Poverty Reduction Through Conditional Cash Transfers (CCTs)

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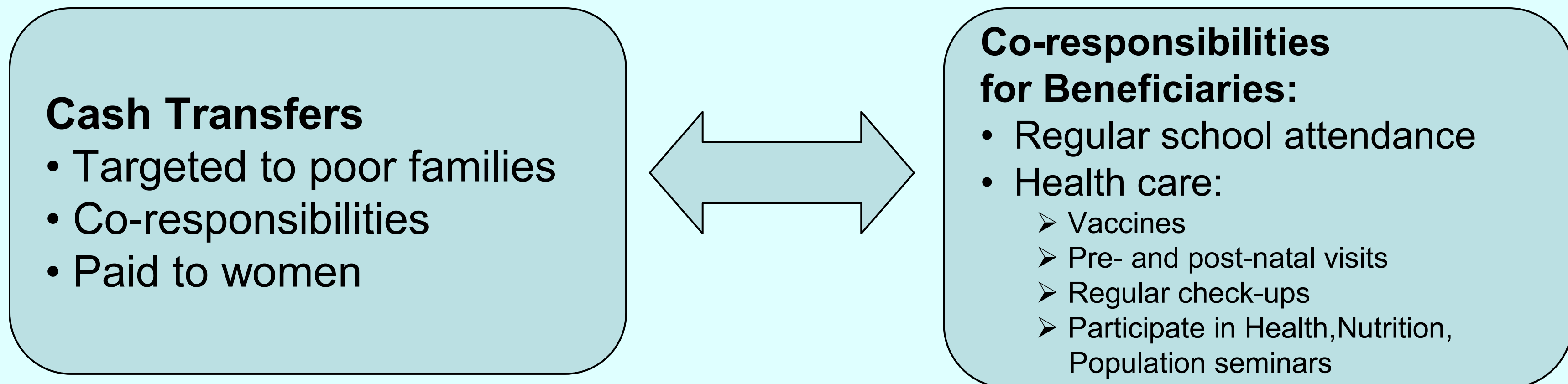
Children in Secondary school in Mexico

Women enrolling in the Child Support Program in Pakistan

How does a CCT work?



Interactions:

(a) "Income effects" of the transfers:

- Immediate poverty relief, redistribution
- All relief has some structural effect (demand for education, health)

(b) "Price effect:" Stimulating demand:

- Conditionality (co-responsibility) aspects of transfers seeks to foster behavioral changes
- Synergies between simultaneously promoting health and education

Seeking to break poverty trap
by providing immediate relief (transfers)
and incentives for investments in health and education

Defining Characteristics of CCTs

CCTs

- transfer cash*
- to poor households chosen through an objective poverty targeting mechanism
- on condition that their children go to school and use preventive health care

Twin goals:

- Immediate income support through cash transfers
- Long run poverty reduction through improvements in poor children's human capital (health, nutrition, and education)

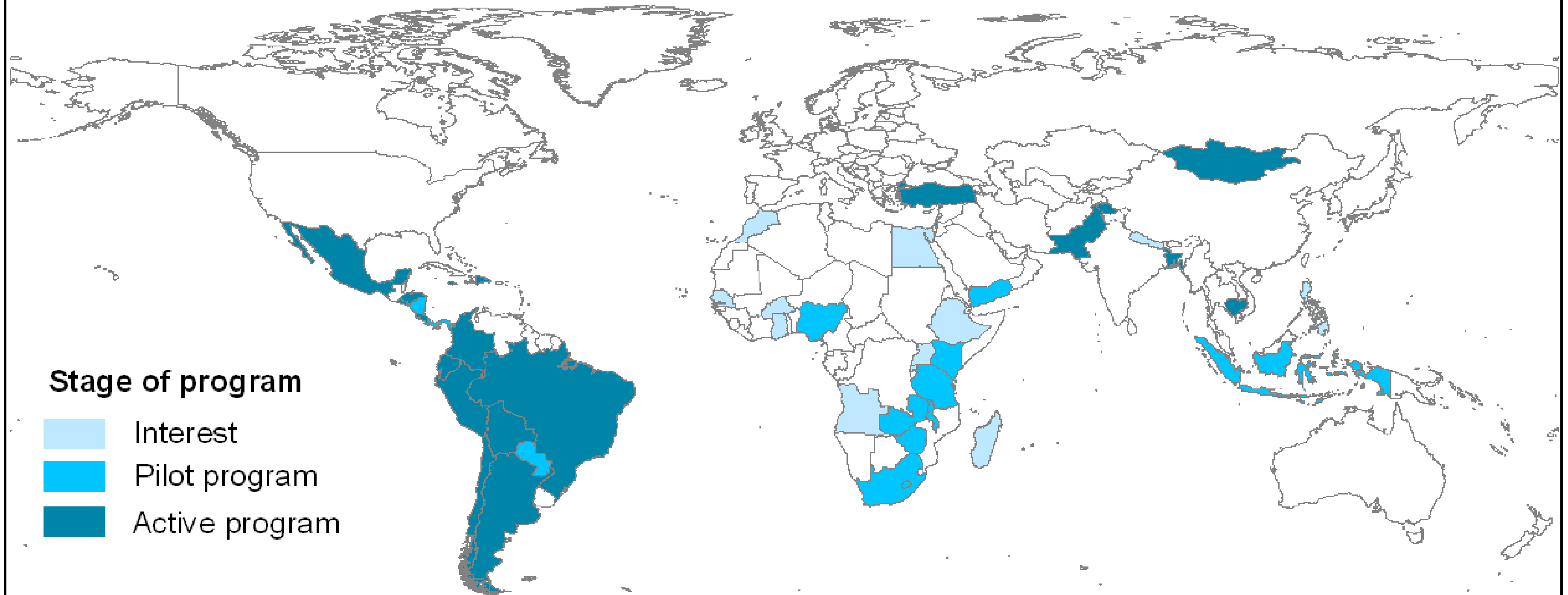
Not a "dole out" because the poor beneficiaries have to comply with specific, monitorable actions to remain in the program.

* food may work too, though with much higher administrative costs

CCT Experience Around the World

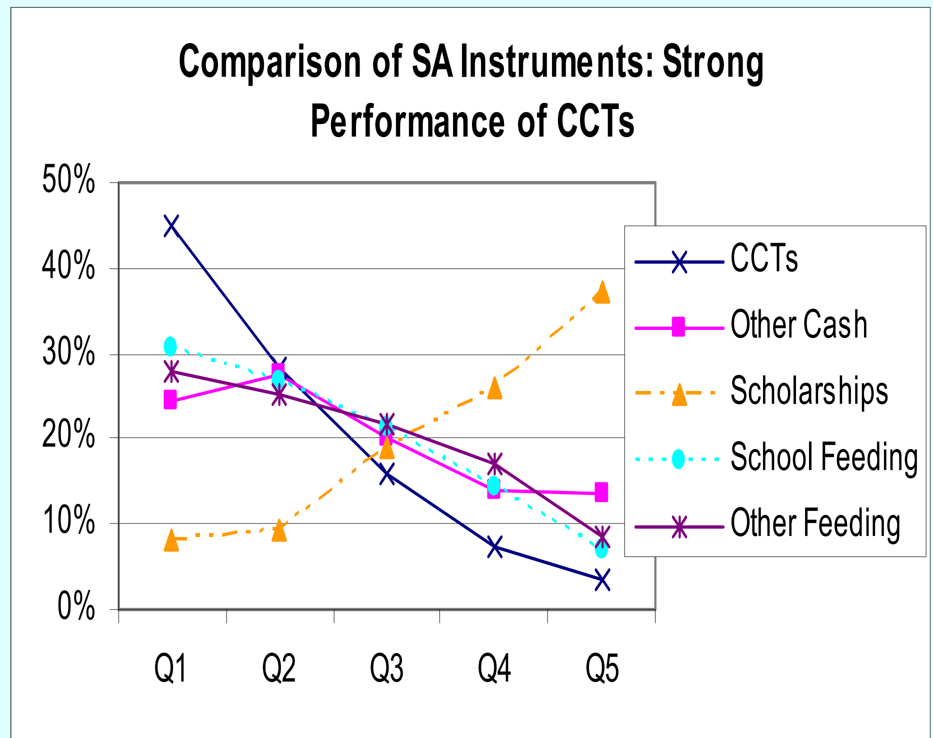
1997
Stage of program
Interest
Pilot program
Active program

2007



Impact Evaluation shows: CCTs reduce poverty

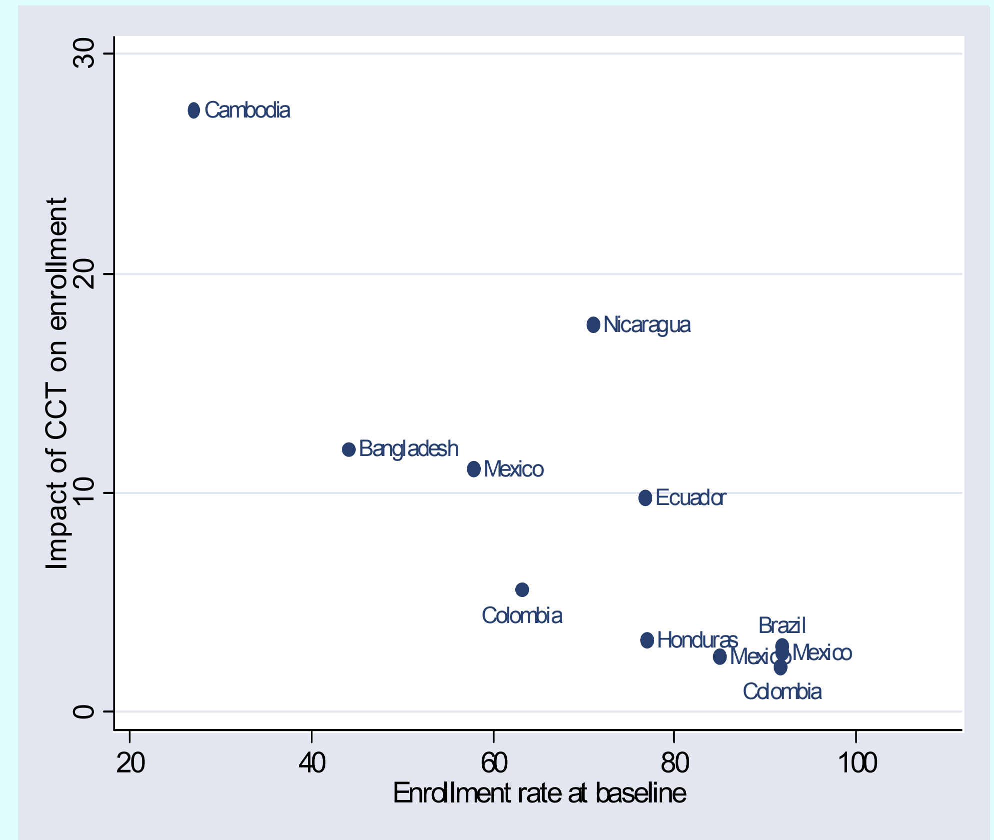
- ✓ Very well-targeted
- ✓ Reduce poverty in proportion to coverage and size of transfer
- ✓ Reduce child labor, but not adult labor
- ✓ Evidence in Mexico that families invest about 25% of their transfer, with a return that raises their income by 24% over 6 years



Source: Lindert, Skoufias, and Shapiro, 2005

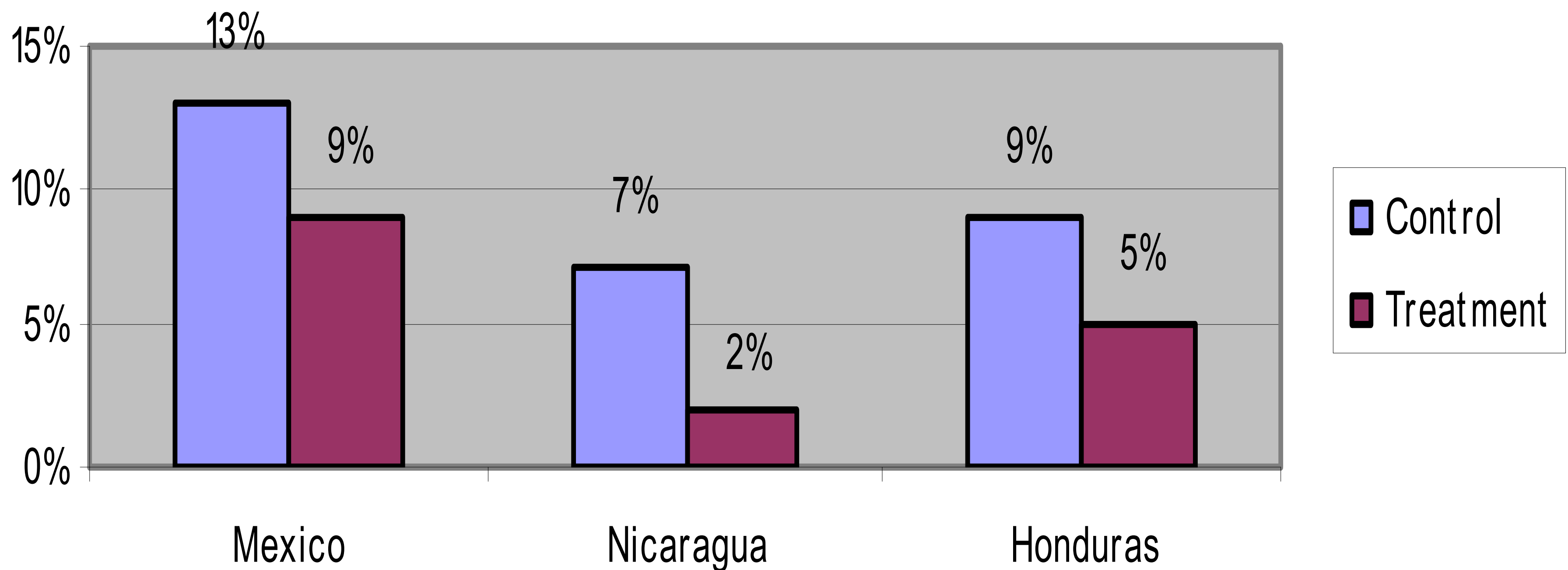
Impact Evaluation shows: increased school enrollment

- ✓ Significant effects in all evaluations done
- ✓ Larger effects for countries and grades with lower initial enrollments
- ✓ Larger effects for the poor, ethnic minorities, girls, those in rural areas

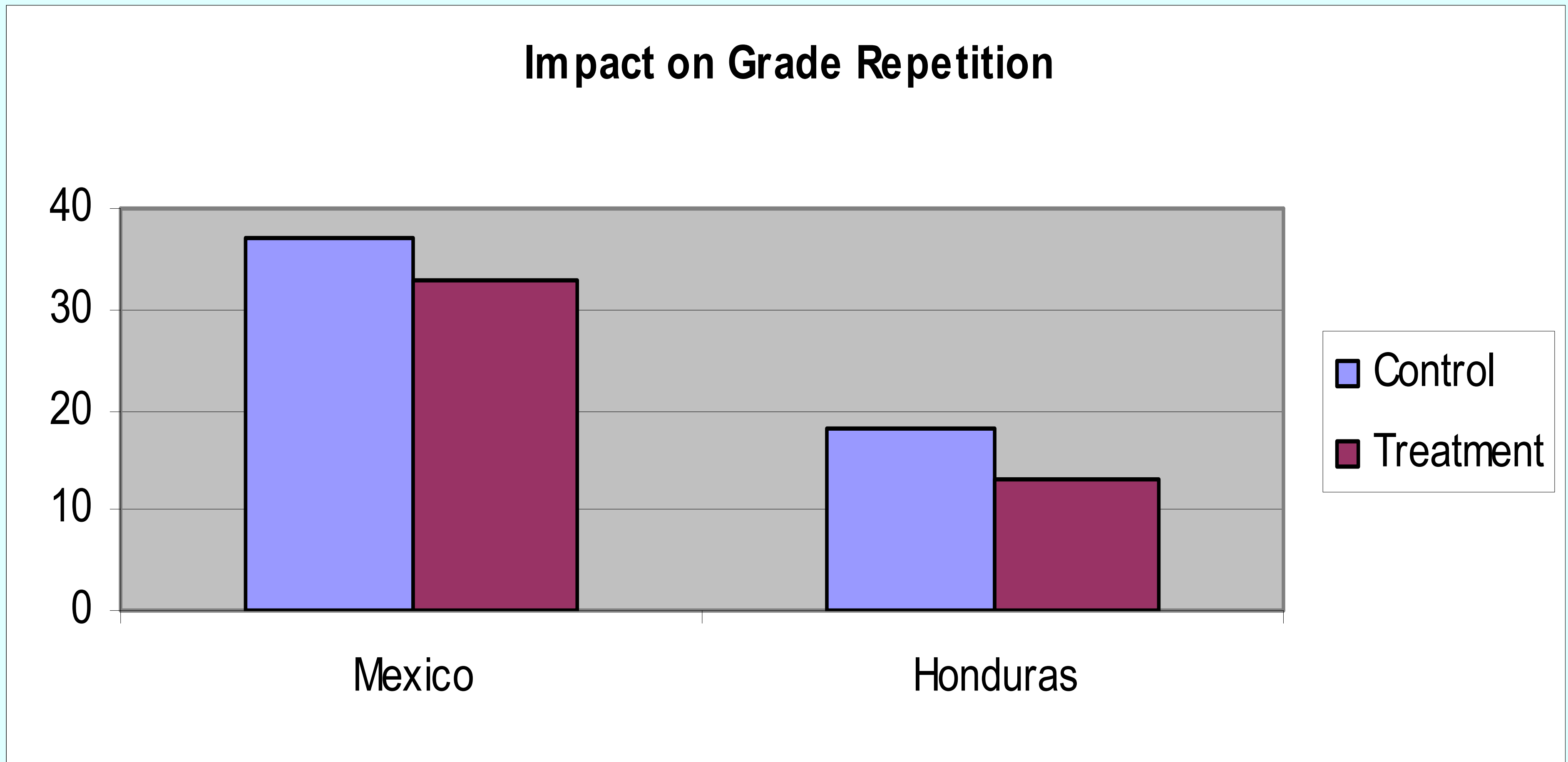


Source: Schady 2006

Impacts on Education



Impacts on Education



Impact Evaluation shows:
higher use of preventive health services

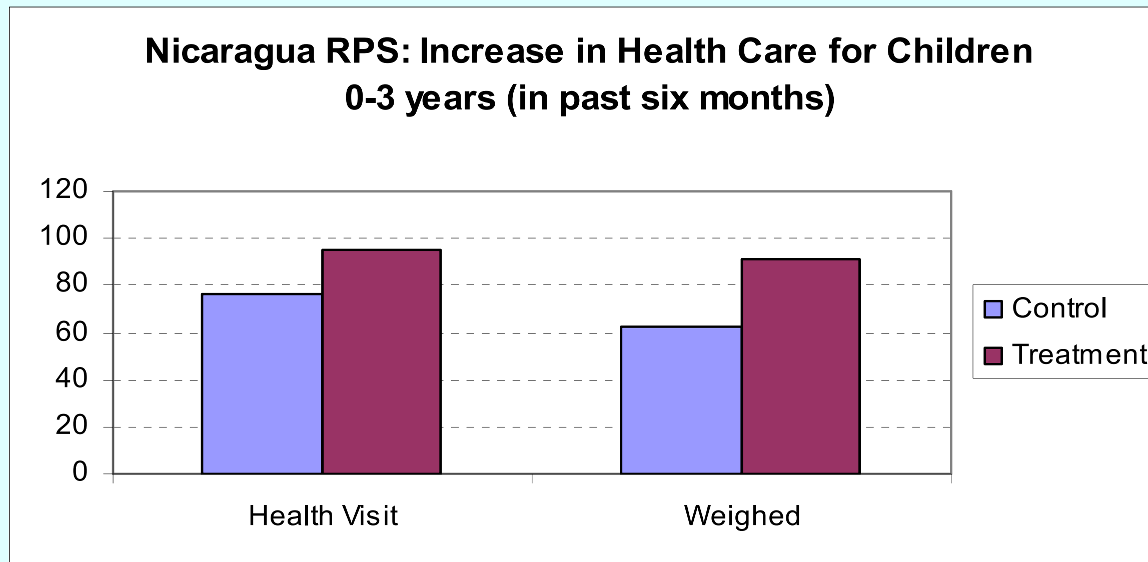
Evidence from four countries (Mexico, Nicaragua, Honduras, Colombia):

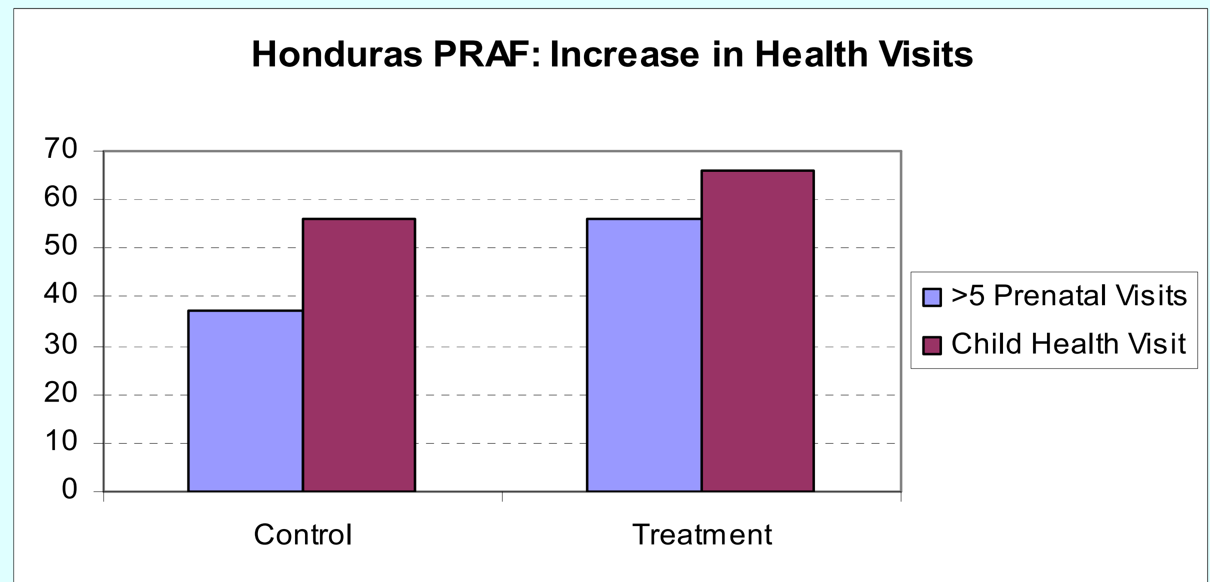
1. **CCTs increase coverage of some preventive services for children, but not others:**
   - Significant effects on use of growth monitoring services
     - Colombia: 23-33 % points
     - Honduras: 20 % points
   - No effects on immunization rates, because already so high

2. **Mexico: Increase in use of preventive health care by adults as well as children**
   - Probability that an adult age 50+ has been taken to a preventive visit is 16 to 18% points higher in PROGRESA-Oportunidades communities
   - Adults more likely to have had check-ups for diabetes and hypertension

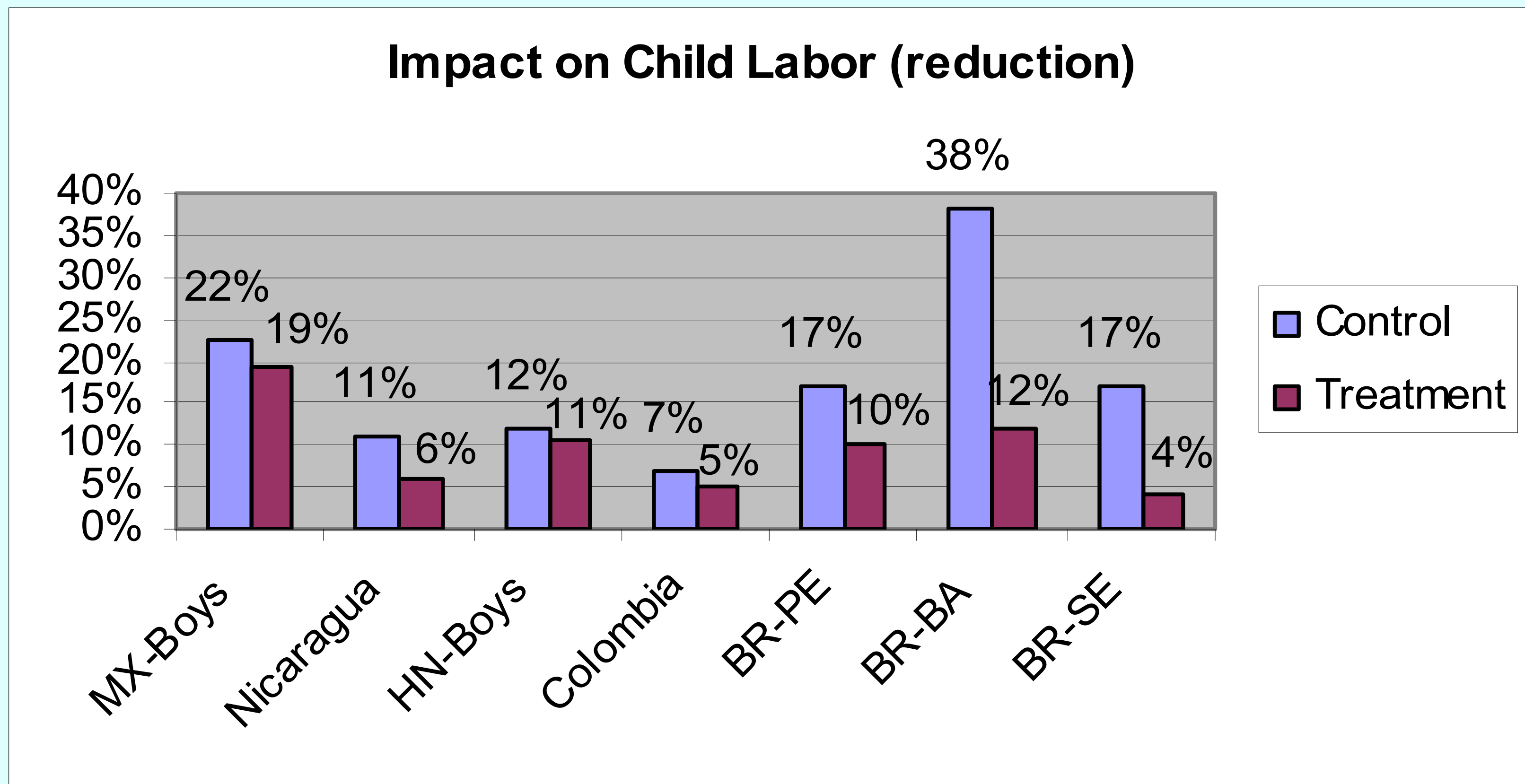
3. **Mexico: Increase in use of public health facilities may be offset by reduction in use of private health care**
   - Reductions in out-of-pocket expenditures on health
   - Unclear what implications this has for quality of care received (may vary by country)

Impact Evaluation shows: increasing number of health visits





Impact Evaluation shows: reduction in child labor



Source: Olinto (2004)

Impact Evaluation shows: empowerment

Empowerment of women

- through paying the transfer to them
- by providing venue/need for participation in community groups, transactions
- Increase in documentation – ID cards, formalization of unions, registration of births
- no increase in family violence

Community

- Increased organization not explicitly sought, but sometimes observed, especially among beneficiaries

Good record on accountability

Many programs, especially the ‘classics” in Latin America, have shown:

- Monitoring conditionalities
  - requires strong Management Information System which safeguards program management more generally
  - makes it hard to invent ghost beneficiaries
- Robust targeting systems deliver benefits to poor families
- Automaticity of payments via banking sector limit possible diversion of funds
- Quality control mechanisms better developed than for many other programs (spot checks, data base cross-checks, hotlines, etc.)
- Good record on transparency
- Systemic and robust impact evaluation

These programs have acted as leaders in modernizing social sector management

CCT in the Philippines

Background: Philippines

- Limited progress in reducing poverty
  - Slower reduction in poverty than in other countries in the region; one-third of population below national poverty line and close to one-half below $2/day poverty line.
  - Poverty rate seems to have increased between 2003 and 2006.

- Education indicators are falling
  - Primary net enrollment rate has fallen in recent years (from 90.29% in 2002 to 84.4% in 2006).
  - Primary drop out rate has risen (from 6.9% in 2003 to 7.3% in 2006).

- Troubling health indicators
  - One of higher maternal mortality rates in the region, esp. among middle income countries

Background: Philippines

Despite huge issue, more could be done to address poverty…..

- Total budget to targeted transfers and subsidies remains small
  - approx. 0.2% of GDP relative to approx. 2.0% of GDP in some Latin American Countries.

- Numerous small transfer programs
  - Largest ones are rice distribution programs
  - DSWD programs are relatively small (only 3% of national budget)

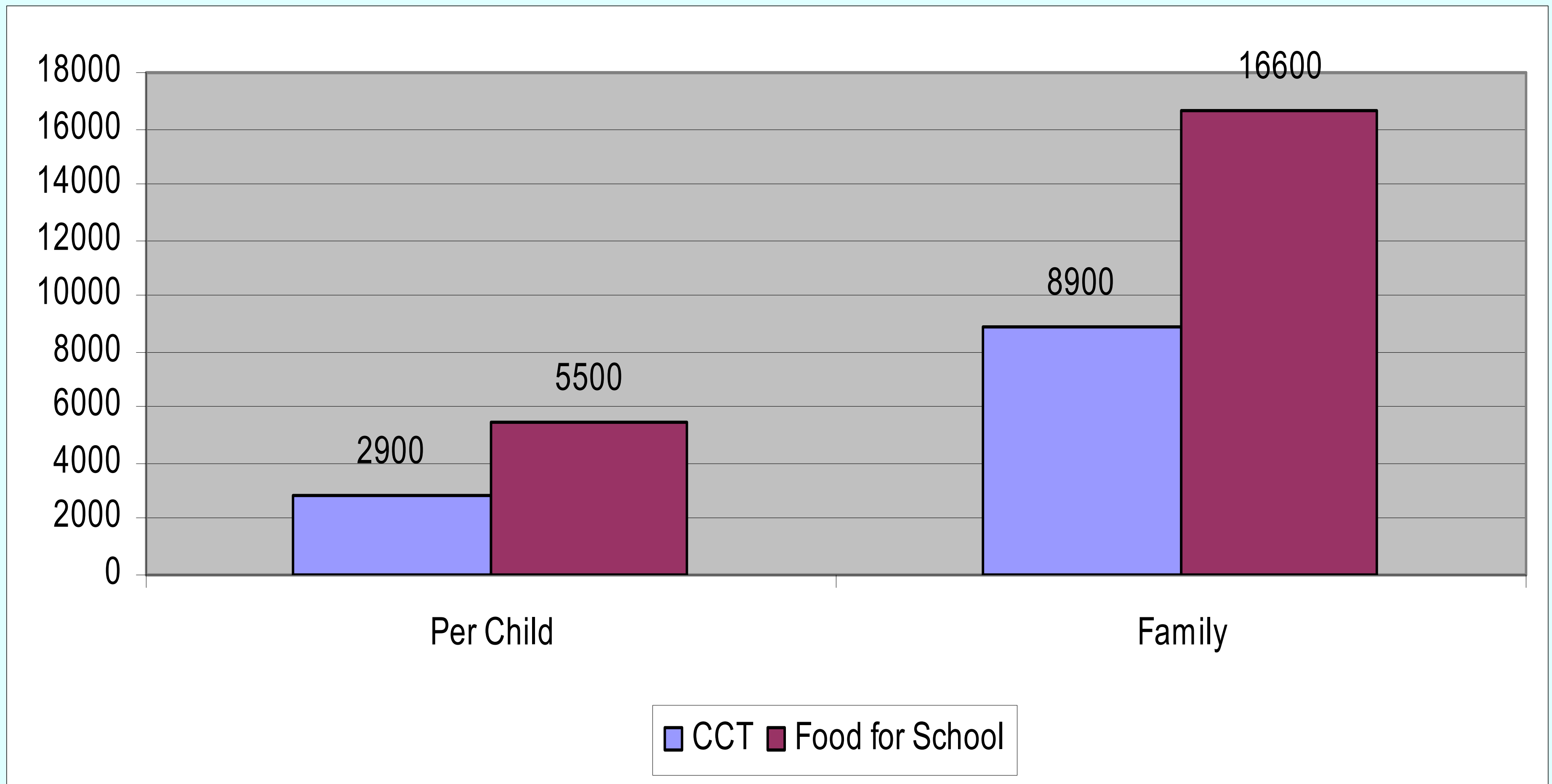
- Targeting is extremely poor
  - Different targeting regimes for different programs (some central and some local government targeting).
  - e.g. Only 38% if food-for-school program estimated to go to the poor.
  - Targeting susceptible and has long history of political intervention

Motivation

- CCT pilot program offers the opportunity to address:
  - Chronic poverty and human capital problems to help break cycle of poverty;
  - Cushion poorest from shocks (e.g. current food prices)
  - Actions detrimental to human capital development of poor as a result of shocks.

- CCT pilot could also be strategic entry point to help country shift to:
  - Better targeting systems and better M&E systems
  - Move from badly targeted commodity subsidies to better targeted cash transfers.

Cheaper delivery than comparable programs



CCT Design Elements
Philippines

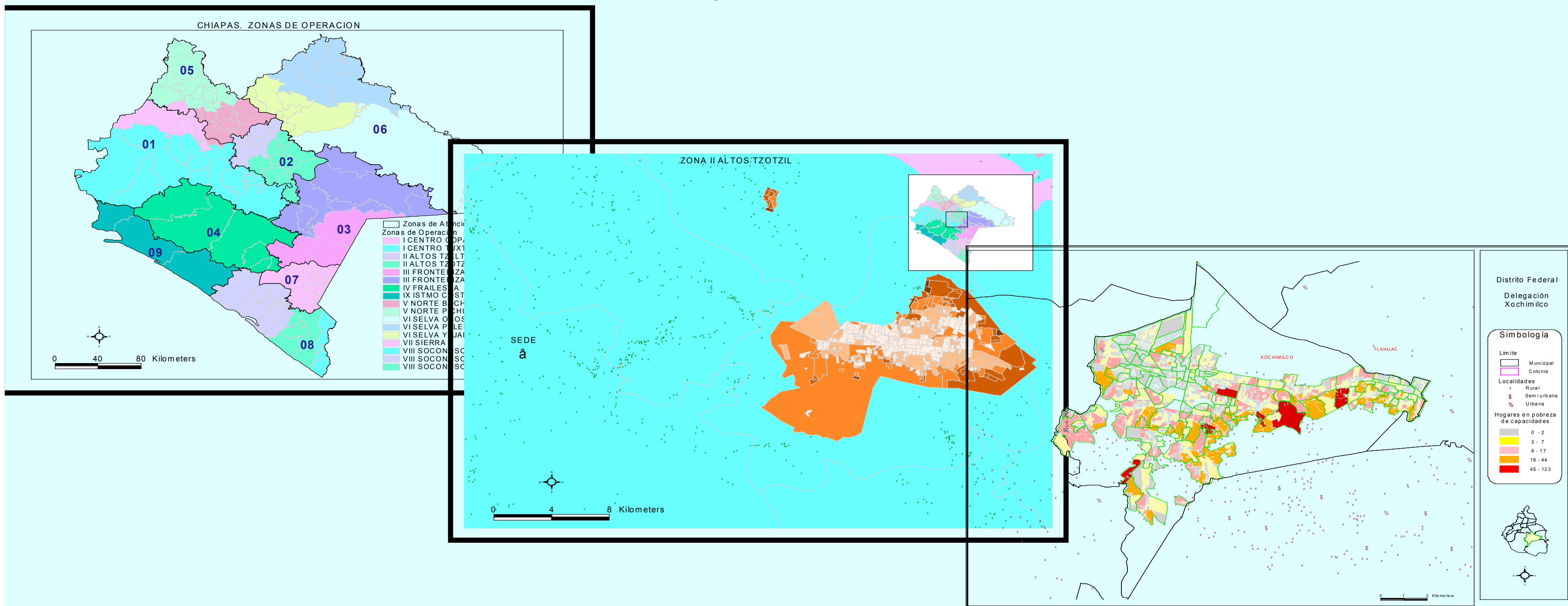
Co-Responsibilities

- **Education**:
  - Regular attendance in school among children (6-14 years)

- **Health and Nutrition**:
  - All children (0-5 years) to complete entire Dept of Health protocol
  - Full vaccination protocol
    - Monthly growth monitoring
  - All pregnant women to adhere to protocol
    - Regular prenatal and postnatal check-ups at health clinic
    - Delivery with skilled health professionals

Targeting

- Like many CCT programs, combine geographic and household targeting to determine eligibility
  - **First, select priority areas:**
    - Geographic targeting (micro-area poverty maps)
    - Conditional on supply side assessment



Targeting

– **Collect data on household characteristics**

– **Apply objective household eligibility criteria**

- **Proxy means-testing** (used in most countries)
  - – Eligibility based on a weighted index of characteristics (score) that are easily observed but not manipulated and that are associated with poverty
  - – Broader multi-dimensional notion of poverty
  - – Move away from subjective or "politically motivated" targeting
  - – Fairly impressive results globally

– **Enrollment: Verify and Issue ID Cards to beneficiary households**

- **Beneficiary households enrolled for 5 years and then "graduate"**

Delivery System: Philippines

- **Program Management**
  - Department of Social Welfare and Development (DSWD)
- **Money**
  - Program determines payments based on achievement of co-responsibilities
  - Payments to be made [bi-monthly]. Using payment through ATM/cash points.
- **People**
  - Health centers and schools to verify co-responsibilities
  - Social workers (probably) to liase with beneficiary families at village level. (DSWD has regional presence). Will explain program, relay information, record complaints.
- **Pilot Areas**

  - Agusan Sur, Misamis Occ. Pasay, Caloocan,

  - Pilot Experience/lessons to be used to design a wider program