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WASHINGTON UNIVERSITY
Political Economy and Public Policy

**The Potential for
Conditional Cash Transfers
to Influence Health Outcomes**

by

Dawn Dziuba

**Master's Thesis presented to the
Graduate School of Arts and Sciences
of Washington University in
partial fulfillment of the
degree of Master of Arts**

May 2010

St. Louis, Missouri

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2010

Master's Thesis

**The Potential for Conditional Cash Transfers
to Influence Health Outcomes**

Acknowledgments

With gratitude to my committee: Norman Schofield, John Drobak, and Lee Benham, as well as deep appreciation to Dr. Larry Lewis and everyone at Washington School of Medicine Barnes Jewish Emergency Department.

I. Introduction:

The recent upheaval of health care reform has sparked much debate over not just what government should provide, but who should pay for it. Will the health insurance mandate lead to increased use of health resources? How should resources be distributed? Who should be responsible? The answers to these questions are complex, and offer the opportunity to spur further discussion of health policy programs.

This thesis tests the theory that conditional cash transfers (CCT) can work as a political and economic policy to impact choice and behavioral equilibriums. The theoretical support for this experiment draws upon the work of Norman Schofield, John Rawls, Tommie Shelby and others. The process of forming new health legislation inspired debates in the United States Senate and House of Representatives, as well as the public sphere, which have highlighted a quandary regarding access to health care. One policy option to address this quandary is the use of conditional cash transfers (CCT). CCT offers monetary incentives to a targeted population to achieve a desired behavioral effect. CCT programs can alter behavior only if the material conditions to support the change in behavior are created as part of the program. CCT is a relatively new and untested concept; thus, we do not have enough information to draw a conclusion as to whether the use of CCT could generate the type of belief cascade described by Schofield in *Architects of Political Change*. This paper explores the potential for CCT as a public policy option that may serve as an important basis for discussion regarding just how resources should be used, a question that is particularly important given the recent expansion of health coverage. This research is important for understanding a policy option that has been relatively unexplored. Given the economic concerns that have impacted the budgets of many

policy makers, CCT is an important option to consider when deciding how to distribute government resources.

II. Theoretical Support

This section discusses the basis for development of a CCT program by drawing on political theory and discussing how these ideals might be actualized in a social welfare program utilizing CCT.

A. Discussion of Rawls Veil of Ignorance

Theoretical Support for a CCT program can be drawn by from a social justice perspective. One of the challenges with many social welfare policies regards how to achieve a just distribution. How should goods and services be distributed? How should resources be allocated in a manner consistent with justice? Shelia Foster, a Professor of Law at Fordham University, summarizes Rawls as follows:

The central underpinning of Rawl's theory of justice consists of the notion that equal and rational people (in the original position/behind a veil of ignorance) would agree to live by a set of principles decided upon together. Furthermore, that such free and rational people would agree upon both a liberty principle (that every person has extensive basic liberty rights). And a difference principle (that social and economic inequalities are to be arranged so that they benefit the least advantaged, while upholding equality of opportunity.¹

Some very important observations can be drawn from this comment, for instance, that the idea of justice is not inconsistent with the idea of liberty. Nor is justice divorced from reason or reality. Rather, decisions about principles are made by "equal and rational" people. Thus, there is a presumption that decisions will have a rational basis, and this is also consistent with the

¹ Foster, Shelia. "Panel III: Equal Citizenship: Race and Ethnicity: Rawls, Race, and Reason. 72 Fordham L. Rev. 1715, 1715.

“rational basis” test that is frequently used in law. In addition, the theory suggests that such people would agree to a set of principles “decided upon together.” Thus, this suggests that the decisions are not made by a king or self-appointed ruler, but by some process that encapsulates some notion of requisite notion of input from all members of the class of equal and rational peoples. In this decision making process, liberty is not lost, and arguably takes the form of some minimum threshold of basic rights. While the nature and scope of these rights will always be debated, it is important to note that they are still cognizable, and that there is a ‘bottom rung’ representing this minimum which should not be forsaken.

Through the lens of Rawl’s veil of ignorance, arguably, members of society would have a system of rules, institutions, and social frameworks designed in such a manner that they would assent to regardless of where they originated in the system. In other words, designing a system where people did not know, going in, whether they would be in the position of the employer or the employee, born with privilege or born into poverty, etc. They would lack knowledge of whether they will be male or female, of a majority or minority race, healthy or disabled or challenged in some way. Without this knowledge, the theory would surmise that the social and economic system would be designed to benefit the least advantaged. However, Rawl’s social system would still permit and encourage opportunity. It is from this lens that in a sense, justice really would be blind, because members of the society are making decisions regarding its structure without knowing where they will end up. This is an important aspect to keep in mind for deciding how CCT would be allocated towards expenditures. If people were blind to which categories they would fall into, their decision making process may be different regarding the allocation of CCT when compared to decision makers who know what category they are in and who can arrange the policy framework in such a way that it benefits their own interests.

Foster further writes, “the basic notion behind Rawl’s theory stands secure as a very appealing one: Justice – and in particular just distributions – can be achieved through a fair process that is open to all – regardless of race, gender, ethnicity and other characteristics – and which attends to benefiting those least well off.”² CCT has the potential to address the need to benefit the least well off by helping provide access to health care for those who lack financial resources and encounter challenges to going to the doctor. The impact of perspective gained from drawing upon Rawl’s work is important because it takes into account that positions can radically change.

I agree with Foster that there is an allure to “Rawl’s belief in the ability of reason to lead to just results, and that attending to the needs of those less well off is the obligation of every rational person.”³ This speaks to an ideal that is supposed to be embedded in most social welfare programs, but is often complicated by reality once a person finds themselves feeling the weight of being a member of different categories that may have different advantages or disadvantages. A classical economic perspective assumes that people will always act in their own rational self interest. From this Rawl’s veil of ignorance has a unique appeal. It would not necessarily be inconsistent for people to pursue their own self interest and yet still favor Rawl’s veil of ignorance as a guiding principle in the formation of important public policies. In fact, it may actually be well within the sphere of a person’s rational self interest to choose Rawl’s veil of ignorance. The more debated questions are: first, whether this is the best ideal or guiding principle to follow; and second, whether selection of the veil of ignorance can be consistent with

² Foster, Shelia. “Panel III: Equal Citizenship: Race and Ethnicity: Rawls, Race, and Reason. 72 Fordham L. Rev. 1715, 1716, (April, 2004).

³ Foster, Shelia. “Panel III: Equal Citizenship: Race and Ethnicity: Rawls, Race, and Reason. 72 Fordham L. Rev. 1715, 1719. (April, 2004).

the underlying drivers of economics that we have alluded to previously. This paper asserts that that there exists the possibility for compatibility. An exploration of these principles in the context of a CCT program provides a useful framework for drawing out their intricacies in application.

Could CCT achieve the fairness of equality or of opportunity that is discussed in the idea of Rawls's notions of justice? Here it is helpful to turn to Tommie Shelby's discussion of Rawl's fair equality of opportunity principle, who writes that

“this principle, were it to be institutionally realized in a well-ordered society in which the basic liberties were secure and their fair value guaranteed, would mitigate, if not correct, these race-based disadvantages by insuring that the life prospects of racial minorities are not negatively affected by the economic legacy of racial oppression.”⁴

Shelby surmises Rawl's principle as the ideal that those who are similarly situated in terms of ability “should have the same prospects of success regardless of their initial place in the social system.”⁵ The application of Rawl's principle should help correct for some of the initial disparity. A person would have the opportunity to succeed or fail. Thus, those who were in situations of advantage would move about the social system in part as a consequence of their choices. More importantly, those who initiated in situations of social disadvantage would have a greater opportunity to move or change their position. One of the reasons Shelby discusses for social members rejecting mainstream values is that they view them as unattainable and something that belongs to a higher positioned, exclusive middle and upper class. Conditional cash transfers are a crucial means for those who experience economic barriers to changing their position. Moreover, CCT is a way of rewarding people for making positive choices. The use of

⁴ Shelby, Tommie. “Part III. Equal Citizenship: Race and Ethnicity: Race and Social Justice: Rawlsian Considerations.” 72 Fordham L. Rev. 1697, 1710.

⁵ Shelby, Tommie. “Part III. Equal Citizenship: Race and Ethnicity: Race and Social Justice: Rawlsian Considerations.” 72 Fordham L. Rev. 1697, 1710.

CCT will empower people to change their position. Because people will feel like they have a choice, they will be less likely to engage in the “us versus them” mentality that many socioeconomically challenged people feel because they cannot see beyond their current circumstances an ability to obtain the resources necessary to advance. This is certainly true for the case of advancing health, where obtaining a healthy environment and lifestyle can be expensive. A social welfare program should be designed to promote this fair equality of principle in the context of conditional cash transfers as a possible response to the current quandary of inequity in health care.

B. Definition of Theoretical Terms from Schofield’s Architects

This section explores the theoretical framework as set forth by Norman Schofield in his book, Architects of Political Change, which is helpful for exploring the impetus for consideration of a conditional cash transfer proposal. Schofield defines terms describing a system of core beliefs, preferences, and equilibriums to model choices. In his theoretical framework underlying the beginnings of a theory of democratic choice, Schofield defines several terms that are adapted from social choice theory. Understanding the terms is important to understanding the process of policy transformation in response to different constitutional quandaries described by Schofield faced by different societies throughout the past several centuries. We will later apply these terms to a discussion of the current quandary and potential impact of this proposal to alter the belief and preference system. Schofield terms the instigator of the transformation an architect of change, a leader or theorist who “interprets or frames the quandary troubling the society in a way that leads to its resolution.”⁶ The architect is an agent of political transformation.⁷ The

⁶ Architects, p3.

quandary indicates a time of great uncertainty in the electorate⁸. Schofield defines a core belief as the belief that is equilibrium, or “is collectively agreed upon (in some appropriate social choice sense) by the members of the community.”⁹ Schofield describes what is necessary for widespread belief change to occur. When there is a “clear discord” between core beliefs and some empirical aspect of reality, then some members of the society may be forced to change their beliefs.¹⁰ A cascade may result when others observe the effects of a small number switching beliefs, as their propensity to change beliefs will increase¹¹. The architect of change is an agent who is able to trigger this change in a social situation by providing a plausible argument for the option for which individuals will change their beliefs.¹² However, the preconditions to generate a cascade are “unclear and may indeed be unknowable” according to Schofield.¹³ Schofield describes the instance of the emperor’s new clothes, which may be insightful here. In that instance, a child pointed out that what the emperor thought was a great outfit turned out to be nothing at all.¹⁴ An informational cascade describes the transformation from one equilibrium to another as a consequence of the effect of information and its credibility on a group. The architect of change “is able to transmute, in some fashion, the belief in question so that it is once again tenable, and provides the common knowledge foundation for cooperation.”¹⁵ Understanding this framework is important for our later discussion of both the quandary and the proposed policy solution of conditional cash transfers. Schofield describes valence as an aspect of judgment that is subject to rapid change that can spread like an infection

⁷ Architects, p21.

⁸ Architects, p16.

⁹ Architects, p261.

¹⁰ Architects, p261.

¹¹ Architects, p261.

¹² Architects, p14.

¹³ Architects, p261.

¹⁴ Architects, p261.

¹⁵ Architects, p98.

in a democratic society.¹⁶ As will be further described below, CCT presents the possibility of having this positive effect because it entails a mechanism to change attitudes towards government welfare programs and choices that impact one's lifestyle and health, along with the overall health of the community. Schofield identified historical occasions in which these types of "infections" occur, and suggested "that these belief transformations may take the form of a change in a key constituent or core belief induced by the obvious need to deal with a quandary facing the society."¹⁷ Schofield suggests that the plurality rule "engenders risk taking to face fundamental democratic dilemmas."¹⁸

III. Scope of the Current Quandary

The current quandary regarding inequity in health care has been the subject of much debate in both the United States Senate and House of Representatives, as well as the public sphere. It can be phrased as follows: Is there a constitutional requirement regarding equitable access to health care? Specifically, how should scarce resources be allocated to address health disparities in a manner consistent with the democratic and constitutional ideals of a right to life, liberty, and the pursuit of happiness? This question will certainly be litigated further given the recent passage of health care reform, and courts will have to conduct an in depth discussion and analysis of such underlying principles in order to answer important constitutional questions involving access to medical care, health policy, and underlying constitutional concerns implicating arguments about rights and liberties.

The gap that has resulted in inequity in health care is a significant concern. The urgency of addressing this quandary has been amplified by the current financial crisis, resulting in an

¹⁶ Architects, p278.

¹⁷ Architects, p278.

¹⁸ Architects, p278.

increase in the numbers of the uninsured and underinsured population.¹⁹ Lack of equitable access to health care is a significant problem that rises to the level of the quandaries of the type described in *Architects of Political Change*. According to recent government data for 2007, nearly an estimated 46 million Americans, or 18 percent of the population under age 65, were lacking health insurance.²⁰ Nearly twice that amount – close to 90 million – spent went for some period in 2006 or 2007 without health coverage.²¹ This illustrates the scope of the quandary implicated here. Clearly, access to health is not equal, and there is a widespread disparity in the United States between those who have access to this important resource, and those that do not.

This disparity in coverage is also reflected as a disparity in costs. According to a study by the Kaiser Family Foundation, a nonprofit health research group that conducts an annual survey of employer medical benefits the total cost for family coverage now averages \$12,680 a year, up 5 percent from 2007.²² While this as well as other estimates regarding the cost of health care may be debated or disagreed with, such arguments cannot defeat the sense of urgency felt by both the public and policy makers regarding escalating costs.

It has been further reported in a study based on its national survey of households by the nonpartisan Center for Studying Health System Change, that “nearly one of every five families had problems paying medical bills last year. More than half of these families said they borrowed

¹⁹ Parks, Dave. *UAB Doctor Pushes Federal Bill to Tackle Emergency Room Crisis*. The Birmingham News. March 12, 2009.

²⁰ DeNavas-Walt, C.B. Proctor, and J. Smith. *Income, Poverty, and Health Insurance Coverage in the United States: 2007*. U.S. Census Bureau., August 2008. [accessed at <http://www.nchc.org/facts/coverage.shtml>]

²¹ Families USA. *Wrong Direction: One Out of Three Americans are Uninsured*. September 2007. <http://familiesusa.org/assets/pdfs/wrong-direction.pdf> [accessed at <http://www.nchc.org/facts/coverage.shtml>]

²² Abelson, Reed. “Health Care Costs Increase Strain, Studies Find.” *New York Times*, September 24, 2008. [accessed at <http://www.nytimes.com/2008/09/25/business/25health.html>]

money to pay these expenses, and nearly 20 percent of those having difficulty said they contemplated declaring personal bankruptcy as a result of their medical bills.”²³

The quandary regarding how to address the need for equal access to health care is consistent with the uncertainty in the electorate described by Schofield in previous examples used to illustrate his Architects of Political Change framework. Given the millions of people who either lack access or who have unequal access to adequate health care, this quandary is important because of the uncertainty for so many Americans of whether they will have equal access to health care in the future. The quandary of the present day has been discussed in countless circles in several different ways. Some have questioned whether there should be a constitutional right to health care that can be derived from the other rights implicated in the Constitution. A bill has been proposed by Representative Jesse Jackson on March 3, 2009 to amend the Constitution of the United States regarding the right of citizens of the United States to health care of equal high quality.²⁴ A further concern stems from President Obama’s attempts to reform the United States health care system to initiate national health care coverage. One of the concerns is the constitutional implications given the text of the Tenth Amendment of the U.S. Constitution, which provides “The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”²⁵ Arguably, a nationalized health care may implicate or infringe upon the specific powers reserved for the fifty states. It would impact states’ ability to be laboratories for policy experimentation.

²³ Abelson, Reed. “Health Care Costs Increase Strain, Studies Find.” New York Times, September 24, 2008. [accessed at <http://www.nytimes.com/2008/09/25/business/25health.html>]

²⁴ For more information about the bill H.J Res. 30, see <http://www.govtrack.us/congress/bill.xpd?bill=hj111-30> The bill would amend the U.S. Constitution to state: Section 1. All persons shall enjoy the right to health care of equal high quality. ‘Section 2. The Congress shall have power to enforce and implement this article by appropriate legislation. [<http://www.govtrack.us/congress/billtext.xpd?bill=hj111-30>]

²⁵ For discussion, see <http://www.tenthamentcenter.com/2009/06/11/the-50-laboratories-model-for-health-care/>

The importance of this was further discussed in recent debated over whether or not to include a public option in the bills in both the House and the Senate. The importance of this issue is evident in the heated arguments that occurred over the best way to address the public need to have access to health care. Even with the recent passage of health care reform, these questions still remain unanswered. The recent health care reform will likely escalate the importance of finding answers, and the judiciary may be called upon to provide such clarity.

IV. Empirical Research

This section describes empirical research designed to identify any barriers, as well as clinical and demographic variables associated with patients having access to medical care following their visit to an emergency department. From this research we can derive appropriate elements of a CCT program.

A. Barriers to Follow-up at FQHCs

The objective of this study was to identify barriers to follow-up (F/U) for patients lacking a usual source of health care referred from Barnes-Jewish Emergency Department (ED) to any metropolitan federally qualified health clinic (FQHC).

Methods: Study participants consisted of a convenience sample of patients discharged from the ED with no primary care physician (PCP), referred to any metropolitan FQHC. Patients were excluded if they were not English-speaking, had no working phone, or could not provide informed consent. Patients were given information regarding the FQHC closest to them for F/U and were asked for a number where they could be reached by phone. Research assistants used a

standardized questionnaire to determine: 1) If the patient followed-up; 2) If not, what was the major reason they did not F/U. Lastly, all patients were asked to identify the most important issue to improve access to FQHCs.

Results: 352 patients consented to be in the study, with complete F/U data on 201, 30 of whom were excluded for having an alternate source of care.

Of the remaining 171 patients, 80 patients (46.7%; 95%CI 39.3-54.3) followed up to an FQHC. Of 91 that did not F/U, transportation was the major identified barrier N= 23 (25.3%; 95%CI 16.3-34.2); followed by “thought it would cost more than I can afford” N=16 (17.6%; 95%CI 9.8-25.4). Other reasons included “feeling better” N=12(13.2%; 95%CI 6.2-20.1); and “unsure of where are when to go” N=8(8.8%; 95%CI 3.0-14.6). Only one patient (1.1%; 95%CI 0-3.2) said they “prefer to use the ED.” (See Chart 1.)

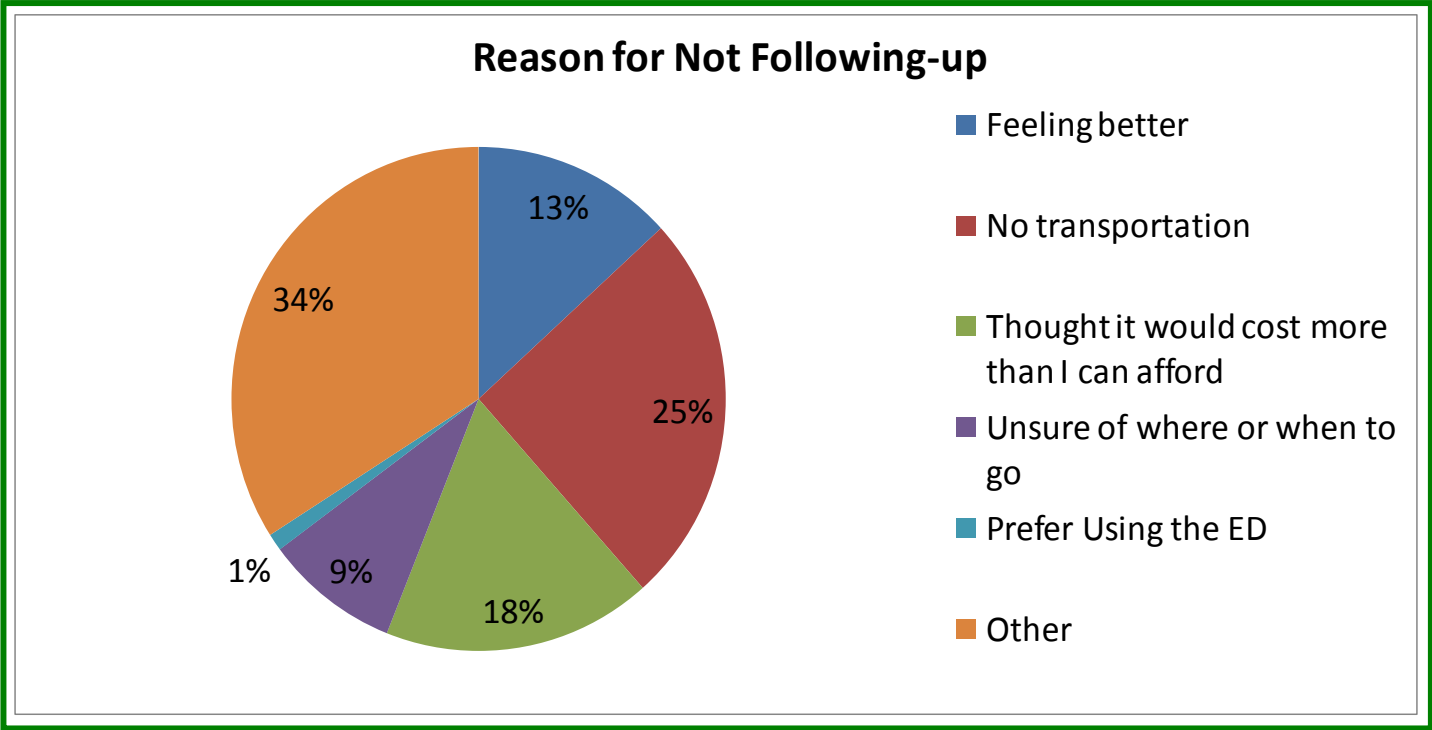
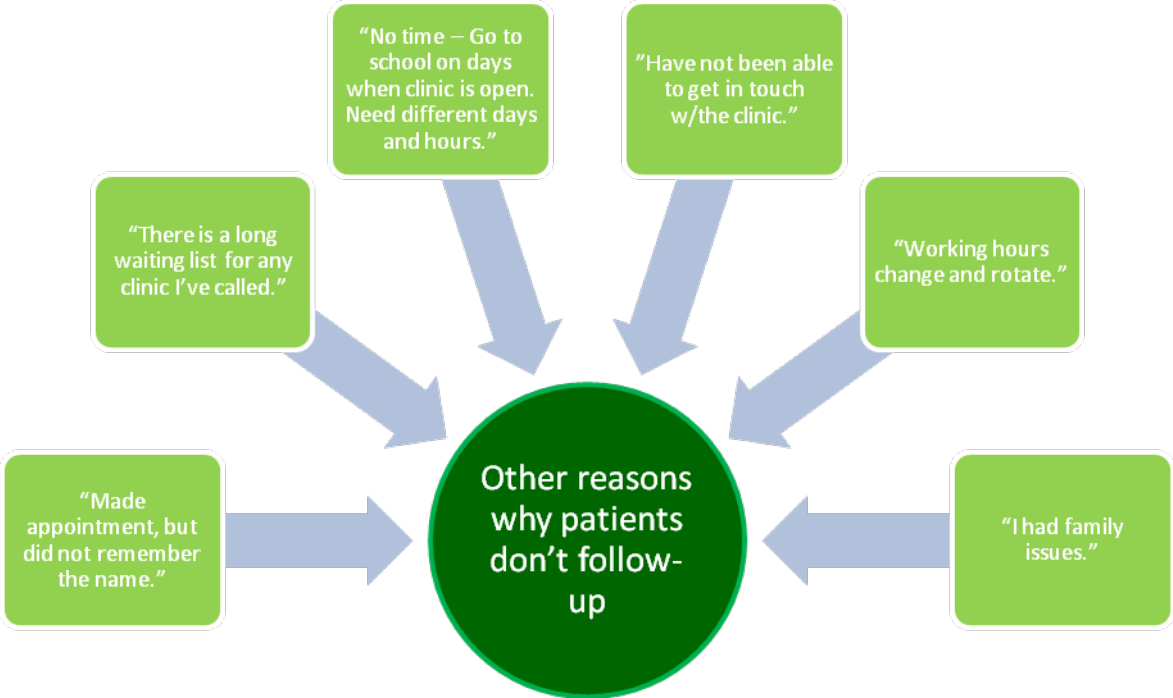


Chart 1: The major identified barrier given by patients who did not follow-up with a clinic after their visit to the Emergency Department.

31 patients (34.1%; 95% CI 24.3-43.8) chose “other” as the major reason they did not follow up, reasons of which are listed in Graphic 1.



Graphic 1: This graphic illustrates various reasons given for patients who indicated the “other” category for why they don’t follow-up.

Of patients who kept their appointment, 29(36.3%; 95%CI 25.7-46.8) drove themselves and 23(28.8%; 95%CI 18.8-38.7) had a family or friend drive them. For public transportation, 19(23.8%; 95%CI 14.4-33.1) used the bus or metro and 2(2.5%; 95%CI 0-5.9) used a taxi. Only 4(5%; 95%CI 0.2-9.8) walked and 3(3.8%; 95%CI 0-7.9) indicated “other”. (See Chart 2.)

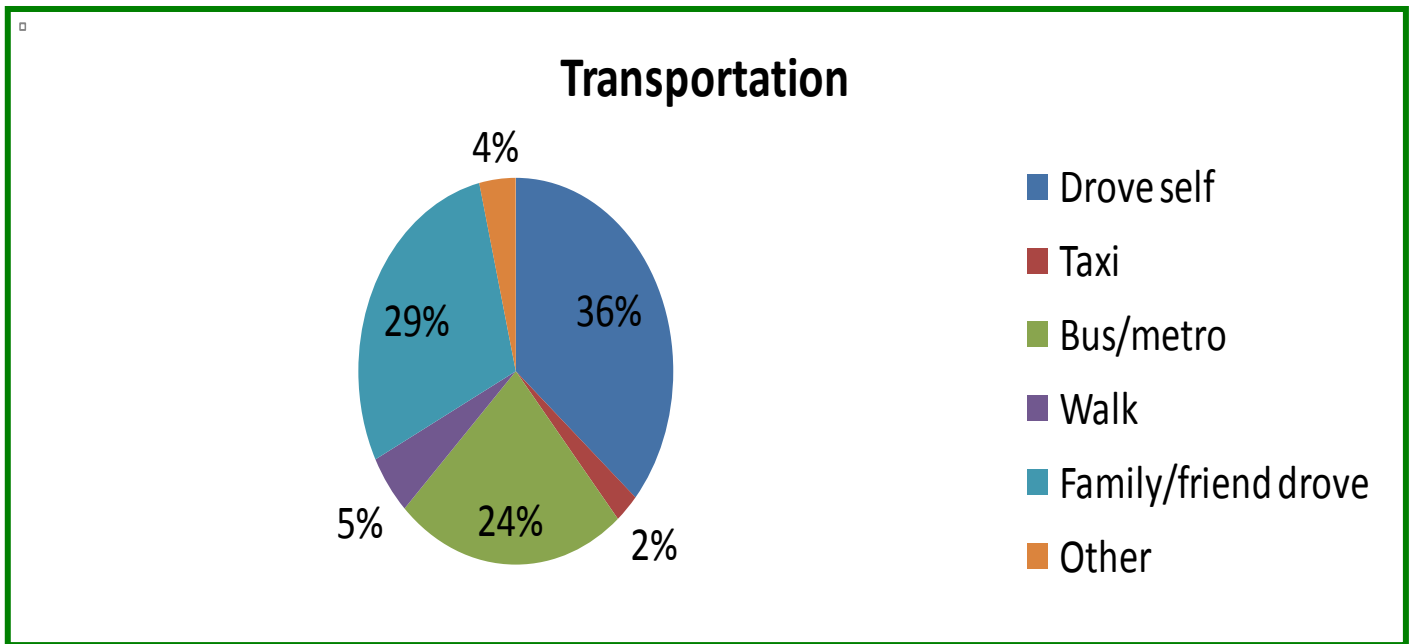


Chart 2: This chart illustrates the transportation method of those patients that were able to go to their follow-up appointment.

Important discussion is drawn from these observations about transportation. One-fourth of the patients who did not go to their follow-up appointments said that a lack of transportation was the main reason. This is important when compared to the patients who were able to go to their follow-up appointments. Approximately 29% had a family or friend drive and 36% drove

themselves. This would suggest that they had knowledge of a means of transportation prior to the initiation of their need to follow-up. This raises the question of whether those who cited transportation as the reason they did not follow-up were unable to drive themselves or did not know someone who could take them.

The F/U rate in this study was higher than in previous reports and may reflect a selection bias in patients able to be followed-up by phone, or an effect of knowing they would be contacted about their appointment.

In conclusion, transportation and cost were the major barriers to F/U to an FQHC. Offering transportation and lower cost alternatives would likely increase F/U at FQHCs in this population.

B. Demographic and Clinical Variables Associated with Follow-up

This study identified demographic and clinical variables associated with follow-up rates (F/U) at federally qualified health centers (FQHC) among patients discharged from an urban-based Emergency Department (ED).

Methods: The setting of the study was a large urban-based academic ED. Participants consisted of a convenience sample patients discharged from the ED with no PCP, referred to any metropolitan FQHC. Exclusions: Not English speaking, no working phone, could not provide informed consent.

Data was acquired and analyzed via F/U telephone interviews which were conducted over a 2 month period, using a standardized questionnaire. Demographic variables were obtained by direct interview at the index ED visit. Clinical variables of interest were obtained by self-report

on telephone interview. Co-morbidities included diabetes, high blood pressure and heart problems. The association of clinical and demographic variables to successful F/U was analyzed initially with bivariate analysis and then using logistic regression analysis.

The results were that 352 subjects were enrolled. F/U interviews were completed with 201 subjects, 30 of whom were excluded for having an alternate source of care. We had complete data regarding F/U on 171 subjects for demographic and clinical variables analysis.

Demographic data: 97 were women (56.7%) and 137 were African-Americans (80.1%). Mean age was 34.1 years. (See Chart 3.)

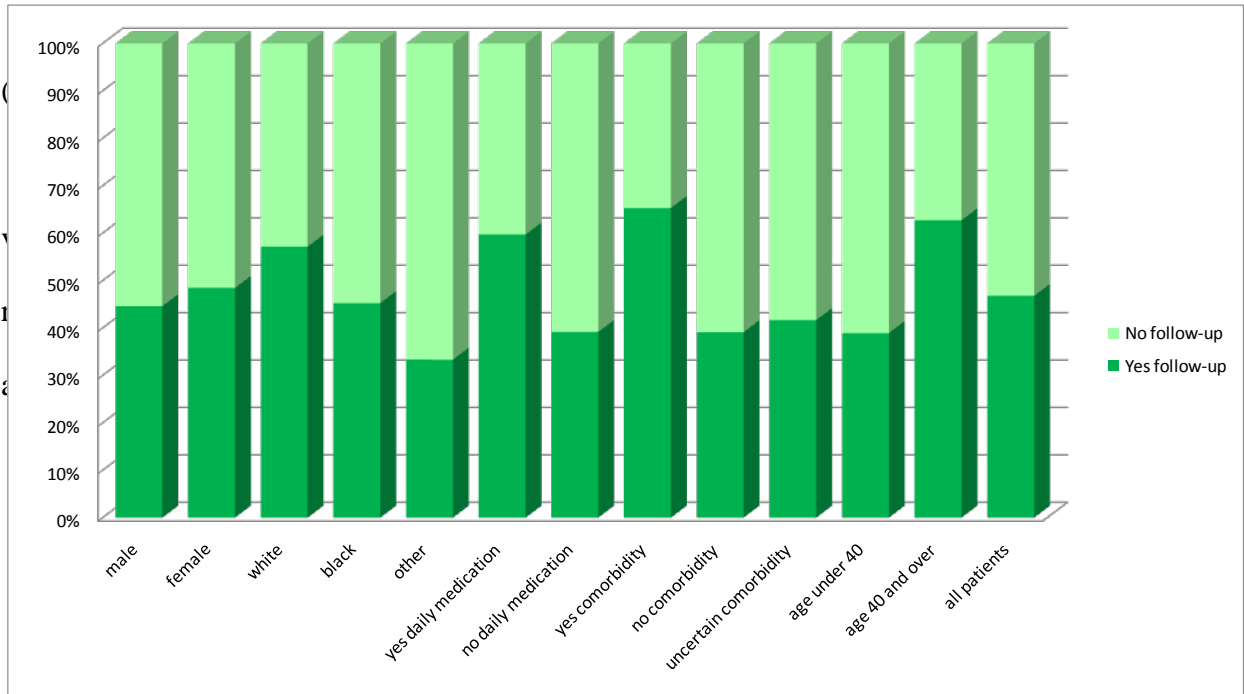


Chart 3 illustrates the proportion of patients who followed up and who did not follow-up in each demographic.

Variable		F/U Yes	F/U No	OR (95% CI)
Gender	F	47 (48%)	50	1.16 (0.64-2.14)
	M	33 (45%)	41	Ref
Race	W	16 (57%)	12	1.61 (0.71-3.66)
	AA	62 (45%)	75	Ref
Daily Med	yes	40 (60%)	27	2.30 (1.22-4.35)
	no	38 (39%)	59	Ref
Co-Morbidity	yes	32 (65%)	17	2.93 (1.45-5.92)
	no	43 (39%)	67	Ref
Age	≥ 40	36 (62%)	22	2.57 (1.34-2.57)
	< 40	44 (39%)	69	Ref
All patients		80 (47%)	91	

Table 1 illustrates the rate of follow-up by demographic variable, along with the odds ratio for following up based on demographic variable.

Our F/U rates exceeded those in other studies, but only included subjects reachable for phone interview. This may select subjects more likely to F/U than those unable to be reached. We have no F/U information on the latter group. On bivariate analysis age, co-morbidity, and daily medication statistically increased F/U rates. On multivariate analysis, adjusting for gender, age, race, comorbidity, and daily medication, the only statistically significant factor was age. This is largely due to the fact that medication and comorbidity are highly interdependent.

In conclusion, older and sicker patients F/U more often than younger less sick ones, but still less than two-thirds of the time. It is important to identify the major barriers to F/U in an effort to improve these numbers. Finally, specifically targeting younger patients with chronic disease may improve their F/U rates.

V. A Proposal the use of conditional cash transfers (CCT)

This section discusses the possibility of using conditional cash transfers as a policy to address the quandary of unequal access to health care. It further explores the possibility of CCT to use monetary motivation to empower individuals to play a larger role in improving their own health.

The approach of conditional cash transfers is a relatively new and sparsely tested policy proposal. CCT refers to the use of monetary incentives offered to a targeted population in order to achieve a desired behavioral change or effect. This type of incentive program has its roots in use in both Central and South America to improve school attendance, increase the rate of follow-up for healthcare check-ups, and encourage parents to attend educational talks regarding health, nutrition, and family planning.²⁶ Preliminary evidence suggests that CCT may have a significant effect on health-related behavior.²⁷

CCT has been further utilized as an approach to encourage patients to follow-up for regular health check-ups and also to comply with specific preventative strategies. The use of financial incentives to help motivate patients to better understand their medical conditions and to take steps to better control them is a relatively young concept.²⁸ The first CCT programs to really gain attention were initiated in Mexico and were recognized for yielding an increase in pre-natal visits.²⁹ The idea of CCT is to remove any financial barriers to obtaining primary care by paying patients to keep their appointments, and then motivate them to comply with lifestyle

²⁶ Levy, Santiago. *Progress Against Poverty: Sustaining Mexico's Progresa-Oportunidades Program*. Washington, D.C.: The Brookings Institution, 2006.

²⁷ Rivera, JA, et al. *Impact of the Mexican Program for Education, Health, and Nutrition (Progresa) on rates of growth and anemia in infants and young children: A randomized effectiveness study*. JAMA 2004; 291: 2563-2570.

²⁸ Levy, Santiago. *Progress Against Poverty: Sustaining Mexico's Progresa-Oportunidades Program*. Washington, D.C.: The Brookings Institution, 2006.

²⁹ Levy, Santiago. *Progress Against Poverty: Sustaining Mexico's Progresa-Oportunidades Program*. Washington, D.C.: The Brookings Institution, 2006.

and medical regimens to better control their disease by paying them for demonstrated improvements in control.

Although there is some information available about programs that have utilized CCT, very few studies that have attempted analyze them with any type of scientific rigor or to really explore the theory behind arguments that they impact belief modification. This is important, because we do not yet know if the use of a CCT policy could generate the type of belief cascade described by Schofield in *Architects of Political Change*. In light of this background, I propose the following:

Hypothesis:

I hypothesize that barrier removal (with provisions for transportation and copayment costs) and conditional cash transfers will increase compliance with follow-up visits, with the policy of conditional cash transfers having the greatest impact.

Scope:

1. To determine if the removal of the two major barriers to access of primary care, those being transportation and co-payment costs, will lead to significant improvements in outpatient clinic follow-up rates, weight control, and diabetes (DM) management over a one-year follow-up period, compared to a control group, consisting of routine “usual” care.
2. To determine if a conditional cash transfer (CCT) program will lead to additional improvement in outpatient clinic follow-up rates, weight control, and diabetes management over

a one-year follow-up period, compared to the control group, and the group with barriers removed.

Procedure Summary:

Frequent emergency department users with chronic conditions who lack a usual healthcare source are identified and placed into one of three groups: a control group, a “barrier” group of patients who receive transportation vouchers and no co-payment, and an “incentive” group which receives financial compensation in addition to barrier removal for their follow-up visits.

Inclusion criteria:

Two or more ED visits within the prior 12 months (including the index ED visit)
Having no identified usual source of healthcare, or the usual source of healthcare is the participating Federally Qualified Health Clinic (FQHC). The subject must be eligible and willing to receive care at an FQHC.

Exclusion criteria:

Under 18 years of age, terminal illness with life expectancy less than two years, cognitive impairment or inability to give informed consent, no working phone, not English-speaking, no permanent residence or not a St. Louis resident.

Enrollment:

During study hours, any patient who meets selection criteria will be approached and asked if they would like to participate in a health study. The patients will be told that if they consent to participate in the study, they will be randomly assigned to one of three groups.

VI. Advantages to the Target Population from CCT

This thesis differs from Schofield's theory in that there is not necessarily an architect of change, but more of a team that designs the program, drawing on their varying areas of expertise. The information exchange is encouraged by the CCT, as patients gain health information when they go to the doctor.

This program is important in offering an alternative to social pressure to make money other ways. With all the marketing of unhealthy choices – alcohol, drugs, smoking, sugary snacks, etc. there needs to be some incentive not to engage in the unhealthy behavior. This program gives the recipients a choice. It literally increases their chances for survival by encouraging health and demonstrating a means of earning income as opposed to less healthy alternatives. This is an important counter measure to counteract the pressure exerted from marketing that glamorizes unhealthy lifestyles. This is important in order to create a belief cascade to change opinions in the manner described by Schofield.

This CCT specifically targets health goals of increasing follow-up rates to the public health clinic. This has an important societal value of a more efficient allocation of resources: If patients utilize health care clinics instead of the emergency room, this may alleviate strain on

overcrowded emergency departments. Importantly, this will permit the appropriate level of services to be allocated to the appropriate need.

This is consistent with a policy that helps the least well off. In addition, this policy is further advantageous because the welfare recipients will learn to associate the incentive with behavior that is beneficial to them and cost efficient for the government. There is a particular need to address the ethos of the poorest members of the target population, and how CCT may be an effective way to alter their core beliefs with potential to impact health outcomes. Shelby's work sets forth an important theoretical groundwork regarding the population addressed by a CCT policy that would be targeted to predominantly uninsured or underinsured members of lower socio-economic classes, which have been characterized as the "ghetto poor." Particularly relevant are his assertions that any attempts by policy makers to break the identity of the "ghetto poor" with self-defeating behaviors will fail to meet requirements of justice.³⁰ His theoretical argument is that justice requires that any policy must focus on values of self respect and equal moral self worth. He asserts that a just policy proposal must look for "ways to engage the ghetto poor as potential allies in the fight against injustice rather than seeing them solely as the passive beneficiaries of liberal reform efforts."³¹ This is important, because giving conditional cash transfers to patients is different from typical welfare policies which are directed "at" a person with limited or passive participation by the recipient. Thus, CCT has the potential to change the core beliefs of the population targeted by this policy.

The theoretical notions laid out by Shelby are important concerns for addressing the health disparities of access to health care. Research has shown that reducing morbidity and

³⁰ See generally, Shelby, "Justice, Self-Respect, and the Ghetto," Presented at Justice and the American Metropolis Conference, May 8-9, 2009.

³¹ See generally, Shelby, "Justice, Self-Respect, and the Ghetto," Presented at Justice and the American Metropolis Conference, May 8-9, 2009.

mortality may depend as much on motivating changes in behavior as on developing new treatments.³² Paying patients for behaviors that are beneficial to them is a unique method in which to address Shelby's concerns. Incentive programs such as CCT should be "aligned in such a way to maximize the likelihood that individuals will engage in behavior that is beneficial, making those that would otherwise engage in unhealthy behaviors better off without adverse consequences to others."³³ CCT is unique in that it creates incentives for patients to engage in healthy behaviors without infringing on the freedom of others, a frequent criticism of other policy proposals.

This policy proposal has important implications for changing notions of redistributive justice. In his paper "Beyond the Equality-Efficiency Tradeoff", Clarence Stone, Emeritus Professor of Government at University of Maryland, argues the view that economic growth and redistributive justice are incompatible is a problematic one. Discussions of redistributive justice are typically framed as a zero-sum game, where one group's gains necessitate another group's losses. Stone proposes a different framework from which to pursue justice, namely one of "social investment." This framework is more likened to a positive sum game, as one group's win is not dependent on another group's loss. The reason is because social investment takes future rewards into account, which may not typically be part of the present time state analysis of most redistributive justice policies. CCT can act as a form of social investment because it creates a positive sum gain for the patient and encourages forward looking behavior with respect to health outcomes.

³² Loewenstein, George; Brennan, Troyen, Volpp Kevin. *Asymmetric Paternalism to Improve Health Behaviors*, JAMA 2007 2415-2417.

³³ Loewenstein, George; Brennan, Troyen, Volpp Kevin. *Asymmetric Paternalism to Improve Health Behaviors*, JAMA 2007 2415-2417.

Stone acknowledges that favoring social investment over free-rider calculations may involve deferring to a future outcome that may be less than certain; however, he states that “at stake is the public good of societal well being.”³⁴ Stone writes that “social investment is a way of joining instrumental considerations with concerns about justice.”³⁵ Stone’s discussion encompasses the argument “about making the rising generation productive, making its members contributing members of society rather than a drag on productivity.”³⁶ Stone’s argument is particularly pertinent to the potential of CCT as a policy to address the quandary of health inequalities. This policy pulls the public toward the public good of positive choices that result in community well-being. This has the potential consequence of creating a belief cascade to value being a productive member of society.

The potential to alter the behavior of individuals is important given the economic analysis that often accompanies the choice to engage or refrain from certain behavior. Economist Charles Phelps has an insightful perspective on the economics of obesity:

“What underlying economic phenomena might cause this obesity epidemic? One “culprit” could well be technological change. First, as technology alters the general nature of the work we all do and increases the marginal productivity of workers, the number of calories expended in everyday work has fallen. Jobs have become more sedentary and less strenuous through time. In parallel, the increased value of time makes it ‘more expensive’ to shed calories through dedicated exercise. At the same time, the cost of acquiring calories has fallen because of technological improvements in the agricultural sector and mass production marketing of food at all levels of production, including prepared meals.”³⁷

From this insight, we can make an argument that CCT has the potential to impact the economics of exercise by making it more cost beneficial to engage in exercise and other healthy

³⁴ Stone, Clarence. “Beyond the Equality-Efficiency Tradeoff,” p2-3. Presented at Justice and the American Metropolis Conference, May 8-9, 2009.

³⁵ Stone, Clarence. “Beyond the Equality-Efficiency Tradeoff,” p4. Presented at Justice and the American Metropolis Conference, May 8-9, 2009.

³⁶ Stone, Clarence. “Beyond the Equality-Efficiency Tradeoff,” p4. Presented at Justice and the American Metropolis Conference, May 8-9, 2009.

³⁷ Phelps, Charles. Health Economics. (Fourth Edition) p46.

behaviors that are more conducive to meeting certain health targets. CCT can alter the economic analysis by creating incentives to exercise and providing the financial means to help facilitate action.

This alteration of perspectives is important. It helps provide the recipient with the means to improve their condition. Without the financial means to make improvement, the recipient may be more likely to feel subject to the will of those in power. This can lead to rejection of government policy. Conditional cash transfers are an important tool in empowering individuals to be able to be healthy. Lack of income can be debilitating. Many healthy foods are more expensive than unhealthy ones. Also, having the means to exercise has a cost. While some activities are less costly than others, joining a gym or a team may have a membership fee. There may also be the cost of equipment to be taken into account.

Spread of CCT Programs

Current programs utilizing conditional cash transfers have had mixed results. Some have been very successful, while others have had more questions raised regarding their effectiveness.

There has been an increase in the number of countries that are experimenting with CCT over the last decade:

“In 1997, three developing countries had CCT programs: Bangladesh, Brazil, and Mexico. Over the next decade, these programs spread across the world to cover over two dozen countries by 2008. There are now CCT programs on every continent, in both rich and poor countries, from Mexico's Oportunidades to New York City's Opportunity NYC. CCTs have also grown tremendously within countries. Mexico's Progresa began in 1997 with 300,000 households; its successor Oportunidades now reaches 5 million households.”³⁸

The increase use of CCT in countries worldwide illustrates the potential for its appeal to a

³⁸ “Conditional Cash Transfers: Paying People to Invest in Children.” U.S. Fed. News. Feb 13, 2009.

wider audience. CCTs Conditional cash transfers can offer the promise of helping to break the cycle of poverty³⁹ by giving individuals the means to invest in themselves and take ownership over their lives. These examples support the argument that CCT has the potential to create a belief cascade and alter the social position of its recipients.

Answering Criticisms of CCT

** People may try to game the system.*

One of the criticisms of CCT is that people may still may unhealthy choices in order to try to game the system. For this reason, careful consideration must be given to the behavior that the CCT is designed to influence.

For example, obesity is a controversial area with regards to the possibility of paying people to lose weight. A criticism could be that some people might resort to unhealthy techniques in order to lose weight. The purpose of the CCT is to encourage healthy behaviors, not to be contravened by unhealthy behaviors. For a CCT program to be successful with respect to obesity, more research would be needed to gauge how people would respond to the program, and how they could be encouraged to use healthy means of weight reduction as opposed to more dangerous ones. To meet this end, it may be wise to have a coach or someone who would regularly help people stay on target and who would check in with them regularly. This would be one means of encouraging positive lifestyle choices in conjunction with the CCT program to reward meeting of certain health targets.

** People may use the CCT for unhealthy purposes.*

³⁹ “Conditional Cash Transfers: Paying People to Invest in Children.” U.S. Fed. News. Feb 13, 2009.

The distribution of a CCT is an exercise both in freedom and responsibility. Giving the welfare recipient a monetary incentive gives them the freedom to choose how they will use the money. Recipients have the option of using the incentive wisely or of investing in themselves. Recipients also have the option of making unhealthy choices that will have negative consequences. This is part of the appeal of a CCT program as opposed to other options.

** The recipient may not reach the desired outcome.*

Recipients have the opportunity to succeed or fail. There is a great deal of responsibility placed on the recipient. They have the opportunity to take ownership of their choices. This will empower them in a way that other programs cannot. It also means there is a certain amount of risk in giving the recipient that much freedom. The openness of the risk and the encouragement of responsibility actualize the ideals alluded to in notions of the freedom that forms the foundation of the United States. CCT helps to foster this freedom.