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# *Public interventions targeting the poor: An analytical framework*

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## *Abstract*

Targeted interventions are a key strategy in the toolbox of governments. Their design, implementation and assessment set several challenges. In this paper we propose an analytical framework for interventions targeting the poorest. The framework splits the intervention into sub-components. For each sub-component, key issues and options are identified and roles of different actors are reviewed. We illustrate the framework with an example from the health sector, the experience of the health equity funds in Cambodia.

## *Introduction*

Targeting is seen today as a key intervention in the toolbox of governments (Coady, Grosh, and Hoddinott 2004). In low- and middle-income countries, it has been particularly advocated during the last decade as a strategy to reduce poverty (Ravallion 2003; van de Walle 1998). An outstanding application has for example been the rapid development of conditional cash transfers in Latin America (Rawlings 2004). In the health sector, the concern for poverty reduction and equity has also contributed to bringing targeting on the agenda (Gwatkin, Wagstaff and Yazbeck 2005).

Because of the straightforwardness of the idea, it is commonly believed that “the conceptual issues of targeting are well understood” (Grosh 1994). We would argue the contrary. Many reports used concepts that deserve further scrutiny. Many empirical studies or intervention assessments have a narrow focus. This weakness stems often from a corresponding vagueness in terms of policy objectives.

While “there is no clear recipe for how to target” (Coady, Grosh and Hoddinott 2004), we believe that policy making could benefit from some analytical tools. A high priority is to assist the policy makers in making up

their mind among the many alternative operational options. For that purpose, some organisation of the existing knowledge would be helpful: the lessons learned so far are a bit scattered; organising them in some logical structure would be helpful. Such a framework would be beneficial to future work by scientists and experts as well. Documentation and assessment of targeting interventions would maybe be less ad hoc and more accurate in their findings. A good framework could contribute to a better intervention design, more careful implementation, more informed evaluation and eventually a better outcome for the targeted group.

The purpose of this paper is to take a step in this direction. Our idea is to build the framework around the main objective of the policy makers: to reach the target group. While our framework was initially developed to analyse a very specific experience in the health sector, we believe that, with some adaptations, its relevance can be much broader.

The structure of the paper is the following. First, we come back on the rationale for targeting. We then introduce our field of application: targeted health care for the poor in low-income countries, with particular attention for the health equity fund experience in Cambodia. In the next sections, we develop the framework. We conclude by identifying some ways forward.

### *Targeting: the rationale*

Targeting is the policy option of concentrating the benefits of an intervention on a pre-identified specific group (Atkinson 1995; Sen 1995b). In fact, every policy involves to some extent targeting. As Amartya Sen put it, “Economic policies - those aimed at poverty removal as well as others - try to achieve some results. And any such attempt must involve *some* targeting. If the aim is to increase female literacy or to vaccinate children, surely the policies must somehow concentrate on the illiterate females or the unvaccinated kids. Like Monsieur Jourdain in Molière’s *Le bourgeois gentilhomme* who spoke prose “without knowing it,” we are all targeting all the time if any selection of beneficiaries counts as that” (Sen 1995b). Talking about targeting therefore amounts to discussing policy.

Targeting has sometimes been interpreted in a narrow sense: it is the delivery of a good or a service *only* to a select group of individuals (Grosh 1995). The key point behind this restrictive approach is that “some group of

individuals should be excluded from receiving the program benefit” (Grosh 1995).

For a funding agency, there can be two main motives for concentrating its resources on a specific group. One is purely normative: by mandate or preferences, the agency has to focus on one specific group of beneficiaries (e.g. UNICEF’s mandate to focus on children). From the agency perspective, a beneficiary of the target group has more value than a beneficiary of the non-target group. In some extreme cases, the agency may even attach a negative value to benefits accruing to members of the non-target group (‘they do not deserve’). The second motive is instrumental and has to do with efficiency: the agency has no specific preferences as far as the different groups are concerned, but it has observed that the return of its intervention in terms of its objectives is higher for a specific group (e.g. the case of UNICEF deciding to target mothers with various interventions as a way to improve child health).

Excluding other groups from the benefits of an intervention obviously stems first from the constraint of limited resources (the inputs) that the agency faces: some choices have to be made. Furthermore, it may be that the good or service delivered by the program (the output) has some rivalry features: one must exclude others because their consumption of the good or service restricts the possible consumption by the members of the target group. An underlying assumption is that the consumption of the considered good or service is valued as well by those who are not the ‘target’, they have a demand for it. Their demand for the good or service creates a second possible reason to restrict their access: the agency may make their utilisation of the good or service conditional upon paying a fee, which will allow to maximise resources for the program.

Targeting henceforth often boils down to organising the *excludability* for a rival good or service in reference to a group of concern. If exclusion is not an objective per se, but only a means to maximise resources for the target group, the ‘leakage’ of resources to the non-target group and the resources going to the administration process of the program are on the same footing.<sup>1</sup> This makes the decision for the agency easy: for a given amount of resources,

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<sup>1</sup> If we assume that the agency is indifferent to who implements the administration process (e.g. its own administration, a non-governmental organization) and attaches a value of zero to benefits accruing to the non-target group members.

it should choose the intervention that maximizes the total benefits for the targeted group.

The best way to understand targeting probably is to look at a peculiar situation.

### *Targeting health care for the poor*

As long as they were under the free universal health care model, low-income countries paid little attention to the utilisation of their public services by the poor.<sup>2</sup> It is only around the late eighties, when user fees were widely introduced, that the barriers to access became a topic for research and policy. Policy makers and international agencies acknowledged very early the fact that user fees could constitute a barrier limiting utilisation of public health services. In order to tackle this equity problem, most of the governments decreed that the poor should be exempted from paying.

There is a large body of evidence today that such waivers by fiat have failed (Kivumbi and Kintu 2002; Stierle *et al.* 1999; Willis and Leighton 1995). A first cause is the conflict of interests at the level of the health facility. As an organisation that faces the obligation to raise its income (to cover its running costs, purchase drugs or top-up health workers' incomes), a health facility has no reason to bear a cost without any compensation. Indeed, every patient leads to more medical and paramedical work, more drugs, more catering and more troubles. These costs - i.e. the poor patient - are not welcomed by the health facility if they are not compensated by an income. Regulating only is clearly quite a myopic solution.

Nevertheless, this explanation does not explain the poor performance of all waiver schemes. In some countries, hospitals are compensated for the poor patients they treat. In spite of this, the coverage remains very low. The limited budget is of course an explanation, but there is another one: there are participation costs for accessing the free treatment (Abel-Smith and Rawal 1992). Fees are just one of the many costs for the patients. The problem is particularly substantial for hospital care. Poor people statistically live far from hospitals. In order to benefit from the free medical care, they

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<sup>2</sup> Targeting on the basis of medical criteria has of course a long history in public health. As far as tropical countries are concerned, the first trypanosomiasis programs, for example, were launched by the colonial powers in the early twentieth century (Van Lerberghe and De Brouwere 2000).

have to cover some transportation costs. Hospitalisation induces other private costs. For example, at least one adult has to care for the patient during the whole hospital stay. This means important direct and indirect costs. Moreover, there may be some uncertainty about the eligibility for the waiver. The poorest may then decide to stay at home and forego the treatment. Finally, if the hospital staff has some leeway to decide whom to exempt, one can expect that people with some formal or informal connections with the hospital will manage to be among the beneficiaries. Social capital is not an attribute of the poorest.

Confronted with the failure of the regulatory approach, a few countries have been exploring alternatives that would pay more consideration to the institutional arrangements. A promising experience is the health equity fund in Cambodia (see other papers in this book and Hardeman 2004, for example).

The logic of the health equity fund model is quite straightforward. It rests on two principles: (1) a sponsor (e.g. the central government) commits a specific fund to compensate an identified health facility for its services to poor patients; (2) the management of the fund is subcontracted to a purchasing body independent of the health facility (e.g. a welfare office at local level). The first principle ensures that 'non-paying patients' are accepted by the health facility. The second principle increases the chance that the beneficiaries of the assistance are selected within the poorer group.<sup>3</sup>

Through a double 'purchaser - provider split' (i.e. the establishment of activities under the responsibility of agencies autonomous from each other, whereas the bundling of activities under a single agency was the previous option), the model sets apart the respective functions. Every organisation does what it does the best: the sponsor focuses on financing and organising the general accountability of the arrangement; it contracts an independent body for identifying the poor and tailoring the assistance according to their needs; this body contracts the health facility for the health care delivery.

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<sup>3</sup> Some important conflicts of interests remain with the other option (the management of the fund entrusted to the health facility). The maximising strategy for the health facility is indeed to spend the fund (1) as quickly as possible, (2) regardless of the actual socio-economic status of the beneficiaries (3) on user fees exclusively. With an independent body, especially if it is really committed to the poor (e.g. a local welfare non-governmental organisation), these risks can be limited. They will care more that benefits accrue to the poorest including through an extension of the package to barriers other than the user fees (e.g. transport costs).

The first health equity funds were initiated in Cambodia in 2000. Early assessments disclosed that they were effective in enhancing access by the poor to hospital services. The good results and the attractiveness of the model for the different stakeholders prompted a replication of the approach by other organisations in other provinces. Emulation has led to a variety of models and implementation approaches (Noirhomme *et al.* 2007). Their results do vary to some extent, but they have largely confirmed the initial findings.

### *Framework : A sequential view on targeted intervention*

Interestingly enough, our short introduction to waiver schemes for health services already gives some insight into the difficulty of designing a targeted intervention. First, it shows that designing an intervention targeting the poorest is not straightforward. It is definitely much more than issuing an official decree. The experience with the health equity funds proves that it has a lot to do with resources, incentives and the right interplay of actors. A second lesson from Cambodia is that a similar intervention can be implemented in a variety of ways. Finally, the Cambodian experience has revealed that assessing the intervention can be complex, as there can be an impact on various metrics (see for example, Jacobs and Rice in this book).

If these few elements confirm the need for a framework, they also set the challenge. Policy analysis is indeed not an easy task; as said by Barker, "policies are slippery things" (Barker 1996). Several policy definitions have been proposed in the literature. Some definitions stress the fact that a policy is an in time and space situated set of practices. For example, Barker defines health care policy as "the networks of interrelated decisions which together form an approach or strategy in relation to practical issues concerning health care delivery" (p.6). By this logic, the lack of purposeful action of a government toward a problem is already a policy. Other definitions do not consider the policy phenomenon at a point of time, but over a period of time. These definitions stress the fact that any effort to induce a change into a set of societal practices will take time and will probably go through some stages. There has been a tradition to identify at least four stages in the policy process: agenda setting, policy formulation, implementation and evaluation (Walt 1994). It is widely recognized today that this sequential view of the policy process, largely inspired by the planning paradigm, is more an ideal

norm on how to develop a policy (what the policy maker should aim at); it doesn't really correspond with reality. Contemporary societies are indeed characterized by a plurality of actors, including governmental ones, who may pursue antagonistic goals. In such contexts, the policy (as a set of practices) is open to the influence of multiple actors and it will not always evolve in a logical and linear way.

Policy development is therefore a quite long and complex process. Yet, for those willing to bring some benefits to a specific group, some direction with regard to operational issues is needed. We propose in this paper to focus on such technical matters only; the political aspects will not be covered (on the latter, see for example papers by Jönsson and Yunping in this book). More particularly, we will develop here a view we think useful for national and international experts in charge of designing or assessing interventions. From their perspective, we believe that the sequential normative view is helpful: it highlights some necessary conditions for a targeting intervention to be successful.

Both the review of the literature and our personal involvement in the design of different targeting programs has led us to the conclusion that any effort to bring benefits to a targeted group has to go through a set of different procedural steps. Each step consists in some specific action by at least one actor. It is the different content of these actions and its subsequent consequence (there may be an economic advantage to establish some division of labour and get some actors specialized) that delineate the boundaries of each step. If a step is incorrectly taken, there is a risk that some intended beneficiaries are 'lost' for the intervention; an obvious source of failure that one wants to avoid for a targeting intervention.

While the steps can vary from one intervention to another (some are simpler than others), there are commonalities across experiences. We would contend that at least six actions deserve close attention: (1) the formulation of the intervention; (2) the definition (in measurable terms) of the intended group of benefit; (3) informing the stakeholders, including the target group; (4) the identification of individuals meeting the eligibility criteria; (5) the entitlement; (6) the utilisation of the service subsidised by the programme.<sup>4</sup>

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<sup>4</sup> The number of stages and their order can be different. In some programs, the beneficiary first uses the service and then claims the subsidy. The identification and entitlement is then

All these actions require resources, something which obviously sets also obligations in terms of things to do (e.g., allocating a budget, executing it, auditing...); just like the activities of monitoring and evaluation, these are standard actions and they will not get our attention here.

One caveat has to be formulated with respect to these steps. We do not want to deny that policy is a never ending cycle with feedback loops. Our concern is to highlight that performance of a step is constrained by the coverage achieved by preceding ones. Obviously, someone will use a service if he is entitled to it. Moreover, if it is true that procedures can be revised (for example, after observation of low performance), there are rigidities and dependencies that will constrain the range of manoeuvre for correcting measures. Complementarities and dependency between the different actions required by targeting plead for a good design, including securing enough room for flexibility and feedback loops (e.g. mechanisms for the individuals to appeal against an unfair decision).

We contend that designing a targeted intervention has a lot to do with giving clear-cut content to these six different actions. For the expert, this basic 'framework' can then be seen as a checklist of issues and procedures to address. This division in steps can also be adopted ex post for the evaluation of an intervention. Indeed, on each of these six actions, a head counting approach is theoretically possible (see figure 1 at the end of the paper). The framework then reveals that early choices are quite crucial for the final performance of the programme. This ex post utilisation will be developed in a later section of the paper.

In the present section, we will first develop the framework. While it probably applies to any policy, we will discuss it from a social assistance perspective (i.e. any intervention whose intended beneficiaries are poor). We will review the six components. For each component, we will try to state its content precisely, the key challenges related to it and which actor is in the best position to undertake the related actions. Each time, we will illustrate with the experience of the health equity funds in Cambodia.

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carried out, for example, by the tax department on the basis of the tax return form. The subsidy comes as a seventh stage in the form of a tax discount.

## STEP 1: THE PROGRAMME FORMULATION

We propose to gather under this step all the activities related to the initiation of the intervention.<sup>5</sup> In the sphere of public interventions, the participation of political representatives, governments, relevant ministries and programme managers is required. Participation of other key stakeholders (e.g. think tanks, civil society groups, representatives of local agencies) is maybe not a formal obligation, but they are key to a well-informed policy. Involving some representatives of the beneficiaries at a very early stage is particularly crucial, both because of the support and the information that they can bring.

For an intervention targeting the poor, the key tasks to achieve are: (1) share a common awareness and understanding of the issues and challenges; (2) agree on the target group (in broad terms); (3) come to an agreement on desirable goals; (4) design the programme (a plan for action, the relevant institutional arrangements and a broad idea of the benefit package); (5) commit resources (including funding) and (6) turning the programme into a legal right for poor citizens.

This step is the step in which the policy makers should clearly formulate their ambition (in the midst of some political arbitrages). The first step will usually be a process by which all of them receive sufficient information about the problem: why the situation has to be changed, what can be done... Once there is a common awareness among the key stakeholders, there is an opportunity to make their concern explicit. A reference to a vision of social justice can be useful. Policy makers must also specify the target group. This includes a minimal conceptualisation of their

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<sup>5</sup> The political process by which a societal problem becomes a priority issue for a government is not covered in this paper. We do so because this crucial step normally comes before the involvement of the experts. The reality is that many poverty programs in low-income countries suffer some weaknesses at this level (World Bank 2003). The weakness has of course a lot to do with the limited agency of the poor, but also probably with the imported nature of too many programs. Although the lack of sound political support by the constituency does not prevent experimentation and initiatives funded by international aid, it may limit the sustainability of the program or its scaling up nation-wide. The existence of a trade-off between national political support and fine targeting - "Programs for the poor are poor programs" - is well-known (Besley and Kanbur 1990; Gelbash and Pritchett 1995).

specific situation<sup>6</sup> and some basic idea of what it means as a human experience in the national context.

The clarification of the goals is crucial. Policy makers must specify the needs to be tackled. The history of welfare programmes has shown that nearly any need could be covered, from basic needs such as water, food, health care, education, heating, housing to other needs such as holidays for the children or cultural events (Barr 1987). But the goals may reach beyond the target group. The government may prefer a strategy supporting a national producer, a public provision or local employment. Obviously, the programme will not be a mere distribution of goods and services. Policy makers are trying to achieve different objectives with the programme. Trade-offs will have to be made. The early clarification of the objectives may prevent some policy mistakes. As Grosh put it: "A school lunch program may choose the right children to feed, but if it serves them expensive foods or too few calories, it will not be cost-effective" (Grosh 1995). Only early specification of goals by the policy makers will allow later assessment of the programme performance (Atkinson 1995).

The design of the programme includes deciding on the targeting method (Coady, Grosh and Hoddinott 2004; van de Walle 1998). Should one rely on household assessment, geographical targeting, categorical targeting, self-selection, or more probably on a combination of them?<sup>7</sup> The different administrative, private, incentive, social and political costs of the targeting methods will be determining. The incentive structure, determined by the distribution of decision rights and the source of funds, should be a constant concern (de Neubourg 2002). The benefit package should be at least broadly defined, according to the objectives. A key to success will be the right distribution of tasks among actors (see next sections). This includes clearly identifying the respective obligations for the different involved parties. The commitment of resources, the financial ones in particular, and

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<sup>6</sup> As far as poverty is concerned, there is today a consensus among experts that it is a multidimensional reality. The conceptualization by Amartya Sen of poverty as a deprivation of basic capabilities has been quite influential in this respect (Sen 1995a).

<sup>7</sup> These are the standard terms in the targeting literature. It is debatable whether they are the most appropriate ones. 'Self-selection', a key component of most targeting programs, hides for example the fact that some household members may have limited decision rights within the household.

the enactment of the new rights for the poor (including the right to appeal when a decision is perceived as unfair) will make things happen.

What is the experience in Cambodia with this first step? The first health equity funds were based on the initiative of non-governmental actors. Their approach to the problem has been quite intuitive and pragmatic. Their key objective was to give access to hospital services to those encountering some difficulties in this respect. In the pioneer experience of Sotnikum, the health equity fund was in fact an addendum to a more global strategy trying to boost the performance of the health facilities (Meessen *et al.* 2002; Van Damme *et al.* 2001). The success of the health equity fund was a bit unexpected.

The field practice unveiled the full potential of the model. An early finding - which requires still some rigorous confirmation - was that some models of health equity fund (those informing or entitling the poor before arrival at the hospital) could possibly bring some benefits in terms of welfare protection as well (Van Damme *et al.* 2004). This occurs if the health equity fund induces assisted households to substitute expensive and ineffective treatment in the private sector (a quite dominant practice in Cambodia) for an early use of adequate services in public health facilities. The model can also be implemented in such a way that it contributes to reassurance and empowerment in the event of disease, protection of dignity and self-esteem during the hospital utilisation, i.e. different 'beings' probably highly valued by the beneficiaries (Alkire 2002; Sen 1993). This variety of possible impacts is welcome, but has obvious implications for the programme formulation. Policy makers have to decide which aim they value the most. Enabling access by the poorest and protecting hospital users against catastrophic healthcare expenditure do not necessarily refer to the same target groups, selection mechanisms and benefit packages.

At the beginning, the Ministry of Health mainly encouraged international agencies to experiment and implement health equity funds in their projects. It progressively developed its own view on the strategy. As reported by Annear *et al.* in this book, this has recently led to the promulgation of a decree. Yet, assistance by a health equity fund is not yet a universal right for the poor in Cambodia and it still largely depends on the presence of an international actor willing to allocate funds to the strategy (Meessen *et al.* 2006).

## STEP 2: DEFINING ELIGIBILITY

Targeting obviously requires that one goes beyond a general view of the profile of the targeted individual: one has to set very explicit eligibility criteria. While this exercise is, to some extent, part of the policy formulation process, it serves our purpose to identify it as a different step.

One faces here the difficulty of the vagueness of poverty. This vagueness is horizontal and vertical (Qizilbash 2003). The horizontal vagueness refers to the dimensions that must be included in the definition of poverty: should one look at one dimension only (e.g. income) or to several ones (e.g. literacy, health, nutrition...)? This question is certainly relevant for a basic capability approach (Sen 1995a), but it is also the case for an income or consumption approach, as one has to select the goods and services on which the consumption or income poverty line will be calculated (Van den Bosch 2001). The vertical vagueness refers to the level of the threshold below which one is poor. There is eventually some inescapable arbitrariness in the decision.

To deal with this double vagueness problem, there seem to be two main sources of expertise to tap. There are the 'poverty scientific experts'. Thanks to rigorous methods, they can produce major insights into what poverty is in a given context. One of the key strengths from this approach is that the exercise can be centralised and standardised nation-wide. The actors daily confronted with poverty form the second source of expertise. One can think of NGOs, welfare workers, and of course the 'experience experts': the poor themselves.<sup>8</sup>

The way forward for defining the eligibility criteria will often be a combination of both expertises. For its programme formulation, the government needs a basic understanding of the scope of the social problems: what are the characteristics of those struggling in daily life, how many are they, where do they live, and so forth? Estimates are necessary for budgeting and distribution of resources. Some explicit definition of the target group is also necessary for organising the accountability of the programme (monitoring and assessment). But the criteria relevant for the allocation between groups are probably not valid for allocation to individuals. Some

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<sup>8</sup> Participatory assessment seems a particularly powerful approach. See for example (Asian Development Bank 2001). Yet, one should not underestimate the challenge to implement it. Opposition may even come from professional social workers themselves.

flexibility must be granted to the frontline social workers dealing with individual cases (see also Criel *et al.*, in this book). Making a parallel with medicine is probably relevant. In the health sector, it is well accepted that the decision criteria used by health system managers are not the ones practised by the clinical doctors in their daily practice. Adopting different social justice and ethical criteria according to the respective levels of decision making could also make sense for social assistance interventions.

It is important to acknowledge that the setting of the eligibility criteria is closely related to the budget available for the intervention. Fixing the thresholds eventually is a political decision. They may diverge from the poverty lines just because of the tight budget constraint; sometimes to a point that the programme loses any chance to have an impact.

Finally, at the stage of definition of the eligibility criteria, policy makers must keep in mind the possible impact of the programme on individuals' behaviours. There is a risk that in order to become eligible for assistance, people pick options that are not the best ones from the society's perspective or are even detrimental to themselves in the long run. This is referred to in the literature as the incentive costs of the intervention. Poverty traps due to welfare programmes are a well-known problem in high-income countries (Barr 1987).

What complementary insights do we get from the health equity fund experience in Cambodia?

A recent review of four experiences has shown that health equity funds are using quite different definitions of poverty (Noirhomme *et al.* 2007). Some use lists of criteria and scores, most of them developed by local actors.

Interestingly enough, none of the ongoing health equity funds has referred to the existing national poverty lines. The reason is not so much the non-verifiability of actual household incomes; more fundamentally, this non-reference to the poverty lines corresponds with the primary goal of the health equity funds, i.e. enabling access to hospital services by households having economic difficulties to do so. An ad hoc definition of poverty is then preferable. As experience has revealed, a mere change in the level of the user fees at hospital level may require a change in the threshold (Meessen and Ir 2003).

Obviously, if the goal is to go towards a national policy, there is a need for some harmonisation. The first step will certainly be to agree on some common criteria to be used at central level to allocate the scarce national

resources. If entitlements are to be granted nation-wide, horizontal equity will also require some convergence in the frontline practice.

### STEP 3: INFORMING THE STAKEHOLDERS

This step refers to the different actions to inform the different stakeholders about what the programme has to offer. This requirement of good information has two main reasons: agency and efficiency. The agency argument refers to the need to inform the citizens about the programme and the new rights and entitlements it establishes. Citizens have to be able to take proactive actions, including applying for enrolment, claiming benefits and appealing to authorities. The poor must of course be a particular group of focus.

The efficiency argument is straightforward: poverty reduction is a multi-sector effort and coordination among the many actors is a key to success. This means that the information about the programme should reach not only actors directly involved (e.g. the agency in charge of the implementation, the poor), but also all the actors regularly in contact with the poor through other programs.

To whom should one entrust this function of providing information? Economy of scale may suggest some centralisation (production and printing of guidelines, organisation of training, radio communication...). Centralisation can be also a solution for some conflicts of interests. Nevertheless, in order to reach the poor households, some activities at frontline level will also be necessary. Targeting programmes, especially those relying on household assessments, require an administrative process. Poor households are not acquainted with administrative procedures. Face-to-face information, guidance and adapted messages are necessary. Some local actors must actively interact with the households likely to be eligible for assistance.

We can draw some lessons from the experiences in Cambodia. First, one can notice that most of the transfer of information has been itself targeted. The key concern was to identify the poor and inform them about their entitlements (see the next sections). The actors in charge of the identification have directly gone to the communities and, as much as possible, straight to the households potentially eligible for assistance. Interestingly enough, some local NGOs in charge of the identification have been very reluctant to reveal the eligibility criteria (Noirhomme *et al.* 2007). Obviously there is a conflict between the information and the identification

steps: good information contributes to reducing the exclusion errors (as poor people are then in a position to appreciate their own eligibility and take action accordingly), but may lead to more inclusion errors (as non-poor have enough clues to communicate their profile in a distorted way in order to get the entitlement). The experience of Cambodia reveals a second fact: mouth-to-mouth communication can be a quite powerful strategy in rural communities. Once poor patients are back at home, they are quite keen to share their experience in the hospital with fellows and relatives. Uptake of the benefits - i.e. experience - is also probably a major way to consolidate one's own knowledge about the scheme. Health staff are also good promoters of the scheme. Information on the programme is definitely a step involving a lot of different actors and a never-ending process.

#### STEP 4: THE IDENTIFICATION OF THE INDIVIDUALS ELIGIBLE FOR ASSISTANCE

This step amounts to screening an actual population to identify individuals meeting the eligibility criteria set in Step 2. This role is carried out by an identifying agent/agency. The challenge here is to deal with a double asymmetry of information: the one between the sponsor and the identifying agent and the one between the identifying agent and the population. Both asymmetries may lead to inclusion or exclusion errors.

The sponsor of the programme (e.g. central government, donor) has difficulties in assessing the performance of the identifying agent. How can a central government, far away from the communities, be sure that the local agency identifies the households correctly? How can one protect the programme against clientelism, bribes or mere laziness? Obviously, good accountability mechanisms have to be set up; administrative procedures, data reporting and field monitoring will help; some contractual arrangements are also good at reducing incentives for frauds (e.g. a matching grant system may ensure that local governments are careful about the use of the program resources). We believe that one of the keys for the incentive problem is to choose the right agent for identification. In many countries, the elite captures the identification process. Experience in the health sector has shown that entrusting this role to the health care providers was not a good idea either.

The problem of finding the right arrangement is compounded by the second information asymmetry, the one between the identifying agent and the individuals pretending to meet the eligibility criteria. This exercise entails

some administrative costs. If the criteria rest on variables for which data are available (e.g. the national income-tax database) or easily verifiable at the point of use (e.g. gender), the cost can be kept under control. But this is not the general situation in low-income countries. Targeting the poor often requires the collection of specific data through visits, interviews and questionnaires.

If the benefit is attractive enough and not too stigmatising, there will be an incentive for some households to cheat on their actual status. In order to avoid fraud, the eligibility criteria will have to be based on non-alterable variables. Clearly a link should be established between this step and Step 2. Observable proxies (e.g. house condition) are preferable, but they will require home visits. In some contexts, observable variables capture too little of the reality. Obviously, ownership of cattle is easier to observe than the amount of savings on a bank account. There may also be some laws securing privacy. A last problem is the fact that households' socio-economic status is dynamic. The identification process must be flexible enough to deal with households moving above or below the threshold. Updates are necessary; they are costly.

All these factors mean that administration costs can be quite important. If these costs weigh on the programme budget, they will reduce resources available for benefits. If they weigh on the households (e.g. participation costs such as submission of certificates), it will reduce the coverage of the intervention.

In terms of assignment of the identification function to an actor, it is noteworthy that a solution addressing quite well one of the two asymmetries may fare badly with the other one. Local elites, for example, have good and updated information on household characteristics within the communities, but if accountability mechanisms to the sponsors or the community are not in place, they may use their information rent to capture the programme benefits (Conning and Kevane 2002; Galasso and Ravallion 2001).

Another point is to be aware of economies of scope and externalities. Economies of scope refer to the efficiency gain obtained from entrusting the identification for different kinds of assistance (food, health care and education...) to one single body.<sup>9</sup> The externality problem refers to the

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<sup>9</sup> The efficiency gain can exist in terms of targeting outcome (poor rightly identified), but also in terms of poverty reduction outcome (poor eventually lifted out of poverty), if addressing several needs at the same time increases the chance of success of each individual program.

possible side effects of entrusting the identification to an agent that also has some other roles in the community. The teachers are certainly very able to provide a list of pupils eligible for a free daily meal, but this may undermine their relationships with the parents (Coady, Grosh and Hoddinott 2004).

Regarding identification, what are the key lessons from Cambodia? A first observation is that the different projects have entrusted the identification function to different local bodies (Noirhomme *et al.* 2007). Local NGOs, pagodas, or a team mixing staff from different agencies have been quite successful alternatives for identifying poor households in the community or at the point of use. Those who have pre-identified households in the community (i.e. before a specific episode of illness) have sometimes used an identification process in two steps: first an inclusive listing by an identifying agent member of the community (e.g. the village chief), then a restrictive screening by an identifying agent accountable to the sponsor (e.g. staff of a local NGO). One lesson seems to be that such a two-stage approach is quite protective for those in charge of the first stage, as it allows them to deter pressure by non-poor (Meessen and Ir 2003).<sup>10</sup>

It is noteworthy that in order to reduce exclusion errors, several schemes have established two opportunities for a household to be identified: one within the community (before any episode of illness) and one at the hospital (once they use the services). The second solution permits to include poor people who were not identified by the community screening (including those who were not poor at that time) and poor patients from 'non-screened' communities.

Both monitoring and assessment have shown that the different identifying agents were very good at limiting inclusion errors. We see three main explanations. The first one is that poverty of a rural household is quite easy to observe in Cambodia. Economic growth has increased the inequality between different layers of society (as not everybody has benefited from the growth), which 'helps' to identify those lagging behind (Ministry of Planning 1997). A second explanation is that the asymmetry of information between the sponsor and the identifying agent seems to be kept under control by good accountability mechanisms. A third explanation is that social workers in charge of selecting households for assistance seem to be particularly

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<sup>10</sup> The most cost-effective strategy would probably be to entrust the identification to some community members, with the second stage only applied to some samples as a cross-check.

concerned about leakage to non-poor. It is unclear yet if this stems from social pressure, a directive by the managers or is more a result of the importance attached to truth and honesty by the social workers.<sup>11</sup>

#### STEP 5: THE ENTITLEMENT

This step refers to the action of granting the entitlement for assistance to the sub-population identified in Step 4. The key issue is to establish the new status of the individual as a right they can vindicate. The identified households must indeed have faith with regard to their new rights; they must feel secure about the fact that they will get the benefit once they request it and will be supported by someone if their rights are denied.

This purpose implies that this step is carried out by an organisation with some authority. This authority could be granted by the law or stem from a good reputation among the beneficiaries. The individual enrolment requires that some formal certification occurs. One reason is to ensure that enrolled individuals will be clearly identifiable in the future by concerned parties (e.g. shops that must grant a discount). If identity cards are not available, certificates with pictures are useful.

As the entitlement has an economic value, it is important that the certification is fraud-resistant at every level. The agency and individual workers granting the entitlement must be highly accountable with respect to this. A computerised database, an option today feasible even in very poor countries, can help.

Ideally, the entitlement must quickly follow the identification, our Step 4. A reduced time lag between both steps is an element of a well performing targeting system. The entitlement must be clear on the benefit package to which it gives access (see Step 6). The entitlement stage is another opportunity to inform the individual about his right; this is useful for complex interventions (e.g. assistance conditioned upon some behaviours, see below). This informing better takes place through face-to-face contacts, especially if the target group largely consists of illiterate people. The face-to-

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<sup>11</sup> We have observed similar patterns of behaviours with social workers in Belgium. A hypothesis would be that the personal nature of the relationship between the social worker and the recipient creates high expectations in terms of honest disclosure of status and behaviours. This could be particularly true if the social worker is the one who calibrates the assistance and defends the applicant's case before the managers.

face contact will moreover allow the social worker to provide complete information and to answer any questions.

It is noteworthy that the entitlement step permits establishing supplementary conditions for eligibility, not in terms of characteristics (something already done at Step 3) but in terms of behaviours. Conditional cash transfers, for example, provide money to poor families contingent upon certain patterns of behaviour, such as sending children to school or bringing them to health centres on a regular basis (Rawlings 2004). Waiver schemes, vouchers and other consumption subsidies only benefit entitled individuals if they actually use the service.

In terms of actors, there are obvious reasons to entrust part of the tasks related to the entitlement to the agent in charge of the identification. Nevertheless, a complete overlap must be avoided. For the identifying agent, it will be much easier to interact with the applicants if they know that a superior authority has the final say on the enrolment (see also Criel *et al.* in this book for the practice in the Belgian welfare system). Protecting the identifying agent is particularly crucial if he is also the social worker in charge of calibrating the assistance.

In Cambodia, the different projects have entitled individuals through different ways. The major difference lies between the schemes that have decided to entitle households before any episode of illness (in their communities) and those that entitle the households at the point of use (at the hospital) (see Jacobs *et al.* in this book, for a comparison in terms of outcome). The first strategy provides of course a much stronger entitlement. In fact, a health card system is tantamount to a real health insurance. Receiving one's entitlement only at the hospital level causes uncertainty for people from remote areas. The fact that they are not sure about their eligibility for assistance may deter them from using the hospital.

While weaker in terms of entitlement, the second track has the advantage to save resources. Organising the identification and the entitlement at community level may be costly. Creation and management of the database of enrolled households consume resources as well. It is known that one project in Cambodia depleted the resources available for assistance because of its willingness to screen the whole population for distributing health cards to eligible households. In another project, there has been a considerable time lag between the identification and the final entitlement (Noirhomme *et al.* 2007). However, as reported by Ir *et al.* in this book, the

main challenge to pre-identification is the fact that poverty is a dynamic phenomenon; time may eventually render the identification out of date.

#### STEP 6: THE DELIVERY OF ASSISTANCE

This step consists in the action of delivering the assistance to the sub-population entitled in Step 5. The key issue here is to provide the assistance that will bring a real benefit for the assisted person. Just like in the definition of eligibility, the policy makers and the frontline actors share a responsibility.

We have seen that policy makers have to decide in their programme formulation on: (1) the need(s) to be tackled; (2) the actual institutional arrangement; (3) the broad content of the benefit package.

Inasmuch as the arrangements are concerned, a key decision for the government is whether it is better to make or buy the goods or services able to respond to the identified need. If the goods or services are unavailable on the local market, the intervention can not refrain from setting up a local resource (e.g. digging of a well, construction of a school), either as a direct provider or with subsidies to attract possible providers. If the government opts for direct provision, a related issue is whether the goods or services should be accessible to the poor only or open to a large group (possibly with a fee charged upon those able to pay). The second option is particularly interesting as it increases the political support for the program in the whole population and reduces the stigma upon the poor.

But the problem often is not availability, but utilisation by the poorest. There are four kinds of determinants of the utilisation of the good or service: the content of the benefit package, private participation costs (such as transportation costs, opportunity cost for the user or the relatives, the fees, the complementary goods or services to buy to bring about an effective outcome, stigma), information and decision rights.

Households may decide not to participate in the program if they see little value in the accessible services, for example because of their low quality. Participation costs may create insurmountable barriers, especially for the poorest. If poorly informed, households may wrongly assess the final outcome from the service. Finally, the target group (e.g. girls) may have limited decision rights within the household.

Because of the inescapable role of self-selection in any targeting programme, the definition of the benefit package is fully part of the targeting arrangement. Different assistance packages differently address the four

determinants (e.g. a cash transfer is theoretically more empowering than assistance in kind, but a transfer can have limited impact if households are misinformed or if they face a monopolistic provider).

Policy makers have some key choices to make in this respect, but many policies entrust a major role to front line actors as well. Their key responsibility will be to tailor the assistance to the individual profiles. For some households, financial assistance will be enough. For others, social care and support will be necessary. To some extent, the benefit package has to be personalised. It is noteworthy that this calibration may contribute to making the assistance more efficient (Sadoulet and de Janvry 2004).

An element that should not be overlooked is the incentives set by the mode of remuneration of providers. A lump sum payment, for example, is not equivalent to a reimbursement of actual expenditures. More generally, rules for disbursement of funds (e.g. credit facilities, monthly invoice) must be set.

The experience of Cambodia has been rich in lessons learned (see Annear, Bigdeli *et al.* in this book). A key characteristic of the health equity fund model is the distribution of tasks along a purchaser - provider split. One should note that the agencies managing the health equity funds do not only purchase from the health care facility; local shops and taxis are other providers of goods or services. The need to tackle the different barriers has been acknowledged very early in most of the schemes.

In terms of health care package, a majority of schemes have decided to limit themselves to hospital services. This level of care is seen as a source of greater impact than health centres, both in terms of health and welfare protection. Lump sum payments have been adopted by most of the schemes. It is seen as a good strategy to prevent over-prescription and cost escalation. Moreover, promoters of the model have stressed the importance of implementing the schemes only in public hospitals with a satisfactory level of quality of care. Interestingly enough, an ongoing experiment in Phnom Penh is trying to go one step further in the empowerment of its beneficiaries by taking an active role in defending their patient rights as hospital users (van Pelt, Mao and Vannak 2004).

#### OTHER THINGS TO DO

We believe that the six steps developed above deserve particular attention. This is crucial for a successful targeting intervention. This does not mean

that there are no other ways to increase the chance for the intervention to reach its objective. Knowledge is crucial throughout the existence of the program. At the early stage of the policy design, it is important to have a good understanding of the actual situation of the poor: who are they; where do they live; what are their needs; what are their own views on possible solutions? As already mentioned, their involvement in the discussion could be very useful. Systematic reviews (Lavis *et al.* 2004), study tour and pilot studies are nice ways to inform policy makers about the pros and cons of alternative strategies.

Once the program is in place, monitoring and evaluation are standard processes to accumulate knowledge and eventually improve the intervention. Monitoring can be understood as the routine follow-up of the different steps structuring the intervention: are the different actors complying with agreed procedures and rules? Evaluation refers to the assessment of the outcomes generated by the programme: is the programme achieving its objectives? Both activities are expected to hint at possible corrections of the intervention.

Monitoring and evaluation have mainly to do with collecting useful and reliable data; processing them into analysis; and using the accumulated knowledge to review the programme and its operation. Most of the data will document Steps 2 to 6: were the eligibility criteria the right ones; was the information correctly disseminated in terms of message content and coverage; was the identification fair and exact; was the entitlement process rapid and empowering; were the funds used properly; did the benefit packages get delivered to the target group; did it make a difference? In order to process this knowledge into action, a feedback loop will have to be activated. Information has to be transmitted to actors capable of correcting processes (e.g. take disciplinary sanction, interrupt a contract), reorganising the overall arrangement or setting new objectives.

Just like for the six steps, there are questions about who should take up this monitoring and evaluation role. Obviously, sponsors are concerned about the right use of their funding. Local actors are usually in a good position to monitor the delivery of the benefits (Conning and Kevane 2002).

In Cambodia, there were not so many studies to prepare the launch of the health equity funds. The approach has been quite pragmatic. The international agencies behind the experiences have paid more attention to monitoring and evaluating. Besides accounting, the quality of targeting has

been a focus of interest. For the quality of the health care services delivered to the beneficiaries, the general practice has been to rely on existing mechanisms internal to the health system.

In terms of impact assessment, the projects have relied mainly on indicators that are easy to monitor (e.g. number of beneficiaries, average benefit). One must acknowledge that measuring the outcomes generated by a targeting intervention is not easy, especially if it achieves different outcomes. There is clearly a challenge for researchers there.

### *Reaching the targeted group: the framework as an evaluation tool*

In the previous section, we have developed our framework mainly as a way to identify the key operational issues that are present in any targeted intervention. From that perspective, the framework can for example serve as a check-list for those in charge of designing targeting interventions. Besides this 'soft prescriptive' power, we believe that the framework has also some utility for all those trying to assess the performance of a targeting intervention.

Performance assessment is a complex task that cannot be fully developed here. Obviously, a key dimension of an intervention's performance is whether it reaches its intended population of benefit or not.<sup>12</sup> There are different ways to assess that; the simplest one is to adopt a head count approach and calculate the proportion of the targeted population that has actually been reached by the program.<sup>13</sup>

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<sup>12</sup> Two other issues are the link between the benefit and the outcome for the individual (e.g. hospital admission and health recovery) and the actual contribution of the intervention to the utilisation of the service by the individual. Take the example of the health equity fund scheme: if there had not been any intervention at all, some poor would have used the hospital anyway. In that case their utilisation of the hospital can not be considered as an outcome of the program (yet, the savings made by the household thanks to the waiver are one of its results). The assignment of a change in an outcome variable to an intervention raises several methodological challenges (Angrist and Krueger 1999; Duflo, Glennerster, and Kremer 2006).  
<sup>13</sup> A more sophisticated approach is to compound the share of the assistance that has actually benefited different socio-economic groups. For an exposition to benefit-incidence analysis, see for example Demery (2000).

As a reminder, there is a normative dimension implicated in head counting, as it assumes specific weights for the 'counted' individuals (regardless of their needs or distance to the threshold, the targeted households get a score of 1; all the non-targeted ones get a score of 0).<sup>14</sup>

It is easy to see that adding a head counting approach to our framework of the targeting intervention as a sequence of steps results in a 'head count framework'. This allows to assess how many people are 'in' at the different stage of actions. For obvious reasons, the number of poor reached in one stage will largely depend on the number of poor covered by the previous stages.<sup>15</sup>

Figure 1 illustrates this logic. From a given population of poor individuals, some of them may not be recognised as deserving assistance by the policy makers (e.g. illegal migrants). Once the target group is specified, there is an issue to agree on the indicators (the variables and their cut-off values) that can identify those belonging to the group. If the threshold is too strict, many poor will be excluded. Communication on the intervention is another step where many poor can be 'lost': those who have no access to the media and other sources of information will not hear about the program and undertake the subsequent steps (e.g. submit an application). If there are important participation costs for being identified (e.g. to go to an office to fill in an official application), many poor will not show up. Ideally, the agency in charge of the identification should be very close to the target population (both physically and informatively). There is also a risk that the entitlement stage becomes a bureaucratic and time-consuming process. This can temporarily reduce the access of the target population to the intervention. Eventually, the entitled individuals may have a low interest in taking up the benefit. This will be the case if the service that is offered by the program is of low relevance or quality, or if major participation costs remain. If the final resources are too limited (because of a too low initial budget or a

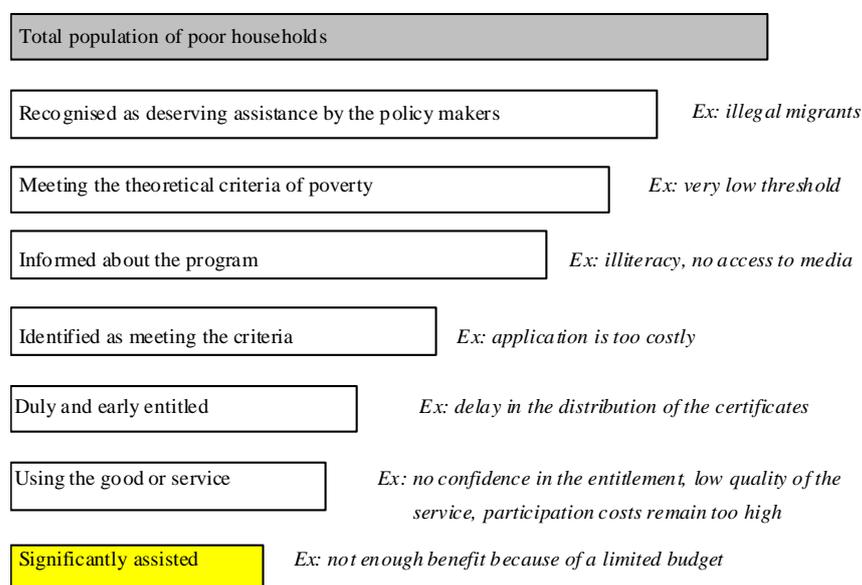
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<sup>14</sup> An alternative would be to assign weights according to the distance to the threshold. Negative weights would apply if exclusion of some households is an objective per se of the intervention. The decision about the 'right' weights is obviously a responsibility of the policy maker, not of the evaluator.

<sup>15</sup> Noteworthy, for some stages, the measure of program participation may require a clear definition. For example, the same household using several times the supported service should be counted only once.

low efficiency in the processing of the six steps), the final outcome for the target group could be disappointing.

Figure 1. Targeting, step by step



For this head count application of the framework, clear definitions of what program participation actually is at each stage will be necessary. On the numerator side, for example, the same person using several times the supported service should be counted only once. Yet, utilisation by different members of the same household provides another statistic. On the denominator, one can take the total population, the eligible one or the one reached at the previous stage. This produces different indicators and helps to organise those already present in the literature (Hernanz, Malherbet and Pellizzari 2004).

In many situations, especially in countries with developed tax systems, the framework will have to be adapted to the intervention of interest. In some programs, the utilisation of the service comes before the identification and the entitlement stages. This is for example the case with child care subsidy in the United States. Yet, this does not invalidate the idea of a chain

of stages that create each possible bottlenecks: the limited supply of service can, for example, be the main reason for the low take-up of the benefit (Queralt and Witte 2002).

Obviously, these different ideas still require empirical validation. This is one of the objectives of the POVILL project (see Lucas *et al.* in this book).

#### RELEVANCE AND PROSPECTS

At the start of the paper, we have argued that the design and the study of targeting interventions could benefit from some kind of a framework. As the prime concern of such interventions is to reach their target group, it makes sense to build the framework around this objective.

We have put forward a framework that views any targeted intervention as a chain of specific actions. We have distinguished these steps by the possibility of entrusting them to different actors. Noteworthy, a possibility does not mean a necessity: it could be, like in the case of the health equity funds in Cambodia, that the same actor eventually carries out several of the steps. Such a set-up is not rare in targeting schemes, but is not necessarily optimal. Key attention should be paid to the possible conflicts of interests; accountability mechanisms and incentives must be right.

The sequential nature of our targeting framework must not be misunderstood. It is a logical one, not a real time one. It does not mean for example that a step is carried out once and for all by the agency in charge of it. Most of the steps are in fact performed on a continuous basis (but for different individuals). Neither does the sequential nature preclude the simultaneous execution of some of the six actions. The core idea is that the performance of the whole targeting process is determined by the performance of each isolated step and that these steps are successive from the individual's perspective.

The development of this framework has largely been inspired by our professional involvement in the health equity funds in Cambodia. No surprise, the framework fits this experience well. Its relevance for other contexts or programs still needs to be assessed. Comparative analyses would in fact be a nice way to assess the descriptive power of the framework. Our intuition is that it could be a useful tool for understanding the difficulties encountered by many programs. The low take-up of welfare benefits is a reality in many countries; it deserves more scrutiny.

Ironically enough, the framework can also be used to map the tricks

used by agencies when they purposely try to ration their assistance (for example, because of budget constraints): restrictive definition of eligibility, poor marketing of the program, very limited benefit package, participation costs such as bureaucratic steps to undertake...

Whatever the outcome of such validation exercises, we believe that in terms of scheme design, the framework will never provide any blueprint. It is more a tool for mapping issues and difficulties than a source of easy solutions. Ideally, it should be completed by other analyses (e.g. a stakeholder analysis, policy risk analysis).

We have ended the paper by making the hypothesis that the framework could be a useful tool for assessing the distributional performance of interventions as well. The division in steps shows that it could make sense to make a sub-analysis of programs: exclusion and inclusion errors may happen at each step. What is the point to screen accurately the households, once most of the poor are missed because of a too restrictive definition of poverty?

Hopefully, the framework will help those trying to fix bottlenecks not to lose track of the main goal: to have an impact on the poorest.

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