Social Protection in Indonesia: Past Experiences and Lessons for the Future

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Poverty Before and After the Crisis

Poverty Incidence (%) vs Year

- Old Method
- New Method

Crisis Onset

Year:
- 1980
- 1985
- 1990
- 1995
- 2000
- 2005
- 2010
..but vulnerability remains significant

- After poor individuals, the next 50% of Indonesians have budgets of IDR 16,000 ($US 1.75) per day.
- After that, the next 20% live on at most IDR 25,000 per day.
- Thus, an average Indonesian is still dangerously close to the poverty line.

Source: Susenas (2010) and World Bank staff calculations.
Outline of Today’s Talk

• Background on First Generation of Social Protection
• Second Generation of Social Protection
  – Impact evaluation of unconditional cash transfer program, 2005-6
• Current Debates re the Future of Social Protection in Indonesia
First Generation of Social Protection

- Introduced in response to Asian financial crisis

- Programs include
  - Scholarships targeting poor students
  - Employment and public works programs
  - Subsidized rice (OPK)
  - Subsidized health care services for the poor
  - Block grants to schools and public health facilities

- Targeting of beneficiaries
  - Based on limited available institutional data on household and student welfare
  - Approach varied across programs
First Generation Targeting Outcomes

Program Coverage (%)

- Subsidized Rice
- Primary School Scholarships
- Lower Secondary School Scholarships
- Upper Secondary School Scholarships
- Employment Creation
- Medical Services
- Nutrition

Program Coverage (%)

- Poor
- Non-Poor
Program Effectiveness: Rice and Jobs

• *Subsidized rice* (OPK) largest program played critical role in ensuring food security
  – in-kind transfers approx. 10% of median household beneficiary expenditure
  – targeting outcomes heavily criticized and led to overhaul of program into successor Rice for the Poor (Raskin)

• *Employment programs* led to moderate increases in household welfare and labor market outcomes
  – self-targeting feature of program induced dynamically progressive benefit incidence
Program Effectiveness: Health and Education

• Mixed evidence on health program impacts
  – Majority of poor households received health cards but overall utilization of health services limited
  – Nevertheless, health card access increased utilization rates among the poor and shifted from private to public
  – Block grants to service providers had relatively larger impact than health cards (Sparrow, 2006)

• Scholarships for poor students and block grants to schools prevented large-scale dropouts
  – Programs reduced demand for child labor among parents, especially in rural areas
  – 13% of students would have dropped out of school without the scholarships
Second Generation Policies and Programs

• Financed largely through savings generated by fuel subsidy cutbacks
• Transition from regressive, generalized fuel subsidies to progressive, targeted welfare programs
• Main programs include
  – Unconditional cash transfer (UCT) in 2005-6 and 2008-9
  – (Universal) Health insurance for the poor (Askeskin/Jamkesmas) launched in 2005
  – School operational assistance grants 2005-6
  – Subsidized rice (Raskin)
Fuel Subsidy Downsizing & UCT

- The price of oil in Indonesia is fixed by the government and highly subsidized.
- To ease the pressure on the budget as oil prices increased, the GOI slashed fuel subsidies by increasing the domestic retail price of oil in 2005 (30% in March, 120% in October) and once in 2008 (by 29% in May).
- Fuel subsidy downgrading led to a large price shock with the poor expected to be hit hardest.
- To help poor and near-poor cope with the shocks, the GOI introduced a UCT program twice:
- Quarterly transfers of Rp100,000 (US$10) to ~19 million households.
Evaluation Methods and Data

• Nationally representative household-level panel data from 2005/6/7
• Matched difference-in-difference estimates of the impact of the UCT on following outcomes over two time horizons 2005-2006 and 2005-2007
  – Aggregate household expenditures per capita
  – Healthcare utilization
  – Educational continuation
  – Child and adult labor supply
• Propensity score model based on targeting criteria explains 20% of variation in recipient
Targeting outcomes

• The selection to determine the beneficiary households for the UCT program in 2005 was based on
  – (i) potential eligibility lists drawn up by local leaders
  – (ii) the data collected in the 2005 Socioeconomic Survey by BPS

• The method used proxy-means testing, based on 14 country-wide indicators and local weighting scheme

• Goal was to reach all poor and near-poor HH

• Based on regional poverty lines,
  – 50% of poor households received UCT
  – 39% of near-poor households received UCT
  – 73% of UCT recipients non-poor

• 43% of households believed non-poor households in village received UCT

• 15% of households dissatisfied with own treatment status
### UCT (1) Increased Healthcare Utilization

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<tr>
<td>Δ Outpatient Visits/capita</td>
<td>0.052*</td>
<td>-0.026</td>
</tr>
<tr>
<td>Public</td>
<td>0.013</td>
<td>0.028*</td>
</tr>
<tr>
<td>Private</td>
<td>0.020*</td>
<td>-0.012</td>
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<tr>
<td>Δ Inpatient Visits/capita</td>
<td>-0.002</td>
<td>-0.003</td>
</tr>
<tr>
<td>Public</td>
<td>0.003</td>
<td>0.009</td>
</tr>
<tr>
<td>Private</td>
<td>-0.001</td>
<td>0.003</td>
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and (2) reduced child labor

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<tr>
<td>Δ Share of Students/HH Working</td>
<td>-0.011*</td>
<td>-0.017*</td>
</tr>
<tr>
<td>Δ Hours Worked/Student</td>
<td>-0.204*</td>
<td>-0.167</td>
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<tr>
<td>Δ Days Worked/Student</td>
<td>-0.055*</td>
<td>-0.080</td>
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Significance: * 10% level.
but (3) the impact on aggregate expenditures was less clear.

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<td>Avg. Expenditure/Capita Growth (nominal)</td>
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<tr>
<td>Recipient vs. Non-Recipient</td>
<td>-3.5%*</td>
<td>-2.5%</td>
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<td>Recipient vs. Non-Recipient in Urban</td>
<td>-0.8%</td>
<td>+2.1%*</td>
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<td>Urban Recipient vs. Rural Recipient</td>
<td>+1.6%</td>
<td>+13.6%*</td>
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(4) the timing and size of the transfers mattered.

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<tr>
<td>Avg. Expenditure/Capita Growth (nominal) in early 2006</td>
<td></td>
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<tr>
<td>2 Disbursement Recipient vs. Non-Recipient (0 Disb.)</td>
<td>-6%*</td>
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<tr>
<td>1 Disbursement Recipient vs. Non-Recipient</td>
<td>-11%*</td>
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<tr>
<td>2 Disbursement vs. 1 Disbursement Recipient</td>
<td>+5%*</td>
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School Assistance Grants (BOS)

• Operational grants provided to all primary and junior secondary schools

• Primary goal: eliminate tuition fees for all students or focus on poor students when BOS funds less than overall tuition

• Secondary uses of funds
  – Transportation support, uniforms, school bags, stationery, other fees

• Program functioned as a generalized education subsidy but little evidence that program disproportionately reached poorer students (SMERU, 2006)
The Road to Universal Health Insurance for the Poor

- Program launched in 2005 to ensure access among the poor to services at public health facilities
- Ministry of Health manages and operates the program providing benefits to 30% of households
- Impact evaluation by Sparrow et al (2010) provides strong evidence on program’s early successes
  - improved access to health care in the population
  - increased outpatient utilization among poorest quartile of HHs
The Way Forward (1): Improved Targeting

- Low inequality makes targeting difficult
- Gradual improvements in data infrastructure identifying poor and near-poor households
- Continued efforts to improve data, analysis and implementation led by Targeting Working Group at National Team for Accelerating Poverty Reduction
The Way Forward (2): The Role of CCTs and UCTs

• CCT introduced in 2007 serving approximately 800,000 HHs deemed chronically poor
  – benefits schedule ranging from Rp600k to Rp2.2mn annually depending on household structure

• Receipt of benefits conditional on
  – Enrollment and attendance of children aged 6-15
  – Visits to health clinics for maternal and infant health svcs

• Impact evaluation by World Bank finds
  – increases in health services utilization
  – limited effect on enrollment, which was already high before the program
  – program most effective in areas with strong health and educational institutions

• Raises questions regarding
  – precise role for conditionality
  – whether UCTs complement or substitute for CCTs
Concluding Thoughts (1)

- Progress has been made in addressing poverty and vulnerability.
- Approaches to poverty have evolved over time and Indonesia is also now better prepared to anticipate major shocks.
- Raising income of poor and near poor is essential but we also need special assistance programs.
Concluding Thoughts (2)

These are some of the challenges:

- Targeting of beneficiaries remain difficult;
- Scale-up and upgrade capacity in programs and implementing agencies that have carefully designed initiatives but lack resources to deliver them effectively;
- Coordination and integration remain elusive;
- Managing ‘voice’ and ‘noise’;
- Effective public communication (including program objective, eligibility and exit strategy), and information dissemination.