Financial incentives to promote social mobility

Conditional cash transfer schemes have been shown to improve health and health behaviours in poorer countries. **Ian Forde** and **Dagmar Zeuner** wonder whether a similar strategy can work in the UK

As part of its strategy to promote social mobility, the government is piloting a scheme of child development grants.[1] Disadvantaged families will be offered up to £200 (€233; $335) as long as they attend and take up services offered by Children's Centres, including parenting advice, liaison with job centres, and identification of children with special educational needs. The idea is modelled on the conditional cash transfer schemes from Latin America that offer disadvantaged families money if mothers attend parenting seminars, infants attend health check-ups, and other stipulations are met such as compliance with immunisation and school enrolment. Although increasingly imitated, such schemes are controversial because they explicitly intertwine social mobility with behaviour change. Some unfavourable health, education, and nutrition choices cluster with, and partly determine, socioeconomic disadvantage, and engagement with public services is thought to stimulate positive behaviour change. Conditional cash transfer schemes further assume that targeted cash incentives will secure such engagement. The same reasoning underpins the UK government's child development grants.

Here we consider UK experience in promoting social mobility and behaviour change and review the international evidence on conditional cash transfer schemes to throw light on how such schemes should be designed.

UK programmes

Social mobility, or the degree to which people's social status changes between generations, can be viewed as a measure of the equality of life opportunities and a reflection of parental influence, individual talents, motivation, and luck.[w1] All sources agree on the crucial role of the home environment in early life, such as provision of consistent discipline. Developmental measures are worse in poorer children as early as 22 months and continue to fall further behind.[w2] Tackling the problem was one of the Labour government's central commitments. Success, however, has been elusive: the most recent figures show a slight increase in the number of children living below the poverty line[w3] as well as a decline in social mobility.[w4]

The two flagship social mobility initiatives were the New Deal for Communities and Sure Start local programmes. The New Deal for Communities was launched in 1998 and sought to transform deprived neighbourhoods, emphasising local variation as a key innovation. Residents were encouraged to identify local problems (such as fear of crime) and develop local solutions. Initial evaluation found negligible impacts on health, education, or satisfaction with services, although area based outcomes, such as neighbourhood sentiment, fared better.[w5] The evaluators concluded that community engagement was difficult, and there was little evidence that area based attempts improved the chance of success.

Sure Start programmes, which began a year later, aimed to improve the health and development of children under 4 years in socially deprived communities and also encouraged local variation. Early evaluations found worse social functioning and verbal ability among children of teenage mothers and single and unemployed parents in Sure Start areas compared with similar children elsewhere.[w6] Later evaluations, however, showed a more consistent effect, with all families showing modest improvements in development, home environment, and likelihood of vaccination.[w7]

The government also invested heavily in understanding the drivers of individual and societal behaviour. A widely used framework is the 4E's model (enable, engage, encourage, and exemplify).[w8] The model uses an array of tools to change behaviour at individual, community, and societal levels (figure). Initiatives have nevertheless mostly focused on health, the environment, and adults not in education, employment, or training. Sure Start is the only initiative targeting parenting, although family nurse partnerships have recently started. This programme, developed over the past 30 years in the United States, aims to improve antenatal health and enhance child development by providing intensive, nurse led home visiting for vulnerable, first time parents. Nurses coach and support parents to adopt healthier lifestyles and develop parenting skills.[w10]

Initially, attention focused on financial and informational levers, but now, self belief and confidence to change are seen as critical.[w9] Family nurse partnerships exemplify this shift, providing highly personalised support structured within a broadly specified framework.[w10] Interest in conditionality—that is, benefits that are payable only if the recipient meets certain conditions or behaves in a certain way—has also been growing. Already well established in welfare to work entitlements, conditionality is increasingly being explored in areas such as weight management.[w11] The evidence shows, however, that incentives or reward schemes are successful only if limited to simple, discrete behaviours, such as vaccination. Complex, sustained behaviours such as weight management, and presumably parenting skills, are less responsive.[w12 w13]

There are three unanswered questions about the government's child development grant scheme: can conditionality improve parenting in the early years? should the scheme be targeted at individual households or areas? and, what is the scope for local variation across schemes? Below we examine the international evidence on conditional cash transfer schemes to look for answers.

Evidence on conditional cash transfer schemes

Conditional cash transfer schemes are becoming increasingly popular for several reasons. Firstly, they overcome some of the barriers to use of services (such as travel costs or incomplete information).[2] Secondly, the schemes target early childhood. Conditional cash transfer schemes encourage investment in children's long term welfare, at the same time as supplementing families' immediate income or serving as a safety net. Thirdly, a partnership between government and families is created, which is a critical element in securing health equity.[3] Finally, conditional cash transfer schemes treat poverty as a multidimensional problem, requiring joint input from health, education, and

welfare services. Experience with conditional cash transfer schemes has been generally positive. A systematic review in low and middle incomes countries showed that compliance with conditions was strong and translated in many cases to reduced rates of anaemia and stunting and improved self rated health.[4]

Objections, however, exist. These centre on the principle of benefits being tied to conditions, concerns about sustainability, and the generalisability of findings in low and middle income countries to high income settings. Opponents point out that poor people do not lack will or ambition to improve their families' lives but the opportunities to do so. They claim that conditional support is deplorable if it is essential to a family's livelihood and that conditions are drawn up by well paid professionals with little understanding of the reality of poverty.[5] The quality of services that programme participants are required to use is critical: enforcing the use of low quality services may worsen outcomes.

Conditional cash transfer schemes were also developed in a particular context: a dominant view in Latin America is that poverty is a result of individual failure rather than lack of opportunity, which perhaps makes conditionality more socially acceptable.[6]

Can conditionality contribute to improved parenting?

Cluster randomised trial data from Mexico[7] and Nicaragua[8] and prospective matched cohort data from Colombia[9] and Jamaica[10] show significant increases in children's visits to health centres, associated with better vaccination rates and receipt of health advice. The study did not collect data on more complex aspects of parenting, except for analysing household spending, which shifted toward fruits, vegetables, animal products, and children's clothing.[9] Focus groups reported that schemes were well liked and that conditions were not viewed negatively.[11]

Two caveats apply when translating this evidence. Firstly, conditionality necessitates high quality services. In Peru, services struggled to cope with increased demand and quality of care deteriorated.[12] This is relevant domestically given the wide variation observed in the implementation of Sure Start objectives.[w14] Secondly, the UK child development grant is much smaller than the incentives used in Latin America. In Mexico and Colombia, cash transfers equate to about 20% of monthly household income and are maintained throughout a child's school years. In the UK, the average monthly income of the lowest quintile households is around £1200 a month.[w15] A single payment of £200 is likely to be a weaker incentive. This is critical given the complexity of parenting and any associated behaviour change. Notably, the only other conditional cash transfer scheme in a high income country, Opportunity NYC (http://opportunitynyc.org), offers disadvantaged families in the Bronx, Harlem, and Brooklyn an average of $250 a month for complying with conditions. Evaluation of the scheme is awaited.

Should the scheme be targeted at individual households or areas?

Most conditional cash transfer schemes use sophisticated mechanisms to identify individual target households. They are generally successful, with an estimated 60% of benefits going to the poorest 20% of the population in Mexico, Brazil, and Chile.[13] In Mexico, however, community relations suffered because household selection did not match local perceptions of need and some households felt unfairly excluded.[14] Furthermore, post-hoc evaluations estimated that household rather than geographical targeting was only just cost effective and, after accounting for social tensions produced, may not have been worth it.[15] Very few user views about conditional cash transfer scheme have been published, although those that have do not mention stigma.[14]

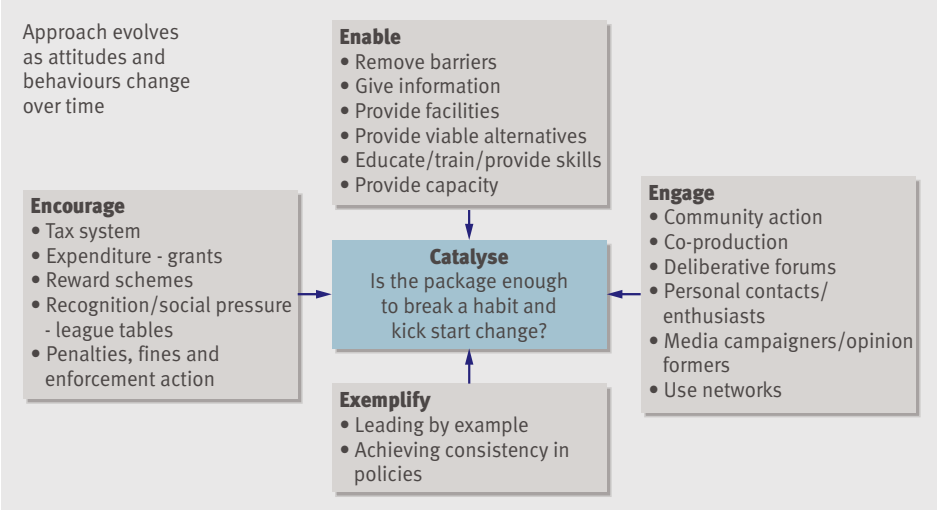
Targeting households has had negative consequences in some schemes. A 2-4% increase in birth rate occurred in Honduras,[16] and in Brazil, a 31 g reduction in children's weight gain per month was seen, presumably because mothers viewed cash transfers as conditional on their children remaining underweight.[17] Such perverse effects highlight the importance of good design and clear communication.

Although the proposed UK child development grant is small, it is just as important to ensure that benefits do not go to better off people. A complementary risk is that inequalities will worsen if families who do not respond to the incentive are left behind as others accrue new skills and capabilities. This is critical because upward social mobility has been shown to be associated with widening area based health inequalities in the UK.[18] The issue is complicated by the large socioeconomic heterogeneity we often see within small geographic areas. The solution may be to target areas and then use additional routine data to identify households needing support, as adopted by family nurse partnerships. Outreach to include particular households may also be needed, although it must be done carefully to avoid a sense of intrusion, and it is crucial that the government make clear how families that do not participate in Children's Centre activities will be identified and provided for.

What is the scope for local variation?

Local variation is not a feature of Latin American conditional cash transfer schemes. Participants have complained they want more involvement in how schemes are run,[19] although the lack of variation may, of course, be central to the schemes' success.

Two exceptions stand out. In Chile's *Puente* scheme, counsellors support families to draw up their own conditions, such as supporting rehabilitation of family members in prison. Non-experimental survey data showed high compliance (up to 96.9%) and positive effects on social exclusion: 42.9% of beneficiaries reported that their principal gain was improved relationships within the family and community.[20] El Salvador's *Red Solidaria* also has a mechanism for communities to identify development needs. In addition, local lay women are elected to act as a link between the organisation running the conditional cash transfer scheme and beneficiary families. These women sometimes modify conditions for specific families. Women in this position report several benefits, including greater self esteem.[21]



Although UK experience of community involvement in social mobility schemes has been disappointing, the success and popularity of *Puente* suggest that we should not abandon giving users say in the public services offered locally. Recent guidance from the National Institute for Health and Clinical Excellence on public health also encourages greater community involvement.[w16] The Young Foundation is experimenting with personalised incentives to encourage change to healthier behaviour in the Birmingham population and may provide further evidence on the question of tailoring.[w17]

Conclusions

The evidence that child development grants will contribute to social mobility is currently limited. Conditional cash transfer schemes, from which the idea derives, offer little generalisable evidence, though they do offer some insights that may be relevant to designing a UK scheme. They suggest that the services offered have to be of high quality, that the incentives proposed may need to be increased to bring about more complex behaviour change, and that targeting at the area level is probably most efficient, although special efforts may be required to include the most disadvantaged households.

Further research is needed on unresolved domestic policy questions such as appropriate targeting mechanisms and scope for allowing local variation. Given the health select committee's recent damning criticism of the persistent lack of evaluation of new initiatives to tackle inequalities,[w18] child development grants must be accompanied by a strategy for robust evaluation.

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ANSWERS TO ENDGAMES, p 581. For long answers use advanced search at bmj.com and enter question details

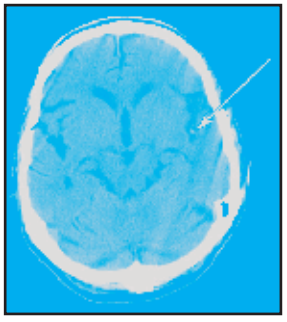

Fig 1 Non-contrast enhanced computed tomography scan of the patient's head showing an area of hyperdensity in the distal middle cerebral artery seen in the sylvian fissure on the left (arrow)—the dot sign

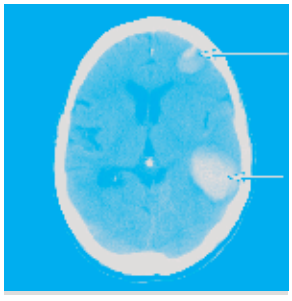

Fig 2 Computed tomography scan of the patient's head 24 hours after treatment showing two areas of haematoma within the left cerebral hemisphere (arrows)

PICTURE QUIZ

Stroke

1 Middle cerebral artery dot sign (fig 1).
2 Eye deviation towards the side of the infarction; contralateral hemianopia; contralateral sensory loss; global aphasia; apraxia; and visual, motor, and sensory neglect.
3 Post-thrombolysis multifocal intraparenchymal haematomas with a midline shift (fig 2).
4 Parenchymatous haemorrhage category 2 (PH2)—blood in more than 30% of the infarct area, with a substantial space effect.

CASE REPORT

Transient loss of consciousness and a heart murmur

1 A transient loss of consciousness, chest pain on exertion, and a heart murmur are suspicious of a cardiac syncope.
2 The next diagnostic step should be transthoracic echocardiography.
3 Patients with a cardiac myxoma may be asymptomatic or they may present with one or more of the classic triad of cardiac, embolic, or systemic signs.
4 The treatment of choice is surgical excision. The survival rate is similar to that of the general population.

STATISTICAL QUESTION

Statistical significance and confidence intervals

C