Disability in Conditional Cash Transfer Programs: Drawing on Experience in LAC

by Daniel Mont

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Introduction

Conditional cash transfer (CCT) programs are a relatively recent innovation in social assistance programs. In the past, many transfer programs were criticized for not reaching the most poor and vulnerable, and for creating work disincentives. Benefits were provided based on poverty criteria that often were not well defined. In addition, they did not include incentives or support to rise from poverty by increasing earnings.

CCTs are designed to address short-term poverty while at the same time putting conditions on the receipt of transfers that encourage longer term human capital investments. These conditions – most notably school attendance and participation in nutrition and health programs – are designed to hopefully reduce future poverty.

Evaluations of early CCT programs, generally located in Latin America, are promising. They showed increasing school enrollment, decreasing child labor, and improved nutrition and immunization rates. For example, after the establishment of the PROGRESA program in Mexico secondary school enrollment rates increased about 8 percentage points for girls and over 4 percent for boys. In Columbia, the rate of enrollment in growth monitoring for pre-school children rose 37 percentage points. And in Nicaragua, the rate of pre-school children's enrollment in a nutrition monitoring program was over 90 percent, compared to about two-thirds for control areas.[1]

This paper was originally intended to examine how CCT programs in the Latin American and Caribbean (LAC) region deal with the issue of disability. Are disabled people served by these programs? Are they subject to the same conditionalities? If not, should they be? And if they are, does their participation raise additional programmatic needs? Do any of the programs address the particular needs that disabled people may have in meeting these conditionalities?

Unfortunately, program data on disabled people is very limited, even when it exists. Therefore, this paper can not draw upon analyses that examine the participation and outcomes of disabled people in these programs in any depth. However, it raises important structural and theoretical concerns, and relies upon the limited data and anecdotal evidence that exists. It argues for increased attention on collecting information relating to disability, so planning for these programs can better incorporate a particularly vulnerable population.

We know that disability prevalence is quite significant. In Ecuador, the prevalence rate is estimated at 12.1 percent[2]; in Nicaragua it is 10.3 percent,[3] and in Brazil it is

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[1] Rawlings, L.B., "A New Approach to Social Assistance: Latin America's Experience with Conditional Cash Transfer Programs," SP Discussion Paper Series, No. 0416, The World Bank, August 2004

[2] Flores, R., D. Yepez, and M. Pramatarova, "Ecuador: La Discapacidad en Cifras," INEC (Ecuador), 2005

[3] INEC (Nicaragua), "Encuesta Nicaraguense para Personas con Discapacidad, ENDIS 2003

14.5 percent.[4] Data also shows that disabled people are disproportionately poor, uneducated, and unemployed. For example, in Ecuador only 54 percent of disabled children have received a primary education. In Guyana 42 percent of disabled children and youth between the ages of 4 and 16 reported not attending any education or training facility, even though education was mandatory. [5]

Employment is also a problem for disabled people. For example, in Brazil the labor force participation rate of disabled men aged 35 to 39 is about 80 percent, compared to about 95 percent for non-disabled men.[6] Overall, the unemployment rate for disabled adults in Guyana is about 67 percent.[7]

Not addressing the particular needs of disabled people within the design of CCT programs thus could potentially give short shrift to a significant part of the population that, on average, is even in more need of support.

It should also be noted that CCT programs with health and nutrition components have another impact with regards to disability – namely, prevention. Malnourishment, lack of micronutrients, and poor access to health services are all contributing factors to the creation of disability. Poor health – resulting from malnourishment and disease – was the cause of a large majority of disabilities of children under age 5 in Ecuador – 91 percent in rural areas and 73 percent in urban locations.[8]

Defining Disability

Disability is often defined as a physical, mental, sensory, or psychological condition that limits a person's activities. The social model of disability conceptualizes disability as arising from the interaction of a person's functional limitations with the physical, cultural, and policy environments. If the environment is designed for the full range of human functioning and incorporates appropriate accommodations and supports, then people with functional limitations would not be "disabled" in the sense that they would be able to fully participate in society. This is in contrast to the older medical model of disability that viewed disability as residing solely in the individual, and often associated it with a particular medical condition. This approach to disability is imbedded in the International Classification of Functioning, Disability and Health (ICF) developed by the World Health Organization[9].

[4] Bercovich, A. "People with disability in Brazil: a look at 2000 Census results," Working Paper of Instituto Brasileiro de Geografia e Estastistica (IBGE), 2004
[5] Mitchell, H., "Raising the Profile of Disability in Guyana: An agenda for action," National Commission on Disability, UNICEF, and VSO, 2005
[6] Ibid, 4
[7] Ibid, 5
[8] Ibid, 2
[9] See the ICF homepage at www3.who.int/icf/icftemplate.cfm

It is important to keep in mind that disability is a very heterogeneous phenomenon. Not only can it be physical, mental, sensory or psychological, but it can range from minor to severe in nature. It can be short-term or long-term, constant or episodic, and acquired at any age.

In fact, disability can be viewed as part of the normal life cycle of every individual, especially as a society ages. For example, in Brazil while the overall rate of disability is 14.5 percent, the rate among people aged 65 and over is 54.0 percent, compared to just 4.3 percent for those under age 15. Conceptualizing disability as something that limits a person's participation in society implies that disability-related services should be designed and delivered in a way to promote that participation, and not create separate or "special" structures.

The heterogeneous nature of disability means that the interventions needed to accommodate disabled people can vary dramatically, ranging from quite minor to very significant. In Brazil about 40 percent of the children not attending school because of a disability were not doing so because of vision problems correctable by glasses. This relatively minor medical condition could turn into a very disabling condition if it prevents children from getting an education.

Many transfer programs specifically targeted at people with disabilities conceive of disability as a very severe condition that prohibits employment. Therefore, disability programs can set up strong work disincentives by providing benefits based on a person's claim of being unable to work. In some countries these anti-work effects have been quite strong -- in the Netherlands and Poland, for example.[10] On the other hand, evidence suggests that employment programs for disabled people can be cost-effective[11] And, as a rule, disabled children can successfully attend school, even in developing countries.[12]

Incorporating Disability into CCT Programs

The question remains, though, how does one deal with disability in the context of CCT programs? First, it should be recognized that due to their overrepresentation among the poor, disabled people are already being served by existing cash transfer programs that do not have any special provisions for disability. A recent study found that participants in Chile's Solidario program were twice as likely as non-participants to have at least one family member with a disability.[13] In fact, over 25 percent of participants' households had such a member.

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[10] Mont, D., "Disability Employment Policy," SP Discussion Paper No. 0413, The World Bank, July 2004

[11] Kregel, J, D. Dean, and P. Wehman, "Achievements and Challenges in Employment Services for People with Disabilities: The Longitudinal Impact of Workplace Supports," VCU Rehabilitation and Training Center on Workplace Supports, May 2002

[12] Peters, S. "Inclusive Education: An EFA Strategy for All Children," EFA Working Papers, The World Bank, November 2004

[13] Galasso, E., "*With their effort and one opportunity:* Alleviating extreme poverty in Chile," Working Paper, Development Research Group, The World Bank, March 2006

Therefore, the question is not, should CCT programs address disability, but how?

There are four basic approaches to dealing with disability:

1. Treat disabled people exactly like non-disabled people under the current systems
2. Exempt disabled people from the conditions associated with CCT programs
3. Provide additional assistance to disabled people to help them comply with CCT requirements
4. Couple CCT programs with policies to make service delivery more inclusive

In the following, these options are discussed.

1. Treat disabled people exactly like non-disabled people under the current system. This is clearly the default approach in most CCT programs, e.g. in Mexico, Colombia, Ecuador, etc.. Since low expectations and stigma are often the barriers preventing disabled people's participation in society, it could be that CCT programs actually provide an incentive that is particularly important for disabled children. However, the problem is that many disabled people have poor access to services which can prohibit them from either learning about government programs, enrolling, or complying with the conditions placed upon the receipt of benefits. Therefore, it is possible that this approach excludes some disabled people from benefits provided by CCT programs. Most likely the effect varies depending on the nature and severity of the disability. Lack of data prevents us from measuring the overall net effect and how these countervailing forces play out in different societies.

2. Exempt disabled people from the conditions associated with CCT programs. The argument here is that disabled people are not capable of fulfilling the conditions associated with the program. A child with a disability may face barriers preventing them from attending school or accessing other services. In these instances, exempting disabled people would still ensure that their families receive poverty relief even if they were not able to fully comply with the conditionalities.

This approach was taken in Jamaica's Program of Advancement through Health and Education (PATH). Once certified by the National Council for Persons with Disabilities as being permanently disabled to an extent which prevents them from attending school, children do not need to enroll in school to receive benefits. Actually, it is not just being unable to "attend" school, but being perceived as unable to benefit from school. A deaf child, for example, who could physically attend school, could also be certified as exempt if it is thought they would not benefit from instruction in the school setting.[14]

If these children are truly unable to attend or benefit from school, this strategy seems reasonable. And indeed, barriers to their attendance most likely exist. But the danger is that it gives schools an easy way out of not addressing the inclusiveness of their

[14] Personal communication with Colette Risden of the PATH program.

school system. Although the marginal impact of how CCTs address disability on the overall inclusivity of the school system would most likely be very small, it still creates a tension between short-run poverty alleviation and the promotion of inclusive policies that may be better in the long run. If disabled children were losing benefits because of inaccessible schools it may create political and moral pressure for reform. In the meantime, though, the program is not doing its best to achieve the immediate goal of poverty reduction.

The counterargument, of course, is the additional costs associated with making schools more inclusive, and the need for professionals trained in inclusive education Pressure to reform without the capacity to do so would only serve to deny benefits to poor families with disabled children. Making schools more inclusive, however, often does not involve large expenditures[15]. Therefore, that strategy should not be dismissed without careful examination of what is possible in the local setting. Much work is going on in the LAC region demonstrating the practicality of inclusive education. [16]

Besides, exempting a category of people from the conditionalities of a CCT program when not necessary goes against the basic philosophy of CCT programs. That is, short term poverty relief should be coupled with long term investments in human capital that mitigate against long-term poverty.

Nevertheless, as stated above, denying cash benefits to poor disabled children because they are not attending inaccessible schools undermines the primary goal of the CCT program – namely reducing poverty among vulnerable populations. Therefore, what is needed is some sort of coordinated approach that addresses both current poverty and the promotion of inclusive services.

3. Provide additional assistance to disabled people to help them comply with CCT requirements. Many barriers to service delivery could be overcome with various forms of assistance: glasses, wheelchairs and other assistive devices, sign language interpreters, personal assistants, etc. One option is for CCT programs to provide this assistance to eligible recipients.

The downside to this approach is the complex administration of individualized assessment, in addition to the costs of the supports recommended by those assessments. In fact, even option 2 -- *Exempt disabled people from the conditions associated with CCT programs* – requires an administrative structure for disability determination that does not exist in many countries.

On the plus side, though, providing individual supports can increase not only the long-run productivity of the disabled person but also the short run productivity of

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[15] Steinfeld, E., "Education for All: The Cost of Accessibility," Education Note, The World Bank, August 2005 and Peters, S. J., "Inclusive Education: Achieving Education for All by Including those with Disabilities and Special Education Needs," The World Bank, April 2003

[16] "Disability and Inclusive Development in the LAC Region: Mid-year Report FY05," The World Bank

family members who presently have to care for housebound relatives. In Nicaragua, families (generally women) spend about 10 hours per day caring for significantly disabled family members.[17] Once again, though, data does not exist to make good estimates of how much household labor would be freed up by providing accommodations to disabled children, and at what cost.

Moreover, studies have shown that disabled people need more income in order to avail themselves of the same opportunities and living standards as non-disabled people.[18] Without taking into account the differences in costs of various activities (e.g., transportation, medical care) the poverty rates in Great Britain for disabled and non-disabled people are respectively 23.1 and 17.9 percent.[19] Taking into account the added costs associated with disability – or as Amartya Sen refers to it, "conversion disability"[20] – the poverty rate for disabled people would be 47.4 percent. This would support the argument that if the goal of a CCT program is to get families to a certain minimum level of well-being, the income eligibility thresholds and the size of the benefits distributed should take disability into account.

The challenge is in the administration of such an approach. How can one operationally assess a poverty threshold for each family with a disabled member? And if disabled people were given a standard cash premium, wouldn't that create an incentive for fraud? And wouldn't a uniform cash premium for disability be unreasonable given the wide variance in the nature of disability and the types of supports needed?

One way of both minimizing fraud and the issue of different levels of needed supports would be to not give cash premiums, but rather in-kind benefits that directly increase disabled people's access to education and health services. These would not be particularly valued by non-disabled people, and could be individually tailored to disabled people's need.

This approach, however, has serious drawbacks. Direct provision of these supports would significantly increase the administrative complexity of the program. And in-kind benefits, as a rule, are less efficient than cash which is fungible and can be put to use more efficiently by families.

A somewhat better strategy may be to provide reimbursements for approved expenditures for people certified as having a disability. But this, too, has administrative issues. And in a much broader sense, it has other limits. Money for a wheelchair, for example, does not go far to assuring a child with a mobility disability

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[17] Ibid, 3

[18] Kuklys, W. *Amartya Sen's Capability Approach*, SpringerVerlag, 2005, and also Wiebke Kuklys, "Amartya Sen's Capability Approach: Theoretical Insights and Empirical Applications," Ph.D. dissertation, Sidney Sussex College, Cambridge University, 2004

[19] Poverty is defined here as 60 percent of the national median income.

[20] Sen, A. "Disability and Justice", a speech delivered at the World Bank's second international conference on disability, November 2004

an education if his or her school has no ramps, narrow doorways, and inaccessible toilet facilities.

An additional issue lurking in these second and third approaches -- exempting disabled people from conditions and providing additional assistance to disabled people to help them comply with conditions – is the notion of disability determination. It is one thing to have a conceptual definition of disability and quite another to have an operational one that can be used for determining program eligibility.

For example, the Brazilian Program for Cash Benefits to Disabled Persons and their Families bases eligibility on a list of impairments, but there are no clear criteria to evaluate severity. So, as often happens in programs of this nature, the definition of disability varies by doctor. In fact, 45 percent of medical officers associated with the program consider the evaluation questionnaires less than efficient. Only 6 percent approve of them.[21] In some countries – particularly in former Soviet countries – this discretion on the part of doctors has contributed to problems with fraud.[22] This is where adoption of the ICF framework can be of use.[23]

4. Couple CCT programs with policies to make service delivery more inclusive. A common concern with CCT programs is that their long run effectiveness is tied to the quality of the health and education services with which they are associated. A benefit of CCT programs is that they can serve as a mechanism for coordinating services across sectors, and as an impetus for improving services. A successful CCT program is one that links social assistance with existing services that can provide value to recipients.

Improving the inclusiveness of health and education systems will strengthen the effectiveness of a CCT Program. As the data from Chile suggest, disability is a common reality of people in these programs, and available disability prevalence rates in LAC suggest this is not a unique situation.

However, it is interesting to note that Jamaica's PATH program reports fewer disabled recipients than they projected. According to their estimates, they should be serving about 19,000 disabled people. They are only serving 5,000 at this point due to the fact that disabled did not join the program despite intensive promotion efforts. The reasons behind this under representation are unclear, and PATH is in the midst of

[21] Medeiros, M., D. Diniz, and F. Squinca, "Brazilian Programme for cash Benefits to Disabled Persons and their Families: and analysis of the Continuous Cash Benefit Programme," Working Paper #16, UNDP, 2006

[22] Hoopengardner, T., "Disability and Work in Poland," SP Discussion Paper No. 0101, The World Bank, January 2001

[23] As an example of a guide for using the ICF to assess eligibility see Australian Institute of Health and Welfare (AIHW) 2003. ICF Australian User Guide. Version 1.0. Disability Series. AIHW Cat. No. DIS 33. Canberra: AIHW.

a study examining this issue. One possibility is that there are barriers preventing disabled people from participating in the program. Another possibility, put forward by program administrators, is that disabled people may be being cared for by extended family who are, in essence, providing familial transfers that make potential recipients ineligible. In the near future we should have some answers.

In the end, the most efficient way of integrating disability into CCT programs, is the development of cost effective means aimed at minimizing the number of disabled people who are not capable of accessing education and health services as they currently operate. Lessons from inclusive education programs already underway in countries like Brazil, Panama, and Uruguay can be used to leverage the impact of CCT programs.

Inclusiveness does not happen over night, however. Often it is a graduated process that comes in stages – both across different types of disabilities and across different school districts within a country.

In fact, among school aged children, most disabilities are learning disabilities.[24] These disabilities are often associated with retention and promotion problems in school but are not as apparent as blindness, deafness, mobility limitations or significant intellectual disabilities. Moreover, many non-disabled children also have similar issues with their learning styles. Thus, inclusive education methods can have a broader impact than the disability prevalence rate would suggest.[25]

The acceptance of inclusion as an important element of economic development can vary significantly from one country to another. Only recently, has the development community begun searching for best practices. Therefore, while building inclusive services may be the long-term goal, short run approaches of providing additional assistance to families with disabled members or even exemption of conditionalities for severely disabled people may be in order.

Conclusion

CCT programs are proving to be effective tools for increasing the use of educational, nutritional, and health services by poor people. As is well known, the value of this increased utilization depends on the quality of the services.

One aspect of quality of services that has not been addressed sufficiently is their inclusiveness. This means that not taking disabled people into account can seriously undermine the well-being of disabled people who qualify for these programs. And

[24] *Equiyt in Education: Students with Disabilities, Learning Difficulties, and Disadvantages*, Centre for Educational Research and Innovation, OECD, 2004
[25] Ibid., at 12

evidence on disability from the LAC region suggests disabled people probably represent a significant share of recipients.

There are four basic approaches to dealing with disability:

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- Exempt disabled people from the conditions associated with CCT programs
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- Couple CCT programs with policies to make service delivery more inclusive

These approaches have advantages and drawbacks (summarized in Table 1). While the first strategy may induce some disabled people to avail themselves of services they would otherwise not use, it will also cut off benefits to many poor disabled people, especially those with severe disabilities. The second strategy provides short term poverty reduction, but does nothing to eliminate barriers to inclusion that lead to poorer outcomes for disabled people in the long run. The third strategy increases the long term human capital of disabled people but introduces additional costs and a great deal of administrative complexity. Also, it does not address inclusion in a systemic fashion. The fourth strategy probably will have the best outcomes for disabled people, but requires the most extensive collaboration and a longer term focus and understanding of disability issues by policy makers, program managers and field staff including health and education services. Fortunately, however, inclusive approaches – especially in education – are growing in LAC and can begin serving as models for reform.

To get a better handle on the costs and benefits of these approaches – and simply to better understand the scope and scale of the issue – programmatic data on CCT programs and associated services needs to include information on the type and degree of disability in the population. This would help to better identify the issues that keep disabled from equally participating in and benefiting from CCT programs.

Table 1: Summary of Approaches of Incorporating Disability into Conditional Cash Transfer (CCT) Programs

Approach	Advantages	Disadvantages
Treat disabled people exactly like non-disabled people under the current system	- May induce some disabled people to avail themselves of services who were not accessing them previously due to stigma and low expectations	- Excludes disabled people from receiving benefits even if they are not capable of complying with conditions because of inaccessible services - Those excluded are more likely to be among most severely disabled people
Exempt disabled people from the conditions associated with CCT Programs	- Provides short-term poverty reduction to disabled people, especially those with severe disabilities who can't comply with conditions	-Adds administrative complexity associated with disability determination -Re-enforces low expectations of disabled people's ability to comply with conditions -Removes an incentive for reforms to make services more inclusive
Provide additional assistance to disabled people to help them comply with CCT requirements	-Provides short term poverty reduction to disabled people -Increases the utilization of services by disabled people which acts against long-term poverty	-Adds a great deal of administrative complexity in determining not only disability but the type and level of needs -Does not address inclusive services in a systematic fashion, but on an individual basis -If benefits are in-kind that introduces more administrative complexity and is a less efficient way of providing benefits
Couple CCT programs with policies to make service delivery more inclusive	-Addresses both short and long term poverty among disabled people -Able to have a more coordinated, and thus efficient, approach toward inclusion	-Requires highest level of collaboration -Good practices in this area are only beginning to be developed -Requires longest time horizon