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PUBLIC HEALTH AGENCIES AND CASH TRANSFER PROGRAMMES: MAKING THE CASE FOR GREATER INVOLVEMENT

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PUBLIC HEALTH AGENCIES AND CASH TRANSFER PROGRAMMES: MAKING THE CASE FOR GREATER INVOLVEMENT

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Contents

Executive Summary

This report examines the case for greater involvement by public health agencies in cash transfer schemes, a form of welfare assistance. It seeks to identify opportunities, obstacles and actions that might support greater involvement.

The issue arises because cash transfer schemes are an increasingly common form of welfare assistance across the world. Health gain is an explicit objective of such schemes, yet the public health community to date have largely been passive observers rather than active participants.

The first part of the report describes the schemes, sets them in historical context and considers the mechanisms through which they might affect health outcomes. It concludes that there are good theoretical reasons why cash transfers might be expected to improve health.

The second part of the report critically examines the evidence surrounding cash transfer schemes. It finds that cash transfers beneficially impact a range of health outcomes and broader determinants of health. Furthermore, it finds that cash transfers have potentially significant impacts on access to health systems and that there are aspects of scheme design and implementation that the health sector is well placed to assist. Together, these constitute a compelling argument that public health agencies should develop more substantive engagement with cash transfer schemes.

Part three of the report seeks to identify concrete opportunities, obstacles and actions for greater involvement in these schemes. It recommends that public health agencies assist in advocating cash transfer schemes as a priority consideration in country level plans for social policy and makes further specific recommendations for action by national and international public health agencies.

Introduction

The aim of this paper is to examine the extent to which cash transfer (CT) schemes to low-income households contribute to public health objectives and to argue for greater involvement, if appropriate, by public health agencies in the design and operation of CT schemes. The issue is both timely and important: cash transfers are increasingly capturing the attention of policy-makers and funders, particularly in low- and middle-income countries.

Most CT schemes are 'owned', intellectually and operationally, by economists working outside of the health sector, for example, in the development, welfare and labour sectors. Despite health gain being an explicit objective of almost every scheme and heavy reliance on the health system to achieve programme objectives, the health sector has had little substantive engagement with the operation or design of CT schemes to date. It is an appropriate moment to reassess whether this relative lack of engagement is desirable or appropriate, both from the health sector's point of view and the perspective of the schemes and their beneficiaries.

'Public health agencies' or 'public health objectives' are defined broadly to include all those that work within, have an interest in, or are relevant to the planning, delivery, research and evaluation of health services, whether at the systems level or at patient point-of-contact. The terms are used to convey a deliberately general notion of 'the health sector', with which they are used interchangeably.

The first part of the paper defines cash transfer schemes, sets them in context and discusses the mechanisms through which they secure health and welfare gains. The second part makes the case for greater public health involvement, critically reviewing the evidence around their impact on health and health systems. Design and implementation questions are considered, paying particular attention to questions of conditionality, targeting and fit with other social policy. The third part of the paper recommends concrete roles that public health agencies might adopt in relation to CT schemes. It considers some institutional risks posed by involvement and opportunities presented by current health sector initiatives.

Methods

A scoping literature review around CT schemes was undertaken. Systematic literature reviews of CT schemes exist. The objective was not to repeat these, but rather to understand how CT schemes have evolved and currently operate, gather evidence of their impact on health and social determinants of health, and identify areas where critical discussion of their evolution and operation, or the empirical evidence base, say little. The search strategy is given in Appendix 1.

Additionally, information and professional views were sought from experts and other interested parties, as listed in the acknowledgements.

Part I: defining and explaining cash transfer schemes

What are cash transfers?

Cash transfers are regular, predictable amounts of money given to households and individuals by governmental or nongovernmental agencies. Pensions, child benefits, disability benefits and regular household grants are the most common types of transfer and may be universally available or targeted towards households with fewest resources. Some cash transfers are made conditional upon compliance by the recipient with certain behavioural requirements, typically specified by the agency distributing the funds. Such 'conditional cash transfers' raise particular theoretical and pragmatic challenges, discussed in detail later, as are the issues raised by targeting.

This paper does not consider cash transfers made in emergency or disaster relief settings, remittances sent home by family members living abroad or financial incentives offered to comply with discrete health behaviours such as treatment compliance or weight loss.

Historical context

Historically, cash transfers have featured little in low- and middle-income country policy. Governments and donors typically preferred supply-side interventions (addressing the quality and accessibility of schools, hospitals or other public services) or in-kind transfers of goods or food. This contrasts sharply with high-income countries, where transfers, such as universal child benefits and state pensions, are often the norm.

Since the economic collapse of the late 1990s, a shift away from the neo-liberal Washington consensus of the 1980s, which was characterized by the dismantling of state services and replacement with segmented private services (often with user fees), has occurred. Draibe and Riesco write of the emergence of a new development strategy, which repositions the state as a leading actor and renews a commitment to both the urban poor and rural peasants.[1] Welfare models in the developing world now more closely resemble European models than previously. Increasingly, they are characterized by higher levels of social insurance and an emphasis on minimum standards and on security, rather than social assistance as an option of last resort. This has coincided with a desire to foster human capital more directly and correct some of the institutional shortcomings typical of previous interactions with low-income households.[2]

> *"Cash transfers (CTs) are regular, predictable amounts of money given to households and individuals such as pensions or child benefits. They are well established in many high-income countries."*

Part of this shift included experimentation with CT schemes. The policy of trying conditional CT schemes arose in response to the deep economic recessions seen in Latin America in the 1980s, intensified by the Mexican and Asian crises of 1995 and 1997. Municipalities in Brazil began experimenting with conditional welfare in 1995;[3]

Progresa[*], the first nationwide conditional CT scheme, began in Mexico in 1997 and served as the prototype for schemes which rapidly replicated across Latin America, Jamaica, Kenya, Macedonia, Pakistan, South Africa, Turkey and elsewhere.[4] More recently, conditional CT schemes have been developed for high-income settings such as New York City[5] and are likely to become more prevalent in the future. For example, the United Kingdom has also announced a pilot scheme.[6]

There are a number of theoretical arguments why cash transfers to low-income households are a good policy option to secure welfare and development objectives. These are set out in the next section. Appendix 3 illustrates the specific policy content of a number of different CT schemes.

How might cash transfers improve health and welfare?

Cash transfers aim to support low-income communities in managing risk and vulnerability and to contribute to economic growth favouring the worst-off. Several mechanisms might deliver this. First, the risk-averse attitude of low-income households is well recognized. Because of a scarcity of resources, such households rationally choose to minimize their exposure to environmental, economic and social risks, where possible. This frequently implies, however, that they forego economically more profitable opportunities. Planting reliable but low-yield crops is an example. The Organization for Economic Cooperation and Development (OECD) refers to this necessarily dysfunctional management of risk as a "major brake on human and economic development".[7] Furthermore, the experience of economic shocks often forces impoverished households to make decisions which satisfy immediate survival needs at the expense of future income. Examples of such decisions include the sale of land and livestock, or the withdrawal of children from school; these may permanently and irreversibly weaken the household's ability to prosper. Resource transfers can relax some of the constraints households face around managing risk and enable them to manage response to shocks more effectively.

Second, resource transfers can promote positive social norms. It is known that transfers made to women increase their status and self-esteem, as shown, for example, by shifts in decision-making power within the household[4]. Furthermore, those resources are more likely to be spent on children's schooling and nutritious food, than if transferred to men.[4,7] The OECD also notes that transfers alongside other elements of social protection can contribute to building social cohesion and a sense of citizenship.[7]

Third, transfers can support human capital development by encouraging greater use of public services if accompanied by information on good ways of investing the extra resource (sometimes referred to as "social marketing") or, as mentioned above, by conditions which specify actions with which the beneficiary must comply to receive the transfer. These most commonly include enrolment in primary and secondary education, completion of primary immunization schedules and adherence to programmes of antenatal and well-child care.

> *"Giving poor households regular cash has the potential to contribute significantly toward several health sector objectives, particularly around primary care, maternal and child health and health equity."*

All of these mechanisms can translate into short- and long-term health gains, as shown in Appendix 2, a schematic representation of CT mechanisms and effects.

It is evident, therefore, that transferring resources directly to the poor has the potential to contribute significantly toward, and align with, several public health priorities, particularly around primary care, maternal and child health, and health equity.

* *Progresa* was renamed *Oportunidades* in 2002. For consistency across the evidence presented in this discussion paper, it is referred to as *Progresa* throughout.

Comparison with in-kind transfers

Although transferring cash has hitherto been an unpopular policy option (perhaps because of a pejorative view that it is unwise to allow welfare recipients complete freedom in their consumption choices), there are several reasons why cash transfers might be preferred over in-kind transfers of goods or food. Most evidently, cash allows the recipient autonomy to decide how best they can consume and invest, with the concomitant dignity that this implies. Cash is more easily distributed and collected than bulky goods, with evidence that it is no more prone to losses from corruption or street theft than commodity transfers.[8] Cash is also likely to stimulate local markets, rather than suppress them as might in-kind transfers, and have multiplier effects throughout the local economy.

Equally though, one must note a set of concerns. If a policy has a particular objective, to increase preventive care or improve nutrition for example, this may be less reliably met through cash transfers than through transfers of supplements or vouchers. Cash may be more difficult to target, since it is likely to have a greater appeal to the wealthy than in-kind transfers, and may be doubly regressive if it creates an inflationary drive on local markets. Nor should one lose sight of concerns around mis-spending, criminal diversion or institutional values-based reluctance to distribute cash, as noted above.

Summary

Cash transfers are regular, predictable amounts of money given to households, most often the worst-off. They might be expected to improve health outcomes through several mechanisms such as enabling recipients to better manage risk, contributing to economic growth, building social cohesion and supporting human capital development through greater use of health and education services.

The next section examines the evidence on whether CT schemes achieve these aims.

Part II: making the case for greater public health involvement

Despite the fact that health gain is an explicit objective of all CT schemes, intellectual and operational 'ownership' of the schemes has thus far been dominated by economists beyond the health sector. It appears that the public health community has failed to engage substantively with the opportunities and issues raised by CT schemes. For example, in over 400 documents referenced in a recent evidence review of conditional CT schemes, only 15 were from public health, medical or nutritional institutions and journals.[4] Several reasons may lay behind this. First, health practitioners may view cash transfers as primarily a tool for poverty reduction, thus peripheral to their expertise and core concern and better left to other agencies. This is likely to be linked to the continued dominance of the biomedical model of health and disease in public health practice. Second, some nervousness may be felt around involvement in schemes that in some cases advocate conditionality and in most cases carry heavy political branding. Finally, there may simply be distaste at the notion of distributing cash to the poor, rather than something more under the control of planners and bureaucrats.[8]

Nevertheless, there are at least three good reasons why the public health community should get more involved with CT schemes:

1. the evidence shows that they yield clear returns for health;
2. CT schemes have significant impacts on health systems;
3. the health sector has particular expertise that could benefit CT schemes as they continue to evolve.

Investing in cash transfers yields clear returns for health

The following summary brings together some of the findings of national CT programme evaluations. Where evidence exists, particular reference is made to distributional and equity effects.

Health outcomes

Maternal and childhood mortality

There have been few estimations of long-term outcomes such as mortality. Analysis of routine national statistics from Mexico though, suggests an 11% reduction in maternal mortality and 2% reduction in infant mortality in communities participating in *Progresa*.[9]

Childhood and adult morbidity

Infants participating in *Progresa* were less likely than controls to suffer from acute respiratory or diarrhoeal illness: newborns were 25.3% ($p<0.05$) less likely to be reported being ill in the previous month and 0-3-year-olds 22.3% ($p<0.01$) less likely.[10] Subgroup analysis found that benefit was restricted to the poorest third for diarrhoeal disease.[11] Older children had a 12% lower incidence of illness.[12] Effects were not seen until the child had been receiving benefits for at least twelve months. Secondary analyses by another author found an increased rate of respiratory illness in 'treatment' children after two years.[11] This self-reported morbidity however may reflect greater awareness of symptoms.

Although all CT schemes incorporated an element of evaluation, the evidence base is disproportionately drawn from Mexico. *Progresa* randomized some communities to receive the programme in 1998 and others a year later. Detailed surveys of approximately 80,000 individuals in 14,500 households were conducted at baseline and thereafter six-monthly for two years; attrition rates were low. Analyses included intention-to-treat protocols and, despite randomization, estimated 'double-differences'. These control for baseline differences and secular trends that may have been concurrent with the programme. Randomized designs were also implemented in Nicaragua, Ecuador and Honduras, with 'control' groups destined to receive the intervention after a pre-determined delay.

Where randomization was not feasible, a variety of econometric techniques have been used to estimate differences between intervention and control groups, such as propensity score matching in Colombia and South Africa and regression discontinuity analysis in Jamaica. Zambia's Kalomo evaluation lacks a control group. Most countries employed nongovernmental agencies to evaluate their programmes; relatively little work is published in peer-reviewed literature, which complicates objective assessment for some commentators.

Effects were also seen in older age groups, even though the intervention's focus was on children. Adults aged 18-50 showed 19% fewer days of difficulty due to illness and a 7.5% increase in the distance they were able to walk without fatigue (no p-values given). No effect was seen for those aged 6-17, which the authors concluded was 'not surprising since this is generally a healthy group to start with'.[13]

In Colombia's *Familias en Acción,* significant decreases in the incidence of recent diarrhoeal illness were reported in under 2-year-olds (27% reduction, $p<0.05$) and in 2-4-year-olds (16% reduction, $p<0.05$), although no significant effect was seen for older children or for respiratory illnesses in any age group after one year.[14,15] No effect was seen in Jamaica's *PATH* scheme after one year.[16]

Pensions and other non-conditional cash transfers in sub-Saharan Africa have been suggested as important mitigators of the HIV/AIDS burden in the region. In Zomba, Malawi, cash transfers to adolescent girls were associated with a 60% reduction in recipients' risk of HIV infection, against a background prevalence of 22%.[17] The study authors suggest a variety of mechanisms underlying their finding, including a reduction in early marriage and transactional sex, improved nutrition and healthcare use and, notably, the increase in school attendance enabled by the cash transfers.[18] In a population already affected by HIV, randomized CT recipients in Uganda demonstrated better compliance with anti-retroviral treatment than controls, partly through defrayed travel costs to clinical facilities.[19]

Childhood anaemia

The *Progresa* evaluation found a significant difference in mean haemoglobin level (11.12 vs. 10.75g/dL, $p=0.01$) and rates of anaemia (44.3% vs. 54.9%, $p=0.03$) between treatment and control groups after one year. At second follow-up, by which time 'control' communities had received the intervention for one year, differences between the groups were no longer apparent underscoring the programme's rapid impact. Prevalence of anaemia, though, remained high.

No impact on rates of anaemia was seen in Nicaragua's programme for children aged 6-60 months: prevalence was approximately 33% in both treatment and control groups after two years.[20] The Nicaraguan programme does not offer food or nutritional supplements; transfers consist solely of cash and educational sessions. This may explain the absence of effect on anaemia prevalence. No impact was seen in the Colombian scheme.[15]

Childhood growth

The *Progresa* evaluation found an improvement in mean height-for-age at two-year follow-up, equivalent to an extra 1.016cm/year in growth (or an additional one sixth mean growth per year) for 12-36-month-olds.[12] The programme did not

fully correct height deficiencies and stunting remained prevalent. Nevertheless, Behrman and Hoddinot estimate that one centimetre extra growth potentially translates into a 2.9% increase in adult earnings.[21] These findings were not robust if an intention-to-treat analysis was used. In Nicaragua, rates of stunting fell in both treatment and control groups, by 5.3% more in treatment communities (the 'double-difference'; $p<0.1\%$). There was no significant difference seen for wasting but the weight-for-age score (indicative of chronic malnutrition) had a double-difference of 6.0% in favour of the programme ($p<0.05$).[20] There was only a small effect seen in Colombia in under 24-month-olds, who showed a 6.9% decreased probability of being chronically malnourished after a year, with no effect seen in older children.[14,15] Improvements in growth were not replicated by evaluations in Honduras[22] or Brazil, or in the unconditional transfer scheme in Ecuador[4] after two years.

Namibia's *Basic Income Grant* was associated with a reduction in the prevalence of underweight children from 42% to 10%[23] and participation in South Africa's *Child Support Grant* was associated with adult height gains of 3.5 cm among boys.[24]

Health care knowledge

Ten year follow-up of *Progresa* participants showed improved knowledge of lifestyle risk factors including smoking, alcohol, sexual health and family planning, and reduced smoking rates.[25]

Social determinants of health

Poverty and equity

CTs reduce poverty and can contribute to greater wealth equity. For example, Namibia's *Basic Income Grant* was associated with a steep fall in the number of residents below the food poverty line from 76% to 37% in one year.[23] In South Africa, the *Child Support Grant* in South Africa reduced the poverty gap by 47%[26] and a non-contributory pension scheme reduced the probability of poverty by 12.5%.[27]

Similarly, a comprehensive review of conditional CTs by the World Bank found that, with few exceptions, conditional CTs are also strongly progressive.[4] Irrespective of the measure used, *Progresa* had a significant impact on reducing poverty in its first two years of operation: headcount declined by 17%, poverty gap by 36% and severity of poverty by 46%.[12] Furthermore, the scheme's poorest infants consumed the most *papilla*, a daily nutritional supplement included within the scheme, and gained the most height (if an indigenous head of household or being in receipt of another social assistance programme are taken as proxies for poverty).[28,21] The finding is not borne out, however, by work by Bando[29] and there was no significant association for many other indicators of poverty. In Ecuador[30] and Nicaragua,[31] progressive trends across socioeconomic position were seen for primary school enrolment, completion and health check-ups.

Coady, reviewing several conditional CT schemes, concluded that 81% of benefits go to the poorest 40% of families.[32] Jamaica's *PATH* programme provides an example of a more detailed analysis: the programme reaches 20% of the poor; half the intended target. Of all beneficiaries, 59% are poor and 27% extremely poor, however, 6% of beneficiaries fall into the top two wealth quintiles.[16]

> *"Focus groups in Colombia and Mexico reported that women had acquired a more prominent role and had greater freedoms as a result of the cash transfer schemes."*

Soares estimated the impact of conditional CT schemes on the Gini coefficients of Mexico, Brazil and Chile[33] and found that all three programmes are well targeted to the poorest individuals and that, on average, about 60% of conditional CT resources flow to the poorest 20% of the population. Although the amounts that schemes transfer are tiny in comparison to mainstream social protection transfers (approximately 0.01% total income in Chile; 0.5% in Mexico and Brazil), the schemes accounted for 21% of the inequality reduction observed in Brazil and Mexico and 15% observed in Chile between the mid-1990s and mid-2000s. While these are substantial improvements, the authors concluded that most inequality derives from differences in labour and social security incomes and that more attention should be paid to policy in these areas to adequately address the issue.

EL SALVADOR: RED SOLIDARIA

El Salvador's conditional CT scheme is distinctive in that it combines an emphasis on building social cohesion through actions that tackle poverty, with conditional CTs' traditional emphasis on co-responsibility and conditionality.

Red Solidaria **comprises three strands: a conditional cash transfer to mothers in poor households; investment in health, education and nutrition services to improve the range, quality and accessibility of basic services to poor rural households, with particular emphasis on connecting all rural facilities to power, water and sanitation grids; and microcredits to support poor rural households to increase, diversify and sustain their productive capacity. Local communities are given the opportunity to determine their own infrastructure and development needs. They are also expected to participate directly in improving the local physical environment.**

http://www.redsolidaria.gob.sv/

Economic productivity

A recent review by *Save the Children* which looked at 16 schemes concludes that cash transfers do not provoke lassitude or dependency, as some commentators feared: in Kalomo, Zambia, transfer recipients continued their engagement with local farming markets and were able to bargain more effectively.[34] Likewise, pensioned households in South Africa engaged more often with the labour market, as grandparents' provision of child care allowed other adults to seek work.[34] In general, the evidence is that transfer recipients put more effort into finding work and do so more successfully.[7]

Cash transfer schemes also enable entrepreneurship. In Maharashtra, India, transfers allowed farmers to plant riskier but more productive crops.[8] In Mexico, *Progresa* beneficiaries typically invested 12% of their transfer, gaining on average a yield of 17.5% - even greater for women.[9] Being a recipient of cash transfers unlocks access to further credit, since borrowers can demonstrate a regular income as collateral.[7]

These effects allow local economies to benefit more widely. In Kalomo, for example, CT recipients used transfers to employ others.[8,35] Malawi's *DOWA* transfer scheme is estimated to have generated two- to three-fold the amount transferred through increased production and product value[36] and similar multiplier effects have been observed in Namibia,[37] Ethiopia[38] and Paraguay.[39]

Household spending

In Mexico, *Progresa* was associated with 11% greater median food expenditure in treatment households; dietary quality as well as quantity increased and most additional expenditure went on fruits, vegetables and animal products. Median caloric acquisition was about 8% higher overall.[40] Similarly, in Colombia, *Familias* was associated with a 15% increase in household consumption, mainly accounted for by food, children's clothing and footwear. Alcohol and tobacco consumption remained constant.[41] In Nicaragua, a drop in coffee prices was experienced during the operation of *Red de Proteccion Social*. Control communities exhibited a sharp decline in their household consumption; however no change was seen for treatment communities implying a protective effect of the programme.[20] Treatment households altered their consumption patterns to spend more on meat, fruit and vegetables and less on grains, potatoes and bread ($p<0.01$). Similar improvements in dietary quality, and spending on children's clothing and soap, were associated with the implementation of non-conditional transfers in Meket, Ethiopia[34] and in Kalomo, Zambia.[42]

Education

All CT schemes are associated with increases in school enrolment, particularly for secondary education. In Brazil's *Bolsa Familia*, which covers children up to 15, participants were 20% less likely than controls to have a day's absence from school and 63% less likely to drop out of school.[43]In Mexico, primary school enrolment was already over 90% and *Progresa* had little impact in this age group. Secondary school enrolment was worse (67% for girls and 73% for boys) and larger increases were seen in this age group (of approximately 8% and 5% respectively). The programme was more successful at keeping children in school rather than encouraging those who had left school to return.[12] Likewise, in Colombia, no impact was seen for

8-11-year-olds, among whom 90% already attended school. In older children, *Familias* was associated with a 10.1% increased attendance in rural areas and 5.1% increase in non-rural areas. Rurally, however, school absence remained prevalent with only 56% of this age group attending school.[15] A substantially larger benefit was seen in Nicaragua, with an increase in secondary school enrolment to over 90% (double-difference 17.7%, $p<0.01$) and a decrease in child labour for 7-13-year-olds.[20]

Malawi's CT scheme resulted in a 5% increase in school enrolment amongst 6-17-year-olds.[44] South Africa's *Child Support Grant* was associated with a similar impact on school attendance of 6-8%, but no reduction in child labour.[45]

Caution should be exercised in interpreting enrolment rates, since they do not necessarily reflect attendance or grade completion. There was no improvement in standardized attainment test scores in Mexico[9] or Ecuador.[46]

School enrolment shows particularly strong progressive distribution patterns. Ecuador's *Bono de Desarollo Humano* programme exerted most effect among the poorest households.[30] In Nicaragua, gains in primary school enrolment were 28.4% for extremely poor pupils, 15% for poor and 9.8% for non-poor, with a similar distribution in grade completion.[31]

Parenting skills and early childhood development

Two studies examined the effects of conditional CT schemes on parenting skills. No effect was found in Ecuador, in an evaluation using the HOME scale, which measures maternal punitiveness and lack of warmth.[47] In Nicaragua, however, children in treated households were more likely to have access to pen, paper and books, and parents were found to spend more time reading to them.[48] Evaluations of the non-conditional transfer schemes in Zambia and Ethiopia found some evidence of improved child care, such as more frequent bathing,[34] which complements the findings of increased spending on children's clothing and soap, mentioned earlier.

Early *Progresa* evaluations found no measurable impact on children's cognitive ability, despite increases in school enrolment.[12] Later evaluations suggested that the cash transfer was associated with a small improvement in cognition; however this was an assessment of the cash-effect within participants, rather than comparison with non-participants.[49] In Nicaragua, small cognitive improvements were seen, of 0.1-0.2 standard deviations equivalent to approximately 1.5 months of catch-up in children delayed 28 months on average.[46] The Ecuadorean programme was associated with a small improvement (~0.25 standard deviations) in cognitive development among the poorest quartile of children.[47]

Gender roles

Surveys asking about intra-household decision-making in Mexico found that the majority of decisions on purchases, child care and schooling were jointly taken by the male and female heads of household. The extra income given to women through *Progresa* made husbands less likely to be sole decision makers, including over use of the extra income.[50] The authors also undertook focus groups with beneficiary women. They reported an increase in self-esteem, through leaving the house more often (usually for *Progresa* activities), having more opportunities to speak to other women about problems, being more comfortable speaking out in groups and being better educated through educational workshops. The authors noted that some aspects of intra-household tension were probably not captured by the focus groups, such as domestic violence and alcohol abuse.

A similar picture emerges from Colombia. Decisions regarding schooling and child health care are shared jointly by the mother and father, but the baseline report found that spending decisions, particularly regarding food, were typically the prerogative of the father.[14] Focus groups expressed the view that women had acquired a more prominent role and had greater freedoms to provide for their children as a result of the programme and that it had not generated significant conflicts within the household.

Social capital, social cohesion

The little evidence there is around the impact of CT schemes on social cohesion presents an unclear picture. Although there is some evidence that conditional CT schemes can redress intra-household power imbalances, there is conflicting evidence regarding intra-community cohesion. A quantitative study in Colombia found evidence of a positive impact on social capital,[51] however qualitative work in Mexico noted an increase in community tensions as a result of perceived unfairness in who was excluded from scheme participation.[52] Regarding solidarity across society more widely, including non-poor groups, it has been suggested that social pensions in Mauritius were an important contributor to social cohesion across disparate groups.[53]

Adverse effects associated with cash transfer schemes

Some conditional CT schemes have been associated with unintended adverse effects. In a Brazilian pilot scheme, each additional month of exposure was associated with a rate of weight gain 31 grams *lower* in beneficiary children compared to non-participating children ($p<0.001$).[54] Although this study is weakened by lack of baseline data, short follow-up, significant amounts of missing data (10-20%) and systematic differences between participating and non-participating women, the authors concluded that the difference observed may have been due to mothers viewing the cash transfers as conditional on their children remaining underweight, since their experience from an earlier programme had been that benefits stopped as children's health improved. Although this effect may have disappeared with longer follow-up (as mothers realized they were mistaken), this nevertheless underlines the importance of clear communication about the purpose and operation of conditionality.

> *"Although cash transfers are tiny in comparison to mainstream social protection transfers, the schemes accounted for 21% of the inequality reduction observed in Brazil and Mexico and 15% observed in Chile between the mid-1990s and mid-2000s."*

The scheme in Honduras was associated with an increase in birth rate of between 2 and 4% ($0.001<p<0.053$, depending on the model used). This is possibly because the scheme allowed childless households to qualify if they subsequently had a child, in contrast to schemes elsewhere with more fixed eligibility criteria.[55] This pro-natalist effect may not necessarily imply an adverse outcome (it could, for example, simply reflect a tempo shift with households deciding to start their family earlier), nevertheless an increase in fertility amongst low-income, rural women is a serious unintended consequence if real, and stresses the importance of careful programme design.

Fernald et al. examined how cardiovascular outcomes varied among adult beneficiaries of Mexico´s *Progresa*. They find that a doubling of cumulative cash transfers was associated with increased Body Mass Index (BMI) ($0.83 kg/m^2$, $p<0.0001$) and diastolic blood pressure (1.19mmHg, $p=0.03$).[56] Caution is needed in interpreting their findings since differences in household composition and behaviour that determine the cash accumulated (whether in a conditional or non-conditional scheme) are likely to distribute non-randomly across households. A recent study directly comparing female participants in Colombia´s *Familias en Accion* with unexposed controls also reports adverse increases in participants´ BMI ($0.25 kg/m^2$; $p=0.03$) and obesity risk (O.R. 1.27, $p=0.03$).[57]

Cost-effectiveness

Much less information is available on the cost-effectiveness of CT schemes. Commenting on why there has been so little cost-effectiveness evaluation of the schemes, Skoufias notes that it is an "immense task" to identify all relevant impacts, costs and comparisons with all alternatives and that "assigning a monetary value to the increased nutrition, health and education of a child over his or her lifetime as a result of the social programme requires a series of assumptions that stretch the limits of credibility".[12]

Cash transfer schemes impact substantially on health systems

Given that CTs include health gain as an explicit objective and that conditional CTs universally mandate increased health services utilization as one of their conditions, it is unsurprising that these schemes incur substantial impacts on health systems.

The *Progresa* evaluation found that use of preventive services increased by 18%, including earlier prenatal care.[58] A separate survey of households reported a 53% increase in visits to public clinics with no decrease in visits to private clinics, suggesting beneficiaries were not transferring from private to public providers. A negative impact, however, was seen for 0-2-year-olds, for whom total clinic visits (public and private) fell by 25% compared to non-beneficiaries, hospital stays fell by more than half and visits to private doctors by a third. Large reductions in hospitalization were also seen for adults aged over 18. Health care utilization is a poor measure of health care need and these results may be consistent with a positive health impact of *Progresa*.[13]

In Nicaragua, preventive clinic visits increased by 17.5% ($p<0.05$) and a strongly progressive gradient was seen across poverty tertiles ($p<0.05$).[20] In Honduras, *PRAF* was associated with a large impact on antenatal care and child immunization and growth monitoring (~15-20% compared to control households; $p<0.01$).[22] In Colombia, *Familias* was associated with significant increases in preventive health care visits for 0-24-month-olds (17.2 to 40%, $p<0.05$) and 24-48-month-olds (21.3 to 66.8%, $p<0.05$); no significant impact was seen in older children.[15] The Jamaican *PATH* programme evaluation found a significant increase in clinic visits for children (from 0.73 to 1.01 visits per six months, $p<0.001$), which was associated with better vaccination rates and receipt of health advice. No effects were seen for the elderly, but this group had high attendance rates already (1.20 clinic visits per six months).[16]

The limited evidence on health access from unconditional cash transfer programmes in African contexts also suggests positive impacts on access to health services. For example, the Mchinji cash transfer programme in Malawi enabled significantly more participating families to afford health services when children were ill, compared with non-participating households. Households receiving pensions in South Africa and Namibia spent 40% and 14% respectively on health services and medicines, and cash transfers in Kenya were used to increase antiretroviral (ARV) treatment for children and adults.[34]

Aside from increases in service use, little else is known about CTs' impact on other health system elements such as workforce, financial flows or provision of other services. Prior to implementation, planners of conditional CTs had recognized that health and education services (the 'supply side') needed to be of adequate quality and accessibility if conditions were to have any validity or force. This stimulated co-investment in the supply side in a number of conditional CT schemes.[4,59,60] Similarly, planners in African countries recognized that local service infrastructures were often too inadequate to justifiably impose conditions, either because services were inaccessible to the majority of the poor or too weak to bear the strain of additional demand.[61] This is one of the reasons why conditional schemes have not been widely used in Africa.

Despite these insights, evaluations generally give no description of the safety, quality or accessibility of services before or after the implementation of CTs. An exception is an isolated report of services struggling to cope with increased demand and the quality of care deteriorating at some sites in Peru after introduction of *Juntos* in 2005.[62] Other insights are available from focus groups undertaken with beneficiaries and professionals involved in Mexico's *Progresa*[51] There, 75% of beneficiaries felt that health services had improved since the inception of the programme, including the manner and disposition of health professionals and time spent in consultations. Remote communities reported more frequent and longer contact with visiting health workers. Doctors reported that the programme had brought about additional training, although no increase in staff numbers. Some caution is needed with this study since it is not clear how focus group participants were recruited. It is also worth noting that *Progresa* has developed a system of 'sentinel points' which hold public services to account by taking user views on their quality and publishing them online.

Nevertheless, the lack of information on service quality is a clear deficiency if one wants to give a complete account of the extent to which CTs contribute to better well-being. It is particularly problematic in the case of conditional CTs, because their central rationale is that services are underutilized by those who most need them, even when freely accessible and of decent quality, for a variety of reasons which a conditional incentive can help resolve. Whether or not this is really the case, however, is difficult to determine. Furthermore, the question of whether it is more appropriate to wait for adequate service infrastructure before considering conditionality, or whether the introduction of conditional schemes can be used to drive the development of service infrastructure, as appears to have happened in Mexico, is left unresolved.

There is also relatively little research on how CTs impact on the mix of private and public health service use. Theoretically, CTs could stimulate uptake of private health care (through greater household wealth), public health care (if a conditional CT scheme) or both. Likewise, CTs could contribute to an overall increase in health service use or a zero net-effect, if users substitute public for private care, or vice versa.

In short, the impact of CTs on health systems, particularly access, is likely to be substantial, but suffers from a lack of scrutiny and research. The health sector should be centrally placed to offer technical assistance on this issue, describing,

understanding and anticipating health system impacts setting by setting and ensuring that the safety, quality and accessibility of health care services are maintained despite, or indeed because of, the presence of a CT scheme.

Summary

Cash transfers appear to yield clear returns for health. Rates of acute illness for children and adults decrease and some longer-term markers of health, such as prevalence of childhood stunting and anaemia, can also improve. Use of preventive health care services increases and impacts on social determinants of health, such as economic productivity and gender relations, also appear to benefit. Ongoing scrutiny of the schemes is appropriate, however, since possible negative impacts such as increased fertility have occasionally been observed.

Schemes continue to evolve and can benefit from health sector expertise

There is now sufficient experience with CT schemes to give guidance on design and implementation for maximum effect. Some conclusions are clear and unsurprising - CT schemes should transfer sufficient amounts, be sustainably funded and become mainstreamed as substantive and permanent welfare programmes. Those CTs focussing on children should start early, supporting infants in their earliest months and years and ideally include support for antenatal care.[7,34]

Three design considerations, however, require more detailed thought: conditionality, targeting and relation to other social protection policies. The rest of Part II discusses each of these in turn. In doing so, it draws upon the work of the WHO Commission on Social Determinants of Health (2005-2008) which gathered global evidence and expertise on the causes and solutions to health inequity. It found that most differences in individuals' and communities' health and well-being are avoidable. They are thus not inevitable but a consequence of policy failure. The Commission recommended that policy makers and health practitioners should adopt the following actions as local, regional and global priorities: improve the conditions in which people are born, live, work and age; tackle the inequitable distribution of power and resources; and develop the knowledge base by measuring the problem and evaluating action. Although clinical care is not the focus of a social determinants approach to health, the health sector nevertheless retains a key role as an advocate for policy making in other areas that is attuned to health improvement and reduction of health inequities.

Conditionality

One of the most contentious issues relating to cash transfers is whether conditionality is appropriate. Opponents deploy a range of moral and empirical arguments against the imposition of behavioural requirements. Morally, they claim that conditional welfare is deplorable if that welfare is essential to a family's livelihood. Opponents note that conditions are typically drawn up by well-paid professionals with little understanding of the reality of poverty and can be demeaning, stigmatizing or irrelevant as a result.[63] Some have suggested that conditions, most commonly applied to CTs in Latin America, are only necessary because of particular attitudes to poverty in the region, namely that poverty is the outcome of individual failure rather than lack of opportunity. According to this view, conditions are needed because the poor behave irresponsibly and need close supervision. Conditionality may thus be seen as little more than 'a way of ensuring middle-class support for the poverty budget'.[65] If so, 'demand' generated by conditional CT schemes is not demand in any real sense. Families do not express their preferences but adopt behaviours dictated by Ministries, perpetuating clientalism and entrenching attitudes to poverty. One author writes of the risk of "infantilizing" participants.[52]

Empirically, opponents point to the fact that the cost-effectiveness of conditionality is unclear[64,66] and that conditions are variably enforced. Few families are expelled from conditional CT schemes, which underlines the superficial and unnecessary nature of conditions. They identify other means to encourage demand for healthcare and schooling,[67] such as making services more attractive or more accessible. Evidence from Peru and Nepal shows that provision of good information, without conditions or incentives, can work if services are of high quality and access is relatively easy.[68,69] Furthermore, there are studies which show a beneficial impact of non-conditional transfers, or which separately identify the impact of the cash element of conditional CTs and find benefit. A non-conditional cash transfer scheme in Ecuador, for example, had positive effects on the physical, cognitive, and socio-emotional development of children. Effects were generally small and did not

CHILE: EL PROGRAMA PUENTE

Chile's conditional CT scheme approaches chronic poverty as a multidimensional problem, takes the family as the unit of intervention and seeks to comprehensively address their psycho-social, as well as material, needs. Programme counselors support families over a two-year period to decide themselves how their quality of life can best be improved. Households are able to select their own sets of conditions. These include traditional co-responsibilities around participating in health, education and training, as well as innovative conditions such as participating in community groups, fair distribution of household chores, supporting family members in the penal system and receiving counseling around domestic violence prevention. As well as a cash incentive, participants gain preferential access to welfare programmes.

***Programa Puente* has low levels of opt-out (5%) or drop-out (5%). Of beneficiaries, 43% report that their principal gain has been improved relationships within the family and neighbourhood.**

http://www.programapuente.cl/index.html

improve across all outcomes, such as mothers' parenting skills, but were substantially larger for poorer children and for girls.[47] Social marketing campaigns on good ways to use transfers (investing in children's education, for example) and making transfers to women are thought to be key to the success of non-conditional transfers.

Although such evidence is useful, it does not bring us closer to answering the critical question of whether conditionality has a separately identifiable *additional* effect (positive or negative) or cost, relative to non-conditional transfers. This is only answerable with a head-to-head comparison of a conditional and non-conditional scheme, identical in other respects, including accompanying social marketing and female beneficiaries.

Inferences relevant to the question have been drawn from data simulations and from observation, exploiting unintended discontinuities in programme implementation. Six such studies are available. Simulation on Mexican data (which predicted observed outcomes well when compared alongside), found that a pure income transfer programme, paying close to the maximum transfer available under *Progresa*, was associated with an increase in schooling of only about 20% of the conditioned programme, at greatly increased cost.[70] Simulation on Brazilian data found that parental choices around children's schooling and labour under a non-conditional transfer scheme were almost unchanged from those where the scheme did not exist.[71] Similarly, simulation on data for fifteen sub-Saharan African states concluded that a cash transfer without conditionality would not lead to any substantial increase in school attendance,[61] although this must be contrasted with observational evidence from South Africa's pension scheme presented earlier.

Observational data from Mexico exploits the fact that some *Progresa* beneficiaries did not receive the forms needed to monitor their children's attendance at school and were consequently unable to describe the scheme's conditions. Children from these households were 21% less likely to continue to secondary school ($p<0.01$). Moreover, the difference was larger for illiterate households, suggesting that the absence of conditions has the potential to worsen inequity.[72] In Ecuador, the *BDH* programme as finally implemented did not explicitly make transfers conditional, but conditionality had been the initial intention and public information was disseminated to that effect. As a result, some households believed that they were required to "ensure that children attend school". School enrolment in such households increased by 7-13% ($p<0.001$) in contrast to households believing the transfers to be non-conditional, where no significant difference was found.[30] In Cambodia, the *CESSP* scheme offered cash transfers to the entire household, made conditional only on school enrolment of children in lower secondary school. School enrolment improved for children in this age group, but not for their siblings, indicating that the income effect was nil if non-conditional.[73]

Finally, evidence from a randomized head-to-head trial of conditional and unconditional transfers is

available from Zomba, Malawi.[17] Transfers made to adolescent girls conditioned on regular school attendance were effective at preventing drop out (amounting to ten extra of days of schooling per year, $p<0.05$), whereas unconditioned transfers had no discernable effect compared to controls. Conditioned transfers were *less* effective, however, at preventing teenage pregnancy and marriage. The authors demonstrated that this was because a large enough number of girls (11% over one year) failed to comply with programme conditions and, lacking any income support, became more prone to marriage or pregnancy. In contrast, girls receiving unconditional transfers were able to avoid teenage marriage or pregnancy, whether or not they attended school.

Several possible policy conclusions follow:

1. that the size of the conditioned incentive should be increased, to maximize school attendance;
2. that the incentive should become conditioned upon additional target behaviours, namely delaying marriage or pregnancy;
3. that conditionality is inappropriate in this setting, for these outcomes, and should be abandoned; or
4. that simultaneous but distinct policy objectives should be met by simultaneous but distinct policy instruments: an unconditional cash transfer to prevent teenage marriage offered alongside a conditional cash transfer to improve school attendance and educational attainment.

As shown, most of the evidence around the relative benefits of conditionality pertains to school enrolment, with little evidence (other than that from Zomba) on health outcomes. A number of other evidence gaps remain, including whether more intensive social marketing could replicate the effect of conditions, as well as a thorough understanding of whether and how conditionality is actually applied in the field. Anecdotal evidence suggests that conditions are variably enforced both across and within schemes; in some it is reported that beneficiaries continue to receive programme benefits even when they do not comply with programme conditions. Likewise, the nature of any 'penalties' enforced is variable. In some schemes, non-compliers are ejected; in others they are offered additional support.[59] Clearly, these issues complicate quantification of a separately identifiable effect of conditionality.

Perhaps the most important evidence gap centres on what participants themselves feel about conditionality. Anxieties about detrimental effects of conditionality are exclusively expressed by (typically Northern) academics, as remote from the experience of real poverty as the policy designers they criticize. Very little work has been done to gather the views of conditional CT scheme beneficiaries. *Progresa* is one of the few conditional CT schemes to have published qualitative research. Although not exempt from methodological criticism (such as failure to specify how focus groups were recruited), beneficiaries there reported that the scheme was well-liked.[74]

Less information is available on how conditionality affects programme costs, in line with the relative lack of information on scheme cost-effectiveness noted earlier. Estimates of programme cost ascribable to conditionality range from 2% to 24% of total programme administrative costs.[66] Total administrative costs for conditional CTs, relative to overall budget, are similar to other welfare schemes.[4] Alvarez et al. provide empirical evidence that conditionality improves targeting efficiency by screening out the relatively wealthy, who find the conditionality requirements overly burdensome and leave the programme. In contrast, the extreme poor have low dropout rates. There are two important exceptions to this, however - Indigenous households are more likely to drop out (perhaps because of linguistic difficulties in complying with conditions), as are very low-income households living in wealthier communities. The authors suggest that conditionality can be usefully included in programme design as a means to improve efficiency, but only if properly realized through close monitoring and if special attention is paid to groups likely to drop out, with clear re-entry mechanisms provided.[75]

What particular contribution might the health community bring to bear in this debate? A human rights-based view of low service uptake - the fundamental issue which conditionality tries to resolve - would seek to place equal stress on *entitlement*, alongside any application of conditionality. This recognizes that there are several ways to stimulate service uptake among those most in need and starts with the realization that individuals will forego investments in their household's health and education if they perceive the net yield to be less than other options. Thus, efforts to increase the perceived net gain of services can be expected to increase demand - this is possible through several means. Monetary costs, both direct (such as user fees) and indirect (such as travel costs to inconveniently located facilities) can be cut or subsidized; non-monetary

costs, such as derogatory staff attitudes, must also be minimized or abolished. The perceived value of a service can be augmented both by increasing its true value, that is improving service quality, and its perceived value. The latter is achievable through socially- and culturally-tailored information that corrects misperceptions about the short- or long-term benefits of taking up health and education services. At the same time, such information should make clear users' entitlement to effective, acceptable and accessible services as an established and enforceable right. Such information, once given, is permanent and self-propagating and can drive a continuous process of quality improvement through the mechanism of enforceability.

A programme that encompasses all these mechanisms could be called an "entitlements approach". Its defining feature is that it transfers power as well as resource. The risk in a conditionality approach is that these other mechanisms to stimulate demand are forgotten or dealt with tokenistically. This becomes clear in the literature, where issues such as service quality are only cursorily dealt with.

Conditionality is only one tool to increase service uptake. In practice, the blend of tools and relative need for conditionality should be decided in each setting, paying particular attention to the objectives of the scheme and the political, social and economic context in which it will operate. The public health community is ideally placed to contribute to these decisions and ensure that they are made in a way that does not lose sight of peoples' entitlement to effective, acceptable and accessible services.

Targeting

One of development policy's longest running debates concerns the net benefit of targeting an intervention so that only certain groups (typically the poor or otherwise marginalized) receive it. Proponents use an efficiency argument: targeting is necessary so that those most in need benefit most, with leakage to less needy groups reduced. Those who are less inclined toward targeting deploy a number of arguments: the information needed to target may be lacking or prohibitively expensive to obtain; focussed initiatives detract attention from securing welfare gains for all, rich and poor; targeting is unnecessary since universal benefits can still favour the poor in relative terms; and universalism contributes to other objectives such as nation building.[76]

It is beyond this report's scope to resolve this debate. It is worth, however, reflecting more fully on one aspect, namely the risk of residualized or "ghetto" services, where interventions or policies targeted solely at the poor become inferior in terms of quality, sustainability or both. This observation was most famously stated by Richard Titmuss in 1968 ("services for the poor are poor services"), and recently repeated by Sen.[77] The argument is that the poor and marginalized have little political leverage and so interventions focussed on this constituency will often be crowded out by matters of more concern to the middle classes and social elites. Cash transfers are particularly at risk, since they typically carry prominent party-political branding and may not survive political cycles.

Barrientos writes that formal welfare systems (in Latin America at least) were previously organized through formal employment benefits, and so were 'truncated' in the sense that significant sections of the population at the less well-off end of the spectrum were not provided for.[60] Although newer welfare initiatives such as feeding programmes or cash transfers are welcome, they carry an attendant risk of creating 'parallel' welfare systems, with provision for the poor being characterized by unintegrated, reactive interventions of last resort.

The general consensus is that targeting has been vital to CTs' success, particularly as compared to earlier welfare programmes that were characterized by inefficiency and, in several cases, failure to reach the poor.[78] The impacts of cash transfers on poverty and equity have been identified as one of the reasons underlying the survival of such schemes across regime changes in several Latin American countries, a counterpoint to the unsustainability argument outlined above.[4] The high costs associated with some targeting strategies, however, are widely acknowledged. These costs are not just financial. In Mexico, qualitative work found that most *Progresa* beneficiaries thought the targeting process was unfair, and authors reached the conclusion that the social cost exacted by this tension may outweigh any gain in allocative efficiency achieved by household-level targeting.[51] There are, clearly, myriad ways in which beneficiaries in a truncated or tapered programme can be defined and identified. In regions such as Africa, which has greater income equality than Latin America, simple geographical targeting may suffice, avoiding the need for expensive, and potentially divisive, household targeting.[34,61]

A social determinants approach to the issue would seek to avoid an inevitable link between targeting and residualization. Targeting does not need to imply truncated policy, from which some groups are bluntly

excluded, but can exist within universal policy if benefits are tapered. In tapered policy, all groups have access to, and thus an interest in, the intervention but resources and benefits are proportionately greater for those in greater need. The requirements of being pro-poor and non-ghettoized are thus both potentially satisfied. This is the path that welfare systems in most high-income countries have pursued. It is important to note, though, that tapering does not escape the need for (possibly expensive) data on the population profile. Bastagli considers other means to minimize the risk of residualized welfare policy and finds that expansion to cover more households; increased transfer size; reformed targeting to minimize exclusion errors; improved communication with participants and local officials regarding the purpose of conditions; investment in the quality of local services; and improved coherence with other policy interventions have all been important developments in this regard among the conditional CT schemes of Latin America.[2]

Again, the decision whether and how to target should be decided setting by setting. The public health community can contribute to decision making by ensuring that any decision to target is carefully weighed against the need to build social cohesion, avoid ghettoization and tackle inequity across the social gradient.

Relation to other social protection policies

Aside from the question of targeting versus universality, CTs should not be seen as a silver bullet capable of roundly resolving poverty in a single intervention. The main risk that emerges by losing a broad perspective is that the other dimensions of chronic poverty are forgotten, leading to a merely partial solution to the problem of social exclusion.

Full mitigation of this risk requires a broad suite of social protection policies that addresses all the disadvantages associated with chronic poverty (not just a lack of income) in a co-ordinated and inclusive manner. Such a suite includes welfare support for groups ineligible for CTs (such as households without children or pensionable adults), insurance mechanisms for risk sharing and resource pooling, facilities for emergency relief and birth registration to ensure access to services. Policies to invest in human capital (such as literacy), to improve the quality and accessibility of services and to tackle stigma and discrimination are also necessary. At the same time, wider macroeconomic policy must foster national growth, pro-poor distribution and decent labour standards alongside action to secure rights, democracy and socio-political stability.[8,34] Only with action across all these fronts can effective and sustained progress to lift families out of chronic poverty be made.

Although this point is self-evident, it is worth stating, because the huge international interest generated by CTs can exaggerate their overall significance within the wider portfolio of social policy. In particular, although progressive, CTs are likely to be weak instruments to overcome the fundamentally inegalitarian nature of most welfare systems. These typically favour richer quintiles by virtue of being organized through formal employment or through elements such as tax breaks, which may be of little relevance to the poor.[1,78]

The health community has an important role to play here, ensuring that CTs are not unduly emphasized in the portfolio of policies necessary to secure sustainable improvements in health and welfare, by underlining the need for concerted and comprehensive action on social determinants of health.

Summary

The evidence from several years of experience with CTs at national and local levels, in a variety of settings, shows that CTs can reliably deliver on several public health objectives. Participants report fewer acute illnesses and show long term health gains, around childhood growth for example; positive impacts are also seen around social determinants of health. CTs also have potentially significant effects on health systems, particularly in terms of access.

CTs are not static policies, but continue to evolve. Particular questions persist around the application of conditionality, targeting, the schemes' place within a broad suite of social protection policy and safeguarding the safety, quality and accessibility of health services. The health sector is naturally placed to assist on how these issues are settled in the context of specific national or regional schemes.

Taken together, these insights provide a compelling argument that public health agencies should develop more substantive engagement with cash transfer schemes.

Part III: making recommendations for greater public health involvement

This section considers the roles that public health agencies might adopt in relation to cash transfer schemes. It begins by considering the institutional risks implied by involvement and possible mitigation. It moves on to identify opportunities presented by current health sector initiatives and concludes by offering recommendations for the health sector's further engagement with cash transfer schemes.

Identifying and mitigating risks of greater involvement

In addressing risks, it is useful to consider the reasons why the public health community may have thus far failed to engage substantively with CTs. As suggested earlier, three explanations seem plausible.

Uncertainty around the ethical issues raised by mandating behaviour in marginalized communities is likely, or at the very least a concern that CTs (conditional or not) might have negative consequences, such as a reduction in productive activity or heightened stigma. Furthermore, prominent political branding is typical of most CTs and historically the public health community has preferred to maintain some distance between the political cycle and its work. Second, a lack of interest may have played a role. Health practitioners may view CTs as primarily a tool for poverty reduction and thus peripheral to their expertise and core concern. There is also probably a sense that CTs are already 'owned' in an intellectual and operational sense (in both cases very successfully) by the community of economists beyond the health sector, and that public health practitioners should be wary of expanding their 'empire' in an unsustainable way. Both views may combine with the belief that public health should predominantly concern itself with proximal interventions within health systems and leave action on upstream or social determinants of health to other agents. Finally, there may simply have been an aversion to the notion that the poor could benefit from something as simple as receipt of regular cash, rather than more sophisticated aid dependent on the presence and active management of professional groups.[4]

Which of these concerns are valid? Certainly the belief that public health has little purchase beyond health systems is not valid because the Commission on Social Determinants of Health has shown that purposeful and sustained action on upstream determinants is critical if health objectives are to be met. One must recognize, though, that the proximal position is stubbornly held and requires persistent persuasion and advocacy over time if it is to be softened. The concern that public health involvement in CTs may overlap unproductively with other agencies' ownership of the schemes rings more true, but the clear convergence between CT objectives and public health objectives and the technical expertise that the health sector can contribute to CT schemes are a strong mandate for involvement, rebutting any charge of empire building. Furthermore, CTs can remain under the remit of welfare and labour ministries, with the health ministry as a supporting partner. The concern that CTs might have practical negative consequences is mitigated to a large extent by the evidence which shows almost entirely positive impacts. Nevertheless, some caution is necessary because some impacts are under-researched (such as stigma) and other unanticipated consequences inevitably arise, as shown earlier, underlining the need for close programme monitoring.

Perhaps the most valid concerns are those around the ethical issues raised by conditionality and the prominent political branding of schemes. As well as having a clear understanding on the evidence around conditionality (already presented), the former can be mitigated by developing a clear institutional values-based narrative on CTs, based on rights, entitlement

and equity, incorporating elements from the earlier discussions on conditionality, targeting, service quality and the necessity of a broad policy suite that is sensitive to the multiple dimensions of chronic poverty. Similarly, the latter risk is best mitigated first by acknowledging that political interest and support is critical to public health success, but also by making a strong argument for the sustainability and mainstreaming of these schemes as part of the institutional narrative on them.

Identifying opportunities through current health sector initiatives

The *Health in All Policies*[79] approach recognizes both that other sectors contribute to and impact on health and that health is a driver of many outcomes in other sectors. Two conclusions follow. First, that the health sector can catalyse collaborative working across traditional government agencies and sectors; second, that investments in health need to be made to secure other sectors' outcomes, whether made by the health sector itself or other sectors. CTs offer a paradigmatic opportunity to illustrate these actions: CTs have multisectoral objectives (poverty reduction, education and human capital accumulation, productivity gains, women's empowerment, better health) and recognize the inter-relation and positive reinforcement between all of them. CTs also make explicit investments in participants' health in order to support these other outcomes. As governments consider and explore the *Health in all Policies* approach, CTs offer a validated and effective vehicle with which they can contribute to its implementation.

The World Health Report 2008[80] re-establishes the central role of the primary health care approach to provide responsive, people-centred care that improves health and reduce health inequities in the face of persisting and rapidly evolving challenges, such as an increasing and ageing population, climate change and intensifying global commerce and exchange. CTs display many features which align closely with the report's priorities: an emphasis on primary, rather than tertiary care, on public services, rather than commercial providers, and on continuity of care; an explicit attempt to address the inverse-care phenomenon and expand access for those most in need; recognition that the function of health services is to build personal and social capabilities, rather than merely control disease; and coherent action across multiple, non-health, drivers of health outcomes such as social protection, education and female empowerment. Together, these suggest that those seeking to renew primary health care should consider CTs as a possible priority tool to support its objectives at a national level. There are, however, areas where CTs' fit with the primary health care agenda is less clear: CTs are predicated upon an 'adequate' supply of services, consequently issues around the quality and safety of care are assumed away or reduced to a peripheral concern; it is unclear whether CTs (particularly conditional schemes) are responsive to beneficiaries' demands or needs, and whether beneficiaries are truly able to participate in health service decisions that affect them; and little is known about the effectiveness of CTs' health promotion and education. These represent areas where the health sector could offer conceptual and practical expertise in an effort to improve the schemes' relevance and impact.

> *"Cash transfer schemes could be used to support many current health sector initiatives at local, national and global level."*

Recent efforts at advancing health promotion seek to identify interventions that are effective across several outcomes (such as maternal and child mortality, physical activity or healthy diets) and at several levels (including the individual, community, wider environmental and health service levels). Cash transfers are potentially a health promotion tool that meets both aims. There exists a solid evidence base that CTs are associated with improvements across many outcomes, including child health, household diets and access to medicines and professional care for households affected by HIV/AIDS. Furthermore, they are known to act at several levels, including the individual (by incentivizing healthy behaviours and removing barriers to healthy choices), the community (by directing specific attention to marginalized community groups and creating opportunities for community participation), health services (by reducing barriers to access and enhancing prevention and health education) and the wider environment (by encouraging cross-sectoral working and emphasizing co-benefits). It is fair to say, however, that several drivers central to health promotion exist as relatively peripheral, or poorly evaluated, elements of CTs. This represents a fertile opportunity for the health community to contribute to the design and operation of CTs to maximize their health impact and, by association, their impact across other sectors.

Recommendations

There is now sufficient evidence and experience with cash transfer schemes to make the following key recommendation:

Public health agencies should assist in advocating for cash transfer schemes as a priority consideration in country level or local plans for social policy.

Alongside this advocacy, further specific recommendations can be made as follows:

National Ministries of Health and other national and local public health agencies should:

- **consider cash transfers as a concrete policy option** in pursuit of health, health equity and action on social determinants of health;
- **build partnerships** with colleagues from the development, welfare and education sectors to consider the design, funding, implementation and evaluation of cash transfer schemes in individual settings; **and**
- **offer technical assistance** around key aspects of scheme design and implementation, such as strengthening the health system and service quality, safeguarding the right and entitlement to health, ensuring provision of high-quality health information to users, addressing equity concerns, making appropriate choices around targeting and conditionality setting by setting, and collecting and responding to users' views.

International and regional public health agencies should:

- **offer technical advice and support to welfare ministries** on the design, funding, implementation and evaluation of national and local cash transfer schemes, where requested. This might take the form of a policy brief that builds on the information contained in this paper;
- **build partnerships and become an active stakeholder** alongside colleagues from the international and regional development, welfare and education sectors to consider general issues around the design, funding, implementation and evaluation of cash transfer schemes as they continue to evolve; **and**
- **assist in the mobilization of resources** to support cash transfer schemes in partnership with national and international partners, within the United Nations system and elsewhere.

It is recognized, of course, that organizations such as WHO are technical agencies whose core functions do not include acting as a donor or significant funder of country level or local initiatives.

Conclusion

Cash transfers to low-income households can make an important contribution to public health objectives, have a potentially significant impact on access to health systems and could benefit from public health technical expertise. A strong case exists, therefore, for public health agencies to develop a defined programme of institutional involvement with cash transfer schemes.

Rather than cursory stakeholder participation, "involvement" should comprise something more substantive and robust, including:

- articulation of an institutional view on cash transfers;
- assistance in advocacy of cash transfers as a central element of social policy;
- systematic engagement with funders and implementers around the design and operation of cash transfers; and
- an offer of strategic and technical assistance on particular aspects of cash transfer policy.

The overarching recommendation is that public health agencies should assist in advocating for cash transfer schemes as a priority consideration in country level or local plans for social policy, with a number of concrete next steps possible to advance this.

Appendices

Appendix 1: literature review search strategy

A scoping literature review was undertaken to inform this report. A scoping literature review has been defined as a process which aims "to map rapidly the key concepts underpinning a research area and the main sources and types of evidence available, and can be undertaken as stand-alone projects in their own right, especially where an area is complex".[81] Scoping reviews seek "to be as comprehensive as possible in identifying primary studies (published and unpublished) and reviews suitable for answering the central research question" and aim to produce a critical, narrative account of a field of research.[82] They can be contrasted with systematic literature reviews, which typically have a tightly focussed research question (precisely specifying intervention, outcome and population), exclude many methodologies (such as qualitative studies or non-randomized quantitative studies) and aim to produce synthetic quantitative estimates or weighted comparative estimates of an intervention's effect. Key markers of quality and rigour, however, apply equally to scoping and systematic reviews. A well-conducted scoping review is comprehensive, transparent and reproducible, with explicit study selection criteria and data extraction procedures.

The objective of this review was to understand how CT schemes have evolved and currently operate, gather evidence of their impact on health and social determinants of health, and identify areas where critical discussion of their evolution and operation, or the empirical evidence base, say little.

Several resources were searched:

bibliographic databases:
Econlit, Econpapers, WoS, IBSS, ZETOC, Geobase, PubMed, CAB.

information gateways:
Intute, ELDIS, RFE, ERN/SSRN, Handbook of Latin America Studies, LILACS.

grey literature sources:
SIGLE.

government and national CTs websites:
Brazil, Chile, Colombia, Dominican Republic, Ecuador, El Salvador, Honduras, Jamaica, Kenya, Mexico, Nicaragua, Pakistan, Paraguay, Peru, South Africa, Turkey.

other websites:
Institute for Fiscal Studies, World Bank (*including* Poverty Impact Evaluations Database), Inter-American Development Bank, World Health Organization, World Food Programme (*especially* Food for Education *section*), UNESCO, London School of Economics.

Search terms were chosen to maximize sensitivity at the expense of specificity:

bibliographic databases, information gateways and grey literature sources and other websites:
cash transfer* OR "cash transfer* OR conditional cash transfer* OR "conditional cash transfer*" *in all fields*

government and national CTs websites:
full name OR commonly used acronym of national CTs.

No limits were placed on publication date, language, population, study design or publication type. Reference lists of key articles were examined and authors were contacted to source additional material.

Inclusion and exclusion criteria:
Full documents meeting the following criteria were retrieved for detailed review:

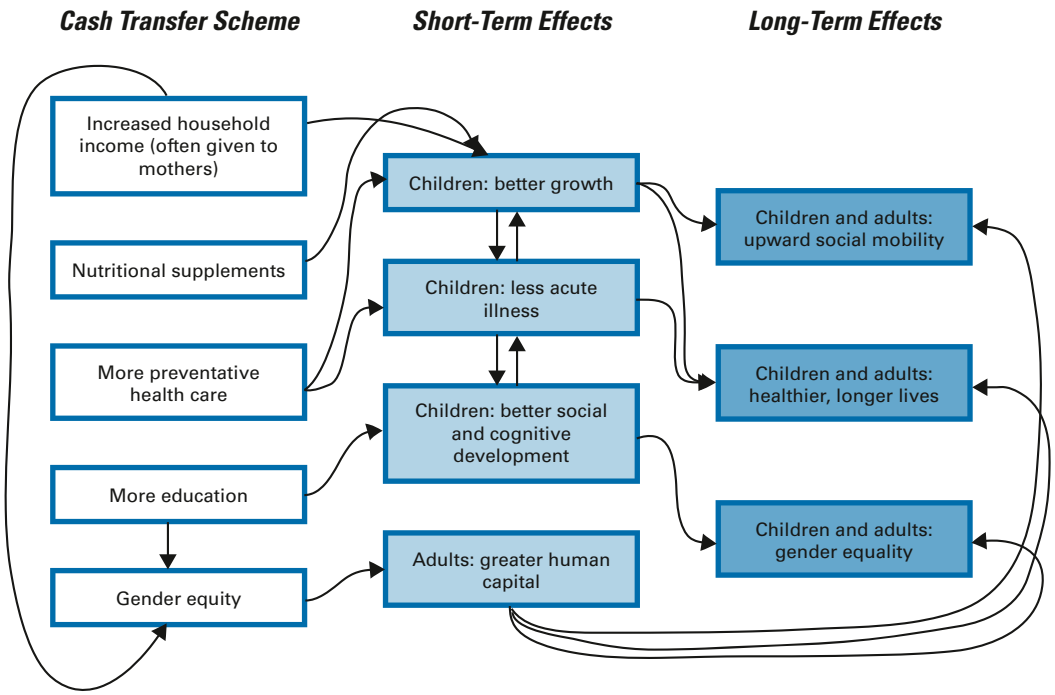
- all documents initially assessed as being relevant to the review's question, *and*
- in English or Spanish, *whether*
- of any publication type, including non-peer reviewed material.

The following documents were excluded from further detailed review:

- interim reports or pilot evaluations of specific CTs, where a final report for that CT was available, *or*
- purely journalistic pieces, *or*
- documents that solely considered CTs' costs or logistics rather than outcomes, *or*
- documents in other languages.

Appendix 2: system map

A schematic representation of how cash transfers can translate into short- and long-term health and well-being benefits is set out below.



Appendix 3: selected cash transfer schemes

Country/ Programme	Total cost*, US$ (year)	Percentage of GDP	Number of beneficiaries	Monthly transfer amount	Targeting	Conditional/ Unconditional	Administrative Costs	Funding Source
Mexico - *Progresa / Oportunidades*	2.8 billion (2004)	0.66	5 million	19.5% of mean consumption of poor households in non-*Progresa* areas	Geographical; proxy means-testing	Conditional - health, education	9%	National budget and Inter-American Development Bank
South Africa - *Child Support Grant*	1bn (2005/6)	0.7	3.6m	R180 per child (=15–20% household monthly income)	Categorical and means tested	Unconditional		National budget
South Africa - *Old Age Pension*	1.8bn	1.4	1.9-2.1m	R740	Categorical and means tested	Unconditional		National budget
Lesotho - *Pension*	19.8 m	1.4	69,046	US$25, rising to US$29 in 2007	Categorical	Unconditional	10%	National budget
India - *National Rural Employment Guarantee Scheme*	2.5 bn (2006/7)	0.3	Target of 40m	Set according to state agricultural minimum wage	Self-selection	Unconditional; guarantees minimum number of days of work		National and state budgets
China - *Minimum Living Standards Scheme*			22m (2006)	Set locally; averages nationally as 14% of average wage	Means-tested	Unconditional		National budget
Malawi	3 m (2008)	Approx. 0.08	13,045 households	US$4-13 depending on household size	Community targeting	Unconditional		National budget
Nicaragua - *Red de Proteccion Social*	6.37 m (2004)	0.1	21,619 families	Food security transfer - 18% per capita expenditure; plus school transfer	Geographical	Conditional - health, education	25% (including design and evaluation)	Inter-American Development Bank
Colombia - *Familias en Accion*	125 m (2004)	0.11	400,000 families	Average US$50: 30% household consumption	Geographical; Proxy means-testing	Conditional - health, education		National budget, World Bank, Inter-American Development Bank
Ecuador - *Bono de Desarollo Humano*	200 m	0.7-1	1.2m households	US$15: average of 15% of household expenditure	Proxy means-tested	Intended to be conditional, but not implemented	6.8% (not including fixed and evaluation costs)	National budget and World Bank

**Important to note that cost figures may include total programme costs including supply-side support*

Adapted with kind permission from: Lasting Benefits: the role of cash transfers in tackling child mortality. London, The Save the Children Fund, 2009.

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SOCIAL DETERMINANTS OF HEALTH

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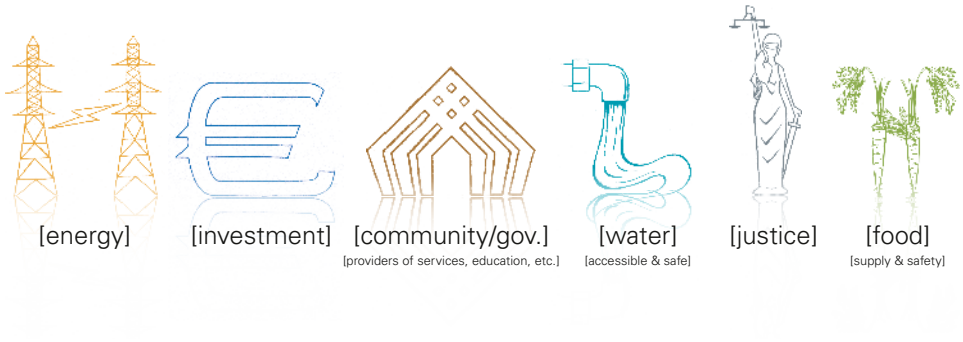

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