

Research Agenda on Conditional Cash Transfers – Lessons from a Systematic Review on the Effects of CCTs



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“Conditional cash transfer: a magic bullet for health?”

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Outline

1. Why were/are CCTs being promoted?
2. What is the evidence on the effectiveness of CCTs to improve health outcomes?
3. What critical questions remain unanswered?

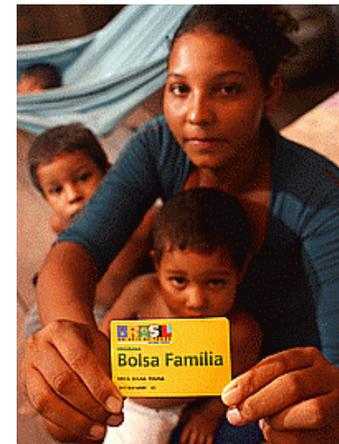
What are CCT programmes?

- Cash transfers
 - Varying size (function of complex rules)
 - Varying justification (20-40% of poverty line vs. transport costs)
- Conditional on a set of requirements
 - “Classic” CCTs: health visits and attending school
 - More recently specific behaviours
 - Other requirements: obtaining IDs, birth certificates
- Usually targeted at particular groups
 - Targeting the poor based on rich information systems or proxy indicators
 - Targeting some areas (poor health indicators)
 - Targeting some groups (pregnant women)



Rationale

- Safety nets in the short run
 - Providing social transfers: *Progresa* replaced in-kind transfers
- A long term investment in human capital
 - Long run effects of investing in health and education justify social transfers
- Addressing demand-side barriers
 - Indirect and opportunity costs
 - Cultural barriers?



Systematic review methods

- Objective
 - to assess the effectiveness of CCTs to increase the use of health services and improve health outcomes
- Inclusion criteria
 - CCTs with health component
 - Low and Middle Income Countries
 - Experimental or quasi-experimental study designs: (C)-RCT, CBA, ITS
- Appraisal of studies
 - Quality of analysis
 - Risks of leakage, contamination
 - Similarity of control and intervention groups

6 included studies

- 5 large-scale programmes from Latin American countries
 - Programmes targeted at poorer areas/groups
 - Conditional on health and education requirements
 - Varying transfers size (10-30% of household consumption)
- 1 small-scale experiment in Malawi
 - CCT to incentivise collection of HIV testing results



Oportunidades



Synthesis of study findings

- CCTs increase uptake of preventive services
 - Health visits
 - ANC visits coverage
 - Immunisation rates
- CCTs linked to improved health outcomes
 - Nutritional status and growth of children
 - Unclear effect on anaemia
 - Recent studies show lower obesity and hypertension

Other study findings

- Other effects (out of the scope of the review)
 - Positive effects on education
 - Positive effects on food consumption
 - Increase in income-generating activities
- Adverse effects
 - Increase in fertility when only pregnant women were eligible
 - Misunderstanding of rules – Brazil: women kept children under-nourished to remain eligible?

Are CCTs pro-poor programmes?

- They can be when they are targeted at poorest populations
 - Very good for the programmes that have well functioning systems (Brazil, Mexico, Colombia)
 - Less effective and more difficult when Proxy means testing
- Are CCTs pro-poor when there is no targeting?
 - Richer people are more likely to use (social) services

Key messages from the systematic review

- Body of good quality evidence
 - Usefulness of staggered implementation or randomised large-scale pilots
- Robust findings showing that CCTs can
 - Increase uptake of services
 - Improve some health outcomes



UNANSWERED QUESTIONS

1. What is still UNKOWN about these well-evaluated programmes?
2. What aspects do we need to explore about these successful programmes to draw lessons FOR OTHER SETTINGS?

Are CCTs cost-effective interventions?

- Administrative costs are a first source of inefficiency
 - “Usual” costs of administration the programmes
 - Costs of monitoring/conditioning
- Marginal costs of new users
 - People formerly using the health services (without incentives) get paid to do so
 - Costs of the transfers themselves: could we have achieved similar effects with less money?
- Cost-effectiveness of CCTs?
 - Compared to classic supply-side interventions
 - More acute issue if there is no targeting

What happens in the long run?

- What is the Return on Investment in the long run?
 - Do CCTs actually change people's habits once the carrot is no longer there?
 - The answer might mitigate the perspective on costs
- Exit strategies
 - How to design programmes that remain a safety nets for the poorest without creating dependency/incentives to remain eligible?
 - When people stop being eligible, what happens to them?

Why did these programmes work?

- What is the relative impact of the various aspect(s) of CCT programmes?
 - e.g. Improvement of health status amongst children in Mexico
 - Could we have achieved similar results with some more simple intervention?
- To what problem(s) were they a solution to?
 - NOT direct financial barriers, NOT lack of infrastructure, NOT absenteeism, etc...
 - Demand-side barriers? Lack of awareness?

What were the key enabling factors?

- Strong political support?
 - Ensuring sustainable and prompt funding
 - Ensuring coordination across various sectors
- Strong institutional capacity?
 - Monitoring of conditionality, payment systems, targeting mechanisms
- Presence of good services/infrastructures ?
 - The necessity to ensure good quality services: the examples of Nepal and Jamaica
 - Supply-side supplementary interventions
 - Other broader infrastructures: banks, roads, etc.



What is the ethics of CCTs?

- “Internal governance” of the programmes
 - Misunderstandings of complex eligibility rules (Brazil)
 - Poor design (Bangladesh)
- Ethical implication of using powerful tools
 - Encouraging irreversible changes (contraception)
 - Encouraging dangerous behaviours (Brazil, SA)
- Research fad or policy-relevant interventions?
 - Interest of economist to understand effects of economic incentives on behavioural changes
 - Scaling-up?

Key messages

- Robust evidence of positive effects
 - CCTs have shown that large scale rigorous evaluations are possible
 - CCTs increase uptake of services
 - CCTs are not pro-poor by nature, they are if targeting is effective
- CCT are complex and plural interventions
- Need to understand how/why/under which conditions CCTs work
 - Need for more than just C-RCT (process, qualitative, etc.)

THANK YOU.