INDONESIA SOCIAL ASSISTANCE
PUBLIC EXPENDITURE REVIEW
UPDATE

Towards a Comprehensive, Integrated, and Effective Social Assistance System in Indonesia

WORLD BANK GROUP

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Foreword

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In the last decade, Indonesia has reduced its poverty headcount rate from 16.6 % in 2007 to 10.6 % by early 2017. This is an impressive accomplishment that deserves to be celebrated. Recently, however, the pace of poverty reduction has slowed down. In addition, high income inequality remains a major challenge. Reducing poverty further and improving equality therefore requires sustained effort – more and better spending as well as further improvements in the effectiveness of government programs.

It is heartening to see that in early 2017, the Government of Indonesia renewed its commitment to address inequality and financial exclusion. The government decided to use social assistance programs as important tools to reduce inequality, both in terms of income and opportunities. Recent improvements in fiscal management have also enabled higher overall budget allocations for social assistance. At the same time, the application of a uniform targeting mechanism has improved the targeting of social assistance benefits towards the poor and vulnerable.

This report assesses the strengths and weaknesses of Indonesia's main social assistance programs, which currently benefiting close to 100 million people. As an update to the World Bank's 2012 report *Protecting Poor and Vulnerable Households in Indonesia*, this document reviews the progress achieved from 2011 until 2016 and proposes options for feasible reform and policy planning. We at the World Bank believe that Indonesia's social assistance system could be further developed to provide an effective suite of support to poor households that can address lingering risks and gaps in opportunities faced by its people.

Indonesia aspires to reach high-income status by 2030. It is nonetheless facing a number of significant challenges. Not only is an accelerated growth of about 8-9 percent annually over the next 15 years needed, but this growth needs to become more inclusive and pro-poor. Furthermore, Indonesia, like several other middle-income Asian countries, must address the looming aging population challenge, i.e. 'to prosper before getting old.' A comprehensive, integrated, and effective social assistance system can continue to protect the poor and vulnerable from suffering under destitution and various shocks while, at the same time, support their upward mobility so that they can lead productive lives through better human development and more sustainable livelihoods.

We at the World Bank Group stand ready to continue working alongside with the Government of Indonesia, using all of our tools and expertise, to bring in the human and physical investment that Indonesia needs to become a high-income country. I know that this is possible and we are eager to provide our support in making that vision a reality.

This work is the result of strong partnerships between many government agencies and the World Bank. We are especially grateful for the support and cooperation of the Ministry of Finance (MoF), National Development Planning Agency (Bappenas), the Ministry of Social Affairs, and the National Team for the Acceleration of Poverty Reduction (TNP2K). We would also like to thank the Australian Government that, through the Department of Foreign Affairs and Trade, generously provided financial support for the production of this report, and in partnering with the World Bank to provide technical advice and support to the Government of Indonesia towards achieving further poverty and inequality reduction.

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Abbreviations & Acronyms

ASLUT	Social Assistance for the Elderly Program, *Asistensi Sosial Lanjut Usia Terlantar*
Bappenas	State Ministry of National Development Planning, *Menteri Negara Perencanaan Pembangunan Nasional*
BLSM	Unconditional Cash Transfer Program, *Bantuan Lansung Sementara Masyarakat*
BPNT	E-voucher, non-cash, component of Rastra, *Bantuan Pangan Non Tunai*
BSM	Poor Students' Support Program, *Bantuan Siswa Miskin*
Bulog	National Logistics Agency, *Badan Urusan Logistik Nasional*
CMRS	Crisis Monitoring and Response System
DJSN	National Social Security Council, *Dewan Jaminan Sosial Nasional*
ECED	Early Childhood Education and Development
FDS	Family Development Sessions
GoI	Government of Indonesia
IDR	Indonesian Rupiah
JKN-PBI	Recipient of Government Paid Health Insurance Premium - *Penerima Bantuan Iuran within the National Health Insurance Program, Jaminan Kesehatan Nasional* -
KKS	Family Welfare Card, *Kartu Keluarga Sejahtera*
KPS	Social Security Card, *Kartu Perlindungan Sosial*
M&E	Monitoring and Evaluation
MIS	Management Information System
MoEC	Ministry of Education and Culture
MoRA	Ministry of Religious Affairs
MoSA	Ministry of Social Affairs
NER	Net Enrolment Rate
ODA	On-Demand Application
OJK	Financial Regulatory Authority, *Otoritas Jasa Keuangan*
OOP	Out-of-pocket Spending
P2B	Sustainable Livelihoods Program, *Pengembangan Penghidupan Berkelanjutan*
PBI	Recipient of Government Paid JKN Health Insurance Premium, *Penerima Bantuan Iuran*
PIP	Smart Indonesia Program, *Program Indonesia Pintar*
PIS	Healthy Indonesia Program, *Program Indonesia Sehat*
PKH	Conditional Cash Transfer Program, *Program Keluarga Harapan*
Raskin	(Former) Subsidized Rice Program, *Beras Miskin*
Rastra	Subsidized Rice Program, *Beras Sejahtera*
SA	Social Assistance
SJSN	National Health Insurance System, *Sistem Jaminan Sosial Nasional*
SLRT	Integrated Referral System, *Sistem Layanan Rujukan Terpadu*
SRIS	Social Registry Information System
TNP2K	National Team for the Acceleration of Poverty Reduction, *Tim Nasional Percepatan Penanggulangan Kemiskinan*
UDB	Unified Database
WFP	World Food Programme

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Executive Summary

P. 01

Indonesia has committed to developing a comprehensive & effective social assistance system for poor & vulnerable households

Since 2010, the Government of Indonesia (GoI) has set official poverty reduction targets and emphasized the importance of a well-functioning social assistance system in continued poverty reduction. The Government has executed several consequential social assistance reforms, while spending on permanent social assistance programs rose in real terms between 2010 and 2016. Several rounds of reduction in expensive and untargeted subsidies were achieved, and the expenditures saved reallocated to the social assistance sector through: (i) temporary, emergency, unconditional cash transfers targeted to poor and vulnerable households; (ii) benefit and coverage increases for Indonesia's education cash transfer program; and (iii) conditional cash transfers. Standardized procedures for targeting and identifying potential beneficiaries, drawing on a newly updated national registry of around 26 million poor and vulnerable households (the Unified Database, or UDB), were put in place for all implementing agencies to adopt. Most recently, the Government has released the National Financial Inclusion Strategy, which calls for achieving greater financial inclusion by transforming cash-based social assistance payment systems into a cashless system using one single card (*Kartu Keluarga Sejahtera*, KKS). In 2017, the Government has decided to reduce electricity and LPG subsidies, and is planning to redistribute the LPG subsidy to poor and vulnerable households via the KKS card in 2018. Moreover, the conditional cash transfer program (PKH) has expanded from 3.5 million households in 2015, to 6 million by end of 2016, and expected to reach 10 million in 2018.

With Indonesia's economic development facing new challenges, now is a good time to review and update social assistance reform strategies.

However, despite the efforts in expanding coverage of the social protection system, the pace of poverty reduction in Indonesia has slowed significantly in recent years, while both chronic poverty and vulnerability have persisted. The average annual reduction in the headcount poverty rate fell from 1.2 percentage points between 2007 and 2010, to just 0.5 of a percentage point between 2011 and 2014. From 2014 to 2017, poverty reduction continued at the same slower rate, falling by just 0.6 of a percentage point to reach 10.6 percent as of March 2017. Key reasons for this slowdown in the pace of poverty reduction are that those living in poverty are increasingly further away from the poverty line, and so require greater effort—better spending, targeting and integration—to lift them out of poverty. Moreover, the 24 percent of Indonesians living between the poverty line and 1.5 times the poverty line are still highly vulnerable to falling back into poverty[1] if they experience a shock, such as illness, a natural disaster, or any other interruption to their regular earnings and livelihood.

Moreover, income inequality is on the rise, while access to opportunities remain unequal. While inequality in Indonesia by end-2004 was on par with its level in 1980, the Gini coefficient rose by about 6 percentage points in the period 2005-12, and declined subsequently by 1.7 points to 39.3 Gini points by March 2017. Worsening inequality is also evident in non-income poverty indicators, such as education, health, and labor-market outcomes. While all Indonesian households experience good outcomes more often than they did 10 years ago, the gap in achievement between poor and non-poor households has widened for some indicators. The administration that took office in late 2014 added a focus on reducing inequality, identifying social assistance as a means of reducing inequality in both incomes and opportunities.

This report reassesses the strengths and weaknesses of Indonesia's main social assistance programs, and proposes feasible reform options, both program-by-program and for the social assistance system as a whole. This 2017 update, following an earlier World Bank (World Bank, 2012j) report seeks to provide evidence of the progress made between 2011 and 2017, together with relevant benchmarks for future reforms and policy planning. The review presents analytical evidence on salient program features and issues, and proposes additional efforts and options toward a truly integrated system.

[1] Susenas (2016) and World Bank staff calculations.

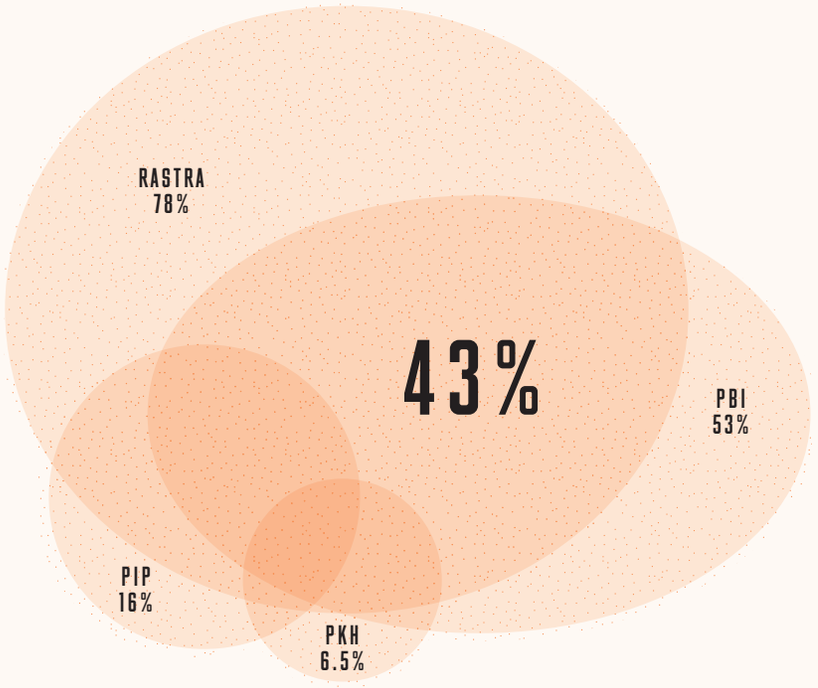
Poverty rate:

10.6%

From 2014 to 2017, poverty reduction continued at the same slower rate, falling by just 0.6 of a percentage point to reach 10.6 percent as of March 2017

The path toward a comprehensive and effective Indonesian social assistance system is clear

FIGURE ES1 | SA convergence in the poorest 10 percent of households



ALL FOUR	2.2%	PIP,PKH	2.6%
RASTRA, PBI, PIP	11%	RASTRA,PIP	14%
RASTRA,PIP,PKH	2.5%	RASKIN, PKH	6%
PBI,PIP,PKH	2.3%		

Source Susenas 2014 and World Bank staff calculations

Persistent poverty, vulnerability, low mobility, and inequality can be ameliorated by a more effective social assistance system. A comprehensive social assistance system can provide the basic necessities that poor households do not access frequently enough, providing an immediate, direct impact on extreme poverty. It can simultaneously assist poor and vulnerable households to mitigate risks by encouraging larger or more consistent investments in members' human and financial capital, as well as reducing reliance on negative coping behaviors, which can sacrifice productive investments for the sake of maintaining minimum consumption. This helps households to absorb and mitigate negative shocks in the most flexible ways such that welfare losses are less severe and not compounded. Finally, a robust social assistance system can make government-driven policy reform more palatable, thereby encouraging more sustainable economic growth.

Beneficiary households would be well-served by better coordination and integration of the existing social assistance programs. While the main programs are more effective and efficient than they were just a few years ago, and coordination is more prevalent than before, institutional "silos" still exist within the social assistance sector and most activities are carried out with limited coordination among programs, implementers, and stakeholders. Results from simulations indicate that an integrated social assistance system—bringing the existing set of independently operating programs and their implementing agencies together via common minimum standards—could provide a boost to consumption expenditure equal to between 14 and 21 percent of an average targeted household's budget and would have an immediate impact on poverty. The "overnight" reduction in the headcount poverty rate that would result from benefit integration is expected to be 2 to 4 percentage points, depending on the coverage rate chosen being 10, 25 or 40 percent, all else being equal.[2] Even partially integrated social assistance could slow down the rate of increase in inequality that Indonesia has experienced recently. For example, extending a social assistance package to the 10 million poorest households that combines the three current direct cash or near-direct cash transfers into one, would create benefit with a magnitude similar to that in countries where direct transfers reduce poverty without distorting labor-market decisions. Renewed efforts and consistent attention are required to broaden and deepen the work begun by the previous administration.

Efficiency gains from integration in the provision of social assistance program sub-processes—outreach, targeting, enrolment, beneficiary verification, benefit transfer, Monitoring and Evaluation (M&E), grievance and complaints—can accrue from the elimination of the duplication that is currently pervasive. As this report details, these processes (except targeting) are carried out independently and without regard to a common standard by many different agencies, although some convergence with regard to benefit delivery systems was begun in late 2016. However, this confusing landscape is difficult for actual or potential beneficiaries to access, and is responsible for a de facto, ground-level separation of programs and initiatives targeting the same poor and vulnerable populations. For instance, Figure ES1 shows that in 2014 no more than 2.2 percent of the poorest 10 percent of households received all four of Indonesia's main social assistance programs.[3] This reality has not changed significantly when referring to 2016 data. The current administration urgently needs to develop a broadly agreed integrated social assistance system operation plan, which includes clarification of the roles and responsibilities of all the agencies involved in the provision of social assistance.

[2] All else remaining equal. For reference, if actual headcount poverty continues to fall at the rate experienced between 2013 and 2014 (about 0.1 to 0.2 of a percentage point per year), it would take about 10 years to achieve the "overnight" reduction that the least expensive integration scenario could achieve immediately.

[3] The conditional cash transfer program, PKH, has both the lowest coverage targets and the strictest means cutoffs. Therefore, any households receiving PKH would automatically qualify (in principle) for the other three programs.

Additional reforms can help social assistance programs reduce poverty more efficiently at any level of expenditure, but new programs for uncovered risks will raise anticipated expenditures. As currently less than one-quarter of social assistance benefits reach poor households, further program and system-wide reforms discussed in this report would allow social assistance expenditures (at any level) to reduce poverty more efficiently. However, overcoming persistent poverty requires new programs or more generous benefits (or both). Of equal importance, Indonesia should be prepared to spend more to safeguard progress already made through the establishment of pre-planned social assistance responses to the natural disasters and macroeconomic instability that are part-and-parcel of Indonesia's geographic location, and economic and financial openness.

This report provides an updated assistance review to support the current Government's social assistance reforms and poverty and inequality reduction efforts. In addition to providing an empirical review of the impact of social assistance reforms that have taken place over the past six years, this update indicates areas in which further reforms are needed, with a focus on the next generation of reforms and making progress toward an integrated social assistance system.[4] The recommendations provided here fall into three broad categories:

I

Increase accessibility to social assistance programs by poor and vulnerable households in order to achieve poverty reduction targets. Increased coverage may naturally result from system integration, but should be pursued rapidly and independently.

II

Create new programs and innovate within existing programs to provide solutions for key Indonesian life-cycle risks and vulnerabilities. For instance, these could include early childhood education, retirement savings, and macroeconomic or natural disaster crisis responses, which Indonesia's current social assistance programming do not address adequately. Without further innovation attuned to the Indonesian context, the social assistance system will, no matter how well-integrated, remain incomplete.

III

Boost integration of the social assistance system by: (i) continuing to develop a suite of social assistance delivery processes that are integrated across, and serve all, existing and future social assistance initiatives; (ii) improving coordination at the regional and local levels among implementation partners, local governments and public service agencies; and (iii) reforming and revising operations within individual social assistance programs to prepare them for incorporation into an integrated and more effective system.

Table ES1 below summarizes suggested actions within these three overarching social assistance system-wide goals for the current administration:

The Government should intensify social assistance reform efforts to ensure that Indonesia remains on the right path of poverty and inequality reduction

[4] As the 2012 review made clear, social assistance cannot bear the entire burden for improving household welfare and reducing inequality; rather social assistance should be complementary to policies and programs that improve access to high-quality, low-cost public goods and services and access to high-quality, secure jobs.

TABLE ES1 | Building a comprehensive & integrated social assistance system

GOAL	SHORT-TERM ACTIONS (NEXT YEAR)	MEDIUM-TERM ACTIONS (NEXT 2 YEARS)	LONG-TERM ACTIONS (NEXT 4 YEARS)
Increase accessibility by poor and vulnerable households	All social assistance initiatives incorporate the beneficiary eligibility criteria and select beneficiaries from one common targeting database (based on the current Unified Database). Each program will also need to incorporate two-way updating—from the targeting database to program-based beneficiary lists, and from program-based information to the targeting database, the initial step toward constituting a dynamic, two-way, social registry information system (SRIS) to ensure progress inclusion of all poor and vulnerable households.	**A.** New programs (proposed to cover key uncovered risks) eligibility criteria incorporated into the SRIS functionality. **B.** Outreach for, and registration of, potential beneficiaries through a dynamic SRIS conforms to a jointly agreed structure, principles, and implementation arrangements.	Omnibus funding—rather than program-by-program negotiations—for all eligible beneficiaries (as determined by the SRIS) in all programs officially part of the "One System" coordinated social assistance framework.
Address key uncovered risks and vulnerabilities	Agencies responsible for health, education, social insurance, development planning, poverty, and crisis monitoring and response identify sector-specific uncovered risks faced by Indonesian households.	**A.** Agencies responsible for health, education, and social insurance propose, with cost estimates, social assistance programs covering as yet uncovered sector-specific risks to development planning and poverty agencies **B.** The national crisis response framework strengthens the roles of existing social assistance delivery platforms as part of "crisis response" strategy and negotiates with social assistance-executing agencies for joint planning, deployment, and monitoring .	Approved programs and operational arrangements (for crisis response) are piloted within the newly created "One System" coordinated social assistance framework.
Boost "One System" framework for social assistance	Bring all institutions, agencies, and initiatives providing social assistance under common standards and procedures for targeting, beneficiary selection, payment systems, grievances and complaints, and performance M&E.	Formalize the division of roles, responsibilities, financing, authority, and accountability between central and local agencies involved in social assistance.	Formally establish Indonesia's "One System" social assistance framework and formalize the roles and purview of each of the system's partner executing agencies in health, education, social insurance, planning, poverty, and crisis monitoring and response.

Continue expanding & deepen programmatic reforms for existing programs

Households would benefit from a more integrated and navigable social assistance landscape. Indonesia's current social assistance programs correspond logically to the important risks faced by poor and vulnerable households (see Section 3). Integration of these programs through common standard setting; through central-level oversight and regulation of locally-implemented (and locally relevant) initiatives; and through the provision of holistic outreach, beneficiary selection, and facilitation, could make a significant difference for poor and vulnerable households that currently do not have access to every program and initiative for which they are eligible.

Three out of the four major and active SA programs are at or nearing the right coverage level. Rastra and PIP are at the right coverage level of 25 percent of the population and PBI/JKN nearing its target of 40 percent coverage, the main program that remains low in coverage, at just about 10 percent, is PKH, covering 6 million families at the end of 2016, PKH is relatively low in coverage. The government has recently decided to expand the program up to 10 million families in 2018 bringing the program closer to a coverage level (14 percent) comparable to other similar countries with a maturing CCT program: Brazil's *Bolsa Familia* covering 14 million families or 25 percent of the population; Phillipines' Pantawid Pamilya covering 4.4 million families or 20 percent of the population; Mexico's Prospera covering 5.8 million families or 20 percent of the population.

Despite having expanded significantly, the current array of SA programs still do not cover large shares of their target population. Viewing coverage by a welfare disaggregation of poor, vulnerable and non-poor and vulnerable (Figure ES2), considerable coverage gaps persist due to inclusion errors. While targeting errors can be improved, and have improved for some of the programs over the years, they can only improve further to some degree. A prime reason is that the current targeting database, the UDB, is not dynamically updated and does not currently allow for non-included households to request inclusion. A second reason is that, the use of proxy means testing, in the absence of more accurate means testing, within Indonesia's targeting database means that not all poor and vulnerable households can be correctly identified, even with the best possible methodology and implementation of a targeting system.

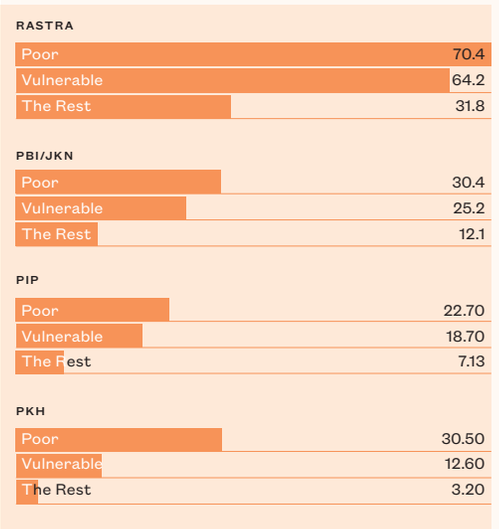
Significant increases in allocative efficiency via system-level improvements is within reach. With improved targeting through a more dynamic targeting database, through the governments SLRT and ODA initiatives, a future SA system in Indonesia could continue to reduce allocation of benefits to the non-poor, non-vulnerable populations (the grey bars in figure ES2).

Improvements within existing programs will lead to a more effective system. Many programs are not providing an entire benefit package to those to whom it was promised: in other words, these programs are not providing the right benefits. Other social assistance programs are not providing benefits at the right time: benefits are distributed either too early or too late related to some necessary purchases or investments that households make. And, with few exceptions, social assistance programs do not always reach the right people: over half of the benefits available end up with non-poor, non-vulnerable households. Most program level performance M&E mechanisms have not been effectively assessing the gaps between the program design and actual implementation and therefore have not supported adaptation of program design and implementation arrangements to achieve better results.

The table ES2 and and the remainder of this section summarize the priority operational reforms recommended for each existing program.

FIGURE ES2

Coverage of major active household targeted social assistance programs (%), 2016



Source Susenas 2016. Note: for PKH 2014 data is used to impute allocation of beneficiaries with 2016 coverage level of 6 million families.

RASTRA

Subsidized Rice Program

Previously called Raskin (Beras Miskin), Indonesia's Rastra (Beras Sejahtera) has strong potential but has been failing operationally to achieve fundamental social assistance goals. The consistent provision of a basic food package could protect poor households from food-price volatility, calorie scarcity, and malnutrition. However, Rastra suffers from dilution of benefits and coverage errors, missing rice, and hidden financing burdens, all of which reduce the transfer values provided to target households.

Poor targeting, dilution of benefits, and missing rice are long-standing and well-known Rastra issues. It is the least well-targeted of any of Indonesia's social assistance programs and the average benefit package is significantly diluted when the "right" to buy Rastra rice is re-allocated at the local level to include many non-poor households. In addition, large quantities of rice procured for Rastra do not reach localities and no extra effort is made to put Rastra rice in targeted households when total supplies are low. Finally, a lack of clarity concerning responsibilities and financing at the "last mile" of Rastra distribution means that Rastra-purchasing households—especially those in remote areas—receive a lower per-kilogram benefit than promised.

Nevertheless, Rastra is the largest social assistance initiative in terms of coverage and second-largest in terms of budget, making reforms that much more urgent. Only with the incorporation of the PBI component into the much larger Universal Health Coverage initiative under JKN has Rastra fallen from first into second place in terms of the size of its program budget. But it is still huge, and as such Rastra reforms have the potential to make the greatest impact for both government and households.

Rastra should revise practices to achieve its social assistance mandate. Rastra quotas and actual household allocations should be based on a dynamically updated national registry. The "last mile" of Rastra allocations should be monitored to ensure that a full allocation reaches all eligible households first. Rastra socialization should be re-enforced with performance incentives so local communities can develop grassroots monitoring and provide feedback to implementers. It has been also suggested that Rastra increase local-level transparency by listing eligible beneficiaries at the village level, and formalize and regularize the process of recipient replacement that is currently often achieved unilaterally by the village administration (Perdana et al., 2015).

In response to long standing delivery issues, reform is underway as the Government has introduced an e-voucher initiative. Rastra reform has begun shifting towards cashing out the Rastra benefit, initially in areas with functioning rice markets, while the current operational model will likely remain in the more remote areas of Indonesia. Starting in 2017, 1.4 million Rastra beneficiary families in 44 cities will be able to purchase rice and in some cases other pre-specified food items from a network of e-Warongs, which are operated by various entities, including small traders and chain stores. These e-Warongs are supported by a participating bank and equipped with EDC/Pos devices for processing transactions using the combo KKS card. To be successful in delivering the Rastra benefits (as well as PKH and potentially PIP, and even selected targeted subsidies), the initiative needs close M&E of implementation processes

[5] For example, the criteria summarizing household characteristics varied across districts; in some districts, midwives and health center officials distributed PBI / Jamkesmas cards according to their own criteria, regardless of economic status; there were no incentives in the system to either maximize PBI enrolment or minimize targeting errors, while the list of eligible beneficiaries compiled by district officials was not subject to validation by higher levels of program administrators.

JKN-PBI

Subsidized Social Health Insurance

The PBI component of JKN (recipients of JKN health insurance fee waiver) has accomplished major coverage increases and has successfully been merged into the National Health Insurance (JKN) system. JKN-PBI is the largest single source of health insurance coverage in Indonesia, covering over 92 million individuals in 2016. JKN-PBI's value to households is significant as it promises a nearly unlimited-in-value health benefit to poor and vulnerable households. In other countries health insurance coverage expansion is often accompanied by falling rates of out-of-pocket expenditures, while in Indonesia out-of-pocket expenditures for health have only fallen slightly, indicating systemic issues with JKN-PBI (World Bank, 2016b).

First, JKN-PBI outreach and facilitation need major improvement. JKN-PBI households, for example, often do not know which treatments, procedures, providers, and medicines are covered and which are excluded. This lack of knowledge reduces utilization rates and the value of the JKN-PBI program (World Bank, 2016b). Establishing common information standards, and verifying that the standard has been met, is essential for delivering valuable healthcare services to poor households.

Second, JKN-PBI's targeting and beneficiary selection procedures need further reform to minimize exclusion of eligible households. For example, previous local-level variation in eligibility determination and targeting practices (World Bank, 2013d)[5] may have been reduced through JKN-PBI (named Jamkesmas at the time) joining the UDB-based targeting system, but as yet there is no mechanism for local-to-central registry updating that would keep local-level JKN-PBI allocations current. In order to mitigate this risk, JKN-PBI should develop a robust grievance, and reporting system that runs in parallel to the UDB-based grievance reporting system, so that households unfairly excluded from JKN-PBI beneficiary status can be reinstated when they most need it. To further empower the poor and vulnerable, such a grievance system could be complemented by efforts to raise beneficiary awareness of program entitlements.

Third, M&E systems for JKN-PBI should be upgraded to monitor health, healthcare usage, financial protection and cost (from the household side), and supply-side performance and readiness. As there is significant regional disparity in the availability and quality of healthcare services, access to health care could be an issue due to weak supply. An issue underlying this is the lack of full clarity on the roles, responsibilities and capacities for overseeing administrator performance. JKN-PBI should explicitly recognize that mutual assistance and support (especially through information sharing) between program administrators and healthcare providers will only improve the healthcare service options delivered to low-income beneficiaries and will help JKN-PBI to make good on its unlimited benefit package promise.

Lastly, JKN generally must make strong efforts to serve poor households more effectively while addressing other priorities that do not necessarily regard the poor and vulnerable population segment. A report (World Bank, 2015b) indicated that JKN's current priorities are the expansion of membership to the private and informal sector; increasing contribution collections from those not currently contributing; improving financial and fiscal sustainability; and enhancing the JKN administrator's overall governance structure. While crucial for JKN's future and the consistent availability of all JKN services for all households, these items do not provide immediate improvements for poor and vulnerable households.

92 MIL.

"JKN-PBI is the largest single source of health insurance coverage in Indonesia, covering over 92 million individuals in 2016."

PKH

conditional cash transfer

PKH's positive impacts in welfare, in health-seeking behavior, and in education can be extended if the program scales up. Two impact evaluations have shown that PKH families have greater access to health and education. They show that PKH households have a 2.7-percentage-point decrease in severe stunting and an 8.8-percentage-point increase in the rate of transition from primary to secondary school for children in beneficiary families (TNP2K, 2015a; World Bank, 2011a). These impacts were estimated most recently in 2013 before the program was expanded to the current size of 6 million families. In addition, the program has also demonstrated that it can be flexible with its operational protocols and varied in its approach to service provider coordination and assistance.

Further innovations in its facilitation approach can help PKH to serve more households in need. For example, since 2013 "Family Development Sessions" (FDS) were introduced through PKH to provide group-level training in early childhood education, parenting, health and nutrition, household finances, small business development, and entrepreneurship. PKH could take the lead in facilitating access to social assistance and publicly provided services more generally by using its own resources to mobilize local governments, service providers, and other stakeholders to provide access for poor and vulnerable households to all locally available resources.

PKH needs to continue strengthening its administration capacity, information management, and HR systems, as well as the capacity of affiliated service providers. Continuous enhancement of core program functions is essential for efficient delivery of benefits and effective access for households: timely verification of beneficiaries' status and conditionality fulfillment; regular Management Information System (MIS) updating, adjustment of benefit levels and timely disbursements; determination of local-level capacity for distributing benefits and implementation support; and suggestions for remediation of local supply inadequacies in health, education and program socialization, are some of the aspects that need strengthening.[6] As the program has been expanded significantly and is expected to undergo further expansion, especially towards more remote regions, it is critical to strengthen the delivery systems to keep up with the needs of the program.

PIP

Cash Transfer for Poor and at Risk Students

PIP has begun to demonstrate its full potential but can still deliver more to those most in need. With recent increases in coverage and reforms to implementation, PIP is now making significant positive contributions to welfare in poor and near-poor households (with students) and to the Government's drive to provide universal basic education. PIP should focus on continuous and coordinated monitoring, evaluation, and improvements in delivery: most importantly, benefit-level updating should occur more frequently in order for the PIP transfer to remain relevant. PIP should be at the forefront of positive outreach to poor students, especially those approaching the senior secondary or university levels, and facing the highest out-of-pocket and opportunity costs.

PIP's biggest hurdle may be its current institutional form. PIP is split among two ministries and several directorates, each of which carries out most program functions independently. While some effort has been made since 2013 by TNP2K and Kemenko PMK to ensure a greater degree of coordination within policy and planning, some aspects are still lingering. For instance, there is currently no mechanism to jointly provide (and jointly review the effectiveness of), for example, management performance reviews, M&E efforts, socialization campaigns, a grievance redress platform, or a policy review of the suitability of a "transition bonus" for eligible students making the leap from one school level to the next. There remain many opportunities for better program integration that can in turn provide a better experience for students and households.

[6] All of these PKH processes (as well as some others) were found to be not operational or only sporadically operational in a first round of implementation "spot checks" completed over 2008 and 2009 (Centre of Health Research, 2010) and more recently throughout 2016 by the World Bank Social Assistance team through several spot checks.

TABLE ES2 | Priorities for currently active social assistance programs

PROGRAM	ISSUE/ CONSEQUENCE	SUGGESTED CHANGE
Rastra	Large inclusion errors; dilution of benefits	Select beneficiaries based exclusively on the common targeting database and put in place a two-way updating mechanism between the common targeting database and Rastra beneficiary records.
		Monitor and evaluate the e-voucher initiative started in February 2017 (Non-cash Food Assistance or BPNT) as a possible alternative delivery system to Rastra. Assess the implementation and make adjustments to ensure the expected program outcomes can be achieved as well monitoring on actual benefits to beneficiaries in terms of convenience, quantity and quality of food items purchased.
		Further adapt and improve the e-voucher program design to ensure its applicability in rural areas and inclusion of nutritious food options in addition to rice.
JKN-PBI	Access in some places not assured; low utilization. Uneven access to quality health services, low level of knowledge of JKN-PBI entitlements and persistent mis-targeting.	Improve outreach, facilitation, and beneficiary support so that intended beneficiaries are aware of what services are covered and what a "best practice" healthcare service schedule looks like for all household members.
		M&E systems for JKN-PBI should be upgraded to monitor health, healthcare usage, financial protection and cost issues (from the household side), and supply-side preparedness indicators and outcomes.
PKH	Unequal coverage; low benefit levels; inadequate training and support to facilitators; limited coordination with health and education service providers at national and sub-national levels	Continue expanding while strengthen implementation capacity, revamp IT systems, improve HR management and ensure adequate training of facilitators, and expand family development sessions for all families. Increase benefit levels. Improve information sharing with service providers and service provision planning authorities.
PIP	Benefit levels incommensurate with education costs; low uptake at advanced education levels; weak monitoring	Adjust benefit levels annually to ensure they are in line with actual costs of attending each level of school.
		Develop outreach facilitation, and beneficiary support modules for senior secondary and university school-dropouts.
		Consider delegating the responsibility of outreach and enrollment to MoSA
Suitability of Program Composition	Not all important household risks to well-being are covered	Facilitate greater incorporation into the social protection system livelihoods and labor market activation initiatives for instance under the Pengembangan Penghidupan Berkelanjutan (P2B) initiative.
	A crisis Monitoring and Response System (CMRS) exists but is not yet actively used	Continue refining the crisis-data-collection-and-monitoring system while planning for a range of social assistance initiatives that can be flexibly and quickly deployed at the household level when social or economic crises strike.

OBSTACLES

Allocations and “last mile” not currently controlled by local governments nor the Rastra administrator.

The National Health Insurance system (SJSN)—of which JKN-PBI is now a part—is focusing more on financial sustainability, which may potentially divert attention away from improving JKN-PBI service in the short term.

The budget for expansion and system strengthening needs to be guaranteed. Better coordination with health and education service providers would require enhanced and formalized coordination mechanisms at national and sub-national levels.

PIP is fragmented internally; policy and planning proceed independently for regular and madrasah schools.

Uncertainty over which of the many small livelihoods projects currently active in Indonesia will be effective and which can be scaled.

Monitoring requires coordinated, timely inputs from many government agencies; response requires flexible, just-in-time expenditures difficult to include in regular budget negotiations.

A future social assistance system should be able to respond to as of yet uncovered risks

Besides strengthening and successfully completing planned coverage expansions of existing programs, new programs covering important risks that are currently not being addressed would make an integrated social assistance system more effective. There are some life-cycle risks not adequately addressed by the current collection of social assistance programs; see section 3 of this report for more detail.

Currently, poor and vulnerable elderly, very young children and disabled receive very little social assistance in line with their needs. Nearly 70 percent of pre-school age children from poor households are not enrolled in any pre-school initiative. For children who are 5 to 6 years old and their parents, there are no national programs or initiatives that provide low-cost access to Early Childhood Education and Development (ECED) activities, or outreach and information to parents who might not yet fully understand the value of such activities. To begin addressing this risk, the government could consider a fee waiver to access PAUD early child hood learning centers for 40 percent of the poor and vulnerable children aged 5 to 6 years old. Such a program would cost just over IDR 6.1 trillion per year and would bring myriad benefits such as reduced malnutrition, greater cognitive development and more time for mothers to work. For the elderly, income security remains a dire issue; while poverty and vulnerability rise with age, a third of the elderly are either living alone or with one other person while 40 percent do not have health insurance. Compounding these risks is the lack of a social pension for those who are elderly and no longer working. To address this risk in the short term, a social pension could be set up targeting the poor and vulnerable elderly. Covering 40 percent, or approximately 7 million of those aged 64 and older, the cost to provide a minimum level of protection would be just about IDR 27 trillion.[7]

The disabled are also more likely to be or become poor or vulnerable as they are often limited in their opportunity to generate income. In addition, they may face above average expenditures in health. Recent survey data on the disabled does not exist and so no new program simulation is introduced; the Ministry of Social Affairs however, plans to subsume both the disabled and elderly programs (ASODKB and ASLUT both currently at very low coverage) within the PKH CCT opening up possibilities to scale up protection for both the elderly and disabled that are currently not covered by corresponding social assistance programs.

The social assistance system should provide active support to poor and vulnerable individuals and households moving from a state of dependence and vulnerability to one of independence and resilience. For example, students from poor and vulnerable households getting ready to enter the labor market or under-skilled individuals already working would benefit from labor-market activation programs, or "livelihoods" initiatives such as job training (or re-training), skills enhancement and second-chance education. To some extent, the Government is responding to this unmet need under the Sustainable Livelihoods Program (P2B) launched in 2015 by the State Ministry of National Development Planning (Bappenas). The current P2B strategy developed by Bappenas centers mostly on the household and, after identifying a household's particular need, develops a strategy centered on skills training, professional coaching, and training and thoughtful sequencing of cash grants, credit and the transfer of assets. Several approaches under the P2B framework had been piloted in six sub-districts as of late 2016, with positive outcomes. Future prospects for a coordinated and wider P2B roll-out, however, remain unclear (Bappenas, 2017).

In addition, Indonesia's Crisis Monitoring and Response System (CMRS) should be operationally linked and leverage the social assistance system when needed. Households in Indonesia are vulnerable to stresses that the international and national economies, as well as the environment, inevitably produce, and there is as yet no pre-planned response mechanism providing social and economic support to mitigate against large negative shocks to a household's welfare. A functioning monitoring system is already in place, managed and analyzed by TNP2K. The system makes use of timely, high-quality data inputs from across several government agencies. It is also currently focused on social disasters and does not include a natural disaster component. Response protocols for both sorts of crises at different levels of severity are needed so that programs under different ministries can be automatically funded, activated, and implemented when needed, and so that budgetary and parliamentary procedures do not prevent timely assistance from being released. Indonesia should also develop programs that can be deployed rapidly and counter-cyclically, such as public works. Certainly such a set of protocols would require intensive institutional coordination across several government agencies that should be part of the response system. While some ideas and protocols have been discussed there has been little take up of these ideas in the current administration.

If the current suite of programs remains over the next decade or so, rather than further coverage expansion beyond planned targets by 2018, the next steps would be to pursue greater integration, improved delivery systems and common standards, better targeting and the development of new programs to address uncovered risks in line with the main recommendations of this report.

[7] Both estimates assuming 10% administration costs. For the ECED fee waiver: unit cost per child per year of about IDR 1,000,000 (adjusted for inflation to 2019 and based on 2013 World Bank and Unicef estimates of IDR 800,000 per year per child) and planning for a gradual scale up to reach a 40 percent coverage level by 2019. For the Social pension: the minimum pension payout is modelled to follow the BPJS Labor pension programs current value of IDR 300,000 and adjusted for inflation to 2019.

Indonesian social assistance programs are more united under common, minimum standards for delivery than ever before, but continued effort should be made to achieve effective integration.

Social assistance execution has historically been highly fragmented across ministries and agencies, but the Government's push for greater financial inclusion may consolidate social assistance delivery in an important way. At the central level, the execution of the major social assistance programs is still shared by six central institutions (World Bank, 2012j). This is likely to continue and need not necessarily change radically in order for social assistance delivery to improve. However, the President's Decree on a Financial Inclusion road map in 2016 has made an important push to begin achieving fully integrated digital social assistance payments by 2022 (MoSA, 2016d).

Indonesian social assistance programs are more united under common, minimum standards for delivery than ever before, but continued effort should be made to achieve effective integration. Efforts at integration have been made: an identity-card-based system; "bilateral" automatic eligibility efforts, where receipt of one transfer makes a household automatically eligible for another; and an integrated outreach effort to "enroll" households in all programs for which they are eligible, were all piloted recently. However, very little progress has been made regarding common standards and processes in Monitoring and Evaluation (M&E); in outreach, socialization, and awareness; and in grievance procedures. This is due to institutional fragmentation and the lack of a common, authoritative standard, without which these sub-processes are still needlessly duplicated and delivered with varying quality. Likewise, though Rastra and PKH began using the UDB in 2012, and while PBI and PIP joined in 2013, only PKH and PIP, since 2013, have fully adopted the UDB standard for use in quota-generating, eligibility determination, and beneficiary selection, and only PKH has implemented a two-way updating procedure that works in concert with the UDB.

The Government has launched two initiatives to build common platforms: (i) an Integrated Service and Referral System as the citizen interface for multiple government services (SLRT) and the On Demand Application (ODA) as a way to update household information with the involvement of the local government; and (ii) a delivery gateway for social assistance cash and in-kind transfers (such as for PKH, PIP, Rastra and some selected subsidies) using one integrated social assistance card (a "combo" KKS card) (MoSA, 2016d). Both initiatives bring Indonesia closer to its "One System" framework. However, beyond the two pilots, there still exist many overlapping government-wide systems and agencies with social assistance expenditure oversight or M&E responsibilities, spanning sectors and levels of government, with different spheres of influence and only partially overlapping information needs producing a confusing landscape that does not yet produce authoritative regulations or guidance for social assistance providers.

Variability in local execution exacerbates the negative effects of a fragmented central architecture. Qualitative and quantitative evidence suggests that idiosyncratic and varied eligibility determination procedures, targeting frameworks, and benefit ownership and control rights, negatively affect Social Assistance program integration at the household level. For example, the allocation of household "rights" to purchase subsidized Rastra rice is done by village heads and sub-village administrations; a portion of PIP benefits (and the right to distribute them) is still controlled by schools; and the distribution of the fee-waiver component of subsidized health insurance coverage has not previously been monitored or evaluated. The fact that such practices persist and are tolerated indicates a low level of coordination between central-government-level policy planners and funding authorities, and the regional- and local-level administrations that have been delegated crucial portions of important social assistance processes.[8]

Indonesia's "One System" social assistance framework would mean all institutions, agencies, and initiatives providing social assistance would be bound by, and evaluated according to, common standards. This approach achieves economies of scale, reducing duplication of crucial social assistance delivery processes, such as targeting and beneficiary selection, payment systems, grievance and complaint recording and monitoring, and M&E,

[8] Unlike most other public social expenditures which are in large part executed by regional governments (primarily district-level governments), 85 percent (on average) of SA programming expenditures are centrally executed. See the Expenditure Summary report in this series or World Bank (2012j) for more detail on the history and contemporaneous particulars of this arrangement.

BOX ES1

International experience on Social Assistance integration

International experience suggests that an integrated social assistance system can be achieved in a variety of ways. Brazil has successfully merged multiple cash, in-kind, and indirect social assistance transfers into one single conditional cash transfer program, called *Bolsa Familia* ("Family Grant").[9] While it is nominally executed by the Ministry of Social Development, payments and the management information system (MIS) are "outsourced" to the *Caixa Economica* Federal (a public bank), while regional governments are tasked with beneficiary selection, updating, complaints, compliance verification, and facilitating connections to complementary public and private services.

Colombia and Chile have instead left the expanding program collection alone and pursued integration through common standards, as well as local-level unified outreach, facilitation, and planning for the achievement of better outcomes with beneficiaries. While in both countries central-level bodies regulate the use of the national targeting database and are uniquely authorized to determine eligibility, each registry's "implementation" is decentralized, as municipal-level administrators maintain and locally update it through the receipt and processing of applications and grievances. In addition, both Chile and Colombia use locally sourced social workers and program facilitators who, in concert with local government, determine poor and vulnerable household needs. They then match households' profiles with existing national and local social programs, for example in child care, youth training, micro-credit, scholarships, or housing subsidies.

[9] Created in October, 2003. Law No. 10.836, 2003.

The Government has had key initial successes in uniting portions of the social assistance portfolio under a common targeting and beneficiary selection system (today, the UDB). But the ultimate goal for this system is to put in place a dynamic, two-way updating approach,

BOX ES2 Poverty databases as a basis for designing social protection systems: experience from some Latin American countries[1]

A common feature in social assistance beneficiary targeting in Chile, Colombia, Mexico, and Brazil is the use of national poverty databases as authoritative registries of poor and vulnerable households. Common design elements and implementation choices in these targeting systems as follows:*

A. Efficient data collection. Following sequential steps of collection and processing under strict supervision procedures contributes to the quality of information gathered.

B. Simple, user-friendly management information systems (MIS). Information management procedures remain crucial in the construction of a reliable and always-current database. Unique country-wide individual identification is often used to avoid duplication and to link registry information and beneficiaries with other systems and programs.

C. Standardized household assessment. In Chile and Mexico, which use proxy-means tests to assess household vulnerability, to 90 percent of program benefits are received by the poorest 40 percent of households, while costs are relatively low—from US$2 to 8 per interview on average in Latin America—and administrative requirements are manageable. These countries have found that providing a household assessment within a broader geographic targeting framework greatly improves targeting accuracy.

D. Clearly-defined institutional roles have proven essential for the success of household targeting systems. Cross-country comparisons reveal some important advantages of centralized design, administration, database management, and eligibility determination while day-to-day operations are delegated to the local levels. However, the most effective organization of an authoritative beneficiary targeting and selection institution will depend to a great extent on capacities and comparative advantages.

E. Transparent monitoring and oversight mechanisms ensure credibility and can help control fraud, malfeasance, and corruption. When multiple checks—such as supervision of household assessment interviews, verification of information, automated checks, comparing registries with other data, random-sample quality control reviews, and citizen or ombudsman oversight —are built into the system, potential beneficiaries and non-beneficiaries alike can be confident that eligibility determination is undertaken the same way everywhere anonymously and decentralized data collection is more likely to conform to a common standard. Authoritative, common standards for the implementation and use of rigorously designed targeting systems that query single, unique, and authoritative registries of poor households have over time served as an institutional coordination mechanism and have standardized access of poor and vulnerable household to a larger set of social programs and services.

* Source: Castañeda, et al., 2005.

that are currently pursued differently (if at all) by most agencies with a social assistance delivery mandate. It can also help the Government in rationally allocating limited resources based on: the risks potential beneficiaries face; their unmet needs; and the social assistance program mix that can remedy these two shortfalls. Finally, it encourages individual agencies to work as "one government" that has an increase in beneficiary welfare and a reduction in beneficiary risk as the ultimate goal.

Indonesia will require clarity regarding the division of roles, responsibilities, financing, and authority between central and local agencies responsible for social assistance. While social assistance transfers are executed by the central government, many support functions—beneficiary socialization and outreach; M&E; complaint and grievance-handling—are delegated to regional and local governments. These same governments also determine to some extent policy, planning, and service schedules in front-line health and education providers, and can execute their own policies and schedules even when they contradict, for example, national social assistance guidelines or objectives. At the same time, enterprising districts have developed their own social-assistance initiatives to complement or enhance national initiatives. These areas will need technical support to improve, expand, and harmonize these local initiatives within the national framework. In particular, village funds allocated according to the Village Law could be harnessed to support both national-, provincial-, and district-level social assistance program implementation.

The establishment of common platforms and further collaborative refinements will encourage ongoing integration of individual programs under one roof. For example, the Government has had key initial successes[10] in uniting portions of the social assistance portfolio under a common targeting and beneficiary selection system (today, the UDB). But the ultimate goal for this system is to put in place a dynamic, two-way updating approach, where program-level data on household characteristics and current trajectory can inform the overall targeting system, and data can help program implementers update their operational priorities. This two-way participation encourages implementing agencies to invest in common standards they are also bound to uphold. The next wave of integration platforms—in M&E; socialization, outreach, and induction; and grievance complaint and reporting, for example—should likewise focus on participatory improvements and refinements.

[10] While all Social assistance programs are now using the UDB to at least generate initial beneficiary quotas, not all programs use the UDB to determine eligibility and select beneficiaries, meaning SA integration through a common targeting standard is far from complete.

Picture source SLRT 2017

A "single-window" framework could generate cost-savings for the Government.

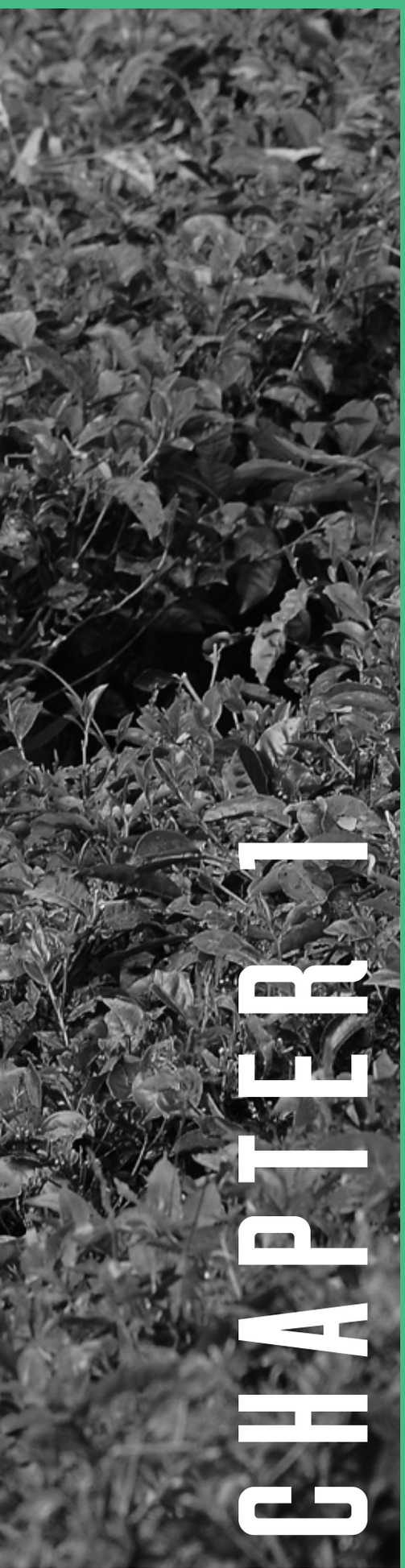
Regional or staggered "pilot" programs can efficiently test approaches to integration and provide a baseline for further refinements. For example, a "multi-channel" complaint and grievance system—where there are several ways of reporting and different actors who might be "first responders" depending on when, where, and how an individual complaint is received—can be tested alongside the traditional system in a few representative areas. Similarly, socialization, outreach, and active induction strategies—of which there are an incredible variety that are potentially effective—can likewise be tested in various forms in different regions. In addition, technology pilots—linking standard identity cards to the updated national registry and using electronic identification technologies to reduce error and fraud, for example; or switching to automated, electronic, or depersonalized payment mechanisms to minimize leakage or corruption—will be necessary to keep expanded programs (and an expanded social assistance sector) working efficiently for the Government.

Integration for households can also be achieved by delivering socialization and public awareness of common standards, regardless of location or the manner of a household's first contact with social assistance programs. Currently, much of the social assistance socialization is delegated to the Ministry of Communications and Information, which has very little experience specific to delivering public awareness or outreach to poor, marginalized, vulnerable, or difficult-to-reach populations. Clearly, the less effectively disseminated are public awareness strategies, the more serious will be the gaps in eligible or potentially eligible household access to benefits. Adherence to a common socialization standard, where compliance is measured by awareness surveys completed by the standard-setting agency would improve adherence to a common targeting standard, reduce variability in benefit access, and generate a minimum level of performance.

Also critical is the effective provision of service-provider links. Indonesia's decentralized administrative and public expenditure framework makes local governments responsible for the majority of social expenditures in health and education. Furthermore, in addition to providing support services for social assistance programming, local and regional administrations have begun experimenting with social assistance programming for residents.[11] To help households take advantage of this diverse programmatic landscape and better understand a diverse set of operating principles, Indonesia should train a cadre of knowledgeable facilitators who would be tasked with counseling and providing strategies for vulnerable households to take advantage of all locally available programs. Locally placed resources for "tying it all together" would help poor and vulnerable households access an integrated package of benefits and complementary services, and would allow them to more quickly exit poverty and vulnerability.

A "single-window" framework could generate cost-savings for the Government. For example, extending a combined PKH, PIP and monetized-Rastra package to 10 million households, with an average benefit of about 20 percent of the value of annual household expenditures in the target population (or IDR 3.3 million per family per year) would create a single transfer with a magnitude similar to that in countries where direct transfers reduce poverty without distorting labor market decisions.[12] The fiscal cost of the transfers alone—at about 0.3 percent of GDP—is slightly less than the cumulative cost budgeted for these three transfers (delivered independently) in 2016 (just over 0.4 percent of GDP in 2016). In addition, participating government agencies would see lower benefit delivery and oversight costs. The savings could be channeled back into social assistance to create, for example, the cadre of locally placed facilitators mentioned above.

[11] This is most noticeable in health insurance: many districts (and some provinces) have developed their own health insurance offerings for poor and vulnerable households that complement the national health insurance initiative (formerly Jamkesmas, now JKN-PBI). See the JKN-PBI chapter in this report.
[12] In Mexico and Colombia the transfers of conditional cash transfer programs range between 21 to 25 percent of average consumption of target groups.



CHAPTER 1

Social Assistance Expenditure Analysis

Public expenditure on social assistance programs has roughly kept pace with increases in national output and total public expenditures (Figure in Box 1.1). Social assistance expenditure magnitudes have been increasing steadily, with total central and sub-national spending on permanent social assistance[13] rising by 128 percent in real terms between 2009 and 2016. However, these permanent programs still receive relatively small budgets or output shares when compared with other sectors. For example, in 2006 permanent social assistance programs accounted for about 1.9 percent of total national expenditures, or 0.9 percent of GDP. By 2016, the analogous numbers were 3.8 percent (out of 2016 total national expenditures) and 0.7 percent (out of GDP). [14]

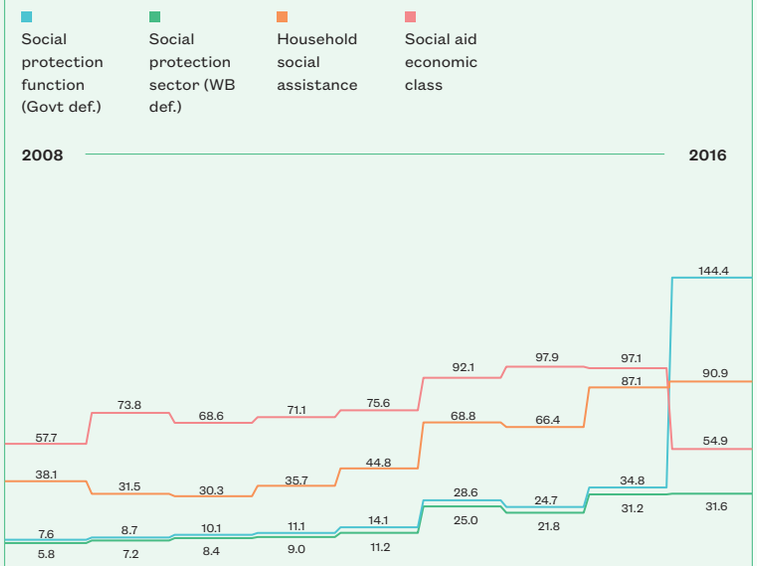
[13] Excluding BLT/BLSM; see the following paragraph in this note.
[14] Sub-national expenditure data for 2016 use planned budget.

BOX 1.1 Defining social assistance spending in Indonesia

In this note, social assistance spending follows the definition developed in the previous Social Assistance PER (World Bank, 2012j). Social assistance is defined as non-contributory cash or in-kind transfer programs targeted in some manner to the poor or vulnerable. Indonesia budget composition does not have a specific budget line that includes the social assistance sector. Since 2009-14, the GoI has designed the Master Plan for the Acceleration and Expansion of Indonesia's Poverty Reduction (MP3KI). The GoI articulates its poverty alleviation strategy around three "clusters" (where households, communities, and micro-enterprises are targeted); the first pillar (households) is roughly equivalent to the definition of SA used in this note. No official budget category meets either the SA definition used here or the definition of the GoI's first poverty reduction cluster.

Economic classifications in Indonesia's budget expenditures include a "social assistance" category, which is used broadly and includes a wide array of social spending in areas such as education, health, agriculture, industry, and disaster relief. Functional classifications of Indonesia's budget expenditures include a "social protection" category, which up until 2016 was used narrowly and consisted mainly of initiatives at MoSA (Ministry of Social Affairs). In 2016, however, the social protection function was reclassified to include components that were previously mapped under the "General Government Administration function" including food / housing subsidies and social contributions. This note aggregates identifiable social assistance expenditures and examines the total as if it were a standalone sector and budget item. At the central government level, 10 major social assistance programs, as well as remaining MoSA and minor social protection expenditures, are aggregated to create total social assistance expenditure. At the sub-national level, where budget data are more limited, the functional classification "social-protection" expenditures are used as a proxy for aggregate social assistance expenditures.

Public spending on social assistance by various definitions (Idr Trillion)



Source MoF, Bappenas, and World Bank staff calculations.

Public expenditure on SA has increased markedly, but remains low as share of GDP and of national expenditure. Indonesia spends less as share of GDP in social assistance (at 0.7 percent of GDP) than the average of lower middle-income countries. The spending is less than half of the average spending of that group, which is about 1.5 percent of GDP (Figure 1.1).[15] When Indonesia is compared with some of its regional peers in the East Asia and Pacific region (EAP), the share of GDP for SA is similar to countries such as Vietnam and Thailand, but it is lower than most Latin American (LAC) and East Europe and Central Asia (ECA) countries. Global evidence shows that aggregate spending of social assistance (social safety nets) rises as countries become richer, but still averages at just 1.6 percent of GDP. The average for richer countries is about 1.9 percent of GDP, while lower-income countries spend on average about 1.1 percent of GDP (World Bank, 2014b). Likewise, when comparing social assistance spending with other types of spending in the national budget, as shown in Figure 1.4, social assistance expenditure is one of the lowest shares, similar to agriculture spending.

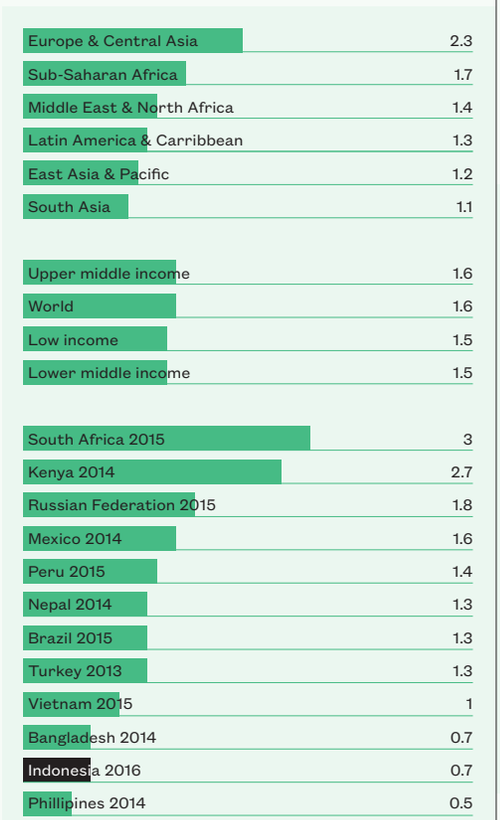
[15] Countries data refer to different years.

0.7%

Indonesia spends less as share of GDP in social assistance (at 0.7 percent of GDP) than the average of lower middle-income countries.

FIGURE 1.1

Social assistance spending as a share of GDP (%) – regions, income levels and selected countries



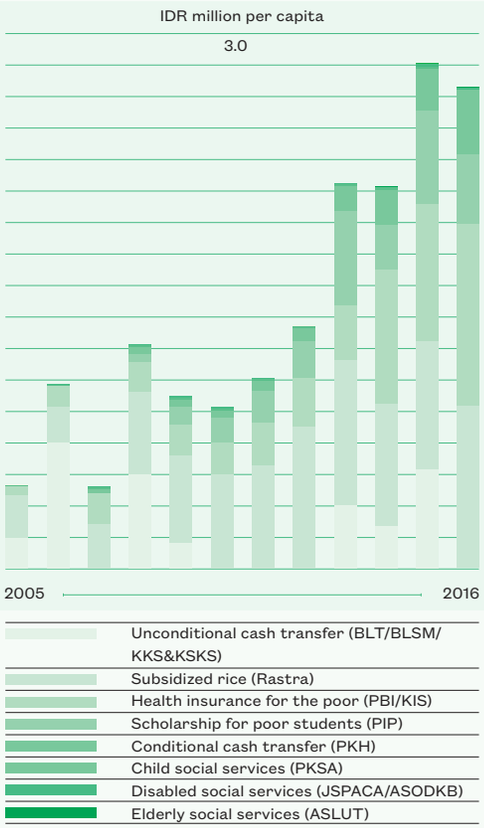
Source World Bank Aspire 2017 and World Bank staff calculations.
Note Selection based on data availability and being recent enough. For the categories of regions and income levels, the value shown represents a 2008-14 average, for the regions category, all income levels are considered in the value shown. Countries shown are neighboring countries and several other lower middle-income countries to provide perspective on Indonesia's position.

IDR 24.8 TRILLION

Previously known as Jamkesmas, and now as PBI under the National Health Insurance program JKN within SJSN, the social assistance sector's health insurance program saw its allocation increase significantly to IDR 24.8 trillion in 2016 (from IDR 8 trillion in 2013)

FIGURE 1.2

Health insurance for the poor and unconditional cash transfer (BLSM) have been the main drivers of recent increase in central government spending on HH social assistance programs (central government expenditure on major SA HH programs, per capita/poor headcount, 2010 prices), IDR million)

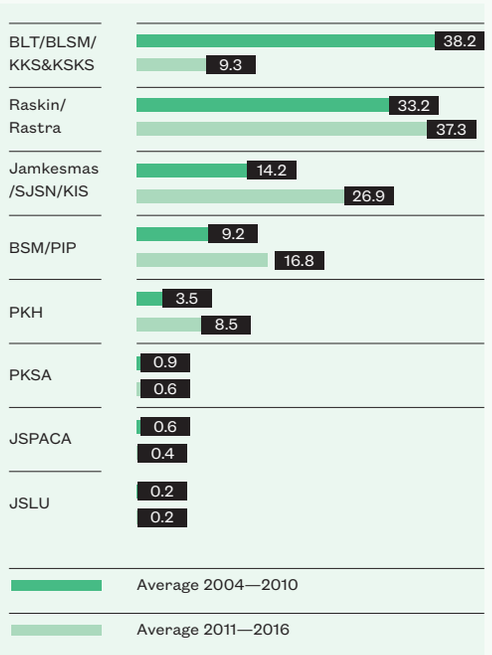


Source MoF, Bappenas, BPS, and World Bank staff calculations.

Among permanent programs, the health insurance fee waiver program targeted to poor and near-poor households attracts the largest social assistance budget allocation. Previously known as Jamkesmas, and now as PBI under the National Health Insurance program JKN within SJSN, the social assistance sector's health insurance program saw its allocation increase significantly to IDR 24.8 trillion in 2016 (from IDR 8 trillion in 2013), following the

FIGURE 1.3

On average, higher spending is allocated for Rastra, JKN-PBI & PIP (central government major SA HH programs, percent)



Source MoF, Bappenas, and World Bank staff calculations.

enrolment of an additional 16 million beneficiaries, as well as an increase in the per-capita premium calculated by the GoI. At 34 percent of all social assistance expenditures on permanent programming in 2016, PBI now ranks just higher than the subsidized rice program, Rastra, in terms of SA allocation magnitudes.[16]

Permanent programs providing larger proportions of benefits to poor and near-poor households—PBI, PIP, PKH—have seen their social assistance expenditure shares rise recently. While the rapid recent rise in enrolled PBI beneficiaries in the JKN account for the lion's share of this pro-poor increase, both PKH and PIP have been expanding coverage as well: PIP quadrupled the number of beneficiaries between 2010 and 2016, while PKH more than doubled the number of covered households during the same period. Together with the slight reduction in the number of Rastra beneficiaries, this has led to a majority of permanent-program expenditures being directed to the set of programs emphasizing pro-poor coverage.[17] When viewing social assistance ex-

[16] Prior to the 2014 budget year, Rastra was consistently awarded a majority share of SA allocations for permanent programming; Rastra's share approached 60 percent in most years before 2013. Spending on Rastra declined in 2013 when budgeted coverage fell by 2.5 million households.
[17] See the Program Notes in this report for additional details on poor and near-poor coverage in the permanent social assistance programs.

penditures of the earlier, pre 2011, government administrations, Raskin/Rastra expenditures were higher, while Jamkesmas/PBI, BSM/PIP and PKH were lower overall, especially in the past two years of the current administration's tenure.

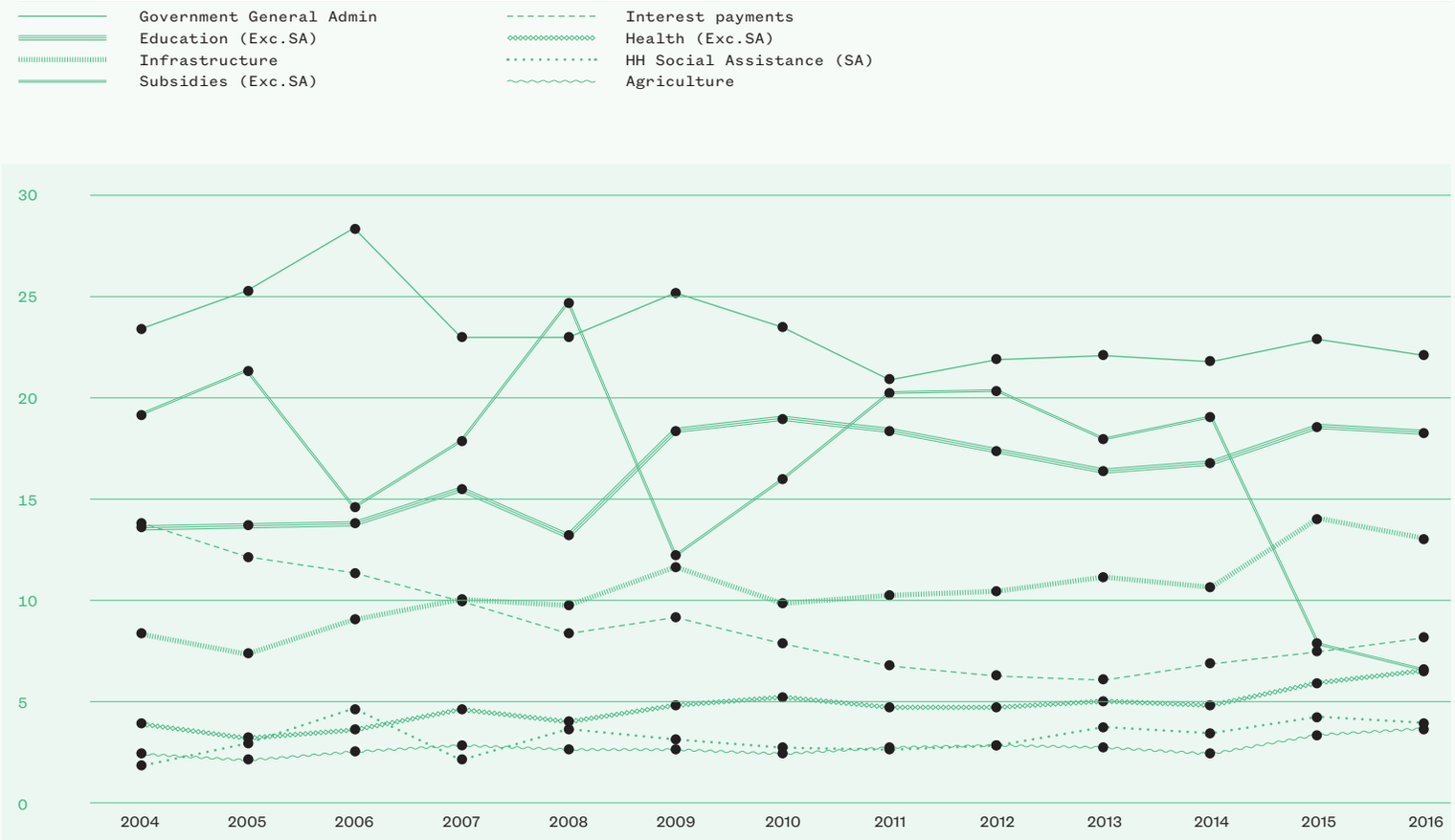
Social assistance spending measured on a per-poor or vulnerable individual basis has risen. This result has been driven automatically by coverage increases in most programs (and resulting increases in spending on social assistance programs) that occurred simultaneously with a decline in the number of poor and vulnerable households. Total spending increased in 2016 almost three times the level in 2010, while the poverty headcount poverty fell by about 3 million people.

In certain years, emergency unconditional cash transfers drive social assistance expenditure temporarily higher. On several separate occasions—during the 2005-06, 2008-09, 2013, 2014, and 2015 fiscal years—the GoI revised its energy subsidy policy, driving subsidized fuel and electricity prices higher instantaneously and economy-wide prices higher over the short to medium term. In each instance, the GoI distributed a temporary unconditional cash transfer to about 30 percent of the Indonesian population as compensation for the negative impacts on household purchasing power from these policy revisions. The GoI's use of these energy-subsidy-adjustment periods to also expand permanent social assistance programs in recent instances (July 2013 and November 2014) were no exception. So while the pronounced spikes in social assistance spending in 2005-06, 2008-09, 2013, 2014, and 2015 were temporary, a much smaller increase in permanent SA-program spending was also generated during those periods.

Government administration, education, and energy subsidies and infrastructure have remained priority items in annual budgets through 2016 (Figure 1.4). While government administration (including defense spending) has reliably accounted for just less than one-quarter of national expenditures, energy subsidy spending has been more volatile (tied as it is to international energy price fluctuations). However, on average, it also accounted for just less than one-quarter of national public expenditures between 2004 and 2014, although through 2015 and 2016 it was significantly reduced to just 7 and 8 percent of national expenditure. Since 2009, education spending (excluding social assistance delivered via Ministry of Education programs) has accounted for just under one-fifth of national expenditures. Infrastructure spending saw a large uptick in 2015, from 11 to 14 percent of national expenditure. With about two-thirds of an average annual budget accounted for by those four items, increases in other sectors' shares have been limited. Spending on development priorities, such as health and social assistance spending, has risen over the years but in relative terms received only marginally more in 2016 than they did in 2004.

FIGURE 1.4

Sectoral composition of national expenditure, 2004—16 (Percent of national expenditure, %)



Note: National expenditure is the sum of central and sub-national government's actual expenditure including subsidies and interest payment. 2015 sub-national and 2016 use budget data.
Sources: World Bank staff calculations based on MoF data.

Indonesia does not have policy instruments triggered by business cycle events. Fiscal rules, the structure of public revenues and expenditures, and the format of the budget formulation and revision procedures in Indonesia, all constrain the disbursement of public expenditures. These include disbursements on social assistance transfers and other social protection instruments, such that they cannot be "conditional" on non-budgetary events (such as an increase in prices or an increase in layoffs), as they are in other countries that have, for example, unemployment insurance. Once a budget has been agreed (or revised and agreed), no events external to the legislative-budgetary cycle can then determine expenditure magnitudes for any program, initiative, or transfer. While social assistance spending has often increased upon the enactment of subsidy reform, the connection was purely political and therefore negotiated and uncertain—not automatic—as was the subsidy reform itself. Furthermore, beneficiaries for these compensatory social assistance transfers were pre-determined and receipts of the transfer did not depend on the beneficiary experiencing an event (as in unemployment).

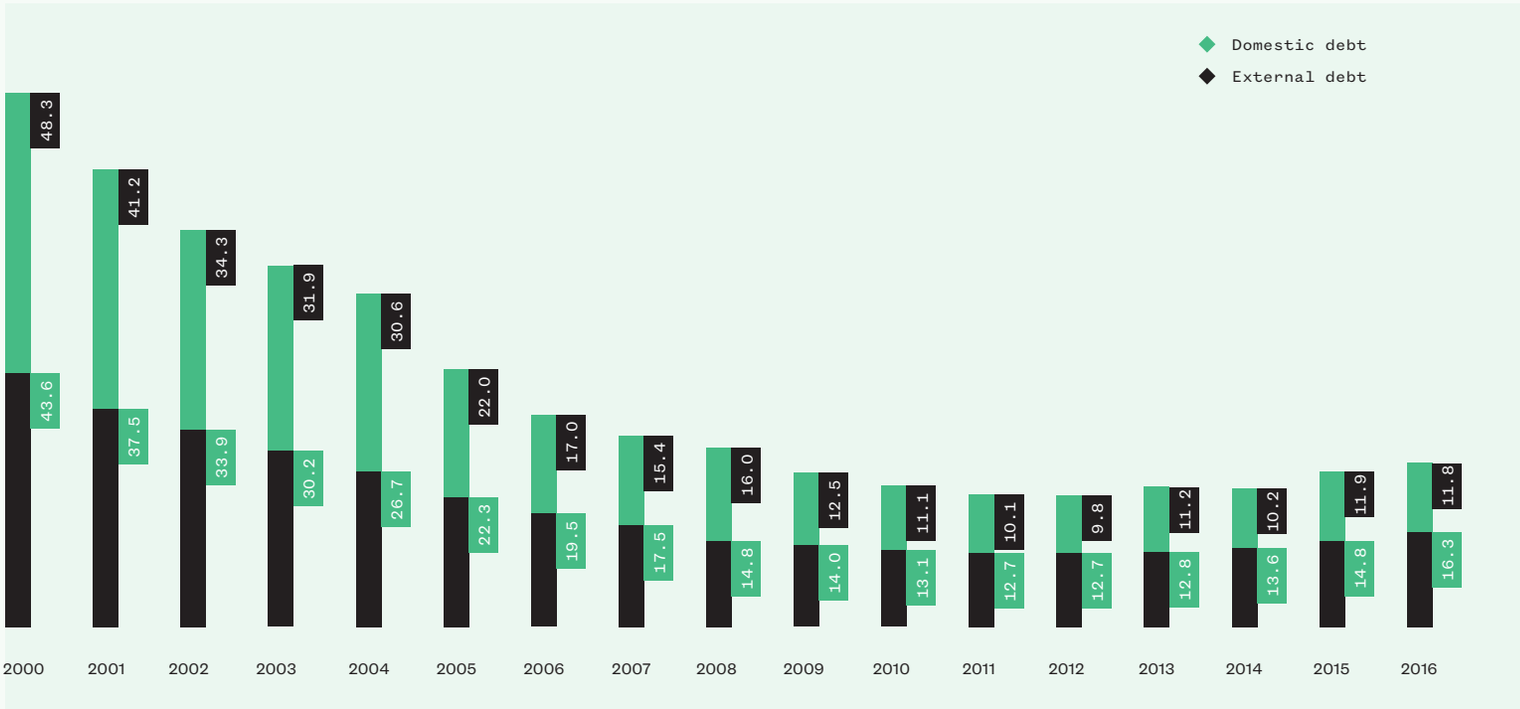
The current administration has instituted an expenditure-stabilizing energy subsidy reform accompanied by significant reallocation of remaining expenditures to development priorities including social assistance. The subsidy policy revision (effective from January 1, 2015) eliminates subsidies for low-octane gasoline and introduced a fixed per-liter subsidy for diesel, so net-of-subsidy prices for both fuels now track international oil price movements (adjusted by nominal exchange rates). As a result, and in contrast to previous energy subsidy policy revisions that kept domestic energy prices insulated from international oil price fluctuations, the fuel portion of the GoI's subsidy bill fell sharply to IDR 43.6 trillion (0.35 percent of GDP) in 2016's revised budget, from the IDR 391 trillion (3.8 percent of GDP) allocated in 2014 (World Bank, 2017a). Although, the implementation of the new fuel pricing system has been uneven so far, the 2016 budget sustained the 2015 reforms. The recent removal of the electricity subsidy to 18.9 million non-poor households with 900 VA connections is estimated to save IDR 15 trillion in 2017.[18] The fiscal space unlocked by these reforms has allowed expenditure reallocation toward the GoI's development priorities, including infrastructure, agriculture, and social programs. The centrally executed social assistance sector received IDR 75 trillion in 2015 and an IDR 73 trillion in 2016, compared with IDR 56 trillion in 2014.

At the same time, Indonesia's unaddressed challenges in revenue generation could partially eliminate the fiscal savings from energy subsidy reform. While expenditures immediately became less volatile upon the most recent energy subsidy reform, Indonesia's debt levels have stabilized at low levels, despite a sharp uptick in 2016. Furthermore, while overall debt- and fiscal-management practices have remained prudent (Figure 1.5), domestic revenue growth continues to decelerate. For example, domestic revenue growth was down slightly to 7.6 percent in 2015 from 8.0 percent in 2013. In 2015, the trend reversed and revenues fell by 0.5 percent. For 2015, the decline in overall revenue growth was due to a range of factors: slower nominal GDP growth; declining commodity prices (particularly crude oil prices); and lower oil lifting. In addition, various tax policy revisions and the implementation of a mineral export ban (effective January 2014) contributed to the decline in revenue growth (World Bank, 2015b).

[18] Based on recent discussions, the government may revise the target and add 2.4 million new customers as eligible for the subsidy

FIGURE 1.5

Indonesia's public debt has stabilized at low levels (Percent of GDP, %)



Source world bank staff calculations

Central government ministries and agencies remain primarily accountable for delivering social assistance programs. Central government spending accounts for more than 87percent of total social assistance spending. Essentially, all social assistance programming covered in this report is planned, executed, and implemented by the central government.

Social assistance program implementation remains highly fragmented across ministries and agencies. At the central level, the responsibility for executing these major programs has been shared by six central institutions, while the remaining central social assistance expenditures were distributed across 12 ministries, 12 programs, and more than 87 activities (World Bank, 2012j). More recently, the government has begun efforts to slim down the number of Ministries executing the main household targeted social assistance programs to MoSA (PKH, Rastra, ASLUT and ASODKB), MoEC & MoRA (PIP), MoH (PBI-JKN) and Kementerian ESDM for the energy subsidy). Similarly, M&E of social assistance programming, as well as expenditures oversight in general, remains a confusing landscape. Many overlapping government-wide systems and agencies with M&E responsibilities, spanning sectors and levels of government, have different spheres of influence and only partially overlapping information needs (World Bank, 2012j).

Provinces and districts allocate a small amount of their own resources on social assistance spending. Social assistance spending by sub-national governments accounted for around 1.2 percent of total sub-national spending over the past five years. Case studies from the Social Assistance Public Expenditure Review 2012 indicate that districts—which execute the majority of the sub-national social assistance expenditures (Figure 1.6) but which have few discretionary resources—allocate social assistance expenditures for program administration, including civil servant salaries, in support of central government programs.[19] Recent analysis shows that significant increases in spending by local governments over the past decade are not associated with any improvement in outcomes (see Development Policy Review 2014), measured broadly.

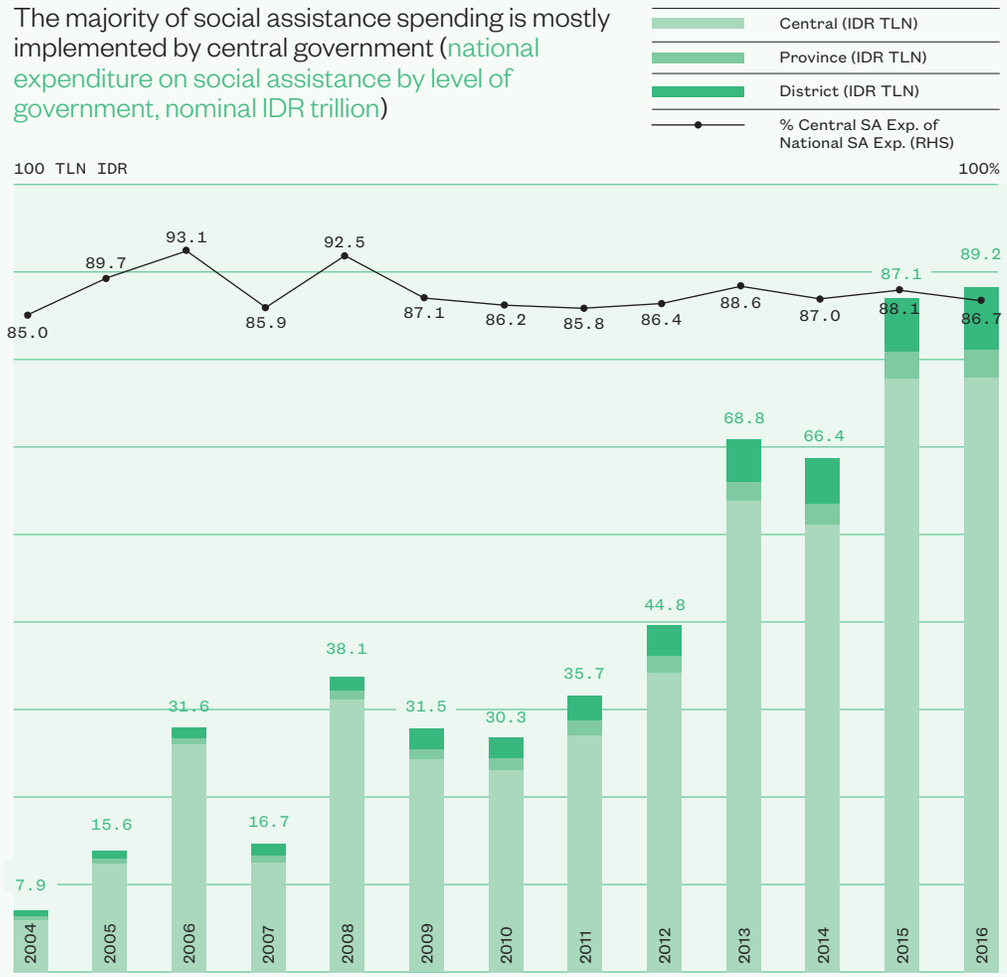
87%

While the central government spends the most, districts have been increasing their spending and allocate social assistance expenditures for program administration, including civil servant salaries, in support of central government programs

[19]Based on recent discussions, the government may revise the target and add 2.4 million new customers as eligible for the subsidy

FIGURE 1.6

The majority of social assistance spending is mostly implemented by central government (national expenditure on social assistance by level of government, nominal IDR trillion)



Source MoF, Bappenas, and World Bank staff calculations.
Note 2015 sub-national and 2016 uses budget data.

FIGURE 1.7

Social protection expenditures by intervention, 2006—16

Source MoF and World Bank staff calculations and estimates.
Note Based on data available at the time of writing.

The current administration began to modify access to social assistance programs. As part of the revised 2015 budget, a card-based beneficiary-identification system was instituted within the existing social assistance programs. This included: (i) a Family Welfare Card (KKS), which identifies 15.8 million households eligible for receiving an unconditional cash transfer (BLSM); (ii) the School Cash transfer Program (PIP), which identifies 19.5 million children eligible to receive cash transfers to cover education costs; and (iii) the Healthy Indonesia Program (PIS), which identifies over 92 million individuals eligible to receive premium fee waivers for the JKN health insurance program. The increase in social assistance spending accompanying the 2015 energy subsidy revisions (see above) was directed primarily to PIP, PIS, and PKH. The first was intended to nearly double coverage by adding about 10.5 million new student beneficiaries; the second added another 2 million beneficiaries (after having just added 10 million new beneficiaries between 2013 and 2014); and the third increased coverage by another 200,000 households.

New programs for currently uncovered key risks will raise anticipated expenditures. When the poverty rate is falling, those that remain impoverished are by definition the most difficult to bring out of poverty. Entrenched, persistent poverty may require additional programs or more generous benefits (or both) to overcome.[20] In addition, natural disasters and macroeconomic instability come part and parcel with Indonesia's geographic location, and economic and financial openness. Such crises can instantaneously wipe out years of poverty-reduction progress. Indonesia needs to safeguard that progress by planning for an SA response when crises become acute. Both stubborn poverty and susceptibility to natural disasters and international instability, therefore suggest that social assistance expenditures should rise beyond current levels, even after current programs are revised, so that they deliver more of benefits to more poor households.

Social insurance expenditures still exceed social assistance expenditures, though far fewer households and individuals are covered by these programs. Although social assistance expenditures grew faster (at a 29 percent cumulative growth rate) than social insurance spending (12 percent) between 2011 and 2015, social insurance expenditures are still 30 percent larger than total social assistance expenditures (including non-permanent spending on temporary cash transfers accompanying energy subsidy reductions). On the whole, central government expenditures on social protection—social insurance plus social assistance—has remained relatively low, accounting for 1.52 percent of GDP in 2015 (Figure 1.7).

Design and operational reforms within programs can help social assistance benefits reduce poverty more efficiently regardless of the level of spending. It is clear that, with less than one-quarter of social assistance benefits reaching poor households, social assistance expenditures could reduce poverty more effectively if program- and system-wide reforms resulted in more poor households receiving available benefits. The following sections in this report offer greater detail on how and why increased coverage has only led to increased shares (of total social assistance resources available) in some programs. They also suggest how integration and better program design can remedy current shortcomings to make social assistance expenditure a more efficient tool in poverty reduction.

[20] Section 3 of this report provides more detail on, and potential solutions for, key risks and vulnerabilities not currently covered by social assistance programs.

As part of the revised 2015 budget, a card-based beneficiary-identification system was instituted within the existing social assistance programs.

01
KKS
Family Welfare Card

02
PIP
School Cash transfer Program

03
PIS
Healthy Indonesia Program

ANNEX 1

Central government expenditure on social assistance programs, 2004—16

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Unconditional cash transfer (BLT/BLSM/ KKS&KSKS)	-	4,487	18,619	-	13,966	3,733	-	-	-	9,300	6,200	9,470	-
Subsidized rice (Rastra)	4,831	6,400	5,300	6,600	12,100	13,000	13,925	15,270	20,926	21,497	18,165	21,846	22,077
Health insurance for the poor (Jamkesmas/JKN-PBI/SJSN/KIS)	-	1,300	3,074	4,567	4,448	4,620	4,763	6,300	7,300	8,100	19,900	19,884	24,815
Cash transfer for poor and at risk students (BSM/ PIP)	-	-	-	-	1,238	2,562	3,607	4,700	5,400	14,100	6,600	6,388	10,572
Conditional cash transfer (PKH)	-	-	-	605	946	1,068	1,123	1,600	1,900	3,600	5,200	6,324	8,542
Child social services (PKSA)	n/a	104	211	187	311	296	254	256	306	339	345	462	294
Disabled social services (JSPACA/ ASODKB)	n/a	65	130	152	190	217	209	70	79	79	79	531	351
Elderly social services (JSLU/ ASLUT)	n/a	26	53	57	69	82	75	48	64	64	64	201	142
Other social protection (SP)	1,899	180	197	295	297	302	352	1,944	2,743	3,871	1,268	3,879	8,591
Total Central Social Assistance by major programs	4,831	12,382	27,387	12,169	33,269	25,578	23,956	28,244	35,975	57,079	56,553	72,062	72,908
Total Central Social Assistance (nominal)•	6,730	14,028	29,411	14,228	35,263	27,472	26,127	30,646	38,718	60,950	57,821	76,738	77,356
Total Central Social Assistance (real)	13,227	16,578	16,398	19,574	25,156	25,650	26,127	28,517	34,724	52,077	46,878	56,960	58,815
National expenditure on HH SA (nominal)	7,919	15,644	31,575	16,560	38,125	31,536	30,298	35,736	44,817	68,822	66,423	87,110	89,249
National expenditure on HH SA (real, 2010 prices)	15,654	27,181	47,980	22,782	45,034	34,074	30,298	33,253	40,195	58,803	53,852	67,758	67,857
National expenditure on HH SA (% of GDP)	0.32	0.53	0.89	0.39	0.73	0.53	0.44	0.46	0.52	0.72	0.63	0.75	0.72
National expenditure on HH SA (% of total central + SNG)	1.77	2.96	4.68	2.08	3.65	3.11	2.72	2.60	2.82	3.73	3.41	4.19	3.81

• total central social assistance by major programs includes "other MoSA" social assistance expenditure,

Source 2004 – 2011: World Bank 2012h. 2012- 2016: Ministry of Finance, and World Bank staff calculations.
Note 2015 sub-national and 2016 (both central & sub-national) use realized data.

ANNEX 2

Targeted beneficiaries of five major social assistance programs, 2008—16

	2008	2009	2010	2011	2012	2013	2014	2015	2016
Unconditional Cash Transfer (BLT/BLSM) ***—households (millions)***	18.7	18.7	-	-	-	15.5	15.5	15.8	-
Rice for the poor (Raskin/ Rastra) ***—households (millions)***	17.5	17.5	17.5	17.5	17.5	15.5	15.5	15.5	15.5
Health insurance for the poor (Jamkesmas/JKN-PBI/SJSN/KIS) ***—People (millions)***	76.4	76.4	76.4	76.4	76.4	76.4	86.4	88.2	92.4
Cash transfer for poor students (PIP) ***—students (millions)***	4.6	4.9	5.8	8.2	9.5	16.6	11.2	20.37	19.7
Conditional Cash Transfer (PKH) ***—poor families (millions)***	0.72	0.72	0.81	1.11	1.51	2.4	2.8	3.5	6

Source Ministry of Finance (2008-13; 2015-16), Bappenas (2014).

CHAPTER 2

Main Portfolio of Social Assistance Programs

In Indonesia, **targeted social assistance interventions (non-contributory)**, which transfer resources (in-kind, cash, or services) to particular at-risk groups include the following main programs: (i) the unconditional cash transfer program (BLSM); (ii) the largest in-kind transfer program (Rastra); (iii) the health insurance fee waiver program (JKN-PBI); (iv) the educational cash transfer for poor and at risk students program (Program Indonesia Pintar/PIP) directed to poor and low-education individuals in primary (SD), junior secondary (SMP) and senior secondary (SMA) or equivalent education; (v) the conditional cash transfer program (PKH); and (vi) small cash transfer programs for vulnerable children, disabled and vulnerable elderly.[21]

[21] This section describes the main social assistance programs described in that represent 99 percent of total Social assistance budget (See Annex Tables). The latter two cash transfers are not discussed specifically in this review as they are very low in coverage and have not been planned for future scale up or transformation. Importantly, the old age cash transfer (ASLUT) may however be included in PKH, the extent to which is as of yet unclear.

Unconditional Cash Transfer (BLSM)

BLSM has a clear objective, namely to temporarily protect welfare in times of anticipated macroeconomic stress, which it achieves efficiently. Current BLSM operations have improved slightly on previous iterations by delivering larger shares of available benefits to targeted households. However, non-targeted households still receive substantial benefits from BLSM, while from a household- and community-based perspective BLSM accessibility still remains difficult.

2.1

OVERVIEW

The unconditional cash transfer program (Bantuan Langsung Sementara Masyarakat, or BLSM) has a clear objective: to supplement consumption for poor households facing anticipated, policy-based price increases. In late June 2013, and again in November 2014 and 2015, the Government reduced existing fuel subsidies and compensated poor and near-poor households for the subsequent rise in fuel, food, and transport prices with a temporary unconditional cash transfer. It was expected that the BLSM transfers would be large enough (in terms of both coverage and amount transferred) that the "regular" pace of poverty reduction would not slow when fuel and economy-wide prices spiked as a result of the subsidy reduction.

BLSM reached households everywhere in Indonesia. In 2013, about 15.5 million were targeted to receive IDR 600,000 (about US$53) in two phases for a total cost to government of IDR 9.3 trillion (US$864 million).[22] BLSM was in theory funded partially from the implied budgetary savings from subsidy reductions. It was targeted to the poorest 25 percent of Indonesian households that, because of consumption patterns, were receiving only small shares of resources transferred via the Government's energy subsidy program and were therefore most at risk from the negative impacts on consumption from price increases.

IDR 6.5K

In 2013, it was estimated that an increase in the fuel price of premium gas to IDR 6,500 (US$0.50) per liter would increase the poverty headcount rate by 1.5 percentage points without any BLSM compensation

BLSM provided cash assistance to households affected by an economic shock. BLSM (2013) added cash amounts to a (25-percent-poorest) household's budget equal to about 11 percent of regular expenditures.[23] Average fuel prices in June 2013 increased by 33 percent. While BLSM-targeted households consume little fuel directly, fuel price increases are passed on to other economic sectors, especially food and transport, which account for significant shares of expenditure. It was estimated that an increase in the fuel price of premium gas to IDR 6,500 (US$0.50) per liter (which would have represented a 44 percent increase for that fuel type at that time) would increase the poverty headcount rate by 1.5 percentage points without any BLSM compensation (World Bank, 2012j).

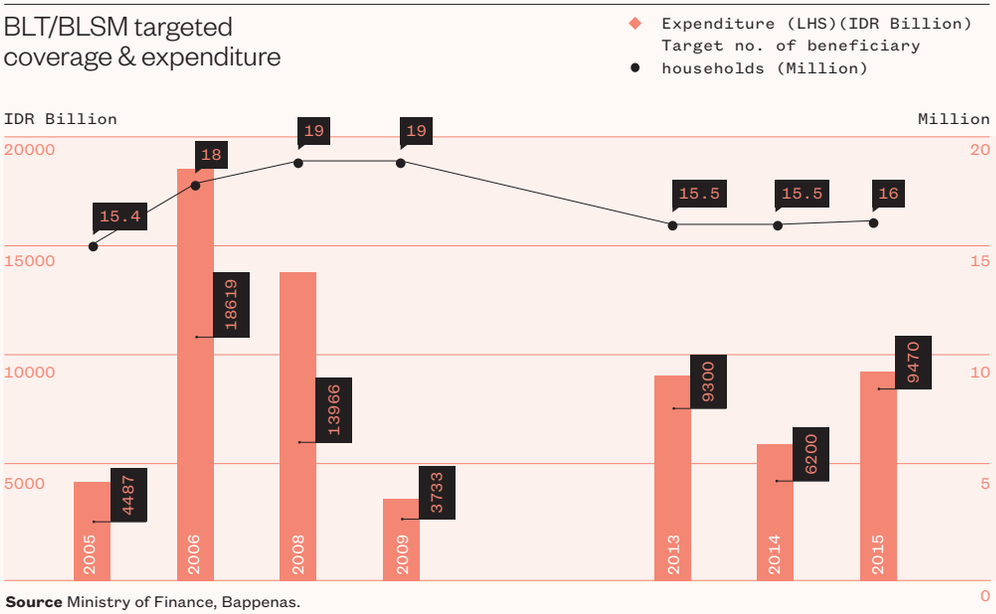
Positive experiences with BLT/BLSM continue to outweigh negative experiences. Indonesia has several years of experience with direct emergency cash transfers: in 2005, subsidy cuts raised household fuel prices by an average of over 125 percent and the Government responded with a BLSM-like transfer (Bantuan Langsung Tunai, or BLT). Again, in 2008, when international crises in both financial markets and in food prices combined with another domestic reduction to fuel subsidies, the Government released another emergency direct cash transfer (again called BLT in that year) (World Bank, 2012c). While the political and social debate over the suitability of unconditional cash transfers for Indonesian households has continued to be lively, the incidence of negative social impacts associated with BLT/BLSM has been on the decline. Judicious local intervention—village leaders actively re-allocating BLSM benefit pools to defuse protests and negative disruptions—may be responsible for this decline.

[22] For Indonesian Rupiah conversion into US$ the October exchange rate value of each year is used (except 2015).
[23] Bank (2016) shows that in 2012, fuel and electricity subsidies received by an average poor or near-poor household were valued at slightly less than 10 percent of total consumption expenditure. So BLSM 2013 provided a direct transfer which was not smaller than the transfer previously received indirectly through purchases of subsidized energy. Additionally, energy remained subsidized (though at a lower rate) after the BLSM cash transfer was distributed.

‹50% "... the total transfer executed under BLSM (2013) had a magnitude of less than half of the total BLT I transfer"

FIGURE 2.1

BLT/BLSM targeted coverage & expenditure



Source Ministry of Finance, Bappenas.

PROGRAM SIZE, INSTITUTIONAL SET-UP, ELIGIBILITY, & BENEFITS

BLSM (2013 and 2014) covered households in all provinces and districts, though it was smaller in scope than previous BLT programs (Figure 2.1). The 2005/6 BLT program provided a per-household transfer of IDR 1.2 million (US$122) to about 17 million households; BLT II (2008/9) provided IDR 900,000 (US$80) to about 19 million households; and the BLSM program provided IDR 600,000 (US$53) to about 15.5 million households. In other words, the total transfer executed under BLSM (2013) had a magnitude of less than half of the total BLT I transfer.

BLSM is a diffuse program with nearly complete delegation of sub-processes. The Ministry of Social Affairs (MoSA) is the key policy and executing agency for BLSM, with that agency's sub-district social welfare workers (Tenaga Kerja Sosial Kecamatan) facilitating the distribution process. The dissemination of information materials is undertaken by the Ministry of Communications and Information, while funding disbursement is executed by the Ministry of Finance. Subsequent funding distribution to recipient households is likely to continue to be achieved via the national postal service's branch network (PT. Pos) as well as the banking system. Coordination at the provincial and district levels is facilitated by provincial and district governments, as well as BLSM facilitators (Bappenas, 2014). Figure 2.2 below summarizes BLSM flow of funds and task management.

Roughly the poorest 25 percent of Indonesian households qualify for BLSM. Eligible households use their *Kartu Perlindungan Sosial* (KPS) or *Kartu Keluarga Sejahtera* (KKS) (see Box 2.1 below) social protection cards to prove eligibility for BLSM and other social programs. Households receive KKS cards via the national postal service (PT. Pos) after having been verified as poor or vulnerable by the national registry (UDB). KPS/KKS holders should retrieve their BLSM transfers at the nearest post office. Should there be another BLSM launched, households will need either a KPS card or a "Developing Productive Families" KKS card. As of 2017 and in coming years, an increasing share of households may be able to receive benefits electronically.

BLSM (2013) benefits provided a boost to beneficiary household in the target group of about 11 percent; average monthly household expenditures in the poorest 25 percent of households in late 2013 were equal to about IDR 1.3 million (US$123).

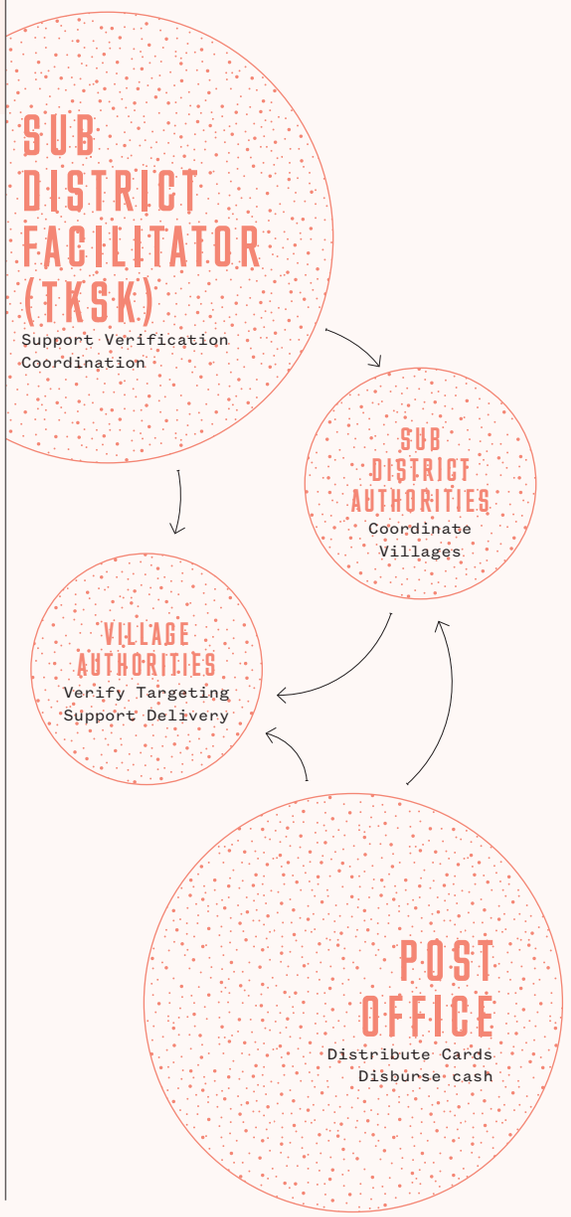
FIGURE 2.2

Institutional responsibility & flow of funds (as of 2015)

1 MoSA manages targeting and creates registry of families

2 Ministry of Finance releases funds to PT. Pos

3 PT. Pos cooperates with sub-district authorities and facilitators to organise distribution



BOX 2.1

"Developing Productive Families", *Kartu Keluarga Sejahtera* (KKS) & *Kartu Simpanan Keluarga Sejahtera* (KSKS)

The KKS and KSKS introduced by the current Government as part of the new SA scheme are meant to give households access to social assistance programs such as Rastra, a rice subsidization program, and BLSM, an unconditional cash transfer (UCT) program that was launched in November/December 2014 in response to a reduction in the fuel subsidy. The KKS and KPS have been used to disburse BLSM transfers electronically and in cash, using the post office (PT. Pos) and a state-owned bank, Bank Mandiri, respectively.

Coverage & Eligibility

By November 2014, 1 million KKS and KSKS cards had been disbursed to families targeted in the first phase of the program's implementation. These two cards are intended to cover 15.8 million households, and will be replacing the existing social protection card, the KPS. The KSKS card contains a cellular phone SIM card to which UCT benefits are transferred for some households (Bappenas, 2014).

Targeting for the entire range of cards is done using the Unified Database (UDB), a registry of poor households employing a proxy means test methodology to rank households in terms of predicted expenditure. To be eligible for the KKS, a household must be considered poor or near-poor, namely, being in the poorest 25 percent of households according to the UDB.

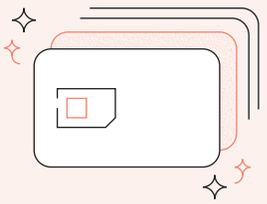
Program Flow & Benefit Structure

Through November and December in 2014, with the coordination of provincial and district level authorities, the 1 million cards were sent to PT. Pos offices at the village level where households were to pick up their cards, exchanging their KPS for the KKS. The remaining 14.8 million households were to continue using the KPS card to access KIP and KIS until they received a KKS and KSKS card

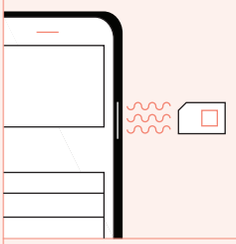
olders of the KKS or KPS card received the BLSM UCT transfer in November/December 2014 to account for higher prices experienced by households due to the reduction in the fuel subsidy. Over those 2 months, households received IDR 200,000 per month (US$16). Out of 15.8 million household recipients of KPS and BLSM, 1 million were to receive the payments via a program called E-money which was accommodated by the KSKS card, detailed above.[24] The other 14.8 million households received the UCT by presenting their KPS card at the nearest post office.

As of early February 2015, 93 percent of BLSM benefits had been claimed by beneficiaries. To date, there is no way of telling how many of those benefits were claimed through the use of the SIM card itself, since benefits could also be claimed by scanning a bar-code on the KSKS package at the post office. By late 2015, local media reports were suggesting that around one-quarter of the recipients were leaving some money in their account rather than withdrawing all of it.

Holders of the KSKS could access their e-money account by withdrawing it in cash at the post office, but they could potentially use applications on their phone to do transfers, bill payments, and even ATM withdrawals. For rural areas where banks or post offices are far away, this capability is particularly innovative and marks an important step in moving toward greater financial inclusion in Indonesia (TNP2K, 2014k). In 2017, the KKS is being equipped with a magnetic strip to allow for cash withdrawal from ATMs, bank agents, and pre-determined locations for specific social assistance transfers. For others, the KKS can be used to purchase subsidized Rastra rice at pre-determined locations under the Governments' e-Warong program.



STEP 1
Take the KSKS SIM card off the card



STEP 2
KSKS SIM card is put into the phone

STEP 3
Total savings status is communicated via SMS

STEP 4
The SMS and the housing of the KSKS SIM card are to be presented at the nearest post office to withdraw funds from the savings account.

[24] E-money was facilitated by Bank Mandiri and three major phone network operators. As opposed to a PKH e-money pilot in 2014, the SIM cards are pre-activated and are valid until December 2019, indicating the SIM card could be used to accommodate future e-money initiatives.

Source TNP2K, 2014k and local media reports

FIGURE 2.3

BLT/BLSM coverage by expenditure quintile (percent)

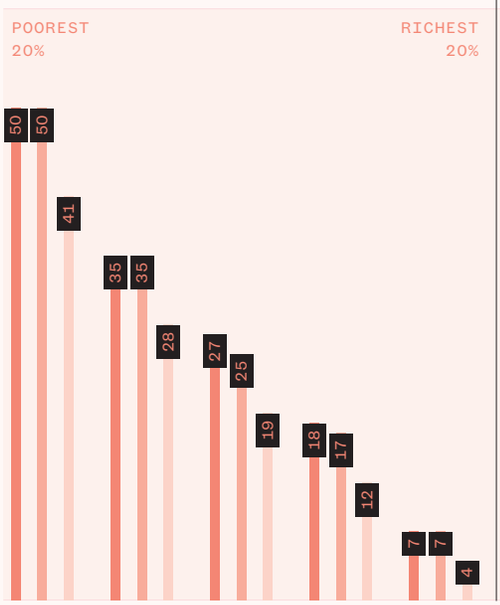
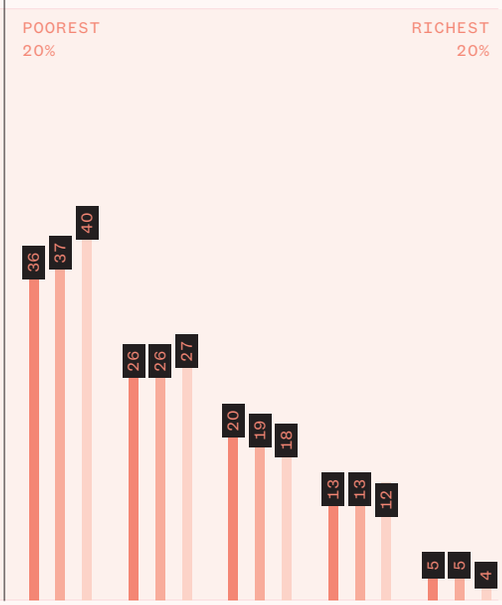


FIGURE 2.4

BLT/BLSM incidence by expenditure quintile (percent)



Source: Susenas (various years) and World Bank staff calculations.

FIGURE 2.5

BLT/BLSM coverage by expenditure quintile (percent)

Source: Susenas (various years) and World Bank staff calculations

BLSM in 2013 covered fewer people overall than in previous years but has improved on the share of resources distributed to poor and near-poor households.

COVERAGE, TARGETING, & IMPACTS

BLSM (2013) covered fewer people overall but has improved on the share of resources distributed to poor and near-poor households. Overall coverage in previous emergency unconditional cash transfer programs (2005/6 or 2008/9) was higher at about 27 percent compared with about 21 percent in BLSM (2013). While all households regardless of income rank were covered at lower rates in 2013, the poorest 20 percent "lost" the fewest BLSM households—there were 17 (41) percent fewer poorest (richest) quintile households covered in 2013 relative to the 2008/9 BLT (Figure 2.3).

As the number of covered households in the poorest quintile fell the least (in between 2008/9 and 2013 iteration of the BLT/BLSM program), this has led to further increases in the share of available benefits received by that same poorest quintile (Figure 2.4). While the total benefit pool is smaller in 2013 (than either 2005/6 or 2008/9), the poorest 20 percent of the population have seen their share increase by about 10 percent (from 2005/6).

Leakage to non-targeted populations is still significant in BLSM. In order to facilitate comparisons between BLSM and other social assistance transfers (which may have slightly different target groups) Figure 2.5 shows coverage and incidence for the "Poor", the "Next 30" percent, and "The rest".[25] The figure illustrates that, while the poverty headcount rate fell by about 4 percentage points between 2008 and 2013, the share of BLT/BLSM benefits accounted for by the "Poor" group fell by only 2 percentage points. The "Next 30" group, which contains the same proportion (30 percent) of near-poor households in every year, gained the most in terms of share of available BLSM benefits. Finally, while "The rest" grew larger (by the same 4 percentage points that the poverty headcount fell), this group's share of BLSM benefits stayed roughly constant. Together, these patterns indicate that over the years it has been executed, about two-thirds of the BLT/BSLM benefits available have gone to the poor and near-poor populations. However, BLSM has not yet stemmed leakage to non-targeted populations.

[25] The "Poor" are all households with per-capita expenditure below the relevant year's poverty-line expenditure; the "Next 30" are the 30 percent of Indonesian households with the lowest per-capita expenditure levels who are not counted as poor; and "The rest" are those households not "Poor" or part of the "Next 30". As headcount poverty rates have been declining in Indonesia—from nearly 16 percent in 2005 to just over 11 percent in 2013—the number of households in the "Poor" and "The rest" groups will change (while the "Next 30" is always the 30 percent with the lowest per-capita expenditure amounts who are nonetheless not poor). This definition will be used in the analysis of all main SAP described in this section.

TABLE 2.1

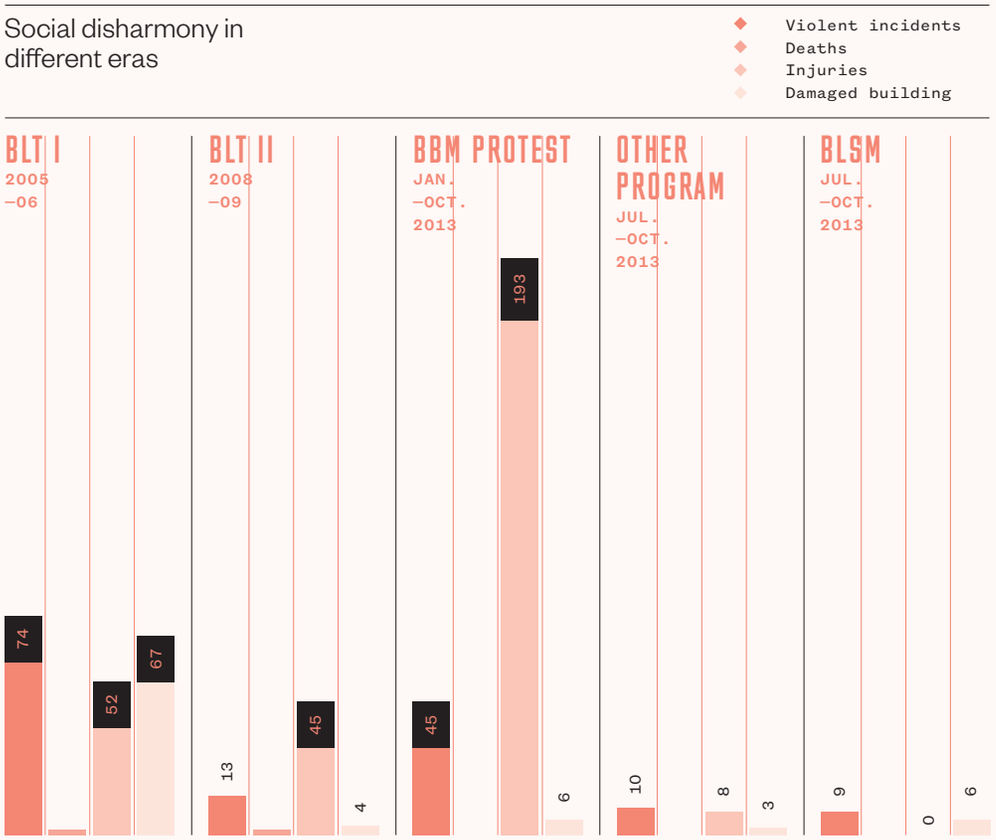
Characteristics within Indonesian populations, 2014

	% of all Indonesians who:	% poor population who:	% of BLSM recipients who
Do not have access to bottled, tap or well water	18	31	27
Do not have access to private sanitation	27	53	54
Live in rural areas	50	62	66
Live with more than 5 household members	25	44	31
Have not completed primary education	10	13	15
Are illiterate	8	14	14
Work in the agriculture sector	34	58	50

Source Susenas 2014 (to capture late 2013 into early 2014 transfer) and World Bank staff calculations. 'Work in...' refers to share of working individuals, not all Indonesians.

FIGURE 2.6

Social disharmony in different eras



Source World Bank 2015a

On average, BLSM is distributed to households that exhibit correlates of income poverty. BLSM has a large overall coverage target (25 percent of the population) but still fails to distribute benefits to over half of the very poor households in the first decile. However, on average, BLSM transfers are being delivered to households that exhibit most of the non-income correlates of poverty, such as relatively low access to clean water, sanitation, and education (Table 2.1). The distribution of BLSM shows no significant differences (in incidence) for rural versus urban households (not shown).

Previous BLSM-like transfers have protected the worst-off households.. BLT prevented consumption expenditures in poor households from being negatively affected by fuel subsidy reductions. BLT transfers were used to buy basic necessities (especially rice); on one-time costs such as school fees or clothes for Idul Fitri holidays; or on transportation. In addition, there was a spillover effect: the BLT program actually helped to stimulate an increase in spending among non-recipient households. Heads of households who received BLT were not more likely to leave work. On the contrary, BLT households were more likely (by 10 percentage points) to report that they had found new jobs and moved into employment, perhaps using the BLT money for job-specific transportation or childcare.

BLSM saw in 2013 further reductions in social disharmony from the introduction of a valuable cash transfer. Only nine incidents of non-fatal violence were reported (Figure 2.6), while cumulative social disharmony (of any type) continued to fall from peak levels during BLT 2005/06. Nonetheless, about 80 percent of a set of villages studied during and after BLSM 2013 reported some unfair exclusion from BLSM. Protests and negative impacts on relationships between leaders and citizens occurred in one-third of these villages. In such villages, local authorities were often blamed for BLSM's inclusion and exclusion errors. Protests and conflict tended to arise in areas where relations between inhabitants and local leaders were already strained prior to the launch of BLSM. Local leaders opted to manage such tensions by either not participating in the program, or by sharing out BLSM benefits.[26]

Decreases in BLSM-related tensions may be due to local management and control rights. Over one-quarter of BLSM recipients received less than the stipulated amount at least once, and one-fifth reported transfer reductions in both tranches.[27] Of the 27 percent that experienced at least one reduced BLSM transfer,

[26] Based on data from a Susenas-based Social Protection Module from March 2014 where households are asked about their participation in the 2013 BLSM rounds in June – August and September – December.
[27] During two previous instances of BLT, there were reports that after cash transfers were collected by recipients some PT. Pos officials and community officials charged "fees." This occurred 10 percent of the time in 2005, and 46-54 percent of the time in 2008-09. This was typically done to re-distribute to households that were not included in the list (due to miss-targeting or otherwise) and to subsidize collective transportation and identity card costs.

about three-quarters (73 percent) noted that the reason given by those reducing the amount (most often village or sub-village heads) was for the purpose of sharing the BLSM benefits among those in the village who were not targeted but deemed eligible.[28] That is, village leaders actively re-allocated BLSM benefit pools to provide reduced transfers to those who believed they were eligible but did not receive BLSM, in order to defuse protests and negative disruptions. This practice is referred to as "bagi rata" (equal sharing) and it is done at the district level through reallocating quotas, rotating access to various programs over time and, based on survey data, and reducing the benefits received by targeted beneficiaries (World Bank, 2015a).[29] Linking anecdotal with survey evidence, the dilution of the BLSM benefits is not a hidden activity, nor is it perceived negatively. It seems to be an accepted practice anchored in local conceptions of social justice; one village official explained: "people here have a saying: 'no one's above and no one's below, everyone's the same". Bagi rata is seen as a legitimate response to community expectations, as according to a sub-district official: "If they hadn't shared out BLSM, village heads here would have been finished". By managing potential conflict this way, negative social impacts may have been reduced, while targeting accuracy and benefit delivery suffered instead. BLSM funds reached almost all recipients on the beneficiary lists, but local officials increasingly extracted "fees" from beneficiaries (World Bank, 2015a).

There is no evidence indicating BLSM-like transfers undermine social capital. Critics in Indonesia have argued that significant, non-universal cash transfers erode social capital (as proxied by, for example, semi-voluntary community improvement projects). However, no research to date has clearly proven that the effects of cash transfers undermine social capital.

ACCESSIBILITY

BLSM does not track program processes and outcomes; potentially eligible but excluded households do not have a clear recourse. Beyond a little-used community verification process that helps village authorities address targeting errors, BLSM has no mechanism, tool, or protocol to report on its own performance (World Bank, 2015a). Households may lodge BLSM-related complaints via SMS to the "Lapor!" hotline, but evidence concerning this hotline's use or the links from "Lapor!" reports or management to BLSM-executing agencies or partners is unavailable.

Recent studies reveal shortcomings in BLSM information dissemination and awareness campaigns. A nationwide information campaign was produced and delivered before the first BLSM transfers were made. However, research has revealed that BLSM facilitators had little effect on raising awareness of the program's design, aims, beneficiary selection, or beneficiary responsibilities. Community members questioned the transparency of the beneficiary selection process and would lodge their complaints about wrongful inclusion or exclusion with village leaders. However, village leaders often knew little about BLSM or beneficiary selection logic, and they generally preferred not to become involved (World Bank, 2015a).

BLSM's accessibility has not improved over previous emergency cash transfer iterations. Despite a new card-based ID system for BLSM-eligible beneficiaries, the pathways by which households and individuals learn about and access the BSLM process remain the same. Recipients are still informed of their eligibility through, and must retrieve BLSM funds from, PT. Pos. While the rate of "deductions" from BLSM packages has retreated from its BLT 2008/9 peak (when nearly half of transfer packages had fees deducted or were re-distributed), beneficiary control over transferred resources remains weaker in 2013 than in 2005/6. Roughly one-quarter of BLSM beneficiaries in the 2013 round indicated that deductions were taken from their transfers (see above).

CHALLENGES, RECOMMENDATIONS & MOVING FORWARD

Compensatory UCTs have been shown to be effective in protecting poor Indonesian households from anticipated price shocks. From March 2013 to March 2014, the headcount poverty rate decreased from 11.4 to 11.3 percent. If there had not been a BLSM (with a transfer budget of about IDR 9.4 trillion), the headcount poverty rate would likely have remained flat or increased. At least in the short run, use of BLSM has protected the purchasing power of many poor and vulnerable households (World Bank, 2014; World Bank, 2013b; World Bank, 2012c).

Though the program's ability to find priority households has improved from previous iterations (such as BLT I and BLT II), BLSM (2013) exhibits both exclusion and inclusion targeting errors. There are inherent difficulties with the UDB but inconsistent use of the local verification system to redress errors made specifically with respect to BLSM targets likely undermined the program's overall effectiveness, as village heads frequently re-allocated BLSM transfers (World Bank, 2015a).[30] Village leaders also chose not to support BLSM in some cases. Increasing the scope for community-based targeting methods to complement to the use of the national registry prior to the launching of BLSM would likely help reduce targeting errors and direct dissatisfaction with the program away from local authorities.

While information campaigns were launched and information materials were distributed, the qualitative and quantitative findings indicate that the information provided and the manner in which it was provided were inadequate. In future rounds of BLSM, more time and resources should be used for socialization with clear structures of accountability communicated to all actors. This process should occur well in advance of the launching of BLSM. This would likely have a positive spillover on targeting: the village-level targeting-error redress process would be used more effectively if responsibilities and program logic are agreed on, and absorbed by all stakeholders.

[28] World Bank staff calculations, 2015. While the most common intent, namely to redistribute benefits more equally, of BLSM deductions and the most common identity of those making deductions, namely the village or sub-village head, were the same in previous BLSM iterations in 2005 and 2008/9, the deduction rate, at 27 percent, is higher than the 2005 BLT but lower than the 2008/9 BLT; see World Bank (2012c).
[29] The first two trends were found in 19 out of 24 districts surveyed in a forthcoming qualitative study.
[30] Such that more local households received a lower-valued transfer..

Subsidized Rice for the Poor (Rastra)

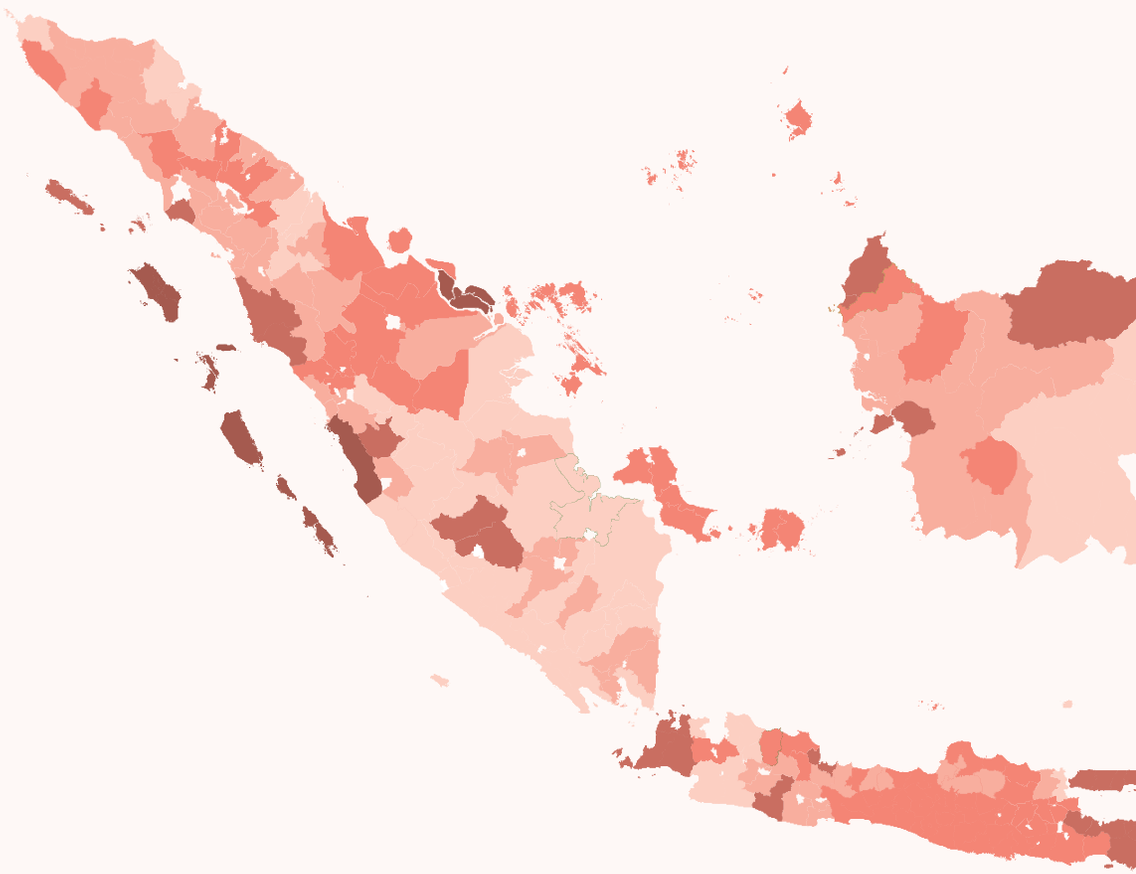
Rastra has positive potential: the consistent provision of a basic food package could protect poor households from food-price volatility, calorie scarcity, and malnutrition. However, in its operation, Rastra fails to achieve most of these fundamental social assistance goals. Dilution of benefits, missing rice, and hidden financing burdens all reduce the transfer values provided to target households. Rastra reform has begun shifting towards cashing out the Rastra benefit, initially in areas with functioning rice markets, while the current operational model will likely remain in the more remote areas of Indonesia.

OVERVIEW

Food availability is an important issue for poor households in Indonesia, as are food prices. For poor Indonesian households, food expenditures represent two-thirds to three-quarters of the household budget. The majority of poor and near-poor households are net consumers (rather than net producers) of rice, while rice consumption accounts for about two-thirds of all food expenditures.[31] Food prices are more unstable than other economy-wide prices. Over a 15-year period, the average annual percentage change in the economy-wide and food-only price indices was 7.5 and 8.2 percent, respectively. However, measures of price volatility were nearly twice as large in the food-only index. In other words, in Indonesia food price highs are higher (and lows are lower) than the general price level. In welfare terms, such

FIGURE 2.7

Vulnerability to food insecurity in Indonesia, 2015



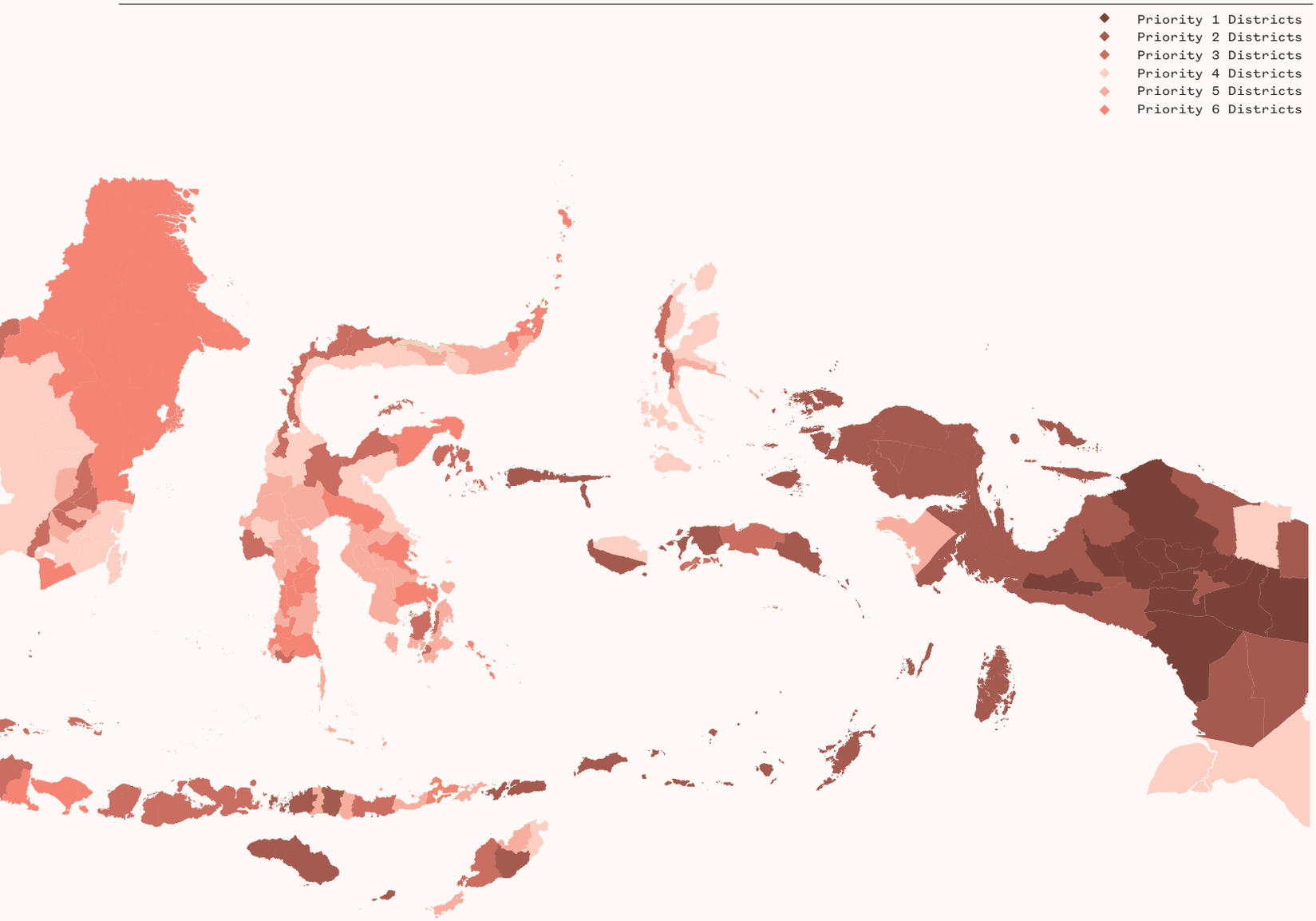
Source: adapted from World Food Programme. 2015. *Food Security and Vulnerability Atlas of Indonesia*.[33]

2.2

heightened volatility is riskier for households with consumption baskets weighted more heavily with food items.

Some regions in Indonesia do not produce enough calories for their local populations. The United Nations' World Food Programme (WFP) estimates that about 12 percent of Indonesia's 514 districts are food insecure. Figure 2.7 below provides a summary showing higher levels of food insecurity (light yellow, pink, and red areas) in eastern Indonesia (especially Papua), the island districts off the western coast of Sumatra, and remote districts in Sulawesi. The most food insecure districts (Priority 1) are all still found in Papua, and the majority of Priority 2 districts are in Papua and East Nusa Tenggara (NTT).[32]

Rastra, previously called Raskin, allows households to purchase rice at a subsidized rate. Originally developed to provide food consumption assistance to households during the Asian financial crisis (1997/98), Rastra was until very recently the largest permanent household-based social assistance transfer in Indonesia. Rastra rice is purchased wholesale by the state-owned National Bureau of Logistics, Bulog, which then delivers rice to over 50,000 regional distribution points where it is sold at below market prices. Through these operations, Bulog intends to stabilize the domestic rice price and to protect households from food insecurity. By design, Rastra's transfers of important basic commodities may significantly increase household welfare, especially in food insecure areas where regular markets cannot be relied upon for a consistent supply of reasonably priced foodstuffs.



[31] In contrast, high-protein items like meat, fish, and diary represent about 10 percent of food expenditures.
[32] As compared with the previous estimate of food insecurity in 2009, 67 percent of all districts saw an improvement in food availability. See WFP (2015) for more.
[33] The WFP analysis divides 13 indicators into two sets: chronic food and nutrition insecurity and transitory food insecurity, these indicators are combines into a single composite indicator that ranks the priority level of districts.

PROGRAM SIZE, INSTITUTIONAL SET-UP, ELIGIBILITY, & BENEFITS

While Rastra's total target coverage has fallen recently, its nominal expenditures per targeted beneficiary continue to rise (Figure 2.8). From 2013 to 2016, Rastra's policy authority (see below) assumed 15.5 million households would purchase the full Rastra subsidized rice package and in those 4 years the Government allocated about IDR 21.5, 18.8, 21.8 and 22.1 trillion, respectively, for the program.[34] While Rastra's share of the social assistance budget has fallen from over half in 2009[35] to just about one-third in 2016, per-beneficiary spending has risen by about 60 percent over the same period.

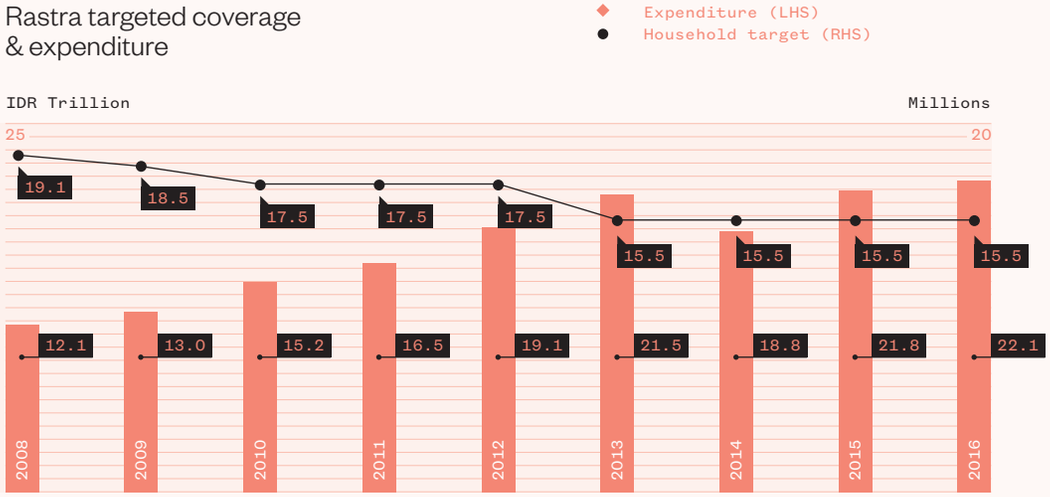
Rastra's delivery procedures are complicated by the granting of meaningful managerial authority to sub-national actors. Figure 2.9 presents a stylized, simplified, and optimistic flowchart describing Rastra in operation: a list of eligible households (by name and address) is generated by the unified database (UDB); and the list is then given to the national postal service (PT. Pos), which is responsible for distributing social assistance program beneficiary cards (*Kartu Keluarga Sejahtera* [KKS], or *Kartu Perlindungan Sosial* [KPS]) to those on the list. Local governments also receive the list and generate verifications of households together with an official request for Bulog to distribute the statutory Rastra-rice amounts to local distribution points. Bulog complies by delivering the requested amounts of Rastra rice (for sale at a stipulated below-market price) to these distribution points. In order to buy Rastra rice, households must possess their KPS/KKS card and proceed to their local distribution point to complete the sale. As part of Rastra reform initiatives, after several pilot schemes in 2016, in 2017, 1.4 million beneficiaries in 44 cities are able to purchase rice using digital cash by way of the KKS card based e-wallet at e-Warong. The program is likely to continue undergoing significant reform beyond 2017 (MoSA, 2017).

However, officially and in practice, the final allocation and local distribution of Rastra rice—everything occurring at and after the very bottom-most arrows in Figure 2.9—depends on the involvement of sub-village, vil-

[34] For Indonesian Rupiah conversion into US dollars the October exchange rate value of each year is used (except 2015).
[35] In 2009, Rastra targeted over 18 million households with a budget of IDR 13 trillion (US$1.35 billion) and accounted for 55 percent of the total assistance budget in that year.

FIGURE 2.8

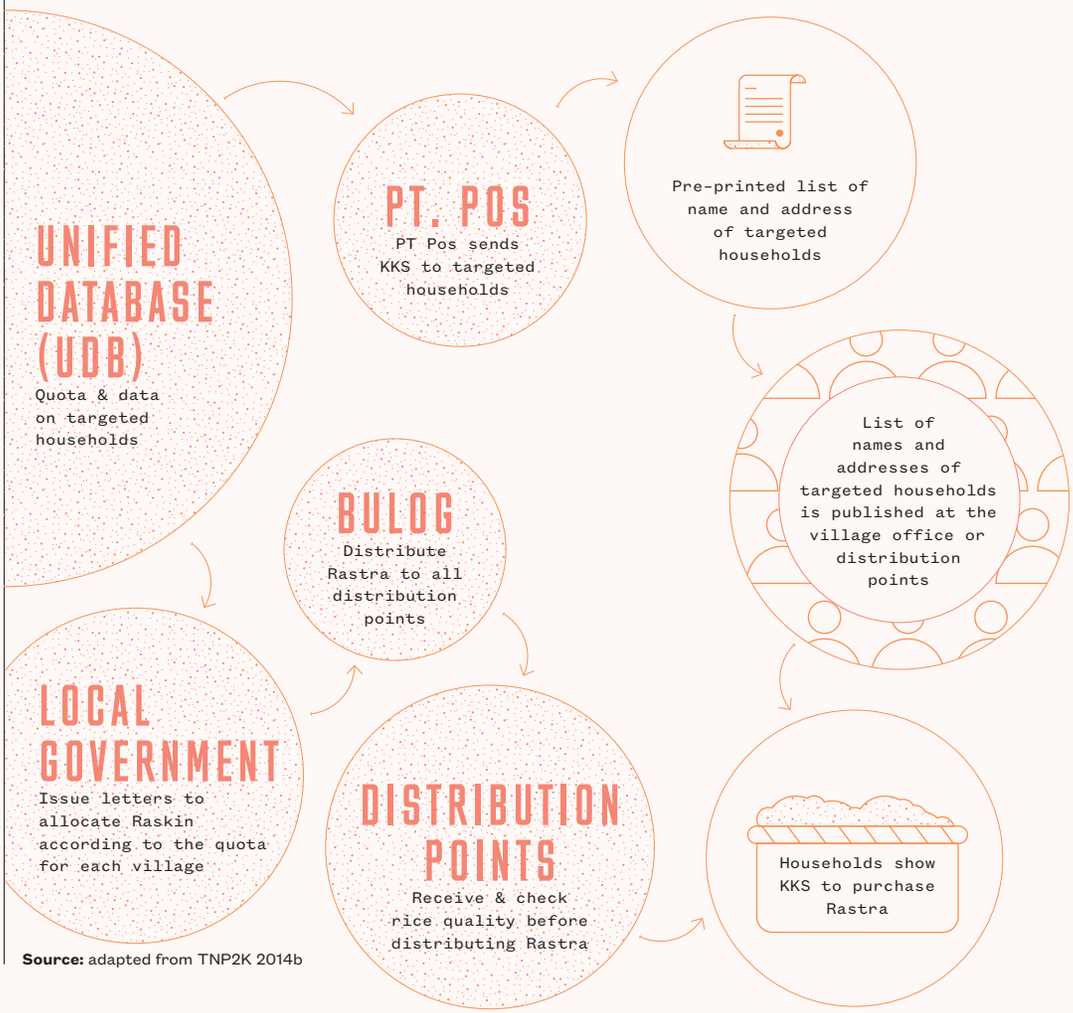
Rastra targeted coverage & expenditure



Source MoF financial note on the national budget 2008-12. 2015 and 2016 are realised budget.

FIGURE 2.9.

Rastra targeted coverage & expenditure



Source: adapted from TNP2K 2014b

FIGURE 2.10

Urban/rural Rastra coverage by expenditure decile, 2016 (Percent)

Source Susenas 2016 and World Bank staff calculations.

lage, sub-district, or possibly district, administrations. At the furthest remove from local delivery, and before the UDB stage, Rastra's central-level policy group, the "*Tikor Rastra* Pusat" generates total Rastra quotas, and sale and purchase prices for rice. Bulog then determines its own cost of distribution. Local areas to which rice is delivered are expected to pay (with public or private funds) all or part of this cost. Rastra rice may incur additional costs in remote areas when it is transferred from the distribution point to the actual point of sale.[36] Some local governments use general public revenues to cover these additional costs, whereas in other areas households are expected to pay these transport costs. Finally, local authorities are responsible for independently preparing a sales report, which means those same authorities are free to distribute the "right" to buy Rastra to anyone regardless of whether they are officially eligible.

Poor and vulnerable households are eligible for Rastra. Since 2012, TNP2K had been using the UDB in order to generate a list of the poorest 25 percent of households that are eligible to purchase Rastra benefit packages. The Rastra beneficiary list is updated every year at the local level through village or community meeting schedules (the musyawarah desa/kelurahan series). As with most of the other social assistance programs, Rastra has now switched to KKS/KPS-based eligibility for beneficiaries. However, as indicated above, village authorities still have final authority when it comes to Rastra beneficiary selection.

On paper, the Rastra benefit package is commensurate with needs. Eligible households have the right to purchase 15 kilograms of rice (per month) at a price roughly 80 percent below market price. Poor households dedicate (on average) two-thirds of their food expenditure budget to rice alone, while mean per-capita rice consumption is 9.5 kilograms per month (or 114 kilograms per year) (TNP2K, 2014b). Therefore, a full Rastra package purchased every month could mean a welfare gain of as much as 32 percent to a family of four, by providing about 40 percent of desired rice consumption at 80 percent below market price.[37]

COVERAGE, TARGETING, & IMPACTS

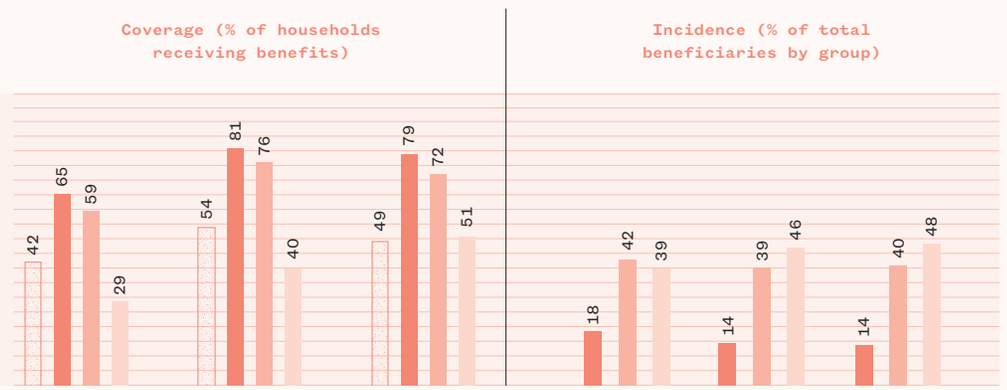
Rastra actual coverage[38] is higher than targeted coverage. At around 44 percent of the total population covered in 2016 Susenas data, Rastra coverage still dwarfs the next largest program, JKN-PBI. While coverage reaches 70 percent in 2017 for the poorest decile, coverage in the richest deciles is still high especially for rural areas (Figure 2.10) (World Bank, 2012d).[39]

Rastra in practice is not an income-poverty-targeted program. In order to facilitate comparisons between Rastra and other social assistance transfers (which may have slightly different target groups), Figure 2.11 illustrates coverage and incidence for the "Poor", the "Next 30" percent, and "The rest". This figure demonstrates that while the poverty headcount rate fell by 3.3 percentage points between 2009 and 2016, the share of Rastra benefits accounted for by the "Poor" group fell by almost 4 percentage points. The "Next 30" group, which contains the same proportion (30 percent) of near-poor households in every year, has a Rastra share that fell by 2 percentage points over the same time period. Finally, "The rest" has a Rastra share that increased by 6 percentage

[36] In non-remote areas, the distribution point is also the point of sale so no additional transport costs are incurred. 37 For details on average rice volumes produced and sold, see World Bank, 2009
[37] For details on average rice volumes produced and sold, see World Bank, 2009
[38] According to households represented in Susenas.
[39] Poor and vulnerable households not purchasing Rastra are more likely to live in urban areas.

FIGURE 2.11

Rastra coverage and incidence by poverty groups



Source Susenas (various years) and World Bank staff calculations.

TABLE 2.2

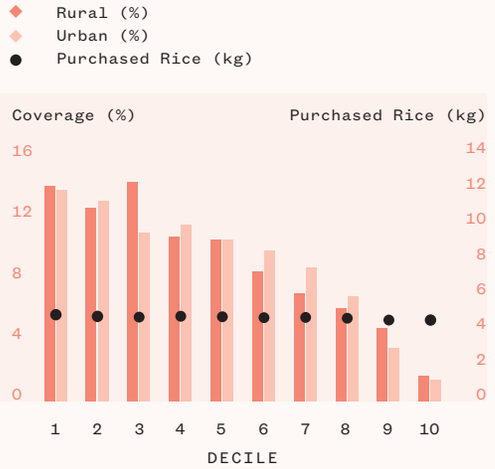
Characteristics within Indonesia's populations, 2016

	% of all Indonesians who:	% poor population who:	% of Rastra recipients who
Do not have access to bottled, tap or well water	16	28	21
Do not have access to private sanitation	22	41	31
Live in rural areas	49	63	62
Live with more than 5 household members	22	38	23
Have not completed primary education	9	13	12
Are illiterate	7	13	9
Work in the agriculture sector	33	56	43

Source Susenas 2016 and World Bank staff calculations. 'Work in…' refers to share of working individuals, not all Indonesians.

FIGURE 2.12

Incidence of Rastra beneficiaries & average Rastra purchases by expenditure decile, 2016



Source: Susenas 2016 and World Bank staff calculations.

The value of actual Rastra transfers is low because of discrepancies between total Rastra rice procured & total Rastra rice purchased; between total benefit promised & total benefit received; & between total number of beneficiaries targeted & actual beneficiaries.

points, showing a deterioration in targeting outcomes. This pattern indicates that as the micro-level poverty situation changes—with many households exiting poverty year to year, while fewer enter—Rastra does not adapt by making changes to micro-level allocations.[40] Indeed, when the centrally decided Rastra quotas were generated in 2012 (for the 2013 Rastra distribution) (TNP2K, 2014e), total coverage was reduced (by about 2 million households), while the non-poor's share of this reduced benefit pool increased (Figure 2.11).

Rastra rice ends up in many households that do not exhibit correlates of income poverty. Rastra's overall coverage, between about 40 and 54 percent of the population in most years, is much larger than other social assistance programs, while Rastra distributes benefits to three-quarters of poor households. However, on average, Rastra rice is purchased by households that appear to be better-off than poor households according to most of the non-income correlates of poverty listed in Table 2.2 (for example, access to clean water or sanitation, and working in agriculture).[41]

Subsidized rice volumes purchased are roughly equal across deciles (Figure 2.12). Rastra households in 2016 purchased about 5 kilograms per month, up by 1.5 kilograms from the 2009 average. Above-median households have declining average purchase volumes; nonetheless these households captured about one-third of the Rastra benefits available in 2015.[42]

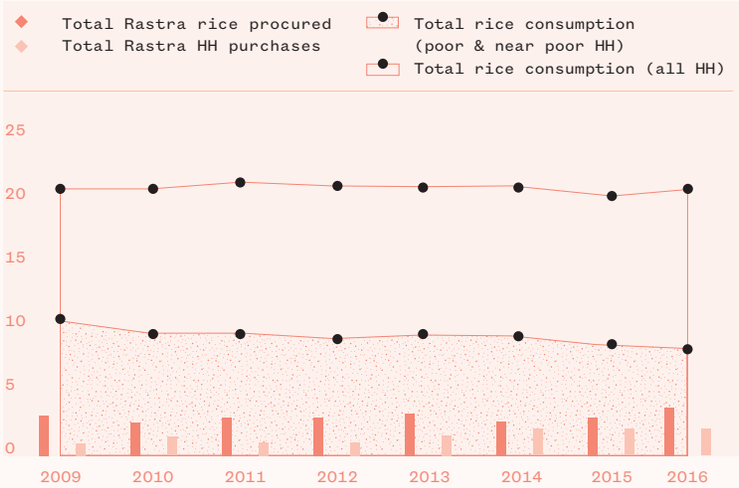
Rastra allocation and distribution differs by area. Some areas, for example, West Sumatra, distribute the entire Rastra package amount to targeted households, while other areas, East Java and Southeast Sulawesi, for example, are prone to disregard "official" targets and share Rastra rice more evenly within local community. Some areas distribute Rastra every month, while others distribute less frequently (once in a 2-, 3-, or 4-month period).[43] These variations are mainly determined by each community and at the local level.[44] Based on monitoring throughout 2012, only 46 percent of 220 villages received their entire Rastra quota on schedule (TNP2K, 2015b). When Rastra was not delivered on time, officials cited transportation problems, payment arrears and local government tardiness in producing and sending distribution-time proposals.

The value of actual Rastra transfers is low because of discrepancies between total Rastra rice procured and total Rastra rice purchased; between total benefit promised and total benefit received; and between total number of beneficiaries targeted and actual beneficiaries. Records show that of the Rastra rice procured to deliver promised benefits, only about half of the procured kilograms (in recent years) are actually purchased by households (Figure 2.13). It is not clear at which stage of the delivery process rice goes missing.[45] In most years,

[40] Previous studies have indicated that households rarely leave the program or are denied benefits once they have begun purchasing Rastra rice, even when they have exited poverty. See World Bank (2012e).
[41] In addition to only weak correlations with poverty characteristics, World Bank (2012e) found that Rastra allocations are not larger where food insecurity is greater.
[42] World Bank (2012f) demonstrated that when more Rastra is available on the ground, this can lead to larger purchases by poor households but just as frequently leads to smaller purchases by poor households.
[43] TNP2K (2014f)
[44] ibid
[45] Earlier estimates (between November 2003 and January 2004) found that up to 30 percent of Raskin allocations went "missing" in between the distribution points and Raskin-buying households; in some areas the estimated rate was as high as 75 percent.

FIGURE 2.13

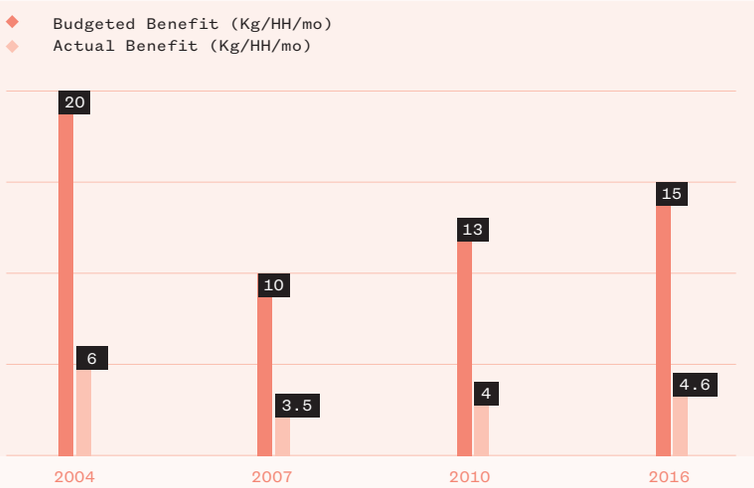
Rastra procurement & rice purchases (billion kg)



Source MoF and World Bank staff calculations.

FIGURE 2.14

Rastra official & actual benefit (kg of rice per-month)



Source Susenas various years and World Bank staff calculations.

15 KG /MONTH

"Rastra should have made 15 kilograms of rice per month available to poor and near-poor households at a subsidized price of IDR 1,600 (US$0.10) per kilogram. "

while procured rice for distribution through Rastra represents about 15 percent of the total rice market (by volume), actual Rastra purchases represent only 5 to 9 percent of market volume.[46]

Rastra should have made 15 kilograms of rice per month available to poor and near-poor households at a subsidized price of IDR 1,600 (US$0.10) per kilogram. This package would have translated into about 10 percent of poverty line expenditure, and between 30 to 40 percent of an Indonesian household's rice needs (see above). Actual purchases as reported by households, however, were far less (Figure 2.14). Households purchased (per month on average) 3.5, 4.0, and 4.6 kilograms in 2007, 2010, and 2016, respectively. As a result, the value of the benefit actually received in those years was closer to just 2 percent of poor households' expenditure.

Rastra rice does not always meet Bulog's own quality standards. Rastra rice is expected to meet a "medium" quality standard (good rice condition; free of pests) and beneficiary households have the right to reject and return sub-"medium" standard rice for exchange. However, monitoring throughout 2012, indicated that only 37 percent of villages received "medium"-quality standard rice (or above).[47]

Higher prices also drive a wedge between promised and actual benefit levels. As seen in Figure 2.14, there is a significant difference between budgeted benefit of Rastra rice, 15kg per month comprising around 8 to 9 percent of poor household monthly expenditure, versus actual average benefit received, 5kg per month comprising around 2 to 3 percent of poor household monthly expenditure. In 2004 and 2007, Rastra buyers paid about IDR 1,160 (US$0.10) and 1,689 (US$0.20) per kilogram, respectively, while the official Rastra price was IDR 1,000. In 2016, while the official price was IDR 1,600 (US$0.10) per kilogram, Susenas respondents reported paying about IDR 2,054 (US$0.20) per kilogram on average.[48]

As mentioned above, a higher-than-stipulated Rastra price often contains additional transport costs that have not, but could have, been paid from public revenues. These markup amounts are not necessarily commensurate with actual transportation costs, however. For example, in a province where market costs for taking goods the distances in between Rastra distribution points to household clusters were about IDR 44 to 125 per kilogram, Rastra rice included a transport surcharge of between IDR 200 and IDR 300 per kilogram.[49]

[46] The figure indirectly demonstrates the importance of rice in the food basket for poor and near-poor households: though they represent about 25 percent of households, rice purchases within these households represents about 40 percent of the total purchases in most years.
[47] Villages receiving sub-"medium"-standard rice found Rastra rice with weevils; brown-colored rice; and rice with unpleasant smells (TNP2K, 2015b).
[48] Reported price paid for Rastra rice varies significantly in all years of Susenas data.
[49] SMERU (2008) found a province where market costs for taking goods the distance in between Rastra distribution points and points of sale were about IDR 44 to 125 per kilogram while the Rastra program charged IDR 200 to 300 per kilogram. TNP2K (2015b) found that "collection costs" were reaching IDR 445 per kilogram in Java and as high as IDR 483 per kilogram, outside Java.

ACCESIBILITY

Rastra policy and oversight functions include many central agencies, as well as their local instances (Table 2.3). To increase effectiveness and accountability, a central-level Rastra Coordination Team (*Tikor Rastra Pusat*) was formed in 2013.[50] *Tikor Rastra* includes the Coordinating Ministries for People's Welfare and for Economic Affairs, the National Development Planning Agency, the Ministries of Finance, Interior, Social Affairs, and Agriculture, the Central Bureau of Statistics (BPS), the State Audit Agency (BPK), and Bulog.

Rastra generates official beneficiary quotas with the UDB, but actual beneficiaries are still determined at the local level.[51] In 2012, TNP2K began using the UDB to generate a list of beneficiaries.[52] Rastra teams at the local level were asked to update these lists via the regular community meeting series (Musyawarah Desa/Kelurahan community meetings). Upon the switch to UDB-based targeting with community verification and updating, it was concluded that any reallocation of benefits achieved through community meetings could improve program targeting, including cross-village targeting. However, more and better socialization is needed to improve community meetings' capacity for determining an efficient local distribution of social assistance transfers.

Rastra's outreach and socialization procedures may be improving. TNP2K launched an awareness campaign to better inform program implementers at all subnational levels about Rastra program logic, the importance of finding targeted households, and the use of KPS identification to confirm eligibility.[53] This campaign reached 106 cities (or urban districts) and 1,114 villages (or rural hamlets) across Indonesia by 2016, but impacts haven not yet been reviewed (TNP2K, 2014b).[54]

Rastra implementers have drawn up strategies to more effectively distribute full Rastra benefits to targeted households (TNP2K, 2014e). TNP2K, jointly with Jameel Abdul Latif Poverty Action Lab office in Indonesia, conducted pilot tests for a "Raskin card" in 2012. The program distributed 1.3 million eligibility identification cards in 53 cities (or urban districts) in 7 provinces. The research team concluded that a "Raskin card" could increase the amount of Raskin rice received by poor households by about 2 kilograms per month, and reduce the Raskin purchase by about IDR 250 per kilogram.[55] The findings for the "Raskin card" provided impetus for the KPS card in June 2013. In 2014, PT Deloitte in tandem with the World Bank and Raskin stakeholders, mapped the Raskin supply chain in order to identify areas where re-engineered solutions could increase delivery efficiency (also known as a "Business Process Review"). Recommendations, which the *Tikor Rastra* endorsed in 2014 and which Bappenas has instructed local governments to pilot, included adapting Rastra in urban areas as a "smartcard"-access food distribution program,[56] and an improved distribution supply chain in rural areas (Table 2.4). Subsequently, TNP2K implemented a pilot to test the suggested new delivery mechanism and informed the development of implementation guidance (Box 2.2).

TABLE 2.3

Rastra-affiliated agencies & their roles

MINISTRY/AGENCY	RASTRA-BASED TASKS AND FUNCTIONS
Coordinating Ministry for Social Welfare	Coordinates implementation
Bappenas	Policy agency (overal poverty/social protection policy function)
TNP2K	Creates list of eligible beneficiaries
Central Bureau of Statistics	Collects and hosts Rastra beneficiary data
Ministry of Finance	Executes Rastra budget provisions
Ministry of Home Affairs	Manages Complaint-Handling Unit
Ministry of Social Affairs	Budget Holder/Formal executing agency
Bulog	Implementing agency (until the "last mile")
Local Government	Responsible authority for Rastra's "last mile"

Source World Bank, 2015c.

TABLE 2.4

Tikor Rastra endorsements

BUSINESS PROCESS AREA	CURRENT CHALLENGES	PROPOSED SOLUTIONS
Transportation	Rastra rice delivered by one transport company (JPL)	Undertake regular tender process to contract transport provider
Quality Inspection	Rastra rice quality inspected by one QA provider (Jastasma)	Undertake regular tender process to contract a quality control company
Monitoring & Evaluation	Diffused responsibilities undertaken by several parties	New M&E Organization
Last Mile distribution (rural)	Local government undertakes distribution	Use local government offices, post office, coops, and military where possible
Last mile distribution (urban)	Local government undertakes distribution	Partner with retail outlets to develop a government 'debit card' for Rastra and other nutritious food purchases

Source World Bank, 2015c.

[50] Corresponding coordination teams were also formed at the district and village implementation level.
[51] Ibid.
[52] The list is called Daftar Penerima Manfaat (DPM).
[53] Materials, including posters and leaflets, were sent to around 78,000 villages/kelurahan. TNP2K has also arranged for media briefings, talk shows, and informative broadcast with around 150 local and national media outlets in major capital cities.
[54] While program implementer knowledge has increased, beneficiary awareness has not responded to the expanded socialization efforts (TNP2K, 2015b).
[55] Positive impacts were larger when the "Raskin card" was accompanied by a socialization module.
[56] Similar to the USA's Supplemental Nutritional Assistance Program (colloquially known as "food stamps").

BOX 2.2

TNP2K— Short report of 2016 pilots on the distribution of non-cash in-kind social assistance

BACKGROUND

Raskin has historically showed poor performance in terms of benefit adequacy due to sharing out of benefits, low quality of rice, higher costs than stipulated due to transport and other costs being levied upon the purchasing household among others. In March 2016, The President instructed Rastra be reformed into a voucher system and be implemented in early 2017. By use of a voucher it is meant that Rastra distribution can be monitored and recipients can receive better quality rice of their choosing. Besides rice, the voucher should also be able to be used for other staple goods. In April 2016, the President also instructed that social assistance and subsidies should be transferred digitally. Distribution should occur via the banking system to lead to better oversight and monitoring. The use of the banking system is expected to support productive behaviors, increase financial inclusion as well as encourage savings. The president also instructed that the various social assistance schemes become integrated into one card and one account.

DESIGN OF PILOTS

TNP2K conducted a digital payment reallocation of in kind assistance between September and October 2016. The purpose was to test and design mechanisms overseeing the entire process as below.

1	Preparation of data on targeted recipients and preparation of merchants.
2	Sending of invitation letter to recipients as initial socialization and education about the programs.
3	Registration and activation by recipients via bank outlets or merchants (via phone or using cards).
4	Distribution of benefits to savings accounts of recipients.
5	Use of benefits and trading of electronic vouchers for goods at a merchant.

Source (TNP2K, 2017)

RECOMMENDATIONS

01 Preparation of data on targeted recipients

If ample time is available, conduct checks to see if potential beneficiaries can be found and ensure there is an application to allow for data updating at the village level. If time is short, the re-checking of potential beneficiaries should be done together with the registration step at the village level done together with a village facilitator and bank employee by opening of a specialized desk during a town hall.

02 Sending of invitation letter to recipients as initial socialization and education about the programs.

Socialization should contain complete information about the program and distribution mechanism including location of registration and transactions. Education to recipients and merchants/agents/shops as banking agents should be done intensively before the program launches to raise understanding.

03 Mode / tools of transaction, registration and activation.

Debit cards or cellular phones methods both have advantages and disadvantages such that choosing to just use one will engender risks to hinder benefit distribution rather than help it. Besides that, banks that participate in the program need to be able to manage risks and innovation related to the mode/tools of transaction. It must be remembered that opening a bank accounts requires citizenship documents such as the KTP and KK to fulfill bank requirements. At the moment not all families have such documents so it should be ensured that the local government can fulfill this important need by providing such documents

04 Availability and spread of merchants/agents/shops

The ratio of merchants/agents/shops to recipients is ideally 1:150. For that reason, there still will need to be more agents added to reach the ideal ratio. The bank should have at least two merchants/agents/shops per village to ensure adequate choice is available for the recipients and to avoid monopolies in price or procurement leading to suboptimal quality of goods. The local bank should ensure technical issues relating to the tools of transaction can be resolved. The bank should take into account OJK regulations related to the recruitment of Laku Pandai agents and there should be involvement of merchants that are already bank agents so that the ratio is reached. Importantly, banks need to conduct adequate training for merchants/agents/shops and should provide a technical support team in each are to provide facilitation to the merchants/banks/shops as needed.

05 Raising the effectiveness of digital payment implementation

It should be clearly defined which staple foods should be available at merchants/agents/shops with suitable price and quality standards. The registration mechanism should be independent and open for all entrepreneurs or existing shop owners that would like to become merchants/agents/shops. To maintain an adequate flow of payments, there should be liquidity support for merchants/agents/shops to provide cash to the recipients.

06 Trading the food voucher and disbursement of digital payments

In trading the electronic voucher to get goods, the merchant/agent/shop must give 1) proof of transaction and information of remaining balance to the recipient 2) clear information about the price of rice, eggs and milk sold. In distributing cash, the Bank must ensure recipients can withdraw cash via the merchants/agents/shops by ensuring adequate liquidity and the proximity of ATMs at low cost to the beneficiary.

07 Services for the recipients

Ensure there is a grievance redress mechanism. Banks and local government should provide a special mechanism for the elderly and special needs recipients on all aspects of the programs operation

08 Involvement of local governments

Local government should be actively engaged in the programs implementation, in particular with validation and verification of recipient data and socialization. Together with banks, local governments should help identify potential merchants/agents/shops to support implementation of the program. Local governments have the role of providing information and receiving complaints as well as checking merchants/agents/shops stipulated prices. They should also provide necessary administration and provide information related to problems and solutions in the implementation of the program and conduct periodical monitoring and evaluation.

09 Raising systems and infrastructures of transaction at the agent/merchant level

Program implementers should coordinate with the Ministry of Information and telecommunication to minimize the risk of poor network signal to ensure electronic transactions succeed in each area. Ensure interoperability of banking agents such that recipients can visit multiple merchants/agents/shops. On sustainability, the agent must have specified staple goods and must have the financial incentives to conduct their own investments to procure these goods.

In mid-2016, a program called e-Warong was launched by MoSA and other government agencies in collaboration with Bank Indonesia, the Financial Regulatory Authority (OJK), Bulog, and multiple national banks. These e-Warong are owned by groups of PKH beneficiary families under the KUBE-PKH program and are supposed to sell Rastra goods (rice, cooking oil, etc) to PKH and Rastra beneficiaries. Cardholders can exchange e-vouchers only for pre-determined goods such as Rastra rice, while other SA program benefits may be withdrawn in cash at the e-Warong or other approved locations via agents of multiple banks.

In February 2017, the government launched a new "non-cash food assistance" (Bantuan Pangan Non Tunai, BPNT*) program, which aims to eventually replace Rastra's subsidized in-kind provisions with a more flexible and accountable e-voucher based delivery system. Under BPNT, each beneficiary household would receive a voucher worth IDR 110,000 per month and can purchase rice and a number of pre-determined food items from authorized providers (E-Warong). The first phase of BPNT involves 1.4 million beneficiary households in 44 cities (MoSA, 2016d) and will be scaled up nationally by 2020. Also in response to the BPNT, the definition of e-Warong was expanded to include market vendors that have already established their food related business and are willing to participate as authorized merchants to the BPNT program. The move towards e-vouchers captures several important objectives: improved targeting, greater access to nurtritious food and a higher degree of choice for the beneficiary, increase financial inclusion and encourage the development of small scale local businesses.[57] The implementation performance of this new program is yet to be evaluated fully while its design most likely needs to be adapted significantly before scaling up in rural areas and to include other food items such as eggs.

* This program is in line and related with the Presidental Regulation No. 63 in 2017 on the Distribution of Non Cash Social Assistance and Non Cash Food Support.

[57] Timmer, P. et al (2017) Evolution and implementation of the Raskin Program in Indonesia. Forthcoming book chapter.

CHALLENGES, RECOMMENDATIONS & MOVING FORWARD

While Rastra's policy relevance is still sound: poor household welfare is negatively affected by food scarcity and food price volatility, it is evident that both the design and implementation performance of Rastra have failed to achieve its objectives. Were the program to expand beyond just rice—for example, by including meat (or other high-protein items) and fruit and vegetables in its benefit package—the program could also help reduce the high rates of micronutrient malnourishment, a precursor to stunting, which is still affecting Indonesian communities, especially those in the poorer eastern half of the archipelago (World Bank, 2013c). The poor targeting performance and weak accountability of the distribution chain have reduced Rastra's effectiveness in terms of its actual impact on poverty and food security.

The ongoing BPNT initiative on the other hand holds great promise in addressing Rastra's weakness. It is expected to better target the bottom 25 percent households using the UDB, provide better access to nutritious food by design, allow beneficiaries to choose and control on when, what type, and how much they buy rice and other eligible food commodities, encourage local retail businesses to participate, and finally cost savings in public spending stemming from better efficiency of service delivery (World Bank, 2017b). One distinguishing feature of the BPNT design is that it is possible to closely monitor the program transactions, which are carried out electronically using beneficiaries' KKS cards and service providers' EDC/Pos devices and hence help hold the service providers accountable if appropriate monitoring and audit mechanisms are put in place as in the case of United States' SNAP program.

Rastra should continue reforms, such as the ones mentioned in the previous section, designed to enhance its efficiency as a social assistance transfer. These reforms include:

1. Rastra quotas and *actual household allocations* should be based on the community-updated national registry.
2. Below the distribution points, Rastra allocations should be monitored to ensure that a full allocation reaches all eligible households first.
3. Rastra socialization should be re-enforced with performance incentives so local communities can develop grass-roots monitoring and provide feedback to implementers.
4. Monitor, evaluate and adapt alternative delivery systems such as the BPNT program, particularly exploring comparative cost-effectiveness of benefit modalities (in-kind, voucher, and cash) in different settings.

TNP2K has also suggested Rastra reforms (in addition to improved targeting) based on recent comprehensive analytical studies (Perdana et al., 2015):

1. Increased transparency by listing beneficiaries by name at village level.
2. Adjust quota ceilings.
3. Formalize the process of recipient replacement done by the village administration.

While Rastra's policy relevance is still sound (poor household welfare is negatively affected by food scarcity and food price volatility), it is evident that both the design and implementation performance of Rastra have failed to achieve its objectives.

Subsidized Social Health Insurance (JKN-PBI)

JKN-PBI's potential is vast: on paper it promises to provide a theoretically in-value, in-kind health benefit to all poor and vulnerable households regardless of location. Unevenly distributed healthcare facilities and personnel, as well as an uneven distribution of quality within the provision of medical services, mean that for most eligible households PBI potential is not in proportion to what it actually delivers. As JKN-PBI is part of the National Health Insurance Scheme and more beneficiaries are covered due to mandatory universal coverage, better M&E, accessibility, and outreach will be key to providing an effective in-kind benefit for poor and vulnerable households.

2.3

OVERVIEW

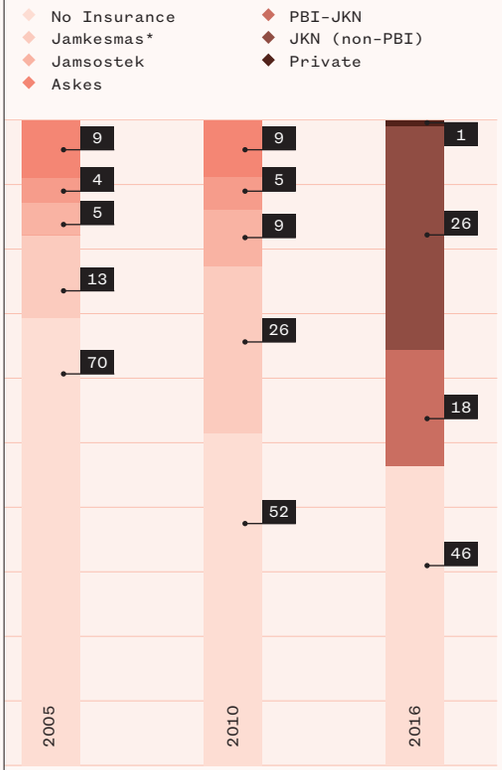
Healthcare access, healthy behaviors, and healthy outcomes for all citizens, are a focus of GoI social policy. Towards the end of the 20th century, the GoI began targeting healthcare services facilitated by public expenditures specifically to poor households: *kartu sehat* or health card (circa 1994) and its Asian-financial-crisis cousin, *Jaring Pengaman Sosial Bidang Kesehatan* (JPS-BK), provided poor households with free curative health care at community health centers and referral care at district hospitals. Then, throughout the 2000s, multiple compensatory transfers to poor and near-poor households—provided during periods when fuel subsidies were adjusted—contained a health services component that again provided free care (in-patient or outpatient, as well as preventative services and pharmaceuticals).

While the household trend in all these areas has been positive, progress has been slow. Figure 2.15 demonstrates that the share of households with no health insurance coverage of any kind has fallen from 70 to 46 percent in the period 2005-2016.

PBI, previously referred to as Jamkesmas, is a component of the *Jaminan Kesehatan Nasional* **(JKN) program** (hereafter referred to as JKN-PBI). Jamkesmas was a subsidized public healthcare insurance program intended for poor and near-poor households that would otherwise not be covered by health insurance.[59] Recognizing that poor and vulnerable households have higher rates of non-utilization, higher rates of preventable conditions, and more frequent income losses due to adverse health events (World Bank, 2013d), Jamkesmas was developed (circa 2005) to improve utilization by reducing the costs of services. Today, Jamkesmas is called *Penerima Bantuan Iuran* (PBI), which is not a program in itself but is part of JKN and it is still targeted to poor and vulnerable households. JKN-PBI makes free the use of all available healthcare services and facilities in accordance to JKN-PBI regulations. PBI is meant to produce social, as well as individual, benefits: by promoting healthy households, keeping students active and alert, and returning adults to work sooner, all Indonesians benefit from a more productive population.[60]

FIGURE 2.15

Health insurance program coverage by insurance type (percent)



Source Susenas 2005, 2010, 2016. PBI-JKN coverage in the Susenas survey is lower than administrative coverage.
Notes: In 2005, a household is considered "covered" if at least one of the household members reports having (a particular type of) insurance. *In 2010, a household is considered "covered" by Jamkesmas if the respondent reports that the household can access Jamkesmas. In 2016, households can report whether they are covered by PBI/Jamkesmas, Jamkesda and others. Households are considered "covered by PBI" if they received assistance from PBI. They might be covered by Jamkesda and other types of insurance as well. JKN includes BPJS Kesehatan and other programs that it has absorbed since 2014 but are still asked in Susenas data as separate categories. Households are considered "covered by Jamkesda" if they received assistance only from Jamkesda. However, as of late 2016, 73 percent of districts existing Jamkesda had already become integrated with JKN and so any mentioning of receiving Jamkesda is taken to be part of JKN (non-PBI). Since there has been some changes in the naming of programs 2016 health insurance data is presented with different categories from 2005 and 2010.

46%

"While the household trend in all these areas has been positive, progress has been slow. Figure 2.15 demonstrates that the share of households with no health insurance coverage of any kind has fallen from 70 to 46 percent in the period 2005-2016. "

[58] Presidential Regulation No. 32/2014 on the Management and Use of Capitation Grants for Quality Improvement in Front Line Services, Minister of Health Regulation No. 19/2014 and Minister of Home Affairs Circulation Letter No. 990/2280/SJ. One regulation provides rules to improve the management and use of capitation grants at non-BLUD Puskesmas; the other two technical regulations enable BPJS Kesehatan to pay capitation grants directly to Puskesmas through a designated account for each center. BLUD (*Badan Layanan Umum Daerah*) is a designation attached to a public service provider meaning that though the provider's legal status is attached to local government and the provider must remain non-profit oriented, it is nonetheless able to execute its activities—including pricing schedules and staffing—in order to improve service delivery to the community. In other words, a BLUD service provider is semi-autonomous, while a non-BLUD provider is not.
[59] Jamkesmas/JKN-PBI was known as Askeskin when it was established in 2005. Now, Jamkesmas has undergone a transition from a stand-alone program managed by the Ministry of Health to a targeted, subsidized component (PBI) of Indonesia's National Health Insurance program (JKN), which is itself under the National Social Security System (SJSN).

BOX 2.3
Askeskin ⟶ Jamkesmas ⟶ JKN–PBI

Following the establishment of the managing bodies for Indonesia's National Social Security System (SJSN) in early 2014, based on the 2011 BPJS Law, the subsidized national health program for the poor and near poor, then called Jamkesmas, completed a merger to become part of National Health Insurance (JKN) affiliate of the SJSN. As of 2016 JKN covers around 166 million individuals including previous Jamkesmas beneficiaries who have automatically become JKN members through PBI, those who have their health insurance fee paid for by the government. JKN is managed by the Social Health Insurance Agency (BPJS Kesehatan),. Including locally financed PBI, the PBI component of JKN, to be referred to as JKN-PBI, will comprise around 64 percent of JKN by the end of 2016 (MoH, 2016).

As the Jamkesmas program, as well as the participants, completes absorption by JKN-PBI, it will cease being a stand-alone program operating with its own budget. Instead, PBI's target group—poor and near-poor households—and eligibility criteria will remain while JKN will include a subsidized program that covers nominal premium amounts households would otherwise be expected to pay. In other words, when Jamkesmas was eliminated, Indonesia also eliminated its healthcare fee-waiver program for poor households; at the same time, Jamkesda (the local government health insurance fee waiver program mirroring Jamkesmas) began merging with JKN-PBI. In its place, the JKN insurance program and an initiative, referred to as PBI Penerima Bantuan Iuran or "recipient of government fee support", was launched to cover JKN premiums for those who qualify for such relief.

When Jamkesmas and Jamkesda (were still implemented, beneficiary selection was ultimately determined in a highly decentralized setting, with local governments helping to identify both pre-listed and additional eligible beneficiaries. As JKN administrators absorb the Jamkesmas and Jamkesda beneficiaries and expand JKN coverage, they will instead use the national registry for targeting, identifying, and contacting beneficiaries.

Other recent regulatory changes which clarify fund flow channels and the permissible uses of funds sourced in these channels may also enhance the ability of the community health center (or Puskesmas), which is usually the first-line provider of medical services, to provide accessible and reliable services to JKN-PBI members[58] In essence these regulations will provide greater autonomy to these health service providers even when they are accountable to, and have their operational funding disbursed by, local governments (APBD refers local government budget, APBN refers to national government budget). However, there are significant shifts taking place: Puskemas continue to receive general subsidies from the government budget to finance operational expenses and medicine but are at the same time also receiving payments from the JKN program; this shift and the interplay between these funding sources and resulting provider behavior and impact on user experience warrants further study.

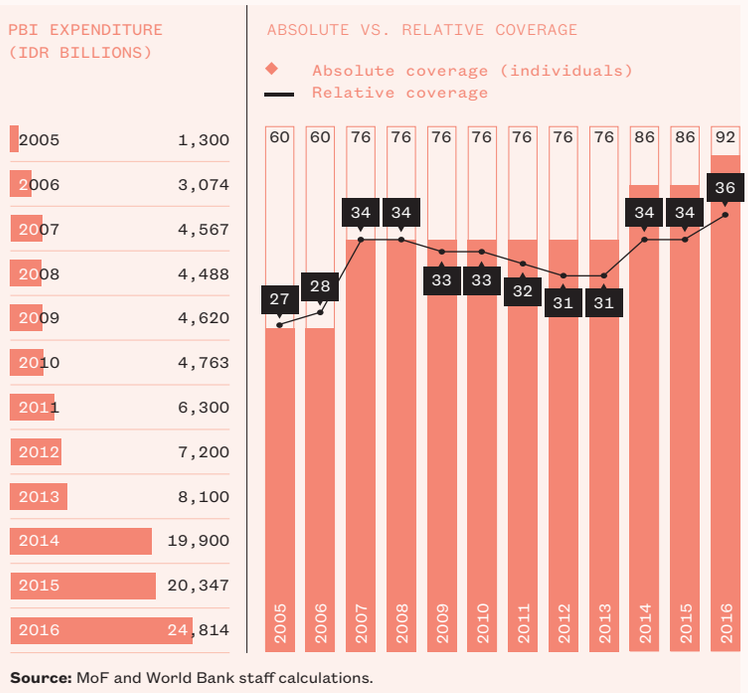
Providing premium subsidies to poor households through the JKN-PBI initiative will see the subsidized national health program for the poor and near poor move away from a vertically integrated program, where service providers, those determining eligibility, and those determining policy for both the program and the service providers are all employed by the same ministry. With BPJS Kesehatan as the national health insurance provider, the UDB and its managers as the card provider and eligibility gatekeeper, and the Ministry of Health as the manager, policy formulator, and regulator of the health service providers, it is unclear whether potential beneficiary access to the program and the services provided will improve.

Source (TNP2K, 2014c) & (World Bank (2016b)

PROGRAM SIZE, INSTITUTIONAL SET UP, ELIGIBILITY, & BENEFITS

As Jamkesmas gave way to JKN-PBI in 2014, both the number of beneficiaries and the program's budget expanded (Figure 2.16). In 2016, the Government significantly raised central government expenditures on JKN-PBI from earlier years to IDR 24.8 trillion, giving the program a 35 and 39 percent share of total central government social assistance expenditures and total central government health expenditures, respectively, in 2016. From 2013 to 2014, 10 million beneficiaries were added, marking the first major program expansion since 2007. From 2014 to 2016, an additional 6 million beneficiaries were added to reach a targeted total of 92 million beneficiaries. Taking the locally financed PBI recipients (Jamkesda) into account, the total increased to 105 million (MoH, 2016). This leaves JKN-PBI as the largest of the social assistance transfers by budgeted expenditure and coverage today.

FIGURE 2.16
PBI expenditure and absolute vs. relative coverage[61]



Source: MoF and World Bank staff calculations.

[61] Absolute coverage is shown as the total population receiving PBI while relative coverage places this number in the perspective of the growing number of the total population by year.

The JKN-PBI initiative will provide households with a true insurance program; Jamkesmas was a fee waiver/supply-side subsidy hybrid. Prior to 2014, the Ministry of Health operated Jamkesmas as a fee-waiver program and as a supply-side top-up through provision of capitation grants and claim-based reimbursement. Local health facilities were allotted Jamkesmas funds based on the size of the population they served, as well as the activities programmed. Hospitals also received operating grants tied to population magnitudes and services offered, and in addition made claims to the Jamkesmas administrator for re-imbursement. (TNP2K, 2014d).

Jamkesmas was accepted at both public and private providers and therefore some risk-sharing between the Government and the private providers was accomplished. However, the fee-waiver portion of Jamkesmas was rarely enforced and out-of-pocket costs were not necessarily reduced for Jamkesmas cardholders, so from a household perspective the insurance value of Jamkesmas was reduced. While the potential value of a Jamkesmas card was very high, as nearly all services available were covered by the fee waiver, in practice the value was considerably less because of both remaining out-of-pocket expenses, as well as a limited supply of services[62] in most areas.

For JKN-PBI, the insurance value of the program for poor households should increase. Services acquired by JKN-PBI beneficiaries will be billed according to JKN standard operating procedures, while complicated funding arrangements within the public service providers should cease to be a constraint on the set of services available. However, it is unclear how or if the service provider's ability to charge fees directly to households will be diminished: premium rates (calculated by the GoI) are not currently based on actual cost of services provided.

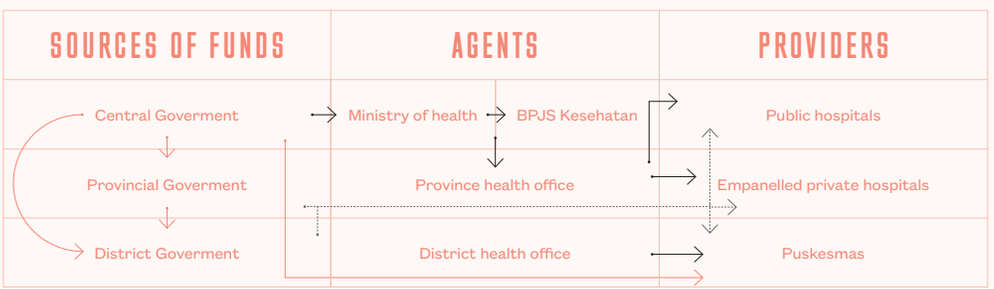
BPJS Kesehatan in coordination with the Ministry of Health executes the JKN-PBI program. Figure 2.17 describes the flow of funds for PBI, based on the Jamkesmas set up from which it transitioned. BPJS Kesehatan receives annual budgeted transfers for PBI based on a per-capita monthly "premium" and the number of poor and near-poor beneficiaries targeted, based on the UDB. In addition, service providers received general operational and capital-cost budgets from central, provincial, and district governments to fund Jamkesda, but as Jamkesda programs further complete their merge with JKN-PBI, the program will be entirely centrally executed. Reimbursement rates to public and private hospitals for PBI coverage are largely the same, varying only by the degree of specialization of the hospital.

Poor and near-poor households are eligible to have their JKN premiums paid by the PBI initiative. PBI-JKN will use the Unified Database, which will have a complete ranking of the poorest 40 percent of households in Indonesia, to receive a list (with name and address) of eligible beneficiaries to be contacted and verified.[63] All members from eligible households are considered JKN-PBI members. In the Jamkesmas program however, though an initial quota was generated by querying a household list containing some socio-economic and demographic information, those given Jamkesmas cards were locally identified by locally-based Ministry of Health staff, service provider staff, and local government. When the number of locally-identified households exceeded the Jamkesmas quota, the remaining households would be encouraged to enroll in Jamkesda, if available (World Bank, 2013d). New eligibility cards, part of the "Developing Productive Families" initiative, will be issued (eventually) to all JKN-PBI beneficiaries (see Box 2.4).

While JKN-PBI offers essentially the same comprehensive benefits package as Jamkesmas, it is considered more generous and inclusive than that of the civil servants (previously Askes, a program now renamed and absorbed within BPJS Kesehatan management of JKN) and formal sector health insurance programs (previously Jamsostek, now absorbed within BPJS Ketenagakerjaan). In the JKN-PBI initiative, JKN premiums are fully covered by the Government; public providers and some private hospitals can provide services; there will be no co-payment, co-insurance, extra-billing or balance-billing allowed; and there are no limits on benefits provided to beneficiaries (including prescribed pharmaceuticals). The supply-side constraints that effectively limited Jamkesmas benefits, however, will not necessarily be addressed by the JKN-PBI program, so JKN-PBI's generous benefits on paper may be of less value in the field (World Bank, 2013d).

FIGURE 2.17

Flow of funds for JKN–PBI



BOX 2.4

Developing Productive Families, Kartu Indonesia Sehat (KIS)

The KIS as part of the new SA scheme introduced by the Government provides a fee waiver for first level healthcare costs and was initiated to help establish comprehensive health insurance.

Coverage and eligibility

By late 2014, 4.6 million KIS cards were sent to individuals in the one million poor households targeted in the first phase of implementation. The KIS card was meant to be given to over 92 million PBI recipients in 2016. Once registered at a public primary health facility, the KIS provides the user with a fee waiver for first level healthcare services, including preventative care and early detection.[64] Targeting is, as Jamkesmas was, also achieved through the UDB, now provided via MoSA. Individuals that live in households considered to be in the poorest 40 percent are eligible to receive the KIS card. Households that do not have the KIS card yet continue to use their Badan Penyelenggara Jaminan Sosial (BPJS) Health card to access health care at a subsidized price (TNP2K, 2014k; collected news stories).

Program flow and Benefit structure

Just like the KKS, the KIS card was sent to the targeted household via the national post office (PT. Pos). Users make use of the card as shown below. The KIS card taps into an existing health insurance network called the Jaminan Kesehatan Nasional (JKN) which provides the recipient with health insurance for the monthly premium of 23,000 IDR (US$1.70) per person. BPJS Kesehatan manages the card and its implementation while the budget comes from the JKN-PBI budget.

Dissemination of information materials

Dissemination of KKS/KSKS, KIP and KIS program information to all stakeholders is managed by BPJS Kesehatan with the help of the Ministry of Information. In 2014, support was provided by TNP2K as well. For instance, in 2014, 20,000 posters had been set up in strategic locations across 500 villages in 19 districts within 9 provinces. Town hall meetings had been held and 30 radio stations and 10 local TV stations had facilitated media campaigns.

Source: TNP2K, 2014k and local media reports.

[62] In other words, the grants and negotiated claims payments did not fully cover the costs of the services at the amounts demanded of those services by Jamkesmas-card-holding households.
[63] The UDB used to be managed by TNP2K but is officially managed by MoSA since 2017.
[64] KIS card holders / PBI-JKN recipients are entitled to fee waivers for any costs incurred at health centers and are entitled to the whole range of possible referrals from public health centers that are registered with BPJS Health.

COVERAGE, TARGETING, & IMPACTS

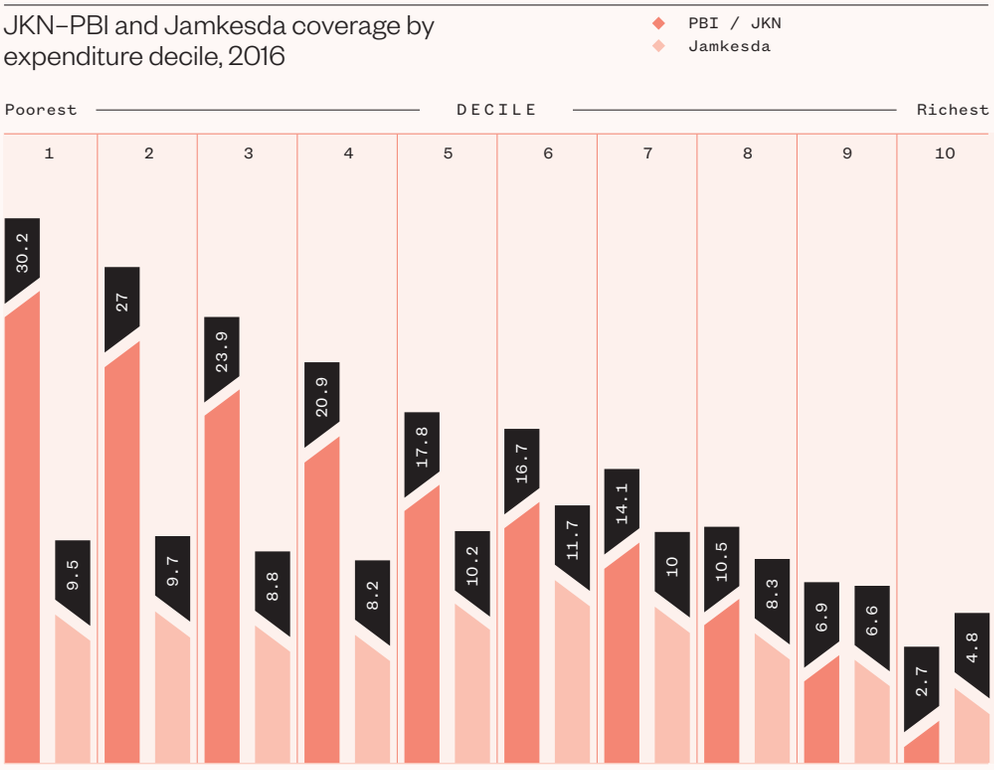
JKN-PBI coverage reached 88 million people in 2015, while expanding to over 92 million people in 2016. In 2014, about 7 percent of these JKN-PBI beneficiaries "transferred" from the locally-run health insurance programs, Jamkesda, as well as the PJKMU (TNP2K, 2014c), since then more recipients of old programs now phased out have become absorbed within JKN managed by BPJS Kesehatan. Figure 2.18 shows program coverage by decile for PBI and Jamkesda as of 2016. PBI coverage in the first decile is relatively low, at 30 percent, while coverage in the richer deciles is also significant: 18 percent of households in the fifth decile are covered by PBI.[65] Jamkesda has low coverage for most deciles, but a considerable increase in coverage can be seen between the 5th and 8th deciles

The transformed and expanded JKN-PBI allowed the program to provide more benefits to poor and near-poor households. In order to facilitate comparisons between JKN-PBI and other social assistance transfers (which may have slightly different target groups), Figure 2.19 shows coverage and incidence for the "Poor", the "Next 30" percent, and "The rest" for PBI recipients only. The figure demonstrates that while the poverty headcount rate fell by less than 1 percentage point between 2012 and 2016, the share of PBI benefits accounted for by the "Poor" (incidence) group grew only slightly by 2 percentage points; the "Next 30" group, which contains the same proportion of near-poor households in every year, saw a similar increase in its PBI share. All the while, "The rest" has fallen by 4 percentage points. Together, this

[65] Household coverage discussed here and as measured in the Susenas survey may differ from official estimates of the number of cards distributed for at least three reasons: (i) Susenas survey weights may not reflect the correct probability of contacting a JKN-PBI receiving household; (ii) households themselves may be KIS cardholders but mistakenly report coverage by Jamkesda (or any other scheme) or may think they are covered even though they are not cardholders; and (iii) not all distributed cards have actually reached beneficiary households.

FIGURE 2.18

JKN–PBI and Jamkesda coverage by expenditure decile, 2016



Source: Susenas 2016 and World Bank staff calculations.

FIGURE 2.19

JKN-PBI coverage and incidence by poverty groups

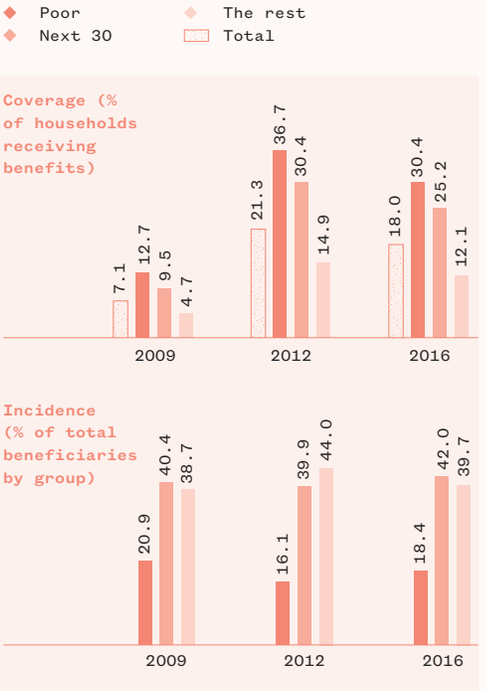


TABLE 2.5

JKN–PBI coverage and incidence by poverty groups

	% of all Indonesians who:	% poor population who:	% of PBI recipients who
Do not have access to bottled, tap or well water	16	28	21
Do not have access to private sanitation	22	41	34
Live in rural areas	49	63	58
Live with more than 5 household members	22	38	26
Have not completed primary education	9	13	14
Are illiterate	7	13	10
Work in the agriculture sector	33	56	44

Source: Susenas 2016 and World Bank staff calculations. 'Work in…' refers to share of working individuals, not all Indonesians.

pattern indicates that as the micro-level poverty situation changes—many households exit poverty year to year, while fewer enter—PBI's merger with JKN and implementation revisions have allowed it to continue to find, albeit at a slower pace, the remaining eligible poor and near-poor households.

On average, JKN-PBI household exhibit correlates of income poverty. JKN-PBI overall coverage (in the 2016 Susenas) at about 18 percent of households, is close to triple the 2009 level. These additional PBI benefit funds have on average been to households with most of the non-income correlates of poverty (Table 2.5).

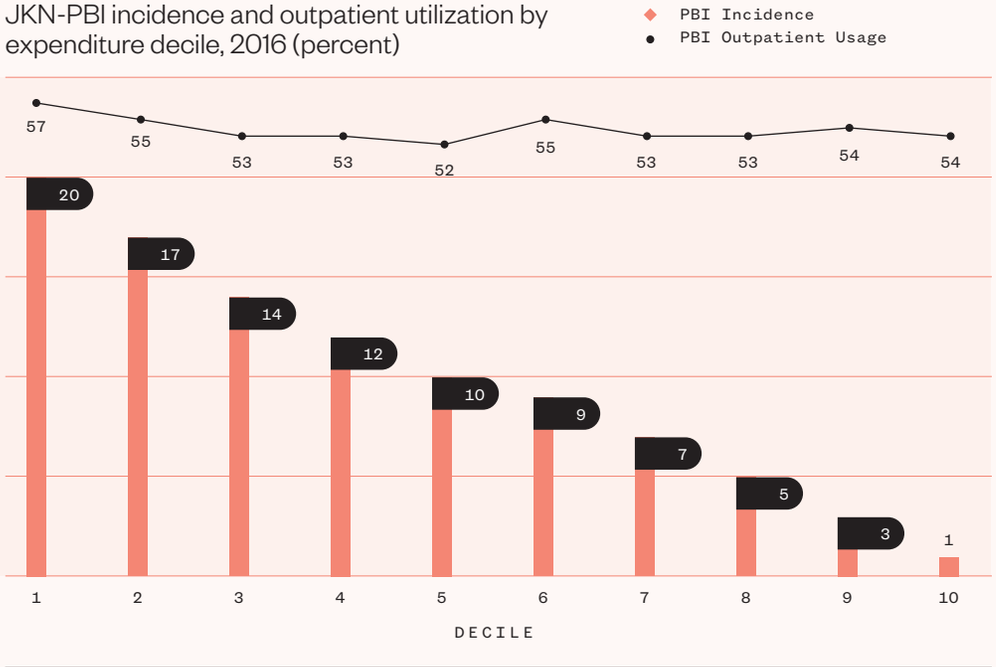
The switch to UDB-based targeting has delivered a larger share of benefits to poor and near-poor households. Previous analyses of Jamkesmas targeting found that it did not efficiently distribute benefits to its target population (TNP2K, 2014c; World Bank, 2013d; TNP2K, 2013). Figure 2.20 illustrates that, by 2016, JKN-PBI benefits are concentrated in the lowest deciles: the bottom 30 percent of households contains just over half of the JKN-PBI beneficiaries. However, leakage to the non-poor is still evident, with 37 percent of the JKN-PBI benefits going to the top 60 percent of the households. Figure 2.20 also summarizes outpatient usage rates (for those with certain PBI coverage): outpatient usage rates in the richest decile of households are generally the same across all deciles, indicating that it may be difficult to eliminate leakage entirely when the benefit package available is of such high value.

Healthcare utilization is growing for PBI beneficiaries at a rate similar to those who are beneficiaries of other insurance programs (Figure 2.21). For example, outpatient utilization rates have grown by about 3 percentage points in between 2012 and 2016 for Jamkesmas/JKN-PBI beneficiaries; and by about 2 percentage points for those without formal health insurance. Inpatient rates have grown also by about 2 percentage points for JKN-PBI/Jamkesmas beneficiaries; and by about 1.5 percentage points for those without formal health insurance.

Both private outpatient clinics and public hospitals have accounted for most of the increase in PBI-facilitated utilization. For those with no insurance, private outpatient clinics, and private and public hospitals (in similar amounts) account for the increase in their utilization rates. As the increases in utilization (for PBI recipients at least) do not come disproportionately from either poor or rich households, the preference for private outpatient facilities among PBI members, and those with no insurance, suggests that the differences in total household costs between service-provider types (see below) do not outweigh the perceived differences in quality.

FIGURE 2.20

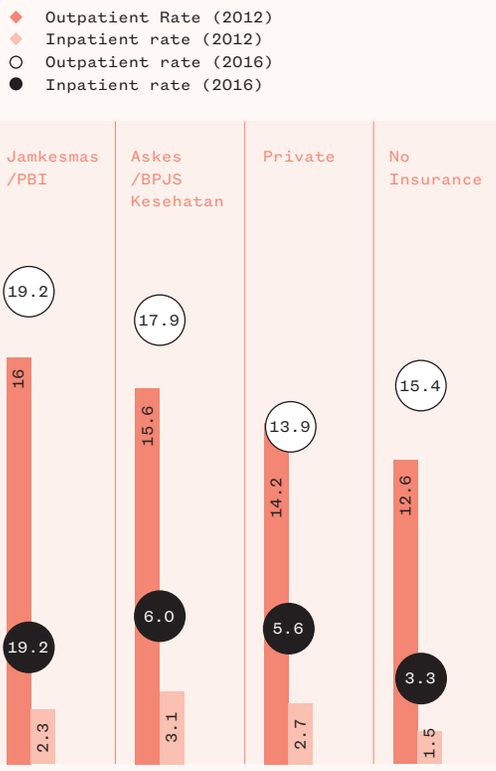
JKN-PBI incidence and outpatient utilization by expenditure decile, 2016 (percent)



Source: Susenas 2016 and World Bank staff calculations.

FIGURE 2.21

Rates of utilization by insurance type (percent)



Source Susenas various years and World Bank staff calculations.

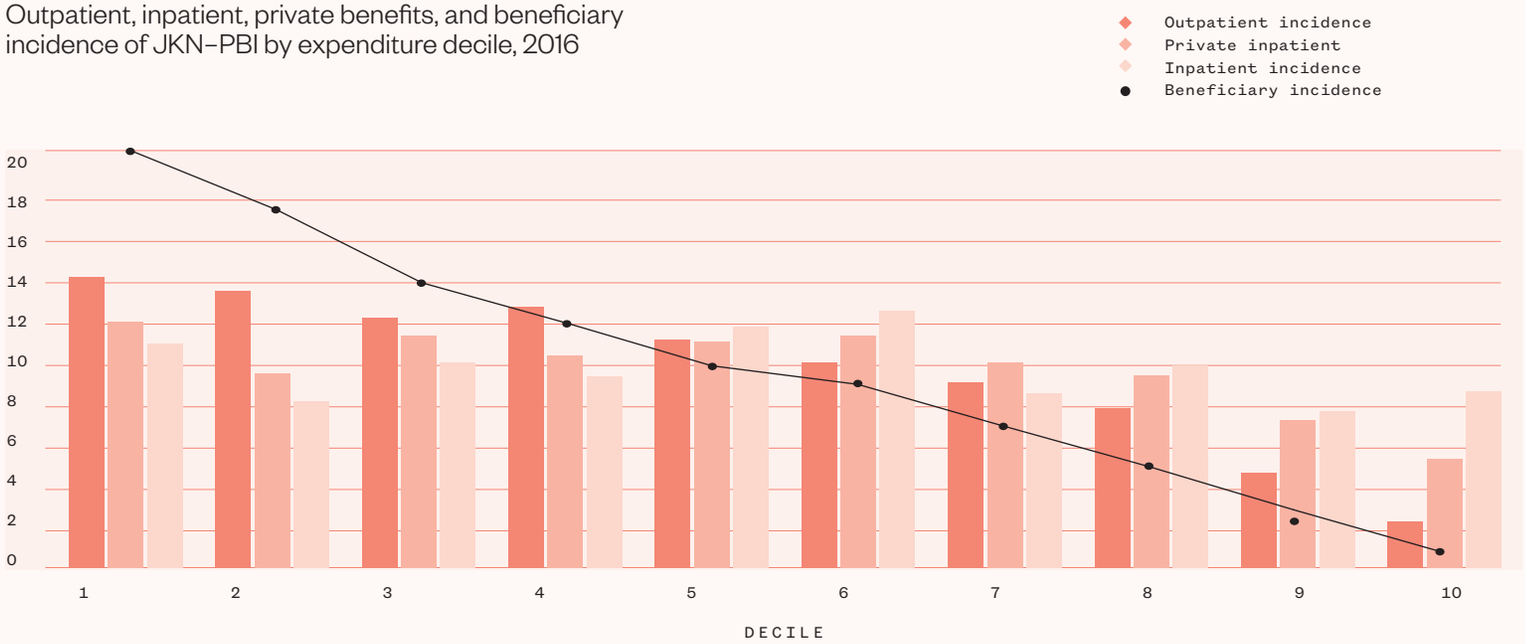
ACCESSIBILITY

Poorer households with PBI do not visit providers—especially high-value inpatient providers—frequently enough to give them a disproportionate share of benefits available. Reviewing the previous trends: Figure 2.20 shows that most PBI beneficiaries are concentrated in poorer households and that PBI use is roughly constant regardless of income level and Figure 2.21 shows that PBI households in general have seen increases in healthcare utilization rates. Yet, Figure 2.22 below shows that PBI benefits—acquisition of healthcare services at a healthcare provider—are generally not concentrated among poorer households. For example, while the bottom 30 percent of the population accounts for just over 50 percent of the PBI beneficiaries, the same bottom 30 percent accounts for only 32, 26, and 12 percent of all outpatient, all inpatient, or private-facility inpatient utilization, respectively, accounted for by PBI recipients or KIS cardholders.

The variation in access and quality (private vs public) for poor and vulnerable households indicates an interplay of various factors. In other words, high quality services may not be available for poorer segments of the population lowering the value of PBI-based access to health care. Based on demographic and household characteristics alone, poorer households would be expected to prefer more health care than richer households (World Bank, 2013d). Nonetheless, the richest

FIGURE 2.22

Outpatient, inpatient, private benefits, and beneficiary incidence of JKN–PBI by expenditure decile, 2016



The value of PBI is not uniform; it is proportional to the extent & quality of the services actually available.

households represented in the Susenas survey in 2016 have outpatient, inpatient, and private-facility inpatient utilization rates that are in the range of 22, 131, and 610 percent higher than the poorest households.[66]

Circumstantial evidence indicates that cost of access is a constraint: those provinces where the difference in the amount of private-facility outpatient care acquired by rich and poor households is greatest—mostly provinces in remote eastern Indonesia—is also where the total amount of outpatient care acquired by poor households is lowest. In other words, in those areas where private-facility care is too costly for low-income individuals to access, public facilities are either not providing a low-cost alternative, or they are providing a low-quality alternative that low-income households do not value. In addition, transportation and opportunity cost of travelling also contribute to the cost of access.

The value of PBI is not standardized; it is proportional to the extent and quality of the services actually available. The variability in health facility coverage and costs means, in essence, that the value of an in-kind PBI transfer received by two similarly-aged individuals with similar health status may be quite different depending on the service environment in which they are located. So there are pre-existing location-based and supply-system-based constraints on poor household access to a full PBI benefit package. While these constraints are not unique to, or produced by, JKN-PBI it nonetheless suggests that an in-kind health transfer to poor households should logically coordinate its activities and share its goals with service providers (a la PKH; see the PKH volume in this report series).

Regular PBI M&E has catalogued disbursement and utilization rates. However, it does not explicitly monitor or target health or financial protection outcomes among beneficiaries. The information collected and discussed during a regular M&E cycle has been used in premium calculations and to remove congestion in the payment and re-imbursement mechanisms.[67] It was not used to revise healthcare delivery mechanisms to ensure qualitative improvements in health outcomes in PBI-targeted households.

The UDB system provides the only direct access to JKN-PBI for potential or actual beneficiaries. Most preparatory implementation activity to date has focused on accomplishing a JKN program roll-out with regional governments.[68] Currently and in the short to medium term, local governments play no role in proposing additions or revisions to the beneficiary list, as this is done centrally via the UDB. While regional governments have been tasked with "socialization" of the JKN program, and they have agreed to deliver program information specifically to JKN-PBI members, the only currently operational grievance and redress system is the UDB-centered system, which currently does not allow for dynamic updating of potential beneficiary data. In addition, this system is not capable of responding to claims about, for example, denial of service (including through long waiting times), low quality service, lack of service, erroneous or disallowed charges, and any other facility- or supply-side-based deficiencies that reduce the value of benefits received.

[66] If instead one first calculates average days of outpatient utilization (in the past month) by decile and by province and takes a 33-province average of the difference in province-average outpatient days between richest- and poorest-decile households, the richest households represented in Susenas 2016 outpace the poorest households by only 8 percent. There is even one province – DKI Jakarta – where the poorest households acquired nearly twice the number of outpatient days (in the past month) as the richest households.

[67] For example, in 2011, the Ministry of Health and TNP2K developed a model and guideline to calculate the premium for Jamkesmas members. However, the JKN-PBI program administrator has calculated their own premium and cost structure for JKN members.

[68] For example, there have been general agreements regarding health infrastructure, human capital, and public health awareness campaigning.

CHALLENGES, RECOMMENDATIONS & MOVING FORWARD

JKN-PBI should continue to reduce the mis-targeting that has made it less effective as a social assistance transfer. A large portion of previous mis-targeting has been due to the significant local variation in eligibility determination and targeting practices (World Bank, 2013d).[69] Now, JKN-PBI members will be selected according to the national targeting systems and procedures, so an emerging risk (for potential beneficiaries) is that the "central versus local" targeting pendulum swings too far in the other direction: if there is no two-way updating to the JKN-PBI list or no UDB system that can receive and act on updates from the field, the lack of local-level information may produce a distribution of JKN-PBI beneficiaries that is unsatisfactory from a local-level perspective. In order to mitigate this risk, JKN-PBI should develop a robust grievance and reporting system that runs in parallel to a UDB-based grievance reporting system.

M&E systems for JKN-PBI should be upgraded to monitor membership, health, healthcare usage, financial protection and cost issues (from the household side), and supply-side preparedness indicators and outcomes. Currently, the supply side is a weak link in the JKN-PBI transfer program: there is significant variability, which is usually but not always correlated with geographical location, in the availability and quality of healthcare services. While it is not JKN-PBI's responsibility to achieve meaningful reform in health care availability, quality, and delivery, it should at least explicitly recognize that the more mutual assistance and support there is between program administrators and providers, the more valuable the transfer will be to low-income beneficiaries.

JKN-PBI should monitor and attempt to remedy the unexpected[70] disparities in "benefit uptake", or the acquisition of facility-based health care, between poor and non-poor households. To reduce these disparities, JKN-PBI will need to do a much better job of explaining to beneficiary households how to use the benefits for which they are eligible. JKN-PBI households, for example, did not know which treatments, procedures, providers, and medicines were covered and which were excluded. This information gap naturally reduced utilization rates (at the margin) and therefore the value of the PBI program (World Bank, 2012). While disparities in utilization are determined by factors other than information sets, such as the total cost of access to health care services of sufficient quality, establishing common information standards for JKN-PBI and verifying that the standard has been reached for all households should contribute to an increase in the value of the JKN-PBI benefit for poor households.

While the goal of JKN is to increase access to, and the quality of, health services while prioritizing equity, many challenges lie ahead. Before 2014,[71] organization, payment and the health service system in general were fragmented. The involvement of hospital associations, medical professionals and academics will be a critical part of achieving Universal Health Coverage by 2019. The plan to reach full population coverage via JKN by 2019 will require a not only a tremendous increase in spending on health care, but also judicious planning for allocating spending optimally. Integrating existing health insurance schemes at national, as well as local, level will prove a great challenge in the short term and requires continuous monitoring and evaluation (TNP2K, 2015c).

[69] For example, the criteria summarizing household characteristics varied across districts; in some districts, midwives and health center officials distributed Jamkesmas cards according to their own criteria, regardless of economic status; there were no incentives in the system to either maximize Jamkesmas enrolment or minimize targeting errors while the list of eligible beneficiaries compiled by district officials was not subject to validation by higher levels of program administrators.
[70] and household composition alone would predict a higher rate of utilization for poor households.
[71] OPP payments are above average from a regional perspective.

Given the great variation among districts in Indonesia, M&E will be paramount in achieving Universal Health Coverage. Based on study by TNP2K published in 2014, reaching UHC by 2019 most efficiently will require at least (TNP2K, 2015c):

01.
Stocktaking of the distribution and needs of public and private health facilities;

02.
Promoting preventative medicines through population-wide interventions;

03.
Raising accountability through monitoring and evaluation;

04.
Strengthening the DJSN (National Social Security Council) as the M&E institution for SJSN implementation;

05.
Adapting existing systems and practices to encourage village authorities to invest in priority health issues;

06.
Developing a master plan to integrate the public and private health sectors;

07.
Synchronizing the provision of government health funding with this plan;

08.
Increasing public sector financing of health care through qualified investment strategies that promote supply-side readiness; and

09.
Assessing payment structures and fund disbursement in coordination with government health priorities at multiple levels.

Premiums and payments should be calculated scientifically in order to encourage healthcare use, not to discourage the provision of services. For example, in July 2013, the premium for poor members (PBI) was calculated at IDR 19,225 per capita per month—a huge increase from the previously calculated IDR 6,000 per capita per month "premium". As of 2017, the premium paid by the Government for PBI recipients is IDR 23,000. Likewise, JKN administrators have demonstrated concern with health facility quality improvement through the establishment of capitation grants and the generation of rules regarding the rational management and use of these grants.[72] Furthermore, the information generated by JKN-PBI M&E cycle now feeds into PBI premium calculations, as well as rationalization of reimbursement and claims payment procedures.

[72] The capitation grant is a monthly amount paid in advance to the Primary Health Care Facilities (FKTP) based on the number of beneficiaries regardless the type and amount of medical services provided (Presidential Regulation No. 32/2014 on the Management and Use of Capitation Grants for Quality Improvement in Front Line Services).

Cash Transfer for Poor & At-risk Students (PIP)

*With a major expansion in coverage coupled with significant reforms to implementation—including to targeting, eligibility volatility, benefit size, and payment schedule—PIP, previously known as BSM (*Bantuan Siswa Miskin*), has begun to demonstrate its full potential as a social assistance transfer. In order to deliver more, PIP should focus on continuous and coordinated monitoring, evaluation, and improvements in delivery. Most importantly, benefit-level updating should occur more frequently in order for the PIP transfer to remain relevant; PIP should consider positive outreach to poor students at the SMA level as they face the highest out-of-pocket-spending and opportunity costs, and are at the greatest risk of non-continuation; and PIP should find ways to pursue integration in program functions such as socialization, M&E, policy-setting, and grievance redress.*

2.4

OVERVIEW

Indonesia enshrines education as a basic right for all citizens. From shortly after independence, the GoI has been devoting resources to initiatives for expanding enrolment in primary, secondary, and tertiary education for all citizens. In 1970, the gross primary enrolment rate was under 70 percent; by 1994, when a mandatory 9-year basic education was enshrined, universal primary enrolment was the norm; by 2016, gross junior secondary enrolment rates were topping 90 percent. Enrolment in tertiary education has risen from about 2,000 students in 1945 to around 5.7 million in 2016.

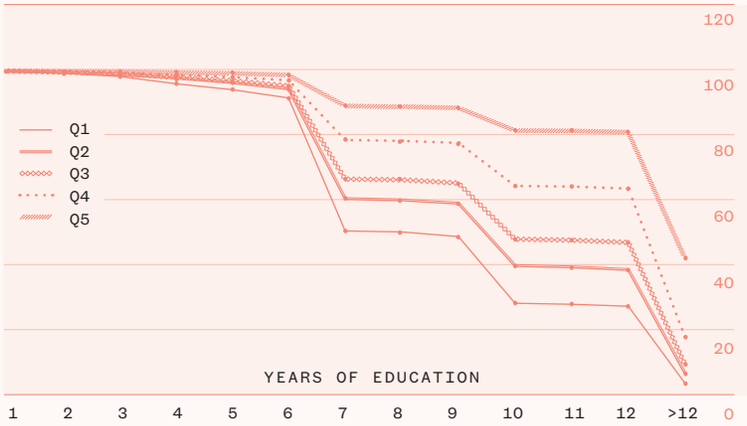
But while average levels of education are steadily rising, students from poor households remain far behind. In 2016, 94 percent of 26 to 28 year olds[73] from all income levels attained at a primary level, 6-year education. However, 90 percent of the poorest 26 to 28 year olds attained a complete, 6-year primary education (while for those from the richest households the proportion remained at almost 100 percent). Even a single year of post-primary education is out of reach for many children from poor households: attainment rates of at least a 7th-grade education drop to 51 percent for those in the poorest households (while the number for those in the richest households is about 90 percent). Achievement gaps at the senior secondary level are larger: 2016 attainment rates of at least 10th-grade education are 50 percentage points lower in the poorest than in the richest households.[74] While the primary school net enrolment rate has been comfortably over 90 percent since the early 2000s, these good starts do not lead to high educational achievement for poor households. Students from poorer households drop out in large numbers during the transitions from primary school to junior secondary school and from junior to secondary school (Figure 2.23).

…while average levels of education are steadily rising, students from poor households remain far behind.

[73] The majority of individuals in this cohort are expected to have finished their educational careers; in other words, their attainment as recorded in the Susenas household survey is expected to be their lifetime educational achievement. Younger cohorts are still enrolled in significant numbers, while older cohorts progressed through an education system that differed in important ways from the current system.
[74] In 2010, attainment rates of at least 7 years of education were 44 and 90 percent for 26 to 28 years olds in the poorest and richest quintiles, respectively, while the 2010 rate of achievement of at least 10 years of education was 50 percentage points higher in the richest quintile than in the poorest quintile.

FIGURE 2.23

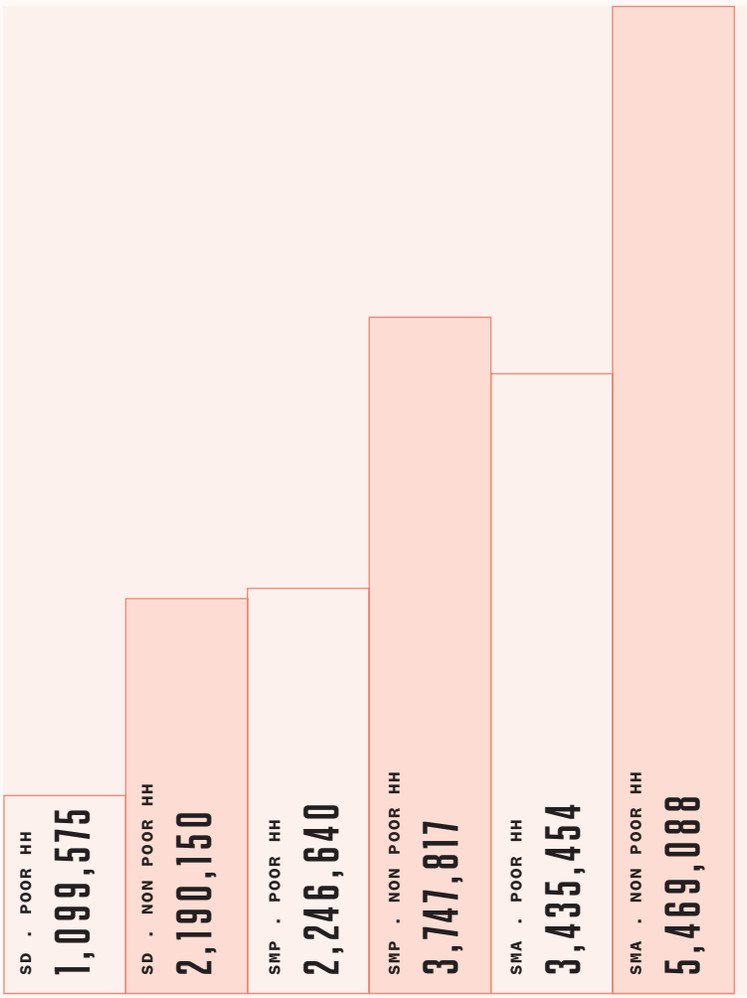
Educational attainment, 26–28 year olds by consumption quintile, 2016 (percent)



Source: Susenas 2016 and World Bank staff calculations.

FIGURE 2.24

Household education expenditures per student, by school level, 2015 (IDR Million)



Source Susenas 2015 and World Bank staff calculations.
Note Average transportation costs are calculated over households who indicate use of public or collective transport.

1,000,000 TO MORE THAN 3,000,000

"…enrolling a student is costly: out-of-pocket costs (including transportation) range from around IDR 1 million to over IDR 3 million (US$77 to US$230) (depending on school level), with poorer households paying slightly less and richer households slightly more."

A key constraint for poor households is the financial cost of access. Figure 2.24 below shows that enrolling a student is costly: out-of-pocket costs (including transportation) range from around IDR 1 million to over IDR 3 million (US$77 to US$230) (depending on school level), with poorer households paying slightly less and richer households slightly more. Secondary education (SMU (*Sekolah Menegah Umum*), or SMA (*Sekolah Menegah Atas)* and SMK ((*Sekolah Menegah Kejuruan)*) can be prohibitively expensive for the poorest households: regular costs to send one child to senior secondary school consume about 18 percent of a poor household's overall budget. For poor households, the opportunity costs of education—incurred as foregone income when a child attends school instead of working—will be relatively larger also, making secondary education doubly expensive.[75]

Registration and other school fees such as tuition and school committee fees make up the bulk of these education expenditures, but quasi-discretionary items such as uniforms, books, and supplies also account for significant shares, especially at the primary school level. Notwithstanding sizeable government funding streams such as BOS (Bantuan Operasional Sekolah)[76] and 2008 legislation prohibiting fees at public education institutions, the total cost of education has risen between 2009 and 2012: average household education expenditures (not including transport) have risen by about 13, 19, and 15 percent at the primary, junior secondary, and senior secondary levels, respectively.[77]

Program Indonesia Pintar **(PIP) lowers the net cost of access to education by providing cash transfers directly to poor students.** Students from poor households who are verified to be eligible by their school[78] are provided annual cash transfers of IDR 450,000 (US$35), IDR 750,000 (US$58), or IDR 1 million (US$77) for enrolment costs at the primary, junior secondary, and senior secondary level, respectively. By lowering the enrolment cost hurdle in a targeted way, the GoI hopes to tackle the low enrolment rates and high dropout probabilities of poor students, and eliminate the education gap (World Bank, 2012h). PIP also helps the GoI meet its constitutional guarantees by providing incentives for all children to complete at least a 9-year basic education.

[75] Costs reported in Susenas are considered official payments. There are no qualitative studies investigating informal payments or elite capture. However, the presence of categories such as 'fees for courses' and 'others' that fall outside of the official fees category show why real costs for school are markedly higher than official estimates.
[76] *Bantuan Operasi Sekolah*, or School Operational Aid.
[77] Expenditures on university level education have increased by over 60 percent in nominal terms between 2009 and 2012.
[78] The role of schools, school committees, and local education stakeholders in selecting beneficiaries was revised somewhat when the PIP program agreed to use UDB procedures for preliminary identification of PIP-eligible students.

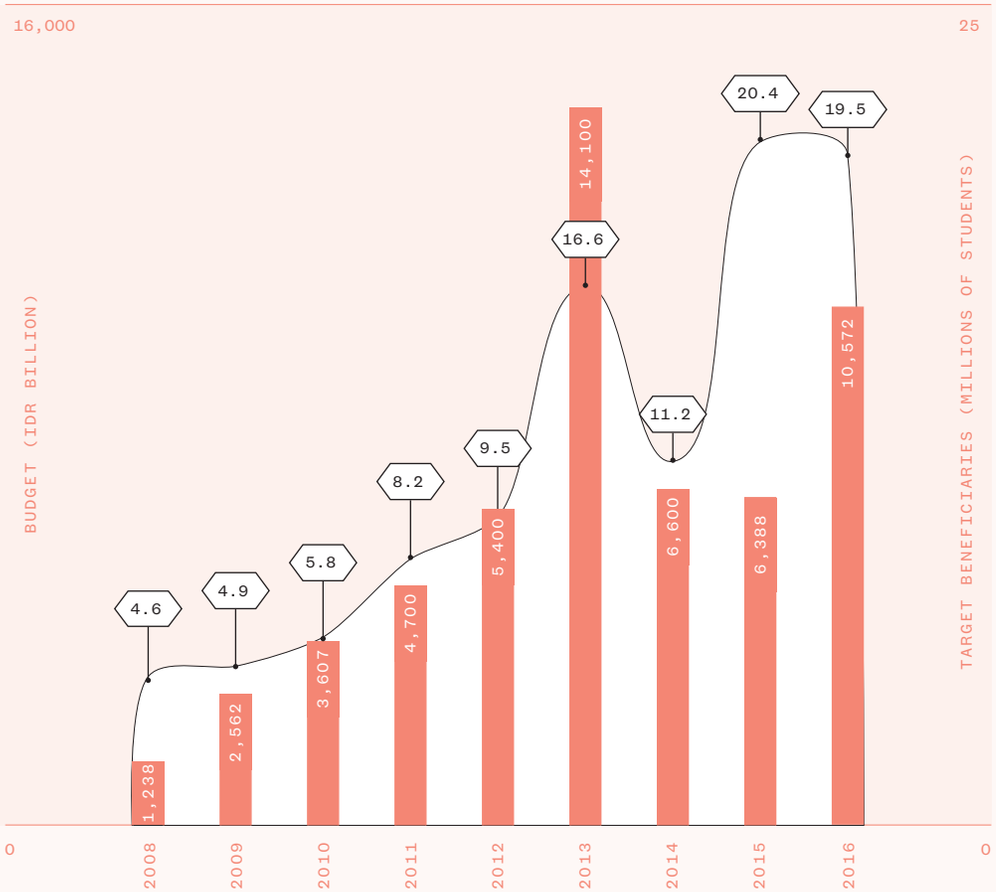
PROGRAM SIZE, INSTITUTIONAL SET-UP, ELIGIBILITY, & BENEFITS

PIP has expanded every year; from 2012, the pace of expansion has picked up dramatically (Figure 2.25). In the year it began operations (2008), Program *Bantuan Siswa Miskin* (BSM) achieved an expenditure level just over one-fifth of the size of the then-largest program, the rice subsidy program known as *Beras Sejahtera* or simply Rastra (see the Rastra program note in this series).[79] in 2016 PIP reached about 19.5 million students while expenditures reached IDR 10.5 trillion, or over 8 times the 2008 level. While PIP is still only the third-largest (in terms of expenditure or coverage) of the permanent social assistance programs, its average share of the social assistance budget has increased from 9 percent in 2005-10 to 14 percent in 2016 (see the Expenditure Summary report in this series).[80]

PIP is a national-coverage cash transfer given to enrolled students or school-age children from the poorest 25 percent of households, who have either a Kartu Indonesia Pintar (KIP) card or a Kartu Perlindungan Sosial / Kartu Keluarga Sejahtera (KPS / KKS) card (see Box 2.5). [81] In 2016, PIP targeted 19.5 million enrolled students between 6 and 21 years of age. Beneficiaries of other social assistance programs—for example, the conditional cash transfer called PKH—are automatically PIP-eligible. PIP provides transfers to students in any school level from primary (Sekolah Dasar, or SD) to secondary (both junior secondary or equivalent, SMP, and senior secondary or equivalent, SMA).[82] The two ministries responsible for education in Indonesia, the Ministry of Education and Culture (MoEC) and the Ministry of Religious Affairs (MoRA), both deliver a PIP program for students in regular and madrasah schools, respectively.[83] Major changes involved in moving to PIP from BSM are that school children not yet receiving PIP in either formal or non-formal education institutions, or those who are not attending school, can reach out and register for PIP cash transfer provided their family has a KPS/KKS card. The BSM program targeted children that were already attending school and were listed in the UDB as poor or vulnerable. With PIP, there are more mechanisms (most are linked the social protection cards KPS and KKS) that allow students to become enrolled in PIP, the aim being to get out-of-school children back to school and to increase take-up rates (TNP2K, 2016).

FIGURE 2.25

PIP targeted coverage and budget by year



Source MoF 2008-14 are budgeted totals, 2015 is realised and 2016 are realised budget.

[79] Rastra was the largest of the permanent social assistance programs in 2008, but there was also a temporary cash transfer, called BLT, in that year; see the BLSM report in this series for more information on these temporary (i.e., non-repeating) cash transfers.
[80] In 2014 one of BSM implementing agencies, the Ministry of Education and Culture, re-directed discretionary expenditures (including BSM expenditures) to curriculum reform and the BSM budget was reduced considerably. It is unknown what happened to the bulk of BSM beneficiaries whose benefits were cut in between the 2013 and 2014 fiscal years.
[81] World Bank (2014d). From 2014 onwards, PIP will encompass the Kartu Indonesia Pintar (KIP) program as well. KIP targets school-age children who are currently not enrolled or who are enrolled in training courses that are not part of Indonesia's mandatory 9-year curriculum.
[82] SMA is used here to refer to senior high school but when referring to Susenas data, vocational school level, SMK, is also included.
[83] In 2016, MoEC manages approximately 92 and MoRA 8 percent of all primary, secondary, and technical school scholarships (according to program administration documents)

The major changes when moving from BSM to PIP are related to eligibility criteria: school children not yet receiving PIP in either formal or non-formal education institutions, or those who are not attending school, can reach out and register for PIP cash transfer provided their family has a KPS/KKS card.

BOX 2.5
Developing Productive Families, *Kartu Indonesia Pintar* (KIP)

Program Indonesia Pintar (PIP) and the associated *Kartu Indonesia Pintar* (KIP) are managed by the Ministry of Education and Culture and the Ministry of Religion. PIP, or KIP, are part of the new scheme for SA implemented by Indonesia's current Government. The goal of PIP is ensure children of schooling age in poor and vulnerable households complete high school. This, through providing access to cash transfers to cover the out-of-pocket costs of attending school.

Coverage & eligibility

Since 2014, the Government has started to distributed KIP cards to replace KPS cards as the primary means of proving program eligibility. Distribution was done through three phases. The first phase was to be conducted on March-April 2015, the second phase was to be conducted on June-August 2015.For the third phase, in 2016, 19.5 million cards were distributed by MoEC and MoRA to PIP recipients.

Overall eligibility for KIP as of 2016 is for school aged children, 6 to 21 years of age: in KPS card holding families that were receiving BSM in 2014, KPS/KKS holders who are not yet receiving PIP benefits, in PKH families, living in orphanages, that have dropped out of school due economic difficulties or natural disasters and those that are not yet going to school or dropped out based on recapitulated data as of the second semester of 2015 (TNP2K, 2016).

Program flow and benefit structure

Eligible households are sent the card (along with the other cards listed above) via two banks. Using the existing PIP program, card holders are entitled to receive benefits as shown below the diagram. While in the future, KIP benefits are planned to be disbursed by both banks and post offices, the payment delivery structure appears to be using the same method as the older BSM program: upon confirmation at the school of registration, funds are released in cash at

EDUCATION LEVEL	PRE 2013 PIP BENEFIT PER STUDENT PER SEMESTER	REVISED 2013 AND CURRENT PIP BENEFIT PER STUDENT PER SEMESTER
SD (primary)	IDR 190,000 (US$15)	IDR 225,000 (US$18)
SMP (junior high)	IDR 275,000 (US$22)	IDR 375,000 (US$30)
SMU (senior high)	IDR 375,000 (US$30)	IDR 500,000 (US$40)

Source: TNP2K, 2014k and local media reports.

The PIP program continues to operate as several largely independent initiatives in two separate ministries, with neither a central coordinating unit nor a unified budget. Within the MoEC, PIP budgets and administration are managed and implemented separately by the separate directorates corresponding to school levels. Within the MoRA, the program is fragmented by the type of religious school: primary to senior high cash transfers are administered by the Secretariat General with a majority of resources allocated to Muslim schools and a smaller share for each of the remaining official religions (Christian, Catholic, Hindu and Buddhist). The scholarship program for students at the tertiary/university level has been renamed *Bidik Misi* and is managed and implemented by the Ministry of Research, Technology, and Higher Education, separate from PIP.

PIP is allocated using the Unified Database (UDB). [84] After the UDB is queried and returns a list of students from the poorest 25 percent of households, KPS or KIP cards were distributed to households (via a delivery specialized firm. Registration to PIP differs by several categories, whether the school is under the MoEC or the MoRA, whether the school is formal or not, whether the student has a KIP card or not and whether the family has a KKS or KPS card. In general, eligible students (or their parents or guardians) take their KIP, KKS or KPS identification and register with a school in order to access PIP (World Bank, 2014d). Upon completing these registrations and also adding school-identified PIP beneficiaries not on the officially-eligible list, the schools send a proposed PIP registry to a District Management Team for verification. All district-level teams then forward the registries to the PIP Central Management Team.[85]

Payment disbursement and final PIP nomination is announced by the MoEC and MoRA, via a decree and recipient lists sent to district level education offices and to payment institutions BNI and BRI banks under MoEC and MoRA management since 2013.). Then, recipient lists and disbursement times and locations are sent to schools directly from the district education offices. The schools then notify the students or parents about the time and location of their PIP benefit disbursement. Since PIP uptake depends on students bringing their KIP, KKS or KPS to school, since not all targeted students may make use of PIP, schools and local education officials may nominate PIP students not on the UDB-generated list only if the PIP quota for the district is not filled yet. The criteria for nomination are meant to include school-aged children (6-21) having characteristics such as living in a PKH family; having a higher risk of non-continuation because of financial difficulty; living in an orphanage; being a victim of a natural disaster; and those that are no longer going to school. (TNP2K, 2016)[86]

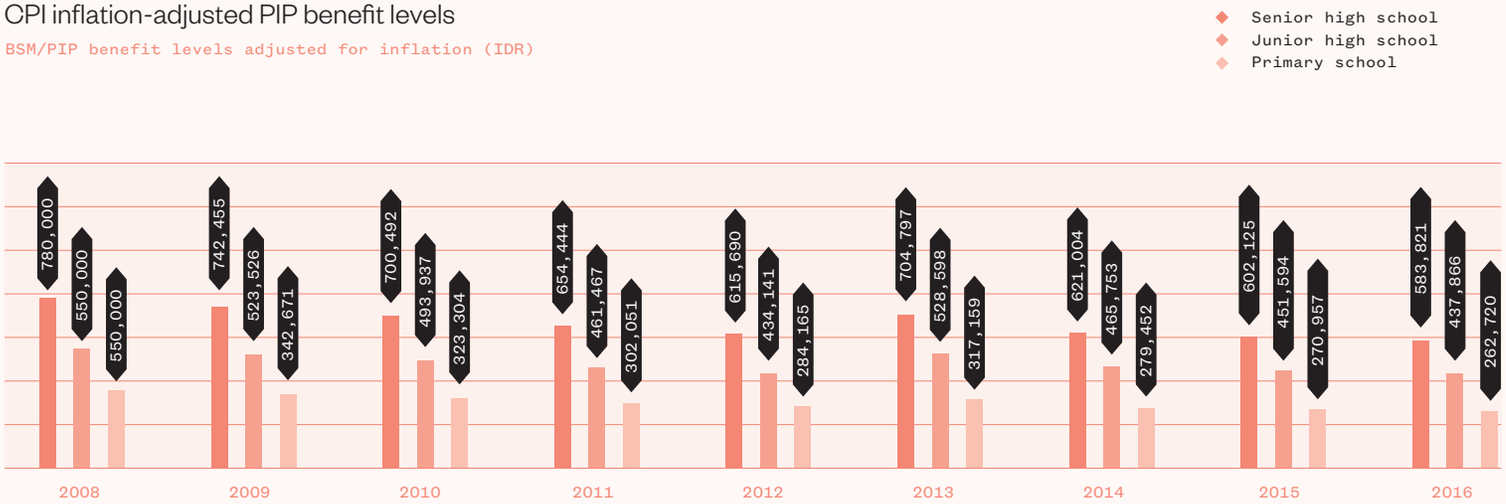
PIP benefits were raised slightly (Figure 2.26) but a large gap remains between the PIP value and the total out-of-pocket cost for households. According to official estimates, the costs for one child to attend a full year of school (including transportation, food, uniforms and materials, and most of the other items listed before) are IDR 450,000 (US$35) for primary, IDR 750,000 (US$58) for junior secondary, IDR 1 million (US$77) for senior secondary school; and IDR 1.8 million (US$138) for university students (TNP2K, 2016). However, households report greater expenditures (in 2012) at about IDR 1.0, 1.5, and 2.0 million (US$78, US$115 and US$154) for a single student in primary, junior secondary, or senior secondary school, respectively. In other words, official estimates appear to be too low by about half. There is no benefit difference between urban and rural areas, although in general expenses are expected to be higher in urban areas.

[84] An additional validation – for PIP-eligible beneficiaries determined by the UDB – is completed by matching PIP-suggested beneficiaries with the Dapodik database, which is an integrated database system used by the Ministry of Education and Culture for national education program planning.
[85] These procedures describe PIP implementation in both the MoEC and MoRA.
[86] Schools may also be able to remove a listed beneficiary from the PIP program by determining that the eligible beneficiary is not poor. Prior to the 2012-2013 academic year, BSM allocation was based exclusively on referrals from schools (in coordination with school committees) and targeting accuracy was low: as little as 10 percent of all BSM beneficiaries at the primary school level fell into the poorest category (TNP2K, 2014a). Program regulations state that for PIP in the future, proposed beneficiaries will be named beneficiaries only after the Government has determined the KIP take-up rate for each education level.

FIGURE 2.26

CPI inflation-adjusted PIP benefit levels

BSM/PIP benefit levels adjusted for inflation (IDR)



Source: MoF, BPS, and World Bank staff calculations.

COVERAGE, TARGETING, & IMPACTS

The PIP transfer value has eroded over time. PIP benefits have been revised once in the program's history and the real value of PIP benefits declined by about 27 percent between 2008 and 2012, if adjusted using consumer price index-based inflation. Benefit levels were increased in 2013 by 25 to 35 percent (excluding PIP at university level which increased by 50 percent), but regular inflation means that even with these benefit amount increases households receive as much in real terms in 2015-16 as they did in 2012. Furthermore, the increase in the total out-of-pocket cost for a household to enroll one student has outpaced general inflation, increasing by as much as 35 to 60 percent from 2009 to 2012.[87] PIP benefits are less adequate in both real terms and in terms of education purchasing power. The failure to adjust for rising costs of living and the rising real cost of education could be undermining PIP's objectives.

PIP transfers are received by households in advance of the period in which school fees are levied. [88] The first of two tranches is received between August and September. The second is received between March and April in the next calendar year. This disbursement schedule is expected to reduce dropout rates. Since most PIP beneficiaries are now selected by querying the UDB, the likelihood of an interruption in the PIP transfer—that is, receiving PIP in one year but not receiving it the next—has been lowered; this is also expected to reduce dropout rates.

PIP covers almost 30 percent of poorest decile households that have school-age children [89] **(Figure 2.27).** However, coverage among non-targeted households ranges between 13 and 21 percent for median-income households, and between 1 and 11 percent for the richer households. Households with children are more likely to be covered by PIP if they are living in rural areas. Indeed, the rural share of PIP beneficiaries is 63 percent in 2016.

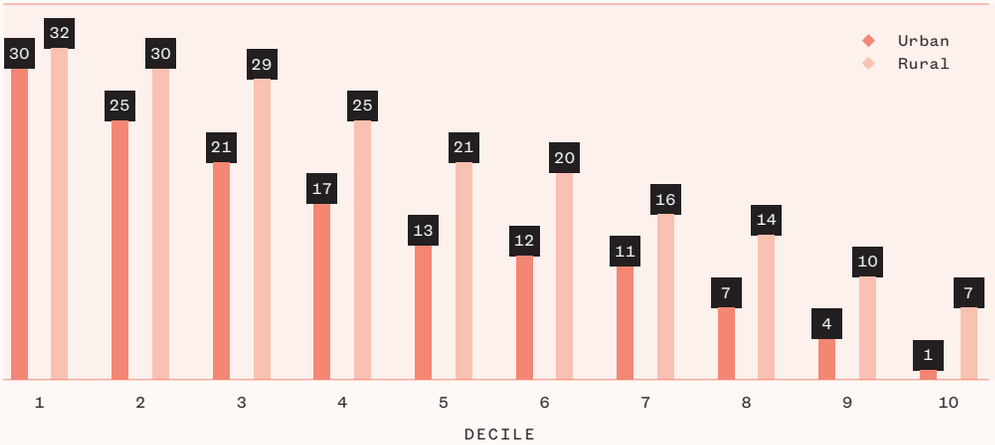
On average, PIP is received by students in households that exhibit correlates of income poverty. PIP's overall coverage for the poorest (in 2016), at about 18 percent of households with at least one school-age child, is around 12 percentage points higher than the 2013 level. These additional PIP funds have, on average, been distributed to students in households sharing most of the non-income correlates of poverty (Table 2.6).

Following continued expansion and revisions to targeting practice, PIP has improved its ability to identify students from near-poor households. In order to facilitate comparisons between PIP and other social assistance transfers (which may have slightly different target groups), Figure 2.28 shows coverage and incidence for the "Poor", the "Next 30" percent, and "The rest". Figure 2.29 demonstrates that while the poverty headcount rate fell by less than 1 percentage point between 2012 and 2016, PIP expanded significantly and the share of PIP benefits accounted for by the "Poor" group fell by about 1 percentage point. The "Next 30" group, which contains the same proportion of near-poor households in every year, has a PIP share that grew by about 6 percentage points over the same period. Finally, while PIP coverage among "The rest" has grown larger (by about 6 percentage points), this group's share of PIP benefits has fallen by 5 percentage points. While the 2012-16 trend looks positive, the changes in incidence of the "Poor" and "The rest" fell by 2 percentage points and increased by 5 percentage points, respectively, between 2015 and 2016, indicating that the expansion between 2015 and 2016 may have led to poorer targeting outcomes. That said, over the whole period since 2012, the pattern indicates that as the micro-level poverty situation

[87] World Bank (2012g) notes that expenditures on education for poor households rose in real terms by 20 to 50 percent between 2006 and 2009. With inflation (as measured by the consumer price index) at about 16 percent in between 2009 and 2012, education expenditures for all households have risen in real terms by about 20 to 45 percent between 2009 and 2012.
[88] This payment schedule was implemented beginning academic year 2013/14. See World Bank (2012g) for more details on the previous mismatch between BSM transfer receipt and payments for school-related bills.
[89] That is, for households with at least one child from 7 to 22 years of age.

FIGURE 2.27

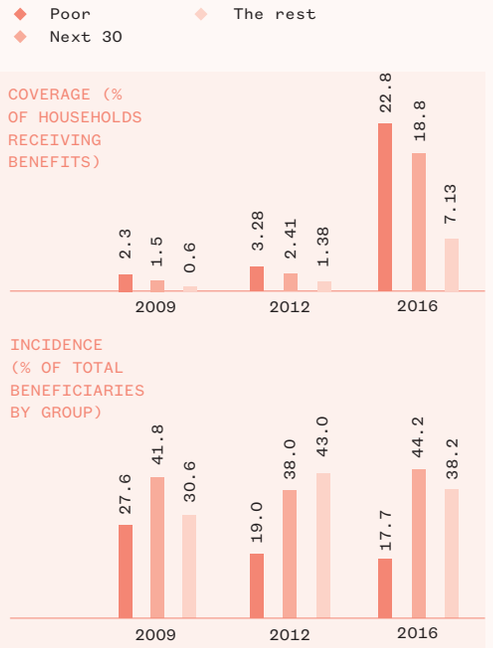
PIP coverage among households with school-age children by expenditure decile, 2016 (percent)



Source Susenas 2016 and World Bank staff calculations

FIGURE 2.28

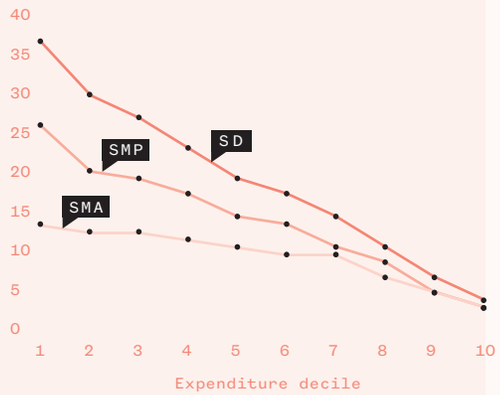
PIP coverage and incidence by poverty groups



Source Susenas (various years) and World Bank staff calculations.

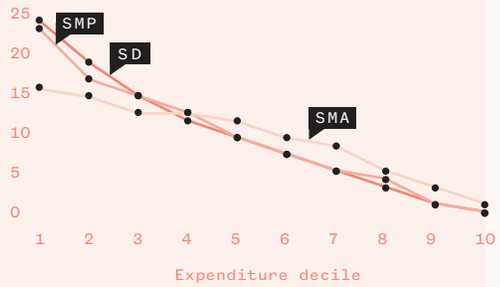
C

COVERAGE (% OF HOUSEHOLDS RECEIVING BENEFITS) BY EXPENDITURE DECILE



D

INCIDENCE (% OF TOTAL BENEFICIARIES BY GROUP) BY EXPENDITURE DECILE



Source: Susenas 2016 and World Bank staff calculations.

Following continued expansion & revisions to targeting practice, PIP has improved its ability to identify students from near–poor households.

changes—many households exit poverty year to year, while fewer enter—PIP's most recent implementation and coverage revisions have allowed it to continue to find the remaining eligible poor and near-poor households.

Poor and near-poor households receive the majority of PIP benefits available (Figure 2.29). [90] Students attending SD, SMP and SMA or equivalent levels of schooling in the bottom 30 percent of households account for about 57, 55 and 45 percent, respectively, of all PIP transfers. Leakage to students in non-targeted households is still significant, as such students in the fifth decile or above captured 31, 32 and 43 percent of the total PIP benefits distributed to each school level in 2016. For example, households with at least one school-age child[91] in the bottom 4 expenditure deciles accounted for almost 70 percent of the PIP benefits available at both the SD and SMP levels. At the SMA level, the analogous number is only 57 percent. Among the "Poor", "Next 30", and "The rest" groups, the poor's share of PIP-SMA benefits decreased between 2012 and 2015.

We have seen that even as poverty rates fell, PIP has provided a greater share of benefits available for students from near-poor households. Figure 2.29 illustrates that the bulk of this increase is due to PIP transfers at the primary and junior secondary levels.[92] However, the targeting accuracy of PIP cash transfers for primary (SD) students has not increased markedly since 2012. SD targeting outcomes increased slightly in 2014 (not shown): from 68 percent of benefits in the poorest 40 percent to almost 70 percent), but fell back to 68 percent in 2015 and 2016. For SMP, targeting outcomes fell by almost 5 percentage points, but appear to have increased again in early 2016 by 1 percentage point. That said, the program went through a major expansion in those years and between 2015, and SMP and SMA PIP targeting accuracy actually increased at the margin (both 1 percentage point higher allocation of benefits in the poorest 40 percent). For the "Poor" between 2015 and 2016, incidence to the poor of program benefits in general fell slightly, but by almost 3 percentage points for the SD school level, suggesting a decrease in targeting accuracy.

More pro-poor allocations of SMA-level cash transfers will require continued coordinated effort. The revised UDB-based targeting and KIP/KPS/KKS eligibility determination proce-

[90] Incidence corresponds to the ranking of beneficiaries per decile as proportion of total beneficiaries. Since PIP benefits change a household's per capita consumption, then to fairly reflect targeting of pre-program household consumption, consumption has been adjusted by the amount the household has reportedly received from PIP.
[91] We have taken coverage and incidence only over households with at least one school-age child in the relevant school-level range, so for primary (SD equivalent), age 7 to 12; for junior secondary (SMP equivalent), age 13-15; and for senior secondary (SMA equivalent), age 16 to 18.
[92] "Basic schooling", which the Indonesian Constitution indicates is the right of every citizen, is defined as 9 years of schooling, from primary through junior secondary.

TABLE 2.6

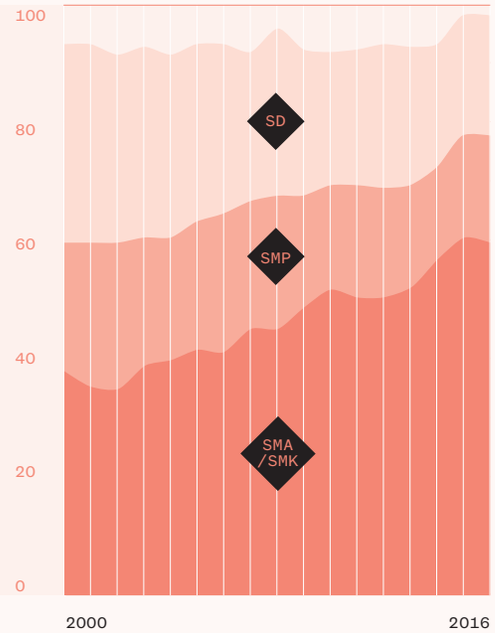
Characteristics within Indonesian populations

	% of all Indonesians who:	% poor population who:	% of PIP recipients who
Do not have access to bottled, tap or well water	16	28	16
Do not have access to private sanitation	22	41	32
Live in rural areas	49	63	63
Live with more than 5 household members	22	38	35
Have not completed primary education*	9	13	8
Are illiterate	7	13	6
Work in the agriculture sector	33	56	44

Source: Susenas 2016, and World Bank staff calculations. *For members of a household receiving PIP that are older than 18.

FIGURE 2.29

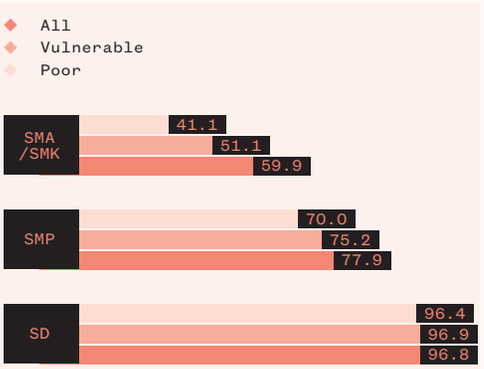
Net enrolment rates (%) by school level (2000—2016)



Source: Susenas (various years) and World Bank staff calculations.

FIGURE 2.30.

Net enrollment rates (%) by school level and poor / vulnerable welfare status



Source: Susenas 2016 & World Bank staff calculations

dures (see above) have reduced the risk that PIP beneficiaries will become ineligible (from any given school year to the following school year). In addition, the revised payment schedule (see above) is expected to reduce the risk that students cannot meet the payments necessary to begin a school year, thereby reducing drop-outs.

Fewer students enroll for upper-secondary education from poor and near-poor households. The lower poor- and near-poor household incidence at the SMA level is likely due in part the significantly higher costs associated with attendance (and the relatively low PIP benefit level). In addition, increased PIP nomination by schools (at the SMA level) is also correlated with high drop-out rates and low enrolment rates for poor and near-poor households.[93] In other words, school-based PIP nomination is greater at the SMA level where there are fewer UDB-based PIP beneficiaries and higher drop-out rates and lower enrolment rates are logically tied to expectations about cost. It is two to three times more expensive for one year of SMA education than for one year of SD education, while the share of this cost that a PIP transfer can be expected to cover is low (and decreasing).[94] Only when PIP can address all of these issues simultaneously, and in coordination with both schools and potential students, will it be likely that PIP-SMA allocations improve substantially.

Significant enrolment rate increases in 2015 suggest a positive role for the much-expanded, reformed PIP program. Figure 2.30 indicates that after 15 years, during which annual average net enrolment rate (NER) increases were 0.8 and 1.0 percentage points at SMP and SMA levels, respectively, the NER increased by 4.1 and 4.6 percentage points, respectively, in 2015. In other words, the magnitudes of the 2015 NER increases at SMP and SMA levels were equivalent to 25 and 29 percent, respectively, of the total 2000 to 2014 increases in the NER. This does not prove conclusively that the significant PIP expansion, coupled with operational reforms enacted, are responsible for the abnormally large increase in the NER. However, it does put into clear relief the lack of NER movement in the years following the establishment of PIP (2008) or its first large expansion between 2010 and 2012 (World Bank, 2012g).[95] As of 2016, the increases in the NER were smaller, at around only 0.1 percentage points for each level of schooling.

[93] According to Susenas 2016, nearly 45 percent of eligible children from the poorest 20 percent of households were not attending SMA.
[94] In addition, the opportunity costs of education (measured as foregone wages and household production) rise as a child acquires more education, so the total cost (out of pocket costs plus opportunity costs) of one year of school at the SMA/SMK level is likely even greater.
[95] Most of the operational or implementation-based shortcomings of earlier versions of the BSM program previously thought to be limiting the program's impacts—the benefit size; the mismatch between disbursement and school fee schedules; and the focus on enrolled students selected by schools—were at least partially addressed in the recent reforms.

ACCESSIBILITY

PIP policy, implementation, and monitoring are executed by two ministries and several directorates with little coordination and few common monitoring or feedback mechanisms. The internal PIP monitoring that is achieved—for example, over the selection process, the resulting cash transfer allocation, fund distribution realization, or the withdrawal process—is carried out by the directorate hosting the particular cash transfer program (together with provincial and district offices).[96] There is no defined procedure that cumulates the information into a PIP-wide program improvement cycle and no incentive for PIP operators to share results or experiences.

PIP socialization and complaint-handling may be improving. A working group consisting of TNP2K, and the implementing ministries MoEC and MoRA, increased PIP socialization effort and presence in 2014. Through stakeholder coordination meetings, traditional and social media campaigns both within and external to the government bureaucracy, the production and distribution of new socialization materials, and larger event-based socialization campaigns in large urban areas estimated to have significant shares of potential PIP beneficiaries, the central government has expanded PIP program information breadth and depth. The same working group has also re-examined existing complaint- and grievance-handling mechanisms, including PIP-generated grievances concerning the UDB and the KPS card system. New PIP guidelines suggest that access to these mechanisms should be expanded, perhaps via the support of local governments as well as continuing efforts by central program administrators. On the TNP2K website a full list of contact details for grievances based on the type of PIP benefit given is provided (IPC, 2014; TNP2K, 2016).

Efforts are being made to improve targeting protocols for the PIP context. When "spot checks"[97] were carried out to assess the effectiveness of the new card-based system for accessing PIP benefits, initial findings suggested under-utilization of, and a lack of socialization about, the program and the cards, while confusion over local roles and responsibilities caused payment delays and data inaccuracies.[98] In 2014, the working group began developing guidelines for PIP recipients to report to schools "out of cycle" in order to avoid delays in the data recapitulation process, while considering a more integrated monitoring and evaluation program—including a shared Management Information System (MIS) that is already in use at the MoEC —to track PIP-reform progress (IPC, 2014).

CHALLENGES, RECOMMENDATIONS & MOVING FORWARD

PIP should continue building on the recent successes it has had in program implementation and positive contributions to household welfare. With the contemporaneous increase in coverage and reforms to implementation, PIP is now making significant positive contributions to welfare in poor and near-poor households (with students) and to the Government's drive to provide universal basic education. When coverage and expenditures rose dramatically between 2012 and 2016 and about 10 million more beneficiaries were added, the UDB-based targeting system that PIP adopted helped put a significant majority of those transfers in the hands of students from poor and near-poor households. A further positive consequence for PIP of switching to the UDB-based beneficiary selection and eligibility procedure is that it has reduced eligibility volatility—that is, when PIP beneficiary eligibility status switches from year to year because of an unpredictable selection process. The revisions made to the payment schedule increased the accessibility, and therefore the relevance, of PIP transfers among students and households expecting large enrolment (and continuing) costs.

Transfer levels should be reviewed and adjusted more frequently if PIP continues serving students at all levels. In a best-case scenario, transfer levels would automatically adjust to any increases in the cost of schooling by, for example, tying benefit-level calculation directly to cost-of-schooling indices reported by households. PIP's current operation led to only one transfer level revision in the eight years of the program's operation, while the general price level has risen by 45 to 50 percent during the same period.[99] In 2009 and 2012 (years for which there is detailed education expenditure data), PIP transfer magnitudes were less than half of the total per-student cost of education as reported by households.

PIP should consider alternative ways of promoting enrolment, re-enrolment, and continuation within the group of students most likely to be inactive in the education system, namely SMA-aged students in poor and near-poor households. As the gap between household expenditures for a year of education and the PIP transfer magnitude is largest at the SMA level and, not coincidentally, this is also the level where PIP struggles to find and keep enrolled targeted poor and near-poor recipients, PIP implementers should develop strategies and principles specifically for the recruitment of poorer students at higher education levels.

PIP's biggest hurdle to further improvements in delivery is its current institutional form. PIP is split among two ministries and several directorates, each of which carries out most program functions independently. While some effort has been made since 2013 by TNP2K and Kemenko PMK coordination is still lacking. In addition, there is currently no mechanism to jointly provide (and jointly review the effectiveness of), for example, management performance reviews, M&E efforts, socialization campaigns, a grievance redress platform, or a policy review of the suitability of a "transition bonus" for eligible students making the leap from one school level to the next. In particular, the lack of a centrally managed M&E and the capacity to conduct case-by-case outreach to PIP beneficiaries will continue to be a weakness for PIP. In other words, even though the recent significant reforms have undoubtedly improved the PIP program, there remain many opportunities for better program integration and monitoring that can in turn provide a better experience for students and households.

[96] PIP students receive transfers upon enrollment but there is no further verification or monitoring of school attendance.
[97] Carried out by interviewing 632 households with at least one grade-7-age child from 15 districts in 8 provinces.
[98] For example, only 22 percent of the cards delivered were utilized during the study period.
[99] Inflation in household-reported education costs has been about twice the level of inflation (in the general price level) in the years it has been measured.

Conditional Cash Transfer (PKH)

PKH has demonstrated positive impacts in consumption and health-seeking behavior (and minor impacts in education) for poor families and the communities in which they live. Its M&E system has been able to provide internal management indicators, as well as indicators of household experience that feed into a program improvement cycle. PKH continues to experiment with program guidelines and benefit packages in order to remain relevant for all eligible beneficiaries but will need to ensure compliance verification functions well and redesign the program to operate in remote areas. While PKH does not get everything right, it should be encouraged to continue innovating and growing in capacity to better support beneficiary families as it expands.

2.5

OVERVIEW

Continuous improvements in education and health outcomes for all citizens have long been a focus of GoI social policy. The 1945 Constitution establishes the right of Indonesian citizens to quality education and health services. In the post-independence and Suharto eras, economic development strategies focused on financing capital investment in education, health, and related social services. Even as the Asian financial crisis unfolded in the late 1990s—with the headcount poverty rate doubling, real economic activity contracting by over 13 percent, and the Suharto regime eventually being removed from power—spending on health and education did not fall from previous levels. To the contrary, a constitutional amendment in 2000 reaffirmed the rights for all citizens to education and medical care, and legislation in 2003 obligated the nation to provide education for all children 7 to 15 years of age.

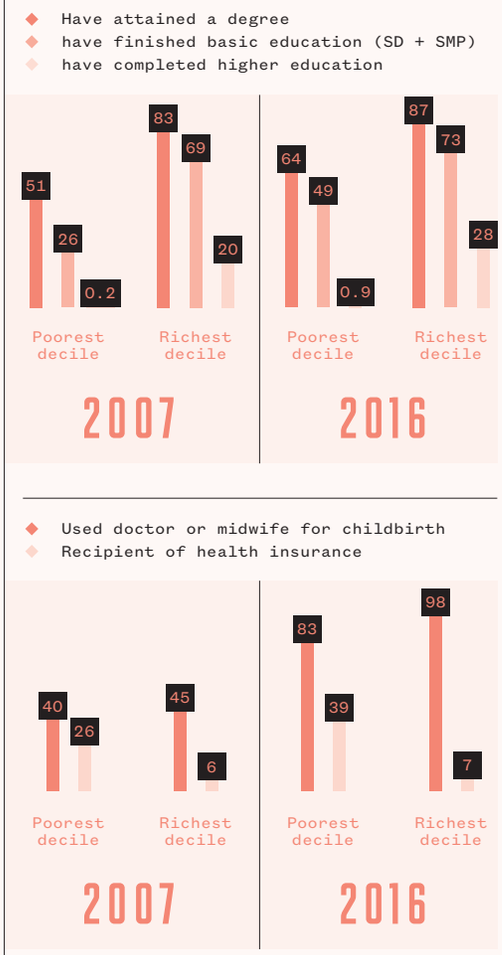
Indonesia has made great strides in these areas, but poor households continue to lag behind. For example, while educational achievement continues to rise for all groups (Figure 2.31), in 2016, 85 percent of people living in poor households will not have completed SMP or equivalent level of school and virtually none of them will have completed higher education. In 2016, about 9 percent of children from the poorest households did not receive a single immunization and there has been only slight improvement in this indicator since 2007.

Program Keluarga Harapan **(PKH), launched in 2007, is a conditional cash transfer for poor households[100] meant to alleviate short-term poverty and increase investments in education and health.** PKH households receive cash transfers when individuals meet specified health or education requirements. The cash transfers provide welfare in the short term and also reduces the opportunity cost of acquiring those services, while the requirements themselves should lead to improvements in the longer term.

[100] PKH is targeted to families rather than households, for the purposes of this review the terms are used interchangeably.

FIGURE 2.31

Educational and health attainment at a glance



Source: Susenas 2016 and World Bank staff calculations.

PROGRAM SIZE, INSTITUTIONAL SET UP, ELIGIBILITY, & BENEFITS

PKH's steady expansion has led to benefit availability in 34 of Indonesia's provinces and coverage of nearly 6 million families (Figure 2.32). PKH, which was rolled out in seven provinces and to just under half a million families in 2007, had by 2016 expanded coverage six times over (to over 3.5 million families) in almost all provinces, including those in eastern Indonesia.[101] The Government has planned to expand PKH to 10 million families in 2018.

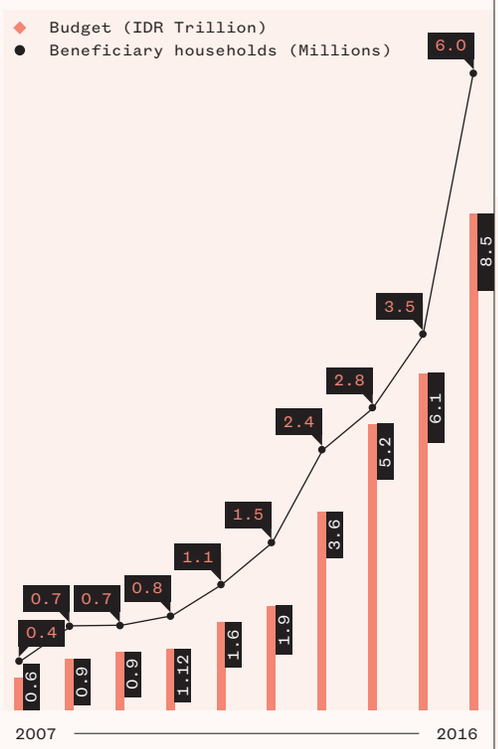
PKH's total budget has increased by nearly the same factor as has household coverage: from under IDR 1 trillion in 2007 to over IDR 8 trillion in 2016 (Figure 2.32). Even though it has expanded significantly, PKH remains the smallest of the national social assistance transfers (Figure 2.33) with less than 50 staff supporting its implementation at the central level. Rastra had an expenditure share about 2.5 times as large as PKH's in 2016, but PKH estimated to be far more effective at reducing inequality and poverty, than Rastra (World Bank, 2016a).

PKH is executed by the Ministry of Social Affairs (MoSA) with funds disbursed to households through a collection of state owned banks (2.34). Before 2017, payments were managed by the postal system (PT. Pos). A centralized program implementation office within MoSA[102] oversees all stages of program implementation. In the first stage of the program, province- and district-level quotas are negotiated and agreed. Then the UDB is queried to extract a list of eligible beneficiaries (eligibility requirements are discussed below). MoSA then distributes that list to its local offices, which are responsible for confirming eligibility. Upon verification of compliance, payments are authorized by MoSA and budgeted funds are disbursed to payment service providers, which in turns transfers funds to regional branches. The PKH cash benefit is then transferred directly to mothers only. Starting in 2016, following the direction of the National Financial Inclusion Strategy, MoSA has begun to shift the PKH payment from previously cash-based model to an electronic cashless model supported by a group of state owned banks (MoSA, 2016d) with the aim to render all payments via this system by 2017.

Verifying the household achievements in health and education, which trigger continued PKH transfers, is done jointly with service providers. PKH facilitators at the local level visit nearby schools, health centers, and hospitals to confirm that mothers and children from PKH households have presented themselves and are acquiring or attending the services required. At some facilities and in some regions, PKH program facilitators visit the service providers and meet with staff to jointly verify attendance. Verification forms are then most often manually submitted to the Management Information System (MIS) in the national PKH database (MoSA, 2016e).

FIGURE 2.32

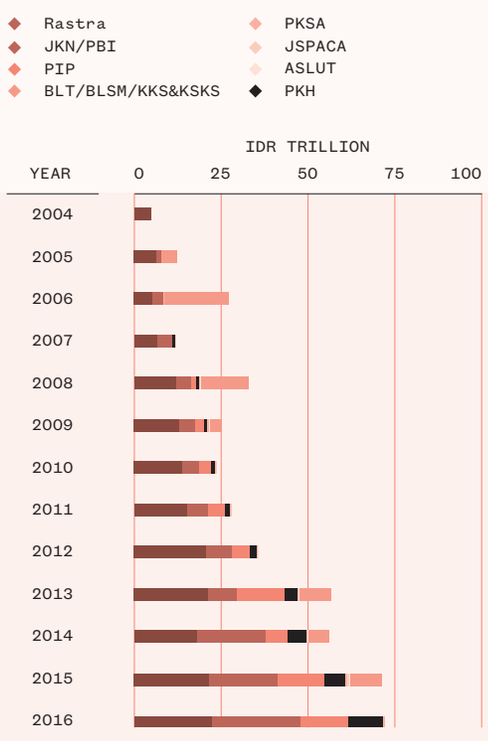
PKH coverage & budget



Source: MoSA (2014/2015/2016) and Ministry of Finance (2008-13)
Note: 2011-13 data are realized budget; 2014, 2015 and 2016 data are realised budget data.

FIGURE 2.33

Central government spending on social assistance programs

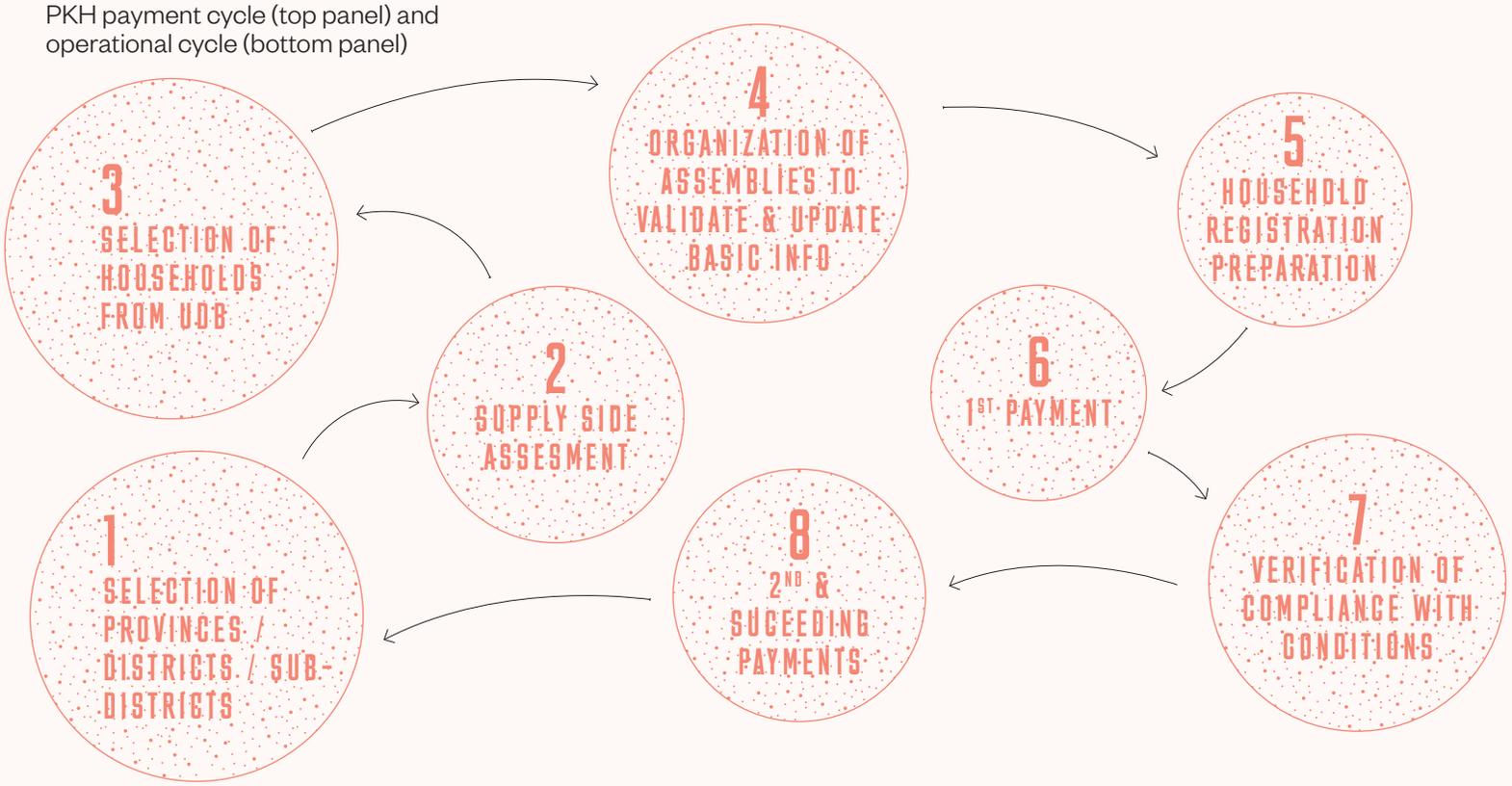


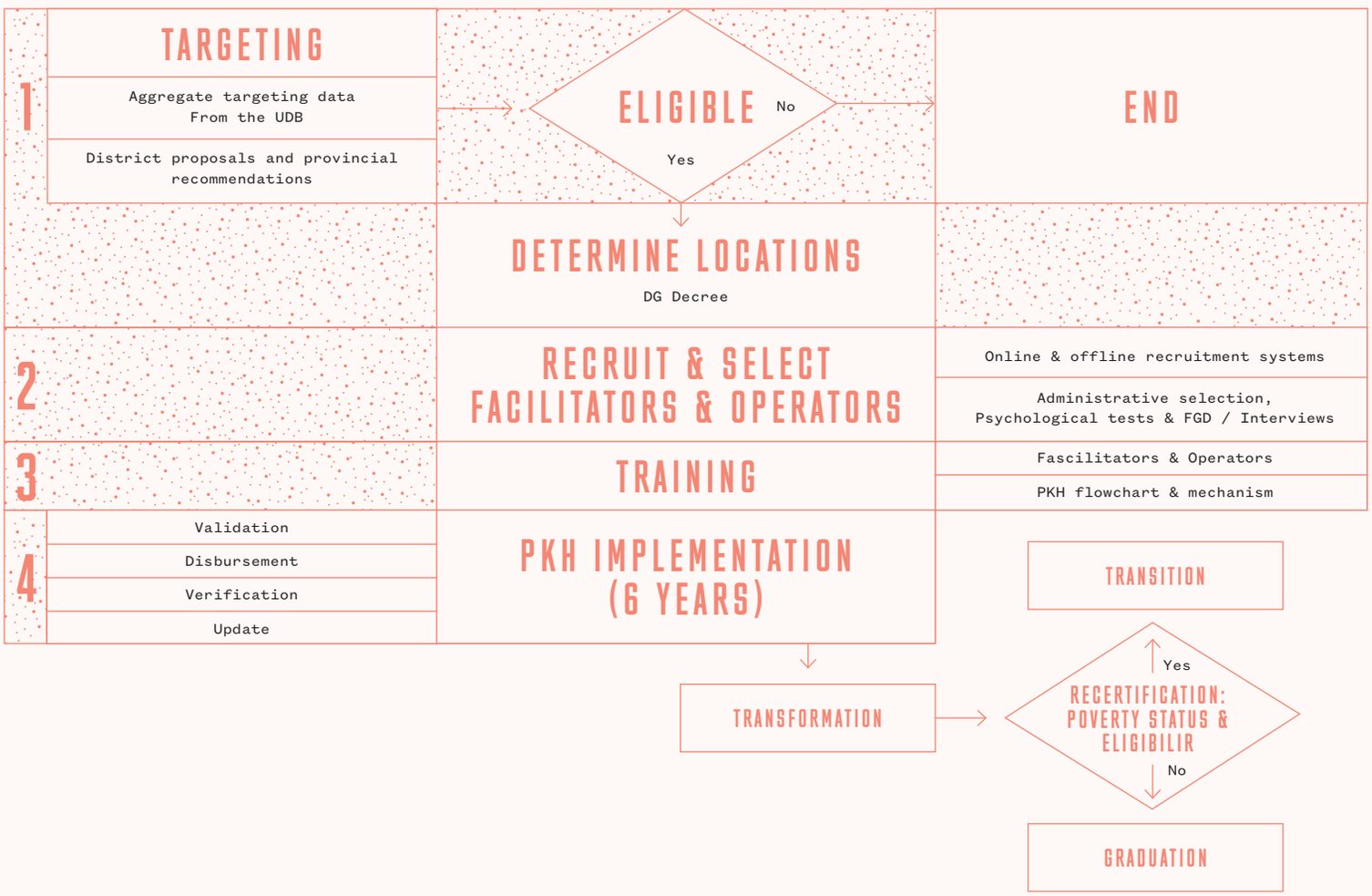
Source: Ministry of Finance; Bappenas; and World Bank staff calculations.
Note: Data for 2011-2016 are realized budget.

[101] As of 2017, PKH families are found in 504 districts out of 514. In the third quarter of 2016 due to lower than projected government revenues, MoSA as well as other ministries faced budget cuts; PKH had to reduce its budget to IDR 9 trillion
[102] As of 2016, the previous implementation unit, UPPKH, is now merged within the institutional structure and is referred to as the Sub-Directorate of Family Social Insurance (Jaminan Sosial Keluarga, or JSK) under the Directorate General of Social Protection and Insurance in MoSA (DG Linjamsos).

FIGURE 2.34

PKH payment cycle (top panel) and operational cycle (bottom panel)





Local governments provide support through service-sector coordination and management, but do not otherwise co-execute the PKH program. Local implementation is completed almost entirely by the regionally based MoSA-PKH program units. As a result, PKH accounts for more than three-quarters of the budget of the Ministry of Social Affairs' Family Welfare unit.

PKH eligibility depends on both household level of consumption and demographic composition. To be eligible in the current coverage target level, households must be considered "poor", or in the bottom 14 percent of households, as defined by the UDB. For the health- and education-related conditions, households must meet at least one of the following conditions: a household member is pregnant or lactating; the household has one or more children below 5 years of age; the household has children from 6 to 15 years of age attending primary or middle school; or the household has children aged from age 16 to 18 that have not yet completed basic education.[103] Disbursement of PKH cash transfers is completed quarterly as households are verified to have achieved the relevant conditions listed in Table 2.7 below.

Participating families receive PKH transfers for 6 years, if they comply with conditionalities and remain eligible. In addition to regular education and healthcare service attendance, PKH mothers attend monthly meetings (attended by other PKH mothers) organized by program facilitators. At these meetings, they receive guidance in fulfilling PKH conditionalities and advice for remaining in good standing vis-à-vis the PKH program. Any family determined to be poor after 6 years of PKH can be provided with and an additional 3 years of PKH transfers accompanied by additional livelihood and income support from programs, such as KUBE-PKH. The government has also been aiming to increase the integration of other social assistance programs such as PBI/JKN, PIP and Rastra with PKH throughout the program's implementation cycle to raise the effectiveness of social assistance and make it more likely that families are sustainably better off due to having participated in the program. The initial step towards this sort of integration was the introduction of the UDB by TNP2K in 2012 as a single source of beneficiary data for all social assistance programs.

In 2016, several policy changes were made to the PKH program. In the face of expansion beyond 6 million families, the target group was revised to become the "poor" (it used to be the "very poor") to allow for the inclusion of more families. Via the use of e-Warong and a network of agents under a collection of state-owned banks, 1.2 million families have received PKH payments made electronically via bank accounts. MoSA aims to roll out digital payments to all PKH beneficiaries by 2018. In addition, MoSA has also begun including new components to extend PKH transfers to the elderly (70 years and older) within PKH families uncovered by other social assistance programs (such as the old age assistance program, ASLUT) and the severely disabled. The conditions and roll-out for PKH recipients targeted to receive these components are still under development and may be implemented more widely in 2017 (MoSA, 2016c).

PKH benefit adequacy was increased in 2013 and 2015 to better help poor households to improve human development outcomes. Before 2013, PKH benefits represented an approximate 10-percentage-point share of beneficiaries' average expenditures, with a slightly higher share in 2007 and a slightly lower share in 2013 (Fernandez and Hadiwidjaja, 2012). PKH benefit levels were raised in early 2015 and again in 2016 (Table 2.8) with the maximum (minimum) annual transfer per household at IDR 3.7 million (IDR 800,000), or about US$284 (US$61).[104] In 2017, the benefit structure was changed to a single unified benefit of IDR 1,890,000 (US$ 140) per family per year. At these transfer magnitudes, a PKH household receives transfers worth about 13 percent of their regular expenditures on average. Figure 2.35 shows an average PKH transfer measured as a proportion of the out-of-pocket costs of a regular outpatient visit, or an average year of schooling. While multiple health visits can be financed from PKH transfers, only one year of education can be purchased with a PKH transfer.

[103] Ibid. Disabled children who attend Sekolah Luar Biasa, a school for disabled children, will also become eligible to receive PKH.
[104] A household's total transfer is based on demographic composition. For example, a household with one child in elementary school and one in junior high school would receive at least IDR 1.7 million yearly. Households receive a fixed amount of IDR 500,000 (US$38) even if no conditions are fulfilled. PKH transfers are disbursed quarterly.

TABLE 2.7

Core PKH eligibility and corresponding conditions

HOUSEHOLDS WITH...	...MUST ACCOMPLISH AT LEAST THESE CONDITIONS TO CONTINUE RECEIVING PKH
Pregnant or lactating women	1. Complete four antenatal care visits and take iron tablets during pregnancy. 2. Be assisted by a trained professional during the birth. 3. Lactating mothers must complete two post-natal care visits before the new born becomes one month old.
Children aged 0-6 years	4. Ensure that the children have complete childhood immunization, take Vitamin A capsules twice a year and take children for monthly growth monitoring check-ups
Children aged 6 - 21 years	5. Enroll their children in the relevant levels of school and ensure attendance at least 85% of school days.
Elderly people aged 70 years or older	6. Complete health check ups at health facilities or receive these at the household via home care and follow day care or social activities if available
People suffering from heavy disabilities	7. Complete health check ups as needed at health facilities or receive these at the household via home care and follow day care or social activities if available.

Source: MoSA 2016c

TABLE 2.8

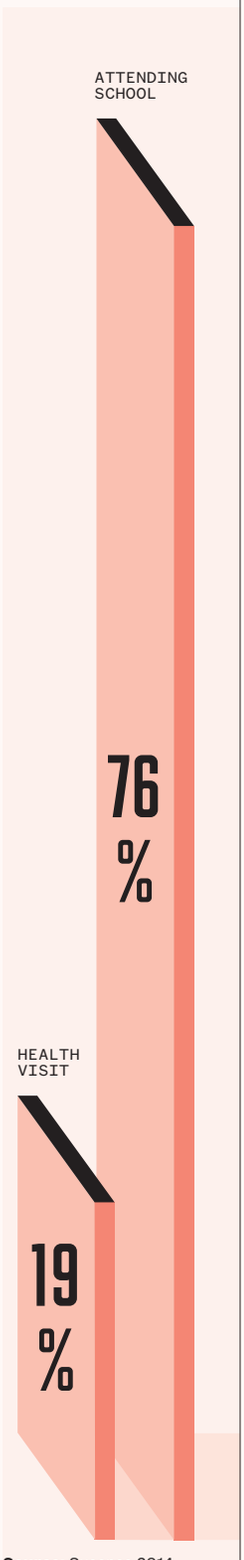
PKH transfer size by component in 2016

POOR HOUSEHOLDS WITH...	...RECEIVE YEARLY	
Children aged < 6 or mothers who are pregnant or lactating	IDR 1,200,000	(US$92)
Children attending elementary school (SD/MI/Paket A)	IDR 4500,000	(US$39)
Children attending junior high school (SMP/MT/Paket B)	IDR 750,000	(US$58)
Children attending senior high school (SMA/MA/Paket C)	IDR 1,000,000	(US$77)

Source: MoSA, 2016c; Exchange rate: US$1 = IDR 12,900 as of October 2016.

FIGURE 2.35

Average cost of health visits & education as a share of average PKH benefit (percent)



Source: Susenas 2014.

COVERAGE, TARGETING, & IMPACTS

PKH total coverage as of the end 2016—at 6 million families—means it could provide benefits to almost all of Indonesia's poorest families, but there is some leakage of PKH to non-poor families (Figure 2.36). Generally, based on 2014 data, coverage is much higher in the poorest decile of families, but there are a significant number of families with PKH in the second, third, and fourth deciles. There are also some families in the richest 60 percent that receive PKH transfers. The coverage headcount shown in Figure 2.36 is taken over all families. If instead coverage is taken only over demographically-eligible families—for example, about 67 percent of families in the poorest decile are demographically eligible[105]—then 11 percent of demographically eligible families in the poorest decile are covered.

On average, PKH is allocated to families exhibiting correlates of income poverty. While there are some non-poor PKH families, an average PKH household "looks" very much like an average poor household along all the non-income dimensions of poverty listed in Table 2.9.

PKH's targeting is the most progressive of the transfer programs covered in this report series.[107] In 2014, just over two-thirds of PKH beneficiaries were from families in the lowest three deciles. Since PKH's goal is to find the poorest of the *demographically eligible households*, any leakage to non-poor families would be noticeable (Figure 2.37). However, relative to the other social assistance programs discussed in this report series, PKH's leakage to non-targeted populations is minimal. There are likely several factors that together lead to better targeting results in PKH[108] including PKH's early adoption of the UDB-based beneficiary selection and a verification system that includes two-way dynamic updating of program participants and eligibility status.[109]

TABLE 2.9

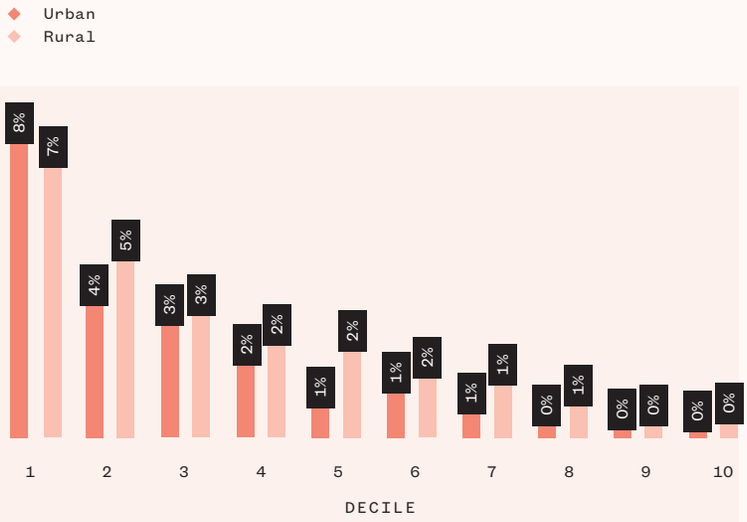
Characteristics within Indonesian populations

PKH	% of all Indonesians who:	% poor population who:	% of PKH recipients who
Do not have access to bottled, tap or well water	18	31	27
Do not have access to private sanitation	27	53	49
Live in rural areas	50	62	63
Live with more than 5 household members	25	44	43
Have not completed primary education	10	13	12
Are illiterate	8	14	11
Work in the agriculture sector	34	58	49

Source: Susenas 2014.

FIGURE 2.36

PKH coverage, by expenditure decile 2014[106]

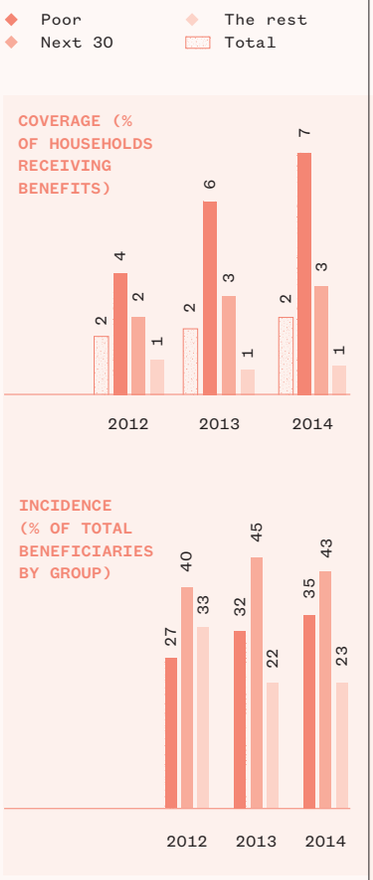


Source: Susenas 2014.

[105] In estimating coverage and incidence, an adjustment is made to better simulate targeting and incidence outcomes. PKH benefits change a household's per capita consumption. To fairly reflect targeting of pre-program household consumption, consumption has been adjusted. The adjustment assumes all of the monthly value of PKH benefits is captured in Susenas when families are surveyed.
[106] The latest available survey data tracking PKH are for September 2014. Susenas data for 2015 and 2016 do not contain the PKH variable used to track program participation; this variable is set to return in the 2017 March Susenas.
[107] By "progressive" we mean that shares of PKH benefits decrease as income shares increase. Note that we compare across programs with different target and coverage levels.
[108] For example, having well-defined, central institutional control over the PKH program may make it less likely that local variation in preferences or administrative skills affects program outcomes. Or, non-targeted households may feel that pursuing limited benefits from a program meant for the "worst off" in their communities is too costly socially.
[109] PKH has been using the UDB since its initial compilation in late 2011. Other social assistance programs covered in this report series may generate overall program quotas (via queries to the UDB) or may generate suggested lists of beneficiaries (via queries to the UDB) without fully integrating the UDB-based beneficiary selection, verification, and updating system.

FIGURE 2.37

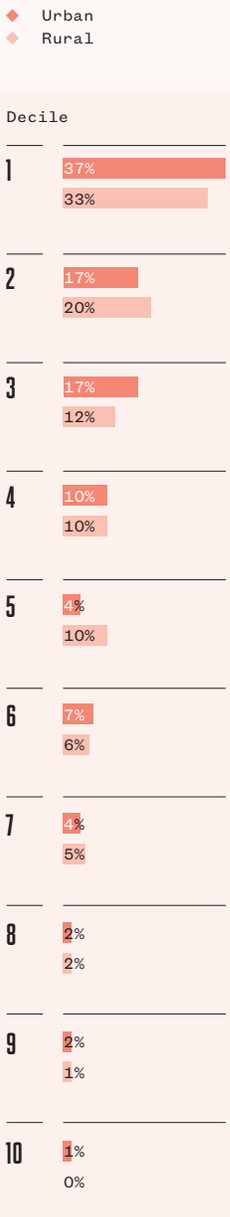
PKH coverage & incidence



Source: Susenas 2014.

FIGURE 2.38

PKH incidence by expenditure decile



Source: Susenas 2014 and World Bank staff calculations.

+8 PP

"...while the poverty headcount rate fell by about 2 percentage points between 2010 and 2014, the share of PKH benefits accounted for by the "Poor" group rose by about 8 percentage points"

As it has expanded, PKH has improved its ability to deliver benefits to poor families. In order to facilitate comparisons between PKH and other social assistance transfers (which have slightly different target groups), Figure 2.37 shows coverage and incidence for the "Poor", the "Next 30" percent, and "The rest". This figure demonstrates that while the poverty headcount rate fell by about 2 percentage points between 2010 and 2014, the share of PKH benefits accounted for by the "Poor" group rose by about 8 percentage points. The "Next 30" group, which contains the same proportion of near-poor families in every year, has a roughly constant PKH share over the same time period, while "The rest" has grown larger (by the same 2 percentage points that the poverty headcount fell), this group's share has fallen. This trajectory indicates that as the micro-level poverty situation changes—many families exit poverty year to year, while fewer enter—PKH has continued to add significant numbers of the poor families that remain.[110]

PKH benefits are concentrated in poor families (Figure 2.38). In 2014, the poorest 10 percent of families received over one-third of the benefits available. The bottom 20 percent received over half of the benefits available, while the bottom 30 percent received over two-thirds of the benefits available. This puts PKH on a par with similar programs such as Brazils' *Bolsa Familia* and the Philippines' *Pantawid* Pamilya Pilipino Program (4Ps), which registered CCT benefits accruing to 57 and 52 percent of the poorest 20 percent of families, respectively.[111]

Overall, conditionality compliance appears high and PKH's initial positive impacts have continued as the program and the families in it have matured. Compliance for both the education and health components is around 80 percent for both, averaged across four verification stages. The first verification stage early on in the year has rather low compliance rates, while the other three are conversely very high.[112] In terms of actual impacts, the original PKH pilot (launched in 2007) was designed to accommodate a randomized, controlled trial (RCT)-based impact evaluation, which involves experimentally comparing two groups of families that differ only in whether they received a "treatment"—in this case, the PKH program—or not (World Bank, 2011b). Both a mid-line and end-line statistical evaluation have been conducted; the former re-visited families after about 3 years of experience with the program and the latter re-visited families after more than 6 years of experience. Results from these evaluations, which indicate that the PKH program was directly responsible for greater investments in education and healthy behaviors while providing consumption budget support, are summarized below.

PKH improves welfare and can bring families above poverty-line expenditure levels. The mid-line evaluation demonstrated that PKH families experienced a statistically significant 10 percent increase in average monthly expenditures. The increase was used mainly to buy high-protein foods and to cover health costs. The end-line evaluation showed that beneficiary expenditure increased by 3.3 percentage points, while beneficiary families' expenditure on food was 3.4 percentage points higher than non-beneficiary families. For protein consumption, the impact was considerably lower, at 1 percentage point (TNP2K, 2015a).

PKH motivated healthy behaviors generally, and maternal and neo-natal practices improved noticeably. The mid-line evaluation demonstrated that PKH was responsible for statistically significant increases in pre-natal care. The likelihood of attending at least four prenatal visits increased by 9 percentage points,

[110] Coverages of small programs like as PKH (3.5 million families in 2015 and mid-2016) are likely underestimated in the Susenas household survey; actual PKH coverage is slightly more than double that displayed in Figure 2.37.
[111] World Bank Aspire Database.
[112] 2016 PKH MIS data.

while newborn delivery at a facility or attended by a professional increased by 5 percentage points. Post-natal care improved by almost 10 percentage points, while immunizations and growth monitoring check-ups increased by 3 and 22 percentage points, respectively. PKH had some impact on severe stunting as well, up to 3 percentage points. Unconditioned health behaviors also increased, indicating that PKH was responsible for increases in general health-seeking behavior in beneficiary families. Visits by any household member to either private or public health facilities increased more in PKH families than in eligible families in non- PKH areas, albeit at a more modest rate of 0.5 of a percentage point. The study also showed that PKH impacts were more pronounced in urban areas in Java, due to the higher availability, better quality, and proximity of health facilities (IPC, 2013).

These positive impacts were less pronounced in the end-line evaluation results. Impacts on healthcare-professional-assisted deliveries or delivery at health facilities were not significant. Significant impacts were registered in the likelihood of children receiving immunization. PKH families saw an increase of 7 percentage points in immunization, while severe stunting (height for age) decreased by 3 percentage points. PKH improved neo-natal visits by 7.1 percentage points but it had no significant impact on outpatient visits or increased intake of iron tablets. Contrary to the mid-line results, there appeared to be no significant impact of PKH on post-natal visit to health facilities (TNP2K, 2015a). The end-line report noted possible explanations as a prevailing belief among mothers that if their delivery went well, there was no need for post-natal check-ups and that some women noted the difficulty in arranging appointments with healthcare professionals (TNP2K, 2015).

PKH's positive impacts on education appeared later. The mid-line evaluation indicated that children from PKH families spent more time in school (if they were already attending), but the estimated impact was small in magnitude, with attendance increasing by just 0.7 of an hour per week. In general, the mid-line evaluation indicated that though education-related behaviors were improving over time everywhere—participation, enrolment, and transition rates all rose—PKH families did not experience a greater improvement than non-PKH families (World Bank, 2012i; 2011b).[113] By the time of the end-line evaluation, however, PKH families were demonstrating positive, if small, changes in these practices. For example, according to end-line results there were statistically significant increases of 2 percentage points in the gross participation rate for elementary school and almost 10 percentage points in the junior high school gross participation rate (TNP2K, 2015a). While the probability of a PKH child continuing to secondary school increased by 8.8 percentage points, there was no significant impact on the probability of dropping out of secondary school.

Child labor continues to decrease in Indonesia but there is no statistically significant impact attributable to PKH, according to either the mid- or end-line evaluations. Child-labor indicators in the mid-line evaluation showed similar patterns as the education-related indicators discussed directly above: while in general rates of child labor were falling in both PKH and non-PKH regions, PKH was not responsible for larger reductions in beneficiary families. The end-line evaluation, meanwhile, has indicated a small (but still statistically significant) decrease in the rate of child labor in PKH families of just over 1 percentage point, which is about equal to the fall in the elementary school drop-out rate (IPC, 2013; TNP2K, 2015a).

7.1 PP

"PKH improved neo-natal visits by 7.1 percentage points"

[113] When the mid-line evaluation was completed, the following reasons were offered to explain the lack of impact on conditioned education behaviors: payments did not coincide with the academic school year, so parents did not have the funds when needed while the amount received was not adequate to cover education fees that parents must usually pay.

ACCESSIBILITY

By design, PKH's M&E system provides evidence for implementing units to use in improving program efficiency and functionality. Operational monitoring is jointly completed by the central PKH implementation team with the cooperation and assistance of many regional and local implementation teams. The PKH M&E cycle begins with data entry into the MIS. These data are collected and entered by local PKH facilitators and summarize key household and administrative indicators.[114] The facilitators liaise with the district coordinator and the operators[115] available at the sub-district level. Meanwhile, the district PKH offices liaises with these two sub-district coordinators, as well as with the five PKH-dedicated working groups at the district level: the data team, the health and education services team, the fund allocation team, the verification team and the M&E team. Finally, district and provincial PKH offices in coordination with local service providers remain jointly responsible for helping to ensure that local basic services are available and functioning so that PKH beneficiaries face few constraints when fulfilling conditions. The MIS system provides a conduit for program-related information to proceed directly from the field to the implementing unit at the central level. In addition, the structure of PKH's oversight and its M&E procedures include many two-way information flows between local, regional, and national levels as well as two-way information flows at any level between service providers and PKH implementers or between families and facilitators.

Program monitoring has led to administrative revisions, making it easier for beneficiaries to access the PKH transfers effectively. As PKH commenced operation in 2007, bottlenecks in household verification, compliance monitoring, and payment delivery, as well as a weakly functioning MIS system, meant that PKH transfers to families were not synchronized with the due date for school fees. Once this constraint on PKH families' access to education was identified, its solution through 2015 —the harmonization of the entire compliance verification and transfer disbursement schedule with education service provider billing cycles—was made part of PKH's standard operating procedure through regulation and MIS functionality was enhanced so that it could signal when delays in these procedures were accumulating. Ensuring this process runs smoothly is key to the effective functioning and responsive nature of PKH. Likewise, once it was discovered that PKH transfers were not commensurate with the actual cost of schooling, the BSM/PIP cash transfer for poor and at risk students and PKH benefits were linked, while the PKH transfer levels were increased. Both actions increased the likelihood that PKH families could access education and remain compliant.

PKH has increased its public information campaign efforts as the program has expanded. PKH's dissemination of program and policy information, known as "socialization" in Indonesia, has suffered from the same inconsistency as do most other policy and program implementation functions in Indonesia's thoroughly decentralized administrative environment (World Bank, 2012i). This is due partly to institutional boundaries: The Ministry of Communications and Information is responsible for the management of PKH socialization activities (and those activities' budget). However, by establishing an "in-house" communications team at the central level and by providing firm direction to the Ministry of Communications and Information, PKH has been able to produce and disseminate widely and deeply a greater volume and variety of media related to program benefits, eligibility criteria and accessibility.

PKH's grievance redress system is theoretically easy to access but has functioned only weakly. PKH participants (and community members) can submit complaints directly to the village facilitator, the PKH facilitator, and the PKH implementing units at the district, province, and central levels, by making either a direct, unstructured report, or by filling in a standardized form (MoSA, 2016e). There is an operational sub-manual dedicated to grievance reporting and redress that describes tasks and responsibilities from the village level upward (Oxford Policy Management, 2012). However, the grievance redress system was found to be mostly un-operational and not used effectively to improve outcomes for PKH families: as of 2013, 7 percent of beneficiaries had submitted written complaints (World Bank, 2011b).

[114] Key indicators include: the share of participants unable to meet PKH conditions in health and education; the type and content of complaints received through the centralized grievance system and entered into the MIS; the disbursement of funds, fund disbursement timeliness, and cause for disbursement delay (when applicable).
[115] The operations coordinator monitors and assists service facilities that beneficiaries attend to remain PKH-compliant as well as oversees and assists the sub district-based administration and MIS teams.

CHALLENGES, RECOMMENDATIONS & MOVING FORWARD

PKH should continue to build on its well-constructed foundation as it expands to serve more families, while incorporating innovations that increase its relevance and effectiveness for Indonesian communities. PKH has twice demonstrated, under rigorous experimental protocols, that it generates positive impacts in welfare, in health-seeking behavior, and in education. It has also demonstrated that it can be somewhat flexible with its operational protocols and varied in its approach to service-provider coordination and assistance in order that PKH families are better served. For example, in 2014, "Family Development Sessions" were piloted to serve families exiting the program. These benefits are available to families still considered poor after six years in the PKH program and they provide training modules in early childhood education, parenting, health and nutrition, household finances, small business development and entrepreneurship, while extending (for up to 2 years) the receipt of cash transfers. In 2017, program implementers are moving to ensure FDS modules are to be given at an earlier stage in the PKH program cycle (MoSA, 2016c).

Now expanded to 6 million families, or about 10 percent of the population, PKH will yield significant impacts on poverty and some impact on inequality as well, if the program is managed well. In early 2016, based on a request from MoSA, simulations were conducted to estimate poverty and inequality reductions that could be expected from an expanded CCT.[116] It was predicted that an expanded PKH, from 3.5 to 6 million families in late 2016, the CCT could reduce the poverty rate by around 0.8 of a percentage point. Therefore, this expansion alone could bring the headcount poverty rate down from its current 10.6 percent to 9.8 percent. [117]

To successfully manage an expanded PKH, the program should strengthen its own human resources as well as its institutional capacity, its IT systems, as well as the capacity of the service providers on which beneficiaries rely. Continuous increase in number and enhancement through training of the local, regional, and national teams that oversee the core program functions is essential for efficient delivery of benefits and effective access for families. Key program functions and enhancements include: timely and complete verification of beneficiaries' status and conditionality fulfillment; regular MIS updating, adjustment of benefit levels and timely disbursements; determination of local level capacity for supporting program implementation; and suggestions for remediation of local supply inadequacies in health, education and program socialization, are some of the aspects to be improved.[118] PKH's recent, and potentially further, expansion will require additional consolidation and strengthening of program delivery systems and in particular the process of the verification of conditionalities. This will need to occur with careful attention to human resources and personnel, as well as IT systems, in the central- and regional-level teams that manage core PKH functions. Lastly it is critical to regularly monitor the program implementation performance and communicate with stakeholders and the public at large to ensure transparency and confidence.

PKH should continue to pursue explicit links to complementary programs targeted to poor families, especially JKN-PBI and PIP. In 2014, less than 30 percent of PKH families in the poorest decile received PIP, JKN-PBI and Rastra, even though they are automatically eligible for all three programs. Through the office of a social assistance ombudsman or deputy, local governments could be mobilized to assist the poorest families in accessing all of the available transfers for which they are eligible. As espoused under the early 2016 verification/validation exercise led by MoSA and district governments, further local government support of the UDB, and associated revision and updating protocols will be important to support the programs goals and positive perception in the short to medium term. In the longer term, a permanent data updating mechanism should be built such as through the Integrated Referral System (SLRT) and On Demand Application (ODA) to help achieve better integration of the entire social assistance portfolio.[119]

PKH benefit levels should remain commensurate with regional or local price changes in the cost of conditioned services. Benefit adequacy was improved in 2013, 2015 and only marginally in 2016, or by three times over a 9-year period. This is too infrequent to keep up with inflation and, given the increase in health and schooling costs specifically, too infrequent to keep the PKH transfer relevant for families that wish to comply with PKH conditions. In comparison to other CCT, at about 13 percent, PKH benefit levels are relatively low and could be raised: Brazils' *Bolsa Familia* and Mexico's *Prospera* account for about 19 percent and 22 percent, respectively, of household monthly expenditures. [120]

[116] Simulations from Susenas 2014. Eligible new PKH beneficiaries' per capita consumption is increased and poverty and inequality are re-estimated using the current poverty line. New beneficiaries are targeted using the proxy means test approach used by the UDB. Poverty and inequality impacts exclude any effect of future economic growth, increased household incomes or higher inflation. This simulation was based on current administrative and operational costs and quality; a PKH expansion may lead to an increase in per-beneficiary implementation overheads. Actual poverty and inequality impacts will depend on all these factors.
[117] Not taking into account growth and inflation, which would affect these results. The same simulation indicated that the suggested PKH expansion would be, all else remaining equal, responsible for a modest drop in inequality as well. A larger expansion estimation—to 8.4 million families —was expected to have a poverty reduction impact of 1.5 percentage points, which would put the current administration on track to meet its 2019 RPJMN target.
[118] All of these PKH processes (as well as some others) were found to be not operational or only sporadically operational in a first round of implementation "spot checks" completed over 2008 and 2009; see Centre for Health Research, University of Indonesia, 2010.
[119] SLRT, *Sistem Layanan Rujukan Terpadu* or the Integrated Referral System (for social protection programs) has been implemented in 59 districts by MoSA under the guidance of Bappenas, while ODA, a complementary an initiative for updating UDB, has been piloted in 12 districts by TNP2K.
[120] Susenas 2014 and Aspire database 2015. [No reference in references section.]

To successfully manage an expanded PKH, the program should strengthen its own human resources as well as its institutional capacity, its IT systems, as well as the capacity of the service providers on which beneficiaries rely.

The "Life-Cycle" Approach to Social Assistance & Safety Nets

OVERVIEW

Effective, efficient social assistance systems help households and their members mitigate risks. Social assistance programs are concerned with helping households absorb, mitigate, and overcome risks to their well-being. Social assistance programs are usually targeted to poor and vulnerable households unable to afford access to the (publicly- and market-provided) goods and services that non-poor households regularly consume, including the investments in human capital, such as health and education that directly reduce risks to well-being. They also provide basic needs for those households that find it difficult to afford even basic necessities and provide an alternative to negative coping strategies, such as asset sales or forgoing investments in human capital, that sacrifice future stability and productivity for a reduction in the likelihood of falling into poverty now.

The individual at risk, the salient risk, and the right time to offer SA-specific benefits or strategies, all depend on an individual's trajectory, or her position in her own "life cycle". An effective social assistance system will combine instruments and strategies so that it is as effective for poorer individuals without employer-based pensions nearing retirement, as for secondary education students unable to afford tutoring for university entrance exams (for example). An effective social assistance system should also be stabilizing over the entire course of an individual's or a household's life cycle. For example, should a newborn who lacks access to weight checks and immunization become a student unable to afford college-entrance-exam tutoring and then an older laborer contemplating retired life without a pension, the social assistance system should remain accessible and effective to this individual at any age. This section identifies key life-cycle risks faced by poor and near-poor populations in Indonesia in order to determine when and where the current social assistance programs are addressing salient risks, as well as whether any SA solution currently available can be relevant for all poor and vulnerable households. Using the rich individual- and household-level data in the Susenas socioeconomic survey, we are able to generate an empirical catalogue of the risks (as proxied by outcome gaps) faced at every stage in the life cycle of an individual or a household. This catalogue then provides a logical benchmark for reviewing social assistance programming, following the GoI's Masterplan for the Acceleration and Expansion of Poverty Reduction (2013 to 2025), which also uses the life-cycle approach as a framework for determining what positive characteristics a social assistance system should have (Box 3.1).

CHAPTER 3

BOX 3.1
Master Plan for the Acceleration & Expansion of Poverty Reduction in Indonesia 2013—2025

Indonesia desires comprehensive social protection programs. According to the Master Plan for Acceleration and Expansion of Poverty Reduction (MP3KI) 2013-2025, social protection programs should help the poor and vulnerable cope with crisis or socio-political, economic or environmental shocks through direct and indirect transfers. To achieve this, the MP3KI calls for preventive, promotional social protection programs to comprehensively address risks to welfare at the individual, household, and community-level.

Social protection in Indonesia will use the life cycle approach to identify risks during each stage of life. The social protection framework will focus on two form of risks:

1. Risk at individual and household level, both for men and women, in each age group, which can occur during the life cycle. Since these risks might be long term or permanent, it is important to have social assistance and social insurance programs which operate on regular basis, including protection from violence and exploitation.
2. Risk at community-level, which occur due to external factors, such as natural disaster, economic shock, and social conflicts. This type of risk should be tackled by temporary social assistance program which can be distributed during the disaster or crisis and targeted to particular beneficiaries.

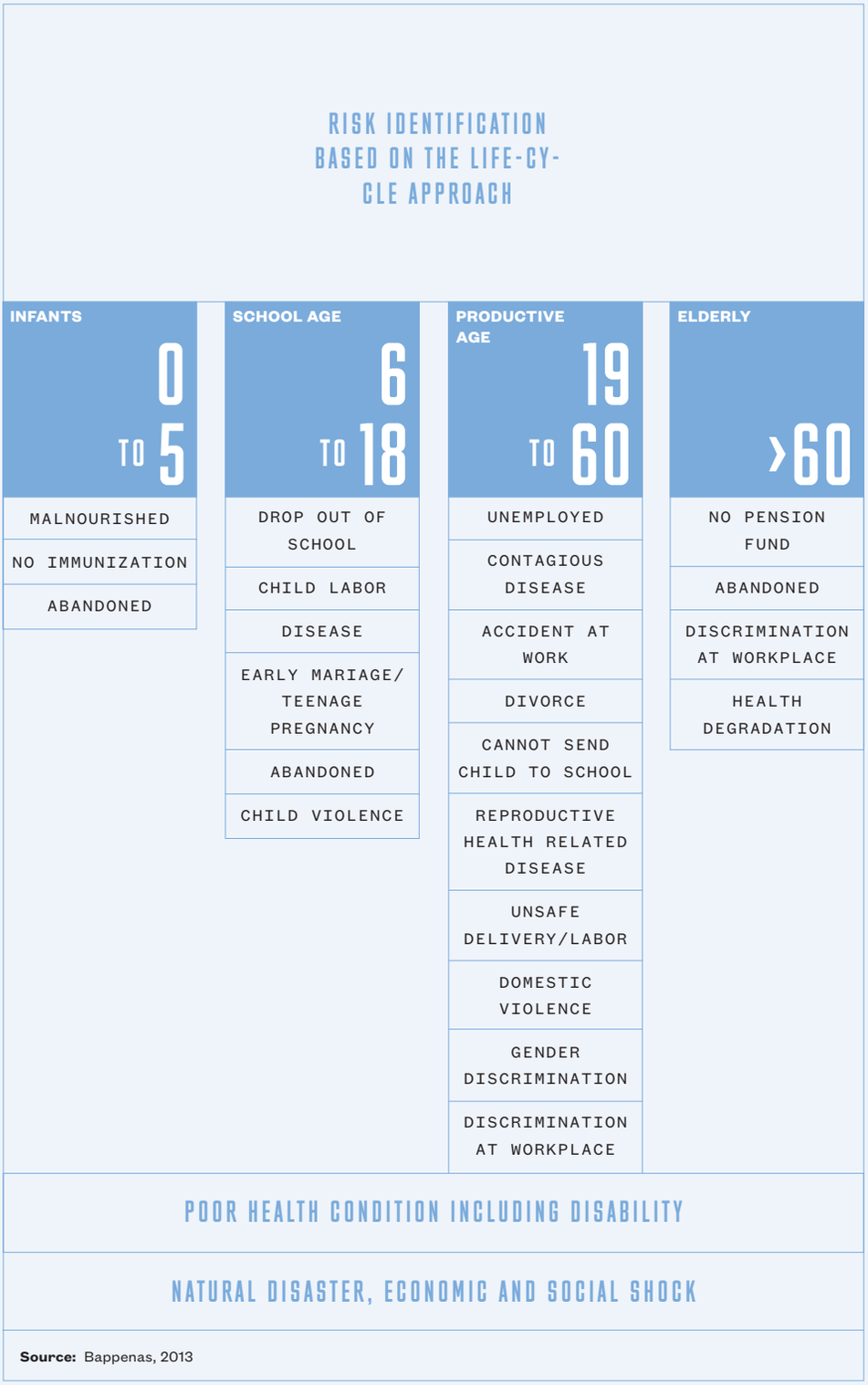
The MP3KI indicates that social protection is composed of (i) social insurance; (ii) social assistance transfers; and (iii) voluntary, individual, privately-purchased insurances. Each of these three components should be implemented via:

• Institutional strengthening, policy integration and social protection interventions, including the involvement of social workers and facilitators, as well as community and social institutions.

• Identification of, and strengthening linkages between, social protection providers and the sector-based facilities and resources, including infrastructure, that also promote sustainable livelihoods.

• Consistent, sustainable, automatic fiscal support for all social protection initiatives.

Source: Bappenas, 2013



Source: Bappenas, 2013

CHALLENGES, RECOMMENDATIONS & MOVING FORWARD

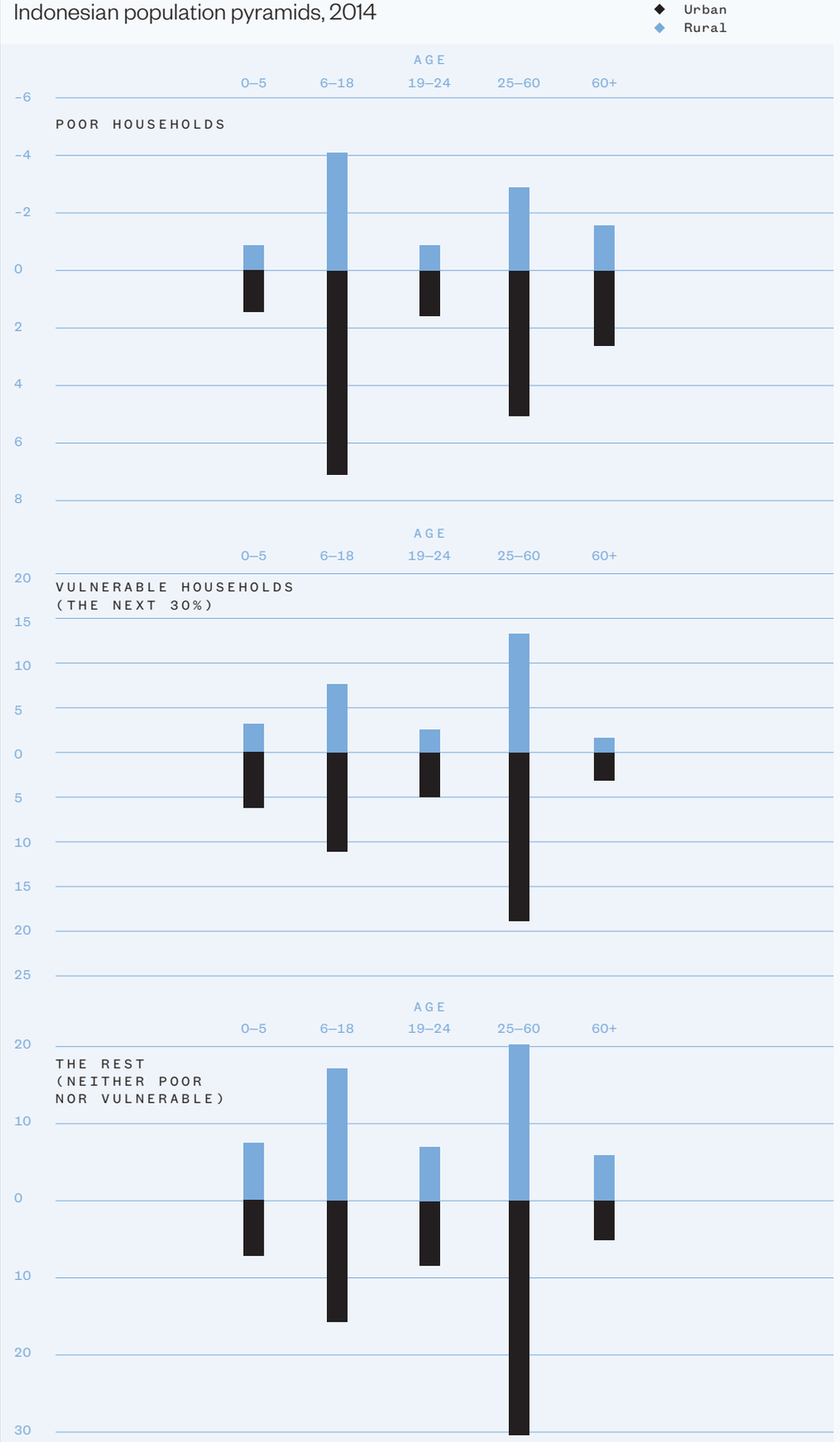
Poor households are predominantly rural. Figure 3.1 below presents population pyramids for three different groups: (i) the poor, or individuals whose consumption expenditure is less than the national poverty line; (ii) the "near-poor" or vulnerable, or individuals in roughly the bottom 40 percent of households ranked by per-capita consumption expenditure who are not counted as poor; and (iii) the rest, or all individuals who are neither poor nor near-poor.[121] In 2014, the Indonesian population was split evenly into rural and urban areas,[122] but poor households and individuals were concentrated in rural areas: just under two-thirds of all poor individuals were found in rural locales.[123] In the chapters that follow, we evaluate SA program targeting—or the ability to locate and provide benefits to poor and vulnerable individuals or households—and return to this characteristic as a benchmark.

Poor and vulnerable households have a greater number of younger-than-school age, school-age, and retirement-age dependents. For example, children from age 0 to 5 years account for about 15 percent of all poor individuals and 13 percent of all vulnerable individuals, but only 10 percent of all non-poor, non-vulnerable individuals. Frequency rates for "School Age" individuals (from 6 to 18 years old) in poor, vulnerable, and non-poor, non-vulnerable populations are 28, 25, and 21 percent, respectively; and for "Elderly" (61 years old or older) 8.4, 7.0, and 7.2 percent, respectively. In other words, the "Working Age" population (from 25 to 60 years old) is squeezed on both sides by more dependents in the poor and vulnerable population. In addition to creating a larger cumulative burden on household income from labor, more dependents usually means greater expenditures on health and education services.

[121] More precisely: the "Poor Households" are those containing individuals with per-capita consumption under the 2014 poverty line; the vulnerable are the next-poorest 30 percent (or the "Next 30 percent") of individuals who are not counted as poor; and "The rest" is everyone else. The headcount poverty rate in 2014 was 11.3 percent, so the "Poor" are 11.3 percent of individuals, the "Vulnerable" are 30 percent of individuals, the "Poor" together with the "Vulnerable" are 41.3 percent of individuals, and "The rest" are 58.7 percent of individuals not counted as "Poor" or "Vulnerable".
[122] In results not shown, we examined age-group population shares within each of Indonesia's 33 provinces and found no significant provincial differences in age-group shares.
[123] 56 percent of vulnerable individuals and 42 percent of non-poor, non-vulnerable individuals are found in rural areas.

FIGURE 3.1

Indonesian population pyramids, 2014



Source: Susenas 2014 and World Bank staff calculations; bars represent millions of individuals within the age ranges listed on the x-axis.

KEY RISKS OVER THE LIFE CYCLE

Children from poor households face disadvantage early. Figure 3.2 presents selected outcomes and gaps by age groups and by the same welfare levels, namely the "Poor", the "Vulnerable", and "The rest". Pre-school[124] might still be viewed as a luxury in Indonesia in that less than half of non-poor, non-vulnerable households have children enrolled. But for children from poor households, it is almost a rarity: nearly 70 percent of pre-school age children from poor households are not enrolled in any pre-school initiative. Furthermore, while pre-school enrolment rates have risen since 2004 for all households, the poor-non poor gap[125] has actually widened: 2004 pre-school enrolment rates have risen faster in non-poor households than in poor households.

Risks for the youngest children can materialize even earlier. While rates of unattended birth in poor households have been halved since 2004, pregnant mothers in the poorest 20 percent of households access ante-natal services from a general practice doctor, a doctor specializing in obstetrics and gynecology, or a nurse less than 5 percent of the time (Riskesdas, 2013).[126] In contrast, pregnant mothers in the wealthiest 20 percent of households access ante-natal care from a doctor more than one-third of the time.[127] Average rates of malnutrition for 0 to 5 year olds at between 20 and 36 percent[128] are 3 to 4 times higher in Indonesia than the East Asia and Pacific Developing Country average.[129] Average height is significantly lower for both boys and girls from rural areas than those from urban areas, and this significant difference is apparent at age 5 (if not before) and persists until adulthood. Since poor households are more likely to be located in rural areas, it can be inferred that the rates and severity of malnutrition are higher for children from poor households than those from rich households (Riskesdas, 2013).[130]

These risks may have lingering impacts as standardized, basic, compulsory education begins. Very few 7- to 12-year-old children do not enroll in primary education. However, nearly 16 percent of primary-school-enrolled children from poor households did not start school on time and the poor-non poor gap in this indicator has increased since 2004 (in other words, the difference in late enrolment rates between poor and non-poor, non-vulnerable households has increased since 2004). While we cannot observe induction into the basic education system in a single cross-section of households (such as Susenas), it is not unreasonable to suggest that children from poor households are more often unprepared—socially, emotionally, or mentally—for the formal schooling system and that that lack of readiness may stem from less prior time spent in structured developmental programs, such as ECED and kindergarten. The 13- to 15-year-old cohort (those near the end of Indonesia's 9-year basic education mandate) from poor households show a slightly higher risk of non-enrolment in the junior-secondary level and of drop-out in, or non-continuation from, the primary level (Figure 1.2). The 13- to 15-year-olds from poor households also show higher rates of late enrolment (or grade repetition) than those from non-poor households, and this gap too has increased since 2004. Compounding these risks is a higher frequency of labor contributed by 13- to 15-year-olds from poor households. In other words, even enrolled children may have additional responsibilities outside of school that make them less productive at school.

As a 9-year basic education ends, the majority of students from poor households exit the education system. For example, nearly 60 percent of 16- to 18-year-olds from poor households are not enrolled in senior secondary school, while nearly 50 percent of the same group have dropped out of school already. While about one-third of 16- to 18-year-olds from poor households are active in the labor market and could thereby be adding work experience to their skills base, the "unemployment rate" among that active population is 5 percent. For 19- to 24-year-olds, Figure 3.2 illustrates that university education is an option only for non-poor and non-vulnerable households, and again the gap in university enrolment rates between poor and non-poor, non-vulnerable households has grown since 2004. It also illustrates that while the rate of labor-market entry for young adults from non-poor and non-vulnerable households has finally caught up to the rate for young adults from poor households, those from poor households are more frequently bringing a drop-out's credentials (that is, they more frequently lack a certificate).

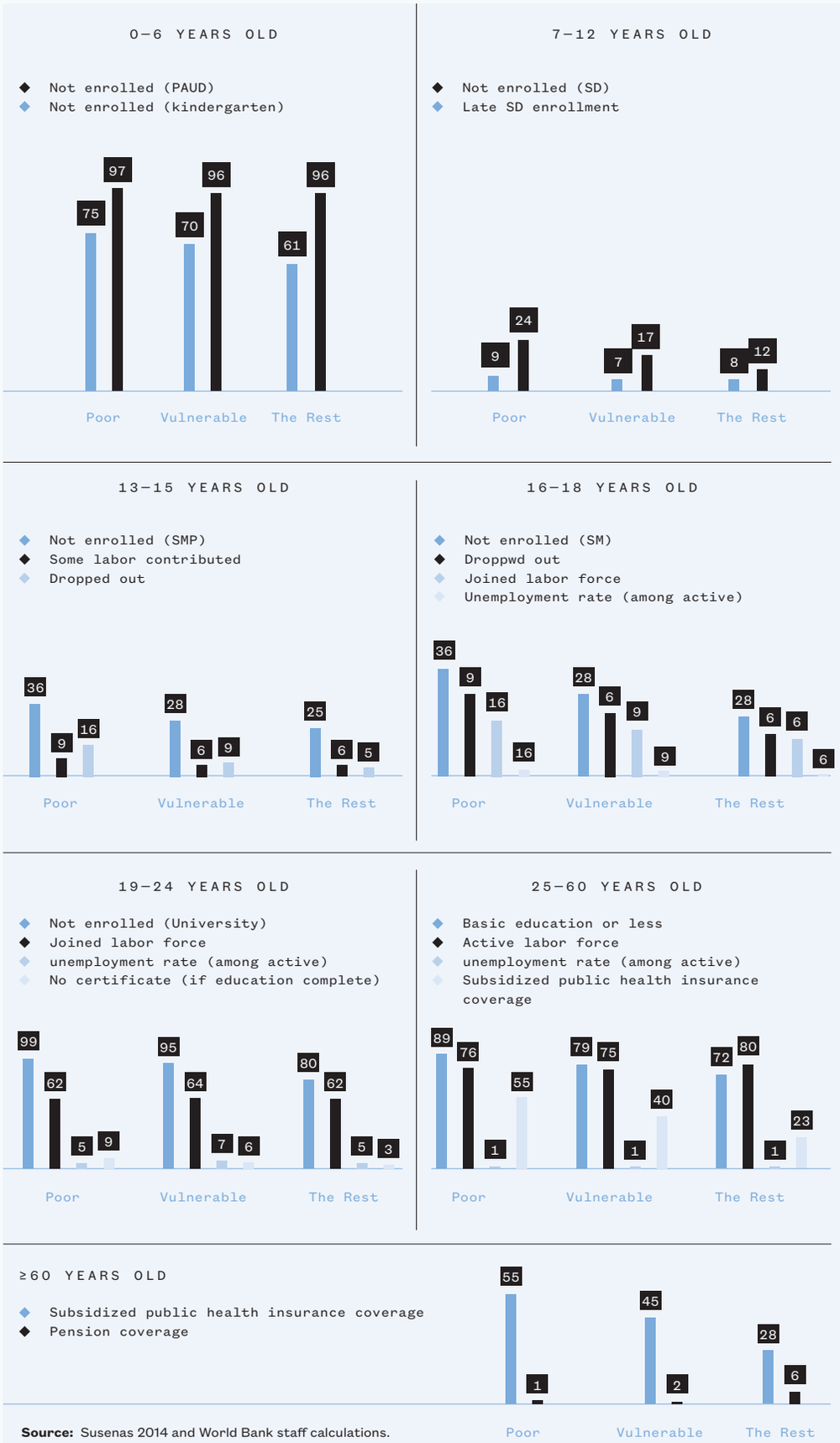
Working-age individuals in poor households have lower-quality jobs. Nearly 90 percent of poor working-age individuals bring to the labor market a "basic education or less" credential. While this does not prevent them from finding jobs—for all households labor force activity rates are nearly 80 percent while unemployment rates (among the "active" labor force) are quite low—it likely limits them to job types that provide few (if any) benefits or extra-salary compensation. For example, while the rate of informality among employed males has stayed about the same in all households since 2004, the rate of informality among employed females has increased noticeably since 2004, and it has increased especially for poor working women. In addition, coverage of government-subsidized public health insurance schemes among poor working-age individuals is about 50 percent, which means that only half of poor households with more dependents (both young and old) and where the primary wage-earner(s) likely has a job with few extra-salary benefits can depend on help with healthcare expenditures. [131]

For the elderly, income security is a serious issue as the elderly absorb the lingering impacts of labor-market choices. As detailed in Figure 3.3, rates of poverty and vulnerability rise markedly for those older than 64. Over 40 percent of the elderly are poor or vulnerable, as compared to 31 percent for the general population. In addition, a large share, approximately 35 percent, of the elderly poor and vulnerable are either living by themselves or with one other person revealing another risk inherent to getting older in Indonesia Pensions for retirement-age individuals from poor and vulnerable households are extremely rare (Figure 3.2). But low coverage is only half the story: it is esti-

[124] Which includes kindergarten, daycare, and ECED centers (known by their Bahasa Indonesia acronym as PAUD centers).
[125] The poor-non poor gap is defined as the percentage point difference in, for example, enrolment rates, between poor households and non-poor, non-vulnerable households.
[126] Instead, pregnant mothers from poor households are most often attended by midwives when they acquire antenatal services. The household ranking here referred to is based on a wealth index compiled independently from the Susenas-based measures of expenditure consumption. In addition, this service-provider quality difference (between poor and rich households) is conditional upon utilization. The publicly-available Riskesdas data summaries do include the average rate of completing the recommended four ante-natal care visits among pregnant or recently-pregnant women: 70 percent in 2013, up from 61 percent in 2010. The summaries do not publish ante-natal care rates by quintiles of the wealth index; it is expected that ante-natal care rates are lower among poor households.
[127] Riskesdas summaries also indicate that those mothers with at most primary education (regardless of wealth level) acquire ante-natal services from midwives approximately 95 percent of the time; Susenas indicates that nearly 80 percent of working-age individuals from poor households have at most a primary education (see below). The constraints to acquiring high-quality ante-natal care, therefore, are not just financial.
[128] When measured by weight-for-age and height-for-age indicators, respectively
[129] According to the World Development Indicators database (accessed on June 4, 2015). The East Asia and Pacific Developing Country set includes Cambodia, China, Fiji, Indonesia, the Rep. of Korea, Lao PDR, Malaysia, Mongolia, Myanmar, Papua New Guinea, the Philippines, Thailand, Timor-Leste, Vietnam and several small Pacific island nations.
[130] We are implying that the rural-urban difference in a height-for-age measure is indicative of a higher burden of malnutrition for poor households. The publicly-available Riskesdas results do not include rates of malnutrition by wealth quintile.
[131] Susenas 2004 & 2014 analysis

FIGURE 3.2

Outcomes & gaps by age group, 2014 (percent)



Source: Susenas 2014 and World Bank staff calculations.

mated that total benefits from the contributory pension schemes for government employees received by the non-poor, non-vulnerable population are 2.8 times greater (when measured on a per-capita basis) than those received by the vulnerable population (World Bank, 2016).[132] In other words, pension coverage is low for all population groups, while non-poor, non-vulnerable households capture the overwhelming majority of the pension benefits available. This result could logically be tied to the quality of jobs to which individuals from poor households are matched: informal employment does not often come with any non-salary benefits (World Bank, 2014a).[133]

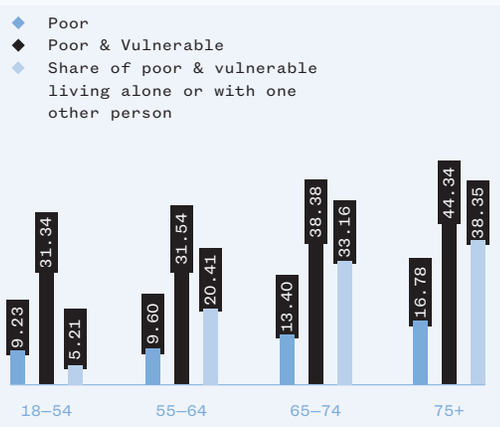
The disabled are also more likely to be or become poor or vulnerable as they are often limited in their opportunity to generate income. In addition, they may face above average expenditures in health. To date, there is only scant data available on the prevalence and trends of disability; the Susenas survey does not include key variables on the subject and so there is little ground to build an analysis on at this point.[134]

Poor households face overall risks associated with the lack of access to basic services and poor housing conditions. Poor households often use lower-quality, lower-cost materials for their residential structures and those residential structures are more often located in areas where publicly-provided utilities do not reach (see Box 3.2). For example, most poor households lack access to improved sanitation facilities, and endure non-permanent housing as reflected by building materials. Such residential location choices can reasonably be viewed

[132] About 12 percent of the labor force (or 5 to 6 percent of the population) was covered by pensions in 2012 with the bulk of that coverage due to the contributory pension schemes for public employees (known then as Taspen and Asabri).
[133] About 60 percent of all employment is considered "informal" in Indonesia (circa 2010).
[134] The UDB does contain a mix of disability variables.

FIGURE 3.3.

Poverty, vulnerability & household size



Source: Susenas 2016 and World Bank staff calculations

as poor households absorbing fiscal risk, or the risk that an electricity or water-supply program will not be fully funded. In absorbing this risk, total residential operating costs (which include the cost of essential utilities such as water and sanitation) become greater. Figure 3.4 summarizes the indicators mentioned above for the poor, the vulnerable, and the non-poor, non-vulnerable ("The rest") households.

BOX 3.2
Housing Policy in Indonesia

Housing is a critical part of public infrastructure as well as an essential service for all families. In Indonesia the demand for affordable housing units exceeds the available supply: there are about 64 million housing units in Indonesia (while the number of households is greater than 65 million), but 20 percent of these units are in poor condition. Formal, private real estate and construction firms are producing about 400,000 units each year, and about 50,000 to 100,000 of these are part of a subsidized mortgage program. A second subsidy program provides 150,000 to 200,000 new units annually by helping finance renovations (for existing housing in poor condition), rental housing, or social housing. That leaves about 200,000 new households with no alternative in the formal market; these households—primarily lower-income households with high population growth rates—turn to the informal housing market.

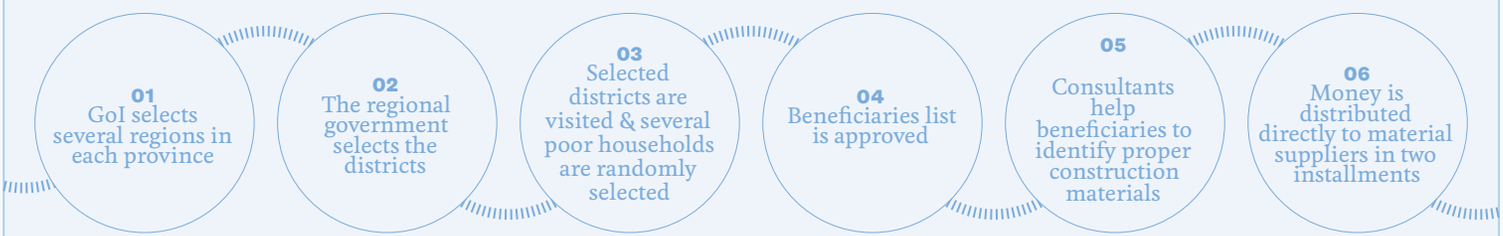
Government Spending on Housing

Indonesia has developed programs to improve housing conditions and provide purchase assistance to lower-income individuals, but they are considered too small (in magnitude) to make a significant impact. In 2013 spending on these housing programs reached about five-hundredths of a percent of GDP, which is much smaller than, for example, in the Philippines (0.31 percent of GDP), Thailand (2.15 percent GDP), or the United Kingdom (1.42 percent of GDP). Public housing expenditures in Indonesia are regressive, however, as the budget favors middle-, upper-middle-, or upper-class-targeted. Housing programs targeting lower income households account for less than half the annual budget for housing subsidies.

Home Improvement and Incremental Expansion for Low Income Households

About 70 percent of Indonesia's total stock of housing was at least partially self- or informally-constructed; among low-income households this number is likely even higher. Most low-income households prefer building and improving their dwellings incrementally as it is difficult for poor household to access mortgage finance: only the top 20 percent (ranked by income) of households access formal housing on the market's terms; the middle 40 percent cannot afford formal-market housing without subsidy support; the bottom 40 percent are unable to afford even a subsidized basic starter unit (which is valued at IDR 15 to 30 million). Lower-income households also tend to dedicate less disposable income (proportionally) to housing, and larger (proportional) amounts on other essentials such as water, food and transport. Lower-income households more frequently finance housing services or home improvement projects by turning to microfinance institutions which generally have worse terms (higher nominal rates and shorter repayment terms) than formal lenders. The BSPS program, managed by Ministry of Housing, provides to lower-income households a subsidy (either IDR 7.5 million for home improvement or IDR 15 million for new construction) for such incremental construction. The BSPS grant is designed to cover only a portion of the total cost; the remainder is to be paid by the homeowner's savings or other assets.

BSPS PROGRAM IMPLEMENTATION SCHEME

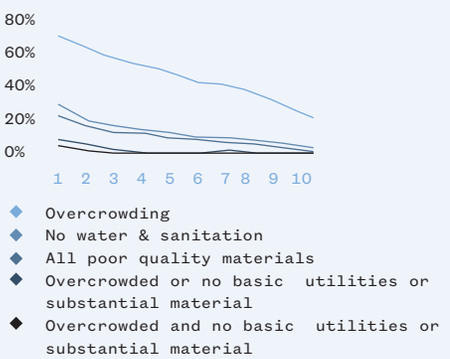


Source: Bappenas, 2011

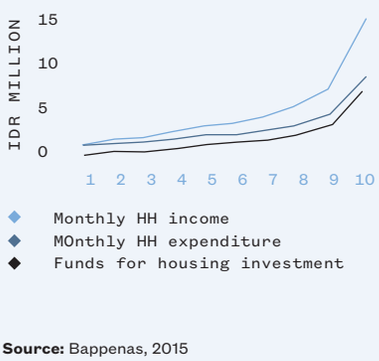
Coverage

While over 80 percent of families own their homes, nearly 30 million housing units from the current stock are considered substandard (due to overcrowding, poor-quality building materials, or lack of access to basic services). Low-income households suffer substandard housing more frequently: 27 percent of first-decile households make do in an overcrowded house and 22 percent do not have access to basic utilities. However, BSPS covers about 140,000 households annually, so 1 percent of Indonesian households (of any income level) with substandard housing are covered by the program.

Housing units with various substandard characteristics, 2014



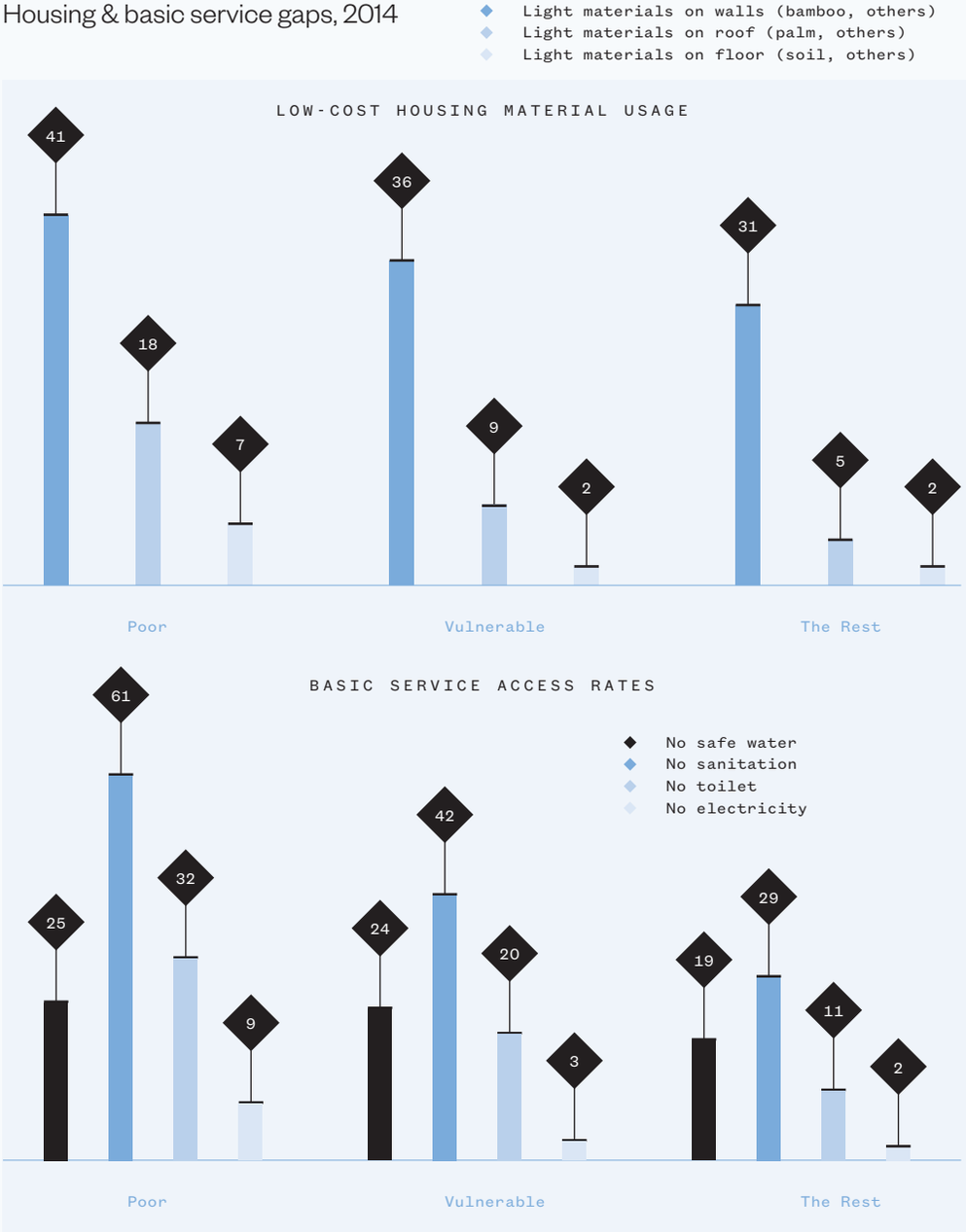
Housing units with various substandard characteristics, 2014



Source: Bappenas, 2015

FIGURE 3.4

Housing & basic service gaps, 2014



Source: Susenas 2014 and World Bank staff calculations

Poor households are more exposed to macroeconomic and fiscal risk than non–poor households.

Poor households are more exposed to macroeconomic and fiscal risk than non-poor households. If we think of a household as a collection of behaviors and preferences, we can analyze the outputs this collection produces. For example, household budget expenditure shares for food, housing, transportation, and services (and so on and so forth) are one such output: poor and vulnerable households dedicate two-thirds of their budgets to food alone; and non-poor, non-vulnerable households dedicate just over half of budgeted expenditures to food.[135] Less diversification in household welfare sources[136] implies greater risk when consumer prices are volatile.[137]

SOCIAL ASSISTANCE PROGRAMS & LIFE-CYCLE RISKS ADDRESSED

Current social assistance programming addresses many of the risks explored above. For example, the Rastra program provides monthly subsidized-rice packages to targeted households; program implementers intend both to keep the local price of rice stable, as well as provide a direct near-cash transfer to poorer households. The JKN-PBI health insurance or fee-waiver program and the CCT program (Program Keluarga Harapan, or PKH) both work to increase access to healthcare services; the former lowers the cost of access for individuals of any age, while the latter conditions the receipt of cash transfers upon healthcare visits for pregnant mothers, their newborns, and their toddlers. The PIP and PKH programs should also work in concert in the education sector: both programs provide cash transfers to targeted households that have demonstrated they are making investments in education for their children. Finally, the BLSM unconditional cash transfer protects general welfare in times

[135] Susenas (2014).
[136] Here we take the value of household expenditures as a proxy for household welfare.
[137] Imagine the expenditure-share weighted price change in the household consumption basket when the price of food increases by 10 percent: in poor households, 66 percent of the consumption basket has become 10 percent more expensive while in non-poor households only 50 percent of the consumption basket has become 10 percent more expensive. Diversification as a macroeconomic risk-reduction strategy works at any level of disaggregation. For example, poor households spend one quarter of their food budget on rice alone (and no other food item has a larger food budget share) while non-poor, non-vulnerable households spend one-quarter of their food budget on prepared food alone (and no other food item has a larger food budget share). But prepared food is itself composed of inputs beyond raw agricultural inputs; prepared food often requires fuel (for cooking and for transport), transport and logistics services, capital investments and infrastructure, and labor. Therefore, when the price of rice goes up by 10 percent, 25 percent of a poor household's food consumption basket will increase by 25 percent. For a non-poor household, the food consumption budget will go up less than that amount as the price of fuel, labor, and capital (and any other inputs to "prepared food") are unaffected.

of acute macroeconomic stress occasioned by subsidy and managed-price reform. In other words, the current array of social assistance programs is a good match to the current array of risks faced by poor households.

However, fragmentation produces a system that is less effective. Nonetheless, social assistance programs are not currently integrated at any level of provision or implementation. Household survey analysis shows that, of the poorest households that are nominally eligible for each of the Rastra, PIP, and JKN-PBI programs, only 8 percent are actually in receipt of all three programs (in 2015), while about 37 percent receive at most two of the three.[138] Therefore, for a household in need of strategies and tools for addressing all risks encountered when they are salient, Indonesia's social assistance system is less effective.[139]

Meanwhile, some important risks do not yet have an adequate counterpart SA solution. For example, low enrolment in structured preschool activities likely reduces school-readiness in poor households, while international evidence shows that thoughtful[140] ECED initiatives can lead to improved child nutrition and health, higher enrolment rates (when basic education begins), and increased mental aptitude, and also that the positive results are often greater specifically for poor households (World Bank, 2012b). Gains to abilities and skill can accumulate through a child's entire education career, so "good starts" may go some way toward reducing the intergenerational transmission of poverty by enhancing learning ability, schooling and future skills development among others.

The elderly are more likely to be poor or vulnerable as they retire without access to pension and to a large extent (40 percent of those over 65 years of age[141]) with no health insurance as well. Indonesia has begun to address this risk through SJSN's BPJS labor program, which integrates and expands the existing suite of labor-related insurance programs including pension and old age savings programs. However, the risk is likely to remain in the medium term for the poor and vulnerable elderly, especially those with a history of informal work. To respond to this risk, that is apparent especially for the poor and vulnerable elderly with a history of informal labor, a non-contributory pension for those who reach retirement age with no pension in place would clearly be beneficial for poor and vulnerable retirees themselves, as well as the households that support them.[142] A specific cash transfer for vulnerable elderly, ASLUT, exists but has had a very low coverage for the entirety of its operation

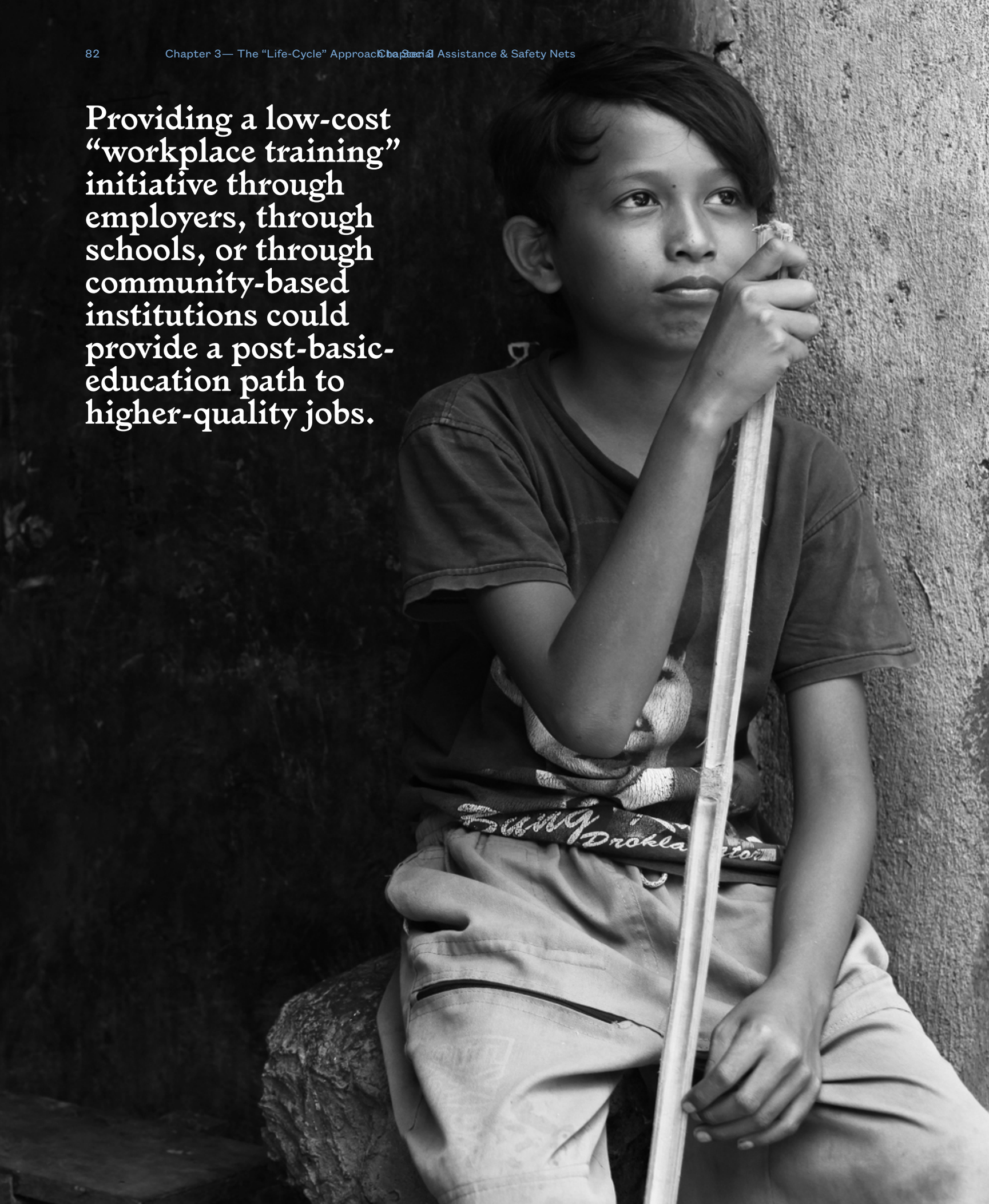
Addressing the risk of disability will require a more systematic and programmatic approach, the initial steps of which were taken recently. A recent law on disability[143] paves the way for some reform at least in terms of inclusion into the labor market: public and private enterprises must have 2 and 1 percent of employees hired be disabled. The law also details the duty of government to protect and rehabilitate the disabled, for instance via social assistance among other pathways, but without an implementation regulation on the law it falls short on stipulating exactly what programs and initiatives would implement the law. An existing program, ASODKB has been in existence but has been mired in low coverage (much like the child cash grant and old age social assistance program). As with the program for the elderly, ASLUT, ASODKB may be merged and expanded within the flagship CCT program, PKH.

Indonesia also provides very little assistance through labor-market "activation" programs. For example, those young adults with poor credentials entering the labor market will more often than not become adults with low-quality jobs and retirees without pensions. Providing a low-cost "workplace training" initiative through employers, through schools, or through community-based institutions could provide a post-basic-education path to higher-quality jobs.[144] Or the high rates of part-time employment among the poor—33 percent of poor, working-age individuals are estimated to be "underemployed"—could be partially ameliorated with workfare programs, including a "basic income transfer" to families for whom workfare labor does not provide a large enough income boost to make the program worthwhile.[145]

Increased exposure to macroeconomic also remains uncovered. While the 2012 Social Assistance Public Expenditure Review recommended that an automatic, temporary, emergency income support facility be established for the poorest households experiencing adverse advents as a result of macroeconomic stress, no such facility has yet been established. The nascent CMRS has established a robust monitoring protocol hosted by TNP2K, but the countercyclical, automatic SA response, triggered by pre-defined adverse events, is still under discussion. Therefore, the CMRS can help poor and vulnerable households to anticipate upcoming shocks, but it does not (yet) give them any additional flexibility in greeting those shocks when they arrive. In 2013 following a significant reduction in energy subsidies and a noticeable spike in inflation, a temporary compensation scheme (known as BLSM; see also Section 4) was negotiated and delivered. BLSM improved on the share of resources distributed to poor and near-poor households (relative to previous versions of the same program), but it was not certain that there would be any compensation.

[138] PKH was still a very small program covering about 5 to 6 percent of Indonesian households in 2014. The percent of eligible households receiving all four main programs—PKH, Rastra, PIP, and PBI—iswas just over 2 percent in 2014.
[139] The rest of the chapters in this report explore the institutional complexities of SA provision in Indonesia that lead to this mismatch between an "effective on paper" system and its "in the field" results.
[140] Internationally, effective ECD initiatives include parental involvement in program design, service provision, and scheduling and provide parent training; collaboration with local stakeholders and active NGOs; and cost-sharing between governments and beneficiaries so that each side has "skin in the game".
[141] Susenas 2016.
[142] Indonesia previously had a very small non-contributory pension program covering only around 26,500 individuals. When the pension initiative under the National Social Security Plan (SJSN) is fully operational, the Government intends to offer subsidized contributions as a benefit to targeted poor and vulnerable households. For a more detailed look at ageing in Indonesia and beyond, see World Bank 2016c. Live Long and Prosper – Aging in East Asia and Pacific.
[143] UU 2016 no. 8
[144] See, for example, World Bank 2011c "*From evidence to policy. Do vouchers for job training programs help?*" Human Development note No. 65766 for evidence from Kenya.
[145] Piloting both workfare programs and a "basic needs" transfer were also recommendations from the 2012 Social Assistance PER.

Providing a low-cost “workplace training” initiative through employers, through schools, or through community-based institutions could provide a post-basic-education path to higher-quality jobs.



CHAPTER 4

Integrated Social Assistance: Possibilities & Benefits

Indonesia needs to spend more on social assistance and more importantly use available resources more effectively for continued contribution in poverty and inequality reduction. While the household targeted social assistance spending have grown since 2005, as a percentage of total public spending the overall social assistance expenditure has stayed roughly constant in the decade between 2005 and 2016.[146] As the pace of poverty reduction has slowed: from 1.2 percentage points reduction in the national poverty headcount poverty rate per year between 2007 and 2010, to 0.5 of a percentage point between 2011 and 2017, the demand for improved implementation performance and the collective impact of major social assistance programs is greater than ever before.

[146] Because there were about 6 million fewer poor individuals in 2015 (than there were in 2005), "per poor capita" real social assistance expenditure as a percentage of GNI per capita had increased from 3.3% in 2005 to 4.6% in 2015.

The existing social assistance programs could bring bigger collective impact in poverty reduction if better integrated. This report documents that while each individual program is relevant for poverty reduction by creating a transparent pathway for beneficiary households to mitigate a clearly-defined risk, none of these individual initiatives is by design to help all targeted households fully mitigate or absorb all risks. These programs either do not provide a transfer large enough, or cover a large enough number of poor and vulnerable households, to have a significant impact on poverty[147]. Therefore, it is essential to coordinate and joint these programs in order to increase their collective impact. An example of a transfer package comprising of the four major social assistance transfers) would boost eligible households' income significantly larger than what have been actually seen among the poor population.

A truly integrated social assistance system would help a household respond effectively to any risk encountered. For example, an economy-wide shock such as a poor harvest may put consumption expenditures of many people at risk. A household may respond by pulling children from school or forgoing health care. A social assistance system that at least partially restores consumption levels will save individuals and households from short-term poverty. However, if the transfer is not large enough or if there is not a separate incentive for keeping children in school, there may still be a long-term negative impact on welfare from reduced schooling. Therefore, this integrated social assistance system would provide likely multiple but coordinated interventions for both immediate relief and long-lasting incentives for health, education, as well as in some cases riskier but more productive income-generating activities that reduce inequality of opportunity for children and adults alike.

An integrated system could also tailor protection strategies to all vulnerable population. In Indonesia, each program naturally focuses on the needs of the specific population for which it is responsible. As a consequence, individuals with some unique characteristics might fall into cracks between the existing programs. For example, there are no significant, national level programs or dedicated agencies for female-headed households, informal-sector workers who live alone or for orphans.[148] If there were, the additional program would very likely be implemented in a "self-contained" manner and with little coordination with other relevant or even complementary programs. Under an integrated regime for policymaking, planning, and implementation, every agency would have incentive to determine individually and jointly how best to reach these disadvantaged groups.

Integration would help Indonesia achieve better fiscal performance. To reduce poverty efficiently given a limited pool of resources, inclusion errors or benefits should be received by as few non-targeted households as is politically, socially, and culturally feasible. However, while Indonesian social assistance programs currently have the same target population in principle, in reality they reach different populations due to uncoordinated implementation. For example, large numbers of non-poor households receive subsidized Rastra rice and utilize JKN-PBI. These inclusion errors increase the cost (to the Government) of reducing poverty through those programs. Another potential efficiency gain is from sharing common processes. The current practices is that each agency delivering social assistance manage all related business practices—data management, compliance verification, updates and payments—which require structures and skills not often internally well-developed. International experience suggests that delegating these program processes or sub-processes allows each agency to focus on their own comparative advantage. Likewise, programs that operate independently of a common policy framework do not naturally achieve coordination on sector-wide performance targets.

POTENTIAL IMPACTS FROM INTEGRATION

While social assistance in Indonesia covers more individuals than ever before, few poor and vulnerable households yet receive a complete benefit package. The social assistance programs covered in this series have broader or narrower upper income (or "means") cut-offs that delimit their target populations, but they all target at least all poor households. Since the publication of the 2012 Social Assistance Public Expenditure Review, JKN-PBI targeted an additional 15 million beneficiaries; PIP targeted an additional 10 million students; and PKH targeted nearly 4.5 million new families. Rastra coverage stayed roughly the same in terms of the absolute number of beneficiaries targeted. However, the proportion of poor households receiving all four "main" programs—Rastra, JKN-PBI, PIP, and PKH—was just over 1 percent in 2013 and just over 2 percent in 2014.[149]

[147] To reduce the incidence of poverty or poverty correlates (achievement gaps in education, in healthy behaviors and health outcomes, or in wages and productivity, for example), benefits provided to targeted households should be large enough to erase their income gap or, when transfers are conditional upon behaviors, large enough to allow households to comply fully without further impoverishment. In the poorest 10 percent of households ranked by consumption expenditure, Rastra covers the most households (68 percent of this decile buys Rastra rice) but Rastra has the lowest transfer value at 4 percent of average total consumption expenditure in this decile. In contrast, PKH has the lowest coverage at 9 percent and the highest transfer value at around 13 percent.

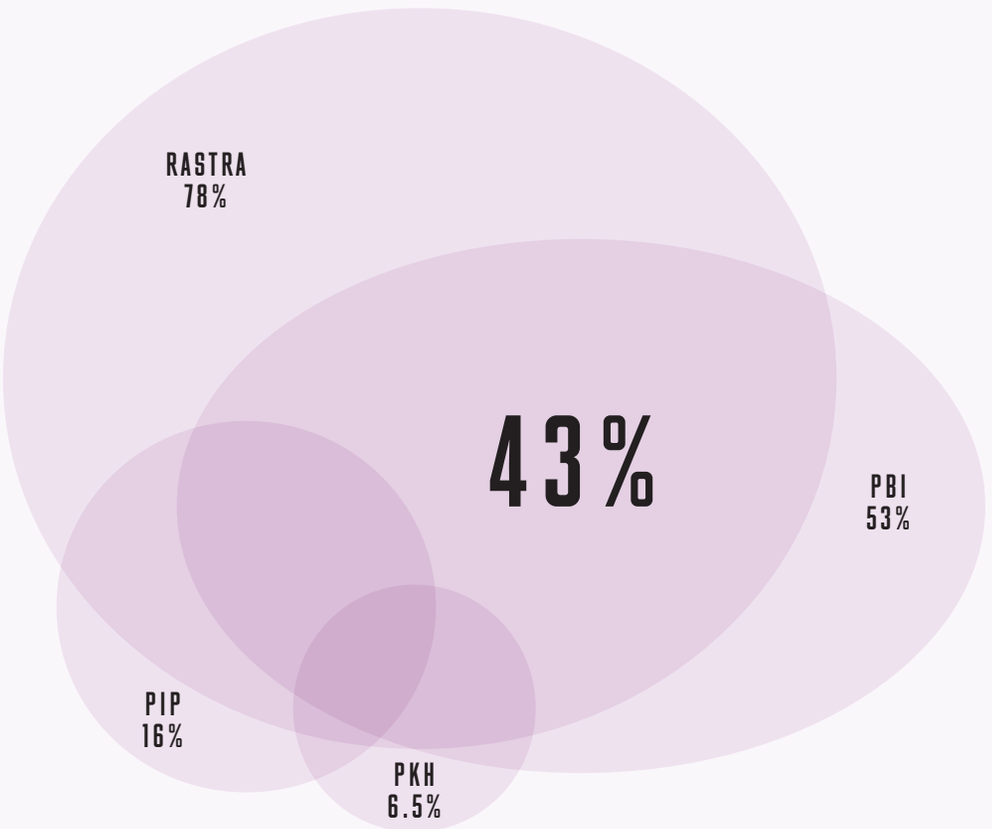
[148] Programs exist for elderly, or for disabled individuals but have been kept at very low coverage.

[149] Observers suggest the percentage-point increase in complete SA-program-portfolio coverage can be traced to coordination efforts (led by TNP2K) that led to the adoption, by all main social assistance programs, of the UDB standard for determining eligibility for new beneficiaries.

A lack of enforceable common standards for local social implementation exacerbates negative effects of a fragmented social assistance architecture. Low program coverage is observed across the array of social assistance, and is partly due to leakage of benefits to non-poor, non-vulnerable households. Qualitative and quantitative evidence from Indonesia suggests that idiosyncratic and varied eligibility determination procedures, targeting frameworks, and benefit ownership and control rights account all have negative impacts. For example, the allocation of "rights" to purchase subsidized Rastra rice is done by village heads and sub-village administrations; a portion of PIP benefits (and the right to distribute them) are still controlled by schools and their local and regional stakeholders; and the distribution of previously Jamkesmas now Kartu Indonesiat Sehat (KIS that proves the recipient is part of JKN-PBI) cards has not previously been monitored or evaluated. That such practices are tolerated indicates a low level of coordination between central-government-level policy planners and funding authorities and the regional- and local-level administrations who have been delegated crucial portions of important social assistance processes.[150] Furthermore, these entrenched and idiosyncratic operating principles suggest that increasing any single program's coverage will bring only a small percentage of targeted households a "full" benefit.

Sizeable, one-time reductions in poverty could be achieved through integration at the household level. To simulate an "integrated" transfer, a single benefit comprised of all the existing cash transfers (PKH and PIP) and a monetized value of the Rastra in-kind transfer, was introduced into a static expenditure model. Smaller and larger groups were "targeted": the smaller (larger) group is defined as the bottom 10 (40) percent of Susenas households ranked by pre-transfer expenditure. Table 4.1 illustrates that a single, integrated benefit could provide a significant boost to consumption expenditure of 14 to 21 percent of an average targeted household's budget.[151]

FIGURE 4.1 SA convergence in the poorest 10 percent of households



ALL FOUR	2.2%	PIP,PKH	2.6%
RASTRA, PBI, PIP	11%	RASTRA,PIP	14%
RASTRA,PIP,PKH	2.5%	RASKIN, PKH	6%
PBI,PIP,PKH	2.3%		

Source: Susenas 2014 and World Bank staff calculations.
Note: PKH's overall coverage is low and is (technically) restricted to the extreme poor; due to PKH's small size, Susenas tends to under estimate the actual size program, leading to lower program overlap among the poor or vulnerable populations.

TABLE 4.1

Integration scenario share out of household expenditure by target group

Target group	Average monthly HH expenditure (IDR)	Average monthly	% of PKH recipients who
Poorest 10%	1,306,137	251,406	19%
Poorest 40%	1,814,236	234,972	13%

Source: Susenas 2016.

A lack of enforceable common standards for local social implementation exacerbates negative effects of a fragmented social assistance architecture.

[150] Unlike most other public social expenditures which are in large part executed by regional governments (primarily district-level governments), 85 percent (on average) of social assistance programming expenditures are centrally executed. See the Expenditure Summary report in this series or World Bank (2012j) for more detail on the history and contemporaneous particulars of this arrangement.
[151] Larger transfers are expected to have both macroeconomic and micro-behavioral impacts. For example, inflation (including higher charges by service providers with knowledge of an individual's beneficiary status), family planning decisions, and consumption patterns would all be expected to change if SA benefits were integrated at the household level. The static expenditure model explore here cannot account for these general equilibrium effects.

A single benefit also generates larger reductions in poverty, vulnerability and inequality than the current fragmented benefit package (Table 4.2). For example, the "overnight" reduction in the headcount poverty rate that would result from benefit integration is expected to be 2 to 4 percentage points. For reference, if actual headcount poverty continues to fall at the rate experienced between 2013 and 2016 (about 0.1 to 0.5 of a percentage point per year), it would take about 10 years to achieve the "overnight" reduction that the least expensive integration scenario achieves immediately. [152]

INTEGRATION NEEDS TO ACCELERATE & LEARN LESSONS FROM OTHER COUNTRIES

Indonesia has made the initial steps toward greater integration by launching the SLRT and ODA initiatives as well as the movement toward digitizing social assistance payments. The Integrated Referral System (SLRT) is implemented by MoSA. The program has the purpose to help identify and refer poor and vulnerable households to social protection programs via the facilitators and 'single-window' offices at the district level. The program facilitators use a tablet-based application that contains relevant data from the UDB, key information about national and local programs as well as an assessment instrument to define a household's welfare status. After an initial piloting phase during 2015-2016 the program was deemed to have a high potential and was scaled up to be implemented in 50 districts in 2016 and up to 150 districts by 2019. Up until 2016, 59 local governments have helped refer 146,000 households for further assistance. The On Demand Application (ODA), managed by TNP2K, was designed to work in tandem with the SLRT and has the purpose to update household information that is used in determining eligibility and relative welfare status used in targeting. ODA has been piloted and is operating in 12 districts.

In line with the governments push to achieve greater financial inclusion, the government has mandated to digitize all social assistance payments. [153]With the purpose of increasing efficiency and ease of access to social assistance transfers, the government plans to integrate all social assistance payments under the KKS card. More recent developments toward digitally rendered social assistance transfers are being spearheaded by MoSA, with 1.4 million previous Rastra recipients now receiving an e-voucher benefit via the KKS card and E-Warong delivery system. In addition, MoSA aims to render PKH transfers to all 6 million beneficiaries via a collection of state owned banks (HIMBARA) and also using the KKS card as the unified payment platform.

Latin America's experience can provide Indonesia with possible strategies for sector-wide integration and for integrating all levels of government to better deliver on shared social assistance tasks. International experience suggests that there is more than one way to effectively and efficiently distribute essential social assistance delivery processes between agencies, and between central and local administrative authorities. For example, Brazil consolidated at the central administrative level its diverse landscape of social assistance initiatives into a single program uniting education-, health-, nutrition-, and basic income-focused transfers for poor and vulnerable households. Chile and Colombia proceeded in a slightly different fashion: coordinating on delivery standards for national and local initiatives alike, as well as strengthening the provision of complementary public services to enhance the local coverage of poor and vulnerable households.

The establishment and refinement of a common, authoritative targeting and beneficiary selection procedure has been an integrative catalyst. The approaches to integration de-

TABLE 4.2

Estimated impact of integration on poverty, vulnerability and inequality

	Headcount poverty (%)	Gini coefficient
2016 September	10.7	.397
Integration: 10% level	8.65	.394
Integration: 40% level	6.72	.388

Source Susenas 2015/16.
Note the following targeting accuracy assumptions are based on survey data SA incidence levels extrapolated to an expanded overall coverage level of 40 percent:

10% level 55% of Decile 1 (D1), 20% of D2, 15% of D3, 10% of D4

40% level 90% of D1, 75% of D2, 65% of D3, 50% of D4, 40% of D5, 30% of D6, 20% of D7, 15% of D8, 10% of D9, 5% of D10.

[152] In results not presented, the integration simulation is run with parameters describing known SA implementation weaknesses like local benefit deduction or local re-allocation of benefit pools to larger populations (and resulting benefit dilution). With these parameters included, poverty rate impacts are reduced by 0.12 to 0.18 of a percentage point.
[153] The PIP program under MoEC and MoRA has had payments rendered with the help of the BRI and BNI banks already since 2013.

tailed below have in common the foundation (and further development) of a unified targeting system that identifies and selects beneficiaries from common populations. In Colombia, for example, nationally- and locally-executed social assistance programs converged operationally around a common target population established by an authoritative household registry. Indonesian programs have a common targeted population in principle but in practice each program makes a unique determination of eligibility and beneficiary selection. If instead for each program an authoritative registry of households was consulted to select beneficiaries according to common and authoritative procedures, poor and vulnerable households would have an integrated benefit package regardless of the extent of institutional or central-local integration.[154]

Brazil has led the way in creating "single window" service for social assistance beneficiaries. In 2003, Brazil began to merge food, gas subsidy, and direct cash transfer programs into a single benefit called *Bolsa Familia* or the ("Family Grant").[155] *Bolsa Familia* remains today a conditional cash transfer in that benefit receipt depends on health care, and primary and secondary education utilization. *Bolsa Familia*'s target population includes any family living below the national poverty line (about 13 million families in 2015), but the size of the benefit depends on household composition and characteristics.

Brazil's single transfer is executed by a single ministry, while sub-processes are delegated to government agencies with comparative advantages. *Bolsa Familia* is planned, administered, implemented, and evaluated by the Ministry of Social Development, but many sub-operations are delegated to other government actors at local, regional, and national levels. For example, the state-owned Caixa Economica Federal bank gathers and reports compliance data generated by health, education, and local government providers; collects and reports updates (made by municipalities) to the Unified Beneficiary Registry (Cadastro Unico); and generates payment instructions, and then makes payments, for all active beneficiaries. The municipalities themselves register families, or update the information of those already registered, in the Cadastro Unico; coordinate and monitor compliance verification reporting by health, education, and local government service providers; are the first point of contact to receive complaints and grievances about either *Bolsa Familia* itself or the Cadastro Unico; and provide links for *Bolsa Familia* households to complementary services and benefits in health, education, and livelihood initiatives (including microcredit and professional counseling) .

Colombia has used a single targeting framework to integrate programs institutionally and at the household level. In 1994, Colombia established a national targeting system—the Colombian System for Selecting Beneficiaries for Social Programs (SISBEN)—to distribute all social assistance expenditures; SISBEN has been updated regularly and remains the authoritative system for identifying and selecting beneficiaries for an evolving suite of financial and social assistance programs.[156] A central government agency formally administers and executes the system—for instance eligibility cut-offs and eligibility determination are completed centrally—while municipalities are tasked with day-to-day operations such as maintaining and updating the registry through applications and grievances received. [157]

Colombia has deployed outreach and facilitation to integrate a diverse program mix at the beneficiary level. Colombia also uses the locally-operated SISBEN system to identify families for the "Together" program, which provides to families a social worker or facilitator who liaises with locally-available social programs and service providers, for example child care and youth training providers, micro-credit facilities, conditional cash transfer programs or scholarships, and housing subsidies. So while integration "at the top" is achieved via adherence to a common standard (embodied by the SISBEN system), integration at the household level is achieved by linking benefits to households through facilitation and active outreach.

Chile's long-standing[158] and authoritative household registry has evolved to capture deprivation, vulnerability, and the relevant risks to well-being in all their forms. By now, about two-thirds of the population (3.7 million households containing about 11 million individuals in 2011) are registered. There are 14 ministries, 24 social services and 200 programs that use the registry to select beneficiaries,[159] which suggests that common standards, when authoritative, can integrate operations even when the programmatic landscape is diverse and the implementing agencies are numerous. Also similar to Colombia, day-to-day operations such as maintenance, updates, and complaint-handling are delegated to municipalities, while financing, planning, administering, quality control, evaluation and user guidelines are completed by the central government. Crucially, household ranking and determination of eligibilities are also completed at the central level and communicated to municipalities.

Chile is also using outreach, service provider linkages, and coordinated social assistance delivery to ameliorate poverty holistically. Households found to be living in extreme poverty are provided two years of professional social counseling services from a locally-based social worker. This social worker formulates a poverty-exit strategy with the household and links them to complementary (and locally available) services to enhance the household's collective human capital, the value and productivity of their dwelling, and the household's ability to generate income. Agencies providing services and programs are encouraged to coordinate on service schedules specifically for extremely poor households. Meanwhile, households receive direct cash transfers that can continue for up to 3 years after the 2-year facilitated introduction (Galasso, 2011),[160] while facilitators regularly monitor a household's progress with respect to its own plan.

[154] Indonesia has already made great strides in this direction with the establishment of the UDB for Social Protection. However, the UDB is not yet authoritative in the selection of beneficiaries, which limits its usefulness as a common standard around which program implementers can converge
[155] Created in October, 2003, Law No. 10.836, 2003.
[156] The first introduction of a targeting instrument to allocate subsidies of social programs was made in the Law 60 of 1993 (Arts. 2 and 3). A task force within National Planning Department (DNP) was in charge of designing and implementing SISBEN; the same team provided assistance to local governments (departments and municipalities) in SISBEN implementation in their areas. Beneficiary eligibility is determined by a proxy means test (PMT) over a set of socioeconomic and demographic variables.
[157] Municipalities also contribute a small portion to SISBEN's operating budget.
[158] Chile's main targeting system, the *Ficha Comites de Acción Social* (Social Action Committees Registry), was established in 1981.
[159] While single initiatives use different eligibility definitions—some use the poorest 5 percent, some the first, second, third, or even fourth poorest quintile, and some use a means cutoff with additional characteristics like disability or advanced age—they all implicitly submit to an eligibility standard that is determined by the same household registry.
[160] The initiative program also now includes a social protection objective: households facing uninsured risk are protected from further impoverishment.

Summary & Main Recommendations

Indonesian administrations have pursued logical, progressive, and empirically founded revisions to SA operations and institutional structure, but overall the pace of reform has been tentative. For example, though public expenditures on household-based social assistance programming have spiked to nearly 1 percent of GDP in years in which fuel subsidies were reduced or eliminated, those increases were temporary; as a share of GDP the level of spending on permanent household-based social assistance programs has remained about constant from 2005 to 2016. Likewise, major coverage increases in most of the main permanent programs have been too small to fully cover the targeted populations. At these spending and coverage levels, Indonesia's social assistance programs eliminate less than 20 percent of the total poverty gap. Operational reforms have been haphazard: some programs have pursued operational reforms, while ignoring their own inefficient institutional arrangements; some have been radically reformed institutionally, while ignoring ineffective operational practices; and some have not made significant reforms in either area.

The current collection of programs should be enhanced to cover more of the salient life cycle risks. Both the previous Social Assistance Public Expenditure Review and this report have noted that there are noticeable gaps at crucial junctures in an individual's life cycle (in addition to gaps in coverage for social assistance transfers that do address salient risks, see below). In particular, for younger-than-school age children and their parents, there is no national, programmatic ECED initiative. For those at the end of their schooling career entering the labor market for the first time, or for those whose lack of schooling have left them in low-skilled, low-paying jobs, there are no national labor-market activation, skills training, second-chance education, or employment services initiatives. For those nearing retirement, there is no social pension system through which welfare levels can be maintained even after labor-market productivity falls. The nascent CMRS has established a robust monitoring protocol, but the countercyclical, automatic SA response, triggered by pre-defined adverse events, is yet to be institutionalized. The current incarnation of the CMRS could help poor and vulnerable households anticipate upcoming shocks, but it does not give them any additional flexibility in greeting those shocks when they arrive.

Independently implemented programs should be integrated under a "One-System" type of approach to cover all individuals in the targeted population and provide the government a more efficient and effective SA delivery system. Three of four of the permanent social assistance programs dramatically increased coverage between 2012 and 2016 (while the fourth had roughly constant coverage), and yet in 2014 less than 5 percent of eligible households in the poorest expenditure decile received all four programs. There are limits, in other words, to comprehensive SA coverage through program expansion alone. Both this report and the previous Social Assistance Public Expenditure Review recommend achieving comprehensive coverage of households and risks through coordination and integration in the social assistance sector instead. The greater the degree of integration, however it is achieved, the less likely any eligible household will fail to receive any particular transfer or service, or initiative that the social assistance sector provides, and the more likely that poverty—which is a multi-dimensional problem—can be affectively ameliorated by a collection of one-dimensional programs addressing in concert the multiple needs of poor and vulnerable families.

Simultaneously, the currently operating social assistance programs should aim to deliver the right benefits to the right people at the right time. For instance, Rastra promises beneficiaries 15 kilograms of rice per month, but delivers only a fraction of that amount. PIP revises its benefit magnitudes too infrequently for beneficiary households to keep up with the increasing costs of and education (in which both PKH and PIP require investment). While the Rastra program—which provides a very small benefit to a population with a significant proportion of untargeted, ineligible beneficiaries—remains the second-largest SA initiative (in terms of public expenditures), the PKH program—which provides a significant benefit to a small population most of whom are actually targeted by the program—remains the smallest (in terms of total public expenditures absorbed by the PKH program). In other words, less effective social assistance transfers are still receiving large budget shares, while more effective social assistance transfers receive small budget shares. The first solution to Rastra's benefit dilution problem is to select its beneficiaries strictly from the national registry. The second solution is to deploy a standard delivery platform that is transparent and accountable. The e-Warong initiative has the potential to be such a platform by leveraging an e-voucher mechanism for the Rastra benefit. If managed carefully, this program is likely to increase the allocation of Rastra rice to targeted beneficiaries and so decrease the program's inclusion errors.

The poor socialization and varied targeting that undermined performance in the past have been only partially remedied with the SA-wide adoption of a unified targeting system; additional reform is necessary. Leakage to non-targeted populations still ranges from low (for example, in PKH) to high (for example, in Rastra). This is partially traceable to how thoroughly each program incorporated procedures into standard operating procedures. For example, Rastra uses the UDB to generate regional rice quotas; the determination of the identity of those who have the right to purchase Rastra rice is made locally. PKH's commitment to UDB procedures, meanwhile, is more thorough and even includes bi-directional updating[161] of household status, which keeps both PKH eligibility lists, as well as the UDB, current. An integrated benefit package of all four of the current social assistance transfers, delivered reliably to all eligible beneficiaries, will only occur once all programs thoroughly adopt a unified targeting procedure.

Finally, an important SA reform that will foster greater program convergence is already underway. The Government has recognized the importance updating the national registry regularly, transforming the existing static UDB into a dynamic and two-way registry of poor and vulnerable households, as exists in other countries such as Chile, Turkey, Brazil, and Australia. A more dynamic social registry of poor and vulnerable households will support SA program integration, faster program response to changes in the needs of families, and also allow poor families excluded from social assistance programs to potentially become included. The SLRT and ODA initiatives that are essentially integrated referral systems will require thorough M&E for them to effectively update the UDB, so that it becomes a truly dynamic and inclusive registry of poor and vulnerable households.

[161] As the Government has indicated that the current schedule of nationwide updates to the UDB—the UDB was established in 2011 and updated 2015—will cease. Therefore this bi-directional updating and integrated referral system—where all initiatives making use of the UDB can provide updates on beneficiaries (or potential beneficiaries) in their own program—is likely to become a critical feature of the new national registry interface.

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