

Should disadvantaged people be paid to take care of their health?

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YES One reason the NHS costs so much is that people do not look after their health. Unhealthy behaviours impose huge costs on society as well as harming the individual. For example, the painful and costly outcome of tooth decay requiring reconstructive surgery in young children is preventable through simple actions by parents, such as supervising tooth brushing and limiting consumption of sugary drinks. Better access to free preventive dental care might help, but this is also a behavioural problem.

Unhealthy behaviours are particularly pervasive among disadvantaged people, who are less responsive to health promotion messages (such as take folic acid before pregnancy or read to your toddler) and less likely to take up free public health services (such as screening programmes). The causes are complex and structural—stressful material conditions and social environments leading to poor mental health and chaotic lifestyles rather than idleness or wantonness as was popularly thought in the 19th century.

There is therefore a case for paying disadvantaged people to take care of their health through a conditional cash transfer. It's a bit like a tax on pollution or, rather, a subsidy for not polluting. It's worth doing if the health benefits outweigh the costs. It may sometimes even save the taxpayer money, if the long term savings are substantial. Of course, we should always be wary of fairytale claims about long term savings. An ounce of prevention is not always worth a pound of cure. But sometimes it is.

The case for offering "prevention payments" to the general population is weak, because of the high costs of administration and waste in paying people for doing what they are already doing. The case for means tested prevention payments is stronger, because disadvantaged people are less likely to be doing prevention activities already, are more responsive to cash incentives, and can be identified through the benefit system. This would also help to tackle growing health inequalities between rich and

poor. Arguably, it is also fair that welfare recipients should be expected to make simple low effort changes in their behaviour to avoid burdening their fellow citizens.

Evidence of effectiveness

This idea is part of the broader international shift in the last decade towards conditional cash transfers—that is, behavioural conditions for receipt of state funded welfare, such as the requirement for people receiving unemployment benefit actively to seek work. This shift has gone furthest in the developing world, with conditional cash transfer programmes requiring disadvantaged families to send children to school and to attend maternal and child health clinics.

The first major programme was Progres (now Oportunidades) in Mexico¹; programmes have since spread to other countries in Latin America (such as Brazil, Columbia, Honduras, Nicaragua) and elsewhere (including Bangladesh, Jamaica, Malawi, Nepal).

A recent systematic review of controlled studies in developing countries found that "Overall, the evidence suggests that conditional cash transfer programmes are effective in increasing the use of preventive services and sometimes improving health status," although it warned that further research is needed on cost effectiveness.² Other reviews have come to similar conclusions.³⁻⁵ In 2007, New York City announced a pilot programme of conditional cash transfers for various activities to promote health.⁶ In the UK, a programme of educational maintenance allowances has been phased in since 2004, which pays young people from low income families to attend training and education after the age of 16.⁷ In February 2008, Prime Minister Gordon Brown mooted the idea of a broader conditional cash transfer programme, including cash incentives for children to attend health check-ups.⁸

Careful implementation

Carefully designed conditional cash transfers have the potential to improve population health and reduce health inequality. By averting the need for costly public expenditure, they may even reduce the tax burden.

Conditional cash transfers are not a panacea,

however, and should not be used as ideologically driven political gimmicks. Programmes need careful piloting and evaluation of cost effectiveness in well designed studies with meaningful outcome measures—not just the descriptive case studies that all too often pass for evaluation of UK government programmes. They should be used only when the programme is likely to do more good than harm to disadvantaged individuals, taking account of compliance costs, stigma, and stress to recipients⁹; the behaviour change is sufficiently verifiable to deter fraud and gaming; and the programme is likely to be cost effective, taking account of all benefits and costs, including administration and monitoring.

Are conditional cash transfers an example of the nanny state gone mad? Not really. One person's unhealthy behaviour imposes external costs on fellow citizens. So this is not excessive paternalism. It is partly an application of John Stuart Mill's classic harm principle: "The only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others." In this case, the harm is financial: unhealthy behaviours increase the tax burden. General practitioners already receive financial payments to do what the state thinks is best (through the quality and outcomes framework). If we pay general practitioners to comply with evidence based guidance, then why not pay less advantaged people as well?

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Young Mexican schoolboys in class at San Juan de Las Manzanas, a school that is a part of the Progres Initiative. Families of children who regularly attend the school receive government benefits



Many countries are turning to cash incentives to encourage people to look after their health. **Richard Cookson** argues that such schemes can save money in the long run, but **Jennie Popay** believes the problems need a deeper solution

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NO Of course people living on low incomes would welcome more cash, but handouts conditional on behaving in ways defined as good by highly paid health professionals are problematic.

Poverty has long preoccupied public health, and social reforms and charitable handouts have always been part of the response. But the welfare systems introduced in Organisation for Economic Cooperation and Development countries in the early 20th century shifted from “the poverty problem” to a concern with inequality: from charity to comprehensive systems of social protection based on entitlement.¹ These systems were not perfect but their aim—to develop fairer, more inclusive and cohesive societies—remain relevant.²

Increasingly conditional cash transfers are the acceptable face of contemporary global welfare.³ Like means tested benefits, these transfers are stigmatising, separating off poor people from society. But they are doubly stigmatising because they also label people as irresponsible, unwilling to behave in socially acceptable ways. Unlike benefits that require people to meet predefined eligibility criteria (such as caring for dependent children or having income below a certain level) they also make the transfer of cash, often needed to meet the most basic of needs, conditional on recipients adopting behaviours defined as appropriate by people with little understanding of how to survive in poverty.

Cash transfers dependent on behavioural and financial conditions now target all aspects of poor people’s lives: US Medicaid focuses on screening and chronic disease management, Oportunidades in Mexico and Solidario in Chile focus on maternal and child healthcare, and initiatives in the UK focus on further education and employment.

But do they work? The evidence is limited, but the box (see bmj.com) shows some of the reported benefits and disbenefits.⁴ There are positive benefits but results are mixed, benefits generally small, and positive outcomes more likely for service use than for health status or behaviour change.

Many of these problems are the same as those reported in research on targeted means tested policies. These programmes are difficult to target, administratively costly, and they have little transformative potential at the individual or societal level. They are also doubly stigmatising. So the question is whether behavioural conditionality itself has any added value. A paper on Oportunidades in Mexico reports that gains in children’s health, growth, and development were directly and positively related to the level of cash transfer—the more cash people received the more children gained—but some improvements were too small to be clinically meaningful.⁵

Conditions are unnecessary

So some behaviours are responsive to cash payments, but this does not mean that behavioural conditionality is necessary. Research on cash benefits for dependent children in South Africa that are not linked to behavioural conditions found mothers spent the money on food, clothing, and school fees.⁶ Similarly, an experimental study of cash benefits without behavioural conditions in rural Ecuador reported positive outcomes for physical, cognitive, and socioemotional development of children, and the poorest children had outcomes 20% of a standard deviation higher than comparable children in the control group.⁷ And research in the UK has repeatedly found that poor mothers spend the unconditional universal child benefit on promoting and protecting their children’s health and wellbeing, often at risk to

their own.⁸ When extra cash is available and people are able to make healthier choices, they often do so.

But some behaviours in low income groups are very resistant to change. A recent King’s Fund review⁹ concluded that although cash incentives seem to change simple behaviours (such as uptake of services), they fail to have lasting impacts on complex behaviours—that is, those closely linked to increased risk of serious ill health and premature mortality (smoking and diet). It is not too difficult to see why. These unhealthy behaviours may be “enjoyable,” as the authors of the King’s Fund report suggest. But research also shows they are woven into the fabric of poor people’s social lives, operating as coping mechanisms and helping them survive poverty and its multiple humiliations.¹⁰ To change this is neither simple nor low effort. Cash might coerce some people into changing behaviour but if their lives do not change we should not be surprised if they lapse or substitute other unhealthy behaviours.

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William Beveridge’s report on social insurance identified five giants

on the “road to reconstruction”: want, disease, ignorance, squalor, and idleness.¹¹ The response to Beveridge’s giants—universal systems for social security, health care, and education free at point of use and action to build and sustain full employment, increase public housing, and renew neighbourhoods—have delivered unprecedented improvements in living standards and population health.^{12 13} Surely, we can respond to the 21st century’s giants of inequality in income, wealth, and health with something more imaginative and a greater likelihood of success than conditional cash transfers with a fragile evidence base. History is a better source of evidence for public health than economics when it comes to understanding what works to reduce poverty and health inequalities.

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