

# Assessing the equity impacts of conditional cash incentives

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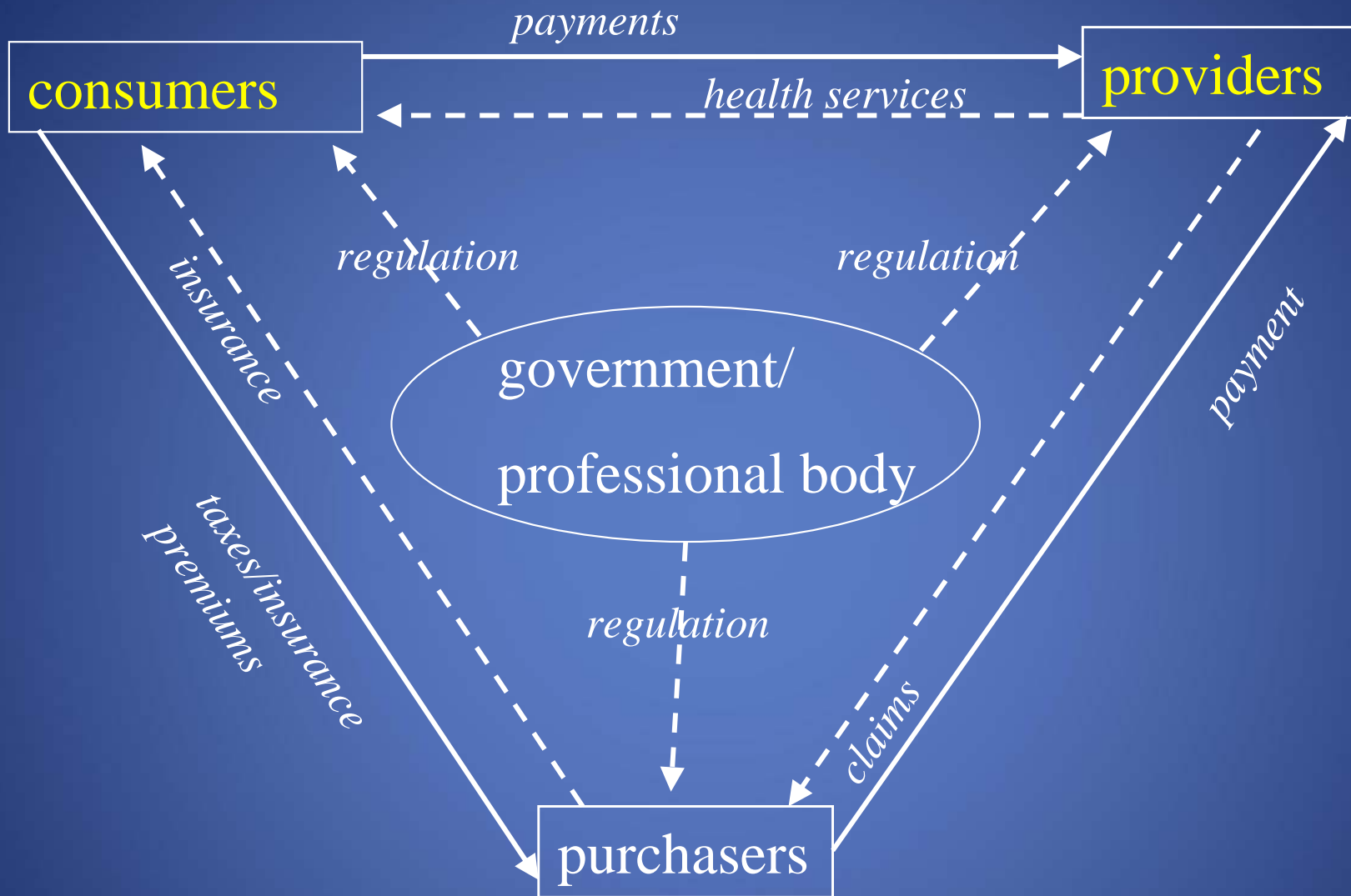
# Overview

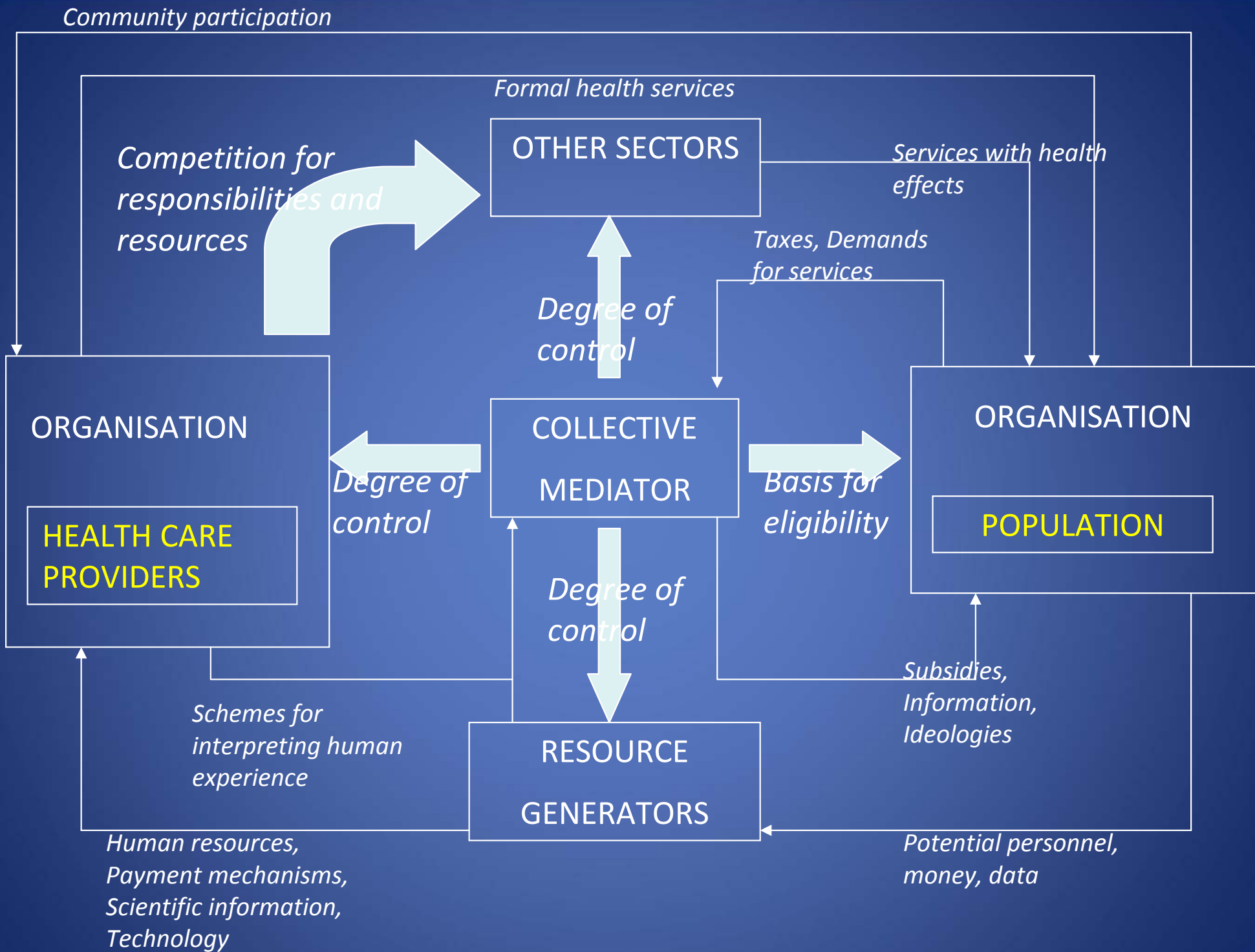
- Starting points:
  - Health systems
  - Equity concerns
  - How new health system interventions influence equity
- Reflections on conditional cash incentives
- Conclusions

**STARTING POINTS**

# 1) Health systems

- Are made up of sets of relationships among a range of organisational & individual actors
- Performance is the consequence of actors' behaviours towards each other & whether they work together towards common goals
- Behaviours & relationships are driven both by personal factors & wider 'institutions'

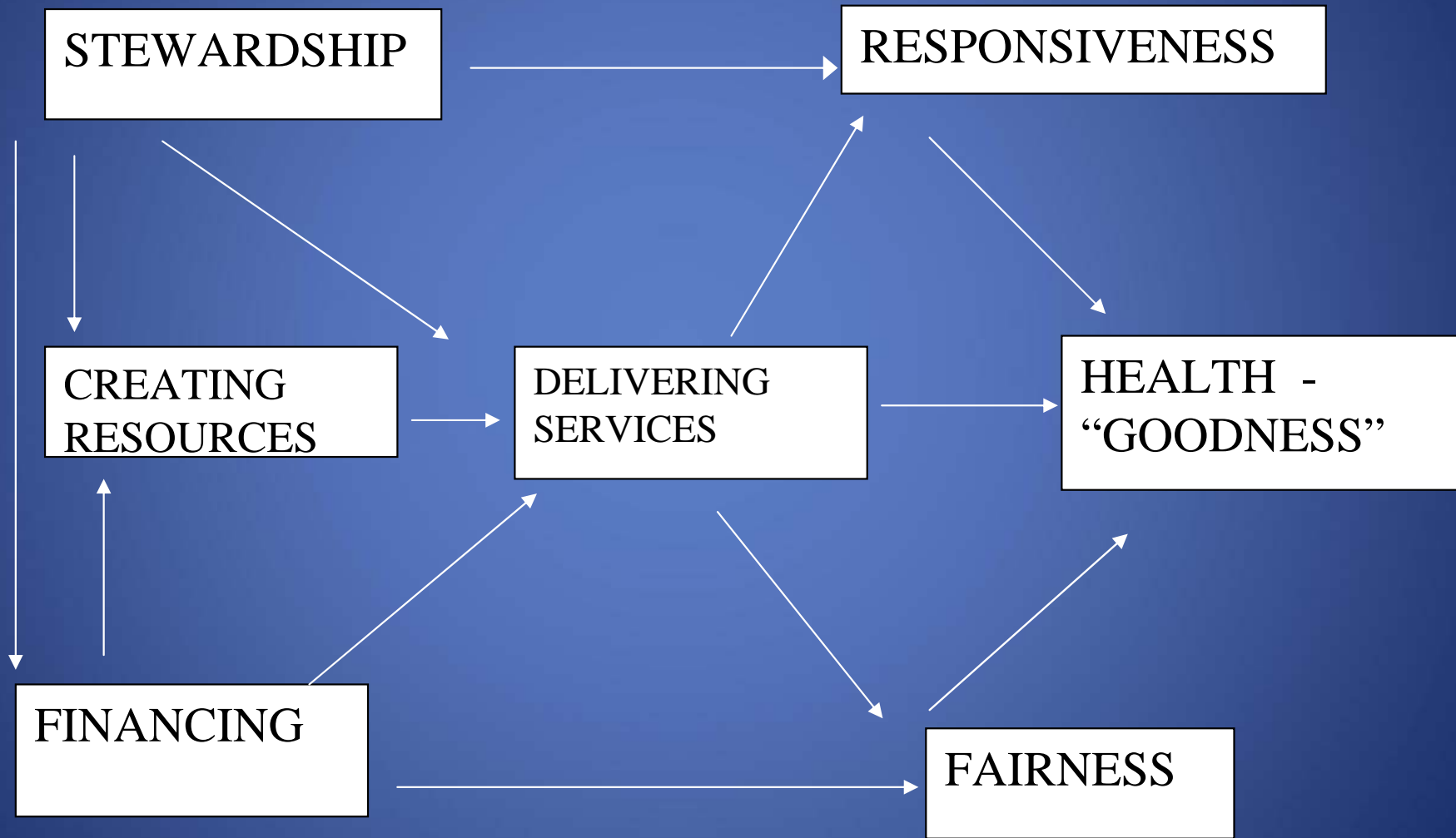




Frenk, 1994

***FUNCTIONS***

***OBJECTIVES***



Source: WHO (2000)

*'Another mother took her child who was critically sick (to the clinic). When she arrived she found a big queue and so she asked the health worker in charge to help. But she was told 'don't you see a queue? If you saw the child was sick why didn't you attend earlier? Stay there!' ...*

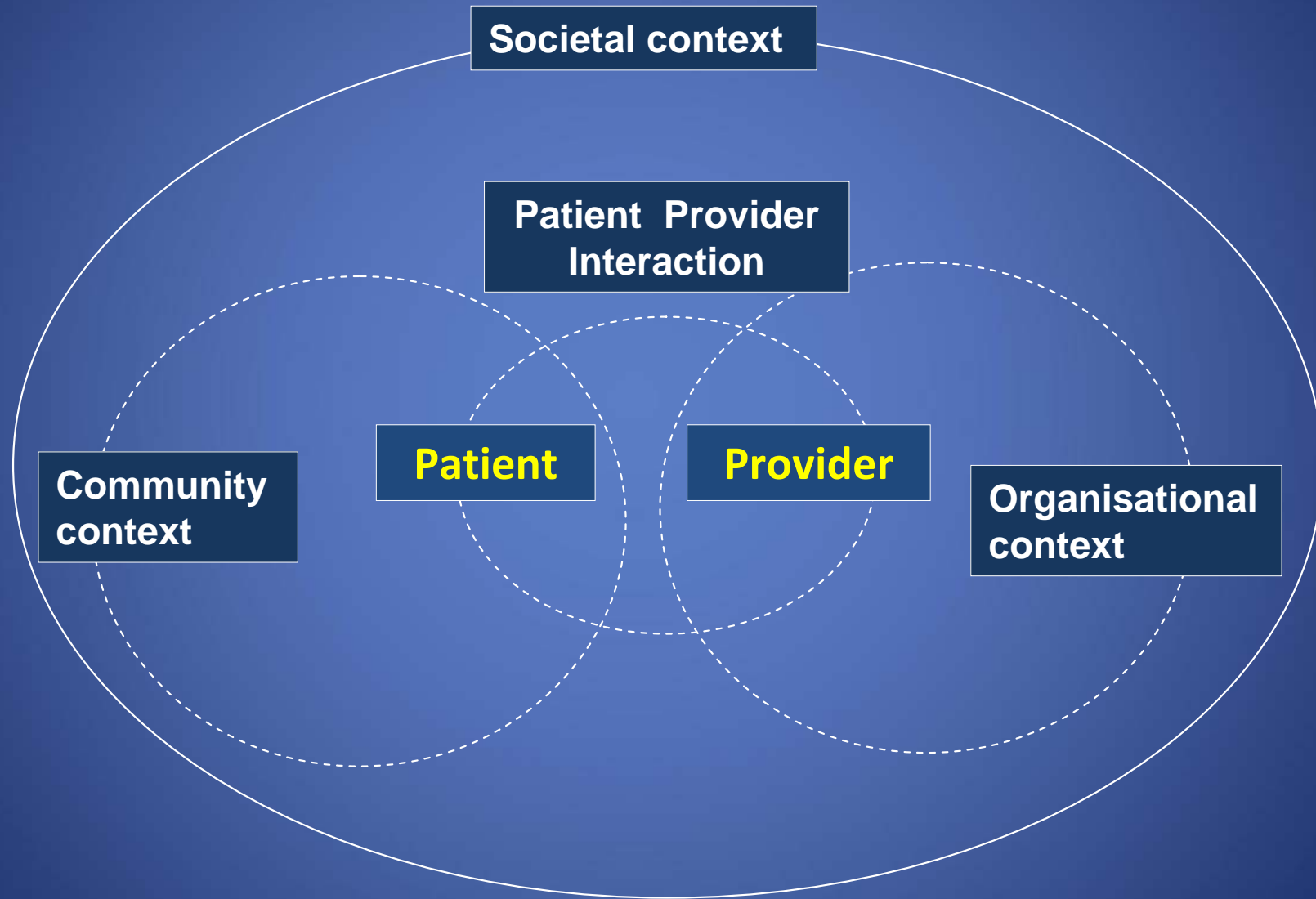
*After a short while the baby struggled with illness and died '*

*(Tanzania)*

# Provider behaviour towards patients

- Providers often rude, even abusive to patients
- Providers often experience
  - patients as demanding, difficult
  - workplaces (people, procedures) as unfair & insecure
    - lack of control, autocratic decision-making, failure to keep promises, lack of caring support

# Drivers of behaviour & relationships



## 2) Equity & Access

# Action towards equity requires

*“...(a) that there be a reasonable degree of equity in respect of outcome concerning the distribution of basic resources*

*and (b) that people treat each other as ends, and not merely as means.*

(Brecher 1997)



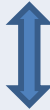


What do patients  
want from health services?

*“Treat us with dignity and respect”*

*“Treat us the same as they treat others”*

(South Africa)

## ACCESS is a function of the degree of fit between patients/citizens and health care provision

SUPPLY 	ACCESS ELEMENTS	 DEMAND
Geographic location Transport availability Opening hours	Availability 	Household daily & working patterns
Costs of seeking care	Affordability 	Household cash availability, the costs of other basic needs & ability to manage costs
Amongst other things:  Provider behaviours & attitudes towards patients, especially communication practices Provider stereotyping and discrimination towards patients	Acceptability 	Amongst other things:  Lay constructions of health & healing Perceived effectiveness of treatment & possibility of cure Patient ability to exercise voice in relation to providers

# New health system interventions

- Influence health system performance through their impact on actors & relationships
- Influence equity by how they impact on both distributional and procedural justice

# **REFLECTIONS ON CONDITIONAL CASH INCENTIVES**

# What are they?

## I) Specific design features:

- incentive: level, form
- implementation design:
  - who makes what decisions; on basis of what information, generated/provided by whom; within what rules

## II) The implementation process:

- is policy phased in geographically over time or rolled out everywhere at once; are elements of policy sequenced?
- how is new policy communicated to various interested actors, how is the support of these actors secured for the policy, how is opposition contained or offset, how is power exercised in implementation?

# How generate impacts?

- Incentive design sends signals that impact on personal & institutional drivers of behaviour
- Implementation design directly re-frames and/or re-inforces pre-existing institutions:
  - allocation of decision-making power
  - norms of fairness in decision-making (& so trust)
  - accountability mechanisms/procedures

# Embedded theory of change?

- Incentives:
  - offer the deprived subjects the wherewithal to partake in some activity beyond their normal means or outside the normal sphere of interest, which then prompts continued activity and thus long-term benefit to themselves or their community (Pawson 2002)
- Cash grants:
  - reflect theories concerning the irresponsibility of poor people and the need for them to be incentivised to adopt socially-valued behaviour (SEKN 2007)

# How generate impacts?

- Implementation process impacts on:
  - geographical equity
  - implementation feasibility
  - actors' understanding & experience of policy
  - norms of fairness (& so trust)
  - balance of power between actors
- and so re-frames and/or re-inforces pre-existing institutions

**CONDITIONAL CASH INCENTIVES:  
EQUITY IMPACTS?**

# Demand side incentives

## Positive potential

- Aim to tackle access barriers of disadvantaged, & improve their health, by addressing economic & knowledge barriers to access
- Evidence that increased use of conditional services among targeted groups, and perhaps among wider community

## BUT

- Is conditionality necessary for health gain?
- Perverse effects among target groups
- Potential for increased out of pocket payments among target group
- Where limited/poor quality supply, what access gains achievable?
- May miss poorest/most vulnerable, who opt out

# Other possible negative impacts

- Is it clear whether increased use among target group translates into reductions in utilisation inequity *between* population groups?
- Institutional effects impact on *procedural justice & acceptability, so equity*
  - stigmatising, dis-empowering
  - provider behaviours & morale
  - social conflicts

# Supply side incentives

- Equity not a clear goal?
  - perhaps broad intent, through improving staff performance & problem solving in remote, relatively under-served areas?

# Possible negative equity impacts?

- Directly undermine access of poorest by:
  - widening resource gap between better and less well resourced & performing areas
  - encouraging providers to focus on less sick, & to stigmatise poor
- Have institutional effects within provider workplace with negative consequences for provider motivation & behaviours , further undermining access
  - dilute/crowd out intrinsic motivation
  - impact negatively on workplace relationships (supervisors and colleagues)
  - undermine trusting relationships

# Equity impacts depend on

- Who gets incentive? Who assesses performance, and on what basis, with what information?
- How new intervention works with other (pre-existing or newly created) institutions & incentives (e.g. promote/undermine existing accountability processes)?

**CONCLUSIONS**

# CCGs are complex social programmes

- Very susceptible to the effect of different contexts (including policy timing, organisational culture and leadership, interpersonal relationships, and competing local priorities and influences)
- Developed and implemented through processes that evolve over time, and which may break down
- Implemented through the active participation of individuals
- Influenced by the power relationships among implementing actors
- Prone to change during implementation
- Often generate unintended effects, positive and negative

# Assessment challenges

- Impact assessments must
  - include procedural outcomes
  - consider distribution of outcomes across population groups
  - be open to unintended changes & effects
- Process assessments must be carried out
  - which consider:
    - views/experience of different groups on outcomes & unintended effects
    - institutional effects, and consequences for equity
  - and enable
    - learning in implementation – especially what institutional re-configuration needed to support equity goals

# Implementation challenges

- Build equity concerns into design & implementation process
- Build design & implementation process on understanding of existing institutions
- Demand side: how
  - do targeted approaches work within universal systems?
- Supply side: how
  - not crowd out intrinsic motivations?
  - use financial incentives to promote ethical & equitable behaviours?
  - manage implementation processes to re-inforce existing institutional arrangements or to establish necessary, new forms?

‘Successful implementation of policies to promote equity and inclusion requires a focus on human interactions at the micro level, as well, as the development of supportive institutional systems for financing, information and regulation... [It] requires managers who are more than administrators, managers who understand a given context and are able to take appropriate action’.

Freedman et al. 2005: 117