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Social safety nets in India, Indonesia, and Philippines

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Introduction

- Social safety nets (SSN) are "noncontributory transfer programs targeted in some manner to the poor or vulnerable." (Grosh et al. 2008, 4)
  - It is an essential component of social development.
- SSN is a narrower concept than social protection, which also includes developmental programs (eg education) as well as preventive insurance programs (eg. Health or Pension insurance)
- The range of SSN is vast. Examples:
  - Cash or in-kind transfers,
    - Means tested or categorical.
    - Unconditional or conditional.
  - Price subsidies, eg. food or energy.
  - Labor-intensive public works projects.
  - Fee waivers for essential services. Eg health care, education

Case for social safety nets

- SSNs perform four vital functions:
  - *Alleviate inequality and extreme poverty* by targeting support to the poor.
  - *Promote human development* by enabling households to make better investments in their futures.
  - *Promote social cohesion* by giving the poor a stake in the economy and society
  - Serve as *automatic macroeconomic stabilizers* during economic decline
- SSNs are relatively inexpensive in financial terms.
  - Political and administrative requirements are higher.

Challenges in Designing SSN

- While policy discussions on SSN focus on fiscal costs, it is political and administrative capacity issues that require greater attention
- Most governments
  - Face problems designing sensible SSN programs
  - And find it difficult to implement them effectively
- India, Indonesia and Philippines have made progress in improving their SSNs
  - After decades of neglect and misdirected efforts.
- However, coherence and coordination across programs needs improvement
- There is also a need for higher political will and, especially, administrative capacity.

India

- Public distribution of subsidized food has been the traditional form of SSN in India.
- The first major reform was the adoption of National Social Assistance Programmes (NSAP) in 1995. It includes:
  - National **Old Age Pension** Scheme (NOAPS)
  - National **Family Benefit Scheme** (NFBS)
  - Indira Gandhi National **Widow Pension** Scheme
  - Indira Gandhi National **Disability Pension** Scheme
  - Annapurna Scheme [Free **food for poor aged**]
- Together, they provided small benefits to a small proportion of target population

India

- The current SSNs in India have shaped by the victory of the Congress party in 2004 on the "common man" platform.
- The new government enacted:
  - *Public Works programme*. National Rural Employment Guarantee Act (NREGA) (2005).
  - *A subsidized credit programme for micro enterprises.* Prime Minister's Employment Generation Programme (2008).
  - A framework law for *social security for informal sector*. Unorganized Workers Social Security Act (2008).
  - *Health insurance for poor.* Rashtriya Swasthya Bima Yojana (RSBY) (2008).
  - Right to Education (2002, 2009). Guarantees free education for all children, 6 – 14 years as a Fundamental Right
  - National Food Security Act (NFSA) (in Parliament). *Combines existing food and nutrition program for children, mother, poor*

India

- NREGA
  - Government guarantees (a “right” to) 100 days of unskilled employment per rural household in public works.
  - Generated 2.6 bln. days of employment for 55 mln. households in 2010. Majority from lowest castes and women.
  - Provision for community participation in project selection and monitoring
  - Has increased real wages at the bottom and reduced wage disparities. Expanded environment conservation.
- RSBY (National Health Insurance Programme)
  - Provides hospitalization insurance to poor households: potentially 37% of population. Only 10% covered currently.
  - Broad range of treatment at public & private hospitals
  - Government financed. No charge for users.

India

- Despite expansions, SSN in India only covers
  - A small section of the population in **formal employment**.
    - Share of workforce covered actually declined from 33% in 1999 to 26 % in 2009
  - Weak and patchy protection for **poor household**s containing aged, widows, orphans and disabled.
  - Almost no protection for those in **informal or self-employment** (ie 85% of workforce)
- Informal workers pose the most difficult challenge.
  - National Commission for Enterprises in the Unorganized Sector (NCEUS) in 2006 proposed low-cost insurance for hospitalization; life/accident cover; & retirement
  - Projected cost of only 0.5 % of GDP.
  - A weaker version of the proposal was adopted in 2008

Total government expenditures (all levels) in India, % of GDP

	1990	2000	2009
Rural Development	1.00	0.77	1.29
Health care	1.27	1.27	1.24
Social Security & Welfare	**0.28**	**0.34**	**0.88**
Housing	0.15	0.22	0.30
Family Welfare	**0.18**	**0.15**	**0.21**
Labour & Employment	0.14	0.11	0.09

- Government's SSN spending relatively small .
  - Lower than its spending on fuel subsidy (up to 2 % of GDP).

Indonesia

- The current SSNs in Indonesia has been shaped by the experience of the 1997/98 economic crisis.
- When the crisis broke out:
  - Fuel subsidy accounted for 50% of total govt SSN expenditure
  - Food subsidy for 40%, and
  - Subsidy for medicines, fertilizers, etc for 10%
- These programs are expensive and wasteful.
- In 1998 the govt launched a series of ad hoc SSN programs with the assistance of international organizations.
- These programs became the foundations of SSN programs after the crisis
  - Lessons from operating the programs were valuable.
  - Political reforms and economic growth reinforced the process

Indonesia

- Constitutional amendment in 2002 committed the government to offering comprehensive SSN to the entire population.
- In 2004, SJSN (*National Social Security System*) law was enacted.
  - Provides for health insurance, pension, employment injury, and death benefits.
  - It is a framework law. Detailed programs are in the process of being developed.
- The deep reduction in fuel subsidies in 2005 allowed the government space for redirecting funds to SSN (and health and education).
- The Medium-Term Development Plan 2010–2014 affirmed shift from universal subsidy to targeted programs

Indonesia

- Indonesia now has the following major SSN programs:
  - *Subsidized rice for the poor* (Beras Miskin, or Raskin).
  - *Unconditional cash transfer program* (Bantuan Langsung Tunai, or BLT).
  - *Conditional cash transfer program* (Keluarga Harapan or PKH).
  - *Health insurance for the poor* (Jaminan Kesehatan Masyarakat, or Jamkesmas).
- Raskin, BLT, and Jamkesmas target the same population group—the poor and near-poor living on income below 1.2 times the poverty line
  - BLT accounts for 40% of total SSN expenditures, Raskin for 34%, and Jamkesmas for 13%.
  - PKH and especially Jamkesmas are expected to grow rapidly in future

Indonesia

- The government has indicated that CCT will form the basis for further expansion SSN.
  - PKH (Hopeful Family Program) was launched in 2007 .
    - Projected to cover 6.5 million households by 2015.
    - Average transfer per family is Rp1.4 million, or 27% of the national poverty line.
    - Targeted at poor households with pregnant women or children up to 15 years old.
- An employment creation program is under consideration.

Indonesia

- Indonesia thus has the building blocks of a comprehensive SSN .
- Areas of improvement
  - Despite the broad complementarities among programs, their administration is still fragmented across different agencies.
  - Better assessment of the contingent liabilities of different programs.
  - Gradual increase in benefits as circumstances permit.

Philippines

- The impact of the 1997 crisis on Philippines was relatively mild.
  - Yet the government established a range of SSN programs.
  - Programs included a variety of public works, job training, credit facility, and livelihood assistance programs.
  - The programs were small-scale, patchy, and of poor quality.
- Health insurance for the poor established in 1997.
  - Provides insurance to the bottom income quartile
  - Insurance premium is paid jointly by 3 levels of government.
  - 67% of target households were covered in 2008. But only about 50% of poor households are covered due to targeting errors.
  - Insurance covers only 50% of actual expenditures
    - Limits access for the poor.

Philippines

- Subsidized rice is a major SSN program in existence since 1970s
  - Availability has been increasingly targeted at poor households on income below food threshold (P 5000/month)
  - Cost of the program varies: amounted to 0.8 % of GDP in 2008
- The largest expansion of SSN occurred with the launch of CCT program called 4Ps (Pantawid Pamilyang Pilipino Program) in 2007.
  - Provides cash grants to poor households with children: P500 per month per household for health and nutrition expenses, and P300 per month per child for education expenses. Maximum benefit: P1,400 per month for up to 5 years
  - The program covers 65% of all poor households.
  - 4P benefits increased the average per capita income of beneficiaries by 29%. Also positive effects on school attendance, immunization, prenatal visits

Conclusion

- Major SSN improvements in all three countries:
  - India has made strides in creating employment opportunities and health care for the poor
  - Indonesia has a broad set of complementary SSN programs: price subsidies for rice and fuel; conditional cash transfers; and free health care (Jamkesmas).
  - Philippines' SSN strategy is centered on targeted assistance through 4P and health insurance
- Health care for the poor is understandably emphasized in all three countries.
- Meeting the income needs of the chronic poor is also laudable.
  - But focus only on families with children and mother or nutritional needs of the very poor leave out a large chunk of vulnerable population

Conclusion

- The most significant deficiency in all three countries is that SSNs are targeted on formally employed and, especially, chronic poor.
- Insufficient attention to transient poor, most of whom are in informal sectors.
  - More than 2/3rd of the workforce in Indonesia and the Philippines and 4/5th of the workforce in India are in informal sectors.
  - Informal workers are particularly vulnerable to shifts in macroeconomic and weather conditions.
  - The increasing frequency and intensity of economic crises and natural disasters necessitate programs that are on standby, ready for quick operationalization.

Conclusion

- Public works programs are well suited for those vulnerable to recurrent unemployment
  - They keep affected workers in the labor market while providing income support
  - Create long-term public assets for the community.
- Microfinance for the self-employed generates a similarly protective effect.
- There is a compelling case for limited unconditional cash transfer programs for those beyond the reach of CCT or public works, such as the aged or disabled poor.

Conclusion

- A social safety net system comprising cash transfers for chronic poor and public works and microcredit programs for the transient poor are relatively inexpensive.
  - World Bank and ILO have estimated the cost of basic SSN at below 2% of GDP.
- The main barrier to comprehensive SSN is not fiscal capacity
  - It is lack of political and administrative capability.
- Governments find it difficult to
  - Overcome the path dependency of existing poorly designed programs
  - Build the administrative capacity necessary to implement SSN programs

Conclusion

- Political and administrative capacity requirements for SSN are high:
  - Targeted cash transfer and public works programs presuppose a high level of information and administrative capability.
  - Public works programs are technically demanding in terms of designing projects and setting wages. Also require strict corruption control and quality control measures.
  - CCT programs require corresponding efforts on the supply side
- In short, to protect vulnerable populations, government need:
  - Political will
  - Administrative capacity
  - Creating fiscal space is an easier problem to overcome