

## Cash transfer schemes and the health sector: making the case for greater involvement

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Cash transfer schemes can be important contributors to human development and social protection. Although they have significant health benefits, they have rarely been considered an integral part of the health policy portfolio. We believe that a case can be made for greater health sector involvement in the design, implementation and evaluation of such schemes.

Cash transfers (CTs) are attracting increasing interest as effective and acceptable means of improving the welfare of disadvantaged households in low- and middle-income countries. They give households regular, predictable amounts of money in the form of pensions, child benefits or regular household grants. Although such social protection mechanisms are often the norm in high-income countries, CTs have historically been rare in low- and middle-income countries. Instead, governments and donors have typically preferred supply-side interventions (expanding health care coverage, for example) or in-kind transfers of goods or food. Financial shocks during the late 1990s, however, triggered a global shift towards social protection schemes more closely resembling European models (emphasizing social security rather than assistance as a last resort). This shift also reflected a desire to correct shortcomings associated with reforms advocated under the Washington consensus, characterized by the dismantling of State services and their replacement with segmented private services.

### Pathways for positive impacts of cash transfers

CTs can contribute to economic and social development, particularly pro-poor development, for several reasons. Lack of resources makes poor households risk-averse, and they therefore seek to

minimize their exposure to environmental, economic and social risks. As a result, however, they may also pass up more profitable opportunities. Planting reliable but low-yield crops is an example. Economic shocks force impoverished families to make decisions that satisfy immediate survival needs at the expense of future income, such as selling livestock or withdrawing children from school, which may irreversibly weaken the household. Relieving poverty can enable such households to manage risk and respond to shocks more effectively.

CTs can also promote positive social norms. Transfers to women enhance their status and increase their participation in household decision-making. They also increase the likelihood that household income will be spent on children's schooling and on nutritious food. Transfers can contribute to social cohesion and citizenship, as well, if implemented alongside other elements of social protection. In addition, transfers can develop individuals' capabilities and potential by encouraging them to avail themselves of health, education and other public services, either through social marketing or through the establishment of conditions that CT beneficiaries must fulfil – such as enrolment of children in primary and secondary education or completion of immunization schedules.

### Impact of cash transfers on health and well-being

While CTs have sometimes been associated with unanticipated negative consequences, such as increased birth rates among rural women in Honduras<sup>1</sup> (although this trend might merely reflect a decision to start families earlier) and an acceleration in obesity rates among women in Mexico<sup>2</sup> and Colombia,<sup>3</sup> robust evidence from national-level randomized controlled trials

and quasi-experimental methodologies shows that CTs reliably secure welfare gains. In Colombia, a CT programme was associated with a 15% increase in household consumption and a decrease in rates of acute diarrhoeal illness and stunting.<sup>4</sup> In Malawi, Namibia, South Africa and the United Republic of Tanzania, observational and qualitative evidence has shown that CTs can substantially lessen the burden of human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) by enabling improved nutrition and health care and, above all, by empowering women and facilitating access to education.<sup>5</sup> CTs can also impact positively on social determinants of health, without inducing dependency.<sup>6</sup> In Mexico, *Progresa*, a health, education and nutrition programme, significantly reduced poverty in its first two years.<sup>7</sup> Transfer schemes in South Africa and Zambia helped to boost employment and promote trade in local markets.<sup>6</sup> CTs in Brazil, Chile and Mexico were associated with 15–20% of the reduction in national income inequality observed in the decade between the mid-1990s and the mid-2000s.<sup>8</sup>

### Cash transfers and health systems

CTs can also have important impacts on health system use. The *Progresa* evaluation found that use of preventive health care, including earlier prenatal care, increased by 18%.<sup>9</sup> Increases of a similar magnitude were reported in observational data from Colombia, Honduras, Jamaica and Nicaragua.<sup>10</sup> There is little information, however, on the impact of CTs on quality of services. An exception is an isolated report of services struggling to cope with increased demand and consequent deterioration of the quality of care at some sites in

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Peru after the introduction of the *Juntos* programme in 2005.<sup>11</sup> In contrast, 75% of *Progresa* beneficiaries in Mexico felt that health services had improved.<sup>12</sup> These, however, are isolated reports. The lack of information on health systems impact must be remedied to gain a full understanding of the extent to which CTs contribute to better well-being. This is particularly true 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, a problem which a conditional incentive can help to resolve. Whether or not this is really the case, however, is difficult to determine.

CTs and other forms of social protection are increasingly recognized as vital elements in improving health and reducing health inequalities. Nevertheless, health agencies have remained relatively passive observers of CT schemes, rather than active participants in their design, implementation and evaluation. 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.<sup>10</sup>

## The role of the health sector

The case for more substantive health sector engagement rests on three arguments: there is evidence that CTs contribute to health sector objectives; CTs can have a considerable impact on health systems, particularly access to services; and the health sector has the expertise and ability to offer technical assistance on specific issues.

Scope for more substantive involvement exists at every level. National ministries of health and other national and local health agencies should consider CTs as a concrete policy option for advancing health and health equity and for promoting intersectoral action on social determinants of health. The concept of “health in all policies”, for example, recognizes that other sectors contribute to health improvement and that health is a driver of many outcomes in other sectors. The health sector is thus called upon to facilitate better collaborative work across sectors, and CT schemes offer a validated and effective vehicle for doing so, given their cross-sectoral objectives (e.g. increasing economic productivity, empowering women and

improving health), which positively reinforce each other. The call for the renewal of primary health care and the drive towards universal coverage prioritize a range of objectives to which CTs can contribute, including highlighting the importance of primary care, reducing catastrophic expenditure through strengthened pre-payment mechanisms, addressing the lack of health care among populations most in need (the inverse-care law), and identifying ways in which health services can build personal and social capabilities (rather than merely controlling disease).

To exploit these opportunities, health agencies should build partnerships with the development, social protection and education sectors to contribute to the design, implementation and evaluation of CT schemes. Such schemes could benefit from health sector expertise in several ways. For example, CTs are predicated on an adequate supply of services, which may mean that ensuring the availability of services takes precedence, and issues relating to the quality and safety of care become peripheral. It is essential to avoid creating parallel welfare systems or “ghetto” services, which may occur because the poor and marginalized typically have little political leverage. Currently, little is known about whether CTs (particularly conditional schemes) are responsive to beneficiaries’ preferences, whether beneficiaries are truly able to participate in health service decisions that affect them and whether the dissemination of health information through CT schemes is effective. These are areas in which the health sector could offer technical expertise.

Decisions regarding whether to universalize or target, or to introduce conditionality, in CT schemes are critical. The health sector could guide such decision-making by providing a detailed assessment of need and, where possible, of communities’ preferences. Health agencies could also assist in mobilizing resources to support CTs and in innovating to cover previously unmet welfare needs, such as registration of and support for children with disabilities.

## Challenges of health sector engagement

Exploiting opportunities for greater engagement will mean addressing reservations about CTs in the health sector. Health professionals may feel uncertain

about the ethics of conditional schemes or be concerned that CTs could have negative consequences, such as heightened stigmatization of the poor. CT schemes often have a prominent political component, and historically the health sector has preferred to avoid overt politicization of its work. Health professionals may view CTs mainly as a tool for poverty reduction, not one for improving health. They may feel that CTs are already “owned” in an intellectual and operational sense by economists, and that public health practitioners should be wary of “mission creep” and should leave action on social determinants of health to other agents. Health professionals may also be averse to the notion that the poor could benefit from something as simple as regular cash payments, rather than more complex interventions requiring the active management of professionals.

These challenges can be addressed. The belief that public health professionals have little remit or interest beyond the health sector ignores the history of public health and overlooks recent developments such as the conclusions of the Commission on Social Determinants of Health. The view that health sector involvement in CTs may overlap unproductively with the activities of other sectors may have some validity, but the clear convergence between CT objectives and health objectives is a strong incentive for involvement. Furthermore, CTs can remain under the remit of other ministries, with the health sector playing a strong supporting role.

The concern that CTs might have negative consequences is mitigated by evidence of broadly positive impacts. Nevertheless, some caution remains necessary, given that some impacts have not been sufficiently researched, such as the associations between CTs and discrimination, stigma and service quality. More research is also needed on the acceptability and impact of conditionality to answer ethical questions about conditional CT schemes and highlight the contribution that they can make to ensuring universal access to high-quality health care and equitable health outcomes. At the same time, it must be recognized that CTs are not a magic bullet capable of resolving the complex issue of chronic poverty and disadvantage through a single intervention; they must exist within a

comprehensive policy suite that addresses the multiple dimensions of the issue. Politicization of CT schemes is best mitigated by acknowledging that political interest and support are critical to the success of public health initiatives, while also advocating for the sustainability and mainstreaming of these schemes, irrespective of political expediency.

## Conclusion

There is now sufficient experience with CT schemes to argue that the health sector should advocate for their inclusion in national and local social policy frameworks and should seek more substantive engagement in their design, implementation and evaluation. CT schemes contribute to health and

well-being and offer a means of forging constructive links between the health and social protection sectors. ■

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