Incentivizing Use of Health Care

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Economics of incentives

- Economic argument: Incentives as a version of price subsidies
  - Compensate for informal fees, travel costs, time costs.
- Can we afford them?
- Can we administer them?
- Do they exacerbate corruption?
Ethics of incentives

“We propose that concerns around the potential for incentives to undermine recipient autonomy are misplaced when incentives are used to overcome economic obstacles or a lack of effective motivation, and when recipients are incentivized to engage in health-related behaviors or practices with which they are already familiar and which they regard as beneficial or worthwhile.”

Psychology of incentives

• Intrinsic vs. extrinsic motivation
• High discounting and present bias
• Regret and loss aversion
• Nudges as salient signals; fight procrastination
• Change the frame
• Incentives to learn (e.g., bednets)
• Adolescent sensitive periods in brain
Design of incentives

- Size
- Frequency
- Certainty vs lottery
- Unit incentivized: person, family, group
- Unit receiving income: father, mother, teen
- Means testing
Domain: health care utilization

- Family planning
- Prenatal care
- Facility-based childbirth
- Vaccination
- Screening such as HIV testing
- Adherence such as TB meds
## Lim (Lancet 2010): Facility-based delivery CCT in India

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<tr>
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<th>National-level mean</th>
<th>Estimated treatment effect</th>
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<tbody>
<tr>
<td>Antenatal care, three visits</td>
<td>45·7% (45·1 to 46·3)</td>
<td>53·6% (53·0 to 54·3)</td>
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<td>In-facility births</td>
<td>41·0% (40·5 to 41·6)</td>
<td>54·1% (53·5 to 54·8)</td>
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<tr>
<td>Skilled birth attendance*</td>
<td>48·7% (48·1 to 49·2)</td>
<td>59·3% (58·7 to 60·0)</td>
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<tr>
<td>Perinatal deaths (per 1000 pregnancies)</td>
<td>42·0 (40·6 to 43·4)</td>
<td>37·3 (35·6 to 39·0)</td>
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<tr>
<td>Neonatal deaths (per 1000 livebirths)</td>
<td>33·6 (32·1 to 35·1)</td>
<td>30·3 (28·8 to 31·9)</td>
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<tr>
<td>Maternal deaths (per 100 000 livebirths)</td>
<td>294·0 (267·1 to 322·1)</td>
<td>618·0 (576·2 to 660·4)</td>
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Banerjee et al. (BMJ, 2010)

![Bar chart showing fully immunized percentages in different village interventions.](chart.png)

- Control villages
- Intervention A villages (reliable camps)
- Intervention B villages (reliable camps)
- Villages neighbouring intervention A camps
- Villages neighbouring intervention B camps
Domain: non-medical health behaviors

- Contingency management for substance abuse
- Smoking: cash for quitting
- Physical activity
Domain: health outcomes

• Weight loss
• Workplace wellness (blood pressure, cholesterol, tobacco, BMI)
• Sexually transmitted infections
Conditional cash transfer (CCT) programs

- Acceptable and scalable
- Effects for prenatal care, well-child care, vaccination, health education, child anthropometrics
- Long-run affects via poverty alleviation and increased education of next generation’s mothers

Interpretation:
- Price incentives are strong
- Price vs Income pathway

Unconditional cash transfers (UCT)
- Mixed results, likely fade-out?
Promise for Future?

• Incentives often eschewed: good/bad reasons
• Evidence is too suggestive to ignore
• Effects and design will be context-specific:
  – Prices, incomes, prevalence, utilization
  – Knowledge, attitudes, acceptability, buy-in
  – Administrative capacity
Promising domains

- Health outcomes: too little evidence to date
Promising domains

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• Health behaviors: growing importance
  – Substance abuse: middle-income countries, but need estimate cost-effectiveness
  – Smoking cessation: growing demand
Promising domains

• Health outcomes: too little evidence to date
• Health behaviors: growing importance
  – Substance abuse: middle-income countries, but need estimate cost-effectiveness
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• Health care utilization:
  – All MCH domains potentially promising, when combined with education and supply investment
  – Continue to expand evidence base