: Origin, Benefits & Lessons

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What are Conditional Cash transfers?

- Provide cash transfers to poor households contingent on their complying with defined education and health consumption
  - Need to be well targeted
  - Effectively administered and performance systematically monitored in initial programs in Middle Income Countries
  - Specific consumption and program designs differ significantly across countries

Political economy important

- Welfare more politically palatable if beneficiaries asked to do something that leads to improved behaviors
- Economic rationale: information and access to services that are under-consumed (merit good); altruism
- Evaluation results drove pubic policy and overcame politics

CCT Pioneers

- Launched first in Brazil – *Bolsa Escola -> Bolsa Familia*
- Adapted in Mexico as *Progresa (Oportunidades*) where
- Large RCT evaluation demonstrated impact of the program and led to hundreds of studies – and evaluations of other CCT programs
- Expanded to much of Latin America and the Caribbean with variations
- Now moving to lower income regions

Objective of CCTs

- Break the generational cycle of poverty through short term poverty relief and investments in human capital to address long term poverty
- Addressed low demand for education and preventive health care
- Attempted to offer an alternative to out of pocket payments in health care (in Mexico represented 50% of out of pocket payments)

Characteristics of CCTs in Latin America

- Paternalistic: opt out only if want to give up cash transfer
- Strong emphasis on behavioral incentives for consumers – rare in developing countries
- Focus traditionally on supply: if it's free there must be demand. After all the target population is poor.
- Provider incentives equally rare and a problem
- Extended to multiple contexts to incentivize desired behaviors – girls in school

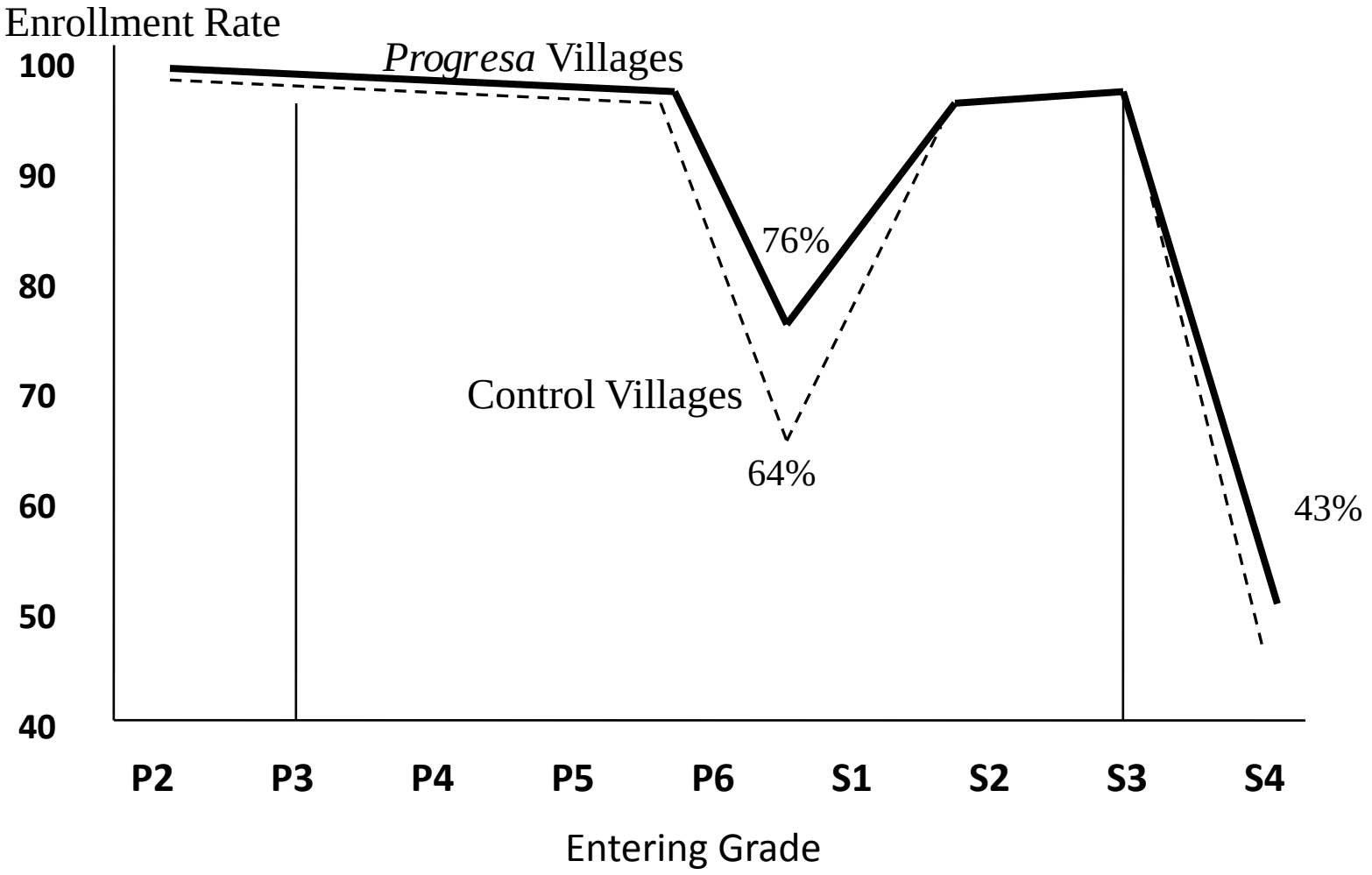
Characteristics of CCTs and Health

- Program defined health package: well baby care, growth monitoring, preventive health visits, nutritional supplements, early childhood development interventions, annual adult physicals, good parenting classes
- Service consumption requirements not always well designed: talks on adults health
- Have been extended to attempts to alter behavior to prevent HIV infections

Impacts of CCTs in Latin America

- Poverty reduced
- Strengthened administration especially of social assistance/welfare programs
- Transfers made to women who improved food expenditures in quantity and quality
- Increased use of public health services
- Nutrition programs improved child nutrition (height-for-age, hemoglobin status) in some programs

Mexico has had some success in education under its *Progresa/Oportunidades* program, 1998



Note: Progresa intervention starts in the third year of primary and ends after the third year of secondary. P = primary, S = secondary.
Source: De Janvry and Sadoulet 2004

Challenges in health CCTs

- Rights and privacy are not part of the approach
- Information isn't enough – is experience?
- Populism an unfortunate form of politicization (eg. adding permanent enrollees during crises)
- Long term dependency a concern
- Supply constraints are severe, even in LAC:
  - Poor quality of supply plagued by absenteeism, shortages of inputs and drugs, and low patient satisfaction
  - Inadequate health care supply limits participation

Challenges in low income countries

- Is it affordable given limited budgets for health care – CCTs meant financing services and paying households to consume them
- What are the opportunity costs of CCTs?
- Is monitoring and MIS affordable and feasible?
- Can administration reach minimally acceptable levels?
- Are CCTs at odds with cost containment objectives in health care. Does it create a culture of overconsumption?

My colleagues will fill in the gaps

Thank you