Conditional cash transfers: what's in it for health?
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Conditional cash transfers: what's in it for health?

by

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1. What are conditional cash transfer programmes?

Conditional cash transfer programmes (CCT) give money to poor people in return for fulfilling specific behavioural conditions. These conditions include for example children’s school attendance, up-to-date vaccinations or regular visits to a health care facility by pregnant women. CCTs are a new type of social programme with the primary objective of alleviating poverty. A CCT has a direct effect on poverty by providing an immediate additional income for the poor. They can make their own choices as to how to spend or save this money. It is also expected to have a positive impact on the recipients’ health, education or other socio-economic well-being, depending on the condition applied. CCTs thus offer a two-pronged approach to combating poverty, through cash as well as by building-up human capital through improved health and education. Thereby they help to break the transmission of poverty from one generation to the next.

The beneficiaries of the CCTs are those of the poor who can meet the conditions. The conditions are in turn often designed to target certain groups within the poor population rather than everyone. For example the residents of particular poor areas, such as slums, may be offered a CCT. Or the programme is offered to households with young children only, or those that have no regular income. Thereby, some of the poor are often excluded from CCTs in order to achieve a specific improvement within a clearly defined population. CCTs that target children and mothers do not cover the elderly poor. CCTs offered only in a poor neighbourhood will not reach poor people living elsewhere. A CCT thus aims to improve a particular problem area, but it is only one part of the social protection system.

2. What kind of health services are used as conditionality?

The conditionality is an incentive to the poor to invest in their own human capital in order to break an inter-generational poverty cycle. Education and health are the most important factors enabling future generations to escape from poverty. Well fed and healthy children are better able to learn, and going to school ensures that they will be qualified to find better jobs, and thus lead a better life than their parents. The conditions must be readily understood and easily measurable to be able to determine who has fulfilled them. They must rely on regular actions that the beneficiaries can take themselves. In the area of education, primary and secondary school attendance are usually used as a condition.

Health services offer a much wider range of interventions from prevention and promotion to primary, secondary and tertiary care services. In preventive and primary health care, regular visits to health clinics and up-to-date immunization levels are the most commonly used conditions. These practices are important for improving people’s health and they can also be easily measured. In practice, health and schooling conditionalities for children are often combined.

By contrast, curative care services are unsuitable as CCT conditions because people need them only when they fall ill, rather than in a regular, recurring pattern. However, for some specific groups that require regular medical treatment CCTs could provide a way to improve compliance
and access to the treatment. E.g. observing anti-retroviral treatment regimes by HIV patients, or regular visits to STD clinics by sex workers.

3. **Where have conditional cash transfer programmes been implemented and do they improve health outcomes?**

CCTs started in the late 1990s predominantly in Latin America, including in Mexico, Brazil, Colombia, Honduras, Nicaragua and Ecuador. They vary much in size and scope. Whereas the Honduran CCT covers some 30,000 households and provides a cash transfer equivalent to 4% of their average consumption, the Mexican programme extends to 5 million households providing cash to a value of 20% of their average consumption. CCTs have also been implemented or are being discussed in other middle and low income countries, such as Bangladesh, Kenya, Cambodia, Turkey, South Africa, Indonesia and Côte d'Ivoire. The evaluations so far have shown that the CCTs increased consumption by poor households, although the impact is often limited depending on the number of beneficiaries and the amount of the transfer. CCTs have been successful in raising school attendance and health service utilization (for example health clinic visits up by about 20 percentage points in Honduras or Mexico). This is true particularly where these indicators were low to start with. But although largely positive, the results so far have not been consistent across every programme and every measure. For example, CCTs appear to have done little to increase vaccination coverage. The long-term impact on education and health are still being evaluated. There is some positive evidence coming mostly from Mexico. There, CCTs appear to have successfully reduced infant morbidity and mortality, as well as obesity, hypertension and diabetes in adults. In Honduras and Colombia, a reduced incidence of diarrhoea among children (by 3-10%) is attributed to CCTs.

4. **What is the difference between conditional cash transfer programmes and health financing schemes?**

CCTs and health financing schemes are designed for different purposes and perform different functions. Both fall within the family of social protection mechanisms. However, health financing schemes are designed to protect from the financial risk of paying for health services and to ensure service availability. By their nature, they also include a mechanisms to collect prepaid contributions (sometimes via taxes), which are pooled before purchasing health services with them. CCTs do not offer risk protection but are a form of social assistance into which the beneficiaries do not have to pay-in upfront.

With relevant conditions applied, CCTs allow extending the coverage of basic health care, such as vaccinations or mother and child care, to those who could otherwise not afford it or do not realize its importance (particularly of preventive care). CCTs may also increase access to curative health care *indirectly*, as the poor can use the cash received on such services. However, CCTs are not specifically designed for protecting households against financial catastrophe from paying for health services.

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1 See also WHO/HSF technical brief for policy-makers No. 1/2005 “Achieving universal health coverage: developing the health financing system”, available at [www.who.int/health_financing](http://www.who.int/health_financing).
5. What makes a conditional cash transfer programme successful?

Many factors are associated with the success of a CCT in reaching its goals. These include the amount of the transfer, the design and enforcement of the conditions, the duration and sustainability of the programme, the efficiency of targeting and the transparency of its administration. Administering a social programme that hands out cash tends to be cheaper than one that delivers goods to its beneficiaries. A more difficult, and sometimes costly, part can be to identify (target) the needy. Monitoring and enforcing compliance with the conditions adds a further layer of complexity to a CCT. For both targeting and conditions it helps when they are simple and easily verifiable to keep costs down.

Of particular importance to achieving health outcomes is the quality and availability of relevant health services. CCTs are demand-side interventions: the cash on offer is an incentive to use the relevant health services more. CCTs have no direct control over health service providers, but their conditionality can only be effective when quality health services are available to use. Where no health centre exists or is able to provide quality services, a cash transfer will achieve nothing for health. Thus, supply-side interventions to deal with potential problems such as low service quality, staff shortage or medical supply bottlenecks, are the first prerequisite for a successful CCT. Furthermore, the amount of the transfer needs to be enough to provide a fair incentive for the target group to fulfil the condition. Where health service providers charge user fees, they must not be allowed to increase them simply because some users receive a cash transfer. Finally, to achieve the long-term effect expected from improved and continued health and education attendance, the programme must be sustainably funded.

6. Key messages

1. Conditional cash transfers are social assistance programmes aiming to reduce poverty. Apart from the extra income, the conditionality gets beneficiaries to invest into their own human capacities, by using basic health services or sending their children to school, which helps to break inter-generational poverty cycles.

2. Conditional cash transfer programmes are not designed to pool risks, such as prepayment for curative care. They are well suited to improve access to preventive, regular health services for the poorest in society.

3. Conditional cash transfers stimulate the demand for health services. To achieve a health outcome, this demand must be met by ensuring that high-quality health facilities are available at an affordable cost. Thus, this requires also investing in the supply of services.

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2 See also WHO/HSF technical brief for policy-makers No. 2/2005 "Designing health financing systems to reduce catastrophic health expenditure", available at [www.who.int/health_financing].