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SOCIAL PROTECTION IN EAST ASIA - CURRENT STATE AND CHALLENGES

Edited by
MUKUL G. ASHER
SOTHEA OUM
FRISKA PARULIAN

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LIST OF PROJECT MEMBERS

PROFESSOR FUKUNARI KIMURA (PROJECT SUPERVISOR): Chief Economist, Economic Research Institute for ASEAN and East Asia (ERIA), Indonesia. Professor, Faculty of Economics, Keio University, Japan.

PROF. MUKUL G. ASHER (PROJECT LEADER): Professor of Public Policy, Lee Kuan Yew School of Public Policy, National University of Singapore, Singapore.

DR. SOTHEA OUM (PROJECT COORDINATOR): Associate Researcher, Economic Research Institute for ASEAN and East Asia (ERIA), Indonesia.

DR. FRISKA PARULIAN (PROJECT COORDINATOR): Associate Researcher, Economic Research Institute for ASEAN and East Asia (ERIA), Indonesia.

DR. MASAYOSHI HAYASHI: Associate Professor, School of International and Public Policy and Graduate School of Economics, Hitotsubashi University, Japan.

DR. WANKYO CHUNG: Researcher Fellow, Department of Public Economics & Social Development, Korea Development Institute.

DR. CHIA NGEE CHOON: Associate Professor, Department of Economics, Faculty of Arts and Social Sciences, National University of Singapore, Singapore.

DR. HAJAH SAINAH BINTI HAJI SAIM: Senior Lecturer, Department of Public Policy and Administration, Faculty of Business, Economics and Policy Studies, Universiti Brunei Darussalam.

DR. ROBERT A. SIMANJUNTAK: Lecturer, Senior Lecturer, Associate Professor, and Professor in Public Economics, Public and Regional Finance, University of Indonesia, Indonesia.

DR. MULIADI WIDJAJA: Staff Expert, Economics Graduate Program, University of Indonesia, Indonesia

PROF. DR. ONG FON SIM: Professor, Graduate School of Business, Universiti Tun Abdul Razak, Malaysia.

DR. TENGKU AIZAN BINTI TENGKU ABDUL HAMID: Associate Professor, Department of Human Development and Family Studies, Faculty of Human Ecology, Universiti Putra Malaysia, Malaysia.

DR. ANICETO C. ORBETA, JR: Senior Research Fellow, Philippine Institute for Development Studies (PIDS), Philippines.

DR. SRAWOOTH PAITOONPONG: Senior Research Specialist, Human Resources and Social Development Program, Thailand Development Research Institute (TDRI), Thailand.

DR. AMONTHEP CHAWLA: Research Specialist, Macroeconomic Policy Program, Thailand Development Research Institute (TDRI), Thailand.

DR. NIPANAN AKKARAKUL: Researcher, Thailand Development Research Institute (TDRI), Thailand.

DR. GIANG THANH LONG: Lecturer, Dept. of Macroeconomics & Director, Centre for Economic Analysis, Forecasting, Training and Sustainable Development, Faculty of Economics, National Economics University (NEU).

DR. VATHANA SANN: Deputy Secretary General, Council for Agricultural and Rural Development (CARD), Cambodia.

DR. LEEBER LEEBOUAPAO: Acting Director General, National Economic Research Institute (NERI), Lao PDR.

DR. ZHANG JUWEI: Professor and Deputy Director General of the Institute of Population and Labor Economics, Chinese Academy of Social Sciences (CASS), P. R. China.

MR. AZAD SINGH BALI: Research Associate, Lee Kuan Yew School of Public Policy, National University of Singapore, Singapore.

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This report consists of the papers from ERIA's research working group on Social Protection in Fiscal Year 2009. It aims to improve our understanding and stocktaking of the current state and challenges and to identify reform initiatives of Social Protection system in 13 East Asian countries. All papers presented in this report were presented in two workshops held in Jakarta over the period of October 2009 to February 2010.

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Mukul G. Asher

Sothea Oum

Friska Parulian

CHAPTER 1

Social Protection Systems in East Asia: An Overview and Reform Directions

MUKUL G. ASHER
Professor of Public Policy
National University of Singapore

1. Introduction

The need for better social protection has been evident in Asia since the 1997-1998 Financial Crises. However, the rapid recovery and subsequent robust growth meant that the Crisis did not lead to sustained efforts to integrate social protection into economic growth strategies.

The current global crisis once again represents both an opportunity for, and a challenge to, strengthening of social protection in Asia. The term 'social protection' is used in this context to denote major branches of social security such as pensions, healthcare, work injury and social assistance.

While demographic, institutional and fiscal challenges are many, the crisis underscores the political necessity of sustaining the process of expanding social protection. The global economic crisis is expected to reduce the medium term growth rate. The trend rate of economic growth is regarded as a singularly important macroeconomic variable that affects the economic security of the young and the old. The global economic slowdown may also impact the pace and quality of job and livelihood creation in Asian countries, raise the cost of debt refinancing (particularly for highly leveraged economies), potentially lower remittance flows and also lower the medium term real investment return on pension assets.

Many Asian countries have pursued aggressive fiscal stimulation packages in which social protection has been an integral component (UNDP, 2010). There are however concerns that overly aggressive fiscal stimulus packages, if not reversed skillfully as economies recover, could potentially lead to higher inflation and reduce the real incomes of the poor. Higher inflation and nominal rates could also increase the cost of servicing the internal debts of several Asian countries such as India, Indonesia and the Philippines.

It is in the above context that the Economic Research Institute for ASEAN and East Asia (ERIA) initiated a project on social protection in 13 countries, all of which are members of the East Asian Summit (EAS). The 13 countries are quite diverse and are at different stages of economic development. The high-income countries in the sample are Japan, the Republic of Korea, Singapore and Brunei. The middle-income countries are

China, India, Indonesia, Malaysia, the Philippines, Thailand and Vietnam. The low-income countries are Cambodia and Laos.

This paper provides an overview of the 13 country chapters presented at two workshops organized by ERIA. The sheer diversity and complexity of the social security systems in these countries precludes a country-by-country summary. Therefore broad common characteristics and reform themes, informed by the country papers, are discussed in this overview.

The paper is organized as follows. Following the introduction, section 2 provides a brief overview of demographic and labor market trends in the sample countries. These set the context in which social protection policies will need to be designed and implemented.

An overview of the various social security systems of the sample countries is provided in section 3. Section 4 discusses broad avenues through which social protection systems in the sample countries could be strengthened. The final section suggests directions for future research.

2. Demographic and Labor Market Trends

Demographic trends for the 13 sample countries are summarized in Tables 1A and 1B. These trends portend rapid population ageing in the sample countries, signified by increasing old age dependency ratios and life expectancies at age 60. For large population countries, namely China and India, the number of elderly projected for 2050 will be 438 million and 330 million respectively. These are very large numbers for which there is no precedent of providing adequate retirement income. By 2050 the sample countries will account for about half of the global population above 60. This suggests that the extent of their success in addressing social protection issues will have significant impact on how these issues are addressed globally.

This rapid population ageing suggests a need to allocate greater economic resources for the elderly. But such allocation will need to be reconciled with macroeconomic

stability, fiscal sustainability and other priorities of the economies such as health, education and infrastructure.

Table 1A. Demographic Trends in Selected EAS Countries

Country	Total Population (in millions)		Average Annual Rate of Change in Population		Total Fertility Rate		Median Age		Life Expectancy at Birth	
	2007	2050	2005–10	2045–50	2005–10	2045–50	2005–10	2045–50	2005–10	2045-50
World	6671.2	9191.3	1.17	0.36	2.6	2	28	38.1	67.2	75.4
High Income										
Japan	127.9	102.5	-0.02	-0.78	1.3	1.6	42.9	54.9	82.6	87.1
Korea, Rep. of	48.2	42.3	0.33	-0.89	1.2	1.5	35	54.9	78.6	83.5
Singapore	4.4	5.0	1.19	-0.38	1.2	1.6	37.5	53.7	80.0	84.6
Brunei	0.4	0.7	1.9	0.76	2.1	1.9	27.3	37.3	77.1	81.1
Large Population										
China	1328.6	1408.8	0.58	-0.32	1.7	1.8	32.5	45	73	79.3
India	1103.4	1592.7	1.55	0.3	3	1.8	24.3	38.7	63.1	75.9
Middle Income										
Indonesia	231.6	296.9	1.16	0.1	2.2	1.8	26.5	41.1	70.7	78.6
Malaysia	26.6	39.6	1.69	0.41	2.6	1.8	24.7	39.3	74.2	80.1
Philippines	87.9	140.5	1.9	0.5	3.2	1.8	21.8	36.3	71.7	78.7
Thailand	63.9	67.4	0.66	-0.27	1.8	1.8	32.6	44.3	70.6	78.1
Vietnam	87.4	120	1.32	0.21	2.1	1.8	24.9	41.6	74.2	80.3
Low Income										
Cambodia	13.9	23.8	1.64	0.68	3	1.9	21.3	33.8	60.9	74.4
Laos	5.9	10.7	1.81	0.78	3.5	2	19.9	31.8	64.8	75.8

Source: UNDESA (2008).
Note: Classification of countries is based on the World Bank Country Classification in 2009 using the *Atlas Method*. [Low Income: per capita income less than 975$ per year; Middle Income: per capita income less than $11,905 per year; and High Income: per capital income $11,906 and above]. East Asian Summit (EAS) comprises 10 countries of the Association of Southeast Asian Nations, and China, Republic of Korea, Japan, India, Australia, and New Zealand. The last two countries have not been included in the ERIA social protection project.

Table 1B. Continued: Demographic Trends in Selected EAS Countries

Country	Life Expectancy at Age 60, 2000–2005		Percentage of Total Population Aged 60 and Above		Population Aged 60 and Above (millions)	
	Male	Female	2005	2050	2005	2050
World	NA	NA	10.3	21.8	672.8	2005.7
High Income						
Japan	22	27	26.5	44.2	33.8	44.9
Korea, Rep. of	19	24	13.7	42.2	6.6	17.8
Singapore	17	21	12.3	39.8	0.5	2
Brunei	18	22	4.7	20.8	0.0	0.1
Large Population						
China	18	21	11	31.1	144	437.9
India	17	19	8	21	89.9	329.6
Middle Income						
Indonesia	17	19	8.3	24.8	18.9	73.6
Malaysia	18	20	6.7	22.2	1.7	8.8
Philippines	17	19	6	18.2	5.1	25.5
Thailand	17	22	11.3	29.8	7.1	20.1
Vietnam	19	21	7.6	26.1	6.5	31.3
Low Income						
Cambodia	14	16	5.2	16.2	0.7	3.9
Laos	15	17	5.4	14.4	0.3	1.5

Source: UNDESA (2008).
Note: See on Table 1A.

Table 1C. Old-Age Dependency Ratios in Selected EAS Countries

Country	Old-Age Dependency Ratio	
	2005	2050
World	11	25
High Income		
Japan	30	74
Korea, Rep. of	13	65
Singapore	12	59
Brunei	5	23
Large Population		
China	11	39
India	8	21
Middle Income		
Indonesia	8	29
Malaysia	7	25
Philippines	6	19
Thailand	11	38
Vietnam	9	30
Low Income		
Cambodia	5	15
Laos	6	14

Source: UNDESA (2008).
Note: See Notes for Table 1A.
Old Age Dependency Ratio is defined as persons above 60 years of age divided by the total population.

The demographic trends suggest that a little more than three-fifths of the new livelihoods to be created globally between 2005 and 2020 will be in Asia (UNDESA, 2008). As the share of the formal sector in total employment is relatively low in many Asian countries (Figure 1), much of the anticipated livelihood generation will need to be in the informal sector, which constitutes 40-80% of the total workforce. As social protection systems have traditionally been based on employer-employee relationships, extending their coverage to the informal sector requires innovative approaches.

There is considerable flow of workers across borders within the sample countries. In general, flows are from developing Asia (such as Philippines) to developed Asia (such as Japan, Korea and Singapore). China and India are major providers, as well as absorbers, of foreign workers. Provision of social security and improved labor and work conditions for these workers should therefore be an important part of the social protection agenda in Asia. Formal totalization agreements[1] and bilateral agreements on the working and living conditions of foreign workers between recipient and sending countries within Asia, merit serious consideration.

Recent agreements by Japan with the Philippines and Indonesia, for special arrangements for workers from these two countries to be employed in Japan on a temporary basis, represent examples of advantage being taken of demographic complementarities, as well as draw attention to the social security needs of foreign workers.

3. Current Social Security Systems and their Coverage

The country chapters suggest that the sample EAS countries have a long tradition of providing benefits under different branches of social security (Table 2). It is also apparent from the country studies that mere establishment of a benefit under a social security branch does not necessarily imply that: 1) the coverage in terms if labor force

[1] The totalization agreements in the social security sector perform a role similar to the double-taxation treaties in governing income tax arrangements internationally. Such agreements must ensure that individuals and employers do not end up paying social security taxes or contributions in more than one jurisdiction, or alternatively avoid paying them in any jurisdiction.

and potential beneficiaries is adequate; 2) all contingencies or risks are covered; 3) the programs are managed with requisite professional competence; and 4) that benefits provided are sufficient and sustainable.

Table 2. Availability of Programs under Different Branches of Social Security in Selected EAS Countries

Country	Old age, disability and survivors	Sickness and maternity		Work injury	Unemployment	Family allowances
		Cash benefits for both	Cash benefits plus medical care [a]			
Brunei	X	b	d	X	b	b
China	X	X	X	X	X	X
India	X	X	X	X	X	b
Indonesia	X	b	d	X	b	b
Japan	X	X	X	X	X	X
Korea, South	X	b	d	X	X	b
Laos	X	X	X	X	b	b
Malaysia	X	b	d	X	b	b
Philippines	X	X	X	X	b	b
Singapore	X	X	X	X	b	b
Thailand	X	X	X	X	X	X
Vietnam	X	X	X	X	X	b

Source: US Social Security Administration (2008).

Note :

a. Includes Old Age, Disability and Survivors; Sickness and Maternity; Work Injury; Unemployment; and Family Allowances. In some countries, the rate may not cover all of these programs. In some cases, only certain groups, such as wage earners, are represented. When the contribution rate varies, either the average or the lowest rate in the range is used.
b. Also includes the contribution rates for other programs.
c. Government pays the total or most of the cost of family allowances.
d. Contributions are submitted to a ceiling on some benefits.
e. Government pays the total cost of most programs from general revenues.
f. Employers pay the total or most of the cost of work injury benefits.

The contribution rates for various components in sample EAS countries' social security system varied greatly. Brunei, for instance has a contribution rate of 10 percent and China's combined contribution rate is 40 percent (Table 3).

Table 3. Contribution Rates for Social Security Programs in Selected EAS Countries, 2008 (in Percent)

Country	Old age, disability, and survivors			All social security programs [a]		
	Insured person	Employer	Total	Insured person	Employer	Total
Brunei	5	5	10 [h]	5	5 [f]	10
China [d]	8	20	28	11	29 [f]	40 [c]
India [d]	12	17.6	29.6	13.8	22.4	36.1
Indonesia	2	4	6	2	7 [f]	9
Japan [d]	7.7	7.7	15.4	12.4	13.1	25.5 [c]
Korea, South [d]	4.5	4.5	9	7.6	8.5	16.1
Laos [d]	4.5 [b]	5 [b]	9.5 [b]	4.5	5	9.5
Malaysia [d]	11.5 [b]	12.5 [b]	24 [b]	11.5	13.8	25.3
Philippines [d]	3.3 [b]	7.1 [b]	10.4 [b]	4.6	8.3 [f]	12.9
Singapore [d]	20 [b]	14.5 [b]	34.5 [b]	20	14.5 [f]	34.5
Thailand [d]	3.4 [b]	3.4 [b]	6.9 [b]	5	5.2	10.2
Vietnam [d]	5	11	16	7	18	25

Source: US Social Security Administration (2008).

Note :

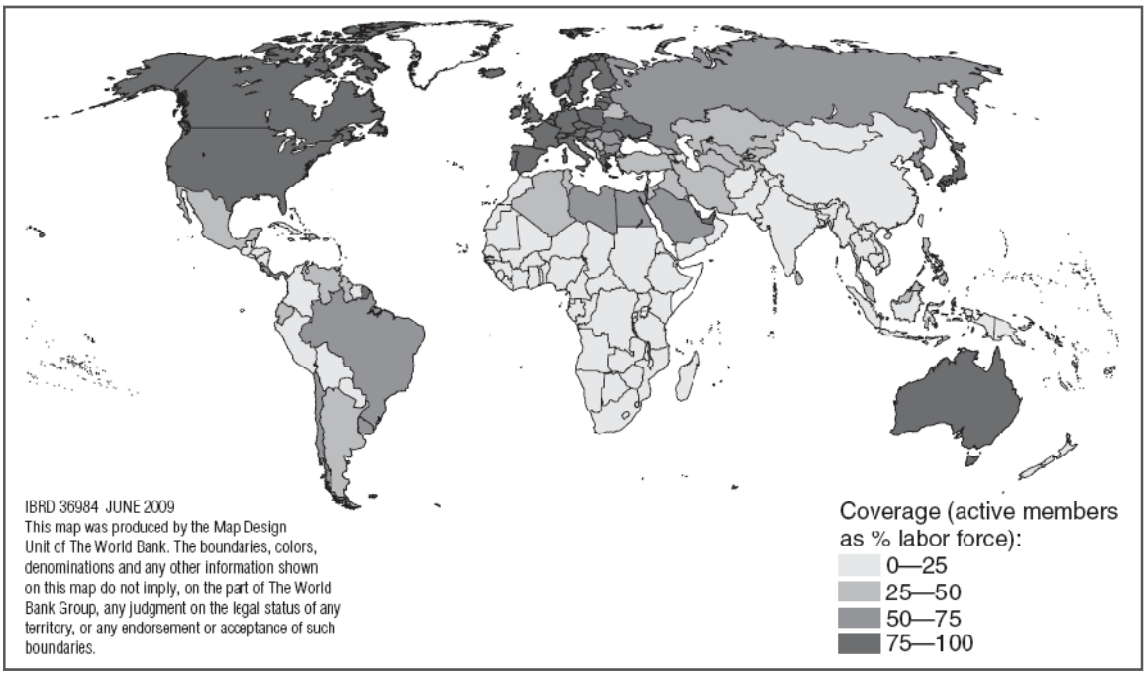
a. Includes Old Age, Disability, and Survivors; Sickness and Maternity; Work Injury; Unemployment; and Family Allowances. In some countries, the rate may not cover all of these programs. In some cases, only certain groups, such as wage earners, are represented. When the contribution rate varies, either the average or the lowest rate in the range is used.
b. Also includes the contribution rates for other programs.
c. Government pays the total or most of the cost of family allowances.
d. Contributions are submitted to a ceiling on some benefits.
e. Government pays the total cost of most programs from general revenues.
f. Employers pay the total or most of the cost of work injury benefits.

Moreover, the country studies suggest that the coverage of the pension branch of social security is relatively low in Asia (Figure 1). This is consistent with the low share of formal sector employment in Asia, as the coverage is primarily confined to formal sector employees.

In most developing Asian countries, the coverage of pension systems varies between 10 and 35 percent of the labor force (Hinz and Pallares-Miralles, 2009, forthcoming). The higher income Asian countries have, consistent with international evidence, higher coverage, with Japan and South Korea exhibiting much higher

coverage. Even in these counties an increasing proportion of the workforce (around 25 percent) does not enjoy the kind of long term employer-employee relationships which provide pension, healthcare and other benefits.

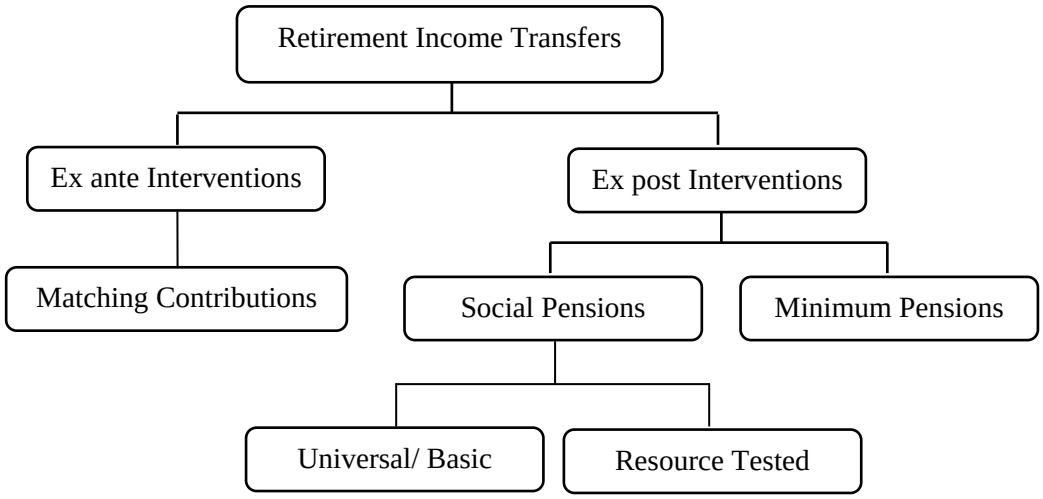
Figure 1. Coverage as Measured by Active Members of Mandatory Pension Systems as Share of Labor Force, Worldwide, Early 2000s



Source: Hinz, R. and M. Pallares-Miralles. Forthcoming.

The country papers suggest that there has been increasing interest in retirement income transfer programs, which do not necessarily depend on formal sector employment and/ or contributions to the pension fund. A taxonomy of such income transfers is provided in Figure 2. Relative roles of 'social pensions' (universal or resource-tested); matching contributions and social assistance are now extensively debated in policy circles and are also increasingly being adopted in the sample countries.

Figure 2. Taxonomy of Retirement Income Transfers



Source: Robalino and Holzmann (2009).

Their effectiveness and sustainability will however depend on strengthening fiscal positions to finance them, and improvements in government service delivery mechanisms to ensure that they are well targeted.

4. Strengthening Social Protection Systems

The individual country papers suggest that there is considerable potential for strengthening social protection systems in the sample countries. The goal should be to construct a multi-tiered system, involving: 1) a mixture of contribution by employers, employees and in selected cases by the government; 2) non-contributory schemes; 3) schemes by the voluntary not-for-profit sector, both domestic and international; 4) family and community-support; and 5) labor market flexibility and tax regulations which permit elderly people to meet a small but not an insignificant proportion of their retirement needs through paid economic activity (including household production). The relative weight of each of the tiers will depend on the specific context, capabilities and objectives of the country.

Among the key challenges in the sample countries are extending the coverage of social protection programs and improving program benefits in a manner that is sustainable over the long-term.

The individual country papers suggest that the following avenues have the potential to strengthen social protection systems in the sample countries. The importance of each avenue will differ from country to country, but all countries will need to combine these avenues in accordance with their priorities and capabilities. The task of strengthening social protection systems should be approached from a medium term perspective as short term fixes and ad hoc measures are likely to be counterproductive. A well considered strategy with appropriate planning and implementation focus will be needed.

Avenue 1. Modernizing and Professionalizing Existing Formal Social Security Organizations in Performing Core Functions

Each provident and pension fund must perform five core functions with a reasonable degree of competence and efficiency (Ross, 2004). These are: 1) reliable collection of contributions, taxes and other receipts (including any loan payments in the security systems); 2) payment of benefits for each of the schemes in a timely and correct way; 3) ensuring good financial management and productive investment of provident and pension fund assets; 4) maintaining an effective communication network, including development of accurate data, and record keeping mechanisms to support collection, payment and financial activities; 5) production of financial statements and reports that are tied to providing effective and reliable governance, fiduciary responsibility, transparency and accountability.

Social security organizations of several Asian countries such as the Philippines, Singapore and Malaysia have been making increasingly sophisticated use of information technology to improve administration and compliance efficiency and to generate management information systems which are conducive to better decision making.

Countries such as China, Thailand, Japan and Malaysia have become more aggressive and professional in investing social security funds. There is also greater willingness to diversify investment risks geographically, e.g. through investment internationally. Diversification among asset classes including in alternative asset classes is also observed in some of the sample countries, such as Thailand, South Korea and Malaysia. These initiatives could potentially lead to higher returns, though risks have also increased.

For the low-income countries - Cambodia and Laos- the priority should be to build capacities of their provident and pension fund organizations to undertake the core functions noted above more efficiently. Realizing the limitations of their financial and capital markets, relatively conservative investment policies are warranted. Greater emphasis on record keeping functions and on reducing administrative and compliance costs merit serious consideration.

Avenue 2. Parametric and/ or Systemic Reforms of some Components of Existing Systems (such as Civil Service Pensions)

The country reports suggest that in many sample countries provident and pension fund programs were set up on a pre-globalization and pre-cold war era basis. The design details of these programs also do not reflect the current tendency towards reduced fertility and longer life expectancy. They also do not fully reflect developments in financial and capital markets and changing labor market dynamics.

In pension economics, there is a "tyranny of small numbers" where a seemingly minor change, such as in life expectancy of the beneficiaries of the provident or pension scheme, or in the real rate of return credited to members' accounts, could have a disproportionately large impact on retirement income security.

The above observations are particularly relevant for the civil service pension schemes in many sample countries. With few exceptions, the detailed provisions of these schemes have not been rationalized to reflect the new environment. For example, longer life expectancy suggests that the age at which the members should become eligible for full pensions should be increased. However in many of the sample countries such as Malaysia and Indonesia, the retirement age for civil servants remains between 55 and 65 years, with lower retirement age for women (for example, in Vietnam) even thought their life expectancy, on average, is higher.

Among the sample countries, India has initiated a shift from a Defined Benefit (DB) system of pensions to a Defined Contribution (DC) system for newly recruited civil servants. This is a major systemic change. However, as only newly recruited civil servants are covered, the transition period will stretch to about four decades.

There are also examples of parametric reforms in other sample countries. Singapore has introduced a deferred annuity scheme called CPF Life to help address the

longevity risk. Several countries such as Japan, Singapore, and Malaysia are encouraging retired individuals to be at least partly active in the labor market through a variety of measures. Many countries such as the Philippines and India are tightening up on pre-retirement withdrawals from their provident and pension schemes. This will ensure that the power of compound interest is harnessed for a longer period.

South Korea[2], India and Singapore are experimenting with converting housing equity into retirement income streams. The country papers, however, suggest that their impact so far has been limited.

Avenue 3. Using Different Types of Retirement Income Transfers, which do not entirely depend on Formal Labor Market Relationships.

These include social pensions, and co-contributions by the State. For poverty alleviation, social assistance targeted at poor in all age groups may be needed. The country papers provide several examples.

In 2007, the Beijing Municipal Government extended coverage of old-age benefit to all elderly citizens under its jurisdiction. This is an example of a social pension. The South Korea 2007 initiative expects to cover 70 percent of all senior citizens through a basic old-age pension (OAP) financed by the government.

Thailand's 30-Baht Scheme for healthcare introduced in 2001, has not only been continued but also expanded with greater state support. In stimulus packages of several countries in Asia, there is a significant social assistance and retirement income transfer component (Damrongplasit, K and Glenn A. Melnick, 2009).

In India, the NREGS (National Rural Employment Guarantee Scheme) is helping to sustain domestic demand, and thereby contribute to growth. India's state governments are increasingly implementing co-contribution schemes under which a member's contribution is within specified limits, matched by the state. However, India's very limited fiscal space will be a major factor in its sustainability in the future.

[2] The Financial Services Commission (FSC) in Korea has recently announced intentions to ease conditions for thereverse mortgage subscription scheme. Currently, those aged 65 or older, with only one home worth 900 million won or less, can provide their home as collateral to the Korean Housing Finance Corporation (KHFC) or local banks in return for lifetime monthly payments. The FSC is considering expanding the program to people aged 60 or 55 (Korean Times, January 27 2009).

Other Avenues

Countries such as China, India, Malaysia, Thailand and the Philippines are encouraging occupational private pension plans and/ or individual retirement accounts to broaden the sources of retirement financing and risk sharing.

India and Indonesia are encouraging the linking of pension with microfinance. Policy makers hope that this will also assist in enhancing financial inclusion and strengthen social cohesion. In some countries such as Japan and Singapore, there is recognition that human capital has similarities with a financial instrument, such as a bond, which could enable members to earn part of their retirement needs by participating in paid economic activity, even during retirement. There is a strong case for other sample countries, particularly the middle income countries, to consider innovation along this avenue.

5. Directions for Future Research

5.1. Civil Service Reform

In the sample countries, particularly countries which are not in the high-income category, reforms of their civil service pension schemes have received relatively little attention. A disproportionate share of the formal sector labor force is in the civil service in these countries; and their pension costs in relation to GDP are relatively large when compared with their share in the labor force. Thus undertaking parametric and systemic reforms in the civil service pension schemes merits serious consideration in these countries.

5.2. Structuring the Payout Phase

In all the sample countries, there are defined contribution schemes for retirement income provision. Some of the schemes are mandatory, such as in Malaysia, Singapore, Thailand, India and Indonesia, while some of the schemes are voluntary, for example in Korea, Japan, and China. The expectation is that the share of provision by individuals in their total retirement income will increase in the sample counties. The emphasis in design has been on the accumulation phase, when the members are working and

contributing towards their retirement income. However, the design of the payout phase has not received due attention. Thus in Malaysia, Indonesia, and India, the national provident fund members are permitted to withdraw their accumulated balances as a lump sum. In the new DC scheme for civil servants in India, a portion of the accumulated balances can be withdrawn as a lump sum, while the amount remaining must be annuitized. Given the uncertainty in forecast longevity, and the limited development of the annuity markets worldwide, there is an urgent need to structure innovative products, which enable members to withdraw balances in a phased manner during retirement. This should therefore be an important area of research in the sample countries.

5.3. Delivery Mechanisms for Retirement Income Transfers

In designing and implementing retirement income transfers from the budget, it is essential that Type 1 and Type 2 errors be minimized.[3] In some countries such as India, the static nature of the definition of the eligible low-income households exacerbates the severity of the above two types of errors. There are strong indications that poor health and associated costs could lead to considerable changes in the distribution of households according to income. In particular, severe illness experienced by the main income earner could push even middle-income households below the poverty line if there is inadequate health insurance coverage.

In several sample countries, for example India and Indonesia, constructing more efficient delivery mechanisms for retirement income transfers remains a challenge. There is a case for more decentralized, experimentation of the type of mechanisms that may deliver retirement income transfers with greater effectiveness. A comparative study of the innovations in this area should have a high priority.

It would also be useful to analyze the incentive implications of different designs of retirement income transfers including those involving co-contributory schemes being implemented in sample countries such as India and Thailand.

[3] When a hypothesis is inappropriately rejected it is called type I error, or when one inappropriately fails to reject the hypothesis, this is called type II error.

5.4. Financing Healthcare

As many of the sample countries will experience rapid ageing and relatively low incomes, financing health expenditure for an increasingly aged population will be a major public policy challenge. The role of the state in delivering healthcare services, provider payment reform, and an appropriate financing mix that reflects the priorities and fiscal capacities of each country would need to be examined with greater attention. There is increasing recognition of the role of community-based health insurance schemes in Vietnam and in India. However, scalability and universality of these community-based schemes is a challenge. As in pensions, healthcare economics and finance is subject to the tyranny of small numbers where a seemingly small change in life expectancy, can cause disproportionate impact on a government's health budget.

5.5. Developing Databases

The absence of robust databases for actuarially fair pricing of health insurance and retirement products is a limiting factor in many Asian countries. The availability and quality of civil records regarding births, death, and other matters are essential for effective social pension programs. Many provident and pension fund organizations have not coordinated with other government and non-government third parties to keep track of potential new members, for example when a new enterprise is registered. This must be addressed, particularly in countries with large and heterogeneous population with significantly differing morbidity and mortality patterns, such as China, India, Indonesia and Vietnam. Measures to enhance indigenous research capacity in social security are also urgently needed.[4]

There is a strong case for considering a Social Security Forum for the 16 country EAS (East Asian Summit) for which ERIA is in the best position to take a lead. This

[4] The Philippines, through its SSS Net services provides a positive example of how IT systems can be utilized for better coverage of the workers, including overseas workers. 779 large employers with over 420,000 employees are registered users of the SSS Net. Payments remitted through the SSS Net comprise almost 11% of SSS's monthly bank collections. Prior to the use of the SSS Net, it took an average of 3 to 6 months to post the monthly contributions to the individual accounts of members. The process has now been speeded-up to just 2 to 3 days. This, in turn, has resulted in a shorter processing time for benefit and loan applications, as well as a reduction in the number of claims rejected due to insufficient contributions having been recorded.

will build capacity among the member countries; provide a solid research base on a comparative basis, and help develop indigenous research capabilities.

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CHAPTER 2

Social Protection in Japan: Current State and Challenges

MASAYOSHI HAYASHI

School of Public and International Policy and Graduate School of Economics
Hitotsubashi University

This study systematically describes the current arrangements for social protection in Japan, including the key elements of coverage, benefits, and management. Special attention is paid to the roles assumed by local governments in social protection schemes. With the exception of public pensions, local governments are involved in every aspect of social policy, covering residuals that fall from upper layers of social safety nets. This study examines the Japanese system in terms of its effectiveness as a social safety net in the face of changing economic and demographic environments in the country, identifies the issues the current Japanese system faces, and offers possible policy proposals.

1. Introduction

The upper layers of social safety nets in Japan are built around full-time employees. Work-related insurance was primarily designed for established businesses and their full-time employees. Mainstream programs for public pensions and health insurance are run by employment-based associations. Those excluded from these mainstream programs are taken care of by residual social insurance programs. This mainstream-residual dichotomy may also be created when a distinction is made between premium-financed programs and tax-financed programs. Here, the residuals are tax-financed programs which include public assistance and a variety of other assistance services. Conceptualized as such, local governments in Japan are responsible for the safety nets at the bottom, covering residuals that fall from upper layers of social safety nets.

While the Ministry of Health, Labor and Welfare (MHLW) at the central government designs and oversees social policies, local governments are involved in almost every aspect of social policy, except public pensions.[1] Municipalities manage the National Health Insurance (NHI), the Long-term Care Insurance (LTCI) and the health care system for the elderly. Premiums for the NHI and the LTCI differ across municipalities and municipalities conduct eligibility assessment for the LTCI. In addition, localities implement a variety of social programs prescribed by national laws. The local social programs are geared toward the following targets: (1) low-income households, (2) children, (3) single mothers and widows, (4) the elderly and (5) the physically and mentally disabled. Furthermore, a substantial number of social programs are planned and implemented at the local governments' discretion. The Ministry of Internal Affairs and Communication (MIC) reports that such local social spending in FY2007 amounts to more than JPN¥ 7 trillion, almost three times as much as Public Assistance expenditure (JPN¥2.5 trillion). There are many cases where a national law simply assigns a specific social program to a locality without specifying

[1] However, we note that municipalities had been collecting premiums for the National Pension in place of the central government until the task was taken over by local offices of the Social Insurance Agency in April 2002.

either benefit levels or eligibility criteria. In such cases, localities have considerable discretion in implementing social programs.

Table 1.1. Shares of Local Spending Unit: billion JPN yen and percent

	(A) central	(B) local	(C) Social security funds	(D) Local	(E): (B)+(D)	(F): (A)+(B) +(C)	Local share: (E)/(F)
Collective consumption	12,365	27,766	674	0	27,766	40,805	68.0%
Social transfers in kind (1)+(2)	1,984	15,974	34,364	25,778	41,752	52,321	79.8%
(1) Social benefits in kind (i)+(ii)	0	0	33,500	25,778	25,778	33,500	76.9%
(i) Social security benefits, reimbursements	0	0	1,323	919	919	1,323	69.5%
(ii) Other social security benefits in kind	0	0	32,178	24,859	24,859	32,178	77.3%
(2) Transfers of individual non-market goods and services	1,984	15,974	863	0	15,974	18,821	84.9%
Social benefits other than social transfers in kind (3)+(4)+(5)	1,708	9,649	49,018	5,583	15,232	60,375	25.2%
(3) Social security benefits in cash	0	0	48,994	5,583	5,583	48,994	11.4%
(4) Unfunded employee social benefits	624	3,206	25	0	3,206	3,855	83.2%
(5) Social assistance benefits*	1,084	6,443	0	0	6,443	7,527	85.6%
Other current transfers**	3,313	3,985	397	0	3,985	7,696	51.8%
Capital transfers	6,506	3,041	62	0	3,041	9,609	31.7%
Gross capital formation	4,097	11,503	61	0	11,503	15,661	73.4%
Purchase of land	216	1,617	-7	0	1,617	1,825	88.6%
Total	30,189	73,535	84,569	31,360	104,895	188,292	55.7%

Source: Economic and Social Research Institute, Cabinet Office, *Annual Report on National Accounts of 2007*.
Notes: * includes social transfers in kind.
** excludes intergovernmental transfers.

Table 1.1 indeed substantiates the local roles in social spending. While localities share 55 percent of the total expenditure, their share of social spending is even higher. Although the local share of social security benefits in cash (pension benefits) is small, its share of social transfers in kind and social assistance is 79.8 and 85.6 percent respectively. Indeed, local governments in Japan are more responsible for social expenditure than those in other countries. Japan's share is one of the highest, after only Denmark and even higher than the combined share of state/ province and local expenditure in the federal countries.

This study describes the current arrangements for social protection in Japan[2], including the elements of coverage, benefits and management. Special attention is paid to the roles assumed by central and local governments in these schemes. We examine the system in terms of its effectiveness as a social safety net in the face of the changing socio-economic environment of the country. The rest of this paper is structured as follows: Section 2 discusses the upper layer of social safety nets which are managed by the central government, i.e. public pensions and unemployment insurance. Section 3 then delineates the scheme for public health care insurance. Section 4 explains the social protection scheme at the bottom, implemented by local governments. Section 5 then concludes the paper by identifying the issues the current Japanese system of social protection faces, along with possible policy proposals.

2. Public Pensions and Unemployment Insurance

2.1. Public Pensions

2.1.1. General Description

Pensions and work-related insurance are managed by the center in Japan. The Japanese public pension system is two-tiered.[3] The first tier is *Kiso Nenkin*, or the Basic Pension (BP), which aims to provide a base-line income for the retired. All residents, including foreigners in Japan between the age of 20 and 60 are expected to pay premiums for the BP. The second tier is *Kosei Nenkin* or the Employees' Pension Insurance (EPI). Its premiums are proportional to income earned and benefits increase in line with premiums paid during the working life of the employee. Those who work

[2] The concept of social protection should be associated with the Japanese terms Shakai Hosho, the literal translation of which is social (Shakai) security (Hosho). The MHLW schematizes policy for "social security" in terms of (1) social insurance (public pensions, public health insurance, long-term care insurance, work-related insurance), (2) public assistance (poverty relief), (3) social welfare (personal social services and income support for the elderly, the disabled, children and single mothers), (4) health (medical service delivery, health promotion, and epidemic prevention) and (5) medical care for the elderly.

[3] On top of these, large firms or employers sometimes provide corporate pensions as the third pillar.

at firms with more than 5 employees and their employers are required to participate in the EPI.

The two-tiered system applies only to employees and their spouses. Employees are automatically enrolled in the BP when they join the EPI. Their premiums include those for the BP and the EPI and are single-scheduled.[4] When the two-tiered scheme applies to those employed in the public sector, the scheme is called *Kyosai Nenkin* or the Mutual Aid Pensions (MAP). In these two-tiered systems, if subscribers are married, premiums paid by employees also entitle their non-working spouses[5] to receive future benefits from the BP.

The public pension for those excluded from the EPI (e.g., self-employed, farmers, and unemployed) is a single-tier system where the BP is the only component. This scheme is called *Kokumin Nenkin* or the National Pension (NP). The NP premiums are uniform and independent of individual characteristics (JPN¥ 14,460 per month in 2009). The BP does not cover the subscribers' non-working spouses. They have to pay premiums for their benefits, even if they do not earn. Low-income (or no income) subscribers can choose to exempt themselves from paying premiums, either partially or entirely but their benefits will be reduced accordingly.

The public pension system thus divides the insured into the following three categories:

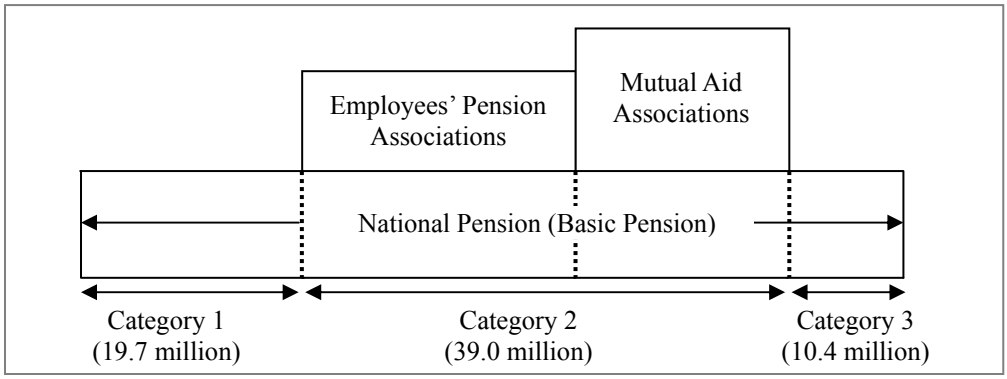
- Category 1: Those who are excluded from Categories 2 and 3 (e.g., the self-employed, farmers and students)
- Category 2: Those who work for companies with more than 5 employees
- Category 3: Non-working spouses of Category 2 subscribers

The public pension schemes that cover each of the above three categories are illustrated in Figure 2.1 along with the number of subscribers to each.

[4] Given this treatment of the BP within the EPI, the very same name "Employees' Pension Insurance" is somewhat confusingly used to denote the two-tiered system in the private sector.

[5] "Non-working" spouses refers to spouses who earn less than 1.3 million Yen a year.

Figure 2.1. Basic Schemes for the Public Pension in Japan



Source: Social Insurance Agency

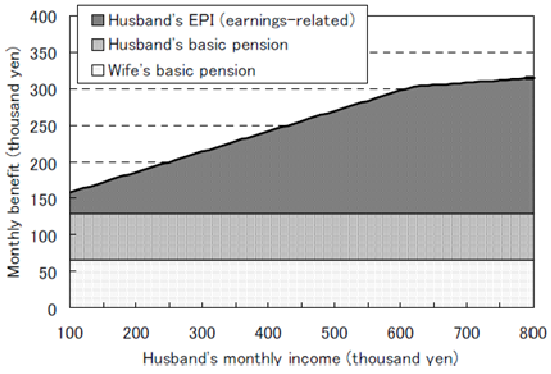
2.1.2. Benefits

Currently, 96 percent of all persons aged 60 and above receive the monthly average BP benefits of JPN¥52,500. While the starting age of eligibility for pensions varies from 60 to 65,[6] a prerequisite for receiving the benefits is at least 25 years of premium payments. Benefits are proportional to the number of years of premium payments, with a ceiling at 40 years of contributions. Nakashima (2009) calculated the combined EPI and BP benefits and their replacement ratio (monthly benefits per monthly earnings) for a couple with a non-working wife with 40 years of contributions, as in Figure 2.2. The BP benefits are flat at JPN¥65,000 for each individual in the couple. While Panel (a) shows that monthly benefits are increasing in line with average monthly earnings, Panel (b) shows that the replacement ratio is decreasing. For example, the combined monthly benefits are JPN¥227,000 for a couple who earned JPN¥348,000 on average with the replacement ratio of 0.652. If earnings were halved (JPN¥174,000), the monthly benefits are reduced to JPN¥179,000 with the ratio of 1.03. If they earned double (JPN¥696,000), the benefits are JPN¥315,000 with the ratio of 0.435.

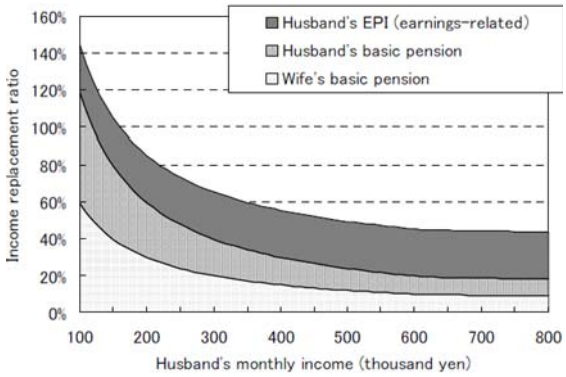
[6] Over the years, the government has increased the starting age for eligibility. In particular, the starting age for males born after April 1, 1949 and females born after April 1, 1954 is set at 65 for the BP, while that for the EPI (net of the BP) remains at 60. The starting age for the EPI will also be delayed gradually over coming years, until it reaches 60 for males born after April 1, 1961 and females born after April 1, 1966.

Figure 2.2. Pension Benefits

(a) Benefits



(b) Replacement ratio



Source: Excerpts from Nakashima (2009).

2.1.3. Financing

For the BP, current benefits are paid out of a pool of collected premiums and transfers from the budget of the central government. The 2004 reform raised the tax-financed portion from one third to one half of the BP benefits. For the EPI, both employers and employees contribute 7.32 percent of employees' monthly salary which includes premiums for the BP. The EPI premiums are capped at a monthly salary of JPN¥620,000.

Administrative costs are all tax-financed[7] both for the EPI and the NP. While the public pension is effectively pay-as-you-go, premiums that are collected but not disbursed are pooled and invested in order to yield returns. The MHLW sets performance goals for this investment. The Government Pension Investment Fund (GPIF) is entrusted by the MHLW to develop an investment strategy that will attain a long-term rate of return which is sufficient to maintain a stable ratio of reserves to annual public pension expenditure. The 2004 Pension Reform set inflation rate at 1.0% and real wage increase rate at 1.1%, and set investment yield at 2.2% so that

[7] The 2004 reform introduced an automatic adjustment of benefits to balance revenues and payments.

nominal investment yield will be 3.2%. The GPIF is thus required to achieve a real yield of 1.1%. Investment performance after FY2004 is listed in Table 2.1.

Table 2.1. Return on Investments

Fiscal Year	2004	2005	2006	2007	2008	Average (2004-8)	1st Qtr. 2009	2nd Qtr. 2009
Return on total investments (%)	3.39	9.88	3.70	-4.59	-7.57	0.77	3.89	1.06
Return on Market investments (%)	4.60	14.37	4.75	-6.42	-10.03	1.08	4.85	1.24

Source: Government Pension Investment Fund (2009a, b).
Notes: 1. "return on total investments" includes returns on FILP bonds.
2. The returns are reported as gross of fees.
3. The five year averages are annualized geometric mean.

2.2. Unemployment Insurance

2.2.1. General Description

Unemployment insurance is called the Employment Insurance (EI) or *Koyo Hoken* in Japanese. With some exceptions, employers are required to participate in the scheme to cover their full-time workers below the age of 65. Part-time and temporary workers who work for 20 hours or more per week are also enrolled in the scheme if it is expected that they will remain in their job for more than six months.

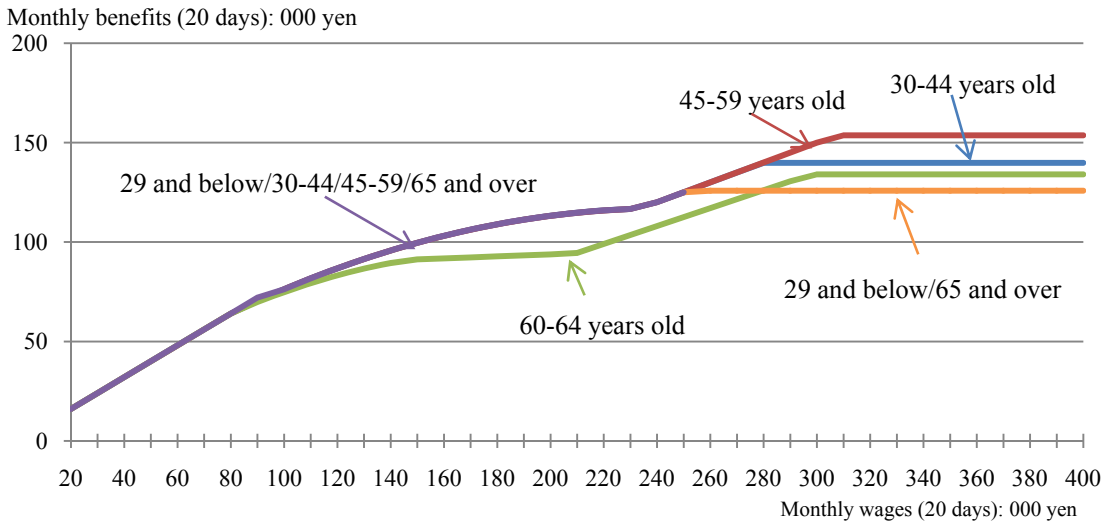
2.2.2. Benefits

When unemployed, the insured are expected to file applications at the "Hello Work" (Employment Security Office) in order to receive the EI benefits. To be eligible, unemployed people are required to have been enrolled on the EI program for a period of at least 6 months during the 2 years prior to leaving their job. The main component of the benefits is the Basic Allowance for the Job Applicants (BAJA), which is proportional to each applicant's most recent salary, prior to becoming unemployed. The proportion ranges from 50 to 80 percent with high-income earners receiving a lower proportion. If the insured are aged between 60 and 65, the proportion is reduced further to 45 percent. Figure 2.3 shows the different benefit schedules.

The BAJA is paid with the condition that recipients are actively seeking new jobs. The EI also provides other types of benefits for job-skill training programs and maintaining current employment status. Once deemed to be eligible, the insured

receives the benefits *after* a seven day waiting period. If unemployment is voluntary, the waiting period can extend to between one and three months, depending on the specifics of the case. In addition, the duration of benefits varies depending on the age of recipient, the period of enrollment in the EI and the reasons for job termination. Benefit duration increases with enrollment period and recipient's age. Voluntary unemployment results in a shorter duration. The details are summarized in Table 2.2.

Figure 2.3. The EI Benefits Schedule



Source: Author's calculation based on the formula by the Ministry of Health, Labour and Welfare.
Note : While the allowance is calculated on daily basis, the figure translates the schedules into those on monthly basis, assuming one month consists of 20 working days.

2.2.3. Financing

All administrative costs are financed from the general account of the central government. A certain proportion of the benefits payments are also tax-financed, with varying subsidizing rates across the types of benefits, typically 25 percent for the BAJA. The rest is financed by premiums (payroll taxes). The standard premium for the EI is 1.5 percent of employees' earnings (monthly salaries and bonuses), of which employers' and employees' share are 0.9 percent and 0.6 percent respectively, with different rates for businesses in the agricultural and construction industries. Due to the recent economic slowdown, the standard rate was temporarily reduced to 1.1 percent with 0.7 percent for employers and 0.5 percent for employees in 2009.

Table 2.2. Duration (Days) of the EI Benefits

Years (x) of the EI enrollment		x<1	1≤x<5	5≤ x <10	10≤ x <20	20≤ x
Voluntary	All ages	n. a.	90		120	150
Involuntary Unemployment	30	90		120	180	n. a.
	30-35	90		180	210	240
	35-45	90		180	240	270
	45-60	90	180	240	270	330
	60-65	90	150	180	210	240
Disabled	-45	150	300			
	45-65	150	360			

Source: Mukuno and Tanaka (2009), Ministry of Health, Labour and Welfare (various years).

3. Public Health Insurance

3.1. The System

3.1.1. General Description

Public health insurance in Japan consists of two schemes which cover different groups within the population. The first is an occupation-based scheme called *Hiyosha Kenko Hoken* or the Employees' Health Insurance (EHI). The EHI is a generic term for workplace-based health insurance and is categorized into (a) *Kumiai Kansho Kenko Hoken* or the Association-managed Health Insurance (AMHI), (b) *Zenkoku Kenko Hoken Kyokai Kansho Kenko Hoken* (*Kyokai Kempo* for short) or the Japan Health Insurance Association-managed Health Insurance (JHIA-mHI), (c) *Kyosai Kumiai Kenko Hoken* or the Mutual Aid Association Health Insurance (MAAHI) and (d) *Sen-in Hoken* or Seamen's Insurance (SI). These occupation-based insurance types cover employees and their dependents.

The other scheme is called *Kokumin Kenko Hoken* or the National Health Insurance (NHI). The NHI is a region-based scheme. The insurers are municipalities which cover residents who are excluded from the EHI. The insured typically include self-employed, farmers, workers of smaller firms and their families. They account for around one third of the total population. Since the NHI covers those who are not covered by the EHI, the system as a whole apparently boasts its universal coverage.

3.1.2. Benefits

The coverage of medical services by the public insurance is standardized by law. Except for some special medical treatments, the coverage is quite wide. There are no differences in co-payments or coverage for medical services, whether they are provided by clinics or hospitals, both private and public. Any people of comparable characteristics receive standardized medical services at identical prices (co-payments), regardless of the type of public health insurance. Patients are free to choose any medical service providers regardless of location, facility type or other factors such as having referral[8] or not. The public health insurance covers 70 percent of medical costs, i.e., co-payments are 30 percent.[9]

Medical service providers are paid for the services and medicine they provide. The fee schedules for medical treatments covered by public insurance are identically set by the central government and are subject to revision every two years based on recommendations from the Central Social Insurance Medical Council (CSIMC). Providers are reimbursed in a centralized manner. Each month, bills for medical treatments and drugs covered by the EHI and the NHI are examined by the Social Insurance Medical Fee Payment Fund (SIMFP) and the National Health Insurance Federation (NHIF) respectively. However, their reviewing capacity is limited and intensive reviews are limited to only high-cost and suspicious cases. To counteract some adverse effects[10], the 2006 reform introduced package payment for the medical treatment of the elderly with the hope of limiting the number of longer hospital stays.

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[8] Patients are required to pay an initial installment fee (usually less than JPN¥10,000) when they choose to receive medical services at designated, usually large-scale, hospitals without a referral issued by a non-designated clinic or hospital.

[9] Co-payments were increased in a series of reforms. For those below the age of 69 in the EHI, the rate was raised from 20 to 30 percent (NHI subscribers had already faced 30 percent rate then). The premium base was also imposed on bonuses, thus applied to the entire annual salaries. For the high-income elderly aged above 70, the co-payment rate was raised from 10 to 20 percent in 2002 and again increased to 30 percent in 2006. In that year, the rate for those aged between 70 and 74 was also raised from 10 percent to 20 percent. The ceilings on co-payments were also raised, in line with personal earnings.

[10] In addition, there has been a gradual shift in the usage of medical resources, from acute to chronic diseases. It is suspected that there is an incentive for medical providers to over-examine and over-prescribe medicine.

3.1.3. Financing

Benefits are financed by premiums, taxes and co-payments whose shares were 52.9 percent, 32.2 percent and 14.9 percent respectively in 2007 with all the programs combined. The premiums for the EHI differ among associations within the EHI. They are levied as a fixed percent of employees' earnings and are shared equally by employers and their employees. The premiums for the NHI differ among municipalities and are based on income level and the number of family members.

The Japanese system of public health insurance is summarized in Table 3.1, each item of which is explained in what follows in this section.

Table 3.1. Public Health Insurance in Japan

Institutional Type			Insurer/ Managing Organization	Coverage
Employees' Health Insurance	JHIA-managed		Japan Health Insurance Association	34 million
	Association-managed		Employees' health insurance associations (1,541)	28 million
	Seamen's Health Insurance		Japan Health Insurance Association	0.16 million
	Mutual Aid Association	Central Government Employees	mutual aid associations (21)	9 million
		Local Government Employees	mutual aid associations (54)	
		Private School Teachers and Employees	Private School Teachers and Employees Association	
National Health Insurance			municipalities (about 1,800)	42 million
			National Health Insurance Associations (165)	
Health Care Service for the Old-Old			prefecture-wise large area unions (47)	13 million

3.2. Employees' Health Insurance

The EHI covers employees and their dependents. The EHI consists of multiple health insurance programs managed by work-place based associations formed by employers and employees in private firms with five or more employees. These multiple health insurance programs are categorized as follows:

a. Association-managed Health Insurance

The *Kumiai Kansyo Kenko Hoken* or the Association-managed Health Insurance (AMHI) is operated by health insurance associations organized by members of large firms for their employees and family members. A single firm with more than 700 employees is eligible to establish its AMHI. More than one single firm can form a single association if their combined number of employees exceeds 3000. In 2009, 1,485 AMHIs (as of April 1st) cover approximately 30 million individuals.

b. Insurance managed by the Japan Health Insurance Association

Employees who are not covered by the AMHI and their family members are covered by health insurance managed by the Japan Health Insurance Association (JHIA). The JHIA insurance was formerly called *Seifu Kansho Kenko Hoken* or Government-managed Health Insurance (GMHI) and was administered by the Social Insurance Agency of the Japanese Government. As one of the reforms in the Social Insurance Agency, in October 2008 the GMHI was revamped into a new public health insurance managed by the JHIA.[11] The JHIA is an independent administrative agency whose functions are defined by national law. As of March 31 2009, about 19.5 million employees and their 15.2 family members are covered by the JHIA Insurance. The JHIA manages the Seamen's Insurance, which covers mariners and their family members with benefits in the event of sickness, injury, childbirth, death and unemployment. It also covers incidents of occupational disability and cases of missing mariners.

[11] The system started with a premium rate of 8.2 percent. In October 2010, the rate will consist of special and basic rates. The special rate is fixed at 3.2 percent in every prefecture and is used to finance Koreisha Iryo Seido or the Elderly Health Care Service (to be explained later). The basic rate differs across prefectures with the highest at 5.06 percent in Hokkaido and the lowest at 4.97 percent in Gunma, Saitama, Chiba, Yamanashi and Shizuoka. These differences are supposed to reflect differences in medical expenditure, after adjusting for differences in age-composition and income factors. Also, additional adjustments are made if the combined rate of the special and basic rates deviates by a pre-determined amount from the original rate of 8.2 percent.

c. Insurance managed by the Mutual Aid Associations

The other type of association that provides occupation-based public health insurance is *Kyosai Kumiai* or the Mutual Aid Association (MAA). There are three MAAs: the National Government Employees' Mutual Aid Association, the Local Government Employees' Mutual Aid Association and the Private School Teachers and Employees' Mutual Aid Association.

3.3. National Health Insurance

Every municipality sets up and manages its NHI insurance association to cover those residents who are excluded from the EHI. Municipalities can choose between two methods of premium collection: a subscription fee system and a local tax system. The fee system has more flexibility in setting premium schedules, while the tax system has more coercive power in collecting contributions[12]. The premiums are levied on income, property and number of insured within a household. Municipalities have discretion over the premium schedule which differs among municipalities. The premiums are reduced for low-income individuals. While the premium schedule is set by municipalities, the rule for premium reduction for low-income households is set by the central government. Currently, the premium is reduced by up to 60 percent (70 percent in some municipalities).

3.4. Health Care for the Elderly

Dependent elderly with family members enrolled in the EHI were also covered by the EHI. The other elderly were covered by the NHI, the cost of which was an increasingly heavy burden on the NHI. In 1983, *Rojin Hoken Seido* or the Elderly Health Care Service (EHCS) was created to lessen the burden on the NHI. In the EHCS, the elderly continued to be enrolled in either the EHI or the NHI and contributed according to the schemes' respective premium schedules as before. But a different scheme was introduced to finance the medical costs for those aged 70 and over[13]. Municipalities not only financed medical costs for the elderly but developed health

[12] Urban municipalities tend to employ the fee system, whereas rural municipalities tend to opt for the tax system (Nishikawa 2006).

[13] The EHCS also applies to those aged between 65 and 70 years who are bed-ridden or seriously disabled.

promotion programs to contain increasing medical costs. Half of the costs were financed by taxes: central, prefectural, and municipal governments share 40 percent, 10 percent and 10 percent of the total costs respectively. The other half is filled by cost sharing among the insurers of public health insurance (employees' associations in the EHI and the NHI) along with co-payments from the elderly.

Since April 2008, those aged 75 and above (called "old-old") have been separated from their public health insurance and covered by *Koki Koureisha Iryo Seido* or the Health Care Service for the Old-Old (HCSOO). A *Koiki Rengo* or large-area union composed of all municipalities within a prefecture manages health care for their old-old. The old-old pay 10 percent co-payments, while 30 percent is applied to the high-income. The benefits are financed from premiums (10%), transfers from public insurance associations (40%) and taxes (50%). The taxes are financed proportionally from the center (4/6), prefecture (1/6) and municipalities (1/6). Premiums differ among prefectures. The average value of annual premiums as of 2008 is JPN¥72,000, with the lowest figure of JPN¥46,374 in Aomori and the highest of JPN¥92,750 in Kanagawa. Premiums are collected by municipalities and are withheld from pension benefits if the pension benefits are more than JPN¥180,000 a year. Premiums are reduced for low-income elderly in three stages (30, 50 and 80% reductions).

For those aged between 65 and 74 (called "young-old"), the EHCS scheme is essentially retained, although the scheme is now called *Zenki Koureisha Iryo Seido* or the Health Care Service for the Young-Old (HCSYO). The young old continue to pay premiums for their public health insurance but their medical costs are taken care of by municipalities through tax-financing and an inter-insurer cost sharing scheme. The 2008 reform has effectively separated the old-old from the then-existing EHCS[14].

[14] However, due to its unpopularity and changes in the Japanese political map (i.e., the new Liberal administration), these new schemes are under serious review. In addition, the inter-association cost-sharing scheme has caused unintended effects. As the economy is rapidly aging, net contributions from health insurance associations to the cost-sharing scheme are increasing, since its mechanism is such that associations with larger shares of younger (older) generations contribute (receive) more. In addition, continuous economic slowdown has reduced wages of employees, thereby decreasing premium revenues which are fixed proportions of labor incomes. These have conspired to cause deficits in some associations to such an extent that they would be better off by dissolving themselves (and joining the JHIA) than by increasing their premium rates.

4. Long-term Care Insurance, Public Assistance and Other Welfare Services

In addition to the NHI and the health care system for the elderly, localities are responsible for the Long-term Care Insurance (LTCI) as well as other social welfare services. The local social programs are geared toward the following targets: (1) low-income households, (2) children, (3) single mothers and widows, (4) the elderly and (5) the physically and mentally disabled. Furthermore, a substantial number of social programs are also provided at local discretion.

4.1. Long-term Care Insurance

4.1.1. General Description

Before the introduction of the long-term care (LTC) insurance, Japan was suffering from inequitable care services, since municipalities with different fiscal resources provided different levels of care services according to their local standards. The Long-term Care Insurance (LTCI) was introduced in 2000 to cope with the difficult task of standardizing care benefits and containing expanding care expenses.

4.1.2. Benefits

The LTCI covers persons aged 65 years and over (Category I) and those aged between 40 and 64 years (Category II). To receive LTCI benefits, prospective recipients first apply to have their needs assessed by their municipality of residence. Upon application, an examiner visits and interviews the applicant to check various aspects of his/her physical and mental state. The checklist, filled in by the examiner, is compiled into a computer program that automatically assesses the applicants' needs. The computer results are then sent to a committee of local experts. They review the results with the written notes from the first-stage examiner and the applicant's doctor and alter the results if necessary. In all of these assessments, only the applicant's physical and mental condition is supposed to be considered.

Those who are found to be eligible are classified into several stages according to the severity of their needs. Until 2005, there had been six categories of LTC needs,

consisting of one stage of Support Required (SR) for the least severe and five stages of Care Required (CR) from 1 to 5 with 5 being the most severe. Since the SR category was divided into Support Required 1 (SR1) and Support Required2 (SR2) in 2006, there has been a total of seven categories. Applicants are informed of the results within 30 days of application. If dissatisfied with the decision, they can appeal to an agency at the prefectural level and ultimately to the courts. Eligibility and its categories are reevaluated every six months.

When certified as eligible, subscribers are entitled to "purchase" long-term care services from providers of their choice,[15] in exchange for co-payments amounting to 10 percent of actual cost (i.e., the LTCI benefit amounts to 90 percent of the expense). Those who are eligible can receive benefits up to a ceiling for which there are seven stages according to the severity of individual needs, from about JPN¥49,700 to PN¥358,300 for actual per-month service expense.

4.1.3. Financing

Municipalities set up special accounts for their LTCI programs and set budgets that are required to balance on a three-year basis. The three-year period for budget planning is called the "program management period (PMP)". When drawing up budgets for a coming PMP, municipalities estimate their LTCI expenditures for the next three-year PMP.[16] After expenditure forecasts are obtained, revenues are considered. The basic scheme is given as follows. First, the central government covers 20 percent of the benefit expenses through the "Long-term Care Benefits Subsidy (LTC-BS)." Secondly, the central government also disburses an additional grant called the

[15] Providers are either public or private, though private providers have to be certified by the prefecture. While a variety of LTC services are covered by LTCI benefits, some services are not covered by the LTCI. For example, meal expenses for those who are hospitalized or institutionalized are excluded from the coverage. Also, the benefits for Category II subscribers are restricted to some specific age-related diseases. In addition, persons classified in the two lowest stages (SR1 and SR2) are not eligible for institutional care services. Of course, the beneficiaries, if they desire, can self-finance the purchase of additional services.

[16] Because LTC prices are set by the central government and are effectively held constant, the expenditure forecasts boil down to the volume of demand for LTC services. Forecasting the volume of institutional care is relatively straightforward since it is capped by the capacity of existing or planned LTCI facilities. On the other hand, estimating the amount of home care is rather complicated, because it involves forecasting the number of eligible people and the extent to which they utilize their entitlements.

"Adjustment Subsidy (AS)". The AS allocates central funds that equal 5 percent of the national total of all LTCI benefits. The AS grants are distributed with matching rates that depend on the percentage of those aged 75 years and over, and the average income of those aged 65 and over. The minimum value of the matching rates is zero and its maximum value differs from year to year.[17] Thirdly, prefectures, through the Cost-sharing Subsidy (CSS), cover 12.5 percent of municipal benefits in their jurisdictions. Finally, another 12.5 percent is financed by intra-municipal transfers from the general account to the LTCI account within a municipality. These four factors are all financed through taxes and these tax-financed shares exclude extra benefits that municipalities provide over and above the national standards.

The remaining part of the LTCI benefits is financed from two types of premium. The first type of premium is paid by those aged between 40 and 64 years (Category II premiums) and are nationally pooled in the Social Insurance Medical Fee Payment Fund (SIMFPF) and then allocated as the Fee Payment Fund Grants (FPFG) to cover 31 percent of LTCI benefits in every municipality. Therefore, this grant works as an equalizing device since it favors municipalities where Category II shares are less than the average.[18]

The second type of premium is paid by municipal residents aged 65 years and over (Category I subscribers) to cover the remaining part of the revenues which varies depending on the size of the AS matching rate. The premium schedule is progressive and consists of products of a standard rate with adjustment coefficients. The national guideline sets out six income brackets and applies a set of adjustment coefficients (0.50, 0.50, 0.75, 1.00, 1.25 and 1.50) with larger values for the upper brackets.[19] The standard rate applies to the fourth bracket.

In each municipality, its standard rate is set so that its budget for the coming three-year PMP is balanced. As such, the standard rates are different across municipalities.

[17] For example, the percentage was 12.03 in 2003, 11.08 in 2004, and 11.65 in 2005.

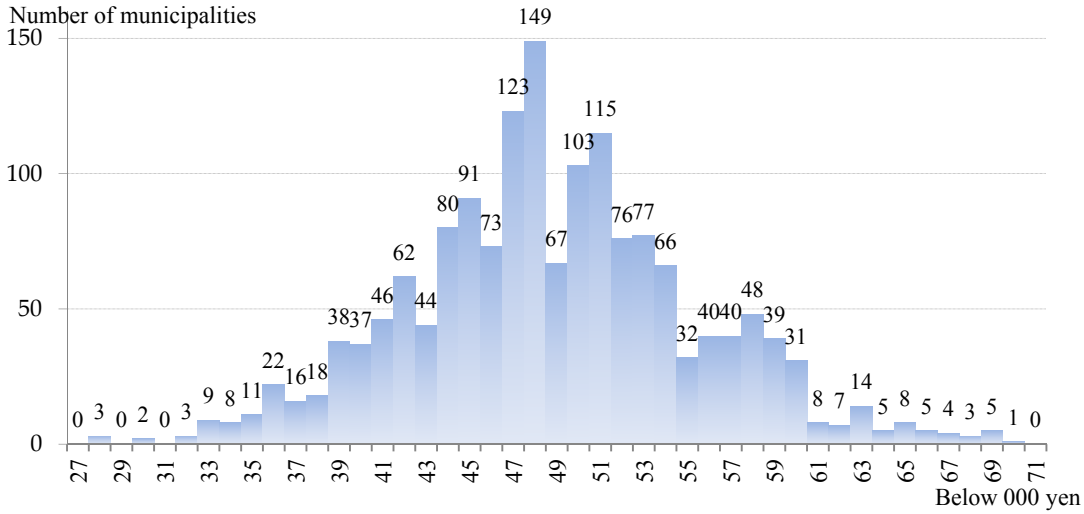
[18] The Category II premiums are collected as a surcharge on public health insurance premiums. In fact, this is a payroll tax and is split equally between employers and employees. The rate is 0.95% of salary for Government-managed Health Insurance and 0.88% for Association-managed Health Insurance.

[19] Some municipalities subdivide brackets higher than the fourth bracket and apply a complex premium schedule to those they consider well off.

Figure 4.1 shows the distribution of the annual standard rates for the current (i.e., 2010-2012) program management period. The rates vary from JPN¥27,180 to JPN¥69,240 with a median of JPN¥48,000.

Since the premium rates are fixed for three years, annually realized budgets do not usually balance. When surpluses occur, they are saved in the Long-term Care Benefits Funds (LTC-BF) against future deficits. If deficits are severe enough to exhaust the funds, loans are made from the Fiscal Stabilization Funds (FSF), which are managed by prefectures. The loans borrowed in a given PMP are repaid in the next PMP with funds financed from Category I premiums. Receiving loans thus implies a future hike in the premiums.

Figure 4.1. Annual LTCI Standard Premiums for the 2010-2012 Management Period.



Source: Available at http://www.mhlw.go.jp/houdou/2009/04/h0423-1.html, the Ministry of Health, Labour and Welfare.

4.2. Public Assistance

4.2.1. General Description

The Public Assistance (PA) or *Seikatsu Hogo* is the *last* safety net in Japan. The Public Assistance Law requires local governments to implement public assistance. Cities and prefectures are required by law to set up welfare offices to implement the PA,

while towns and villages are not. Prefectural welfare offices provide public assistance for towns and villages that do not have their own welfare offices.

4.2.2. Benefits

The PA intends to guarantee the minimum cost of living for Japanese citizens. The minimum costs refer to living expenses for what is referred to in Article 25 (1) of the Constitution as "wholesome and cultured living" and is more than mere subsistence levels. The MHLW determines the costs which apply nationally but vary depending on regional prices and the characteristics of recipients' households, including the size of household and its occupants' age, gender and mental and physical conditions. The minimum costs are calculated for each of the following eight categories of assistance: (1) livelihood, (2) education, (3) housing, (4) medical care, (5) long-term care, (6) childbirth, (7) employment and (8) funerals and other ceremonies. Depending on the circumstances of the needy, the total living costs are given as combinations of these categories of assistance. Most of the assistance is transferred in cash but funds for medical care assistance and long-term care assistance are paid directly to their service providers. In addition, shelter, if applicable, is provided in kind.

The PA payments are equal to the minimum cost of living in excess of what an individual can earn with his/her best effort. To receive the benefits, applicants are required to fully exhaust their available resources, including financial support from family and relatives, as defined by the Japanese Civil Code. The benefits are provided only if such income and resources are insufficient to cover the minimum costs of living. As such, public assistance is provided only after a careful examination or means-test, of the financial situation of the applicants. Most of the assistance is paid in cash but the cost of medical and long-term care assistance is paid directly to service providers. In addition, housing and shelter are provided in kind, if applicable.

4.2.3. Financing

The PA is financed out of general revenues of national and local governments. As explained later in detail, there are two types of fiscal transfers to local governments: The Central Government Subsidy (CGS) and the Local Allocation Tax (LAT). The CGS is purpose-specific and sometimes matching, and is directly disbursed from the budgets of

central line-ministries to local governments. The CGS for public assistance is disbursed from the budget of the MHLW and covers 75 percent of PA benefits. The remaining 25 percent is borne by local governments. But, this local burden is effectively eased in localities with poor fiscal capacity, which receives LAT grants. As explained later, the amounts of the LAT grants are determined to reflect the local burden of PA benefits.

4.3. Other Welfare Services

The Japanese system of income support and personal social services is largely defined by *Fukushi Roppo* or the Six Laws for Social Welfare (SLSW) which consist of (1) Public Assistance Law (as discussed), (2) Child Welfare Law, (3) Law for the Welfare of Single Mothers and Widows, (4) Law for the Welfare of the Elderly, (5) Law for the Welfare of the Physically Handicapped and (6) Law for the Welfare of the Mentally Challenged, the targets of which are self-explanatory. These laws define local governments as providers of social assistance and services.

In addition, the Social Welfare Services Law requires larger municipalities (cities) and prefectures to set up *Fukushi Jimusyo* or welfare offices to implement social assistance and services (as briefly explained in the subsection on public assistance). Smaller municipalities (towns and villages) are not required to do so but there are a small number of them with their own welfare offices. The prefectural welfare offices have their own functions but also cover the functions for towns and villages that do not set up their own welfare offices.

Social assistance and services provided by local governments may broadly be categorized into (1) income support for low-income households and (2) personal social services. The former includes public assistance, which has already been explained, and Child Allowance (*Jido Teate*) as explained below. The latter mainly consists of targeted services for children, females, the elderly and the handicapped.

4.3.1. Income Support (other than Public Assistance)

The Child Allowance also requires a means test, but the threshold is much higher, and the examination process is less strict. The system prescribed by national law targets lower income families with children up to the third grade of elementary school (nine

years of age). Municipalities examine eligibility and make payments. As long as income is below the threshold, the amount of payments only depends on the number of children. An additional allowance, the Child Rearing Allowance (jido fuyo teate), is distributed to single mothers with dependents less than 18 years old.

There is also a variety of income support for the handicapped. In most of the cases, municipalities examine eligibility and make payments within institutional structure prescribed by national law. But in others, municipalities may themselves provide their own supplementary assistance.

4.3.2. Social Services

Social services are mainly targeted at (1) mothers and children and (2) handicapped people. The services for (3) the elderly are mostly provided through the LTCI, while there are still services provided directly by local governments. The social services for mothers and children include personal services for handicapped children, facilities for maternity and day-care and shelters for abused children or children without guardians. The Child Welfare Law requires prefectures and designated cities to set up *Jido Fukushi Jimusho* or Child Counseling Office (CCO) to implement social services for children. In addition, municipalities provide day-care for children who do not have proper parental care. Fees for these day-care services vary across municipalities but usually depend on income and number of children.

The handicapped are categorized into physically disabled, mentally disturbed and intellectually disabled. Additional special care is given to children with these handicaps. Comprehensive measures are available, ranging from facility-based to in-home services. Roughly speaking, municipalities consult with the users, provide relevant services directly and/or make arrangements with welfare agents. Meanwhile, prefectures build and manage facilities and other infrastructure.

The providers of targeted services include local governments and *Shakai Fukushi Hojin* or the Social Welfare Foundations (SWFs). The SWFs are non-profit agents whose functions are defined in the Social Welfare Service Law. In many cases, local governments commission the SWFs to deliver personal social services. The majority of facilities are managed by non-governmental entities like the SWFs.

Traditionally, local governments assessed individual needs and decided the types to be applied. The service provider was the local governments or the SWFs commissioned by local governments. However, the trend in welfare reform is toward a regime where beneficiaries choose the providers based on their own needs. This philosophy is reflected in the introduction of the LTCI, where private firms play important roles as service providers. Local governments monitor and control those private agents that provide welfare services.

4.3.3. Other Discretionary Assistance and Services

Local governments in Japan are not prohibited from developing their own social programs. First, there are many cases where national laws simply mandate that localities conduct specific programs but the central government does not specify either benefit levels or eligibility criteria explicitly. In such cases, localities have full discretion in implementing social programs. An example is the School Expense Assistance (SEA). While the central government mandates that municipalities implement the SEA programs to help children in low-income households attend their primary and junior high school, municipalities have full discretion over eligibility criteria and benefit levels for families with children that marginally fail to qualify for PA benefits. As such, the SEA programs differ greatly among municipalities.

Second, localities often provide supplementary benefits over and above those that the central government mandates. For example, there is a variety of supplementary income support for the handicapped. While there is a national system of benefits for the handicapped, in 2008, the Tokyo metropolitan government provided additional monthly benefits of JPN¥15,500 to the severely handicapped. Furthermore, the special district of Ohta adds JPN¥2,000 on top of the benefits from the metropolitan government. In addition, municipalities in Tokyo also provide monthly additional benefits to the less severely handicapped, with amounts varying from JPN¥ 4,000 (Showa city) to JPN¥13,500 (Bunkyo special district) in 2008.

4.4. Financing Decentralized Social Expenditures

Municipalities and prefectures vary in size in terms of both population and economy. Such disparities make it difficult for most local governments to finance their

expenditures out of their own locally-financed revenues. In fact, only a small number of municipalities are considered to be self-financing. Local governments thus need fiscal transfers from upper levels of government to finance their expenditures. The flows of fiscal transfers take a variety of forms. For local expenditures on income support and personal services which are accounted in local general budgets, the Central Government Subsidies (CGS) and the Local Allocation Tax (LAT) are the two main transfer mechanisms. As for FY2007, the LAT and the CGS account 16.7 and 11.2 percent respectively of the total revenues for the general account (which excludes the special accounts for the LAT and the NHI), while the share of own revenues (local taxes plus miscellaneous revenues) is about 60.5 percent.

4.4.1. Central Government Subsidies

The CGS is a generic term for categorical grants disbursed directly from the budgets of line-ministries in the national government. The subsidies, which are purpose-specific and sometimes matching, are categorized into the following three functions: First, the subsidies help local governments maintain the standards required by national law for specific public services and transfers to individuals. For example, the central government bears 75 percent of PA benefits and 1/3 of disbursements for child and child rearing allowances. The center also provides 50 percent of capital and current expenditures for designated facility services for the handicapped. These cost-share ratios are all prescribed in related national laws. Second, the CGS serves as incentives for local governments to adopt specific projects that contribute to national policy objectives. While the majority of such projects are infrastructure projects, redistribution-related projects are also supported by this type of CGS. For example, in-home services for the handicapped are subsidized by this type of CGS with a maximum matching rate of 50 percent. Also, additional assistance is given to local projects that encourage PA recipients to enter labor markets. Third, the CGS finance services that local governments are required to supply on behalf of the national government (i.e. national elections). In addition, the CGS are disbursed to the special accounts of local governments. Municipalities, as insurers, set up special accounts for the NHI and the LTCI. The central government subsidizes 17 percent of the NHI payments and 24 percent of the LTCI payments through the CGS system.

4.4.2. Local Allocation Tax

The CGS are supposed to help local governments maintain national standards for such local public services. But the subsidies are partial, and the remaining part is borne by local governments. The LAT effectively takes care of the remaining part for localities with insufficient revenue capacities. The LAT is a general-purpose grant which is financed (partially) out of a set of five national taxes (32 percent of personal income tax and liquor tax, 35.8 percent of corporate income tax, 25 percent of tobacco tax and 29.5 percent of consumption tax). The LAT consists of two components. First, the Ordinary Local Allocation Tax (OLAT), which constitutes 94 percent of total disbursements, is distributed according to a gap-filling formula where an amount equal to fiscal needs in excess of revenue capacity is transferred. The scheme is gross in the sense that no revenues are taken from a local government whose gap is negative. Second, the remaining 6 percent of all LAT disbursements goes to the Special Local Allocation Tax (SLAT), which is set aside against unexpected fiscal shocks that may not be accounted by the OLAT. Here, OLAT will be discussed.

The amount of OLAT transferred to a local government is calculated as a non-negative difference between what are called the Standard Fiscal Demand (SFD) and the Standard Fiscal Revenues (SFR), i.e., OLAT= max{SFD$\tilde{}$SFR, 0}. The SFD estimates the level of local expenditure required to maintain standard quality of public services within a local jurisdiction. The SFR is an estimate of the revenue 'capacity' of a given jurisdiction. The SFR is made up of a fixed portion of estimated local tax revenues plus some specified transfers. What is important here is the fact the SFD includes the costs that local governments are supposed to share with the CGS, especially when the subsidies assume the first function described above. In other words, LAT recipients obtain additional financial supports through the LAT system for expenditures subsidized through the CGS system.

4.4.3. Special Schemes for the NHI and the LTCI

Local governments are required to set up special accounts for the NHI and the LTCI. There are also additional subsidizing and equalizing schemes that are designed for those two special accounts. The NHI and the LTCI are also supported through the LAT. Municipalities, as insurers, make transfers from their general accounts to each of

their two special accounts. Designated parts of such transfers are accounted for in the SFD for the LAT disbursements. However, the share of the transfers in the total NHI payments was as small as 1/75 in FY2005. We also note that prefectures share 7 percent of the total NHI payments and 12.5 percent of the total LTCI payments by transferring their funds as revenues in the two municipal special accounts. Such transfers are also accounted for in the SFD.

Over and above the CGS and the LAT, additional schemes are in place for the NHI and the LTCI. Among the schemes for the NHI, the most sizable is the Fiscal Adjustment Grant (FAG). Like the LAT, the FAG has two components. First, the Ordinary FAG (OFAG) which occupies 80 percent of the total FAG is intended to equalize fiscal capacities among the municipal special accounts with a LAT-like gap-filling formula which depends on differences between estimated demands and revenues. Second, the Special FAG (SFAG) sets aside 20 percent of the total disbursements for unexpected fiscal demands such as natural disaster. The FAG accounts for 9 percent of the total NHI payments and is financed out of the central budget.

For the LTCI, as explained, the contributions from Category II subscribers are pooled at the SIMFPF and disbursed among municipalities as the FPFG which makes up 32 percent of the standardized LTCI expenditures. Since the share applies uniformly to every municipality, the grants work as an equalizing device and affect municipalities favorably where Category II shares are less than the national average. In addition, there are the AS grants which are distributed with matching rates that depend on the percentage of the old-old and the average income of those aged 65 and over.

5. Issues and Challenges

5.1. Changing Environments

A set of social safety nets should operate as a system, effectively connecting basic services and assistance together. However, the following changes in socio-economic environments conspire to make the safety nets in Japan disjointed. First, the

population is rapidly aging. The National Institute of Population and Social Security Research (2007) forecasts that the elderly proportion of the population (65 and above) will be 31.8 by the year of 2030 (As of 2005, the share was 20.2). This rapid aging would result in significantly higher demands for medical care, long-term care and income support. At the same time, it also implies that the financing side of population is being eroded, increasing the per capita fiscal burden on the younger generations.

Secondly, Japan has been experiencing structural changes in its labor market. In particular, the share of non-regular workers has been continuously increasing from 15.3 percent in 1984 to 34.1 percent in 2008. Non-regular workers usually have little job security and are typically paid with lower wage rates. In particular, their wage differential has been increasing since the early 1990s. In addition, more youths are "non-active"; being out of both school and labor markets at the same time. While the number of such youths varies depending on its definition, the *Labour Force Survey* by the MHWL estimates the number to be 640 thousand, which is 3.2 percent of 19.84 million labor force aged between 15 and 34 in 2008. This is a 20 thousand increase from the previous year and its share is increasing.

Lastly, there has been an increase in poverty in the country. Its poverty rate (the proportion of the population with income below a half of median income level) increased from 14.6 in 1997 to 15.7 in 2007. In fact, the poverty rate in Japan is the fourth highest among OECD countries only after Mexico, Turkey and the United Sates. This increase in poverty should be related to those in aging population and non-regular employment, since income differentials are higher among the aged and non-regular employees tend to receive lower wages. These two factors are expected to continue to increase, as is the amount of poverty.

5.2. Holes in the Safety Nets

Upper layers of the social safety nets in Japan are social insurance programs built around full-time employees (EI, EPI, EHI). Those excluded from the mainstream programs are covered by residual social insurance programs. Pensions are provided by a nation-wide scheme whose benefits are smaller than those of the mainstream scheme (BP). Medical services are covered by public health insurance managed by municipalities (NHI). Those excluded from these social insurance programs are

covered by the residual programs provided by local governments. In particular, an increasing number of the elderly that are excluded from the EP and the BP are covered by the Public Assistance. In other words, local governments are responsible for the safety nets at the bottom, covering residuals that fall from upper layers of social safety nets.

Our contention in this paper is that, since the system has traditionally been built around full-time employees and the residual functions are left to local governments, a rapid aging of population, changes in labor market structure and an increase in poverty conspire to make the pieces of safety nets operate separately, leaving the needy caught in the holes without help.

Let us see some examples of such holes in the safety nets:

a. Pension Benefits

The NP covers those who are excluded from the EPI. Its annual benefit amounts to JPN¥792,000, with the full years of subscription (40 years) in FY2009. The benefits fail to reach the poverty line (JPN¥1.27 million) for single-member households. The poverty line for two-member households is JPN¥1.80 million, which is still higher than the combined benefits for an elderly couple (JPN¥1.58 million). Furthermore, the NP premiums are difficult to collect. First, they are not automatically levied on payrolls. Second, it would be difficult for the poor to pay the flat-rate premiums (JPN¥14,660 per month) on a regular basis. In fact, defaults and exemptions are continuously increasing. Since the benefits depend on the accumulated premium contributions, an increasing number of retirees are expected to receive pension benefits that are far smaller than the poverty threshold.

b. Public Health Insurance

An increase in the number of non-regular employees as well as non-active youths increases the number of those who are covered by the NHI. Its premiums are also based on fixed amounts and paid directly by its subscribers. On average, its subscribers with annual income of JPN¥1.03 million had to pay an annual premium of JPN¥93,799 in FY2007. Despite reductions in premiums for low income households, it is unsurprising that they tend to fail to contribute premiums. The defaulters can

continue to receive the benefits for some time but eventually they will be excluded from the insurance scheme.

c. Unemployment Insurance

Analogous issues apply to the EI which was originally designed for full-time regular employees. Only 20 percent of the involuntarily unemployed received EI benefits in 2006, which would be due to either exclusion from the system from the outset, or the insufficient duration of benefit payments. A survey in 2005 also showed that the EI program excluded 47 percent of non-regular workers. A good example of such exclusion may be found with single-mothers. According to a survey by the MHLW in 2006, 43.7 percent of single-mothers are not enrolled in unemployment insurance. Likewise, 6.5 and 17.5 percent of them are not enrolled in public health insurance and public pension respectively (Komamura, 2009).

d. Public Assistance

If upper layers of safety nets fail to maintain the minimum costs of living, the *last* safety net is expected to seal the holes. The PA is the last safety net in Japan. The largest group among its recipients is the elderly and its proportion among recipient households (46.1% in 2007) is steadily increasing. With the increase in the protection rate since the beginning of the 1990s, the PA may seem to be working properly. However, a further examination indicates otherwise. In fact, the minimum costs of living guaranteed by the PA are in the vicinity of the poverty line. If the PA had functioned properly, therefore, the poverty rates would have remained minimal. However, as we have mentioned, the fact is that the poverty rate in Japan is in the top four among the OECD countries.

The above argument shows that there are a number of holes in the upper layers of the social safety nets. Those excluded from the EHI are covered by the NHI and those excluded from the BP are covered by the PA. Localities are thus responsible for the safety nets at the bottom, covering residuals that fall from upper layers of social safety nets. In what follows, let us discuss how such holes are to be sealed.

5.3. Sealing Holes in the Safety Nets

5.3.1. Basic Pension Benefits

One of the major problems in the Japanese system of social safety nets is an increasing number of defaults and exemptions from the NP. While the EPI premiums are collected as withholding (payroll) taxes, the NP premiums are paid directly by those who are excluded from the EPI. The performance of the NP premium collection has been aggravated since local offices of the Social Insurance Agency (now Japan Pension Service) took over the task in 2002 from municipalities which had been collecting the NP premiums.

It would be more desirable to finance all of the BP benefits through an increase in VAT, along with the integration of the collection agencies. There are good reasons for tax-financing. First, it evidently strengthens collecting capacities of the authorities. In addition, tax enforcement would be less costly in the case of an increase in VAT.[20]

Second, financing the BP through taxes would not make significant differences from what it is now. If participation in social insurance is compulsory and intends to cover all individuals, its premiums are effectively taxes. All citizens pay VAT as long as they consume, which means that they all, in effect, subscribe to the social insurance that the VAT finances. In this sense, this tax-financing maintains the link between benefits and contributions, if appropriate budgetary arrangements (e.g., setting up a special account) are made.

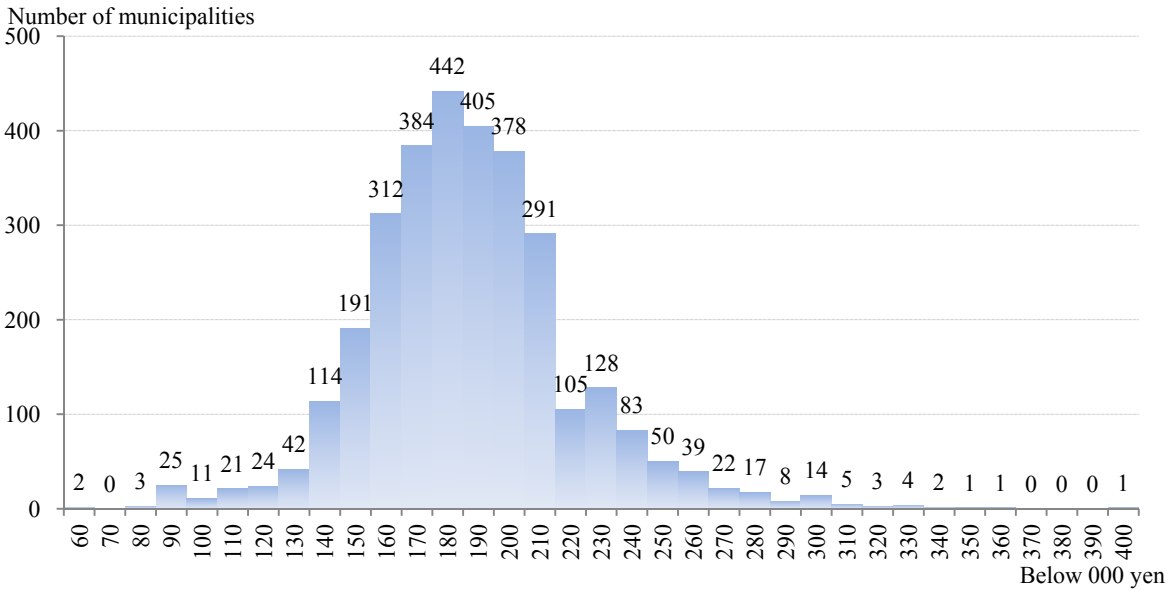
Third, the existing BP is already redistributive in the sense that the half of it finances are derived from taxes. Financing through VAT changes the distribution of burdens among "subscribers" since VAT payments will be proportional to individual consumption, whereas the current premiums for the NP (BP) are fixed at a single rate. But if the *social* insurance aims to be redistributive, the tax-financing would contribute to the cause since the VAT can be made less regressive than the current NP (BP) premiums.

[20] There are three different tax/premium collecting bodies: local offices of the National Tax Agency, those of the Japan Pension Service and tax collection offices of local governments. Pension premiums are basically taxes on income. It is clear that we will benefit from the economies of scale and scope in collecting taxes/premiums by integrating the three collecting bodies into a single enforcement entity.

5.3.2. National Health Insurance

There are three major problems in the NHI system, which originate from the fact that the NHI covers those who are excluded from the EHI and are on average low-income. First, despite the fiscal transfers that help municipal NHI programs, large disparities exist among municipalities. This reflects uneven spatial distribution of the unhealthy and the poor. The former increases medical expenditures and the latter decreases premium revenues. This results in households with identical characteristics paying different premiums in different municipalities. Kitaura (2007) calculated annual premiums for a couple with annual income of JPN¥2,306,000 as in Figure 5.1. Depending on where they live, this household faces a variety of annual premiums ranging from below JPN¥60,000 to JPN¥400,000. This evidently compromises horizontal equity.

Figure 5.1. Annual NHI Premiums for a Couple with Income of JPN¥2,306,000



Source: Kitaura (2007).

Second, municipalities are too small to pool risks. In small municipalities, an expensive medical treatment, even on a small number of patients, would lead to an unexpected hike in deficits in the NHI accounts to be covered either by an increase in premiums or ex-post transfers from the municipal general account. Since an increase

in the premiums is usually avoided, this leads to a further increase in municipal deficits, imposing restrictions on other municipal expenditures.

Third, NHI programs are also suffering from premium collection problems: the average subscribers are low-income and are often reluctant to contribute premiums. The percentage of defaulting households in the NHI hit 20.8 percent in 2009; [21] the highest since records began in 1998. As a result, there are an increasing number of people who are excluded.[22]

The MHLW now encourages parties involved to integrate the NHI at the prefectural level. For example, Kyoto Prefecture has initiated talks with municipalities in its jurisdiction with the prospect of integrating NHI programs at the prefectural level. Pooling risks at the prefectural level will make things better. Nonetheless, such integration at the prefectural level might not help small prefectures much. In addition, many prefectures may not want to share fiscal burden the NHI currently imposed on municipalities. Offsetting such fiscal burden would require a substantial cost-sharing scheme whose funds are transferred from the central budgets. Since such a cost-sharing would, in effect, pool prefectures at a national level, it might be more straightforward to integrate the municipal programs at a national level. Of course, doing so might leave little incentive for localities to develop their own health promotion to contain health expenditures. If such disincentives exist at all, it would be difficult to hit a balance between what the law dictates and what the incentive for a regional health promotion requires. Still, an overhaul of the current NHI is in order.

5.3.3. Public Assistance

Elderly households are the largest category of the PA recipients, being excluded from the current old-age pension. Their number is expected to increase, if aging

[21] While this may be due to the fact that those aged 75 and above are transferred to the newly established system of the HCSOO, the seriousness of the issue is clearly highlighted by this figure.

[22] It is reported by the MHLW that there were 32,930 children (those aged 15 and younger) in September 2008 that had no public insurance policy. Reform in 2009 mandates municipalities to cover such children (though not their parents). Another mandate was issued in 2010, stipulating that municipalities must provide additional cover to those aged below 18, starting on July 1, 2010. Although they made the situation better than previously, these central mandates do not solve the problems.

progresses and holes in the old-pension system remain as they are. In addition, the PA also covers medical expenditures of the poor. Medical assistance (MA) covers full costs of medical treatments and constitutes almost half of total PA expenditures (49.3 percent in 2007). Given the fact that the elderly, the ill, the injured and the handicapped are major recipient groups, it is no wonder that MA occupies such a large portion.

The Japanese system of social protection has no separate institutional schemes for (1) income maintenance for the elderly and (2) medical assistance for the poor. The PA in Japan covers larger groups of recipients than social assistance implemented by local/ state governments in countries like Canada, United State, France and Italy. Our proposal here is to remove the two functions (i.e., assistance for the elderly and medical care assistance for the poor) from the PA, by setting up an independent national scheme for each of the two. In addition, there are no reasons why those two functions should be implemented by local governments. First, disbursing benefits to the elderly, like benefit payments to the retired, would simply require following a set of standard operating procedures without a high degree of discretion. We have already mentioned the creation of tax-financed universal old-age allowance that replaces the current BP benefits. Second, medical assistance for the poor would effectively be administered within a general scheme of public health insurance. We have also mentioned the need to overhaul the NHI. The overhauled NHI would cover those who are currently covered by the PA.

With the two functions being removed, the local fiscal burden for the PA will be reduced significantly. More than 40 percent of recipient households are the elderly, and almost 50 percent of PA expenditures are medical assistance. Furthermore, the sick and injured, by definition, receive MA and so do many of the handicapped. The PA will be targeted mainly at those who can, in principle, work if their problems are dealt with. For example, single mothers would be encouraged to work if local governments could provide good child care for their children. Single mothers may need counseling and continuous encouragement from social workers. Such functions are more than just giving monetary benefits following a uniform set of standards. They involve providing personal social services that require a high degree of discretion as well as coordination with other social programs implemented within the same local

government. In addition, an effective performance of such functions may well be required to take account of local characteristics.

5.3.4. Distribution of Local Revenues

While many social programs are prescribed by central government, there is also a substantial part of services that is at the discretion of local governments. These local functions are more or less financially supported by transfers like the CGS and the LAT grants from the central government. Although the aggregate amount of these transfers is not small, the equalizing effects of them are weakening as the central government is now decentralizing local revenues through tax-point transfers and the replacement of the CGS with the LAT. This is because the tax-point transfers are more advantageous for localities with larger tax bases and the LAT formula is gross so that the LAT cannot take revenue away from rich localities. Discretionary local social programs are very much affected by the differences in local revenue capacity. For example, rich localities in Tokyo have a more generous menu of social services and benefits, while localities with meager revenue sources in rural areas may not. Since the system of central grants is losing equalizing capacities, disparities in discretionary social programs are expected to be aggravated. While it is impossible and possibly undesirable to make every discretionary service identical across localities, we need an alternative scheme of intergovernmental transfers that equalize local funds for redistributive programs.

6. Concluding Remarks

This study has described the current arrangements for social protection in Japan, including the key elements of coverage, benefits and management. We have paid special attention to the roles assumed by local governments in these schemes. Since the system has been traditionally built around full-time employees and most of the residual functions of social safety nets are left to local governments, recent changes in socio-economic factors have made the pieces of safety nets in the country operate separately, leaving the needy caught in the holes without help. To seal the holes in the

nets, we have proposed the setting up of separate institutional schemes to guarantee income and public health insurance for the elderly. We have also mentioned the need for an alternative scheme of central grants that equalizes local funds for discretionary social programs. Of course, since such reforms involve securing more funds, an increase in taxes is unavoidable.

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CHAPTER 3

Social Protection in Korea – Current State and Challenges

WANKYO CHUNG

Research Fellow
Department of Public Economics and Social Policy
Korea Development Institute

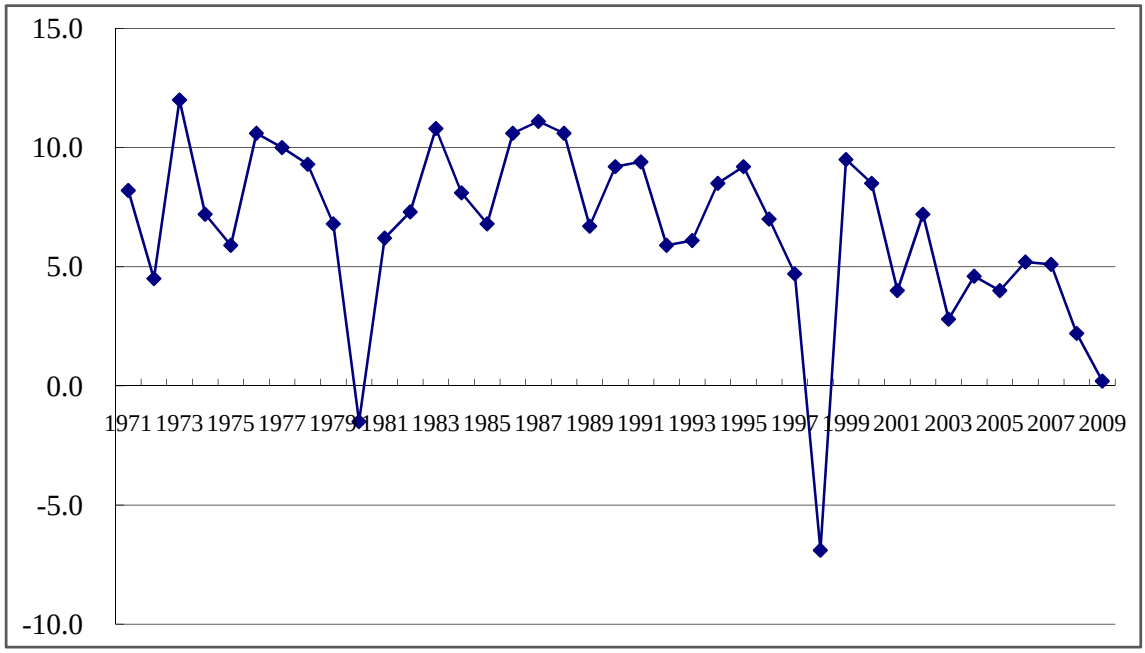
This research looks into social protection for the elderly in Korea, identifies critical challenges to it and seeks for possible solutions. The National Health Insurance was introduced in 1977 and expanded to universal coverage in 1989, protecting the elderly from the financial risk associated with acute illness. A new social insurance for long-term care was introduced in July 2008 to cover long-term care costs associated with aging-related chronic illness or disability. While the pension scheme was introduced in 1988 and then expanded to universal coverage in 1999, only 25% of the elderly were recipients of public pension schemes in 2008 because of its recent introduction. Additional Basic Age Pension was introduced in January 2008 and expanded in January 2009, providing 5% of the three-year average earnings of the national pension insured to the relatively poor 70% of the elderly.

Before they become mature enough to be efficient and effective in protecting the elderly, the social protection schemes face significant challenges ahead. First of all, financial sustainability should be enhanced by reducing their benefit levels and/or increasing contribution levels. With these changes, the inevitable challenge of inter-generational and intra-generational equity should be addressed carefully. Furthermore, coordination among the schemes will become more important over time. Especially, the National Pension Scheme should be coordinated with the newly introduced Basic Age Pension. Also, National Health Insurance should be coordinated with Long-term Care Insurance. Finally but most importantly, measures to help elderly people remain healthy and active in the labor market should be taken, while developing the social protection schemes for the vulnerable elderly.

1. Background and Objectives

The Korean economy experienced robust growth (except for 1980) until the mid-1990s. However, the economy plummeted with the Asian financial crisis, especially in 1998 as shown by the real GDP growth rate in Figure 1. The real GDP growth rate was -6.9 for the year 1998. Although it afterwards recovered, real GDP growth rate has been declining again with the current economic crisis.[1]

Figure 1. Real GDP Growth Rate (1971-2009)



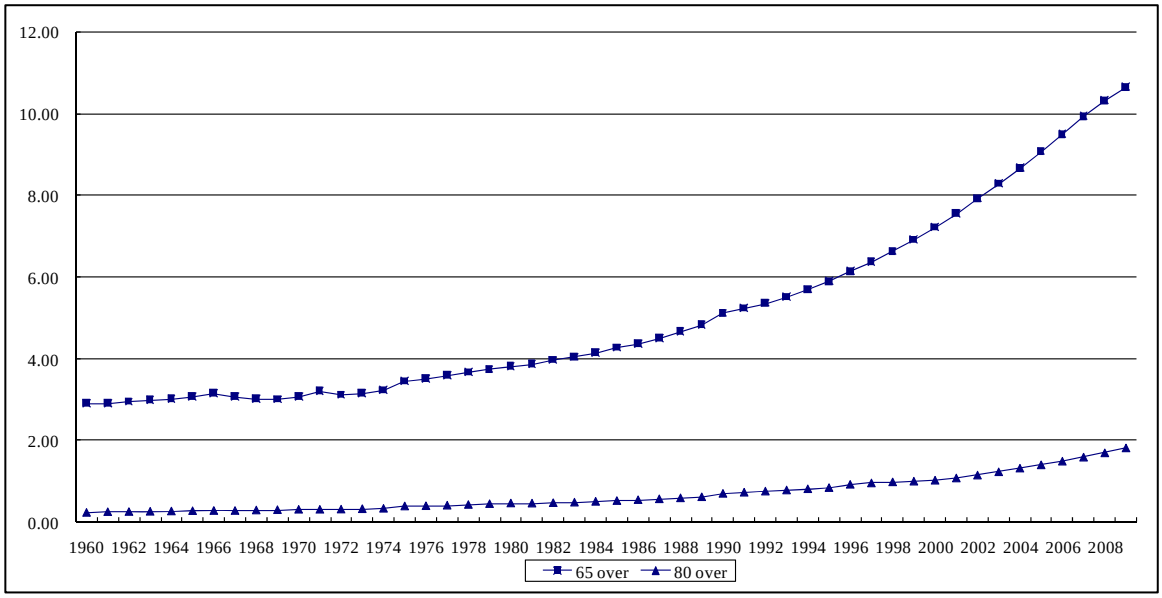
Source: Economic Statistics System (http://ecos.bok.or.kr), Bank of Korea, 2010.

Meanwhile, Korea's population has been aging rapidly. The share of those aged 65 and over in the total population increased significantly from 2.90% in 1960 to 10.65% in

[1] The real GDP growth rate was 0.2 in 2009. Data used in Figure 1 are presented in Table A-1.

2009 (See Figure 2.).[2] Korea is expected to become an aged society by 2018 when the share rises to 14 % or higher, and a super-aged society by 2026 when the share rises to 20% or higher. Similarly, the share of those aged 80 and over in the total population increased from 0.24 to 1.82 during the same period. Population aging in Korea is assessed to be more dramatic than in any other OECD country (OECD 2009).

Figure 2. Share of the Elderly in Population



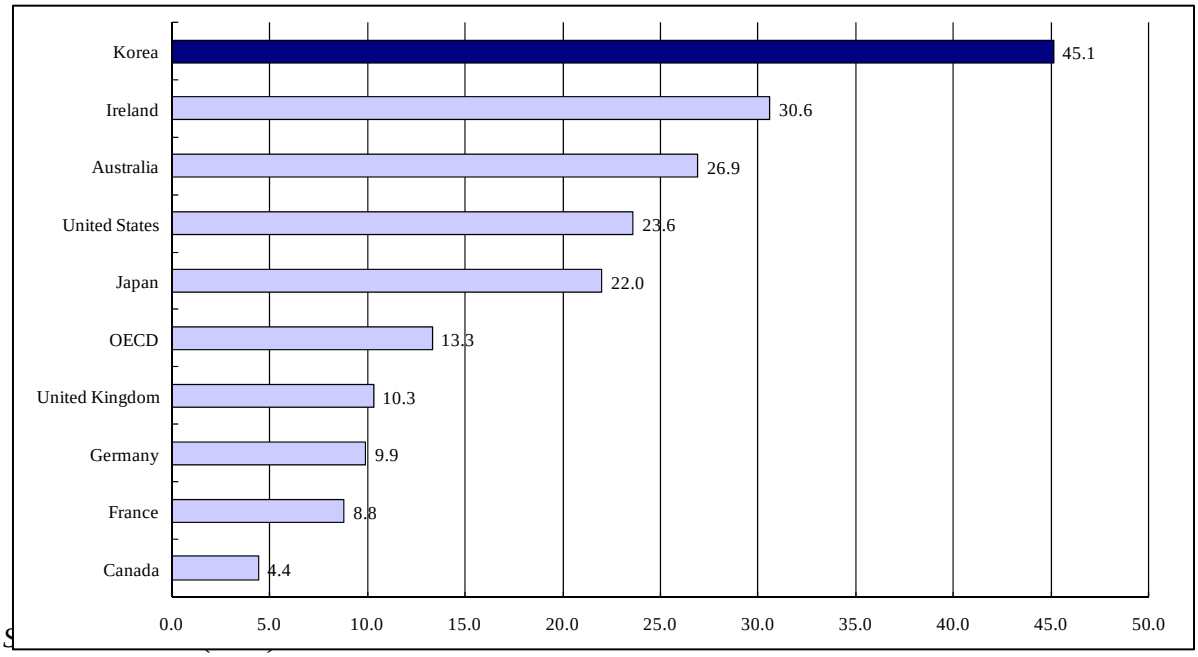
Source: Statistics Korea (http://kosis.kr), Population Projections for Korea 2006.

An aging population, especially during the current economic crisis, has been a growing concern for the social protection of the elderly. It is a fact that the elderly are more prone to illnesses and thus subject to poverty due to significantly high medical costs. The share of total national medical costs borne by those aged 65 and over has increased rapidly from 17.47% in 2000 to 30.79% in 2008. Thus, it may not be surprising that the elderly recipients of the National Basic Living Security (NBLS), the means-tested public

[2] Data used in Figure 2 are presented in Table A-2. Among those aged 65 and over, the male to female ratio increased from 0.597 in 1980 to 0.686 in 2009.

assistance program for the very poor, represented 26.5% (382,050 people) of NBLS recipients (1,444,010 people) in 2008. Furthermore, according to Figure 3, 45.1% of those aged 65 and over in Korea had (equivalent) incomes below half the population median in 2005, the highest old-age poverty rate among the 30 OECD countries (OECD, 2009)[3].

Figure 3. Poverty Rate of the Elderly



Source: OECD (2009).

This research looks into social protection for the elderly in Korea, driven by the high old-age poverty rate, and searches for measures for a sustainable social protection system in Korea. It is notable that the central government's spending for the welfare of the elderly has increased. The share of welfare spending for the old increased from 0.23% in 1999 to 1.59% in 2009. Above all, this study focuses on health insurance and pension systems in Korea. The former protects the elderly from the financial risks involved when

[3] Average for the 30 OECD countries is 13.3%.

they suffer from illnesses and have to bear their own medical costs. The latter directly supports the income of the elderly with pension benefits. In addition, this research introduces the newly initiated long-term care insurance of Korea.

Accordingly, the objective of this research is to review the current state of health insurance, long-term care insurance and pension systems in Korea. Furthermore, this research identifies critical challenges to those systems and seeks for possible solutions.

2. Current State of Social Protection

2. 1. National Pension Scheme (NPS)

2.1.1. Coverage

The pension scheme in Korea was introduced in 1988 and then expanded to universal coverage in 1999. The pension system is operated by the National Pension Service. All residents from 18 to 59 years of age, regardless of their income, are covered under the scheme. The insured persons under the scheme are divided into the mandatorily insured (major group) and the voluntarily insured (minor group). The mandatorily insured persons, who are not able to choose to participate in the scheme or withdraw from it, are further divided into workplace-based insured persons and individually insured persons.

All the employees and employers from 18 to 59 years of age at a workplace are covered by the National Pension Scheme as workplace-based insured persons.[4] Those under the age of 18 are covered by the pension scheme, subject to their employer's consent.

[4] Government employees, military personnel, and private school employees are covered by other public pensions, not the National Pension Scheme, specially designed for each group.

The very poor who are recipients of the National Basic Living Security are not covered by the scheme. Daily workers, casual workers employed for less than a month, or hourly workers working less than 80 hours in a month are not covered either. Meanwhile, individually insured persons are those who are self-employed, excluding non-income earners from 18 to 26 years of age who are studying or performing military service, and excluding also recipients of the National Basic Living Security.

The voluntarily insured persons are divided into two groups: those who are not eligible for the mandatory pension but want to participate in the pension, and those who reach age 60 before completion of the 20-year enrollment period and want to extend the enrollment period up to age 65 to become eligible for their pension (10 years minimum enrollment period is required) or more pension benefit. All foreigners residing in Korea are equally covered by the National Pension Scheme, based on individual qualifications except for foreign students, diplomats, etc.

As of November 2009, a total of 9,972,380 persons (53.27%) out of 18,721,200 insured persons were workplace-based insured persons, and 8,673,534 persons (46.33%) were individually insured persons. The rest were divided into 35,046 voluntarily insured persons (0.19%) and 40,240 voluntarily and continuously insured persons (0.21%) from age 60 to 65.

Among the old aged 65 and over, 25% were recipients of public pension schemes in 2008 (See Table 1). Of these, 22% were entitled to the National Pension, 2.6% to the public pension for government employees, and 0.4% to the public pension for private school employees, respectively. The number of recipients of the National Pension Scheme has increased from 283,179 persons (7.5% of the old) in 2002 to 1,103,007 persons (22%) in 2008. During the same period, the number of recipients of the public

pension for government employees has increased from 63,023 persons (1.7% of the old) to 131,482 persons (2.6%), and those of the public pension for private school employees from 7,421 (0.2%) to 17,663 persons (0.4%), respectively.

Table 1. Pension Coverage of the Elderly

		2002	2003	2004	2005	2006	2007	2008
National Pension Scheme	No. of Recipients	283,179	344,616	458,419	600,421	751,897	944,651	1,103,007
	Share (%)	7.5	8.7	11.0	13.7	16.4	19.6	22.0
Pension for Government Employees	No. of Recipients	63,023	73,439	83,658	93,468	104,942	118,503	131,482
	Share (%)	1.7	1.9	2.0	2.1	2.3	2.5	2.6
Pension for Private School Employees	No. of Recipients	7,421	9,551	8,877	10,298	13,658	15,800	17,663
	Share (%)	0.2	0.2	0.2	0.2	0.3	0.3	0.4
Total	No. of Recipients	353,623	427,606	550,954	704,187	870,497	1,078,954	1,252,152
	Share (%)	9.4	10.8	13.2	16.0	19.0	22.4	25.0

Source: Korea National Statistical Office (http://kostat.go.kr), Statistics for the Old, 2004~2009.

2.1.2. Contribution

The contributions of workplace-based insured persons are equally shared by the employer and the employee, while individually insured persons, including voluntarily insured persons, pay all their contributions themselves. All pension contributions are tax-exempt except for the contributions made by employers for the workplace-based insured persons.

The total contribution to the pension scheme by workplace-based insured persons is 9% of individual average monthly earnings (shared equally by employers and employees) with

a minimum cap of 0.22 million (KRW) and a maximum cap of 3.6 million (KRW) on the average monthly earnings.[5] The contribution rate was 3% between 1988 and 1992, 6% between 1993 and 1997, and 9% from 1999 onwards (See Table 2). It should be noted that Retirement Payment Reserve, money reserved for severance pay, was used for the contribution from 1993 to 1998. However, the use of Retirement Payment Reserve for the contribution was repealed in April 1999.

The contribution rate for individually insured persons was 3% from July 1995 to June 2000 but began to increase by 1% annually from July 2000 up to 9% in July 2005. Thereafter, the rate has remained at 9%. The income of individually insured persons is "any earned income". The contribution rate for voluntarily insured persons was 3% from 1988 to 1992, 6% from 1993 to 1997 and 9% from January 1998 to March 1999 following those for workplace-based insured persons. But, as the pension scheme in Korea was expanded to universal coverage in April 1999, the contribution rate for voluntarily insured persons was cut to 3% from April 1999 to June 2000 and increased by 1% annually from July 2000 up to 9% in July 2005. Thereafter, it remains at 9% following the contribution rate for the individually insured persons. The income for voluntarily insured persons is the higher of the median income of all workplace-based and individually insured persons or any reported income.

Financial support has been available to some workers in the agricultural and fishery sectors since July 1995. As of 2010, when their monthly income is less than 790,000 (KRW), half of the contribution is subsidized but when their monthly income is higher than 790,000 (KRW), the fixed amount of 35,550 (KRW) is subsidized for their pension contribution.

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[5] Amounts less than one thousand (KRW) in the monthly earning are rounded off.

When the contribution is not made by the due date, 3% of the contribution is additionally charged in arrears and an extra 1% for each additional month delayed is charged up to 9%. However, when the insured person is not able to make contribution due to job loss, business failure, etc. the person will be temporarily exempted from paying contribution. Accordingly, the unpaid period is not counted as an insured period but the person is able to increase his insured period by paying the delayed contribution afterwards. As of December 2008, the contribution collection rate is 96.7%. To illustrate, the rate turns out differently among the separately insured groups, for example 99.2% for workplace-based insured persons, 82.6% for individually insured persons and 100% for voluntarily insured persons.

Table 2. Contribution Rate

A. Workplace based Insured Persons

Year	1988-1992	1993-1997	1998	1999 ~
Total	3.0	6.0*	9.0*	9.0
Employee	1.5	2.0	3.0	4.5
Employer	1.5	2.0	3.0	4.5
Retirement Payment Reserve*		2.0	3.0	

*Retirement Payment Reserve is money reserved for severance pay. The use of Retirement Payment Reserve for the contribution was repealed in April 1999.

B. Individually Insured Persons

07.1995 ~ 06.2000	07.2000 ~ 06.2001	07.2001 ~ 06.2002	07.2002 ~ 06.2003	07.2003 ~ 06.2004	07.2004 ~ 06.2005	07.2005 ~
3	4	5	6	7	8	9

C. Voluntary Insured Persons

1988~1992	1993~1997	01.1998 ~ 03.1999	04.1999 ~ 06.2000	07.2000 ~ 06.2001	07.2001 ~ 06.2002	07.2002 ~ 06.2003	07.2003 ~ 06.2004	07.2004 ~ 06.2005	07.2005 ~
3	6	9	3	4	5	6	7	8	9

Source: National Pension Service (http://www.nps.or.kr), 2010.

2.1.3. Benefits

The National Pension Scheme (NPS) is designed as an appropriate income protection system against a wide range of social risks including old age, disability and death. The NPS is an income related scheme where benefits are based on both individual income and economy-wide average income. Pension benefits are calculated by C (A+B)*(1+0.05N), where C is a proportional constant designed for the desired income replacement rate of pension benefits, A is average monthly income of the pension insured over the previous three years, B is individual lifetime average monthly income, and N is the number of insured years in excess of 20 years (calculated by the number of insured months in excess of 20 years divided by 12).[6] The income replacement rate of pension benefits for 40 years of contribution was 70% from 1988 to 1998 and 60% from 1999 to 2007. This replacement rate was further reduced to 50% in 2008 and will be reduced by 0.5% per year to 40% in 2028.[7] However, the pension benefit cannot be higher than either individual lifetime average monthly income or average monthly income of the pension insured over the previous five years. This is intended to prevent economically viable people from retiring early.

Pension benefits (Basic Pension Amount, BPA) are available from age 60 (but this will be gradually increased to 65 by 2033), provided that the individual has contributed for ten years or more. Full benefit is available for those who have contributed to the pension scheme for twenty or more years. Reduced benefit is available, 5% lower for each year,

[6] The pension benefits formula is C (A+0.75B)*(1+0.05N) for the period from 1988 to 1998 but C (A+B)*(1+0.05N) for the period since 1999. Additional credits are available to those who give birth to more than 2 children or completed military service since 2008.

[7] Accordingly, C in the pension benefits formula is 2.4 from 1988 to 1998, 1.8 from 1999 to 2007, 1.5 and declines annually by 0.015 from 2008 to 2027. Afterwards it remains at 1.2.

for those who have contributed to the scheme for ten or more years but less than 20 years. Thus, the pension benefit for those who have contributed to the pension for 10 years alone is 50% of the benefit level for those who have contributed to the pension for 20 years or more, increasing by 5% for each additional contributory year (see Table 3).

Additionally, early pension benefit is available for those who are aged 55 and over (60 and over, when the normal pension age increases from 60 to 65) and economically inactive. Early pension benefit is lower by 6% for each year prior to age 60 when the pensioner begins to receive pension benefit. Thus, the pension benefit at the current early pension age of 55 is 70% of the benefit level at the normal pension age of 60, increasing by 6% for each deferred year of age up to age 60. When the current normal pension age increases from 60 to 65, the early pension age will increase as well from 55 to 60.

The pension benefit for those who are still working from age 60 to 65 (from 65 to 70 when the normal pension age increase from 60 to 65), whose yearly income is higher than the average monthly income of the pension insured over the previous three years (A in the pension benefits formula), is 50% of the full old age pension benefit level but increases by 10% for each deferred year of age up to age 65. However, if they have contributed to the pension for ten or more contributory years but less than 20 years, the pension benefit increases by an additional 5% for each additional contributory year. Since they are economically active, additional pension benefits for the dependents of pensioners are not available to them.

Additional pension benefits (Dependents' Pension Amount, DPA) are available to the dependents of pensioners such as spouse, children, and parents who are economically dependent upon the pensioners. The annual fixed amount (from April 2009 to March 2010) is 214,860 (KRW) for the spouse, 143,220 (KRW) for each child aged 18 and under

or severely disabled, and 143,220 (KRW) for each parent aged 60 and over or severely disabled. When a pensioner dies, 40 to 60% of the pension benefit (Survivor Pension) is available to the surviving dependents such as spouse, children, parents, and grandparents corresponding to the period during which contributions were made.

Table 3. Pension Benefits

Qualification	Benefits
Aged 60, contributed for more than 20 years	BPA+DPA
Aged 60, contributed for more than 10 years but less than 20 years	BPA(5% less for each contributory year lower than 20 years) +DPA
Aged 60 to 65, working	BPA(10% more for each deferred year of age to receive pension benefit up to age 65)
Aged 55 to 59, not working, contributed for more than 10 years	BPA(6% less for each earlier year of age to receive pension benefit than age 60 and 5% less for each contributory year lower than 20 years)+DPA
Divorced spouse, older than 60, married for more than 5 years during which contributions were made	Half of BPA corresponding to the married period during which contributions were made
Surviving dependents of pensioners	BPA(40% if the contributory years is less than 10 years, 50% if more than 10 years but less than 20 years, and 60% if more than 20 years)+DPA

Source: National Pension Service (http://www.nps.or.kr), 2010.

Meanwhile, some part of the pension benefit of a pensioner is available to his/her divorced spouse who is older than 60, if the couple were married for more than 5 years during which contributions were made. The benefit level to a divorced spouse is half the pension benefit corresponding to the married period during which contributions were made.

The number of pension beneficiaries (excluding lump-sum benefit recipients) increased from 292,976 in 1999 to 2,537,213 in 2008 (see Table 4). During this period, the overall cost of pension benefit increased from 1,326,036 million (KRW) to 27,414,488 million (KRW). When pension benefits are limited to old-age pension, excluding

disability pension and survivor pension, there were 2,064,198 beneficiaries of old-age pension and the cost of their pension benefit amounted to 427,860 million (KRW) in 2008.

Among the old-age pension beneficiaries, the majority group, categorized as special, is those who are too old to satisfy the minimum required contributory period of 10 years when the NPS was introduced and expanded, but who made contributions for more than 5 years. The basic pension amount (BPA) together with the dependents' pension amount (DPA), are available to them regardless of their working status. There were 1,673,576 beneficiaries and their pension benefits amounted to 16,181,115 million (KRW) in 2008 (see Table 5). Depending on the period of contributions, full benefit recipients numbered 12,798 and reduced benefit recipients numbered 216,084. Their pension benefits amounted to 49,586 and 2,659,399 million (KRW), respectively. The early pension benefit recipients numbered 159,202 and divided pension benefit recipients numbered 2,425. Their pension benefits amounted to 2,471,217 million (KRW) and 7,975 million (KRW), respectively.

Table 4. Pension Beneficiaries and Benefit Amount (1999-2008)

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Beneficiaries	292,976	633,845	795,528	955,667	1,108,415	1,500,194	1,749,633	1,973,767	2,250,948	2,537,213
Amount	1,326,036	2,250,554	3,551,696	5,204,225	7,222,136	9,791,103	13,001,147	16,900,516	21,649,503	27,414,488

Source: National Pension Service (http://www.nps.or.kr), 2010.

Note : (million KRW, as of the end of each year).

Table 5. Pension Beneficiaries and Benefit Cost, 2008

	Total	Old-age Pension						Disability Pension	Survivor Pension
		Total	Special	Full	Reduced	Early	Divided		
Beneficiaries	2,537,213 (100.0)	2,064,085 (81.4)	1,673,576 (66)	12,798 (0.5)	216,084 (8.5)	159,202 (6.3)	2,425 (0.1)	100,776 (4)	372,352 (14.7)
Amount	27,414,488 (100.0)	21,369,292 (77.9)	16,181,115 (59)	49,586 (0.2)	2,659,399 (9.7)	2,471,217 (9)	7,975 (0.0)	1,633,932 (6)	4,411,264 (16.1)

Source: National Pension Service (http://www.nps.or.kr), 2010.

Note : (million KRW, %).

Pension benefits are taxable but pension income deduction applies with a graduated marginal deduction rate, [100% for 0~3.5 million (KRW), 40% for 3.5~7 million, 20% for 7~14 million, 10% for 14 million and over]. The maximum deduction is 9 million (KRW) per year.[8]

2.1.4. Basic Age Pension

However, because pension benefits are not sufficient to prevent 45.1% of those aged 65 and over from having (equivalent) incomes below half the population median, the highest old-age poverty rate among the OECD countries (OECD, 2009), the Basic Age Pension has been additionally introduced in January 2008, providing 5% of the three-year average earnings of the national pension insured (A in the pension benefit formula above) to the relatively poor 60% aged 70 and over.

The coverage of Basic Age Pension has been expanded to the relatively poor 60% aged 65 and over in July 2008 and the relatively poor 70% aged 65 and over in January

[8] It should be noted that the old, aged 65 and over, receive an additional tax allowance of 1.5 million (KRW) on top of the standard tax allowance [1.5 million (KRW) for each tax payer and dependent] (OECD 2009).

2009. To be eligible in 2009, adjusted income, based on household income and assets, should be less than 680,000 (KRW) for the elderly living alone, and 1,088,000 (KRW) for the elderly living with his/her spouse.[9] The number of recipients has increased from 1,940,000 people in June 2008, to 3,585,000 people in September 2009. Simultaneously, the coverage rate has increased from 61% to 68.6%.

The benefit of Basic Age Pension is 5% of the three-year average earnings of the national pension insured (A in the pension benefit formula above). It will be increased to 10% by 2028. From 2008 to march 2009, the benefit was 84,000 (KRW) for the qualified elderly living alone and 134,000 (KRW) for the qualified elderly living with his/her spouse. From April 2009 to March 2010, the benefit was increased to 88,000 (KRW) and 140,800 (KRW), respectively. It has been financed by national and local taxes.

2. 2. National Health Insurance

2.2.1. Coverage

National Health Insurance in Korea was introduced in 1977 and expanded to universal coverage in 1989. Before being fully integrated into the National Health Insurance Corporation in 2000, there were three different categories of insurance societies, 139 insurance societies for employees (begun in 1977), an insurance society for government and private school employees (begun in 1977), and 227 insurance societies for the self-employed (begun in 1988 for those in rural area and in 1989 for those in urban area, respectively).[10]

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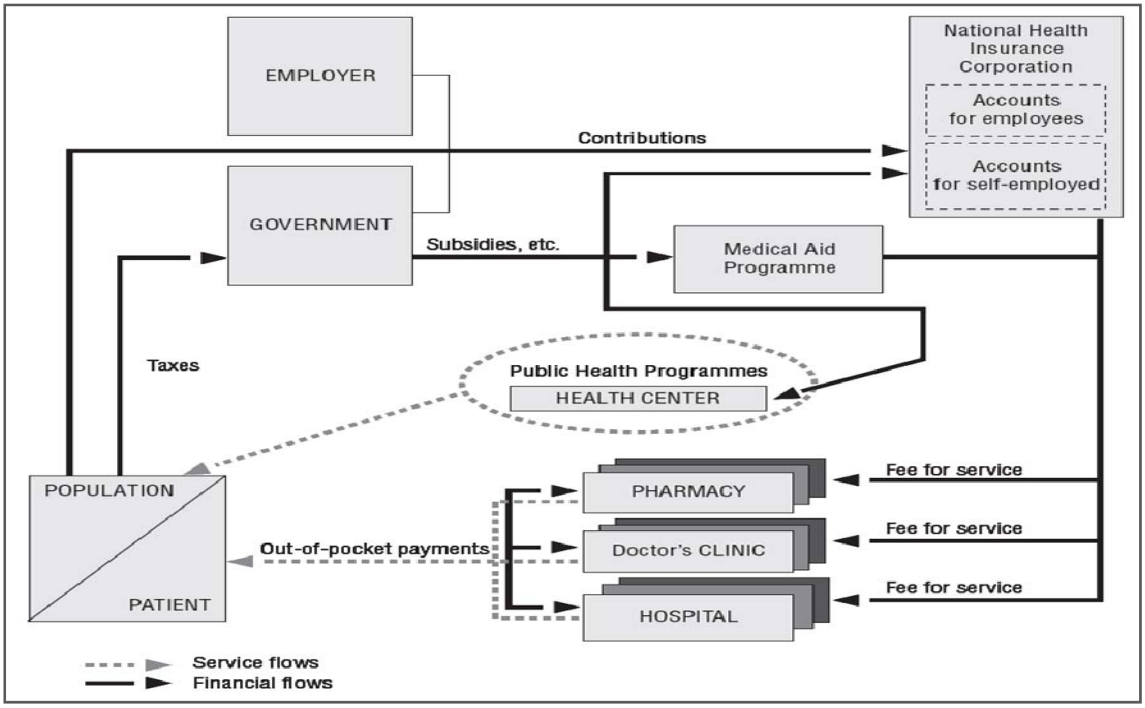
[9] The respective amounts were 400,000 (KRW) and 640,000 (KRW) in 2008.

[10] Before full integration in 2000, insurance societies for the self-employed and those employed in the government and private schools were integrated into the National Medical Insurance Corporation in October 1998.

Enrollment in National Health Insurance is mandatory for all Koreans, except for the poor who are eligible for the Medical Aid Program, which provides the same benefits as the National health insurance but subsidizes contribution and copayments. The number of people covered by the National Health Insurance as of 2008 was 48,159,718 people; with the employee insured comprising 63.2% and the self-employed insured 36.8%, respectively. The remaining 1,841,339 people were covered by the Medical Aid Program. Among the old, 4,599,562 people are covered by the National Health Insurance; with the employee insured (including the insured as dependents) comprising 66.4% and the self-employed insured 33.6%.

Figure 4. Operational Structure of National Health Insurance



Source: OECD (2003).

The operational structure of National Health Insurance is presented in Figure 4. The National Health Insurance Corporation (NHIC), a not-for-profit organization, is in charge

of administering the national health insurance program, collecting contributions and paying fees for services

2.2.2. Contribution

The contribution to the insurance is an amount calculated by multiplying the contribution rate by the average monthly salary for the employee insured, which is equally borne by both the employer and employee. The contribution rate has increased from 5.08% in 2008 and 2009 to 5.33% in 2010. There is a minimum cap of 0.28 million (KRW) and a maximum cap of 65.79 million (KRW) on average monthly earnings. Reduction of contribution by 50% is available to those living or employed on islands or in remote rural areas.

The contribution for the self-employed insured is calculated based on their income, assets, age, etc. Reduction of contribution for the self-employed insured is available by 50% to those living on islands or in remote rural areas, by 22% to those living in rural areas, by 28% to some workers in the agricultural and fishery sectors, by 20% to the very poor due to fire accident or bankruptcy etc., by 30% to those whose family member are all old and at least one member is older than 70, and by a maximum 30% depending on income or asset values to those who have a family member aged 65 or over or disabled.

2.2.3. Benefits

Benefits include all medical care covering diagnosis, tests, drugs, medical materials, treatments, surgery, preventive care, rehabilitation, hospitalization, nursing and transportation. Some cash benefits are available when copayment exceeds 1.2 million

(KRW) within 30 days, which amount to 50% of the excess amount.[11]

Co-payments are 20% of total cost for inpatient care and 30~60% for outpatient care. In the case of outpatient care, a lower rate for less expensive smaller-sized medical institutions applies, to incentivize more use of them, for example 30% for pharmacies and clinics, 40% of (treatment cost and per-visit consultation fee) for hospitals, 50% of (treatment cost and per-visit consultation fee) for general hospitals, and (per-visit consultation fee and 60% of treatment cost) for tertiary care hospital.[12] However, a copayment ceiling system was introduced in 2004. When copayment exceeds the ceiling any additional copayment for the services covered by the National Health Insurance will be exempted. The ceiling threshold is 2 million (KRW) for the 50% lowest contribution payers, 3 million (KRW) for the 30% medium contribution payers, and 4 million (KRW) for the 20% highest contribution payers.

Table 6. Copayments

Classification		Copayments
Inpatient		20% of total treatment cost
Outpatient	Tertiary care hospital	60% of (treatment cost) + per-visit consultation fee
	General hospital	50% of (treatment cost + per-visit consultation fee)
	Hospital	40% of (treatment cost + per-visit consultation fee)
	Clinic	30% of treatment cost
	Pharmacy	30% of total cost

Source: National Health Insurance Corporation (http://www.nhic.or.kr), 2010.

The balance of National Health Insurance is shown in Figure 5.[13] The revenue

[11] Additional cash benefits are available to the disabled, 80% of the expenses for wheelchairs, hearing aids, etc.

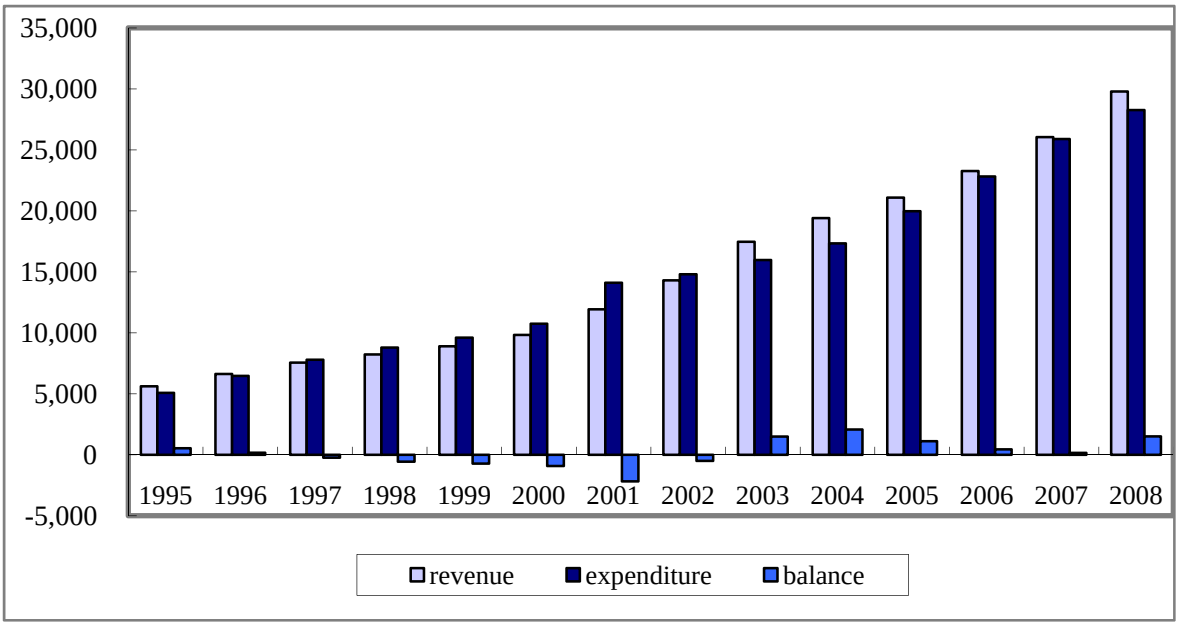
[12] The copayments are lower to those people living in town and township, 45% for general hospitals and 35% for hospitals, respectively.

[13] Data used in the Figure 5 is presented in Table A-3.

increased from 5,614 billion (KRW) in 1995 to 29,787 billion (KRW) in 2008. The main source of revenue was contributions, 24,973 billion (KRW), followed by government subsidies of 4,026 billion (KRW) and others of 787 billion (KRW) in 2008. Simultaneously, the expenditure increased from 5,076 billion (KRW) to 28,273 billion (KRW). The main expenditure was insurance benefits, 26,654 billion (KRW), followed by administrative cost 672 billion (KRW) and others 946 billion (KRW) in 2008. The balance (revenue – expenditure) was negative from 1997 to 2001 but became positive with the increase of government subsidy in 2002. Thereafter, the positive balance declined to 161 billion (KRW) in 2007 but jumped to 1,513 billion (KRW) in 2008 mainly due to the increase of contributions.

It is a fact that the elderly are more prone to illnesses and thus subject to poverty due to significantly high medical costs. According to Table 7, medical cost for the entire population increased by 2.7 times from 12,912 billion (KRW) in 2000 to 34,869 billion (KRW) in 2008. Simultaneously, that for the elderly increased by 4.76 times from 2,255 to 10,737 billion (KRW). Consequently, the share of medical costs borne by those aged 65 and over has increased rapidly from 17.47% in 2000 to 30.79% in 2008.

Figure 5. Balance of National Health Insurance.



Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2002-2008.

Note: (billion KRW).

Table 7. Medical Cost by the Elderly

Total	2000	2001	2002	2003	2004	2005	2006	2007	2008
	12,912	17,843	18,832	20,742	22,506	24,862	28,410	32,389	34,869
Aged 65 and over	2,255	3,163	3,636	4,401	5,136	6,073	7,350	9,119	10,737
Ratio	17.47	17.73	19.31	21.22	22.82	24.43	25.87	28.15	30.79

Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2000-2008.

Note: (billion KRW).

2. 3. Long-term Care Insurance

A new social insurance for the long-term care was introduced in July 2008 in response to rapid population aging. While National Health Insurance covers the medical costs of acute illness, Long-term Care Insurance covers long-term care costs associated with aging-

related chronic illness or disability.[14] Enrollment in the Long-term Care Insurance is mandatory for all Koreans as it is for the National Health Insurance. Long-term care insurance is also operated by the Nation Health Insurance Corporation.

Only those with serious limitations in performing the activities of daily living (ADLs) are eligible for Long-term Care Insurance. The number of beneficiaries increased from 76,476 people in July 2008 to 202,492 people in May 2009. They represent 3.9% of 5,176,242 old people in May 2009. Since 259,456 people are eligible for the insurance, the number of beneficiaries accounts for 78% of those eligible in May 2009.

Currently, Long-term Care Insurance supplies two categories of service: institutional service and in-home services (home-visit care, home-visit bathing care, home-visit nursing, day and night care and respite care). Cash benefits are available only to those who are living in remote areas where long-term care services are not available or those who are not able to live with others due to mental problems etc. As of May 2009, 62,677 people (30.95% of the 202,492 recipients) are recipients of institutional service, 138,811 (68.55%) are recipients of in-home services, and 1,004 (0.50%) are recipients of cash benefits.

The insurance is financed by contribution, which is the contribution rate multiplied by the National Health Insurance contribution.[15] The contribution rates have increased from 4.05% in 2008 to 4.78% in 2009 and to 6.55% in 2010. The central government provides financial support of 20% of the expected long-term care insurance contribution. There is 20% copayment for institutional service users and 15% for in-home service users. This

[14] Further discussion on long-term care is available in Norton (2000).

[15] It should be noted that the National Health Insurance contribution is calculated by multiplying the National Health Insurance contribution rate with average monthly salary for the employee insured, which is equally borne by both the employer and employees. Therefore, the contribution to the Long-term Care Insurance is also equally borne by both the employer and employees for the employee insured.

copayment is reduced by half for the poor and even further to zero for the very poor, who are recipients of the National Basic Living Security.

For the year 2008, the revenue of the Long-term Care Insurance program was 868,974 million (KRW) and expenditure was 554,900 million (KRW). Thus, the balance (revenue – expenditure) was 314,074 million (KRW). The main source of revenue was contributions, 477,011 million (KRW), followed by (central and local) government subsidies of 386,883, million (KRW) and others of 5,079 million (KRW) in 2008. Meanwhile, the main expenditure was insurance benefits, 431,414 million (KRW), followed by administrative cost of 107,897 and others of 15,589 million (KRW) in 2008.

3. Challenges of Social Protection

3.1. National Pension Scheme (NPS)

The National Pension Scheme protects the old from poverty by supporting their income with pension benefits. However, the NPS was introduced and expanded to universal coverage by low contributions but generous benefits. Therefore, its financial sustainability was doomed to be fragile from the beginning. Furthermore, rapid population aging poses a serious challenge to the long-term financial sustainability of the National Pension Scheme. According to Moon (2008), the NPS fund was projected to be in deficit by 2035 and depleted by 2060 if the current contribution and benefit levels are maintained. Thus, to obtain a fiscal balance when the current partial prefunding method changes to the pay-as-you go method, the contribution rates to the NPS would have to rise to a 23.9% level in 2065.

Therefore, the financial sustainability of the NPS should be enhanced by reducing benefit levels and/or increasing contribution levels. This change will inevitably bring another challenge to the NPS: inter-generational and intra-generational equity issues. The policy of reducing pension benefits will have a greater influence on the current generation, while the increasing contribution levels will have a greater influence on the future generation. Depending on the relative changes and timing of those policies, inter-generational equity may improve or deteriorate. In the meantime, the intra-generational equity depends on the relative benefit-contribution ratio of the NPS across different income groups, designed to provide higher benefit-contribution ratios for the relatively poor. Thus, intra-generational equity may improve or deteriorate with changes in the relative benefit-contribution ratio of the NPS across different income groups.

An additional challenge to the NPS is the adequacy of pension benefits in financially supporting the elderly. As noted above, the elderly recipients of the National Basic Living Security, which is the means-tested public assistance program for the very poor, represented 26.5% (382,050 people) of all NPS recipients (1,444,010 people) in 2008. Furthermore, 45.1% of those aged 65 and over in Korea had (equivalent) incomes below half the population median, the highest old-age poverty rate among the 30 OECD countries (OECD, 2009). Since the NPS was introduced recently in Korea, this could be partly explained by the many people who are too old to satisfy the minimum required contributory period of 10 years to be eligible for a full or partial pension benefit. Basic Age Pension was introduced in January 2008, providing 5% of the three-year average earnings of the national pension insured to the many poor among the old without the NPS benefits or with small benefits. Therefore, it will be necessary and important to coordinate the respective roles of the National Pension Scheme and Basic Age Pension

over time as the NPS matures in the future.

Finally, with the aging population and declining working population, it is necessary to increase the labor force participation of the old. Presently, early pension benefit is lower by 6% for each year of age prior to the normal pension age that benefits begin to be received. This will reduce the incentive to retire early. However, pension benefit for the old, who are still working after normal pension age and whose yearly income is higher than the average monthly income of the pension insured over the previous three years, is 50% of the full pension benefit level but increases by 10% for each deferred year of pension benefit. This will increase the incentive to retire at the normal pension age rather than remain active in the labor market past normal pension age.

3.2. National Health Insurance

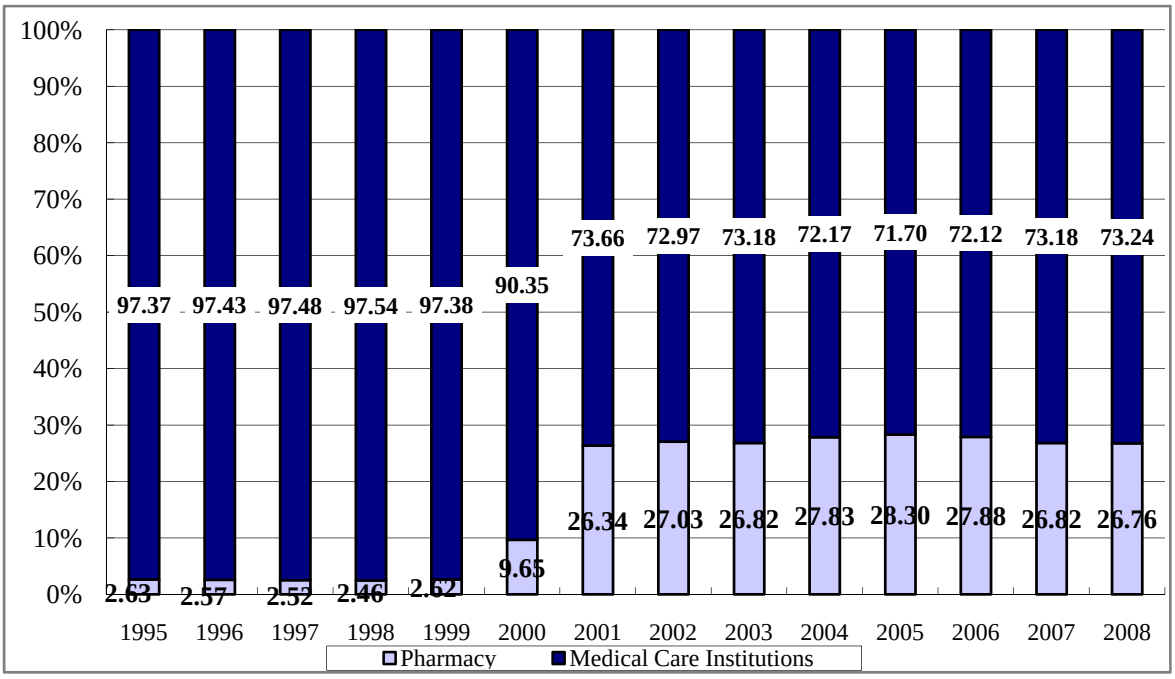
The National Health Insurance scheme was introduced in 1977 and expanded to universal coverage in 1989. This was achieved with low contributions and limited benefit coverage, and may have contributed to the improvement of population health together with other positive changes, for example rising income. Life expectancy at birth of 79.1 years and infant mortality rate of 4.1 (deaths per 1000 live births) in 2006 are significant achievements especially when considering the fact that medical spending remains at 6.3% of GDP in 2007 (OECD Health Data 2009), one of the lowest in the OECD countries. However, health spending has risen at a fast pace over time, challenging the financial stability of the National Health Insurance system as shown in Figure 5 above. Measures to increase revenue and/or to reduce expenditure are needed to ensure the insurance's financial stability.

One of the key stability measures should be a reduction in the spending on drugs.

Since the 2000 reform, which mandates the separation of drug prescribing and dispensing between physicians and pharmacists, the share of insurance spending on pharmacy costs has risen significantly. In 1995, the share was only 2.63% but jumped to 9.65% in 2000 and to 26.34% in 2001. It remains within a range between 26% and 28% (see Figure 6). This spending on drugs is significantly high even by OECD standards. Out of the spending on personal health care, the share of spending on pharmaceuticals and other medical non-durables for Korea is 24.7%, the third highest after the Slovak Republic (27.9%) and Hungary (31.2%) in 2007 (see Figure 7).

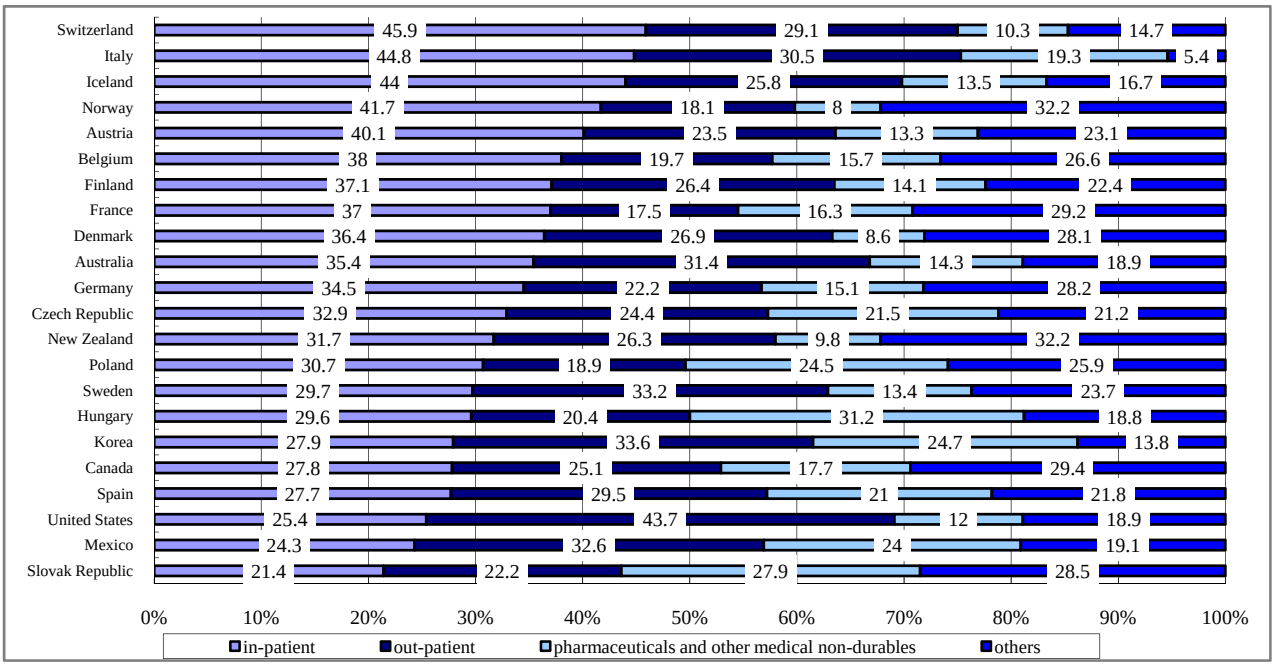
Another challenge to the National Health Insurance scheme is the (in) equity between the employee insured and the self-employed insured in sharing the financial burdens of the insurance. As explained above, contribution to the insurance scheme for the employee insured is the amount calculated by multiplying the contribution rate by average monthly salary; while for the self-employed insured it is calculated based on income, assets, age, etc. There is a potential for the self-employed to underreport their income or not to pay contributions. If anything, the benefit to contribution ratio for the employee insured as a whole increased from 89.73 to 131.52 in 2001 but declined to 76.95 in 2008 (see Figure 8). However, the ratio for the self-employed insured increased from 107.37 in 1995 to 139.10 in 2008.

Figure 6. Medical Spending by Type of Medical Institutions, 1995~2008



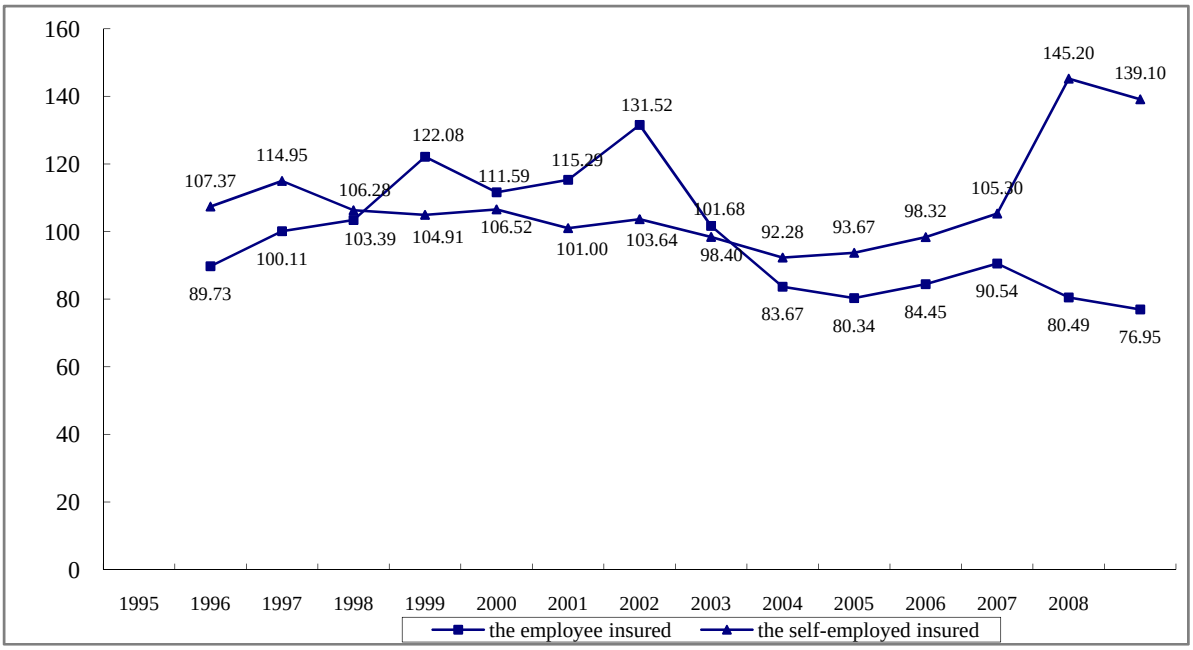
Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2002-2008.

Figure 7. Medical Spending by Type of Medical Services, 2007



Source: OECD Health Data 2009.

Figure 8. Benefit to Contribution Ratio, 1995~2008



Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2002-2008.

Furthermore, a greater attention to the quality of medical care is needed in the future. There should be efforts to enhance the quality of health professionals by licensure, and the quality of medical institutions by both evaluation and compensation based on evaluation results, in addition to increased competition among them.[16] Better education prior to licensure and continuing education to keep the license, will help improve the quality of health professionals. Meanwhile, periodic evaluation of medical institutions and compensation based on the evaluation outcome will help improve the quality of medical institutions.

Finally, access to medical care, especially by the poor old, is another great challenge considering the high copayments and many uninsured services by the National Health

[16] Further discussion on regulation in health care is available in Phelps (2009) and discussion on the entry regulations to the medical sector in Korea is available in Chung (2009).

Insurance. Due to high copayments and high fees of many uninsured services, private spending represents 45.1% in total medical spending in 2007, the third highest next to Mexico (54.8%) and the United States (54.6%), according to OECD Health data 2009. It is also notable that 32% of surveyed people in 2008 answered, "Being dissatisfied with medical treatment due to high medical fees," according to the Social Survey by the National Statistics Office. The answer recorded the highest percentage among other reasons for being dissatisfied with medical treatment, such as unsatisfactory treatment (20%), long waiting time (16.3%), unkindness (12%), etc.

3.3. Long-term Care Insurance

First, the Long-term Care Insurance program covers long-term care costs associated with aging-related chronic illness or disability. It is clear that long-term care costs will rise significantly over time with population ageing. The number of beneficiaries has been growing faster than expected. Contribution, copayment, eligibility criteria, etc., factors related to the revenue and expenditure of the insurance, should be streamlined to enhance the financial sustainability of the insurance.[17] Differential contribution rates across people with different risks of needing to use long-term care and measures to induce more use of less expensive in-home services rather than institutional service will be essential for the financial sustainability of the insurance.

Second, the Long-term Care Insurance scheme needs to improve the quality control of long-term care services. The quality of long-term care suppliers, facilities and workers, should be improved, subject to tight constraints on service fees. Better education of long-

[17] Issues on the long-term care insurance are discussed in OECD (2005) and OECD (2007), and those for the Korean long-term care insurance are discussed in Chung and Jin (2008).

term care workers and periodic evaluation of long-term care facilities and compensation based on the evaluation results will help improve the quality of services. It is, however, unquestionable that they will be constrained by the low wage for long-term care workers and tight control of service fees.

Third, the Long-term Care Insurance scheme needs to coordinate the respective roles of the National Health Insurance and Long-term Care Insurance schemes. While National Health Insurance covers medical costs due to acute illness, Long-term Care Insurance covers long-term care costs due to aging-related chronic illness or disability. Since the transfer of the elderly from hospitals to home or long-term care facilities can save the cost of the health insurance but increase the cost of the long-term care insurance, coordination of them is important alongside satisfying the respective needs of the elderly.

Lastly, inter-generational and intra-generational equity issues should be addressed. Contribution to the Long-term Care Insurance is calculated as the contribution rate multiplied by the National Health Insurance contribution. Therefore, the equity concern in the health insurance between the employee insured and the self-employed insured will be aggravated by Long-term Care Insurance. Furthermore, the relative benefit-contribution ratio of the insurance is largely dependent on the demographic structure of the population; for example, beneficiaries of the elderly and contributors of the working population. Therefore, inter-generational equity is another challenge to take on in the future.

4. Conclusion

An aging population, especially during the current economic crisis, has been a growing concern for the social protection of the elderly. It is a fact that the elderly are

more prone to illnesses and thus subject to poverty due to their significantly high medical costs. Notably, the elderly recipients of the National Basic Living Security, the means-tested public assistance program for the very poor in Korea, represent 26.5% of all pension recipients in 2008, and 45.1% of those aged 65 and over in Korea had (equivalent) incomes below half the population median in 2005 (OECD 2009).

The National Health Insurance scheme in Korea was introduced in 1977 and expanded to universal coverage in 1989. A new social insurance for long-term care was introduced in July 2008 in response to the rapid population aging. While National Health Insurance covers the medical costs of acute illness, Long-term Care Insurance covers long-term care costs associated with aging-related chronic illness or disability. Enrollment in both the National Health Insurance and Long-term Care Insurance is mandatory for all Koreans.

The pension scheme in Korea was introduced in 1988 and then expanded to universal coverage in 1999. However, only 25% of the elderly aged 65 and over are recipients of public pensions in 2008 because of it's the scheme's recent introduction. Additional Basic Age Pension was been introduced in January 2008, providing 5% of the three-year average earnings of the national pension insured to the relatively poor 60% of those aged 70 and over. Its coverage was expanded to the relatively poor 70% of those aged 65 and over in January 2009.

Before they become mature enough to be efficient and effective in protecting the elderly, the social protection schemes face significant challenges ahead. First of all, financial sustainability should be enhanced by reducing their benefit levels and/or increasing contribution levels. With these changes, the inevitable challenge of inter-generational and intra-generational equity should be addressed carefully. Policies to reduce benefits will have a greater influence on the current generation, while policies to

increase contributions will have a greater influence on the future generation. Similarly, changes in the relative benefit-contribution ratios across different income groups and employment status groups will affect intra-generational equity.

Furthermore, coordination among the schemes will become more important over time. In particular, the National Pension Scheme should be coordinated with the newly introduced Basic Age Pension. National Health Insurance should be coordinated with Long-term Care Insurance. Finally but most importantly, measures to help elderly people remain healthy and active in the labor market should be taken, while developing the social protection schemes for the vulnerable elderly.

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Table A-1. Real GDP Growth Rate (1971~2009)

Year	Real Growth Rate	Year	Real Growth Rate
1971	8.2	1991	9.4
1972	4.5	1992	5.9
1973	12	1993	6.1
1974	7.2	1994	8.5
1975	5.9	1995	9.2
1976	10.6	1996	7
1977	10	1997	4.7
1978	9.3	1998	-6.9
1979	6.8	1999	9.5
1980	-1.5	2000	8.5
1981	6.2	2001	4.0
1982	7.3	2002	7.2
1983	10.8	2003	2.8
1984	8.1	2004	4.6
1985	6.8	2005	4.0
1986	10.6	2006	5.2
1987	11.1	2007	5.1
1988	10.6	2008	2.2
1989	6.7	2009	0.2
1990	9.2		

Source: Economic Statistics System (http://ecos.bok.or.kr), Bank of Korea, 2010.

Table A-2. Share of the Old (1960~2009)

Year	Aged 65 and over	Aged 80 and over	Year	Aged 65 and over	Aged 80 and over
1960	2.90	0.24	1985	4.27	0.53
1961	2.91	0.25	1986	4.37	0.55
1962	2.95	0.26	1987	4.51	0.57
1963	2.99	0.26	1988	4.67	0.60
1964	3.02	0.27	1989	4.84	0.62
1965	3.07	0.28	1990	5.12	0.71
1966	3.15	0.28	1991	5.23	0.73
1967	3.08	0.28	1992	5.36	0.76
1968	3.03	0.30	1993	5.51	0.79
1969	3.01	0.30	1994	5.70	0.82
1970	3.07	0.31	1995	5.89	0.85
1971	3.21	0.31	1996	6.14	0.93
1972	3.12	0.32	1997	6.37	0.96
1973	3.16	0.33	1998	6.63	0.99
1974	3.23	0.34	1999	6.92	1.00
1975	3.45	0.39	2000	7.22	1.03
1976	3.52	0.40	2001	7.56	1.08
1977	3.60	0.41	2002	7.92	1.15
1978	3.67	0.43	2003	8.29	1.23
1979	3.74	0.45	2004	8.67	1.32
1980	3.82	0.47	2005	9.07	1.40
1981	3.87	0.47	2006	9.49	1.50
1982	3.97	0.48	2007	9.93	1.59
1983	4.05	0.49	2008	10.32	1.70
1984	4.14	0.51	2009	10.65	1.82

Source: Statistics Korea (http://kosis.kr), Population Projections for Korea, 2006.

Table A-3. Balance of National Health Insurance (1990-2008)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Revenue	5,614	6,630	7,554	8,229	8,892	9,827	11,928	14,305	17,466	19,408	21,091	23,263	26,049	29,787
Expenditure	5,076	6,464	7,795	8,787	9,610	10,744	14,105	14,798	15,972	17,330	19,979	22,817	25,888	28,273
Balance	537	166	-241	-558	-718	-917	-2,178	-494	1,494	2,077	1,111	445	161	1,513

Source: National Health Insurance Corporation, National Health Insurance Statistical Yearbook, 2002-2008.

Note: (billion KRW).

CHAPTER 4

Social Protection in Singapore:

Targeted Welfare and Asset-based Social Security

CHIA NGEE CHOON
Department of Economics
National University of Singapore

1. Introduction

Singapore has pursued neo-liberal economic policies to promote export-oriented growth. This has successfully uplifted Singapore from a third world developing country to a first world developed country. However, how inclusive is this remarkable growth? Has it benefited all segments of the population? Has it lifted the top income tier more than the lower income? One observation from Singapore's recent annual government budget is that, besides using fiscal measures to strengthen existing pillars of growth and to identify new engines of growth, increasingly new initiatives are also implemented to redistribute incomes to older, lower wage workers, to make economic progress more inclusive. There is a shift towards a more embracing attitude towards using cash transfer to the less privileged in the society. Social protection is a necessary function of the government. Social protection ensures adequate standard of living during times of unemployment, disability and retirement. The target groups for social protection include low-wage workers, low income families, unemployed workers and needy elderly. With the feminization of aging, social protection also covers needy female elderly as well.

It is needful to point out that social protection in Singapore is not to be equated with state welfarism. One of the unique features of Singapore, since its independence from the British in 1959, is the absence of a welfare state (even during times of economic recession)[1]. The standard feature of the European-style or Western-style welfare system is characterized by formal institutional social assistance in the form of cash hand-outs to the unemployed, the disabled, the elderly and children. Thus from these perspectives, Singapore appears to be "a stingy nanny and that the city state stays strict with the needy" *(The Economist, February 2010*). The general perception is that, in Singapore, social expenditure is low and social assistance is limited.

[1] For example, as pointed out in an article titled, "Welfare in Singapore: The Stingy Nanny" in *The Economist*, February 2010, "the aftershock of a deep recession, which pushed unemployment among citizens up to 4.1% in September - high for Singapore - has not altered the popular belief that the dole is bad for society."

The social protection model in Singapore fits into what can be loosely referred to as the Confucianist welfare model, with emphasis on individual and family self-reliance and on community support. This model is represented, in Figure 1, as a pyramid with "many helping hands"[2]. Individuals are at the base of this pyramid - individuals must first help themselves. This is an affirmation of the widely and frequently used quote in Singapore -"*It is better to teach them to fish than to give them fish*"-[3]. Family comes next in the pyramid. Welfare assistance is given to households and families are expected to work together. At the top of the pyramid is the government which, in partnership with community and voluntary organizations, offers help in a public-private partnership.[4]

Figure 1. Singapore's Social Protection Pyramid

Source: Ministry of Community Development Youth and Sports.

This paper examines the current state of social protection in Singapore and the challenges it faces. Besides focusing on social support for the needy and unemployed, we also examine social protection for the aged population since aging is an important

[2] See statement by Mr Abdullah Tarmugi, then Acting Minister for Community Development at the World Summit for Social Development, Copenhagen, Denmark, 10 March 1995.
[3] This adaptation is from Lao Tzu, an ancient sage, *Give a man a fish; feed him for a day. Teach a man to fish; feed him for a lifetime*".
[4] Jones (2002) examines the partnership arrangement between the government and the various private voluntary sectors in implementing welfare programs in Singapore.

feature of the Singaporean demographic landscape. Currently, 8% of the population is aged 65 and above and this proportion is expected to increase to 19% by the year 2030 (MCYS, 2006). We will examine critically how the current policies have or have not helped in terms of the employability of older people, financial security and healthcare financing.

The paper is organized into six sections, including this introduction. In the next section, we highlight the socioeconomic performance of Singapore and the issue of income inequality. Section 3 outlines the current targeted welfare program and also Singapore's social policy of investing in education, health and housing; the way that mandatory retirement savings are linked to housing financing has led to asset-rich Singaporeans. This brings us to Section 4, in which we will examine the implications of asset-based social security on retirement financing. Section 5 looks at social protection in terms of how healthcare is financed. Finally section 6 concludes with some policy implications.

2. Economic Development and Income Distribution

Since independence in 1965, Singapore has progressed from the Third World to the First. In 2008, Singapore's per capita GDP in terms of purchasing power parity was US$49,288, surpassing that of the United States (US$46,716) and Switzerland (US$42,534)[5] thus, fulfilling the ruling leader's dream of being the "Switzerland of the East".

The economic management of Singapore is based on two broad principles. First, it adopts a free market system and does not restrict foreign ownership of businesses. Second, it is a highly open economy with a strong outward orientation for trade and investment. Singapore's economic success can be attributed to visionary development strategies and targeted industrial policies of "picking the winners". The development experience of Singapore, over the last four decades, seems to mirror the stages of

[5] World Bank (2009), per-capita values were obtained by dividing the PPP GDP data by population.

competitive development, as described by Porter et al. (2002). The first stage of development from 1960 to 1964 is characterized as *factor-driven* to solve the massive unemployment at that time. Following separation from Malaysia in 1965, Singapore actively pursued an export-oriented growth strategy using tax incentives to attract multinational corporations (MNCs) to Singapore. It also established national companies to harness its location advantage and potential. These include Singapore Airlines, Neptune Orient Line, Development Bank of Singapore and Sembawang Shipyard. The average growth rate during the period 1965 to 1979 was 10% and was accompanied by massive employment creation. By 1979, Singapore had attained full employment, with an unemployment rate of 3.3%. The tight labor market at that time posed new challenges and led to an economic restructuring towards higher value-added and more capital-intensive activities. Singapore entered into the *investment stage* of economic development, with emphasis on investment in capital equipment. In 1985 Singapore suffered its first economic recession. When she recovered, the development strategy was to diversify the economy towards a knowledge-based economy through technology deepening and cluster development. By the 1990s, Singapore entered into the *innovation stage.* The first National Science and Technology Plan articulated that "technological innovation and development is key to the economy's continued success". (NSTB, 1996). As Singapore entered the 21st century, new pillars of growth were identified in the pharmaceutical industry (with particular focus on biotechnology and biomedical science), chemicals, logistics, tourism and financial services. In the face of more intense competition from other cities, Singapore began a series of "remaking" and "reinventing" activities to become a more vibrant and livable global city. In a bid to be such a city, the government approved two casinos to operate in this island city state, hosted the first Formula One night race and will host the world's first Youth Olympic Games. In the 2010, Singapore entered into a phase of economic restructuring to increase total productivity (land, capital and labor) to achieve a more "inclusive and quality" economic growth of 3% to 5% p.a. The Budget 2010 outlines measures to incentivize employers to use labor more efficiently and to lower their reliance on foreign labor by raising the levies imposed on unskilled labor.

Tables 1 and 2 respectively present the economic and social indicators using 2006 data. The sample countries include the four Asian tigers (Hong Kong, Singapore, South

Korea and Taiwan) and six other developed countries (Australia, Canada, Japan, New Zealand, the United Kingdom and the United States). As can be gleaned from the Table 1, compared to the other Asian tigers, Singapore has higher per capita gross national income and relatively lower unemployment rate and inflation rate. Compared to the more developed countries, Singapore has lower unemployment rate. Table 2 shows that Singapore is a small country, with the second smallest population (at 4.4 million) after New Zealand (4.2 million). It is interesting to observe that all Asian tigers, including Singapore, have very low fertility rates. Another noteworthy feature is that Singapore has the highest home ownership rate (at 90%), compared to the United States (69%) and the United Kingdom (72%). Hong Kong has the lowest home ownership rate at 53%. We will discuss, in Section 4, how the unique way of allowing pre-retirement withdrawals of the retirement savings to finance housing, together with other supply-side mechanisms, has encouraged home ownership in Singapore. This has allowed the Singapore government to use an asset-based old age security, whereby several initiatives are implemented to help unlock housing assets to finance retirement.

Table 1. Selected Economic Indicators, 2006 – Comparison with Selected Countries/ Regions

	Singapore	Australia	Canada	Hong Kong	Japan	S. Korea	New Zealand	Taiwan	United Kingdom	United States
Real Growth in GDP (%)	8.4	3.2	2.8	6.8	2.4	5.0	1.6	4.8	2.8	2.9
Per Capita GNI (US$)	30,483	36,651	38,847	27,105	35,169	18,481	24,049	16,532	40,107	43,617
Unemployment Rate (%)	2.7	5.0	6.3	4.8	4.1	3.5	3.5	3.9	5.5	4.6
Lab Force Participation Rate (%)										
Males	76	72	73	71	73	74	75	67	84	74
Females	54	57	62	53	49	50	62	49	74	59
Inflation Rate	1.0	3.5	2.0	2.0	0.3	2.2	3.4	0.6	2.3	3.2

Source: Singapore, Department of Statistics, Singapore in Figures, 2009.

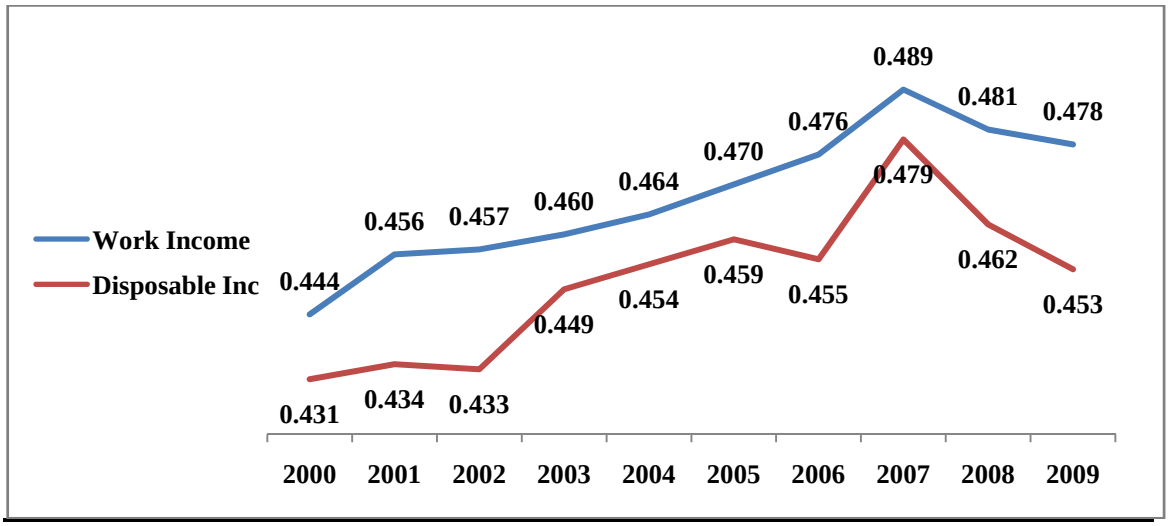
Table 2. Selected Social Indicators, 2006 – Comparison with Selected Countries/ Regions

	Singapore	Australia	Canada	Hong Kong	Japan	S. Korea	New Zealand	Taiwan	United Kingdom	United States
Population (million)	4.4	20.7	32.6	6.9	127.7	48.3	4.2	22.9	60.6	299.8
Life Expectancy at Birth (yrs)										
Males	78	79	78	79	79	76	78	75	77	75
Females	83	84	83	86	86	82	82	81	82	80
Infant Mortality Rate	2.6	4.7	5.4	1.8	2.6	3.8	5.1	4.6	5	6.9
Total Fertility Rate (per female)	1.28	1.81	1.59	0.98	1.32	1.12	2.0	1.12	1.86	2.1
Doctors per 10,000 population	16	28	19	17	22	18	23	17	7	27
Home Ownership (%)	90	70	66	53	61	56	68	88	72	69

Source: Singapore, Department of Statistics, Singapore in Figures, 2009.

During most of 1990s and 2000s, Singapore registered consistent GDP growth of 6% - 7%. Although income distribution improved in the 1980s, the Gini coefficient increased from 0.436 in 1990 to 0.467 in 1999. It continues to trend up, reaching a peak of 0.489 in 2007. See Figure 1. It improves somewhat in 2008 and 2009 due to more targeted redistributive packages to lower-income households. This will be discussed in greater detail in Section 3 of the paper. The ratio, in terms of average income, of the top 20% to the lowest 20% of employed households has also increased steadily. In 2008, the average income of the top 10% is about 13 times that of the bottom 20%. Income skewness is also apparent when we look at the mean income ($6830) and median income ($4870)[6]. More than half of the people earn only two thirds of the average income.

Figure 1. Gini Coefficient among Employed Households



Ratio of average income of top 20% to lowest 20%	10.1	11.1	11.3	11.5	11.7	12.3	12.4	13.2	13.0	12.7

Source: Singapore, Department of Statistics (2009), *Key Household Income Trends*, 2008.
Notes:

1. Work income refers to household income from work per household member.
2. Disposable income is based on household income from work per household member, after accounting for the government's transfer payments and taxes.
3. Figures for the year 2009 are obtained from the Department of Statistics, *Yearbook of Statistics, Singapore 2010.*

[6] All dollars are in Singapore Dollars (US$1 approximates S$1.4).

3. Current State of Social Protection in Singapore – Targeted Welfare System

Social protection programs aim to alleviate poverty, redistribute income, smooth lifetime consumption and provide insurance against longevity risk. How are these achieved in Singapore? The Singapore government adopts a neo-conservative approach towards social welfare, that is, with limited involvement in welfare provision. Social assistance is not an entitlement; and discretionary short term support is rendered to the unemployed, the ill, disabled and poor aged. Social assistance is ad hoc, as poverty is viewed as a short term problem due to special circumstances. There was an aversion towards welfarism as it was feared that this may lead to a "crutch mentality". Singaporeans are often exhorted to steer clear of a welfare mentality[7]. Welfare programs, though modest, are targeted at merit goods. The government prefers to "tilt the playing field in favor of low-income groups" by offering education and housing grants and wage subsidies rather than handing out doles[8]. As pointed out by Asher and Rajan (2008), Singaporean policymakers have consistently emphasized that the best way to develop social security for workers is to pursue economic and human resource policies which provide continuous high employment. Given that the Singapore government has been accumulating budget surplus, the absence of social welfare schemes is not due to a lack of fiscal strength but rather because of ideology[9]. The Singapore government favors the workfare approach and has a firm belief that what is best for the unemployed people is not offering financial support but helping them to advance their own skills and promoting job-matching to help them get re-employed through work support programs.

[7] There seems to be a shift in such ideology. In his National Day Rally Speech in August 2001, the then Prime Minister Goh Chok Tong warned against building up a "crutch mentality" and Singaporeans are exhorted to steer clear of the welfare mentality (See Goh, 2001). However in 2005 during the launch of ComCare, Prime Minster Mr. Lee Hsien Loong said this "With economic restructuring, a small but growing minority of Singaporeans will face hardship. The breadwinner may lose his job, a family member may fall ill or the children may have problems meeting school expenses. ComCare will provide a safety net for this small group" (See Lee, 2005). ComCare (see Appendix 1 for details) is an integrated approach to address poverty and hardship for this group of Singaporeans.

[8] See Speech by Prime Minister Lee Hsien Loong in Parliament, November 2005.

[9] See Jones (2002), Asher and Rajan (2008), and Mendes (2009).

3.1. Low Social Expenditure

One outstanding feature of Singapore's government is that it is 'small and lean'. Total government expenditures averaged around 22% of GDP from 2003 to 2008. Table 3 shows that it is trending upward. The figures for most Asian countries range from 15% to 30%. The Organization for Economic Co-operation and Development (OECD) countries, on the other hand, tend to have a higher ratio (30% to 55%), due mainly to higher expenditure on social security.

Table 3. Government Expenditure, 2003 to 2008

	1998	2003	2004	2005	2006	2007	2008
GDP	137,902	162,382	185,365	201,313	221,143	251,610	257,419
Development Expend	10,557	7,953	8,482	8,107	6,412	6,983	8,880
Operating Expend	14,236	19,236	19,936	20,675	23,463	24,352	28,590
Total Expend	24,794	27,189	28,418	28,781	29,875	31,334	37,470
Total Expend as % of GDP	18.0	19.7	20.6	20.9	21.7	22.7	27.2
Social Expend as % of GDP	7.3	7.6	7.0	5.9	5.3	5.5	6.0

Source: Computed from Singapore, Department of Statistics, *Yearbook of Statistics Singapore,* various years.

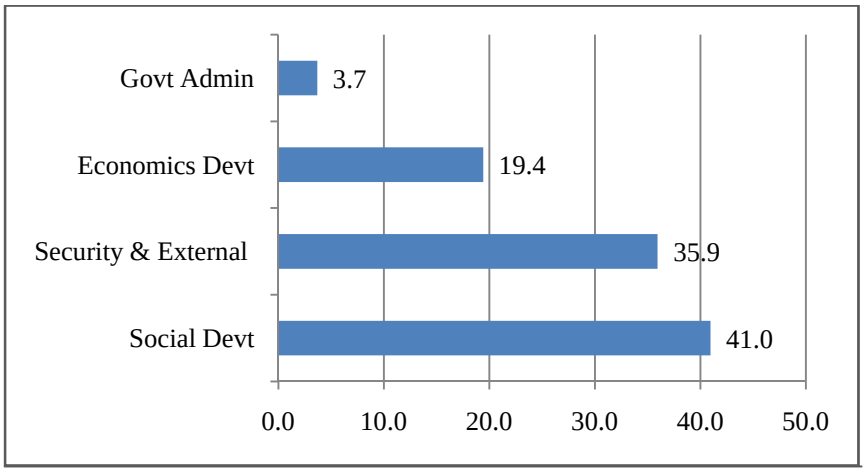
Average social expenditure as a percentage of GDP is around 6% in Singapore. This is very low when compared to other more advanced countries. However, as pointed out by Mendes (2009), this low level of spending can be misleading since Singapore government acts more as a regulator rather than a direct provider and funder of welfare services. The government administers welfare programs through the Ministry of Community Youth and Sport (MCYS), which in turn partners with communities (for example, the Community Development Councils (CDCs)), voluntary welfare organizations (VWOs) and religious organizations. Other government agencies involved in social protection include the Ministry of Manpower (MOM) which addresses labor issues and the Central Provident Fund (CPF) which helps to facilitate income transfers schemes.

Government expenditures are classified into four major categories - social development, economic development, security and external relations and government administration. As can be seen from Figure 2, social development enjoys the biggest share of the budget at 41%. Figure 3 shows a further breakdown of social expenditure.

As can be gleaned from the Figure 3, education expenditure forms more than half of all social expenditure. This is not surprising because in meritocratic Singapore, education spending is regarded as the best form of social protection; and helping to facilitate social mobility. The next largest share goes to healthcare (17.3%), to ensure that Singaporeans have access to good and, affordable medical care. Expenditure on housing (12.3%) highlights an asset-based provision of social security, through subsidized public housing. Singapore is now a home-owning society, and Singaporeans are asset-rich.10 The average home equity among public housing dwellers is about S$154,000, which is three times their annual household income (Chia and Tsui, 2009).

Spending on education, healthcare and housing constituted part of the targeted "welfare" program. The MCYS, which administers the government welfare programs directly to the needy, has a smaller share at 9.2%. Appendix 1 summarizes some of the social protection programmes overseen by the MCYS. With the absence of a formal welfare system, financial assistance schemes are provided on an ad hoc basis. They are mostly interim provisions and have strict eligibility criteria with means testing.

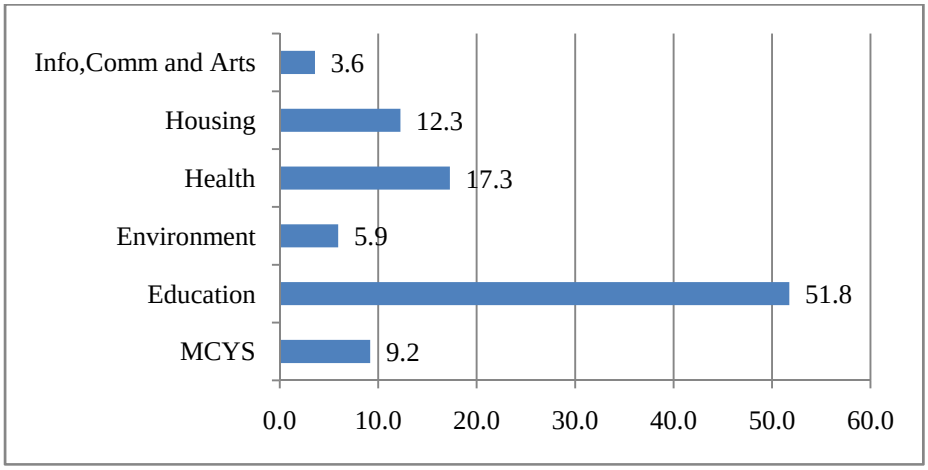
Figure 2. Percentage Share of Total Government Expenditure (Operating and Development Expenditure), 2008



Source: Computed from Singapore, Ministry of Finance, *Budget Statement*, 2009.

[10] Recently, Prime Minister Lee again reiterated that "home, an appreciating asset in Singapore, is a nest-egg .... It's for you to live in, it's for you as an investment and it's for you for your old age." Straits Times, 21 February 2010.

Figure 3. Percentage Share of Social Expenditures, 2008



Source: Computed from Singapore, Ministry of Finance, *Budget Statement*, 2009.

3.2. Workfare, Work Income Supplement as Fourth Pillar of the Singapore Social Security for Older Low-wage Workers

The development and growth strategy of Singapore focuses more on enlarging the economic pie and less on its distribution. However, not everyone has benefited proportionally from the robust economic growth, particularly for older low-wage workers (with less than $1500 work income per month). With global competition, these wage workers are affected by wage stagnation and structural unemployment. Low-wage formal (full-time employed) workers made up 20% of the total employed workers (MOM, 2007). To help these workers stuck in a low-income trap, an unprecedented cash payout called "workfare bonus" was introduced in 2006. Previously, most transfers are top-ups of the mandatory savings accounts, or are shares. The cash payout marks a milestone in the history of social assistance to low-income Singaporeans. For example, a policy observer at the Singapore Civil Service College, Poh (2007), articulated that "when it was announced, it came as a surprise to some Singaporeans weaned on a diet of strict anti-entitlement and anti-dependency rhetoric."

Unlike the European-or Western-style unemployment welfare dole, *Workfare* rewards regular and productive work with a cash bonus. It thus incentivizes work and encourages low- wage workers to take on jobs, upgrade their skills and stay employed. Low-wage Singaporeans who earn $1,500 or less per month through regular work will receive Workfare bonuses ranging from $400 to $1,200 in two portions, depending on

the average monthly income. See Table below for details. Some 340,000 Singaporeans benefited from the scheme in 2006.

Table 4. Workfare Bonus to Reward Low-wage Workers for Work

Average Monthly Income	Bonus to be paid on 1st May, 2006 and 2007*
$400 and below	1.5 months salary, or $75, whichever is higher
Above $400 to $900	$600
Above $900 to $1,200	$400
Above $1,200 to $1,500	$200

Source: Singapore, Ministry of Finance, *Budget Statement*, various years.

Note : Bonus was paid in 2006 for working at least 6 continuous months in 2005 and second installment was paid in 2007 for working at least 6 continuous months in 2006.

After the first trial of the workfare bonus scheme, the government institutionalized the Workfare Income Supplement (WIS) scheme in 2007, as a long term feature of social assistance for older low-wage workers. Workfare provides social assistance to low-wage workers while not eroding the "work ethic which was the bedrock of Singapore's success".[11] As the fourth pillar, WIS will complement the other three pillars of the Central Provident Fund (CPF) in delivering social security in the form of housing (to achieve high home ownership), healthcare (to provide good and affordable healthcare), retirement (mandatory defined contribution scheme for retirement financing) and income equity (to supplement income for low-wage workers). WIS helps to augment the income for low-wage workers from the 15th income percentile (earning $1000 per month) up to the 30th percentile (earning $1500 per month). WIS is targeted at older low-wage workers (45 years and above) who will enjoy higher income transfer than younger low-wage workers (between 35 and 45 years old)[12].

Along with the introduction of WIS, CPF contribution rates for older low-wage workers were also re-structured. Employees' contribution rates for these workers were lowered to boost their take-home pay. While the contribution rate by employers for other workers was increased in 2007, the hike was not extended to these low-wage

[11] See Ng (2007).

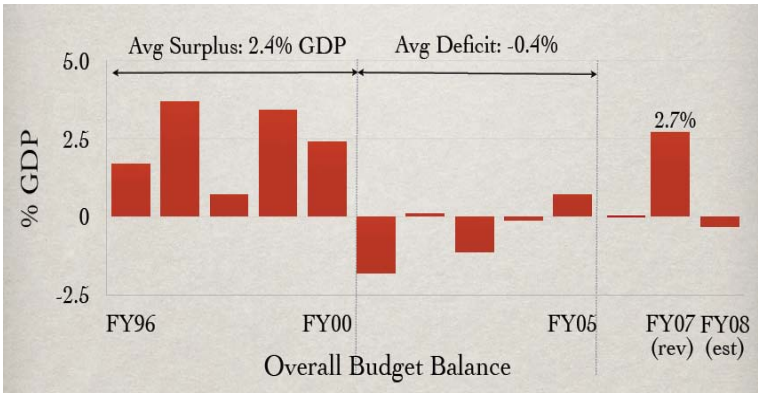
[12] Income transfer to older workers was $1200 per year in 2007; while that to younger workers aged between 35 and 45 was lower at $900 per year.

workers. Lower employer contribution rate lowers employers' hiring costs and helps to increase the employability of these workers. This will impact the accumulation of retirement savings for low-wage workers. To help improve their retirement adequacy, part of the income supplement under WIS is credited into their CPF accounts instead of payments being made only in cash. The allotment is at a cash-to-CPF ratio of 1:2.5. Furthermore, in order to minimize disincentive to work, to be eligible for Workfare, workers must work for at least three months in any six-month period in the calendar year (for half the payouts); or at least six months in the calendar year (for full payout). Self-employed and informal workers who are eligible for Workfare will receive the payouts only if they contribute to their medical savings accounts.

3.3. Other Income Transfer Schemes

The Singapore government adopts a very prudent budget and runs a "small and lean" budget. Thus, with the exception of 2001, 2003 and 2004, for most years, the government enjoys net budget surplus. Figure 4 shows the surpluses and deficits as percentages of GDP from FY 1996 to 2008. Between FY1996 and FY2000, the average budget surplus amounted to 2.4% of GDP. Thereafter, between FY2000 to FY2005, periods of budget deficits alternated with surpluses, though the size of deficits was much greater in magnitude. The average budget deficit was -0.4% over this period. A reversal of the unfavorable budget position was the exception of the large budget surplus of 2.7% of GDP enjoyed in FY2007, to which the exceptional high level of stamp duties collected from the buoyant property market contributed greatly.

Figure 4. Budget Surpluses/ Deficits, 1996 – 2008



Source: Singapore, Ministry of Finance, *Budget Statement*, various years.

Another feature in the budgetary process that has emerged since 2000 is the government's sharing of its surpluses with Singaporeans, in various forms. In 2001, the government distributed New Singapore Shares (NSS) to every citizen. In 2003, Economic Restructuring Shares (ERS) were given to partly offset the increase in goods and services tax (GST). Both the NSS and ERS are in the form of shares on which recipients can earn dividends over time if they did not encash them. However, despite the attractive interest rates, many needy people turn their shares into cash immediately instead of waiting for dividends. The government also tops up the CPF accounts to help the elderly meet their retirement and healthcare needs.

In 2006, a new surplus sharing initiative was introduced - Progress Packages. This is the first ever consolidated surplus sharing scheme for Singaporeans. According to the United Nations, the package represents a paradigm shift in policy objective, structure and delivery with budget surpluses distributed to all Singaporeans, with more for elderly and poorer Singaporeans. Unlike earlier surplus sharing schemes, Progress packages are given in cash[13]. The amount of growth dividends received depends on income and assets (which is based on the annual value of the property) as shown in Table 5 below. Annual value is the estimated annual rent that the property can fetch. It is based on market rentals for similar properties in the vicinity, regardless of whether it is rented out, owner-occupied or vacant.

Table 5. Structure of Growth Dividend

	Annual Value of Home $6,000 or less	Annual Value of Home more than $6,000 and up to $10,000	Annual Value of Home more than $10,000
Annual Assessable Income $24,000 or less	$800	$600	$200
Annual Assessable Income more than $24,000	$600	$400	

Source: Singapore, Ministry of Finance, *Budget Statement*, various years.

[13] The United Nations has conferred the 2007 UN Public Service Award on the Singapore agencies responsible for delivering the Progress Package. The Ministry of Finance (MOF), the Ministry of Manpower (MOM), the Central Provident Fund Board (CPFB) and other partner agencies were recognized for delivering the Progress Package. Singapore is one of the seven winners worldwide, and one of only two in Asia.

At this juncture, it is appropriate to point out that 85% of Singaporeans live in public housing, developed and managed by the Housing Development Board (HDB). The HDB flats vary by room-types. A 3-room HDB is an apartment with 1 living room and 2 bedrooms. Table 6 shows the average annual surplus sharing disbursement to resident households by housing types. Housing types are closely correlated to the economic status of the households. In many income transfer programs, housing types are used as targeting guide, with HDB dwellers living in smaller flats getting bigger transfer than those in larger flats. Surplus sharing has lifted the annual household incomes for poorer households more than the better off households. Figure 1 shows that income distribution has improved with income supplements. (See Figure 1). In 2009, the Gini coefficient improved from 0.478 to 0.453 when government benefits and taxes are included.

Table 6. Average Annual Surplus Sharing Disbursement to Resident Households (on per household member basis) by House Type, 2008 (in Dollars)

	1-&2-HDB	3-room HDB	4-room Or larger HDB	Private Flats, Private Houses	Total
Average annual value of public housing (HDB)	2100-3300	4200	5400-6300	n. a	
Annual Household Income from work per household member, 2008	6290	16950	22290	55460	26130
Surplus Sharing Package, 2008[2]	1670	1320	980	720	1030
Surplus Sharing Package, 2009[2]	2457	1596	1168	927	1273
Surplus sharing package as % of annual household income, 2008	26.5	7.8	4.4	1.3	3.9
Surplus sharing package as % of annual household income, 2009	41.4	9.6	5.3	1.7	5.0

Source: Singapore, DOS (2009) Key Household Income Trends, 2008 and IRAS website.
Note : 2. The Surplus Sharing Package includes growth dividends, top-ups to Post – Secondary Education Accounts and CPF Medisave Accounts, rebates on utilities, rental and Service and Conservancy Charges, income tax rebates and property tax rebates. The Surplus Sharing Package also includes Workfare Income Supplements and GST Credits and Senior Citizens' Bonus disbursed.

4. Income Security for Retirement: Asset-based Social Security

As highlighted in the introduction, housing policy in Singapore has created asset-rich Singaporeans. Housing policy was initiated in 1960. It begins with the setting up of the Housing Development Board (HDB) to build "emergency" public housing on state-owned land to solve the housing shortage at that time by providing affordable rental housing. In February 1964, in line with the strategy of using home ownership as investment in the stake of the country, the Home Ownership Scheme was introduced to encourage existing tenants to buy their flats. Subsided mortgage loans with very attractive repayment schemes were used. Despite this, after two years of implementation, the home-ownership rate remained low. This was mainly due to low purchasing power at that time. To make housing more affordable and to ease financing difficulties, the government allowed pre-retirement withdrawals from the mandatory individual retirement savings accounts under the Central Provident Fund (CPF). Savings can be used to pay for the down-payment, stamp duties, mortgage payments and interest incurred for the purchase.

This scheme marked the beginning of a series of schemes in which mandatory savings under the CPF can be used to finance housing. The CPF was instituted in 1955, originally as a retirement savings scheme. It is a fully-funded system with Defined Contribution (DC). It is mandatory for both employee and employer to contribute a stipulated proportion of the worker's monthly wage directly into his personal account[14]. Contributions to the CPF are tax exempt. Savings are apportioned to three different amounts – the ordinary, Medisave and special accounts. The ordinary account can be used for housing, investment and education, the special account for old age or contingencies, and the Medisave account, for hospitalization expenses and approved insurance premiums.

To encourage home ownership, the HDB also implemented other supply-side regulations and subsidized housing loans. The option to rent was made unattractive or

[14] In 1955, the total contribution rate was only 10%. Since 1968, the rate has increased, rising to a peak of 50% in 1984. Since then, the rate has been kept at around 33% The rates currently are graduated according to age, with an average rate of 36%. See Chia and Tsui (2003) for the institutional details regarding the CPF.

effectively unavailable for the majority due to strict eligibility criteria set out by the HDB. Furthermore, the HDB was able to price public housing affordably as it receives loans from the government at subsidized interest rates. These subsidized loans help the HDB to fund its operations and to finance subsidized mortgage loans given to HDB buyers. See Chia and Tsui (2009).

No doubt, such asset enhancement policy makes housing the most important non-financial assets for Singaporeans. Singapore has the highest ratio of household residential property assets to total assets (at 51%). It also has the highest ratio of housing assets to personal disposable income and GDP[15]. In the National Survey of Senior Citizens (1995), 63.1% of elderly aged 60 and above reported housing among their assets and 48.4% cited their own house as their most important asset.

Since the provision of pre-retirement withdrawal from CPF savings has diluted its original intent as a retirement savings scheme, can this asset-based social security provide for retirement? Being a DC social security, the CPF avoids the sustainability issue in a Defined Benefit (DB) system. But the inherent features of a DC system together with pre-retirement withdrawals in the CPF system have led to adequacy problems. How adequately CPF savings can finance retirement will depend on both the accumulation and decumulation phases. Accumulation of savings depends on employment profiles, unemployment episodes, business cycles and returns to savings. Chia and Tsui (2003) showed that CPF mandatory savings are inadequate to meet retirement needs because of late-life medical costs and inflation. The government has designed several instruments to help CPF members decumulate their savings through an advanced life deferred annuity product, known as the CPF-LIFE scheme. Furthermore, there are also instruments available for house owners to unlock their housing equity to help supplement their retirement incomes. These decumulation instruments available include Reverse Mortgage (RM), subletting, downsizing and Lease Buyback Scheme (LBS).

[15] See Singapore, Department of Statistics (2005).

4.1. Monetizing Options[16]

a. Lease Buyback Scheme (LBS)

The LBS, implemented in February 2009, provided an avenue for lower income elderly in 2-room and 3-room flats to unlock housing equity. They must occupy the flat for at least 5 years and have outstanding housing loans of less than $5,000. The HDB will buy back the tail-end of the lease, leaving a shorter 30-year lease for the elderly to continue living in their flats. The longer the remaining lease, the more housing equity will be unlocked. The unlocked value must be used to buy an annuity product under the CPF Life scheme. The Life scheme is a new feature of the CPF to ensure lifelong incomes for retirees. It operates like a deferred life annuity with a refund feature, which helps to address CPF's absence of mandatory annuitization.

b. Subletting

The elderly also have the option to age-in-place by subletting room(s). They can also sublet their entire flat by moving in with their married children. The diagonal entries in Table 7 indicate that most elderly (74%) prefer to age-in-place. Since October 2003, all HDB flats can be sublet, provided that owners meet the minimum occupancy requirement. We compute the average rental incomes from subletting a room under different rental market environments over the remaining life cycle of the elderly.

Table 7. Housing Preference

Housing Type Content with	1-Room	2-Room	3-Room	4-Room	5-Room
1-Room	**89.3**	14.7	2.7	1.1	2.5
2-Room	5.4	**70.6**	2.9	2.9	0
3-Room	3.5	7.8	**77.3**	13.1	11.7
4-Room	0.9	2.5	9.9	**71.3**	1.5
5-Room	0.4	2.1	3.1	0.9	**71.4**

Source: HDB(2005).

c. Downsizing

The elderly can monetize their housing asset by selling it and downgrading to smaller flats or to HDB Studio Apartments (SA). Table 8 shows that on average,

[16] This section draws heavily from Chia and Tsui (2009).

$79,000 or $132,000 can be cashed out by downgrading from 4-room to 3-room or 2-room flats respectively (based on current market values). More will be cashed out if they downgrade to smaller units. Table 8 presents the monthly draw downs from the annuity generated from unlocked housing equities.

Table 8. Monthly Draw-Downs

		Downsizing from 3-room ($236,000) to:			
Amount	3-Room	2-Room	1-Room	SA($45m^2$)	SA($35m^2$)
Unlocked	..	53,000	88,000	121,000	156,000
Male	..	337-352	560-586	770-806	992-1038
Female	..	302-316	501-526	688-723	931-886
		Downsizing from 4-room ($325,000) to:			
Amount	3-Room	2-Room	1-Room	SA($45m^2$)	SA($35m^2$)
Unlocked	79,000	132,000	167,000	200,000	235,000
Male	502-526	840-878	1062-1110	1272-1330	1494-1564
Female	450-472	751-788	950-997	1137-1194	1330-1403

Note: The range in the monthly draw-downs corresponds to different interest rates (3.75% and 4.24%). These were used by HDB in LBS calculations.

d. Reverse Mortgaging

RM products issued in Singapore lack the "non-recourse" feature and are similar to collaterised loans. When the accumulated payouts reach 70% of the property value, monthly payments stop and loans must be re-paid. There were two major RM providers: NTUC-Income and OCBC Bank. NTUC-Income launched its first term-RM (maximum tenure of 20 years) for private properties in 1998, and extended to HDB flats in 2006. Since inception, NTUC-Income issued 500 such loans, but only 134 remain active. OCBC Bank offered term-based and annuity-linked RMs. However, since 2008, both providers have ceased issuing RM loans.

4.2. Monetization HDB Flats

Monetization options available depend on the type of flat. About 40% of the elderly are in 3-room flats, 33% in 4-room, and less than 20% in smaller flats. (HDB, 2005). Table 9 shows that 3-roomers can access all options. Monetization options are not available for 1-roomers.

Table 9: Monetizing options available

	Reverse Mortgage	Lease Buyback	Downsizing	Subletting
1-Room	X	x	..	x
2-Room	X	y	y	x
3-Room	Y	y	y	y
4-Room	Y	y	y	y

Notes: 'x' means not available; 'y' means available

The expected present value of income stream generated by RM, LBS, downsizing and subletting and the corresponding average monthly draw-downs are reported in Table 10. For females, the LBS generates the highest monthly payout ($635). Subletting a room yields the lowest ($504) payouts but the elderly retain the housing asset. Monthly payouts from downsizing ($607) and RM ($560) 3-room flats are smaller, compared to the LBS.

All monetization options, except RM, involve some kinds of government subsidies. However, the elderly in Singapore have exhibited strong preference for ageing-in-place. Survey results conducted on the social aspects of the elderly (HDB, 2005) indicate that about three quarters of the elderly prefer to age-in-place, and that alternatives such as retirement villages and old folks' homes are not popular. As such, subletting, LBS and RM are viable options as they allow the elderly to age-in-place and generate a steady stream of monthly drawdown.

Table 10. Average Monthly Draw-downs

Flat types	Monetization Options	Average Income Stream	Average Monthly Draw-down	
			Male	Female
2-Room	LBS	79,200	515	462
3-Room	LBS	109,000	709	635
	Downsizing	104,500	676	607
	Subletting one room	86,576	562	504
	RM*	165,200	581	560
4-Room	Downsizing	157,000	783	770
	Subletting one room	86,576	432	423
	RM*	227,500	804	766

Note: * including 30% as loading.

Subletting releases only part of the housing equity, making it possible for the elderly to leave housing wealth as a bequest. However, for the LBS, the bequest motive can be fulfilled if sellers choose a CPF-Life scheme, with lower monthly payouts, and postpones the annuity drawdown to a later age. This may affect retirement adequacy. Similarly, RM allows the elderly to age-in-place. Possibility of bequest depends on the property values net of the accumulated loans at time of death.

Thus, monetizing housing asset helps the Singaporean elderly to supplement their retirement income. It allows the elderly to choose an option that balances their preference for retirement adequacy, ageing in place and leaving a bequest.

4.3. Pitfalls and Challenges

The existing CPF schemes, with their pre-retirement withdrawal feature, have serious limitations in addressing income maintenance, poverty at old age and healthcare financing (this will be discussed in Section 5). Under the current arrangement, the accumulation of savings depends on the economic well-being of CPF members in terms of their ability to work and employability. It also depends on the overall investment health of the CPF Board and its ability to pay higher rates of return. Although monetizing instruments are available to help unlock housing assets, other issues remain.

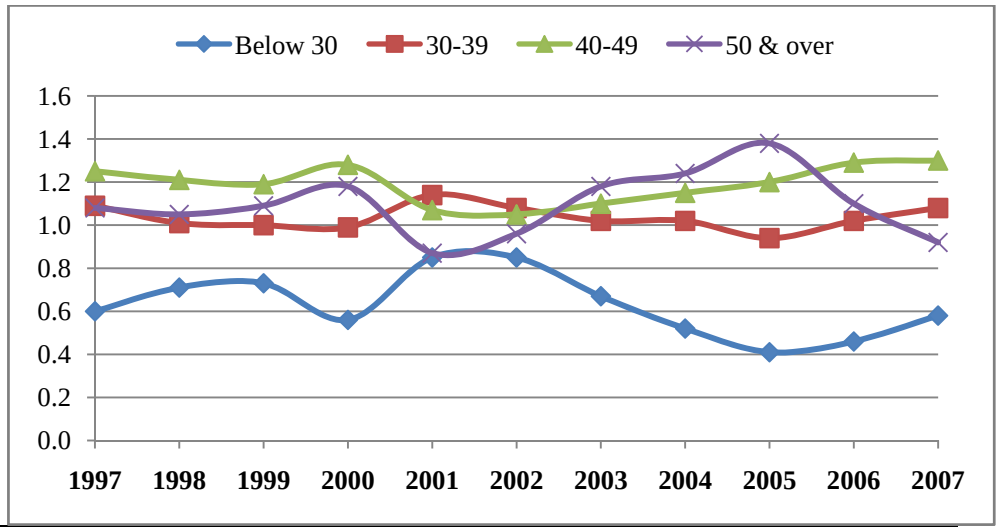
First, the issue of inadequacy is more pressing for elderly people in smaller rental housing. Other vulnerable groups with inadequate savings include workers in the formal sector, homemakers, older female elderly and those who are not in the labor force because of illness. It is necessary for the government to consider a more systematic first-tier system to provide social protection for these people.

Second, in the absence of a social safety network, a longer continuing period of employment will help slow down the spending of accumulated savings. A major issue is the blatant practice of employers who dismiss older employees and hire new workers at lower salaries. Figure 5 shows that older workers (aged 50 and above) are more vulnerable to retrenchment. Furthermore, re-employment also declined with age. Currently, legislation has been introduced to guard against workplace age discrimination. The current minimum age of retirement is 62 years. The Retirement Act stipulates that employees who are below the prescribed retirement age cannot be dismissed by their employers because of their age. The Retirement Act allows

employers to cut the wages of employees by up to 10%, once they reach the age of 60, to help ease the cost burden of retaining these employees.

In 2012, retirement age will be raised to 65. In tandem with this, a new legislation – The Re-employment Act will be introduced in 2012. This legislation serves as a clear government stance against workplace age discrimination and ensures the employability of older workers so that they can work longer to secure financial and retirement security. Under re-employment, when the worker reaches retirement age, both parties can make changes to the existing job arrangement. For example, workers may wish to work part-time or to take on less responsibility. Employers may re-deploy workers to different job functions or adjust their seniority-based wages. This flexibility will allow the company to remain competitive and keep workers employable. There are also various schemes to help re-train, develop and upgrade the skills of older workers to enhance their employability.

Figure 5. Vulnerability to Retrenchment by Age Group, 1997 to 2007



Below 30	0.60	0.71	0.73	0.56	0.85	0.85	0.67	0.52	0.41	0.46	0.58
30-39	1.09	1.01	1.00	0.99	1.14	1.08	1.02	1.02	0.94	1.02	1.08
40-49	1.25	1.21	1.19	1.28	1.07	1.05	1.10	1.15	1.20	1.29	1.30
50 & over	1.08	1.05	1.09	1.18	0.87	0.96	1.18	1.24	1.38	1.10	0.92

Source: Singapore, Ministry of Manpower (2008), p. 8.

Finally, the adequacy of retirement savings to finance the needs of the elderly depends also on the growth in medical inflation and general price inflation. This

implies that the rate of returns of compulsory savings must compensate inflation rates, particularly medical inflation. Other policy implications include the need to contain medical costs, designing health care financing schemes to address medical inflation and long term medical care.

5. Social Protection for the Sick

Singapore does not have a comprehensive health insurance system. Social protection for the sick is mainly in the form of government subsidies for the masses and risk pooling for catastrophic illnesses. As in other aspects of social protection in Singapore, social protection for the sick also emphasizes individual responsibility together with family responsibility and community support. Healthcare financing is an integrated system of a compulsory medical savings account (Medisave), a catastrophic medical insurance scheme (Medishield) and a means-tested medical expense assistance scheme (Medifund). For details, see Chia and Tsui (2005a). To deliver more targeted social protection for the disabled, the Eldershield was implemented as a disability insurance scheme. The Eldershield is currently the only scheme that covers a portion of long-term care costs.

5.1. Medical Financing Schemes – The 3 Ms and Other Aged-care Provisions

Some details of these financing mechanisms are highlighted below:

a. Medisave

Medisave, introduced in 1984, is administered by the CPF Board. Part of the monthly contribution to the CPF is apportioned to the medical savings account (MSA). Savings are to be used for hospitalization and some approved out-patient medical expenses. They can also be used to pay for premiums for some CPF-approved medical insurance. To minimize moral hazard and adverse selection, Medisave incorporates a system of co-payments and deductibles; and withdrawal limits. Since 2005, medical savings can be used for out-patient expenses for with some chronic illnesses (e.g.,

stroke, hypertension, high cholesterol). Children are allowed to use their personal Medisave accounts to pay for their elderly parents' medical expenses.

b. Medishield

As Medisave is a compulsory self-insurance scheme, it does not allow for risk pooling across individuals, Medishield, a catastrophic health insurance scheme, was implemented in 1990 to insure Singaporeans against very large hospital bills. It covers catastrophic illnesses and certain outpatient treatments like kidney dialysis, chemotherapy and radiotherapy for cancer. The age limit for coverage is 85. Again, Medishield has a system of co-payments and deductibles to address issues relating to third party payments.

c. Medifund

Medifund is a government endowment fund set up in April 1993. Medifund was set up with an initial capital of $200 million and capital injections are made whenever there are available budget surpluses. Only the interest income from the capital sum can be used. Medifund acts as a last resort for parents who cannot pay for their medical expenses despite Medisave and Medishield. Its use is subject to means-testing. In 2001, this scheme was extended to VWO-run residential step-down care facilities. In 2002, about 5% of Medifund assistance was used to aid those in such step-down care facilities. In 2006, a total of $40 million was spent to help 290,000 applications, of which about one third of these applicants are elderly. It is expected that demand for Medifund for the elderly will grow as the population ages. There is a proposal to set aside a "Medifund for the Elderly".[17]

d. Aged Care-Provision

Besides the above 3Ms healthcare financing, there are other aged-care provisionssuch as, Eldershield, an Interim Disability Assistance Programme, and Eldercare Fund. Eldershield is a private disability insurance scheme which was introduced in June 2002. All CPF members who reach the age of 40 are automatically

[17] Singapore Parliamentary Budget Debate 2007.

covered by Eldershield and the premiums can be paid out of their Medisave accounts. Eldershield provides basic financial protection for the severely disabled, which is defined as one who is unable to perform at least 3 out of the 6 ADLs. The ADLs include washing, dressing, feeding, toileting, mobility and transferring. As a private long term healthcare insurance scheme, Eldershield complements Medishield, which pays only hospitalization expenses. Eldershield provides monthly cash payouts of $300 to $400, for up to a maximum of 60 to 72 months. These cash payouts are not tied to reimbursement of institutional care and thus policyholders have the flexibility to use the cash to pay for the specific care they require whether it is informal care, home nursing services, day rehabilitation or in-patient nursing home care. Eldershield aims to help defray out-of-pocket expenses and reduce the financial burden in the event of LTC being needed.

Elderly females have greater need for long-term care (LTC). Chia et al. (2008) estimated the LTC costs for Singaporean female elderly with arthritis and osteoporosis who are dependent on care to carry out the basic Activities of Daily Lives (ADL). The costs are calibrated for different care arrangements - nursing homes, community homes and informal/home-based care with domestic helper. They show that only when the government subsidises 75% of the LTC costs will ElderShield be adequate. In the absence of subsidy, ElderShield can cover 25% to 40% of the costs.

5.2. Challenges

The integrated system of using savings (Medisave) together with catastrophic insurance (Medishield), offers flexibility in healthcare financing while limiting moral hazard and allowing risk pooling. A compelling concern is whether the current model of MSAs is adequate to finance the healthcare needs of Singaporeans. Chia and Tsui (2005a) evaluated the adequacy of MSAs in financing healthcare over the post-retirement period for elderly in different HDB flat types. They take into consideration the gender differences in medical consumption, medical inflation and interest rates. They found that using a discount rate at 4% and setting medical growth rates ranging from 4 to 7%, the decreed minimum balance in the MSA ($25,000 in 2004) is inadequate for the female elderly to meet health-care expenditure; although it is adequate for the male elderly.

The current entry age for Eldershield is age 40 and is an opt-out system. To extend the benefit period and the benefit level, it may be necessary to allow earlier enrollment. The problem with this is that there is cognitive bias, in that individuals tend to undervalue the benefits that they can expect from enrollment in LTC. Furthermore, if individuals are time-inconsistent, they will tend to procrastinate in preparing for old age needs. As long as the system is not compulsory, more are expected to opt out. It may therefore be necessary to have mandatory enrollment to avoid adverse selection. Premiums can vary for different age groups since the younger cohorts are likely to make a claim. LTC premiums can also be means-tested and those with low income, as well as widows, pay lower premiums.

However, there is always a poor segment of the population who need social assistance to support a basic subsistence living and healthcare. Medisave being an unfunded self-insurance scheme means that the persistently unemployed will not have accumulated enough savings. Table 11 presents the profile of the economically inactive residents by age group, gender and educational attainment. Excluding residents aged 15 to 25, the number of economically inactive residents is about a third of the total resident labor force. As long as these people are not employed, under a DC system, there is implication on the accumulation of savings for retirement and to finance healthcare.

Table 11. Profile of Economically Inactive Persons by Gender and Age, June 2008

Characteristic	Total			Males			Females		
	Number	Share (%)	Incidence (%)	Number	Share (%)	Incidence (%)	Number	Share (%)	Incidence (%)
TOTAL	1,010,500	100.0	34.4	344,000	100.0	23.9	665,500	100.0	44.4
AGE GROUP (YEARS)									
15-24	306,600	30.3	62.9	158,100	46.0	62.5	148,400	22.3	63.3
25-29	26,700	2.6	11.3	7,500	2.2	6.7	19,100	2.9	15.5
30-39	75,600	7.5	13.0	5,700	1.7	2.1	69,900	10.5	22.7
40-49	106,600	10.5	16.9	9,300	2.7	3.0	97,300	14.6	30.7
50-59	141,300	14.0	27.3	27,500	8.0	10.6	113,800	17.1	44.1
60 & Over	353,700	35.0	73.1	135,800	39.5	60.8	218,000	32.7	83.6
EDUCATIONAL ATTAINMENT									
Primary & Below	353,900	35.0	57.5	95,500	27.7	37.9	258,500	38.8	70.9
Lower & Secondary	195,300	19.3	48.8	80,000	23.3	37.9	115,300	17.3	60.9
Secondary	261,500	25.9	36.5	95,200	27.7	28.7	166,200	24.9	43.4
Upper Secondary	97,900	9.7	26.4	38,200	11.1	20.1	59,700	9.0	32.9
Polytechnic Diploma	40,400	4.0	14.6	19,800	5.8	12.3	20,700	3.1	17.7
Degree	61,500	6.1	11.0	15,400	4.5	5.3	46,100	6.9	17.3

Source: Ministry of Manpower (2009), *Report on Labour Force in Singapore*, 2008, Table 11, p. 51.

As expected, the economically inactive are at the two extreme ends of the age spectrum-73% of those aged 60 and over and 63% of those aged 15 to 24. The economic inactivity rate falls with educational attainment, reflecting the greater employability of better-educated residents and their higher opportunity cost of staying outside the labor force. Consequently, eight in ten economically inactive residents had secondary (26%) or lower (54%) qualifications.

The majority of the economically inactive residents in the prime and older age groups are females. Females are more likely to be outside the labor force than males in the same age group. In June 2008, 88% of economically inactive residents aged 25 to 54 and 112,700 or 71% of those aged 55 to 64 were females. Reflecting their traditional role as the primary homemaker and care-giver, close to nine in ten (88%) economically inactive women aged 25 to 54 and 70% of those aged 55 to 64 were neither working nor looking for work, mainly because of family responsibilities (housework, childcare or care of elderly or sick relatives). Other reasons for economic inactivity among older females aged 55 to 64 include poor health, disability or old age (14%) and retirement

(13%)[18]. A social safety net or other mechanism must be put in place for these groups of economically inactive females.

To enable "increased savings" for women, policies that provide social and financial protection for women serving as home-makers or care-givers need to be put in place to supplement the CPF structure. Perhaps a mandatory specified percentage of the CPF contribution of husbands can be deposited into the CPF accounts of their wives who are homemakers. This helps to grow the homemakers' Medisave balance when they leave the workforce to care for the family. Greater tax relief is given to incentivize tax payers to top-up Medisave accounts for their family members CPF. Since 2009, the rules for top-ups using CPF savings have been progressively liberalized as part of the government's efforts to facilitate family support through CPF. For example the list of recipients for CPF top-ups has been expanded to include parents and grandparents below the age of 55 and to all close family members, and not limited to spouses only. Furthermore, the age limit for recipients has also been raised. Incentives are also given to employers to top-up their workers' CPF over and above the stipulated contribution. This clearly underlines the government's philosophy of "many helping hands", instead of introducing a first-tier social safety net.

6. Conclusion

Singapore has registered very impressive economic progress within a relatively short history of four decades. She has progressed from a third world to first, from surplus labor supply to reliance on foreign labor to meet its labor demand; from housing shortage to asset-rich Singaporeans. The population landscape has also evolved from one with low to one with high dependency ratio; from baby boom to low total fertility rate; the median age of the population has also shifted, indicating an ageing population. However, the ideology to run a small and lean government remains and has been slow to change. Government social expenditures are on enhancing human capital and social capital. Targeted welfare and spending on merit goods to increase the quality of the human resources through education and affordable healthcare remain the key characteristics of the social protection model in Singapore. In the midst of the recent

[18] MOM (2009), Table 11, p. 51.

economic recession in Singapore, the government's policies still steer away from welfarism and towards workfare. The role of the CPF as the center of social security will continue and intensify. It will continue to support the four pillars of social security in housing, healthcare, retirement and support for older low-wage workers. Based on the history of countries which have provided a first tier social safety network, it seems like the ruling party will stay out of this. An asset-based social security for retirement will be here, as the Prime Minister puts it "*home, an appreciating asset in Singapore, is a nest egg… It's for you to live in, it's for your investment, it's for you for your old age*. "(Straits Times, 21 February 2010).

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Appendix 1. Social Protection Provision by MCYS

1. Social Assistance and Support

a. Public Assistance Scheme

Public assistance is administered by the Community Development Council (CDC), which is responsible for the constituency in which the applicants reside. The program offers financial aid on a long term basis. A person is entitled to this assistance as long as he/ she proves to be unable to work (because of old age, illness and disability) and therefore unable to generate any income. Furthermore, he/she does not receive any other subsistence scheme and obtain hardly any support from his or her family member. Assistance comes in three forms: monthly cash grants to provide for basic necessities, medical assistance which offers free treatment in public clinics and hospitals, and education assistance which eases the financial burden of children's schooling expenses. Cash relief is distributed on a per household basis with rates varying from $200 to a $200 to a maximum of $570 per month per household.

b. Interim Financial Assistance

Interim (short term) financial assistance is under the governance of the Community Development Council (CDC). The eligibility criteria of the scheme may vary according to the individual CDC. It provides temporary assistance in terms of cash grants or food vouchers. Being an interim assistance, it only lasts for 3 months. Recipients can re-apply to be reviewed for renewal; however, they may only obtain this assistance for a maximum period of a year. The amount of cash grant individuals or households attain each month ranges from $140 to $600.

c. Rent and Utilities Assistance Scheme

This program is administered by the National Council of Social Service. It is meant for poor families who are still indebted in areas of rent, utility expenses or conservancy charges. The eligibility criteria includes family members suffering from old age, illness or disability, family's breadwinner being detained or imprisoned and some other adverse situations that are justifiable for assistance. The monthly amount a household can retain ranges from $240 to a maximum of $710.

d. Work-Support Program

The Work support program provides aid to people who are jobless in the short term. This program, lasting from 6 to 12 months, is means tested. It is for low household income worker (less than $1500 per month) without any other support. In addition, the unemployed should show his/ her determination to become financially independent. The work-support program also offers grants for selected training courses so that individuals may have a better chance to secure a job.

2. ComCare – An Integrated Care System

MCYS also administers an integrated program under the ComCare Fund, which was launched in 2005 as an endowment fund from the government budget. As in other endowment fund scheme, the government will top up the fund when there is a budget surplus.

The three programmes under ComCare target at the unemployed, the needed children and the elderly and disabled. *ComCare Self-Reliance* provides a safety net for the needy and serves as a springboard for them to become self-reliant and to "bounce back". The *ComCare Grow* is targeted at children from needy families to help them break out of the poverty cycle. The *ComCare EnAble* assists those who need long term assistance (such as the needy elderly and people with disabilities) to integrate into the community.

Generally social mobility is one of the objectives of social protection in Singapore. By providing integrated help, lower income and vulnerable groups are given opportunities so that they will not be left behind as Singapore progresses. For example, in the 2006 Budget, the government focuses on the children from the lower income group to "create hope for the future" to ensure that the children do better than their parents and can help lift their parents out of poverty instead of inheriting their problems. The government thus invests more in education of children from low-income families, to help them become school-ready and work-ready.

CHAPTER 4

Social Protection in Brunei Darussalam – Current State and Challenges

HAJAH SAINAH BINTI HAJI SAIM

Universiti Brunei Darussalam, Brunei Darussalam

Brunei Darussalam is a small state with a population of 406,200 (2009). Its government plays an important role in the social protection of its populace. Through its national development plans, the country has, to date, attained all the objectives which were set out and required to be achieved by 2015 in the Millennium Development Goals. Now Brunei Darussalam is headed towards a future based on its newly established Vision 2035. Its economy is currently highly dependent on revenues from its oil and gas industry while diversification policies have long been put in place.

These revenues fund all development projects and programs, including providing social protection for all citizens and residents of the country. This can be seen from the development of the social protection system in Brunei Darussalam which includes existing features catering for retirement such as the pension schemes, the employee trust fund (TAP), and the supplementary contribution pension (SCP). Government pension provisions for its retirees were replaced in 1993 with TAP, an end of service fund, which is also expanded to the private sector. Later early this year 2010, the government introduced an additional scheme – SCP- to all sectors of the society, which requires citizens to make savings provisions for their retirement incomes.

This paper first outlines the background of Brunei Darussalam. It then explores the current existing social protection system and its benefits. The paper also examines limitations and challenges to this existing system, before finally, concluding and providing some policy recommendations, relating them to the new Vision 2035.

1. Background on Brunei Darussalam

Figure 1. Map of Brunei Darussalam

Brunei Darussalam is situated on the northwest coast of the island of Borneo, 422 kilometres north of the Equator. It is surrounded and split into two parts by the East Malaysian State of Sarawak with the South China Sea to the north. The western part consists of the Brunei-Muara, Tutong and Belait districts, while the eastern part consists of the district of Temburong. Its total land area is about 5,765 square kilometers with 80% of which is covered by tropical rainforest. The capital and main population centre is Bandar Seri Begawan, whose area has been recently enlarged.

1.1. Political System

The national philosophy of Brunei Darussalam is the Malay Islamic Monarchy or Melayu Islam Beraja (MIB). The word Malay refers to both the people and the culture. Islam is its official religion and monarchy is the system of government. Hence, its political system is based on an absolute monarchy with a ministerial system. This means that the Sultan has absolute power in the state; he is the king, the head of State, head of religion, the head of Government, the Prime Minister, the Minister of Finance and the Minister of Defense. The government comprises thirteen ministries, including

the Prime Minister's Office. Ministers are appointed by the Sultan and are answerable to him. The Sultan is assisted by four councils: the Privy Council, the Council of Succession, The Religious Council and the Council of Cabinet Ministers. The Legislative Council resumed operation in 2008; its primary function are to monitor and review all national policies, their implementation and performance. This council is comprised of members appointed by the Sultan.

1.2. National Development Plans

The development of the country is guided by its five-year national development plans. The first national development plan was launched in 1953 and covered the 5-year period from 1953 to 1958. The main objectives of the plan were to lift Brunei Darussalam from its lowly status in Southeast Asia; to modernize Brunei Darussalam within the framework of the Malay Islamic Monarchy; to improve the living standards of Bruneians and to develop non-oil and gas industries. It gave special emphasis to the expansion of education and medical services; the implementation of resettlement schemes; the provision of water supplies; the improvement of agricultural methods and fisheries; the extension of roads and communications; the construction of bridges, buildings and electrical stations; and the installation of broadcasting and telephone systems.

More than 59.78% of the budget was spent on infrastructure development with Health, Education and Welfare receiving 21.77% of the funding. Most importantly, the plan also focused on improving the social welfare of Bruneians. The living standards of Bruneians have improved tremendously. After many successive development plans, about 25-30% of the national development budget continues to be allocated to socio-economic development.

1.3. Economy

There is no personal income tax in Brunei Darussalam. Its currency is pegged to the Singapore dollar. Its economy depends to a great extent on oil and gas exports, equivalent to almost 99% percent of total exports which makes up about 70% of the country's GDP, and is responsible for over 90% of all government revenue. Its economic growth ranged from 7.5% in 2003 to 15.9% in 2006 and GDP per capita stood

at B$47,300 in 2007. However, in recent years, the country has been experiencing a deficit of about 2% (Brunei Government, 2009).

In contrast to oil and gas industries, Brunei Darussalam's agriculture and industrial sectors are less developed. Economic diversification strategies were embarked on by the government as early as the 1980s but met with limited success. The recent issue of food security has forced a revision of these strategies by policy makers.

Table 1. Brunei Darussalam: Gross Domestic Product (2006-2008)

	2006	2007	2008
GDP at current prices (BND million)	18,225.8	18,458.4	20,397.9
Oil & gas sector	12,491.0	12,332.9	14,300.0
Non-oil & gas sector	5,734.7	6,125.5	6,097.9
Government sector	2,008.5	2,239.4	2,152.2
Private sector	3,726.2	3,886.1	3,945.7
Per capita GDP at current prices (BND thousand)	47.6	47.3	51.3
GDP at constant prices (BND million)	11,967.8	11,986.3	11,753.9
Oil & gas sector	6,469.9	6,023.7	5,650.5
Non-oil & gas sector	5,497.9	5,962.6	6,103.4
Government sector	1,977.6	2,206.5	2,266.9
Private sector	3,520.3	3,756.1	3,836.5
Real GDP growth rate (%)	4.4	0.2	(1.9)

Source: Brunei Darussalam Key Indicators 2009 (Brunei Government, 2009).

1.4. Vision 2035

Brunei Darussalam's National Vision or Wawasan was authorized by His Majesty Sultan Haji Hassanal Bolkiah, Sultan and Yang Di-Pertuan of Brunei Darussalam, and launched in January 2008. By 2035, Brunei Darussalam aims to be recognized for the accomplishments of its well-educated and highly skilled people, their quality of life and its dynamic, sustainable economy (Brunei Government, 2008). Although oil and gas resources have contributed much to the nation's prosperity, economic growth has, on the whole, not kept pace with population growth. The public sector which is the main employer of the majority of the citizens and residents can no longer adequately absorb the growing numbers of young people wishing to enter the work force each year. There is a widening gap between the expectations and capabilities of the nation's youth and the employment opportunities currently being created. The oil and gas sector, which makes up about half of the economy and over 90% of export earnings employs less than

3% of the work force. The local business community continues to be underdeveloped and is unable to create the employment opportunities now required.

Taking into account the above, an integrated and well-coordinated national strategy is sought, involving all sectors and comprising the following key elements:

- **An education strategy** that will prepare our youth for employment and achievement in a world that is increasingly competitive and knowledge-based.
- **An economic strategy** that will create new employment opportunities for our people and expand business opportunities within Brunei Darussalam through the promotion of investment, foreign and domestic, both in downstream industries as well as in economic clusters beyond the oil and gas industry.
- **A security strategy** that will safeguard our political stability and our sovereignty as a nation and which links our defense and diplomatic capabilities and our capacity to respond to threats from disease and natural catastrophe.
- **An institutional development strategy** that will enhance good governance in both the public and private sectors, high quality public services, modern and pragmatic legal and regulatory frameworks and efficient government procedures that entail a minimum of bureaucratic "red tape".
- **A local business development strategy** that will enhance opportunities for local small and medium sized enterprises (SMEs) as well as enable Brunei Malays to achieve leadership in business and industry by developing greater competitive strength.
- **An infrastructure development strategy** that will ensure continued investment by government and through public-private sector partnerships in developing and maintaining world-class infrastructure with special emphasis placed on education, health and industry.
- **A social security strategy** that ensures that, as the nation prospers, all citizens are properly cared for.
- **An environmental strategy** that ensures the proper conservation of our natural environment and cultural habitat. It will provide health and safety in line with the highest international practices.

The government intends to ensure that the lifelong basic needs of all citizens and residents of Brunei Darussalam are adequately met, especially in terms of higher education, housing and healthcare as well as their means of livelihood.

1.5. Population

Brunei Darussalam is, today, a small nation. The 2001 population census recorded a population of 332,844, an increase of 72,362 or about 25% from 260,482 in 1991. This represents an annual growth rate of about 2.5%. This rate has declined over the last four decades since the population boom at the end of the Second World War.

Table 2. Brunei Darussalam Population (2006-2009)

	2006	2007	2008	2009*
Total (thousands)	383.0	390.0	398.0	406.2
Male	203.3	206.9	211.0	215.0
Female	179.7	183.1	187.0	191.2
Annual rate of increase (%)	3.5	1.8	2.1	2.1
Population density (per km²)	66	68	69	70
Population by racial group (thousands)				
Malays	255.5	259.6	265.1	269.4
Chinese	42.7	43.1	43.7	44.6
Others	84.8	87.3	89.2	92.2
Population by district (thousands)				
Brunei-Muara	264.7	270.3	276.6	283.3
Belait	63.9	64.9	66.0	67.1
Tutong	44.4	44.8	45.3	45.7
Temburong	10.0	10.0	10.0	10.1
Population by residential status (thousands)				
Brunei Citizens	244.8	250.5	257.0	262.9
Permanent Residents	32.1	32.5	32.2	32.8
Temporary Residents	106.1	107.0	108.8	110.5
Population by age-group (thousands)				
0-4	35.1	34.9	35.2	34.7
5-19	103.1	103.7	105.3	106.4
20-54	218.1	223.1	227.1	232.5
55-64	14.8	15.8	17.2	18.8
65 & Over	11.9	12.5	13.2	13.8
Population median age (year)	26.2	26.3	26.4	26.6

Source: Brunei Darussalam Key Indicators 2009 (Brunei Government, 2009).
Note: * Mid-year estimate.

Table 2 shows the population growth in recent years. In 2008 and 2009, the annual rate of increase was about 2.1%. By mid-2009, the population was estimated to be 406,200. The development of the Bruneian education system may have contributed to the low level of population growth, through compulsory education for all children and the growing number of women pursuing higher education. Another reason for women to pursue their first degrees was that until last year, married women without a first degree were employed in the public sector only on a month-to-month basis. (Unmarried

women could be employed on a permanent basis. This will have contributed to an increase in the numbers of unmarried women and those who chose to defer marriage.) It also helps to explain the increasing number of women joining the workforce.

Table 3. Brunei Darussalam Population by Age Groups and Gender, 1991 and 2001

Age Group	Persons		Male		Female	
	1991 (%)	2001 (%)	1991 (%)	2001 (%)	1991 (%)	2001 (%)
0-14	89,757 (34.5)	100,912 (30.3)	46,298 (33.7)	52,304 (31.0)	43,459 (35.4)	48,608 (29.7)
15-29	76,450 (29.4)	96,340(28.9)	39,716 (28.9)	47,288 (28.0)	36,734 (29.9)	49,052 (29.9)
30-44	63,135 (24.2)	87,337 (26.2)	34,990 (25.4)	44,443 (26.3)	28,145 (22.9)	42,894 (26.2)
45-64	24,045 (9.2)	38,938 (11.7)	12,937 (9.4)	20,373 (12.1)	11,108 (9.0)	18,565 (11.3)
65+	6,994 (2.7)	9,317 (2.8)	3,602 (2.6)	4,566 (2.7)	3,392 (2.8)	4,751 (2.9)
Total	260,381 (100)	332,844 (100)	137,543 (100)	168,974 (100)	122,838 (100)	163,870 (100)

Source: Brunei Darussalam Report on the 2001 Population Census (Brunei Government, 2003).

In terms of population by district, the Brunei-Muara District has the highest population of between 264,700 in 2006 and 283,300 in mid-2009. This was due to the migration of people from outside the district in search of employment and goods and services as the district houses the capital city, centre of government, main commercial development and the international airport.

1.5.1. Old Age

The baby boom after the Second World War accounts for the bulk of the current population aged above 50 years and soon to qualify for the ageing population category. The 2001 population census indicated that those above 65 years of age comprised 2.9% of the population in the country while the overall Dependency Ratio was 48.8. Today, the above 65 category had increased to 13,800 persons (3.4%) by mid-2009. In addition, with the rapid development in local Health Delivery Systems, the life expectancy at birth is now 76.6 years for males and 79.8 years for females. Although women, on average, live longer than men on average, they usually have lower exposure to employment (as well as being faced with the issue of permanent employment status versus the month-to-month status of married women without a first degree until last year) in the formal sector and earn wages that are lower than men on average. Thus,

women become more exposed to the risk of poverty in old age and this issue has become very important in relation to social security protection.

With advanced medical services and treatment, more and more people will survive well into their seventies and eighties. An ageing population would put pressure on traditional social protection systems as more people in the younger age groups are increasingly less able to provide for the greater number of older family and community members. Due to population ageing, weakening of family-based support, and other factors, old-age income support is becoming an issue of growing importance, given that demographic transition is already well under way. Systemic failures are expected to be low coverage, inadequate benefits, lack of financial sustainability, and insufficient support for the elderly poor.

Regardless of the existence of modern medicine, the seven leading causes of death in Brunei Darussalam in the last decade were Cancer, Heart Diseases, Diabetes Mellitus, Cerebro-vascular Diseases, Hypertensive Diseases, Emphysema & Asthma, and Influenza& Pneumonia (Brunei Government, 2008). The number of sufferers increases in direct proportion to increases in age. The majority of deaths amongst elderly population are caused by one or more of the above-mentioned diseases.

Table 4. Brunei Darussalam Labor Force (2006-2009)

Labor	2006	2007	2009*
Labor force (thousands)	181.7	184.8	188.8
Male	109.9	111.8	114.4
Female	71.8	73.0	74.4
Employed (thousands)	174.4	178.5	181.8
Male	106.7	109.1	111.2
Female	67.7	69.4	70.6
Unemployed (thousands)	7.3	6.3	7.0
Male	3.2	2.7	3.2
Female	4.1	3.6	3.8
Labor force participation rate (%)	68.4	67.8	67.8
Male	78.2	77.6	77.7
Female	57.3	56.9	56.7
Unemployment rate (%)	4.0	3.4	3.7
Male	2.9	2.4	2.8
Female	5.7	4.9	5.1

Note: * mid-year estimate.
Source: Brunei Darussalam Key Indicators 2009 (Brunei Government, 2009).

1.5.2. Labor Force

The labor force participation rate of the country for females has increased from 48.3% in 1991 to 58.8% in 2001 (Table 4) and stabilized at about 56% in the last couple of years (Table 5). According to the Brunei Darussalam Report on the 2001 Population Census, in 1991 alone, out of the total workforce of 106,746, 48,998 or 45.9% worked in the public sector while 57,748 or 54.1% worked in the private sector. In 2001, there were 146,254 employed people; 54,865 or 37.5% were employed in the public sector and 91,389 or 62.5% in the private sector. Recent figures (as at November 2009) from the Public Service Department website give a total of 46,757 employees in the public sector, out of which 23,511 are males and 23,246 females (Table 6). 10,576 female employees who were under a month-to-month basis are now employed on a permanent basis. The change was mainly due to the perceived need for equality in employment between the genders.

Table 5. Brunei Darussalam Labor Force Participation Rates (%) by Age and Gender, 1991 and 2001

Age Group	Male		Female	
	1991	2001	1991	2001
15-19	23.8	22.5	13.7	18.6
20-24	84.2	82.4	58.2	66.2
25-29	97.1	96.1	63.9	75.8
30-34	98.1	96.6	60.7	74.0
35-39	98.4	96.2	56.7	68.9
40-44	98.3	95.5	51.5	62.8
45-49	96.3	93.0	43.4	56.7
50-54	94.0	89.8	34.9	46.1
55-59	72.1	50.0	17.6	15.8
60-64	71.0	45.5	13.2	11.2
65+	32.2	13.2	4.2	2.1
15-64	84.3	82.0	48.3	58.8
15+	82.2	78.8	46.4	56.1

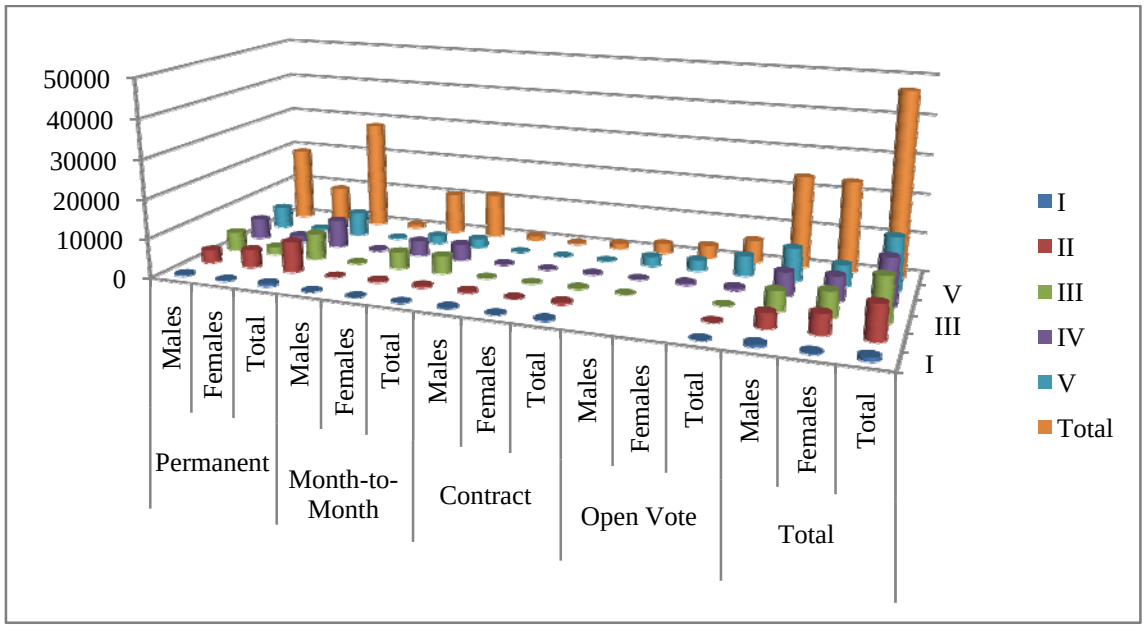
Source: Brunei Darussalam Report on the 2001 Population Census (Brunei Government, 2003).

The increase in the numbers joining the private sector was due to the establishment of the Employee Trust Fund or *Tabung Amanah Pekerja* (TAP) in late 1992, which became fully effective in January 1993 making it easier for workers to enjoy employment mobility among the various sectors. While personnel who entered the government permanent workforce prior to those dates are still on government pension

schemes, and are eligible to retire at 55, those in the private sector and those in the trust fund, now with the newly added Supplementary Contribution Pension (SCP), are eligible to retire at 60, at which age eligible citizens and permanent residents would obtain an old age pension. Others, including foreign employees, employed under contracts of service are given gratuity among other benefits upon completion of their contract.

Table 6. Brunei Darussalam Public Sector Labor Force as at November 2009

Type of service	Gender	Divisions					Total
		I	II	III	IV	V	
Permanent	Males	408	3246	4724	5258	5517	19153
	Females	245	4548	1915	1809	613	9130
	Total	653	7794	6639	7067	6130	28283
Month-to-Month	Males	6	67	166	282	289	810
	Females	11	369	4292	3865	2039	10576
	Total	17	436	4458	4147	2328	11386
Contract	Males	239	419	122	184	55	1019
	Females	30	92	87	17	51	277
	Total	269	511	209	201	106	1296
Open Vote	Males			1	138	2390	2529
	Females				534	2729	3263
	Total	0	0	1	672	5119	5792
Total	Males	653	3732	5013	5862	8251	23511
	Females	286	5009	6294	6225	5432	23246
	Total	939	8741	11307	12087	13683	46757



Source: Brunei Darussalam Public Service Department (2010), **http://www.jpa.gov.bn**.

1.5.3. Unemployment

Unemployment rates are recorded to have increased from 4.7% in 1991 to 7.2% in 2001 (Table 8). Unemployment rates have risen most sharply in the 15-19 and 20-24 age groups, from 37.4% in 1991 to 52.4% in 2001 and from 11.8% to 17.5%, respectively, due to school leavers or graduates looking for their first full-time job, or individuals reluctant to take up employment, until they received a job offer that met their aspirations. Sometimes, these young people have no choice due to their ineligibility to continue their studies in local higher institutions of learning while the local job market may not offer employment opportunities commensurate with their qualifications. There is no unemployment benefit in Brunei Darussalam.

Table 8. Brunei Darussalam Unemployment Rates (%) by Age Group and Gender, 1991 and 2001

Age Group	Males		Females		Persons	
	1991	2001	1991	2001	1991	2001
15-19	33.7	54.8	44.4	49.5	37.4	52.4
20-24	9.7	18.6	15.0	16.3	11.8	17.5
25-29	2.3	7.6	4.2	5.9	3.0	6.9
30-34	1.2	4.1	2.2	2.8	1.5	3.5
35-39	0.6	2.6	1.7	1.7	1.0	2.2
40-44	0.5	1.7	1.3	1.5	0.7	1.6
45-49	0.7	0.9	0.6	0.6	0.7	0.8
50-54	0.6	0.5	1.0	0.2	0.7	0.4
55-59	1.2	0.3	0.7	0.2	1.1	0.2
60-64	0.7	0.1	0.9	0.0	0.8	0.0
15-64	3.7	7.3	6.7	7.1	4.7	7.2

Source: Brunei Darussalam Report on the 2001 Population Census (Brunei Government, 2003).

2. Social Protection Arrangements

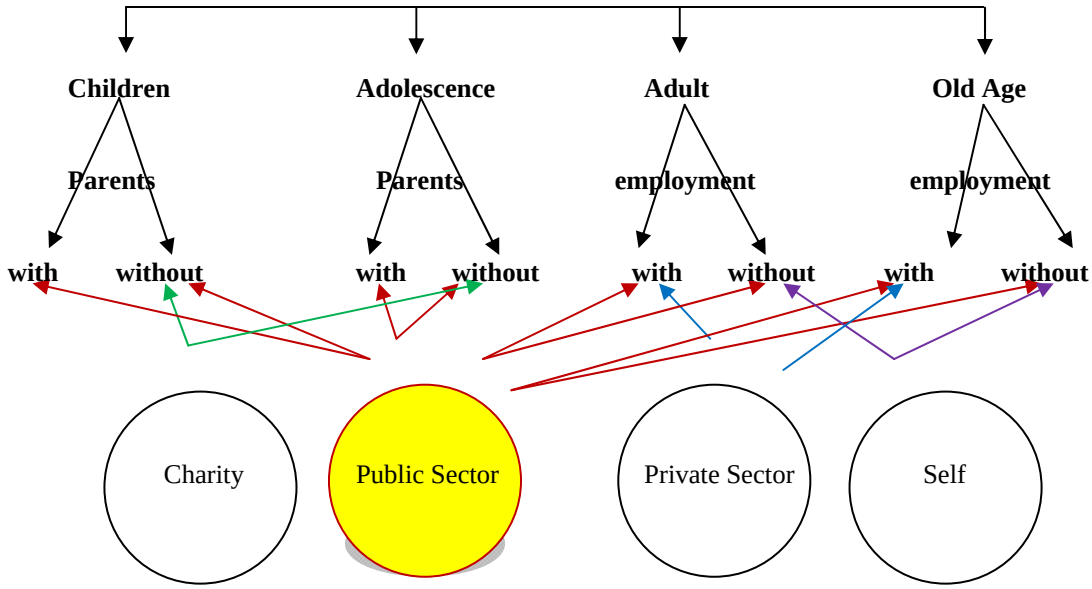
The government of Brunei Darussalam has taken a wide variety of steps to ensure social protection for all of its citizens and residents. The most important ones relate to the education system, housing provision, the health system, retirement packages, and pensions for the aged and the disabled population.

2.1. Current State of Social Protection Systems

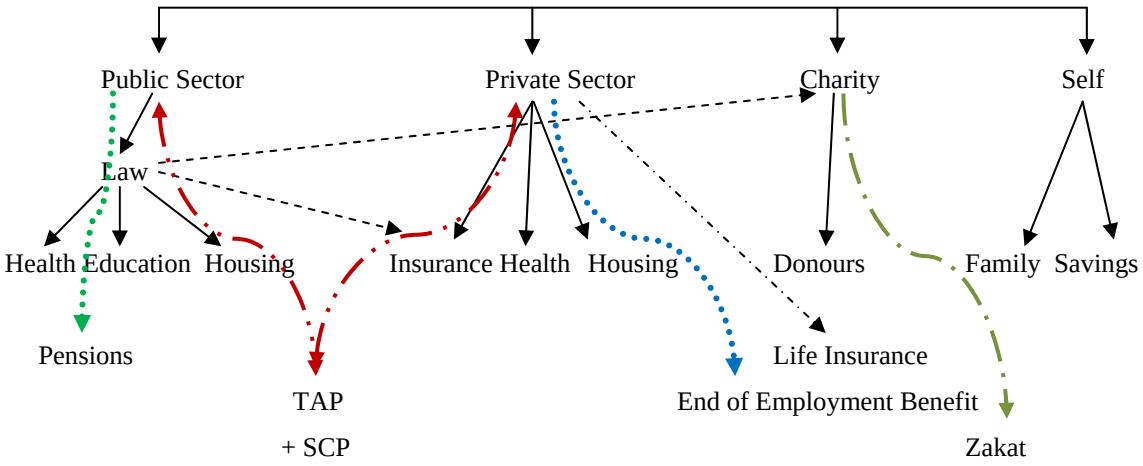
The schematic diagrams below (Figure 2) illustrate the social protection systems in Brunei Darussalam and their relationships. The public sector or the government of Brunei Darussalam is largely responsible for the social protection of the people of Brunei Darussalam. The government provides pensions, health care, education, housing, various allowances and subsidies to the entire population. Since 1993, new entrants to the public sector have been covered by the TAP scheme while those who were employed and confirmed in post prior to 1993 were the last cohorts of the public sector pension scheme.

Figure 2. Brunei Darussalam Social Protection Systems

a) Brunei Darussalam Social Protection Systems, by Groupings



b) Brunei Darussalam Social Protection Systems, by Sectors



Keys:

direct relation

benefit for retirement

end of employment benefit

additional plan

legality

The private sector, depending on company capabilities, provides insurance, healthcare and housing for those employed within it and their dependents. Large private sector companies also provide end of employment benefit to their employees. This arrangement still continues despite the compulsory introduction of the TAP on 1st January 1993 for the private sector.

In 2009, the government introduced an additional contributory scheme – SCP – that came into effect in January 2010. The private sector, through insurance companies or commercial banks, also provides life and/or social insurance to their customers under a wide variety of schemes at different premium rates.

Other pensions distributed by the government are administered by the Ministry of Culture, Youths and Sports. These are better known as social services schemes handled by the Department of Social Services and Community Affairs. The pension is set at B$250 per month.

Other protection systems available in Brunei Darussalam can be classified under charity or self. Charity comprises voluntary contributions, in kind or money, from the public as well as voluntary associations. *Zakat* monies are in this category and further explanation can be found under *Miscellaneous*. Other charity donours include large private sector companies which may have divisions within their organizations to deal with their corporate social responsibilities, among which is their responsibility to give something back to the public or to the community. The "self" refers to personal savings or family financial means. This is related to the pooled resources of extended families, which may provide for the family members in need.

2.2. Education

Table 9. Brunei Darussalam Literacy Rates (1981, 1991 & 2001)

Literacy Rates for Ages 9 and above	1981	1991	2001
Total	80.3	89.2	93.7
Male	86.3	93.1	95.8
Female	73.3	84.7	91.5

Source: Brunei Darussalam Key Indicators 2009 (Brunei Government, 2009).

Table 10. Brunei Darussalam Literacy Rates (1991 & 2001)

Age Group	Males		Females		Total	
	1991	2001	1991	2001	1991	2001
9-14	96.7	99.6	96.6	99.6	99.6	99.6
15-19	98.9	99.4	98.7	99.4	98.8	99.4
20-24	97.4	98.4	97.5	98.5	97.5	98.5
25-29	96.9	97.4	96.0	97.8	96.5	97.6
30-34	96.1	96.8	94.4	96.7	95.4	96.8
35-39	95.9	96.8	89.5	95.4	93.1	96.1
40-44	94.6	96.5	77.0	93.9	87.1	95.3
45-49	90.0	96.7	57.2	90.1	75.9	93.6
50-54	84.0	94.9	39.3	76.8	63.1	86.2
55-59	72.4	90.2	24.4	55.2	48.0	73.7
60+	51.4	64.3	13.6	25.7	33.4	44.6

Source: Brunei Government Report on the 2001 Population Census (Brunei Government, 2003).

The government of Brunei Darussalam has regarded education as the backbone of national development since the establishment of its first national development plan.

The knowledge and skills acquired through education guide a person in future life. Tables 9 & 10 show Brunei Darussalam literacy rates for ages 9 and above. In 2001, the overall rate was 93.7%; the male literacy stood at 95.8% while the literacy rate for the females stood at 91.5%. The rates among the young population (age groups 9-14 and 15-19) are very high averaging more than 99% in 2001 due to the compulsory education system. Brunei Darussalam's bilingual education system established in 1986 has also equipped students with two basic languages, namely, the Malay Language and the English Language.

The relatively high literacy rate and emphasis on education policies within the country are expected to bring it to the same level as advanced economies in the near future. The government attaches great importance to education with the provision of free education at the primary and secondary level being available to all children, and full scholarships offered to children at the highest level of attainment. Expenditure on universal education in the country constitutes a major proportion of social expenditure. This has the expansion of education facilities and institutions. In total, there are 267 educational institutions in the country. Over the past three years, the country has been upgrading a number of its tertiary educational institutes to become universities. To date, three universities and a university college have been established in the country (Table 11).

Table 11. Brunei Darussalam: Educational Institutions

Institutions\ Numbers\Years	2006	2007	2008
Nursery/Kindergarten/Primary/Secondary	84	85	85
Pre-School/Primary	122	122	122
Pre-School/Primary/Secondary	1	1	1
Arab Preparatory	2	2	2
Arab Preparatory/Arab Secondary	3	3	3
Secondary	34	34	34
Technical/Vocational	12	13	13
Nursing	1	1	1
Religious Teacher College (College University)	1	1	1
Institute	1	1	1
University	2	3	3
Total	263	266	267

Source: Brunei Darussalam Key Indicators 2009 (Brunei Government, 2009).

2.3. Housing

Resettlement schemes have been implemented since the early years of the British Residential Administration. Upon acquiring lands from traditional powers and placing them under the central government administration, the administration started relocating the population. Among the earlier projects was the resettlement of the Kampong Ayer people on land in Kampong Anggerek Desa and Kampong Bengkurong. Later under the first National Development Plan, new villages were established as new settlements. Examples are Kampong Mata-Mata and Kampong Burong Pinggai.

Since the mid-1970s, the government has supported an ongoing housing program through the National Development Plan to encourage and support home ownership for all citizens. Since the mid-1980s, citizens of Brunei Darussalam have been eligible for the National Housing Schemes upon reaching the age of 18 although eligibility may depend on criteria such as family eligibility. As of 2000, interest-free home loans have been available to all citizens although this policy may change as the government reconsiders the sustainability of its oil-based economy. Two national housing schemes that should be mentioned are the landless citizen's scheme and the resettlement scheme. Formerly, these schemes were administered by the Land Department and the Housing Development Department, respectively. In recent years, however, both of these schemes have come under the auspices of the Housing Development Department and the development projects are under the National Development Plan. Low cost housings on state land with infrastructure fully subsidized by the government is allocated to low-income citizens on a 99-year lease while higher income citizens are provided with a plot of land at B$13,000.00. The ownership is transferable to next of kin. Through the Landless Indigenous Citizens Housing Schemes, the government has constructed at least eight housing project sites to offer affordable, modern housing to low-income residents. From 1972–2009, over 6,000 new homes were built. More new houses would be completed in the near future to meet the vision 2035.

2.4. Health

Table 12 gives the numbers of medical and health institutions available in Brunei Darussalam. The decentralization of health services from centralized hospitals in each district into residential zones located in central villages as satellite centers catering to a

much larger public within their own vicinities has taken place. For example, services from the RIPAS hospital in the Brunei-Muara District have been transferred to such satellite centers.

Table 12. Brunei Darussalam: Health Institutions

Institution\Number	2006	2007	2008
Hospitals	5	5	5
Medical Centers	6	9	9
Health Centers	15	16	16
Health Clinics	27	26	26
Beds in hospital	1,063	1,068	1,122
Physicians	399	393	564
Dentists	75	81	82
Nurses	1,754	1,915	1,941
Pharmacists	41	42	45
Midwives	429	457	515
Population per Doctor	960	992	706

Source: Brunei Darussalam Key Indicators 2009 (Brunei Darussalam, 2009).

Brunei Darussalam has well-developed health facilities. A primary healthcare system is in place. Medical care in rural areas includes a "flying-doctor" service to the villages, outdoor clinics, and mobile dispensaries, while the capital has a large, modern hospital and a smaller modern one is located in each district in the country. The provision of universal health services to the population is seen as a priority for human development.

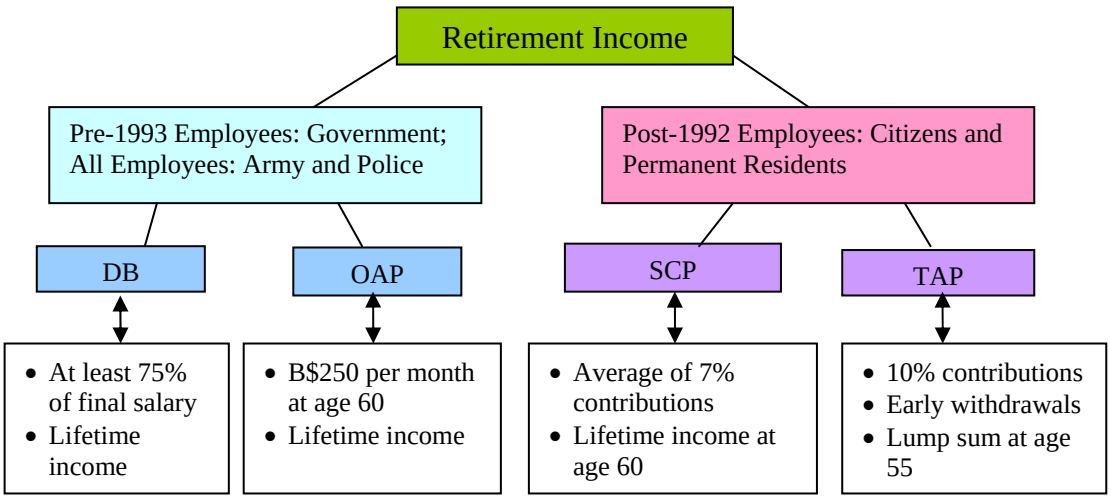
The quality of health and medical services is reflected in the life expectancy at birth of 78.2 and the death rate of 2.7 per 1,000 population in 2008. The virtually free immunization programs have resulted in positive health outcomes. Children are also given the basic WHO immunizations such as BCG, Rubella and Polio. Health and medical services are provided for all citizens and permanent residents at a highly subsidized minimal rate of B$1 registration fee and B$5 for foreigners. For example, vaccination against the H1N1 influenza is currently provided free to citizens and residents of Brunei Darussalam.

2.5. Retirement Schemes

Figure 3 illustrates how Brunei Darussalam plans retirement income for its economically active population. Pre-1993 Government employees and all Army and

Police personnel are eligible for the defined benefit (DB) plan and OAP (Old Age Pension), both of which provide lifetime income. In addition, the DB plan offers a partial lump sum withdrawal in exchange for a lower monthly income payment. These retirees should be able to continue to enjoy a similar standard of living in retirement that they enjoyed during their working years, as the DB plan, will pay at least 75% of final pre-retirement income during retirement. Upon reaching the age of 60, an additional monthly OAP will be received.

Figure 3. Brunei Darussalam: Retirement Income for Economically Active Population



Legend:
DB – direct benefit; OAP – old age pension; SCP – Supplementary Contribution Pension; TAP – Tabung Amanah Pekerja (Employee Trust Fund)

2.5.1. Direct Benefit

Based on the 1957 Pensions Act, (Chapter 38 - New Edition in 1984, Laws of Brunei Darussalam), the duration of service for government employee is up to the age of 55. This means that 55 years of age is the mandatory retirement age set by the Government of His Majesty the Sultan and Yang Di-Pertuan of Brunei Darussalam. Civil servants are provided with retirement pensions or a reduced amount of pension plus gratuity, subject to the following conditions:

- Citizens and permanent residents of Brunei Darussalam;
- In permanent pensionable service;

- Served not less than 10 years;
- Appointment before 01 January 1993;
- Age 55 years.

Pension is a monthly financial provision after retirement. Eligible public service employees would be qualified to opt for either a pension or a reduced pension and gratuity. This Defined Benefit for the public sector is based on the following calculations (http://www.jpa.gov.bn).

1) **A Pension:**

   Pension = [Total service (months) x Final Salary] / 480 = $ A per month

2) **A reduced pension and gratuity amount:**

   Pension = ¾ x $ A per month

   Gratuity = ¼ x $ A x 15 x 12 = $ C in lump sum

480 months or 40 years of service is the base of full pension using the minimum age of economically active population (15 years old). The gratuity is a lump sum pre-withdrawal from 15 years' pension. After 15 years of receiving a monthly reduced pension, retirees will be paid full pensions until death.

Public sector employees may also apply for early retirement with the following conditions:

- Minimum age of 50 years for male officers, or
- Minimum age of 45 years for female officers.

The calculations for their pension and gratuity remain the same. However, this is subject to government approval.

The public sector, the military, the police, public enterprises and large companies including commercial banks have their own social protection schemes for their employees. Public sector, military and police personnel continue to be on government pensionable schemes under their respective institutional arrangements with differing optional pension ages. Public and private enterprises have their own end of service arrangements. All have their own sets of regulations and policies.

Defined Benefit for private sector workers is based on the monthly contribution from the employer. The ratio and percentage are very much dependent on the size of the organization and its profitability. For example, banks usually contribute an amount

equivalent to 5% of their employee's salary in their End of Employment Benefit fund. This fund is internal to the organization and the amount is kept and invested by the organization. An employee can take out the accumulated fund in a lump sum once he or she resigns or retires.

2.5.2. Employee Trust Fund (TAP)

The local labor force is now provided with a mix of provident fund and employer liability legislation. Since 1993, the provident fund has been regulated by the Tabung Amanah Pekerja Act and Chapter 167 on employee trust funds and is under the responsibility of the Ministry of Finance. Both employers and employees make a contribution equivalent to 5% of the employee's salary.

By contrast, citizens and permanent residents not eligible for the DB plan will be covered by the OAP and TAP, which if converted to lifetime at age 55, would provide approximately 25% of pre-retirement income in retirement. It should be noted that, the final batch of pensionable government employees, excluding the military and police, will be 2032.

Table 13 illustrates the retirement benefits obtained with TAP contribution made by an employee at the age of 15 and at the lowest salary scale. With no dividend and no early withdrawals, the contributor would have accumulated about B$38,678.00 at the age of 55. If the contributor keeps his or her TAP money in a bank savings account and takes out a monthly income of B$161.16 for the next 20 years, using the age of 75 as average life span from birth, he or she is above the poverty line. (Using the international extreme poverty line of USD1 (B$1.5) per day, a person must have an income at least B$45-50 a month.)

At the 2008 dividend rate of 4.25 per annum, the employee will accumulate approximately B$84,871.07 by the age of 55. If the amount is spread over the next 20 years, his or her monthly take-out will be about B$353.63. But what would happen if the dividend rate fell to only 2% or there was no dividend at all? A TAP contributor would accumulate a far smaller amount than predicted. Furthermore, according to the TAP Act, retirees can withdraw their monies in one lump sum upon retirement at 55 and no revision has been made to extent the age of contribution to 60. Depending on the dividend, the amount barely covers housing loan repayments. Should the contributor

intend to maintain a monthly income of B$400.00 for the next 15 years, he or she should maintain a savings of at least B$27,000.00. Concerns about possibly insufficient monthly retirement income drove the government to introduce an additional scheme and increase the retirement age to 60 for TAP contributors earlier this year.

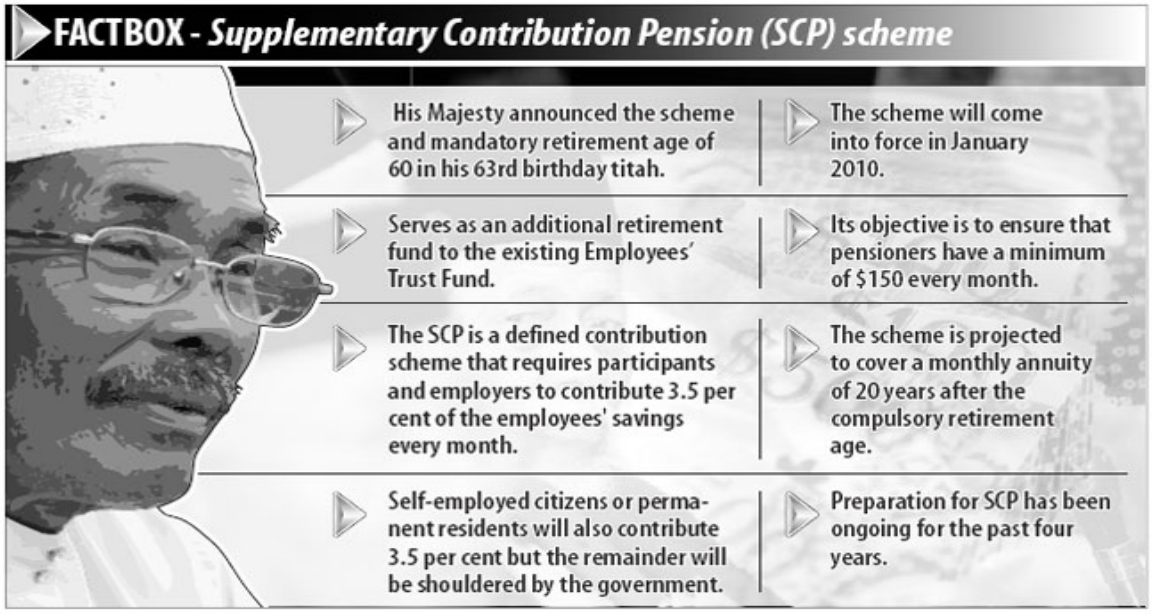
Table 13. Projected Accumulated TAP

Year	Age	Salary (B$)	10% TAP(B$)	Yearly (B$)	Accum. (B$)	2% div. (B$)	4.25% div. (B$)
1993	15	445	44.5	534	534	534.00	534.00
1994	16	455	45.5	546	1180	1090.68	1102.70
1995	17	465	46.5	558	1738	1670.49	1707.56
1996	18	475	47.5	570	2308	2273.90	2350.13
1997	19	495	49.5	594	2902	2913.38	3044.01
1998	20	505	50.5	606	3508	3577.65	3779.38
1999	21	515	51.5	618	4126	4267.20	4558.01
2000	22	525	52.5	630	4756	4982.55	5381.72
2001	23	550	55.0	660	5416	5742.20	6270.44
2002	24	560	56.0	672	6088	6529.04	7208.94
2003	25	570	57.0	684	6772	7343.62	8199.32
2004	26	580	58.0	696	7468	8186.49	9243.79
2005	27	590	59.0	708	8176	9058.22	10344.65
2006	28	745	74.5	894	9170	10133.39	11678.30
2007	29	760	76.0	912	10082	11248.06	13086.62
2008	30	775	77.5	930	11012	12403.02	14572.81
2009	31	790	79.0	948	11960	13599.08	16140.15
2010	32	805	80.5	966	12926	14837.06	17792.11
2011	33	820	82.0	984	13910	16117.80	19532.27
2012	34	835	83.5	1002	14912	17442.16	21364.39
2013	35	850	85.0	1020	15932	18811.00	23292.38
2014	36	865	86.5	1038	16970	20225.22	25320.31
2015	37	885	88.5	1062	18032	21691.72	27458.42
2016	38	905	90.5	1086	19118	23211.56	29711.40
2017	39	925	92.5	1110	20228	24785.79	32084.14
2018	40	945	94.5	1134	21362	26415.51	34581.71
2019	41	965	96.5	1158	22520	28101.82	37209.44
2020	42	985	98.5	1182	23702	29845.85	39972.84
2021	43	1005	100.5	1206	24908	31648.77	42877.68
2022	44	1025	102.5	1230	26138	33511.74	45929.98
2023	45	1045	104.5	1254	27392	35435.98	49136.01
2024	46	1045	104.5	1254	28646	37398.70	52478.29
2025	47	1045	104.5	1254	29900	39400.67	55962.62
2026	48	1045	104.5	1254	31154	41442.69	59595.03
2027	49	1045	104.5	1254	32408	43525.54	63381.81
2028	50	1045	104.5	1254	33662	45650.05	67329.54
2029	51	1045	104.5	1254	34916	47817.05	71445.05
2030	52	1045	104.5	1254	36170	50027.39	75735.46
2031	53	1045	104.5	1254	37424	52281.94	80208.22
2032	54	1045	104.5	1254	38678	54581.58	84871.07
Retirement at 55			55 - 59	Retaining 100%	161.16/mth	227.42/mth	353.63/mth
			60 - 75	+ OAP	411.16/mth	477.42/mth	603.63/mth

In addition to this government-initiated provident fund, most large companies in the private sector continue to have their own end-of-service benefits schemes. Sickness and maternity benefits are considered to be an employer's liability under which private sector employers are obliged to pay the medical costs incurred in government hospitals for treatment of their non-local employees. Work injury is an employer's liability and the employee, or the dependants, are paid a lump sum equal to 48 months of wages up to a maximum of B$ 9,600 and an additional 25% if the employee requires the around-the-clock care.

2.5.3. Supplementary Contribution Pension (SCP)

Figure 4. Brunei Darussalam: Supplementary Contribution Pension



Source: Brunei Times, Dec 3 2009.

The Supplementary Contribution Pension (SCP) was designed to mandate additional savings, supported by employers who will match employees' contribution in order to raise the retirement income to about 50% of average pre-retirement levels, which is considered to be a suitable target for retirees. The SCP scheme is also open to self-employed persons. Figure 4 summarizes the SCP scheme.

The SCP scheme requires an additional contribution of 3.5% from the employee to be made. Employers are obliged to match this sum. The SCP scheme contribution

should amount to 7%. If the employee's contribution is below B$17.50, the government will make up the difference. In the case of a self-employed person, he or she contributes 3.5% while the government will shoulder the additional 3.5%. This addition would ensure a retiree a benefit of at least B$400 per month upon reaching the age of 60. As calculated earlier, the contributor has to accumulate at least B$27,000 before he or she retires in order that he or she receives the intended monthly income for 15 years.

TAP scheme members will withdraw their TAP savings in the form of a lump sum once they retire, as opposed to the SCP scheme where retirees can only receive their monthly annuity as lifetime income. The investment of the fund monies is fully managed by the Department of TAP, under the Ministry of Finance.

2.4.4. Old Age Pension

The provisions for old age are the laws relating to Old Age, Disability and Survivorship passed in 1955 and updated in 1992. There is a universal pension of B$250 payable to citizens at the age of 60. This scheme is administered by the Department of Community Development of the Ministry of Culture, Youth, and Sports. Table 14 shows the number of recipients, both citizens and permanent residents, 60 years of age and above between 2006 and 2009. Last year alone, there were 19,757 recipients. Over this three-year period, the number of old age pension recipients has increased by about 6%. Thanks to modern technology and medicine, the population enjoys a healthier and more secured old age. Currently, the government spends more than B$4 million per month on old age pension.

Table 14. Brunei Darussalam Ministry of Culture, Youth and Sports Schemes – Old Age Pension

	2006	2007	2008	2009
No. of recipients	16,576	17,698	18,644	19,757
% of increase	n.a.	6.8	5.3	6.0
Total Expenditure	B$4,144,000.00	B$4,424,500.00	B$4,661,000.00	B$4,939,250.00

Source: Ministry of Culture, Youths & Sports.

Other pension schemes managed by the Ministry of Culture, Youths and Sports are pensions for the blind, widows and orphans, and the disabled. The schemes are in place and enjoyed by many Bruneians despite not having to make any contribution to the scheme. The schemes which originally paid B$20 per month in 1957 now pay B$250 a month to all eligible Bruneians. The pension is a flat monthly allowance. These allowances are not automatic. A person requiring any of these allowances must apply for them directly. Access to any of these pension types can only be gained after successful application to the Department of Community Development.

2.6. Miscellaneous

Another government-initiated welfare organization set up to assist those in financial need is the Brunei Islamic Council under the Ministry of Religious Affairs. This council collects *zakat* paid by all Muslims annually and distributes these alms to eight *asnafs* or beneficiaries stipulated by the Islamic teachings.

According to the teachings of Islam, every Muslim is required to pay two kinds of taxation, firstly, *zakat fitrah* or tithe of about B$3 annually during the month of Ramadan and, secondly, *zakat harta* or property tax of 2.5% on their savings, goods or property kept untouched for a year. Last year 2009 at the command of His Majesty the Sultan and Yang Di-Pertuan of Brunei Darussalam, the *zakat* monies kept in Baitulmal (money house or bank) were distributed and a number of *AlGarimin* or debtors were selected as recipients of these funds.

The Sultan Haji Hassanal Bolkiah Foundation is another organization providing funds for education, housing and other facilities and services for underprivileged people in the country. Applications are considered on a case by case basis and awards are decided upon by its committee. Another foundation to cater for orphans is the Dana DPMM Al-Muhtadee Billah. These organizations are operated independently.

Other arrangements are made by the private individual and the private sector. Private insurance companies provide protection over and above the state provided protection. Commercial banks in the country also provide insurance coverage for their customers. In addition, the local private sector has also established corporate social responsibility sections or foundations. These institutions have been active in cleaning

campaigns, tree planting campaigns, and other environmental issues. It is recommended that further study into this additional social support system be carried out.

Informal protection is still provided by family institutions in Brunei Darussalam. Parents and family members still support their grown-up or married children/family members who are unemployed. In exchange, unemployed family members normally assist the family by doing house work or taking care of children or aged family members. This system of extended family assistance should also be studied further in order to determine the reasons behind its deterioration over the years.

3. Challenges

Existing social protection schemes in place in Brunei Darussalam are very limited and can be characterized by the following challenges:

3.1. Coverage of Social Protection Schemes

First, the current labor force is covered by social safety nets, particularly pensions and health care (in contrast to high income countries which also cover long term care and unemployment). Health services are provided free or at heavily subsidized rates. For foreign workers, employers must purchase a worker's insurance as a social safety net. Expatriate officers under 3-year employment contracts are given a gratuity at their end of contract and provided with free passage to-and-from their place of domicile. Expatriate workers on two-year contracts, upon completion, are normally provided with a free passage home to their place of domicile. Before employment, workers should undergo a medical check-up. Provided the results of the check-up are satisfactory, an employment visa will be issued by the Labor Department.

The Government gives a variety of allowances to its employees – for instance, a subsistence allowance of B$100, and another special subsistence allowance of B$150, making public sector employment appear more secured and attractive than private sector employment. The government policy of replacing the non-contributory pension scheme for public sector employees with the contributory TAP scheme and extending

the scheme to all workers in both the public and private sectors has led to greater employment mobility of the local labor force.

It should be noted however that this coverage does not cover certain groups of people. For instance, unemployed people are excluded from the scheme and as previously mentioned, no unemployment benefit scheme exists in Brunei Darussalam. Job seekers often do not even possess the means to pay for transportation to job interviews, photocopy their certificates and qualifications, to print out letters of application, to purchase newspapers, or even to access the Internet to search for job opportunities. Due to inflation, the cost of goods and services has increased. Without any means or support from their families, the unemployed might be unemployed for a considerable length of time.

The second important group comprises divorcees, widows/widowers, single parents, orphans, the abused and the disabled. Without adequate education, government allowances or food and shelter, these people are at risk of becoming displaced in society. If they are still young adults, they may be in a better position to find employment although this situation might well change once they reach their late forties or above and job opportunities become scarcer.

The existing and new coverage of TAP and SCP schemes does not extend to retired workers who were once under the government Open Vote and Daily Paid categories with retirement at 50 or 55 before the TAP and SCP schemes were introduced. (These categories can be found in Table 6.) They were entitled to neither a gratuity nor a pension. If they retire at 55, they must wait until they reach the age of 60 in order to be eligible for an old age pension. This means that there will be a gap of 5 years between the ages of 55 and 60, during which time they may have to find some kind of livelihood.

Older people without families or those whose families, including their own children, refuse to take care of them are currently offered little state protection. Similarly, coverage for victims of domestic violence/abuse is still limited despite the existence of widows' pensions and orphans protection schemes in the country. Homes are being built to meet the housing needs of such people through programs put in place by the Department of Community Development, Ministry of Culture, Youth and Sports, or collaborative efforts from all sectors.

3.2. Adequacy and Sustainability of Benefits

Adequacy and sustainability of benefits requires careful and proper planning, in terms of individual, family, community or organization. Employees approaching retirement should be given access to retirement programs which included asset management or fund management. These programs should help them avoid the prospect of being trapped in poverty. Continual revision of the Old Age Pension and related schemes taking into consideration of current inflation should be carried out by the government.

At present the government provides health care and education services free of charge. The focus here should be on the financial and fiscal sustainability of such existing schemes. In the case of social pensions and social assistance, effective delivery of benefits and their fiscal sustainability remain important issues for beneficiary satisfaction. Being fully sponsored by the government coffers, which are dependent on oil and gas revenues; when GDP growth encounters problems, alternative financing may be needed for these schemes. Moving from non-contributory to contributory schemes reduces the strain on government budget and spending. Should the country introduce income tax or property taxation in the future? Should the city tax be based on the Islamic *zakat harta* or property tax at 2.5% of the property value (the value being calculated annually at the end of the year of possession of the property)?

Being highly dependent on the government, complete economic diversification is yet to be attained. Still too dependent on government schemes – government initiatives includes TAP, SCP, amongst others, - the people should be regularly updated on government's vision and encouraged to be fully involved and participate in the country's development. The government formulates all laws and policies related to every aspect of people's lives within the country. This includes the investment of all trust fund monies. The investment fortfolio of the two schemes, however, requires transparency.

Old age and disability pensions are governed by the 1955 (Old-Age and Disability Pensions), amended in 1984 (Universal Pension Amendment). This pension is not considered to be adequate. If an elderly person suffers an acute stroke and is either partially or completed paralyzed or bedridden, they will require such items as adult diapers, soap, wheelchair, nursing care, special food, medications and so forth. I was

informed that only one type of pension is given, either for the disabled or for the elderly. If the amount is insufficient to cover all the necessities, one can submit a written application for additional allowances and all applications are dealt with on a case-by-case basis, although there is no guarantee that an application will be successful.

Local youth unemployment may be due to an inability on the part of young people to meet the entry requirements of the local universities and higher institutions of learning, or to a lack of funds or access to scholarships to continue education at private institutions. Scholarships are only available for study at local government institutions and are not available for study at private institutions. An alternative option for these people would be to become self-employed. Of course, being self-employed does not guarantee financial security and may result in a somewhat 'hand-to-mouth' existence. Current local labor regulations do not assist local farmers and self-employed locals. A substantial number of foreign-operated companies, shops and stores employing foreign labor have contributed to the failure of local small and medium enterprises.

3.3. Management

Governance and management involves the extent to which provident and pension funds and other social security organizations are able to perform the core functions and adopt new technologies. The core functions are to ensure that laws and regulations are adhered to; to ensure the reliable and accurate collection of contributions/taxes and other receipts; and to make correct payments of benefits for each of the schemes without any discrepancies. In the case of pre-retirement loans, the management ensures their timely repayment. Under the TAP scheme, employers would be legally charged 1.5% or at least B$10 per month for late payment or miss-payment of contribution to an employee's TAP. Section 6(1) of the Emergency Order of 1992 (TAP) provides the investment guidelines for the fund. The agency in charge should also secure financial management and productive investment of provident and pension funds assets. This aspect can be seen from the TAP and the *Zakat* monies. These assets are invested both locally and abroad to gain maximum returns. However, their activities are not transparent and not made known neither to the contributors nor to the public. They do not reveal their sources of funding nor where the TAP monies have been invested. Only

annual financial statements are sent to contributors. Last year, TAP recorded no dividend for its contributors.

The management of resources for social protection in Brunei Darussalam is fragmented among various ministries, departments and organizations. This management is in question. The criteria of eligibility to certain resources provided by the government are also being questioned as is committee membership and procedures related to allocation and selection. The recent distribution of *Zakat* funds to *AlGarimin* or debtors, for instance, also encountered criticisms by the public.

With the country's economy experiencing a deficit, future financing of social protection arrangements is uncertain. Provident fund beneficiaries would be taken care of by the new arrangements. Other groups may fare less well until the economy recovers, a recovery which depends on current revenues and investments.

The government bears ultimate responsibility for social protection. Transparency in the management of employees' assets could encourage and enhance participation by contributors. Trust between the management and the contributors would be strengthened since contributors would know where their retirement savings are invested and the rates of returns they are likely to obtain. The country still needs to review its present systems and consider what policy changes are necessary to implement better social security protection provisions in the future.

The most important challenge for Brunei Darussalam is to sustain its distributive policy. From where will future sources of government revenue come apart from revenue from its oil and gas or investments? To ensure sustainability of the social protection system, more emphasis should be attached to contributions from the individual and his or her family members rather than contributions made by the organization where he or she is employed.

4. Policy Recommendations and Conclusion

4.1. Conclusion

In recent years, Brunei Darussalam has attempted to expand its social protection system to encompass not only the formal sector but also the informal sector. It has, over

the years since its first national development plan, attached great importance to the basic needs of the people of Brunei Darussalam. The government has successfully and continuously implemented policies designed to bring the standards of living of the people in line with those in developed nations. The Millennium Development Goals for example have been long attained. The government ensures compulsory and inclusive provision of education, health care, housing, old age pensions and pensions for the disadvantaged and disabled.

By shifting from a non-contributory pension system for government employees entering into service as at 1st January 1993 to a defined contribution scheme covering both the public and the private sector employees, policymakers have already taken step toward a sustainable social security system for the Brunei Darussalam working population. This also ensures the population mobility in the labor force.

However, the existing social protection system in place in Brunei Darussalam is very limited and characterized by:

- coverage which is limited to a proportion of the formal sector labor force;
- focused mainly on old age protection at 60 and above;
- amounts which are insufficient to cover the basic necessities of the disabled, sick and the elderly (multiple); and,
- fragmented administration rather than coordinated management between various ministries, departments and organizations providing the protection.

The above also highlights the main challenges to the existing social protection system in Brunei Darussalam.

- There is a need to review the needs and rights of the informal sector as well as the formal one. The need for necessities like infrastructure such as public transportation, employment opportunities, and educational opportunities, should be given priority.
- The focus on old age pension at 60 and above began in 1959 but this was solely based on a healthy elderly person. The increase in the number of old age with diseases such as diabetes, high blood pressure, and heart problems should be reviewed as the cost of healthcare, food and other care is very high.

- The closing of the gap between retirement age at 55 and old age pension at 60 ensures the population to continue working and saving for their retirement or old age. More defined contribution schemes should be introduced to cover all sectors of the population through voluntary contributions and participation.
- The management of the funds should be made more transparent, independent and autonomous. In addition, contributors should be informed and given a choice of where they want the agency to invest under a signed *akad* or agreement.

4.2. Future Policy Directions

Although the government of Brunei Darussalam has undertaken measures to enhance the social protection of its people, there are limitations. Existing policies should be regularly reviewed and revised to ensure that implementation meets objectives and targets. Similarly, those governing the family institution should also be reviewed. The family institution should be strengthened and those with extended families should be applauded. Their roles and functions surpass those of other institutions. Concessions and incentives to support this mechanism should be promoted and enhanced. Local social or cultural value system should be enhanced. This is in line with the MIB philosophy of the country.

Financial management is another important tool to ensure that savings for retirement are managed to the fullest extent, and fruits of the harvest shared among contributors. This entails full guarantees by government. Islamic banking and finance could be explored to find the best means of management of such finance.

An independent organization, jointly sponsored by both the government and private sector, should manage a national social protection system to ensure coverage and adequacy with no overlaps. Expertise and guarantee in investment portfolio is a must.

In relation to finance, where will future finance come from? The government has had a diversification policy since the 1980s. The aim of the diversification was to ensure that the economy did not concentrate on the oil and gas sector but also on agriculture, tourism, and manufacturing sectors. Another financing option would be the collection of 2.5% tax of the value of people's property based on the Islamic *Zakat harta* or property taxation. These ideas should be further explored.

Other forms of non-monetary social protection should also be explored in the planning for each person's own future and their next generation. To ensure sustainability of the social protection system, contributions from the individual and his/her family members, could be an option, avoiding over-reliance on the organization where one is employed. A holistic yet integrated approach, bringing the private sector, civil society and the public sector together hand in hand, to meeting Brunei Darussalam's vision 2035 as outlined in the strategies should also be looked into.

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CHAPTER 6

Social Protection in Indonesia: How Far Have We Reached?

MULIADI WIDJAJA
ROBERT A. SIMANJUNTAK
University of Indonesia

The efforts to implement social protection for Indonesian society actually are not new. It has been started since 1969, marked with the issuance of Law no 11/1969 regarding the pension provision for civil servants. However, the implementation of government provision of social protection was limited to the groups of civil servants in the society, for both health and pension. The structure of Indonesian social protection lasts for around thirty years, until the economic crises ruined the life of Indonesian social economy in 1998. In year 2000, some social assistance programs, like rice for the poor, were introduced into the social protection programs to help the Indonesian poor mitigate the dire impact of economic crises. At the time, the social assistance programs were not only intended for the group of civil servants per se but also for the whole groups of Indonesian society, as long as they were in needs.

Further, the intentions of Indonesian central government to protect all groups of Indonesian citizens are stipulated into the Law no 40/2004, called the National Social Protection Law (Sistem Jaminan Sosial Nasional – SJSN), issued at the end of the President Megawati administration. Despite the strengths and the weaknesses of the Law, it has been the most important turning point of the journey of the Indonesian social security. In the progress, however, there are no guidelines set for implementation of the Law. There is also no intention from the central government to amend the Law. Instead, the President SBY administration stipulated another Law No 11/2009 regarding Social Welfare to support the implementation of Law No 40/2004.

Meanwhile, even though the Law 40/2004 has no subsidiary law supporting it, the implementation of the Law has brought about some good progress for the social protection issues in Indonesia, especially for the health issue. Four years after the Law was issued, in 2008, the central government launched the National Health Protection Program (Jaminan Kesehatan Masyarakat), followed by the Local Health Protection Program (Jaminan Kesehatan Daerah) 2 years later. The programs totally cover roughly 87 million people, about one-third of total Indonesian population.

Unfortunately, the progress in health protection issue is not followed by the progress in old-age protection issue. So far, there is no solution offered by the government regarding ways to protect the economic life of aging population in Indonesia, especially those who are not working as civil servants. Therefore, there is still much homework to be done for the Indonesian government in protecting the economic life of aging population, as well as protecting the health of the total population.

1. Introduction

The purpose of this paper is to illustrate the current state of Social Protection in Indonesia. The term "social protection" refers to an integrated system of protective measures against risks, in order for individuals, households and communities to minimize the normal day to day risks that can occur in life, mitigate the impact of economic shock, and to support vulnerable groups within society. Social protection includes several public intervention instruments, such as social insurance, social assistance and social safety nets, with additional space for private and community-based initiatives.

Social protection is broken–down into social security and social assistance. On one hand, social security, which is the main component of social protection, is comprised of the key social insurances, including health and pension insurance, unemployment benefits, work injury insurance and disability grants. The financing for the insurance is mainly taken from contributions from the participants. On the other hand, social assistance comprises of non-contributory measures targeted at vulnerable groups and individuals, such as the poor, elderly, and disabled. The financing for this is mainly taken from taxes.

In Indonesia, the effort to increase support for the poor was aided by the Government's decision in October 2004 to implement Law No. 40 in year 2004. It is the Law pertaining to social protection, also known as Undang-Undang Sistem Jaminan Sosial (SJSN). According to that Law, social protection would include pensions and savings for the elderly, national health insurance, work injury insurance and death benefits for survivors of deceased workers. Law No 40/2004 is an important step in the history of social protection in Indonesia because for the first time, after 59 years of independence, the Indonesian Government stipulates a social security program that covers all Indonesian citizens, including formal and informal sector workers, the unemployed and the poor (Bappenas and GTZ, 2004).

The Law No. 40/2004, stipulated at the end of President Megawati's era in order to give the impression to society that the ruling party at that time cared about the welfare

of Indonesian society, had been drafted by a task force appointed through the Vice-President's Office, based on the Presidential Decree (Keppres) No. 22/2002.

Unfortunately, because President Megawati was replaced by Susilo Bambang Yudoyono (SBY) in 2004, the implementation of Law No. 40/2004 moved forward very slowly. There are no guidelines set for the implementation of the law, which also means there has been no specific action taken. Meanwhile, several cash assistance initiatives for the poor implemented under the SBY cabinet have been implemented on a project basis rather than as permanent programs. There are 3 incidences where cash assistance was granted. Twice, in order to prevent the increase of poverty due to gas increases, and once to win the hearts of the people in order to gain victory in the second term election. There are also other types of social assistance projects, such as rice for the poor (beras untuk rakyat miskin - raskin), and the school operational assistance (Bantuan Operasional Sekolah – BOS). However, those projects are small in terms of volume, uncoordinated in their implementation, and have long lags in implementation times between each other.

Meanwhile, there are 2 programs for social assistance that are held within the first term of SBY's presidency (2004-2009). One is known as the family independency program (Program Keluarga Mandiri-PKM). This program is designed to support a poor family with the goal of helping them to be self-sufficient. It is a long term program with some volunteers involved who also work and live within the family as part of the program. Some cash assistance is also provided from the program. However, since there are not many persons who want to be volunteers, this program falls short of expected goals and targets. The other social assistance program is known as the government budget basis school program. This program is introduced to exempt students of public school from having to pay tuition fees from elementary school to junior high school. Even though the students have been exempted from having to pay tuition fees there are still many other fees stipulated by the school that they have to pay.

Currently, the SJSN program is conducted under the Coordinating Minister of People's Welfare (Menko Kesra), and is the basis for the founding of the National Social Security Council (Dewan Jaminan Sosial Nasional - DJSN). DJSN, founded at the end of the first term of the SBY presidency, includes 11 persons, most of who are health experts. However, the existence of DJSN gives little impact on today's

implementation of Indonesian social protection. Neither DJSN has any clear program or coordination with other pension or health care institutions. Widjaja's interview with one of the members of the DJSN stated that there has not been much progress made by DJSN since the council was founded.

While there are many stories regarding the social assistance projects and programs, this is not the case for Indonesian social security. There is little news regarding the progress of the social security implementation. With such slow progress, the state of the current Indonesian social security system is not much different compared to the state of the Indonesian social security system in the year 2004 when the Law was stipulated.

In terms of pensions, health insurance, and housing, Indonesian social security has never adopted a systematic approach; neither in the conceptualization nor in the implementation. The administration of social security services has remained fractured and incomplete, covering only a relatively small part of the population.

Table 1. The Current Indonesian Social Security Institution

	Pension	**Health**	**Housing**
Armed Forces	ASABRI	ASKES	--
Civil Servant	TASPEN	ASKES	BAPERTARUM
Private Sector Employees	Private Pension institutions	JAMSOSTEK	--

Source: Subianto (2006).

From Table 1, the reader can see that for the members of the Armed Forces, the pension is managed by a state-owned enterprise named PT ASABRI, while their health insurance is managed by a state-owned enterprise named PT ASKES. For civil servants, the pension is managed by a state-owned enterprise named PT TASPEN, while their health insurance is managed by PT ASKES. For civil servants, additional social security in terms of housing provision is managed by a state-owned enterprise named PT BAPERTARUM. However, since housing is not actually a common focus for social protection worldwide, we will refrain from discussing and analyzing PT BAPERTARUM.

Next, the authors of this paper will elaborate on the Indonesian social security institution, starting from PT TASPEN.

2. The Current Indonesia Social Security Institution

2.1. Social Security Institution for Pension Program

2.1.1. PT TASPEN

Perusahaan Negara Dana Tabungan dan Asuransi Pegawai Negri (PN TASPEN) was founded in April 17, 1963, based on Government Regulation (Peraturan Pemerintah) No. 15/1963. In 1970, its status changed from Perusahaan Negara (PN) to Perusahaan Umum (Perum). Twelve years later in 1982, its company status changed again into its current status, Perseroan Terbatas (PT) TASPEN. The changes were stipulated by the Government Regulation No. 25/1981.

According to the Government Regulation No. 25/1981, PT Taspen is a state-owned enterprise whose task is to offer a social insurance program for civil servants. The program consists of a Savings Program for elderly people called The Old Age savings program (Tabungan Hari Tua-THT) and a Civil Servant Pension Program.

a. The Old Age Savings Program

This program consists of Dwiguna Insurance and Life Insurance. On one hand, Dwiguna insurance is a multi-purpose insurance that provides protection during the service period of a civil servant. It provides life insurance when a civil servant dies during service. It also provides retirement benefit when a civil servant is alive at the time of retirement. On the other hand, life insurance programs protect the family of a civil servant. It also protects the civil servant him/herself and any spouses and their children.

Participation in the Old-days savings program is mandatory for civil servants, except those civil servants working at the Armed Forces Ministry (Kementrian Pertahanan), and state-owned enterprise workers. Participation in the program begins as soon as one is accepted as a civil servant and membership terminates when the participant retires, dies, or resigns. The benefits of being a member of the Old-days Savings Program are:

(1) Full insurance benefit is paid to the participants whose service ends because of pension and or death whilst being an active member of the civil servants.

(2) Partial insurance benefit is paid to the participants whose services does not end due to a pension or death.

a.1. The Funding of the Old-days Savings Program

Every civil servant, no matter the gender, level and position pays an amount of 3.25% of their monthly salary into their private savings account. That amount includes the payment for both Dwiguna Insurance and Life Insurance. Meanwhile, their benefit is calculated by using the following formula:

The Benefit formula for Dwiguna Insurance:

a.	Retired	RB = BF* IP* (I + Δ I)
b.	Deceased	DB = BF * (56- Age of Entry)* (I + Δ I)
c.	Quit	QB = BF* (I + Δ I)

Where:

RB = Retirement Benefit; DB = Deceased Benefit; QB = Quitting Benefit

BF = Benefit Factor, 0.60 for retired and deceased civil servant, and 0.55 for retired and deceased Judge, else for Quitting.

IP = Installment Period

I = Monthly salary

Δ I = the automatic salary increase, roughly 17% for every 3 years.

Meanwhile, the benefit formula for Life Insurance is given as such:

The Benefit formula for Life Insurance:

$$TB = BF * (1+ 0.1 * B/12) * (I + \Delta I)$$

Where:

TB = Total Insurance Benefit

BF = Benefit Factor. The value is 2 for participants, 1.5 for the spouse and 0.75 for the children.

B = Monthly Benefit

I = Installment

Δ I = the automatic salary increase, roughly 17% every 3 years.

However, due to the increase in civil servants' salaries, as of January 2007, PT Taspen claimed an unfunded liability which totaled Rp. 1.6 trillion for the Old-days Savings Program. This deficit will increase as the salary of the participants (civil servants) increases automatically every 3 years. Without any support from the government budget, this program will not be able to sustain itself in the future years, as the participants start to retire.

a.2. Participants of the Old-days Savings Program

The participants of the program are shown in Table 2.

Table 2. The Participants of Indonesian Old-days Savings Program as of January 2007

Items	Civil Servant	Judges	Government Officers	Total
1. The number of employees (people)	3,637,876	5,101	1,515	3,644,492
2. The number of spouses (people)	2,463,223	4,016	1,168	2,468,407
3. The number of children (people)	4,285,301	7,649	1,712	4,294,662
4. Average age of employees (years)	42.9	46.3	44.6	
5. Average installment period (years)	17.6	19.5	3.0	

Source: PT TASPEN (2008).

As of January 2007, there are roughly 3.6 million civil servants, 5,101 judges and 1,515 government officers (echelon III to echelon I), who participate in the Old-days Saving Program. This amount actually includes all of the Indonesian civil servants. The following section is an elaboration of the funding adequacy of the program.

b. The Civil Servant Pension Program

The pension program is mandatory for all civil servants. The base Law for the civil servant pension program is Law No 11/1969, as well as Government Regulation No 25/1981. This pension program is actually the only public pension program available in Indonesia. At the time the program was introduced in 1970, it was designed to provide incentives for people to be a civil servant.

b.1. The Funding of the Pension Program

Each civil servant pays 4.5% of their monthly salary to the program. Meanwhile, their benefit is calculated by using the following formula:

The benefit formula for participants:

a. Able-bodied	MB = (2.5% * WP * PS) + Allowance
b. Physical Disability due to a working accident	MB = (75% * PS) + Allowance
c. Physical Disability due to a non- working accident	MB = (2.5% * WP * PS) + Allowance

Source: Subianto (2006).

Where:

MB = Monthly benefit payment

WP = Working Period

PS = Principal Salary

Allowance = wife allowance (10% * PS) + children allowance (2% * PS) + rice

Meanwhile, the benefit formula for the inheritor is as such:

The benefit formula for spouse/ children:

<u>Spouse</u>	
a. Participant with able-bodied	MB = (2.5% * WP * PS) * 36% + Allowance
b. Participant died	MB = (72 % * PS) + Allowance
<u>Children</u>	
c. Parental pension	MB = (20% * 72% * PS) + Allowance

Source: Subianto (2006).

In addition to the benefit mentioned above, the family of a participant will receive a condolence benefit as much as 3 times the last monthly benefit plus a 4 months extension of a participant's monthly pension benefit after the participant died.

Next, are illustrations regarding the amount of retired civil servants and the amount of pension benefit they received. They are illustrated in Table 3 and Table 4.

Table 3. The Projected Amount of Retired Groups of the Indonesian Civil Servant Pension Program

Retired Civil Servant Groups	Year 2008 (people)	2009 (people)	2010 (people)	2011 (people)	2012 (people)
Central Government	1,035,229	1,043,635	1,054,830	1,055,141	1,049,246
Local Government	605,349	630,559	680,703	728,329	775,323
Judges	2,780	2,874	2,998	3,039	3,064
Government Officers	5,935	6,312	6,574	6,314	6,027
Armed Forces	268,750	263,380	251,330	236,788	221,210
Veteran	166,601	158,710	143,348	128,725	114,930
Police Force	1,434	1,359	1,216	1,085	966
State-owned Pawnshop	1,127	1,117	1,091	1,052	1,007
Total	**2,087,206**	**2,107,946**	**2,142,090**	**2,160,474**	**2,171,773**

Source: PT TASPEN. (2008)

In Table 3, the reader may see that the retired amount of civil servants keeps increasing from year to year. The largest group is the central government retired civil servants. The second largest group is the local government retired civil servants. The third is the retired armed-forces group. Due to the decentralization program held in Indonesia, the number of local government civil servants is increasing, which will cause the number of its government retirees to rise in the future. As a result, the total number of civil servants who are retired is expected to increase in the future, due to the increase of local government retired civil servants. The increase in the number of central government and armed-forces retirees outweighs the decrease.

Table 4. The Projected Pension Benefit Received by Retired Groups of the Indonesian Civil Servant Pension Program

Retired Civil Servant Groups	Year 2008 (Rp Billion)	2009 (Rp Billion)	2010 (Rp Billion)	2011 (Rp Billion)	2012 (Rp Billion)
Central Government	16,759.3	19,059.3	21,609.9	24,189.9	26,856.2
Local Government	10,735.7	12,667.5	15,531.9	18,801.9	22,553.1
Judges	102.2	118.3	136.9	153.4	170.8
Government Officers	145.4	177.5	211.5	224.7	237.1
Armed Forces	3,621.7	3,983.4	4,194.2	4,343.9	4,452.6
Veteran	1,527,2	1,631.3	1,616.9	1,593.8	1,562.2
Police Force	19.8	20.9	20.6	20.1	19.6
State-owned Pawnshop	16.4	18.2	19.6	20.8	21.8
Total	**32,927.6**	**37,676.5**	**43,341.6**	**49,348.7**	**55,873.6**

Source: PT TASPEN (2008).

b.2. Participants of the Pension Program

The participants of the program are shown in Table 5. As it is assumed that there is an increase in salary for each group of civil servants, the expected pension benefit will increase sharply, even though the expected number of civil servants increases slowly. From the calculation, the reader may see that within 5 years, from 2008-2012, the total expected amount of paid pension benefits will increase by roughly 50%. This increase will put pressure on the central government budget, as the burden to pay the pension benefits falls on the central government. If the system is not reformed, it is expected that the payment system of pension benefit will fail sometime in the future.

b.3. The Adequacy of Civil Servant's Pension

Widjaja's interview with a civil servant retiree and several current civil servants concludes that the actual replacement rate of monthly pensions paid is 70% to 80% of the principal salary. For information, the salary of a civil servant in Indonesia has a

principal component and several allowance components. To some extent, the amount of the allowance component may be much higher than the amount of the principal.

The pension amount increases, and is adjusted to the salary increase. Let us take an example from a female pensioner. When she retired a few years ago from her position as a civil servant, her monthly principal salary by the time she retired was Rp1,000,000 and the amount of monthly pension she received was Rp800,000. In addition to that, she also received a certain lump sum amount from the old-days savings program, paid only once when she retired. Currently, after 20 years of retirement, she receives Rp1,800,000 as her monthly pension. That amount is comparable to 75% of the monthly principal salary of a current active civil servant at the same level when she retired.

This wage-adjusted increase of the pension amount, even though it seems good, it actually does not compete with the increase in the rate of inflation. The average annual inflation rate in Indonesia is 10% under normal economic conditions. Therefore, the real amount of the pension actually decreases, because the monthly principal salary of civil servants is raised by the government once every three years by 17%. The purchasing power of the pension amount of a civil servant retiree actually decreases.

b.4. Governance and Management of PT Taspen

PT Taspen is known to be a state-owned enterprise that has good governance and good management. It has 6 branch offices located in 6 different big cities: Jakarta, Medan, Bandung, Surabaya, Semarang, and Makassar. On its website, PT Taspen announced its annual financial report, cash flow and balance sheet; as part of corporate transparency. Its financial performance is audited by a public auditor. In the last 2 years of available reports, they claimed they had made a handsome profit in year 2007 as much as Rp147,4 billion and in year 2008 Rp385,9 billion.

2.1.2. PT ASABRI

Initially, the pension of armed forces, the police department and the civil servants of armed forces and of the police department was managed by PT Taspen, starting in 1963. However, because there is a necessity for the armed forces to have its own pension program, Perum (Perusahaan Umum – Public Enterprise) ASABRI was founded in

August 1, 1971, based on Government Regulation No 45 year 1971. In 1991, based on Government Regulation No 68 year 1991, the corporate status of Perum Asabri was changed into PT (Perseroan Terbatas - Public Limited Company).

a. Funding and Benefit of PT Asabri

The membership of PT Asabri is mandatory and automatic as one becomes a member of the armed forces. Similar to the insurance fee of PT Taspen, every member of PT Asabri also pays 8% of their monthly salary for the insurance payment. The benefits for members of PT Asabri are: death allowance,benefits for the insured, spouse and children, and disability allowance benefits for the insured.

b. Governance and Management of PT Asabri

As a state-owned enterprise, PT Asabri has its own captive market in managing the social insurance of the armed forces. Therefore, it has no incentive to improve its own internal management and governance. On its website, people can see that its official financial report is not updated. The latest financial report is the one from the year 2005. In addition, there is no official information regarding exactly how many members of armed forces has become a PT Asabri member. One source of information tells that there are roughly 2 million people that have a become PT Asabri member. There is no information regarding how much benefit payment has been made. Currently, PT Asabri has its own headquarters in Jakarta, with 11 branches in 11 big cities in Indonesia.

2.2. Social Security Institution for Health Program

2.2.1. PT ASKES

The Social Health Insurance Program is the initial task of PT.Askes (Persero), based upon Government Regulation No. 69 year 1991. Membership of PT Askes is mandatory. Members include; Civil servants, government officers, retired civil servants, retired armed forces and retired police officers, retired government officers, and veterans, as well as honorarium civil servants.

a. Governance and Management of PT Askes

As a state-owned enterprise, PT Askes has its own captive market in managing the social insurance of civil servants and the armed forces. Therefore, it has no incentive to improve its own internal management and governance. There are no official financial reports available on its website, which means that there is very little transparency.

b. The Funding and Benefits

The insurance fee paid by members equates to 2% of their monthly salary. Benefits can be received not only by the insured person but also by members of the insured's family, including spouse and two children. There is no additional payment needed for visits to doctors and for any medicine prescribed. However,this only includes visits to state-owned hospitals that provide services for Askes card holders. The type of hospital offering services for Askes card holders is actually rare and there is only one in each municipality that is available from PT Astek. In addition, there is no official information regarding exactly how many civil servants and armed forces members have become PT Astek members. Also, there is no information regarding how much benefit payment has been made. Similar to PT Asabri, PT Askes has its own headquarters in Jakarta, with 11 branches in 11 big cities in Indonesia.

c. Social Protection under SJSN

The issuance of Law No 40 year 2004 actually has extended the coverage of social protection, especially health protection, from the workers in the formal sector to those in the informal sector. The proposed framework as stipulated in Law No. 40 year 2004 consists of the following:

1. Five mandatory programs, namely work-accident protection, life insurance, provident fund, pension, and health maintenance programs.
2. Coverage for the entire work force-, including the gradual inclusion of informal workers.
3. Pre-funding for all programs.
4. A tripartite board to assist the President in formulating policies for a national social security system.
5. Several state companies to run the program.

Currently, out of the pension program and the health program, only the health maintenance program is on going under the ones originally intended by the SJSN Law. The pension program still needs some time before it will become fully functional, due to lack of taxes infrastructure and funding. The health protection program under SJSN is the one called Jaminan Kesehatan Masyarakat (Jamkesmas – The Social Health Protection). The following section is an elaboration of Jamkesmas, including the legal basis for its implementation, and its achievements.

The Experiences of Askes Card Holders

Widjaja's interview with 3 Askes participants revealed some interesting phenomena. The interviewed revealed that there are actually 4 classes of services for Askes card holders: Platinum, Gold, Silver and Regular. Platinum is the highest class, usually provided for high level government officers or members of parliament. Among the 3 participants, one is a platinum card holder, while two are regular card holders.

The platinum card holder had no complaints at all with the service. The platinum card holder attended either a high class private hospital or public hospital for services and medicine. However, that is not the case for the regular card holders. The regular Askes card holders stated that neither the service they received from the doctor nor the prescription was satisfactory. They even felt that the hospital administration service for Askes card holders was annoying. PT Askes participants felt that they received a lower quality of service from the doctor; compared to other patients who paid by themselves for medical services. The doctor gave a generic medicine prescription that could only be redeemed at a certain pharmacy, located far away from the hospital. While the platinum card holder and a regular card holder stated that they felt healthier after taking the prescribed medicine, the other regular card holder stated that after taking the prescribed medicine, instead of getting better, he was getting more ill. Finally, he went once again to a hospital - but a different one this time- paid the regular service price, and received good treatment and medicine, and felt better.

The Jamkesmas progam is implemented under the Ministry of Health, through PT Askes. The initial name of the program is Asuransi Kesehatan Masyarakat Miskin (Askeskin – The Health Protection for the Poor). Based on the Decree of the Ministry

of Health No. 1241 year 2004, the purpose of Askeskin is to provide health services for the poor, which is actually alarge part of Indonesian society. The name ‘Askeskin’ was changed to 'Jamkesmas' in 2008, although it is still under the management of PT Askes.

The target group of the Jamkesmas program is the poor, as many as 19.1 million families, or roughly 76.4 million people, assuming that one household has 4 family members. That amount is gathered by the Badan Pusat Statistik (BPS - Cental Board of Statistics) in the year 2006 population census. However, the number of protected people achieved is slightly below the target, roughly 71.5 million people (Table 7).

Meanwhile, the participation of Jamkesmas is based on a quota set by the Minister of Health. For the poor who have identity papers, the names of participants are registered by regents and mayors. For the poor without identity papers, such as the homeless and pan handlers, the participation is registered by the Head of Social Services of each regency and city. Based on the 2 registration systems, PT Askes distributed Jamkesmas participation cards. The following table shows the performance of the Jamkesmas program in the year 2008.

Table 5. The Performance of Jamkesmas Program Year 2008

No	Items	Target Amount	Achievement	Percentage of Target
1	Decree of Regents/Mayors	471	465	98.7
2	Participants (people)	73,770,631	71,563,453	97.0
3	Card Distribution			
	- Regency / City	471	465	98.7
	- Card Issued	71,585,469	71,585,469	94.1
	- Card Received by participants	71,585,469	71,563,453	94.1
4	Hospitals in Charge	855	--	--
5	Service Utilization			
	a. Out-hospital Treatment	--	2.685.502	--
	b. In-hospital Treatment (non ICU)	--	951.471	--
	c. Intensive Care Unit	--	415.985	--

Source: PT Askes (2010).

Readers may see from Table 7 that the Jamkesmas program, by 2008, had already reached 465 regencies and cities, and had already distributed participation cards to more than 71 million people. There are 855 hospitals in charge of supporting the program. Meanwhile, in 2008, there were more than 2.6 million out-patient hospital visits, more than 950 thousand in-patient hospital visits, and more than 400 thousand Intensive Care Unit (ICU) admissions. It can be concluded that this program has been helping many of the poor people to get health and medical assistance, with the support of the central government budget.

Still remaining from Table 7, one phenomenon is the difference between the target amount of people and the amount of cards distributed. It may be concluded that the program does not reach its targeted amount of people due to a lack of the number of cards issued. The authors' impression from that phenomenon is that the program still lacks coordination between planning and the actual implementation. On other occasions, still connected to the card distribution issue, there are reports that the card distribution is not well planned. Some people who deserve to receive the card do not get it, some people who do not deserve the card end up receiving it. In other cases, poor people with the card still had to pay the hospital for the services they received (Kompas, 2010a).

In addition to the Jamkesmas Program, there is also another program named Jaminan Kesehatan Daerah (Jamkesda – Local Social Health Protection). The amount of Jamkesda participants reached almost 11 million people. This program is similar to Jamkesmas, with the local government providing the funding. However, it should be noted that currently, there are still many people who do not have health protection. The total population of Indonesia is 230 million people, while only about half of the population has health protection, either self-supported or state-supported. The current state of health protection is illustrated in Table 8.

Table 6. The State of Health Protection in Indonesia Year 2009

Health Program	The Amount of Participants (million people)
1. Jaminan Kesehatan Masyarakat	76.4
2. Jaminan Kesehatan Daerah	10.8
3. Social Health Insurance for Civil Servant (Askes)	14.9
4. Jamsostek for private employee	3.9
5. Asabri Health insurance for Armed Forces and Policeman	2.0
6. Private Commercial Insurance	8.8
Total	116.8

Source: Kompas Daily (2010b).

2.2.2. PT. JAMSOSTEK

Jaminan Sosial Tenaga Kerja (Jamsostek – Labor Social Insurance) was founded in 1992, based on Law No 3 year 1992. Jamsostek is a state-owned enterprise whose task is to provide employment accident insurance, provident fund, death insurance and health care insurance. A worker can only be a member of PT Jamsostek if one works in a formal labor market. However, unlike the membership at PT Taspen, one should not be a civil servant.

The definition of Jamsostek's schemes according to the Law No. 3 Year 1992 is as follows:

a. The Jamsostek schemes

a.1. Employment Accident Program provides employers with a reimbursement of medical costs and transportation expenses from the place of accident to the hospital. An employee suffering from a work related accident or disease or dead are eligible for benefits. Temporary disability benefits which are available for employees include 100% of earnings for the first 4 months, 75% of earnings for the second 4 months, and 50% of earnings thereafter.

a.2. Provident Fund Program is a compulsory savings scheme payable to employees who have reached the age of 55 or have suffered total permanent disability. The benefit can be withdrawn by the members when they are unemployed after having been a member of the program for no less than 5 years and 6 months. The promised rate of accrued interest is fixed at 10%.

a.3. Death Benefit Program is contributed by employers at 0.3% of wages and provides a cash payment to the heirs of an employee who died before age 55. Benefits provided are death allowance, funeral allowance and 24 months living allowance for the remaining family.

a.4. Health Care Program provides covered employees with medical services and treatment for out-patient, in-patient, maternity, drugs, delivery and other medical services to the members and their families who fall sick.

Programs (a) to (d) are initial programs held since the founding of Jamsostek. Later on, in order to provide coverage for informal workers, Jamsostek adds two additional programs (e) and (f).

a.5. Non-Contracted Workers Program provides programs (a) to (d) for self-employed and informal workers. The program is based on Government Regulation No 14/1993.

Table 7. Jamsostek Contribution Fee

Program	**Production Sector**	**Contribution of Workers With Working Contract Scheme (as % of salary)**		**Contribution of Workers beyond Working Contract Scheme (as % of salary)**
		Employer	**Employee**	**Worker**
1. Employment Accident	Services Sector	0.24	--	1.00
	Agriculture and Manufacturing	0.54	--	1.00
	General Contractor and Trading	0.89	--	1.00
	Ship-building and Storage	1.27	--	1.00
	Mining and Explosive	1.74	--	1.00
2. Provident Fund		3.7	2.00	2.00 (minimal)
3. Death Benefit		0.30	--	0.30
4. Health Benefit		3.00 (single) 6.00 (couple)	-- --	3.00 (single) 6.00 (couple)

Source: PT Jamsostek and Purwoko (1998)

a.6. Construction Services Working Program provides social insurance for construction workers, either paid by a daily scheme or in a lump-sum. The scheme is based on the Regulation of the Labor Force Ministry No. 196 year 1999. The workers can be involved in both private and public construction projects.

Table 8. Laborers Participation of Jamsostek Program (people) Year 2006 - 2008

	2008	2007	2006
Employment Accident program, Provident Fund, and Death Benefit	26.300.000	23.729.950	23.081.367
Construction Services Working Program	3.632.072	3.332.959	2.681.635
Health Care Program	1.800.000	1.621.175	1.412.352
Total	31. 732.032	28.684.084	27.175.354

Source: PT Jamsostek.(2010)

b. Governance and Management of PT Jamsostek

Similar to PT Taspen, PT Jamsostek is also known as a state-owned enterprise that has good governance and good management. It has 6 branches of offices located in 6 different large cities: Jakarta, Medan, Bandung, Surabaya, Semarang, and Makassar. PT Jamsostek announced its annual financial report on its website which included cash flow and a balance sheet; as part of corporate transparency. Its financial performance is audited by a public auditor. For the last 2 years of available reports, they claimed they had made an after-tax profit in the year 2007 as much as Rp679,0 billion and in the year 2008 Rp930,1 billion.

PT Jamsostek is able to manage its own assets in order to pay insurance liabilities. Their revenues are taken from insurance fees, corporate subsidiary revenues, net investment profits and provident fund investment revenues.

3. Bridging the Gap between Reality and Expectation

An observation of the current state of social security in Indonesia for both pension and health protection after the stipulation of Law No 40 year 2004 shows that there has been some progress as well as some drawbacks. On one hand, the progress is that the

amount of people covered by health protection has increased. On the other hand, the drawbacks are: low coverage, program fragmentation and an uncovered informal sector. Since the authors of this paper have already discussed the progress of health protection, we will discuss only the parts of the system that need improvement.

The first issue is low coverage. In terms of the pension program, there has been improvement after the stipulation of the SJSN Law (Law No 40 year 2004). This means that only roughly 20 million workers in Indonesia out of a total of 110 million people of the labor force are covered by the Taspen, Asabri and Jamsostek schemes. The ratio is still low, about 18% of the total working force. In terms of health protection, with 116.8 million people currently covered, this still leaves another 114 million people left without health protection. The ratio of people out of the total population who have health protection is around 50% and that is already a good progress. This is a multiple increase compare to the situation in 2005 when ADB (2007) reported that only 16 % of the total population is protected by the social health protection. However, there is still a great need to protect the health of the rest of the population.

The second issue is the fragmentation of the program. One good argument for reform is to build an integrated pension system, as well as an integrated health system. Currently, there are 3 public pension institutions with three fragmented program; as well as are 3 public health institutions with 5 programs. There are benefits of having a coherent system of social protection. The first is an efficient allocation of administrative resources, both personnel and funding. The second is the ability to enhance coordination among programs targeting the poor. The existing National Social Security Council (DJSN) fails to do these necessary tasks.

The third issue is the protection of the informal sector. The existing Non-Contracted workers protection program held by PT. Jamsostek failed to get membership from informal sector workers. Widjaja (2008) and Bappenas and GTZ (2008) have asserted that the amount of workers in the informal production sectors is increasing relative to the total workers in Indonesia. Angelini and Hirose (2004), in their report to the International Labour Organization, stated that the main obstacle of the protection for the informal sector workers is the very low and unsustained income of workers.

There are roughly 70% labor workers in the informal sector, most of them are unskilled. A large portion of this group, approximately 45%, works in the rural

agricultural sector. The rest are distributed within the service production sectors. Therefore, a failure to protect the informal sector workers is actually a failure to protect the largest section of Indonesian workers loss of income due to death or accidents at work.

4. Current Fiscal Development and Social Protection

4.1. Fiscal Stimulus

In order to mitigate the impact of the global economic crises on the Indonesian economy, in 2009 the Indonesian central government issued a fiscal stimulus package. Unfortunately, no provision was made within the fiscal stimulus program to support the implementation of social protection, for both social protection and social assistance. Included in the fiscal stimulus program are: individual income tax savings; import tax subsidies; subsidy to households and industries; and increased spending on infrastructure.

4.2. Fiscal Decentralization

Starting in the year 2008, one can see that there is a link between fiscal decentralization and social protection issues. In addition to the health protection program that is held at the national level, additional program has been held at the municipality level, with 10.8 million people protected under the local government funding. However, it is not clear why the amount of people protected under the local government budget is only 10.8 million people, compared to 76.4 million protected under the central government budget. Also, it is not clear how the central government and the locals share the burden of health protection among them. In addition, it is not clear how the local governments will manage to sustain their participation in the long run.

4.3. Fiscal Space

Fiscal Space is defined as non compulsory expenditures that the government may spend from the total budget after compulsory expenditures, without causing fiscal insolvency. Included in compulsory expenditures are civil servants' salaries, debt services, subsidy and fiscal decentralization (Ministry of Finance, 2010). According to the official statement, in the year 2008, the fiscal space of the central government budget reached 4.38% of the total budget. In year 2009 it is expected to reach 5.39%, while in year 2010 it is expected to reach 4.66%. Therefore, the average fiscal space is between 4% to 5% annually.

In Table 9, the composition of central government budget spending is listed. The largest spending is on general services, while the second largest is on the economy. In Table 9, consists in the Social Protection programs expenditures are actually spending items no. 7 (Health) and spending items no. 11 (Social Protection). Added together, annual spending for both Health and Social Protection is 3.7% in 2007, 2.9% in 2008 and 3.0% in 2009. This means, given that the annual fiscal space is higher than the annual spending on health and social protection added together, then the central government is still able to increase spending on both health and social protection, up to 100% of the current amount, without having problems with fiscal solvency. For example, if the spending for the 2 items increases by 3% of the total annual budget, given the fiscal space is 5% of the total annual budget, the budget still has fiscal space as much as 2% of the total annual budget.

Table 9. Indonesia: The Composition of Actual Central Government Budget Spending In Percent

No	Central Government Spending Items	Year		
		2007	2008	2009
1	General Services	62.7	76.7	67.7
2	Defense	6.1	1.3	1.7
3	Security and Order	5.6	1.0	2.0
4	Economy	8.4	7.2	9.3
5	Environment	1.0	0.8	1.0
6	Housing and Public Facility	1.8	1.8	2.5
7	Health	3.2	2.5	2.5
8	Culture and Tourism	0.4	0.2	0.2
9	Religion	0.4	0.1	0.1
10	Education	10.1	7.9	12.5
11	Social Protection	0.5	0.4	0.5
	Total	100.0	100.0	100.0

Source: Author's calculation; based on official figures.

5. Final Remarks

Social protection in Indonesia may be classified between the situation before the stipulation of SJSN Law no 40 year 2004 and after the stipulation. It may be concluded that the existence of Law No. 40 year 2004 has great influence on the map of social protection in Indonesia. Major progress has been made within health protection, where the Jamkesmas program covers more than 70 million people. However, in the area of death insurance and disability insurance in the working place, the situation after the SJSN Law remains much the same compared to the situation before. The same thing happened with social protection for pensions and the elderly. There has not been much progress on how the income of the elderly is protected. Only civil servants and the members of the armed forces and police officers are protected, as well as the wealthy population who can pay for the protection for themselves.

Meanwhile, even though Law No 40 year 2004 itself is very utopian, there has been little effort from the current parliament with regards to amending the law or adding any

implementation regulations below that Law. What we mean by utopian is that the Law has a strong purpose to provide social protection for all of the Indonesian population but does not consider how the central government will gather the source of funds to do so (Arifianto 2004). Meanwhile, parliament has issued Law no 11 year 2009 regarding Social Welfare even though the content of Law No 11 year 2009 has no relationship with Law no 40 year 2004. In theory the implementation of Law No 11 year 2009 seems to support the existing Law No 40 year 2004.

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CHAPTER 7

Social Protection in Malaysia - Current State and Challenges

Towards Practical and Sustainable Social Protection in East Asia: A Compassionate Community

PROFESSOR DR. ONG FON SIM
Universiti Tun Abdul Razak

DR. TENGKU AIZAN HAMID
Associate Professor - Universiti Putra Malaysia

1. Introduction

The past economic success of Malaysia has fallen into the middle-income trap. The pressure is for Malaysia to move upwards to become a high income country by 2020. Coupled with this pressure is the global economic recession. Like many other countries, Malaysia has introduced/ implemented stimulus packages to ride out the crisis. However, the impact of the present crisis may still be felt long after the recovery in that such measures may constrain future fiscal flexibility, since the resulting future budgets will need to be financed (Asher, 2009). The Malaysian government has recently announced a deficit at 5.6 per cent of GDP for its 2010 Budget, compared with 7.4 per cent in 2009. The budget deficit has multiple objectives; but stimulating the economy remains the most immediate and urgent task whilst providing and facilitating savings for consumption smoothing are also given due attention. The need for social protection is congruent with national and societal development because the experiences of countries successful in economic, political and social terms has shown that economic development and social protection are mutually reinforcing (Garcia and Gruat, 2003). More so, the strategies for closing the coverage gap in social protection should be regarded as one of the strategies to move Malaysia towards a high income country.

With population aging, countries around the world are re-examining their systems of social protection, with many already putting reforms in place. According to Asher and Nandy (2006), globalization has made safety nets even more essential for three reasons: (1) cushioning the burden of restructuring; (2) increasing legitimacy of reforms; and (3) enabling risk taking by individuals and firms by providing a floor level income in the event that risk taking ventures fail to materialise. More importantly, an improved coverage will foster social cohesion and sustainable economic development.

1.1. Overview of Demographic Profile

Malaysia is a multi-ethnic country with a population of 27.7 million in 2008 (Department of Statistics, 2009), made up of three major ethnic groups - the Malays, Chinese and Indians. Malaysia is classified as a medium income country with PPP per capita GDP of USD 14,081 in 2008 (IMF, 2009). Although Malaysia is not currently an aged society, the proportion of the older population (defined as 60 years or older) is

forecast to reach 9.9% by 2020. According to Kinsella and Wan (2009, p. 13), Malaysia's aged population will increase by 269% between 2008 and 2040, ranking it the fourth fastest aging nation after Singapore, Colombia and India respectively.

Malaysia still has time since the older population aged 60 years and over will only outnumber the younger population aged 15 years old and below by 2045. However, this could be seen as added pressure on the government to provide jobs for the large number of young adults entering the labour market and at the same time, providing some form of protection for the elderly. This is all occurring at a time when Malaysia is striving to move the country out of the middle income trap to become a high income country by year 2020, the year that one out of ten Malaysians will be an older person.

According to the Malaysian 2000 census, 6.2 per cent, or 1.4 million of its 23.3 million people, were aged 60 or over and this figure is projected to be 6.7% (or 1.9285 million) by 2010 (Table 1). The total fertility rate has been decreasing from 4.9 in 1970 to 2.4 in 2005. The age structure for the past four censuses (1970, 1980, 1991 and 2000), shows that the proportion of younger age groups (15 years and below) has been decreasing, while the proportion of older persons has been rising. In addition, the sex ratio of persons aged 60+ shows that the feminization of aging will put further pressure on Malaysia as women suffer from a disadvantaged financial position which raises great doubts about their ability to provide for old age. As the present retirement age is only 55 and 58 for private and public sectors, respectively, the impact of demographic aging is likely to be felt even earlier than the official age of 60, with ramifications for financial preparedness and social protection, demand for health care, community care, long-term care and other related services. There is great uncertainty about what ages people will reach and therefore the resources needed for old age protection will have to be actuarially determined. Associated with this uncertainty are the major issues of (1) feminization of aging, women are living longer and they tend to have lower income and are less exposed to the formal labor market; and (2) health expenditure will rise with age and hence the implications on health financing.

Table 1. Older Persons in Malaysia, 1947 – 2020

Year	Older Population (60+)			Growth Rate Percent Change (per annum)	
	Number (n) in Thousands ('000)	Percent (%)	Sex Ratio (men per 100 older women)	Older Population	Total Population
1947	243.8	5.0	120.0	-	-
1957	288.0	4.6	113.2	1.8	2.9
1970	546.0	5.2	109.0	6.9	5.1
1980	745.2	5.7	97.6	3.6	2.6
1991	1068.5	5.8	89.7	3.9	3.6
2000	1451.7	6.2	91.4	4.0	3.0
2010	1928.5	6.7	96.2	3.3	2.3
2020	3116.7	8.9	95.5	6.2	2.0

Source: Department of Statistics, Malaysia, 2006; 2007.

The life expectancy of Malaysians has improved over the years. In 2005, the life expectancy at birth was 71.4 for males and 76.2 for females while life expectancy at 60 was 17.2 and 19.6 for males and females respectively. The two major characteristics of population aging in Malaysia are the feminization of aging and the rapid rise in the number of the old-old and the oldest-old. This begs the question of what ages will people reach? Moreover, each cohort of older Malaysians is varied in terms of live experiences, expectations and life styles, contributing to the heterogeneity of the aged population in terms of demographic as well as social characteristics which present different needs and demands.

1.2. Labor Force Participation and Employment

Economic participation among the elderly is one way to ensure financial security in old age. Tables 2 and 3 show the labor force participation by age and sex. A drop in labor force participation can be seen for 2008 compared to 2000 among the age groups of 15-19 years and 20-24 years. This reveals a growing late entry into the labor force due to education opportunities as more and more Malaysians gain access to tertiary education. Among the age groups 55-59 and 60-64, the labor force participation rate has also been dropping steadily, with the year 2000 registering a higher participation rate than 2008. In 1975, the labor force participation rate was 60.3% among those aged between 55 to 59 years and it dropped to 49.6% in 2005 after three decades. A sharper drop occurred for the 60 - 64 age group in which the participation rate fell from 50.9%

in 1975 to 37.2% in 2005 and 36.7% in 2008. Since continuing to work is a good way to secure financial sustenance, the drop in labor force participation for these two age groups is disturbing. It could mean that more of the labor force is now in the formal sector for which retirement occurs in the late 50s. In terms of labor force participation for females, the rate remained rather consistent throughout the years with around 44% to 47%. For the men, the rate shows a slight decline from 65.4% in 2000 to 62.6% in 2008.

Table 2. Labor Force Participation Rates by Age Group, 1975 - 2008

Age Group	Labor Force Participation Rates (LFPR) by Age Group and Year							
	1975	1980	1985	1990	1995	2000	2005	2008
15-19	47.0	41.9	36.1	40.7	32.5	27.2	20.6	18.4
20-24	75.1	73.8	74.4	76.9	75.4	73.7	66.8	64.9
25-29	72.1	71.5	72.8	75.3	75.5	79.7	80.6	80.6
30-34	73.3	71.7	72.4	73.8	73.8	77.0	78.0	78.5
35-39	75.8	73.5	73.9	73.5	74.3	75.5	75.8	76.3
40-44	75.0	74.7	74.9	74.6	73.3	75.6	75.1	75.2
45-49	75.2	73.3	73.7	74.4	72.0	74.2	73.6	72.8
50-54	71.0	69.4	66.2	68.6	65.8	67.7	67.0	67.2
55-59	60.3	57.1	54.3	52.4	50.7	52.2	49.6	47.7
60-64	50.9	48.6	44.6	44.4	41.0	42.2	37.2	36.7
Total	**66.7**	**65.0**	**64.5**	**66.5**	**64.7**	**65.5**	**63.3**	**62.6**

Source: Department of Statistics Malaysia, 1978; 1983; 1988; 1991; 1996; 2001; 2005; 2009.

Table 3. Principal Statistics of Labor Force by Sex, 1985 - 2008

Year	LFPR (%)			Labor Force ('000)		
	Total	Male	Female	Total	Male	Female
1985	65.7	85.6	45.9	5,990.1	3,896.7	2,093.5
1990	66.5	85.3	47.8	7,000.2	4,489.8	2,510.3
1995	64.7	84.3	44.7	7,893.1	5,203.1	2,690.0
2000	65.4	83.0	47.2	9,556.1	6,156.2	3,399.9
2005	63.3	80.0	45.9	10,413.4	6,700.9	3,712.5
2008	62.6	79.0	45.7	11,028.1	7,074.6	3,953.5

Source: Department of Statistics Malaysia, 2009.
Note: Labor Force (15 - 64 years) who are either employed (employer, employee, own-account worker or unpaid family worker) or unemployed (active or inactive).

Projecting the population size into the next decade, by 2020 the number of economically active persons (between 15-64 years) will grow to 21.6 million compared to the present 18.4 million. Malaysia therefore needs to generate this number of jobs or

livelihoods. According to Ragayah et al. (2002), the estimated working population not covered by any formal retirement scheme was about 30% or 2.88 million persons in 2000. Based on this estimate, we would not expect many changes to occur in terms of coverage of social protection within the next ten years unless Malaysia embarks on drastic changes, leading to the transformation of the Malaysian economy and implements social protection reforms.

1.3. Health and Health Care Financing in Malaysia

Based on the epidemiology pattern of Malaysians, the common types of illnesses are non-communicable diseases such as diabetes and hypertension, overweight and obesity problems, and an increasing number of all types of injuries (home, workplace and road traffic). The alarming increase in the incidence of non-communicable diseases reflected problems associated with changing lifestyles. There is also evidence of improved health seeking behavior, which refers to Malaysians' awareness of and access to health care (Table 4).

Table 4. Estimated National Prevalence of Health Problems/ Diseases in NHMS*-II and NHMS-III, 1996 & 2006

No.	Health Problems / Diseases	NHMS-II (1996)		NHMS-III (2006)	
		Prevalence	95% CI	Prevalence	95% CI
1.	Overall Diabetes Mellitus (>30 yrs)	8.3	7.8 - 8.7	14.9	14.4 - 15.5
2.	Hypertension (>30 yrs)	29.9	29.1 - 30.7	42.6	41.8 - 43.3
3.	Hypercholesterolemia	n/a	n/a	20.6	20.1 - 21.3
4. a)	Underweight (Adult)	25.2	24.5 - 25.7	8.5	8.2 - 8.9
b)	Overweight (Adult)	16.6	16.1 - 17.1	29.1	28.6 - 29.7
c)	Obesity (Adult)	4.4	4.1 - 4.7	14.0	13.6 - 14.5
5.	Asthma (Adult)	4.1	3.8 - 4.4	4.5	4.3 - 4.8
6.	Smoking (Adult) - Current	24.8	24.1 - 25.4	22.8	22.3 - 23.3
7.	Alcohol Consumption (>13 yrs) - Current	n/a	n/a	7.4	6.9 - 8.0
8.	Home Injury	2.5	2.3 - 2.7	6.5	6.2 - 6.8
9.	Road Traffic Injury	2.5	2.3 - 2.7	4.4	4.2 - 4.6
10.	Workplace Injury	3.0	2.7 - 3.3	4.8	4.5 - 5.1
11.	Recent Illness / Injury	29.5	28.8 - 30.3	23.6	22.9 - 24.3
12.	Health Seeking Behaviour for Recent Illness (<14 days)	42.5	41.4 - 43.6	58.1	57.1 - 59.1
13.	Hospitalization	7.2	7.0 - 7.5	5.0	4.8 - 5.2

Source: Institute for Public Health, NIH, MOH, 2008.
Note: * National Health and Morbidity Survey.

1.3.1. Financing for Health Care

In Malaysia, studies such as the National Health and Morbidity Surveys (NHMS, Ministry of Health), Household Expenditures Surveys (Department of Statistics Malaysia) and the National Household Health Expenditures Survey (University of Malaya) have been used to estimate national spending on health care. Multiple factors have led to escalating health care costs, which are usually financed through "general taxes, compulsory contributions to social security (public and/or private), voluntary contributions to private formal or informal insurance schemes and direct out-of-pocket payments" (Institute for Public Health, 2008, p.66). To date, allocations from the government have been a feature in annual government budgets and form an important source of health care funding. The government has been spending around 7% of general government expenditure on health care since 2004. While many countries in the region such as Thailand, Japan and Cambodia have instituted a national health insurance scheme, Malaysia has yet to introduce such a scheme, although the intention to do so was expressed in the Eighth Malaysia Plan (2001-2005).

The main challenge with respect to the national health insurance scheme lies with the pricing aspect. Again, linking health care and aging, it is clear that there is a positive correlation between the cost of health care and age, with rising age needing more care. Continuing to fund health care from the federal budget will put a strain on the government since more Malaysians are becoming aware of available health facilities and their rights to obtain proper care. This is occurring alongside an increase in out of pocket expenses by individuals. Based on past studies, the estimates for out-of-pocket (OOP) health expenditure were somewhere between RM2.8 billion to RM3.82 billion in 1996, while the Malaysia National Health Accounts reported figures as high as RM14 billion in 2002, with a per capita spending on health of RM555 (IPH, 2008, p. 69). The lower income groups are not burdened by high health care cost since they tend to seek care services from government clinics and hospitals. The NHMS-III survey shows that the higher the income group, the more they spend on OOP health expenditure, in which about 87% of the amount goes to private facilities. Public health care facilities are so cheap that it was estimated medical charges amounted to only about 2% of the operating budget for government hospitals and clinics (IPH, 2008, p. 89). Besides the government and individual spending, multinationals and large local corporations also provide

coverage for medical care in the form of reimbursement for out-of-pocket expenses and health insurance for hospitalization benefits as well as health promotion pur poses.

1.3.2. Medical Insurance

Medical insurance is a fairly recent development in Malaysia and it is not yet a significant source of financing. Naturally, it appeals more to the urban people who have the ability to purchase it. In view of the speculation about a national health care financing scheme, medical insurance might become a program that could be made mandatory for all Malaysians although how this will affect older persons is at the moment unclear. At present, private medical and health insurance (MHI) is gaining in coverage, due in part to the broadening range of MHI products and providers, and also to consumers' awarenss of health promotion and protection. The most frequently seen type of MHI covers is the hospital and surgical insurance policy. These make up about 63% of total MHI premiums written. This is followed by critical illness policies at 28% (which provide lump sum benefit payments upon the diagnosis of an insured illnesses), hospital income (6%) and long-term care (2%) policies. Bank Negara Malaysia (2006, p. 58) estimated that 15% of the total population have MHI protection, mostly individuals below the age of 45 years.

1.3.3. Long-Term Care (LTC)

Malaysia as elsewhere has a range of institutional care services. There are the residential homes provided by the government in the form of long-term care facilities for the destitute. The private sector offers LTC faciltiies, motivated by profit in which the ability to pay applies, and non-government organizations also respond to the needs of older persons for LTC. Institutional care often refers to shelter provided in old people's homes (*Rumah Seri Kenangan*) of which there are eleven (two in East Malaysia) administered by the federal government. Perhaps the most obvious governmental effort in the provision of formal long-term care (LTC) has been the setting up of homes for chronically ill people who are destitute. At present there are two such centres (Rumah Ehsan), one in Kuala Kubu Baru, Selangor and the other in Dungun, Terengganu, with a total capacity of about 150, providing care, treatment and protection to destitute patients. *Private Nursing Homes* are fairly commonly seen in

long-term institutional-type care. They are found in major urban areas and tend to reflect market forces of supply and demand. The types of care nursing homes provide differ from home to home but the basic facilities remain largely the same. Nursing homes run by private organizations are monitored by the Ministry of Health or the the Social Welfare Department. These nursing homes offer 24-hour nursing care for people with different needs. As in many countries, the quality of care is inconsistent.

In addition to institutional shelter provided by the government and private organizations, there are other retirement homes known as *Rumah Sejahtera*, administered by the Central Welfare Council for Peninsular Malaysia (MPKSM). These homes come under the supervision of the Department of Social Welfare, which disburses grants on a regular basis. In reality, these homes can be considered as LTC facilities for residents without reliable dependents.

2. Current Status of Social Protection

The social protection schemes available in this country can be described as multi-pillar, with reliance on certain pillars depending on an individual's occupational history, although Malaysia has not moved towards the full five pillars as outlined by the World Bank. The major formal social protection schemes include the Civil Service Pension Scheme, the Employees Provident Fund (EPF), the Social Security Organisation (SOCSO), the Armed Forces Fund (LTAT) and the Workers' Compensation Scheme. There are also the public welfare programmes administered by the Ministry of Women, Family, and Community Development which can be classified into social assistance (means-tested) and social pension schemes. In addition, some discussion will be made on the non-formal pillar, which comprises homeownership, personal savings, and other financial or non-financial assets.

2.1. Formal Social Protection Schemes

2.1.1. Pension Scheme

The civil service pension, a non-contributory social security scheme, is designed for old age protection for public sector employees. Before 1991, pension expenditures were wholly borne by the federal government through annual allocation from the federal budget. This was a "pay-as-you-go" plan. In 1991, the Pension Trust Fund Act 1991 (KWAP, under Act 454) was introduced with an initial fund injection of RM500 million allocated from the Federal Government to provide a better return of investment for the scheme. The contributors to the fund are the federal government which allocates 5% of its annual emolument budget, while employers (local authorities, government agencies and statutory bodies) contribute 17.5%.

Upon retirement, a public sector employee is entitled to a lifelong monthly payment calculated based on the number of years of service and the last drawn basic pay (excluding all additional allowances enjoyed during employment). In addition, there is also a lump sum gratuity payment, the quantum of which is based on the number of years of service. Besides the lump sum gratuity payment, some agencies give an additional payment known as a "Golden Handshake", in recognition of service. In the past, the amount of pension paid was 50% of last drawn basic pay, equivalent to about one third of gross salary. From January 2009, employees who have served more than 30 years are entitled to 60% of the last drawn basic pay, while those who serve less than 30 years continue to receive the previous 50%. This improves the replacement rate. An employee who has served for at least 10 years is entitled to receive a life-long monthly pension upon retirement. However, the amount of pension is one-fifth of the last drawn basic pay. This rate also covers those who are forced to retire due to injuries or sickness suffered in the course of performing their official duties.

This scheme also provides financial protection to the dependents of public sector employees who die in service or after retirement. This is known as a derivative pension, in which offers the same amount of monthly pension payment is given to the dependent. In 2002, the derivative pension was extended to a widow/widower who remarried, a provision which was not accorded earlier. In 2004, this was further extended to cover parents of personnel who die without leaving a widow/widower or children. The benefit given to this category of beneficiaries is in the form of a once-off ex-gratia payment

since 2009. In terms of coverage, the derivative pension has become more inclusive compared to when it was first introduced.

Pushing back the retirement age of 55 years to 56 years in 2001 and then to 58 years in 2007 has, to an extent, provided a means of extending financial security to a later age. By so doing, a person who opts to retire at a later age will also stand to gain in terms of the amount of gratuity and the monthly pension payment since the formula for pension payout is based on the last drawn salary. Table 5 shows the number of pensioners and pension recipients and the size of the civil service. Based on the number of people in government service in 2008, the pension scheme in Malaysia covers only a small percentage of the labor force, at about 11%, or 4% of the total population. In this sense, it can be regarded as a scheme that has limited coverage in terms of population size.

Table 5. Number of Pensioners and Size of the Civil Service, 2000 – 2008

Year	Number of Pensioners & Pension Recipients	Number of Civil Servants	Value of Pension(RM million)	Current Pension Expenditure as % of total Current Expenditure
2000	433,847	n/a	n/a	n/a
2001	452,930	n/a	4.711	7.4
2002	392,265	n/a	5.134	7.5
2003	411,293	n/a	5.870	7.8
2004	430,414	n/a	6.060	6.6
2005	451,938	1,090,737	6.809	7.0
2006	470,883	1,142,783	7.001	6.5
2007	496,280	1,225,586	8.248	6.7
2008	511,883	1,244,365	8.372	6.5

Source: Department of Public Service Annual Reports, various years.

The pension system can be seen as a financial contract that averages about 55 years, from the time the employee is employed (say at age 25 years) till age 75 years (the life expectancy of Malaysians). Taken together with the derivative pension that for the dependents' lifetimes, this contract poses a challenge in terms of the sustainability of the scheme. A further challenge is adequacy, since many pensioners are believed to receive an amount that could hardly be considered sufficient. Therefore, the major challenges of the scheme are the coverage, benefits level and sustainability of the scheme since this is a defined-benefits scheme in which benefits are clear while the sponsor bears any

risk. Essentially, retirement pensions are aimed at consumption smoothing and also poverty prevention in old age, since pensions payment represent a lifelong benefit to employees. It matches Pillar 1 of the World Bank pension taxonomy, although the coverage is not likely to increase significantly and therefore its role as social protection is limited in scope.

2.1.2. Employees Provident Fund (EPF)

The EPF is a trust fund established under the EPF Ordinance, 1951, later amended to the EPF Act 1991. The EPF is a defined contribution plan based on a prescribed rate of contributions by employees and employers, accumulated as savings in a personal account with full withdrawal upon retirement. The EPF provides a long-term retirement savings route for employees in the private sector and non-pensionable employees in the public sector, as well as those who are self-employed (beginning 2005) to save for old age.

In 1968, EPF began to allow members to make partial withdrawals of up to one third of their accumulated savings. Significant changes introduced in 2008 include the "Beyond Savings" initiative and the restructuring of members' investment choice through the Basic Savings structure. The Beyond Savings initiative gives members greater choice and the flexibility to manage their EPF savings. Previously members could only invest 20% of their savings in excess of RM50,000 in Account I for approved investments, through approved external fund managers. Members can now invest savings in excess of the basic savings amount. EPF has introduced a variable basic savings amount at prescribed age intervals. The main purpose of this basic savings balance is to ensure minimum savings of RM120,000 at the age of 55 years, which translates into a monthly amount of at least RM500 over a period of 20 years, until the retired person reaches the age of 75. However, taking into consideration the rate of inflation, RM500 can hardly be described as sufficient. At best, it could only serve to meet bare necessities.

2.1.2.a. The Rate and Base Structure

The EPF rate of contribution has been well documented by Asher (1994). From December 1980 to December 1990, the rate of contribution for employer was 11% and

the employee contributed 9%, resulting in savings of 20% on net wages and 18% on gross wages. This rate has been more or less stable. As a response to the economic crisis, in 2009, the employee contribution rate was reduced to 8%, while the employers' contribution remained unchanged at 12%. In the past, contributions for employees over the age of 55 years were not compulsory. Effective 1 February 2008, the liability period for mandatory contributions to the EPF for both the employers and employees was extended from age 55 to 75, at contribution rates of 5.5% for employees and 6% for employers. This contribution rate is a minimum and and employees and employers can choose to contribute more than this prescribed rate. This move has resulted in a two-tier contribution rate, one for those who are younger than 55 years and another for those 55 years or older. The rationale behind the introduction of this two-tier rate structure is to encourage people to work after retirement and at the same time to avoid over-burdening employers and employees.

Under the present structure, there are two accounts. Full withdrawal from Account I can take place upon reaching the age of 55, or if the employee becomes incapacitated, leaves the country or dies. Members are allowed to invest up to 20% of the savings in this account at their own risks, while the minimum investment amount is RM1,000. Savings in Account II are designed to help members to make early preparations for a comfortable retirement. Withdrawals are allowed when the employee reaches the age of 50, for making a down payment for a first house or settling the balance of a housing loan, to finance education for self (since January 2001) and children (since 1 April 2000 for university education and 17 January 2006 for diploma education) where the amount withdrawn is limited to tuition fees or Account II savings balance, whichever is the lower, and to pay medical expenses for members and members' children for a list of approved critical illnesses. The amount is limited to the actual medical costs or Account II savings balance, whichever is the lower.

2.1.2.b. Coverage

Table 6 shows the coverage of the EPF Scheme. The important distinction that needs to be made with respect to coverage is the number of active members and total number of contributors. The difference is the total number shows the number of those

who have contributed at some point in time. They may no longer be active contributors for various reasons such as unemployment or a shift to self-employment.

Table 7 provides the density of contribution and the average savings by age group. It is desirable to examine the amount of average savings at age 54 since this will give us a clear indication of the amount of savings available for retirement (Table 8).

Table 6. Coverage of the EPF Scheme, Malaysia, 1980 - 2008

Year	Number of Active Members (in Millions)	As Percent of Total Members (%)	As Percent of Employed Population (%)	As Percent of Labor Force (%)
1990	2.94	49.6	44.0	41.8
1995	3.99	51.4	50.9	49.0
2000	5.03	50.5	56.3	54.7
2005	5.26	47.4	52.4	50.5
2008	5.71	47.3	53.6	51.8

Source: Employees Provident Fund, 1994; 1998; 2004; 2005; 2008.

Table 7. Profile of Active Members by Age and Sex, 2008

Age Group	Total		% of Total Active Members	Total Savings (RM Million)	% of Total Savings	Average* Savings (RM)
	Male	Female				
< 16	813	421	0.02	0.62	0.00	499.89
16 - 25	828,790	768,160	27.99	9,341.13	3.64	5,849.35
26 - 30	592,360	552,158	20.06	24,765.59	9.65	21,638.44
31 - 35	468,520	372,722	14.74	37,711.27	14.70	44,828.08
36 - 40	395,953	286,043	11.95	45,748.93	17.83	67,080.94
41 - 45	328,935	225,435	9.72	47,690.97	18.59	86,027.33
46 - 50	266,261	172,771	7.69	47,304.11	18.44	107,746.37
51 - 55	188,079	99,372	5.04	33,056.35	12.89	114,998.22
56 - 60	75,949	32,194	1.90	7,243.23	2.82	66,978.28
61 - 65	26,710	8,374	0.61	2,495.31	0.97	71,123.98
> 65	13,238	2,934	0.28	1,165.34	0.45	72,058.96
Grand Total	**3,185,608**	**2,520,584**	**100.00**	**256,522.84**	**100.00**	**44,955.17**

Note: *Average is used since EPF does not provide information on median savings.

Table 8. Members' Average Savings at Age 54

Year	Active Members			Inactive Members		
	Number of Members	Total Savings (RM)	Average Savings (RM)	Number of Members	Total Savings	Average Savings (RM)
2003	39,238	3,625,832,417	92,406.15	97,287	1,684,391,472.14	17,313.63
2004	39,535	3,915,853,224	99,047.76	98,677	1,757,913,099.13	17,814.82
2005	42,881	4,585,383,416	106,932.75	107,537	2,029,849,511.08	18,876.35
2006	47,438	5,427,045,812	114,402.92	108,097	2,321,761,533.00	21,478.50
2007	48,501	5,876,552,582	121,163.58	124,094	2,553,084,268.98	20,578.79
Values based on 2000 prices (CPI 2000=100)						
Year	**Active Members**			**Inactive Members**		
	Number of Members	**Total Savings (RM)**	**Average Savings (RM)**	**Number of Members**	**Total Savings**	**Average Savings (RM)**
2003	39,238	3,477,170,692	88,617.43	97,287	1,615,330,216	16,603.76
2004	39,535	3,699,128,085	93,565.91	98,677	1,660,620,392	16,828.85
2005	42,881	4,207,038,845	98,109.62	107,537	1,862,364,598	17,318.84
2006	47,438	4,805,813,043	101,307.24	108,097	2,055,989,988	19,019.86
2007	48,501	5,100,437,378	105,161.53	124,094	2,215,898,905	17,860.95

Source: EPF Annual Reports, various years.

The real values over the period of 2003-2007 shows a decline in the balances of active members. Although the increase in nominal balances from 2003 to 2007 is 31.2% for active members, in real terms, the increase in the balance is only 18.7%. Comparing the balances of active and non-active members, it is obvious that the inactive members have a much lower level of balance to be carried into their retirement years. The levels of balances, at year 2000 prices, showed that the inactive members are worse off in 2007 compared to 2006 even after the payment of a dividend of 5.8%% in 2007. Since the EPF saving scheme is not inflation-indexed, the balances for inactive members will deteriorate further in years ahead. Unless there are other sources to boost their retirement resources, they may become financially vulnerable as they age.

The growth in annual contributions from 1975 to 2008 is dependent on several factors notably the rate of unemployment, the level of wages and wage structure, and the rates of contribution. With the drop in the rate of employee contributions in 2009,

the annual total contribution may see a corresponding drop in the same year. Between 1975 and 2008, the amount of contribution has been increasing, with a substantial increase (83.5%) in 2000 compared to 1995 (Table 9). The total balances, as a percentage of GDP has remained high since 2000.

Table 9. EPF Annual Contributions, Withdrawals and Balances, 1975 to 2008

Year	Annual Contribution (RM million)	As % of Gross National Savings	Total Withdrawals (RM million)	Withdrawal as % of annual contributions	Total Balances (RM million)	Total Balance as % of GDP
1975	331	n.a	100	30.2	3,916	n.a
1980	1,068	6.8	199	18.6	9,129	17.1
1985	2,730	13.8	798	29.2	23,967	30.9
1990	4,139	12.5	1,738	42.0	46,179	39.9
1995	10,324	14.1	3,160	30.6	98,489	45.2
2000	17,040	13.6	9,991	58.6	180,764	57.9
2005	24,367	14.0	13,432	55.1	262,725	50.3
2008	34,543	12.7	21,741	62.9	344,640	46.5

Source: Employees Provident Fund, 2004; 2008, Bank Negara Malaysia, 2008.

2.1.2.c. Dividend Returns to Members

The rate of return on savings in the EPF is dependent on an investment strategy which is constrained by regulations. The EPF ensures that members' savings are secure, and it guarantees a minimum 2.5 per cent dividend annually. Over the years, the EPF has been paying dividends to members at varying rates. In 2008, the dividend was only 4.5%, lower than the Consumer Prices Index (CPI), resulting in a negative real return for the first time in decades (Table 10).

Table 10. Dividend Rate and CPI

Year	Dividend Rate	CPI	Difference
1975	6.60	4.5	2.10
1980	8.00	6.7	1.30
1985	8.50	0.4	8.10
1990	8.00	3.1	4.90
1995	7.50	3.4	4.10
2000	6.00	1.6	4.40
2005	5.00	3.0	2.00
2008	4.50	5.4	-0.90

Source: EPF Annual Reports, various years.

The EPF remains the major pillar of social protection for the formal sector workers in Malaysia. There are advantages and disadvantages in the EPF scheme, which remains largely unchanged as noted by Asher (1994). Like the CPF in Singapore, the EPF places the responsibility for old age income security firmly on the working individual who has to save for later life. However, the financial viability of the scheme and real rate of return are being publicly questioned. As inflation diminishes the true value of the savings, adequacy will be a key issue in the future.

2.1.3. Social Security Organisation Schemes

Through the Employees' Social Security Act (SOCSO) of 1969, the Social Security Organisation was established. It is a central government agency that operates the Employment Injury and the Invalidity Pension Schemes. It covers workers who earn less than RM3,000 (previously RM2,000) per month and is financed by contributions from both employees and employers. Once an employee is covered, he/she is covered even if his/her salary has exceeded the limit of RM3,000. The rate of contribution for the Employment Injury Scheme is 1%, to be contributed by the employer and employee at 0.5%, respectively. For the Invalidity Pension Scheme the contribution comes solely from the employer at 1.75%. New developments in SOCSO include old age pension for private sector and self-employed workers as well as unemployment benefits. This clearly is a move towards social protection reforms.

Table 11 shows that the number of members has been on the rise since 1975 and the number grew to 11.16 million and 11.75 million in 2005 and 2008, respectively. As the coverage increases, so does the number of beneficiaries and the amount of cash payouts. The increase in the number of members from 2000 to 2005 was about 25% while the payout increased by 141% in the same period. In 2010, the government announced that some 206,585 recipients of Socso pensions will receive monthly payments increased by between 0.6% and 11.3% (The Star, Tuesday, March 2, 2010).

Table 11. Statistics of the Social Security Organisation, Malaysia, 1975 - 2008

SOCSO	Number of Registered Employees	Number of Registered Employers	Number of Industrial Accidents Reported*	Number of Beneficiaries	Amount of Cash Paid (RM in Thousands '000)
1975[a]	608,847	18,902	40,979	n/a	n/a
1980	1,706,070	41,710	51,340	14,405	4,126
1985	2,904,782	69,256	61,724	35,471	21,077
1990	4,578,943	106,086	121,104	116,202	95,253
1995	7,422,191	274,017	114,134	182,763	245,478
2000	8,877,304	415,523	95,006	228,705	591,819
2005	11,155,232	578,390	61,182	264,640	883,893
2008	11,747,607	612,953	58,321	278,482	1,131,516

Notes: [a] Peninsular Malaysia Only,
* Excludes occupational diseases

Under the Employment Injury Insurance Scheme, the benefits provided include medical benefit, temporary disability benefit, permanent disability benefit, dependent's benefit, death benefit, and rehabilitation benefit. The Invalidity Pension Scheme covers invalidity or death irrespective of how and where it happens. In terms of coverage, the Invalidity Pension Scheme provides 24 hour protection and offers a pension even after the age of 56. In order to obtain a full pension, the member must at least have made at least 24 contributions. Full pension is 50% of the last drawn pay plus 1% for every 12 contributions over and above the minimum/ basic 24 contributions subject to a maximum of 65%. This pension is for life. Other benefits under this scheme include

constant attendance allowance, provision of artificial limbs and other appliances, funeral benefit and a survivor's benefit. The yearly contribution to this scheme is about RM1.8billion while the payout is about RM1.13 billion. This raises the issue of future sustainability in addition to the issue of adequacy.

2.1.4. Workmen's Compensation Scheme

Since April 1993, foreign workers were no longer covered under SOCSO. Instead, foreign workers are now covered by the Workmen's Compensation Scheme. Only foreign workers are covered under this scheme in respect of compensation for employment injury, as well as non-employment injury, as a result of the Workmen's Compensation (Foreign Worker's Scheme) (Insurance) Order 1993. This Act applies to foreign workers whose earnings are not more than RM500 per month and all foreign manual workers, irrespective of their wage. Casual workers, domestic maids and family workers are not covered under the scheme. Unlike SOCSO, this scheme operates as a law governing the terms and amounts of compensation in the case of death or accident. The employer is solely responsible for providing this social insurance, through private companies.

2.1.5. Armed Forces Fund (LTAT)

The LTAT was established in August 1972 by an Act of Parliament. Similar to EPF, LTAT is a defined contribution scheme for members of "other rank"[1] in the armed forces. The scheme is mandatory, for the ranks specified and the current contribution rate is 10% of monthly salary paid by the individual, while the government contributes 15%. This scheme also has a voluntary feature, in that military personnel with officers' rank are able to contribute to the scheme, which acts as a saving scheme with a minimum contribution of RM25 per month (but with no contributions from the government). All members, whether mandatory or voluntary contributors are entitled to disablement benefit and their dependents will also receive death benefits. Mobilizing members to save is the first major objective of the Armed Forces Fund, the second

[1] Other ranks are military personnel below commissioned officers in rank. This includes warrant officers, non-commissioned officers and privates.

objective being to promote socio-economic development and to provide welfare and other benefits for the retiring and retired personnel of the armed forces.

Upon reaching the age of 50, members are to withdraw the entire sum of savings with no option for monthly payments. This savings scheme also allows members to withdraw money to purchase a low-cost house once in a lifetime. The amount permitted for withdrawal is capped at 40% of the balance in the account or a maximum of RM100,000 whichever is the lower.

Table 12: Armed Forces Fund Board Members' Contributions, Total Asset and Dividend and Bonus, 1995 – 2008

Year	Members' Contribution Account (RM Million)	Total Asset (RM Million at cost)	Dividend and Bonus to Members
1995	2,906.7	3,522.9	-
2000	3,679.6	4,755.1	10.00
2005	4,168.1	5,457.6	15.75
2008	5,851.5	7,168.4	16.00

Source: LTAT Annual Report, various years.

2.2. Social Assistance Types Schemes

Under the "Caring Society" concept, the Malaysian government has instituted many welfare programs with some dating back to colonial days. The Department of Social Welfare, Malaysia under the Ministry of Women, Family and Community Development is responsible for administering most of the federal-based financial assistance programs. These financial assistances are meant to cover two major groups: the productive and the unproductive poor. The former include children, dependents of the sick, prisoners and detainees, poor families, single parent families and their dependents, ex-residents of welfare institutions, while the latter cover the sick, the elderly and the severely disabled. The major intention of the coverage for the former group is to provide assistance until they become productive and independent. For example, children aid amounts to RM100 per child up to a maximum of RM450 per household a month, aiming at easing conditions of poverty for the recipients until the age of 18. In 2005, the total number of beneficiaries for children assistance was 19,346, amounting to slightly over RM43.7 million. The figure has grown over the years and is expected to reach RM80 million in

2010. For the disabled workers, an allowance of RM300 per month is given. In 2005, the number of recipients for the scheme was 11,167 and the amount paid out was RM21.2 million. In addition, there is also a disaster relief fund which is capped at a maximum of RM5,000. A total of 10,158 people benefited from the aid for natural disasters in 2005, and the amount paid out was RM4.8, million. Older persons (aged 60 and above) who are destitute, not able bodied, and without next of kin to depend on for support are eligible for a social pension which amounts to RM300 per month. The number of recipients has increased over the years, from 9,212 in 2000 to 23,256 in 2005, costing RM31.3 million, an increase of 152% in recipients over a span of 5 years (Ong, Phillips & Tengku-Aizan, 2009). In 2006, the amount of monthly assistance was increased from RM135 to RM200 a month, and again increased to RM300 in 2008. In addition to the financial assistance programs described above, the Social Welfare Department also give out help in the form of artificial limbs and so on. Obviously all these aids are means tested and there are eligibility criteria to be followed. According to Ragayah (2004), there is a tendency for this benefit to be biased towards the urban poor due to the accessibility issue. Funding for these schemes comes from the federal operational budget, which sustainability could be a major issue in the future.

Table 13. Social Welfare in Malaysia

Type of Assistance	2000		2005	
	Cases	RM	Cases	RM
Children Aid	8,026	15,285,432	19,346	43,660,680
Senior Citizen Aid	9,212	10,278,238	23,256	31,342,805
General Aid	54,867	41,431,049	95,345	85,456,351
Launching Grant	249	453,630	264	583,230
Disabled Worker's Allowance	5,384	5,856,140	11,167	21,228,600
Disaster Aid	11,937	5,816,631	10,158	4,834,250

Source: MWFCD, 2007; DSWM, 2001.

2.2.1. Zakat

For the Muslims, there is another form of assistance that is based on Zakat or tithing through Islamic institutions such as the State Islamic religious councils (Majlis Agama) or Baitulmal. Of the two general kinds of zakat (zakat on self - fitr; zakat on wealth -

mal), zakat mal (2.5% of ones total wealth) makes up the bulk of voluntary contributions which amounted to over RM800 million in 2007. In Malaysia, each state has its own zakat agency although there are efforts to standardize the collection and distribution of money. The coordination of Islamic affairs is organized by the Department of Islamic Development Malaysia (JAKIM) and a Department of Waqf, Zakat and Haji was established in 2004 (Pusat Pungutan Zakat, 2007). Principally, Zakat reaches out to needy people but faces limitations in scope and size since it is applicable to Muslims only.

2.3. Other Savings Schemes

Although the capital market in Malaysia is not as developed as in other advanced countries the number of unit trust funds has increased over the years. The number of approved funds increased from 67 in 1995 to 127 in 2000 (Ragayah et al., 2002), with the number of investors rising from 6.8 million in 1995 to 9.6 million in 2000. These unit trusts include the government guaranteed schemes under the *Permodalan Nasional Berhad*, such as the National Unit Trust (ASN) and the ASB (Bumiputera Unit Trust), which are only open to the indigenous population, and the *Amanah Saham Wawasan 2020* (open to all Malaysians between the ages of 12 and 29) and the *Amanah Saham Malaysia* (also open to all Malaysians). In order to raise the income of the hardcore poor (those with income equal or less than half the poverty line), the government launched the Bumiputera Unit Trust (ASB)-PPRT loan scheme in 1992. This programme enabled each hardcore poor household to obtain a RM5,000 interest-free loan to participate in the ASB scheme.

In the 2008 Budget, a RM2 billion bond (Merdeka Savings Bonds) based on Syariah principles with a 3-year maturity was proposed for those aged 55 years or older and not employed on a full time basis. This is intended to encourage savings by providing a guaranteed 5% p.a. return for the elderly. From 2008 to 2009, approximately RM4 billion worth of bonds have been fully subscribed. In 2009, Bank Negara also introduced another general savings scheme known as Sukuk Simpanan Rakyat with similar terms as in the Merdeka Savings Bonds except that it is open to all Malaysian citizens aged 21 years and over. It has a more flexible early redemption and RM5 billion worth of bonds was fully subscribed.

The 1 Malaysia Retirement Scheme, administered by EPF, a voluntary savings scheme for non-formal sector workers was announced in the 2010 Budget. This scheme is to encourage the self-employed to save for old age. For all contributions the government will contribute 5% subject to a maximum of RM60 per annum over the next five years.

Besides these specific schemes introduced by the government, there are other private insurance schemes (especially life and medical insurance) and savings that Malaysians, regardless of age could subscribe to. The reality of the situation is that there is a high correlation between the various pillars of protection since it is those who are in the formal sector (under mandatory pillars) who would also have the ability to save (under the voluntary schemes). Therefore, the question remains: "How would those in the informal sector have access to protection?"

2.4. Informal Social Support

A majority of the older Malaysians live in extended family households (49.2%) in 2000 although the figure has dropped from 57.8% in the 1991 Census. This pattern of living arrangement has been steadily decreasing with a concomitant increase in the number of nuclear family households. The breaking of the family unit and dispersion of its members, driven by job opportunities in the formal sector in a globalised economic system, has led to the need for new forms of intergenerational interdependence. Even though extended households have become less common today, an older person can still expect care from his or her family, whether through direct or indirect support. In this regard, intergenerational transfer and support remains strong in Malaysia. A nationwide study in 2005 by Tengku Aizan and her colleagues (2005) found that monetary assistance from sons and daughters is the most common source of income for the elderly but the mean value is low (Table 14). Regardless, the frequency and size of intergenerational exchange involved is difficult to estimate. The contributions of the elderly in providing care for grandchildren and in performing household chores, for example, are equally difficult to quantify.

Table 14. Sources of Income for Older Malaysians, 2005

Sources of Income	Percent (%)		Mean Value per Month Ringgit (RM)
	Male	Female	
Wage income	27.6	11.7	566.41
Side income	4.9	3.8	431.53
Rent (Land)	1.6	1.4	286.19
Rent (House/Room)	2.2	2.7	1,623.08
Daughters	46.2	50.4	162.50
Sons	55.0	60.3	183.38
Grandchildren	3.2	6.5	128.32
Relatives	0.9	2.1	113.49
Agriculture	1.2	8.9	371.27
Pension	20.4	12.2	558.11
Welfare assistance	2.7	5.7	134.39
Business	2.6	2.5	1,003.87
Dividends / Shares / Royalty	1.1	0.6	125.00
Total	n = 1477	n = 1503	551.10

Source: Tengku Aizan et al., 2005.

Based on a recent survey conducted by Ong et al. (2008), retirees who responded to the survey stated incidence of intergenerational transfer from children to parents, although many of them also stated that 50% to 60% of their retirement income comes from their present economic activity. Although this household survey is an exploratory study, it strongly points to the need to include economic activity as a possible source of old age financing.

2.4.1. NGOs

Various senior citizen's clubs and associations are found in most urban localities and there is an umbrella organization known as the National Council of Senior Citizens Organizations Malaysia (NACSCOM). Together with the Gerontological Association of Malaysia (GEM), the GoldenAge Welfare Association of Malaysia (USIAMAS), the Central Welfare Council of Peninsula Malaysia (CWC) as well as a number of pensioners' associations (e.g. civil service, police and the armed forces), the voluntary sector provides many types of service, such as home help, home visits, long-term shelter, day centers, leisure-based activities and policy advocacy for older persons in the

country. Due to funding, human resource and geographical constraints, these services are often limited in frequency, scope and coverage.

2.4.2. Fiscal Incentives and Other Assistance and Subsidies

Tax exemption is provided for the cost of medical treatment of aging parents, capped at RM5,000 a year. The health benefits enjoyed by civil servants have been extended to include their parents. Therefore, care for older persons is expected to be carried out by the family, and the government will only step-in when there are no dependents available. There are the usual concessions in public transport and travel. In addition, in the Budget 2010 the government has allocated provisions in the form of subsidies for a plethora of consumable items including petrol, diesel, cooking gas, wheat, bread, sugar, flour, rice, text books, scholarships, education, health, welfare and highway tolls which are aimed at reducing the burden of the cost of living. Due to these subsidies, and the controlled prices for essential items, the rate of inflation has been kept to a minimum which does not reflect the current economic situation facing not only Malaysia but the whole world. Partly due to the low inflation rate, wages in Malaysia have not improved over the years. This has been singled out as one of the major causes for the middle-income trap that Malaysia is now facing. Recently the government has been considering the removal of subsidies and the imposition of a goods and services tax (GST). While GST is intended to give the Malaysian government the fiscal "space", how this will affect Malaysians and social protection is hard to predict.

2.5. Summary

The previous section provided an analytical description of the current pillars of social protection in Malaysia. Roughly about two thirds of all employed persons are covered under the EPF, the government pension scheme, SOCSO or other savings schemes. Agricultural workers, own account workers, small business operators, petty traders, independent contractors, free lancers, owner-drivers, casual employees and so on are left unprotected. For Pillar 1, the pension system that provides coverage for civil servants, the size and scope of the scheme are limited since it covers only a small percentage of the population. The primary social protection pillar is the EPF, a defined contribution scheme that has a wider coverage and scope, although it has both

advantages and disadvantages. The other schemes are SOCSO, Workmen Compensation, voluntary savings schemes as in the Amanah Saham savings schemes, designed for various target groups. Pillar zero which is in the form of direct cash transfers to the elderly and the needy population are administered by the government and are means-tested with specific eligibility criteria. Pillar 3 a voluntary pillar that covers private saving schemes and private investment such as in the unit trusts, suffers from a lack of data. Therefore it is difficult to estimate the size and the extent of coverage. However, those who subscribe to pillar 3 are also likely to be employed in the formal sector, for which a social protection scheme is already in place. Pillar 4 which refers to informal family support, and to other financial or non-financial support, has the same limitation in data.

3. Improving Social Protection: Critical Issues and Challenges

According to Barr and Diamond (2009), pension systems have multiple objectives and the design must not exceed the country's capacity, i.e., the design must fit the fiscal and institutional capacity at the level of economic development appropriate to the country. In moving forward in social protection reform, the Malaysian government must take into account its fiscal capacity. Up to now Malaysia could still afford to use its fiscal capability as indicated by the last budget deficit of 5.6% for 2010. Factors that Malaysia must be cautious about in moving towards closing the coverage gap, relate to the structural adjustment that the country needs in order to achieve its goal of becoming a high income country status by 2020. In other words, any pension reform design must take into account the current and the future capabilities of the country, as well as the delivery mechanism, including the management and the governance issues of reform. Coupled with these challenges is the critical issue of managing people's expectations, in job creation, in health care, and in ensuring quality of life, with at least a comfortable replacement level based on the individual's lifestyle before retirement. In addition, the three dimensions of pension coverage that need attention are: (1) the proportion of potential beneficiaries covered by the pension system as a whole; (2) the risk

contingencies covered; and (3) the level of benefits (Asher, 2009, ISSA Paper No. 11). In as much as the schemes are examined separately in order to determine the benefits level, extent of coverage and the risk contingencies, the possible linkages between them are crucial since no one pension design will be adequate. This is advocated under the World Bank's framework of the multi-pillar system.

3.1. Issues and Challenges of the Present System of Social Protection

3.1.1. Coverage

As there is a positive correlation between per capita income and social protection coverage, Malaysia will find it challenging to increase coverage through formal sector employment growth (Asher, 2009). About 30% of the labor force is in the informal sector, representing about 6.5 million people by 2020. They are without formal social protection. Their known source of protection lies with the individual and the family. The informal sector workers are heterogeneous with possible movement within the sector itself. Given this heterogeneity, no single scheme is likely to be able to suit all the informal workers. On the other hand too many schemes, targeting too many specific groups, will not be viable or sustainable in the long run, given the small size of the Malaysian population, besides the issue of not wishing to restrict labor mobility. The single major obstacle that hampers the design of any schemes for the informal sector is the serious lack of data. However, any pension reform must take into account this group of informal sector workers. While they are encouraged to contribute to the EPF on a voluntary basis, the take-up rate is low. Towards encouraging more to contribute voluntarily, the government through its Budget 2010 has announced the establishment of 1 Malaysia Retirement Scheme, a voluntary scheme based on affordability, which begs the question of the density of contribution.

EPF as a saving scheme is the largest saving scheme in Malaysia covering about 50% of the labor force (the civil service pension scheme covers only about 7% of the working population). Therefore, there is likely to be some proportion of the labor force that ought to be contributing, but is not. Administrative and compliance procedures need to be stepped up in order to ensure that those who ought to be covered are contributing. LTAT is another saving scheme for the armed forces and the coverage is restricted to armed forces personnel.

An estimated 5% of the population in 2008 is benefiting from the social assistance and social welfare programs at the federal and state level. These cash transfer programs must be carefully designed and managed so that the system is based purely on need, and is means-tested without regards to ethnicity, religion or political affiliation. Effective and efficient management of these schemes can be a challenge, since the people who are in need are located in different localities, even in the most remote parts of the country. Reaching out to this group will be a challenge.

3.1.2. The Level of Benefits

In designing a multi-pillar system of social protection, the level of benefits is important. It is clear that the main objective of pillar zero is to provide the most basic level of need, the subsistence level. Those who are receiving this social pension/assistance scheme, they must be given other forms of assistance so that they are elevated from the poverty trap. This group will continue to benefit from the public health care system, free education and forms of micro credit that will help them to be economically active. Without other forms of assistance, they will continue to be at risk, vulnerable to prolonged poverty.

Although the EPF has the highest percentage of coverage; the benefits level has always been questioned. The average sum of money available at age 55 is not adequate to smooth consumption till age 75 years, or till life ends. Currently EPF is urging that a member must at least accumulate a sum of RM120,000 at age 55. This amount when spread over a period of twenty years is only RM500 a month. For EPF to generate sufficient benefits, the density of contribution and the growth in wages must be considered. Recently there has been much talk and speculation about the wages growth if Malaysia needs, if it is to become a high-income country by 2020. In order to have a high density of contribution, the government may have to re-consider increasing the mandatory retirement age. Another major problem faced by those under the EPF scheme is the cost of health care, in particular for those who do not have sufficient accumulation of savings upon retirement. Unless they are covered by a health care insurance scheme, they will have to seek care from government clinics and hospitals.

In general, the civil service Pension Scheme has achieved a replacement rate of nearly 50%. But for the lower income group, although the replacement rate looks

adequate, the amount of money received could border on the household poverty line of RM720 a month. After the salary and pension revisions in 2007 and revised minimum pension amount, civil servants have the better long term protection in terms of income security in later life.

For SOCSO the scheme has the policy of "once a member, always a member". This enables those who after joining are now earning more than RM3000 a month to continue enjoying the benefits of the scheme. This is a workman's insurance scheme and not a pension scheme. Data on the amount of benefits are not available and hence it is difficult to estimate the adequacy of the level of benefits. However, the problem that is currently facing SOCSO is the issue of sustainability since the payout is about 80% of contributions received. Over the years the rate of contribution has remained the same while the payout has been increasing.

3.1.3. Governance and Management

Clearly, for the mandatory schemes in Malaysia the issues of management and governance are important since these are related to individual contributors expectations and society's confidence in the management of the schemes. The investment policy for KWAP, EPF and SOCSO are very conservative, mostly focusing on government bonds and securities. In order to generate a positive real rate of return, the government may need to consider policy change to allow these agencies to invest in high yield investments. To do so, the structure of governance needs to be strengthened. EPF has been excellent in delivering services but the mandate given to EPF in investment policy can be described as narrow, restricting its ability to generate a higher (positive) real rate of return. As seen in certain years, the real rate of return has sometimes been negative.

The structure of the EPF risk system management structure consists of the Ministry of Finance (at the highest level), followed by the establishment of risk policy which is overseen by four members: on one side there are the investment panel and the investment panel risk committees and on the other the board of directors and the board of risk management committee. It is at this level that risk policy is made. At the next level is the committee that is to ensure risk policy implementation and compliance. There are two types of committees: dedicated committees forming the first group consisting of a management risk committee, a management operation risk committee,

and a management investment committee, while the second group is made up of an independent risk management and compliance functions committee, the risk management department and the settlement and compliance section. The next level is made up of implementers, who execute the decisions taken. To ensure the proper functioning of these committees, there is the audit board committee comprising internal and external auditors. Briefly, investments by EPF have been conservative and the investments are as follows:

- Malaysian Government securities (96.2 billion),
- loans and bonds (137.3 billion),
- equities (87.9 billion),
- money market instruments (19.0 billion), and
- property (1.6 billion).

There is no predetermined quota for investment in the various portfolios that EPF is permitted to invest in. The equity component of the investment has been rising and in some companies, EPF holds a majority of the equity. In such cases, EPF should be the shareholder with management control. However, EPF is an investor whose mandated function does not go beyond investment.

4. Policy Recommendations and Conclusion

In Malaysia, the longstanding principle up till the present day has been that financing social security has primarily been based on individual and family. Given the present state of economic development and the pressure for Malaysia to become a high-income country by 2020, social protection for the purpose of consumption smoothing and poverty prevention is now required, since it is known that countries that have successfully reformed their pension systems have also had sustained economic growth. Malaysia will have to construct a social protection reform plan that will provide adequate benefits to most of the eligible population. This involves the issues of coverage, level of benefits and the issue of governance and management.

Malaysia faces the challenge of implementing social protection reform systems that will (Asher and Nandy, 2006):

- Provide adequate benefits to most of the eligible population;
- Be sustainable financially and fiscally;
- Be affordable by individuals, businesses and the economy as a whole;
- Be robust in riding out cyclical economic crises and turmoil.

Full replacement of income for retirement cannot be obtained purely from one single source (scheme), therefore different tiers must be incorporated so that full replacement can be achieved.

Pillar zero, financed out of the federal budget, has to remain, but it must only be at the very basic level. It must provide subsistence to a group that meets set conditions. Two errors that should be avoided are: (i) giving aid to those who do not qualify and (ii) leaving out the deserving. Therefore, the management of the social assistance schemes needs a high level of coordination and perhaps the administration should be put under one agency for greater efficiency and effectiveness, monitoring and control. E-kasih is one such recent development towards this end. This pillar is the most effective way to provide for the most basic level of need and would be effective in addressing issues of gender, poverty and longevity.

The Informal Sector. Given the situation facing the informal sector, the social protection that is appropriate for it will need to be integrated with development policies and programs. The government has partly addressed the issue of protection for agricultural workers in the 2010 Budget. In order to help these workers and fishermen, the government has put in place RM2 billion in the form of subsidies, grants and assistance to help these groups improve their yield and productivity. For the urban sector, the government will also need to enhance the productivity of urban workers since the rate of urbanization in Malaysia is now about 63%. For small and medium businesses, there are various financing schemes to help their owners and the self-employed. Currently there are available a total of 79 SME funds and grants totaling RM8.8billion. The government intends to consolidates these grant schemes to 33. For micro enterprises, there is a scheme called the Amanah Ikhtiar Scheme that provides

funding for micro business owners. Thus far, these efforts are geared towards providing assistance and funding for them to be more productive, and improve their standard of living. This indirectly caters for social protection in old age. Currently, the government is moving in the right direction by stepping up skills training and micro credit facilities to this group as announced in the 2010 Budget. However, there is an urgent need to put in place a social protection system for the informal sector workers. A multi-tiered social protection system involving a mix of risk sharing arrangements among the stakeholders; individuals, families, employers, the government and civil society must be formulated to safeguard against vulnerability to old age poverty (Asher, 2009). The 1Malaysia Retirement Scheme, a pillar 3 voluntary personal pension plan under the multi-pillar taxonomy within the World Bank framework, is based on affordability. It is important to create awareness among the informal sector workers about the need to take charge of one's later life. This ex-ante intervention is a good beginning (Asher, 2009). While this will provide some form of protection in old age, other pillars, such as pillar 4 could be used to meet the replacement level. Should these pillars fail, pillar zero which is means-tested could be relied on to provide for the most basic of needs.

As for Pillar 1 (civil service pension), since it applies to only a segment of the population and about 7% of the working population, the coverage is limited and it can hardly be regarded as a scheme that could be extended in coverage. The system is generous and to a certain extent is inflation indexed with pension revisions when salary revisions for civil servants take place. Because the amount of pension is tied to last drawn salary, a small percentage of retirees live in poverty. In this regard, using the means-tested conditions of pillar zero, the elderly who fall into this category would still need some help in ensuring that they at least receive basic subsistence. As for the young old, they should be encouraged to work. This may involve the help of community and NGOs in providing retraining or learning new skills. The training program administered by the government should be extended to older people, so long as they are still physically fit to be re-trained.

Although EPF reaches out to about 50% of the labor force, it has its own shortcomings, the major ones being the lump sum withdrawal that individuals prefer. They may not have the financial awareness and knowledge to invest for its utilization over the next 20 years. To address this shortcoming, the government can re-examine

the annuity system to make it attractive for contributors to subscribe to it. Besides this, the argument about the adequacy of the EPF savings has long been discussed and debated. The pre-retirement withdrawal from EPF may need to be reconsidered so that savings remain as savings for old age. However, withdrawal for housing is felt to be proper, since it is used for asset enhancement, which will contribute towards a comfortable life after retirement. Therefore, for EPF to generate an adequate level of savings for retirement, the Account I should have sufficient density of contribution, if the government is unable to convert EPF payment into an annuity scheme. As for Account II, the amount of contribution should be kept low with restricted permissible withdrawals.

SOCSO is a social insurance scheme that is limited in scope. It is not a proper pension scheme but a workman's compensation scheme, although the scheme does pay out a pension for life. It is to a certain extent covering the cost of health care under circumstances of work-related injury and accidents.

Pillar 3 which refers to voluntary savings schemes is the most difficult to estimate in terms of its coverage, since there is serious lack of data. In moving towards encouraging the use of this pillar for old age protection, the government should consider tax advantages to contributors to make it more attractive.

Pillar 4 for the purpose of consumption smoothing and poverty prevention should be regarded as the last resort, since there is a serious lack of data and we do not have longitudinal research that allows us to study the effects of ex-ante intervention and the ex-post intervention. Older persons can still be a significant and valuable human resource. While the longevity among Malaysians has improved tremendously the mandatory retirement age remains at 55 years for private sector employees and 58 for the public sector. Malaysia needs to rethink the mandatory retirement age with the present life expectancy that Malaysians are enjoying.

In conclusion, Malaysia has to move towards a multi-pillar system of social protection (Appendix 1 and 2). While the present sources of social protection in Malaysia suggest the existence of a multi-pillar system, much of the effort is new, such as the 1 Malaysia Retirement Scheme that addresses the needs of the informal sector. The recommendations given above have to be considered within the broader political and economic structures of Malaysia. Currently the government is facing great pressure

to move the economy into the high-income nation category. One of the suggested ways to achieve this is to push up the wage levels of Malaysians. However, this must be pursued alongside improvements in productivity. Once Malaysia achieves the high-income country status, there will be greater fiscal flexibility to sustain the pillar zero assistance and other forms of training and developmental assistance. The current economic growth of 4%-5% will not be sufficient for Malaysia to push forward in social protection reform; it needs a higher level of economic growth, which could be achieved through higher productvitiy improvements and high value-creating economic activities. Therefore the challenges ahead for Malaysia are not only about pension reforms but concern a total structural adjustment for the economy.

Appendix 1

Multi-pillar Social Protection Systems for Malaysia

Pillar	Target Groups			Characteristics	Main Criteria	Funding / collateral	Malaysia
	Lifetime poor	Informal sector	Formal sector		Participation		
0	**X**	**x**	**x**	"Basic" or "Social pension," at least social assistance, universal or means-tested	Universal or Residual	Budget / general revenues	**Federal and State welfare schemes**
1			**x**	Public pension plan, publicly managed, defined-benefit or notional defined contribution	Mandated	Contributions, perhaps with financial reserves	**Civil Service Pension; Retirement Fund Incorporated**
2			**X**	Occupational or personal pension plans, funded defined-benefit or funded, defined contribution	Mandated	Financial asset	**Employees Provident Fund**
3		**X**	**X**	Occupational or personal pension plans, funded defined-benefit or funded, defined contribution	Voluntary	Financial asset	**Bonds and other personal savings schemes, general and/or life insurance;**
4	**x**	**X**	**X**	Personal savings, homeownership, and other individual financial and non-financial assets	Voluntary	Financial and non-financial assets	**House ownership; financial and non-financial assets, remittances from children**

Source: Holzmann and Hinz (2005), Adapted from Asher and Nandy (2006).
Note: The size of x or X characterizes the importance of each pillar for each target group.

Appendix 2

Summary Table: Key Provident and Pension Fund Indicators in Malaysia, 2008

Organisation	Who is Covered?	Contribution Rate	Total No. of Members / Contributors (Million)	No. of Active Numbers	% of Labor Force (11.03 Million)	Contributions Balance (RM Billion)	% of GDP (RM741.2 Billion)	Total Assets (RM Billion)	Pre-retirement Withdrawals
Civil Service Pension	Public servants	Nil	1.24	1.24	11.2	-	4.9 (emoluments as % of GDP)		
	Pensioners and Pension recipients	Nil	0.51	-	4.6	-	1.1 (pension expenditure as % of GDP)		
Retirement Fund Incorporated (KWAP)	Pensionable employees	17.5% - Employer (Agency, Statutory bodies and Local authorities), employees do not contribute	0.11 / 493 Employers	-	-	52.04	7.0		
Armed Forces Fund Board	Members of the other ranks in the armed forces	10% - Employee 15% - Employer (Government)	n/a	-	n/a	5.85	0.8	7.17	
Employees Provident Fund	Employed persons under a contract of service	8% - Employee 12% - Employer	12.07	5.71	109.4 (51.8)	344.64	46.5		Total: 18.2 billion
Social Security Organization	Employed persons under a contract of service with a monthly salary = RM3,000	0.5% - Employee 1.75% - Employer	11.75	-	106.5	53.87 (2007)	7.27 (2007)		No pre-retirement withdrawal
Workmen's Compensation	Foreign workers	Insurance premium RM86 per worker per year	n/a	-	n/a	n/a	n/a		na

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CHAPTER 08

Social Protection in the Philippines: Current State and Challenges

ANICETO C. ORBETA, JR.[1]
Philippine Institute for Development Studies (PIDS)
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This paper reviews the current state of and challenges facing, social protection in the Philippines. It describes the social protection institutions and the schemes that have been developed throughout the years. It also provides an assessment focusing on coverage, administration and management. The paper then lists several reform themes for the country's social protection system.

The paper finds a continuing low coverage of the main bulk of workers - formal private sector wage-workers - even if the system expanded statutory coverage to own-account, overseas, domestic workers and even housewives. The lack of coverage of informal-sector workers persists. There is a continuing threat to sustainability because contributions and benefits are not strongly linked, particularly for the SSS. The funds are also subjected to continuous political pressure to finance social programs that are of doubtful return and which may not be in line with the long-term nature of the fund's obligations. There is also a need to continuously improve the investment earnings of the reserve funds. This may include terminating programs which are unlikely to meet the earning requirements for actuarial viability. Finally, there is a need to examine the increasing operating costs, considering that these are among the highest in the region.

[1] Senior Research Fellow, Philippine Institute for Development Studies. The able research assistance of Michael Abrigo and Emma Cinco is gratefully acknowledged. Opinions expressed here are solely those of the author and not of the Philippine Institute for Development Studies nor the Economic Research Institute for ASEAN and East Asia.

1. Introduction

The recent financial crisis highlighted the many challenges that social protection systems in different countries face. These challenges are often not new, but in fact have long been recognized yet were largely ignored, leading to threats to sustainability. They range from non-coverage of large proportions of the statutory eligible population to weaknesses in the administration and management of the different schemes. Social protection reform has thus become an important and continuing development concern. Reform, however, requires a good understanding of what schemes are in place and what challenges are being faced. This paper attempts to address this need in the case of the Philippines[2].

This paper reviews the current state of, and challenges facing, social protection in the Philippines. The coverage of social protection is potentially broad. To provide a comprehensive view of the extent of social protection in the country, the paper is thorough in terms of describing institutions and schemes. However, it is much more selective in its assessment of the schemes, focusing only on old age security, disability, and health care.

The paper is organized as follows: First, the state of, and challenges facing, social protection in the country, the underlying labor market conditions and poverty are described. A review of the institutions and schemes that have been developed throughout the years follows. Next, the country's social protection system is assessed in three areas, namely, coverage, level of benefits and administration and management. The final section presents recommendations for reforms that are mainly based on existing studies.

2. Developments in the Labor Market and Poverty

Population and Labor Supply. The working-age population defined as those who are 15 years and above, is estimated to be about 59 million in 2009. The number of

[2] Manasan (2009a) also provides a recent review of social security institutions in the country.

those in the labor force is estimated to be approximately 38 million, giving an average labor force participation rate of 64% (Table 1). It is well known that female participation in the labor force in the Philippines is around half that of men (Orbeta, 2003).

Table 1. Developments in the Philippine Labor Market

	2009 October	2008 October	2007 October	2006 October
Household population 15 years and above (000)	**59704 \1**	**58,283**	**56,845**	**55,638**
Labor Force (000)	**38,188**	**37,126**	**35,918**	**35,497**
Labor force participant rate (%)	64.0	63.7	63.2	63.8
Employed (000)	**35,477**	**34,533**	**33,672**	**32,886**
Employment Rate	92.9	93.0	93.7	92.6
Unemployed (000)	**2,711**	**2,593**	**2,246**	**2,611**
Unemployment Rate	7.1	7.0	6.3	7.4
Underemployed (000)	**7,409**	**6,028**	**6,109**	**6,762**
Underemployed Rate	19.4	17.5	18.1	20.6
By Sector				
Total	**100.0**	**100.0**	**100.0**	**100.0**
Agriculture	**34.0**	**35.7**	**36.1**	**36.6**
Industry	**14.5**	**14.7**	**15.1**	**14.9**
Services	**51.5**	**49.6**	**48.7**	**48.4**

Source: NSO, LFS.

Employment, Unemployment and Underemployment. The number of employed people in 2009 is 35.5 million and the number of unemployed is 2.7 million. This gives employment and unemployment rates of 92.9% and 7.1%, respectively. The country has one of the highest unemployment rates in Asia (e.g., Felipe and Lanzona, 2006). It is also noteworthy that a large proportion of the employed are actually not fully employed. Underemployment rate is estimated at 19.4% in 2009.

Sectoral Dis-aggregation. The current (2009) sectoral composition of employment shows that the service sector accounts for the largest share in employment at 51.5%. It has been pointed out that (e.g., Orbeta 2003) agriculture used to have the largest share until the later part of the 1990s. Since then the agricultural sector has been surpassed by services, accounting for only 34% of employment in 2009. The share of the industrial

sector has not changed much over the decades implying that it is the services sector, rather than the industrial sector, that is absorbing the surplus workers from the agriculture sector (Table 1).

Distribution by Class of Worker. The distribution of workers shows that a little over 50% are wage and salaried workers, a little over a third are self-employed workers and the rest are unpaid family workers (Table 2). Almost three decades ago the share of salaried workers was just 45%. It has been pointed out that the increase in the percentage is mostly due to a decline in unpaid family workers, while the share of the self-employed has been stable (Orbeta, 2003). The share of government workers among the salaried is stable at around 8% or around 2.9 million workers which mean that there has been a rise in the proportion of salaried workers in the private sector.

Table 2. Labor Force By Class of Worker (thousands)

	2009		**2008**		**2007**		**2006**	
	October Round		**October Round**		**October Round**		**October Round**	
	%	Number	%	Number	%	Number	%	Number
Labor Force (000)		**38,188**		**37,126**		**35,918**		**35,497**
Total Employed	**100.0**	**35,477**	**100.0**	**34,533**	**100.0**	**33,672**	**100.0**	**32,886**
Wage and Salary Workers	**53.6**	**19,016**	**51.9**	**17,923**	**51.1**	**17,206**	**50,6**	**16,640**
Private	**53.2**	**18,874**	**43.9**	**15,160**	**43.3**	**14,580**	**43.0**	**14,141**
Private Household	5.4	1,916	5.0	1,727	5.2	1,751	5.0	1,644
Private Establishment	39.7	14,084	38.7	13,364	37.7	12,694	37.7	12,398
with Pay (family owned business)	0.4	142	0.2	69	0.4	135	0.3	99
Government/ Government corporation	**8.1**	**2,874**	**8.0**	**2,763**	**7.8**	**2,626**	**7.6**	**2,499**
Own Account	**34.5**	**12,240**	**35.5**	**12,259**	**36.5**	**12,290**	**36.3**	**11,938**
Self Employed	30.5	10,820	31.4	10,843	32.3	10,876	31.9	10,491
Employer	4.0	1,419	4.1	1,416	4.2	1,414	4.5	1,480
Unpaid Family Workers	**11.9**	**4,222**	**12.5**	**4,317**	**12.4**	**4,175**	**13.1**	**4,308**
Unemployed		**2,711**		**2,593**		**2,246**		**2,611**

Source: NSO, LFS.

Distribution of Firms by Employment Size. The distribution of firms by the size of their workforce in 2006 shows that about 92 percent of the firms have less than 10 employees (Table 3). These small firms account for 33% of the total workforce. This is not expected to change in the foreseeable future as the growth of employment is

expected to be in this category (Asher, 2009).

Table 3. Number of Establishments by Employment Size, 2006.

Employment Size	Number of Establishments		Employment	Share in Employment
	Number	%	Number	%
Total	**783,065**	**100.00**	**4,984,883**	100.0
1 – 4	640,254	**81.76**	1,162,830	23.3
5 – 9	79,937	**10.21**	504,994	10.1
10 – 19	37,098	**4.74**	476,812	9.6
20 – 49	15,100	**1.93**	448,455	9.0
50 – 99	5,241	**0.67**	353,751	7.1
100 – 199	2,839	**0.36**	381,013	7.6
200 – 499	1,689	**0.22**	504,874	10.1
500 – 999	567	**0.07**	384,628	7.7
1000 – 1999	224	**0.03**	306,973	6.2
2000 and Over	116	**0.01**	460,553	9.2

Source of data: National Statistics Office, Industry and Trade Department, 2006. List of Establishments.

Notes:

1. Details may not add up to total because some data were suppressed.
2. The 2006 List of Establishments was based on feedback from surveys conducted supplemented by lists from different secondary sources after field updating was done in 2004 and 2005.

Poverty. Poverty incidence has not gone down as fast as expected (Table 4). There is even an indication of a resurgence of poverty in recent years, which is expected to worsen given the financial crisis and the typhoons that severely affected the economy last year. This trend is largely the result of an inconsistent (boom and bust cycle) growth record and a population growth rate that has not gone down as fast as that of our ASEAN neighbors.

Table 4. Poverty Incidence, Gap and Severity, 1985-2006

	1985	1994	1997	2000	2003	2006
Incidence	44.2	35.5	28.1	27.5	24.4	26.9
Gap	14.7	11.3	8.4	8.0	7.0	7.7
Severity	6.6	5.0	3.5	3.2	2.8	3.1

Source: Author's calculation using NSO Family Income and Expenditure Surveys
1985-1994 used regional thresholds; 1997-2006 used provincial thresholds.

3. The Social Protection System

We describe the social security system in the country in two ways. First, as a multi-pillar system following Holzman and Hinz (2005). Second, by institution and the schemes it has developed throughout the years.

3.1. Social Protection as a Multi-Pillar System

Following Holzmann and Hinz (2005), the social security system in the Philippines can be described as a five-pillar system. This is summarized in Table 5.

Table 5. Social Security as a Five-Pillar System

Pillar	Description of institutions and programs
Pillar 0 – Universal or residual social assistance, poverty-targeted, general tax-financed	Social assistance and poverty-targeted programs of government departments such as social welfare, health and labor
Pillar 1 – Mandated public pension, defined benefit (DB) schemes	Pension schemes of the SSS for private sector wage workers, of the GSIS for civilian public sector, and the AFP-RSBS for the military; Work-related accident insurance programs of the Employment Compensation Commission (ECC); health insurance program of the Philippine Health Insurance Corporation (PHIC); Overseas Workers Welfare Administration (OWWA) schemes on worker repatriation and work-related risks
Pillar 2 – Mandated occupational or personal pension plans, defined contribution (DC) schemes	HDMF (Pag-IBIG) compulsory savings schemes, AFP-RSBS compulsory saving schemes, GSIS life-insurance, OWWA life-insurance
Pillar 3 – Voluntary, occupational or personal pension plans and supplementary schemes	Company-based provident fund / pension schemes of large private corporations and public finance and autonomous corporations; GSIS mutual fund
Pilar 4 – Voluntary, informal support (family), formal social programs (healthcare), other individual financial and nonfinancial assets (homeownership)	Private pension, insurance and pre-need schemes, tax-deductible investment to personal accounts (PERA), community-based health insurance schemes

Source: Author's summary from relevant documents.

The zero pillar includes social assistance and other poverty-targeted programs. This pillar would include programs from different governmental departments, notably the Department of Social Welfare and Development (DSWD), the Department of Health

(DOH) and the Department of Labor and Employment (DOLE) to address the needs of the poor. These programs are financed by general taxes. For the DOH, this pillar would include the free primary medical care services at government health facilities and charity beds mandated in public and private hospitals (Banzon, 2008). Manasan (2009b) describes many of the programs of the DSWD and DOLE.

The first pillar includes mandatory defined benefit (DB) schemes. This pillar would include the social security schemes of the Social Security System (SSS) for the private sector, the Government Service Insurance System (GSIS) for the civilian employees of the public sector, and the Armed Forces of the Philippines-Retirement Benefit System (AFP-RSBS) for the military. This pillar also includes work-related accident insurance by the Employment Compensation Commission (ECC), which is administered by the SSS for private sector workers and by the GSIS for public sector workers.

The second pillar includes the defined contribution (DC) schemes. This pillar would include the savings programs of the Home Development Mutual Fund (HDMF) or Pag-IBIG Fund and the compulsory savings of the AFP-RSBS. Included here are also the mandatory life-insurance of the GSIS for public sector workers and the OWWA life insurance for overseas workers.

The third pillar includes voluntary occupational or personal pension schemes. This pillar would include the company provident/ pension schemes of large private corporations and publicly financed and autonomous corporations. The GSIS also has a mutual fund for voluntary investments by its members.

The fourth pillar includes voluntary supplementary schemes. This pillar would include individuals buying additional pension plans or pre-need products for many contingencies in life, usually from the private sector. A new law (RA 5051) officially called the Personal Equity and Retirement System (PERA) was passed in 2008 for implementation starting 2010. PERA allows individuals to make tax-deductible investments in a personal account. If employers make a contribution to it, this is tax deductible as well. Finally, there are nascent community-based health care systems.

3.2. Social Protection Institutions and Programs

The major social protection institutions of the country consist of seven institutions,

namely: (a) the Government Service Insurance System (GSIS), (b) the Social Security System (SSS), (c) the Employee's Compensation Commission (ECC), (d) the Philippine Health Insurance Corporation (PHIC) or PhilHealth, (e) the Home Development Mutual Fund (HDMF) or Pag-IBIG, (f) the Armed Forces of the Philippines Retirement and Benefit System (AFP-RSBS) and (g) the Overseas Workers Welfare Administration (OWWA). Not mentioned here are the line departments that operate social assistance programs and private sector providers of social security schemes. The schemes these institutions developed and the contingencies that they address are summarized in Table 6. Backgrounds of the social protection institutions and the main features of the schemes are described below.

Table 6. Social Security Institutions/Programs and Risks/ Contingencies Covered

Risks/ Contingencies	Formal Sector workers				Unemployed, Housewives, Dependent children
	Government		Private (domestic)	OFW	
	Civilian	Military			
Old age/ Retirement	GSIS	AFP-RSBS	SSS		
Death / Survivorship	GSIS, ECC, HDMF (Pag-IBIG)	AFP-RSBS	SSS, ECC	OWWA	
Disability	GSIS, ECC		SSS, ECC	OWWA	
Separation/ Unemployment	GSIS	AFP-RSBS			
Sickness / Health	PhilHealth	PhilHealth	PhilHealth, SSS, ECC	PhilHealth, OWWA	Private insurers (voluntary)
Life insurance	GSIS (compulsory plus optional), Private insurers (voluntary)	Private insurers (voluntary)	Private insurers (voluntary)	OWWA, Private insurers (voluntary)	Private insurers (voluntary)
Mutual Fund / Provident fund	GSIS(optional), institution-based, HDMF (Pag-IBIG)	AFP-RSBS, HDMF (Pag-IBIG)	HDMF(Pag-IBIG), institution-based	HDMF (Pag-IBIG)	HDMF (Pag-IBIG) (voluntary)
Lending program	GSIS (salary, emergency, policy, housing), HDMF(Pag-IBIG)		SSS (salary, emergency, housing), HDMF (Pag-IBIG)	OWWA	

Source: Author's summary from relevant documents.

3.2.1. Government Service Insurance System

The GSIS was created through Commonwealth Act No. 186 in November 1936 to promote the efficiency and welfare of the employees of the Philippine government and to replace the pension systems established in Acts 1638, 3050 and 3173.

PD 1146, otherwise known as the Revised Government Insurance Act of 1977, expanded, increased, integrated and facilitated the payment of the social security and insurance benefits of government employees under Commonwealth Act No. 186. PD 1146 was amended by the current GSIS law, RA 8291 otherwise known as the GSIS Act of 1997, to further expand and increase the coverage and benefits of the GSIS.

Coverage. The GSIS covers all government employees irrespective of their employment status, except for the following: employees who have separate retirement laws such as the members of the Judiciary and Constitutional Commissions; contractual employees who have no employee-employer relationship with their agencies; and members of the Armed Forces of the Philippines (AFP) and the Philippine National Police (PNP), including the Bureau of Jail Management and Penology and the Bureau of Fire Protection (BFP).

Contribution. The monthly contribution rate is equal to 21% of the member's monthly compensation, with 9% payable by the employee and the remaining 12% by the employer. The employer's share includes a 4% premium for life insurance. Members of the judiciary and constitutional commissioners contribute 3% of their monthly compensation while the government pays a corresponding 3% share for their life insurance coverage.

Social Security Benefits. The GSIS provides the following social security benefits to all its members to provide coverage for contingencies such as retirement, death/ survivorship, disability benefits, separation and unemployment. The fulfillment of its obligations to its members is guaranteed by the government of the Republic of the Philippines (RA 1891, Sec. 8).

Old-age/ Retirement Benefits. The retirement benefits of government employees depend on the mode of retirement chosen. Although the compulsory retirement age from government service is 65, a government employee may apply for any of the following four retirement modes as soon as he/ she meets the corresponding eligibility criteria, which include length of service, age and date of entry into the service:

1) RA 1616 (Gratuity/ Optional Retirement) – The retirement benefits include a refund of the retiree's personal contributions with 3% interest and the corresponding government share without interest and a gratuity benefit equivalent to one month's salary for every year of service, based on the highest rate received, but not to exceed 24 months. To be eligible, a member must have at least 20 years of service regardless of age, must be in service on or before May 31, 1977 and must have no previous record of retirement under RA 1616 or RA 660.
2) RA 660 (Annuity/ Pension Retirement) – Under this mode, the GSIS grants a maximum monthly pension equivalent to 75% of the average monthly salary (AMS) received during the last 3 years immediately preceding retirement for retirees aged 57 and below and 80% of the AMS for those above 57 years old. The benefits can be taken in the form of a) an automatic pension or b) a three-year or five-year lump sum (60 months x basic monthly pension (BMP[3])). For a member to be eligible, he/ she must pass the "Magic 87" criteria, i.e., when the length of service and age of retirement are summed up, the total is at least "87"; he/ she must have been in the service on or before May 31, 1977; and he/ she must have a continuous last three years of service, except in cases of death, disability, abolition and phase-out of position due to reorganization.
3) RA 8291 - A retiree may choose from any of two retirement benefit options: (1) a 5-year lump sum (60 x basic monthly pension (BMP)) payable at the time of retirement plus an old age pension benefit payable monthly for life after the 5-year guaranteed period or (2) a cash payment (18 x BMP) plus a monthly pension for life payable immediately, without the 5-year guarantee. The BMP is subject to periodic adjustment as may be recommended by the GSIS's actuary and approved by the Board. The BMP has been increased by 10% every year. To be eligible, the retiree must have been in government service on or after June 1, 1977, have rendered at least 15 years of service, be at least 60 years of age, and not be receiving a monthly pension benefit due to permanent total disability (PTD) (RA 8291, Sec. 13).

[3] The basic monthly compensation (BMP) is computed as follows: 37.5% of the revalued average monthly compensation (AMC) in the last three years plus 2.5% of the AMC in the last three years for each year of service in excess of 15 years. The BMP shall not exceed 90% of the AMC nor shall it be less than PhP1,300 for those who have served at least 15 years or PhP2,400 for those who have rendered 20 years of service after RA 8291 (Sec. 9) took effect.

4) PD 1146 – The retirement benefit options include a BMP for life guaranteed for 5 years or a 5-year lump sum (60 x BMP) and BMP after 5 years or a cash payment equivalent to 100% of the average monthly compensation for every year of service payable upon reaching age 60 or upon separation after age 60. If a pensioner is re-employed, payment of the pension shall be suspended and the retiree shall refund the GSIS an amount corresponding to the unexpired period.

A new law RA 9946 signed in January 2010 sets the pension of the members of the Judiciary who have rendered at least 15 years of service equal to their basic pay plus the highest transportation and representation allowance.

RA 7699 (Portability Law) applies for workers covered by GSIS or SSS who transfer employment from one sector to another or are employed in both sectors but do not satisfy the required years of service under PD 1146 and RA 8291 without "totalization". This is the process of combining the periods of creditable services or contributions in the private sector, represented by contributions to the SSS with government services or contributions to the GSIS for purposes of eligibility and computation of benefits for retirement, disability, survivorship, and other benefits under either PD 1146 or RA 8291. The amount of benefits that will be received from one System shall be in proportion to the number of contributions remitted to that System.

Survivorship Benefits. Beneficiaries of a member or pensioner who is in the service or has at least rendered 3 years of service at the time of his/ her death (RA 8291, Sec. 20-22) are eligible for survivorship benefits. The benefits include: a) a survivorship pension which consists of the basic survivorship pension which is 50% of the BMP payable to the spouse for life or until he/ she remarries and a dependent children's pension not exceeding 50% of the BMP to be paid until the age of majority, marriage, employment or death of the child; or b) survivorship pension plus a cash payment equivalent to 100% of his Average Monthly Compensation (AMC) for every year of service if the deceased was in the service at the time of his death with at least 3 years of service; or c) cash payment equivalent to 100% of his AMC for each year of service but not less than PhP12,000. RA 8291 also provides for a funeral benefit of at least PhP12,000 (RA 8291, Sec. 23). The amount has been increased to PhP20,000 as of January 2000.

Disability Benefits. Members who suffer disability for reasons not due to any of the following conditions, namely, grave misconduct, notorious negligence, habitual intoxication, or willful intention to kill oneself or another, and who meet the other eligibility requirements of the GSIS are entitled to disability benefits. The disability benefits may include a monthly income benefit for life, an additional cash payment or a cash payment to be determined by the GSIS. The benefits vary according to the schedule of disabilities prescribed by the GSIS as follows: 1) for permanent total disability (PTD)[4], a monthly income benefit for life equal to the BMP effective from the date of disability plus an additional cash payment equivalent to 18 times his/ her BMP or a cash payment equivalent to 100% of his/ her AMC for each year of service he paid contributions, but not less than PhP12,000; 2) for permanent partial disability (PPD)[5], a cash payment in accordance with the prescribed schedule of disabilities; 3) for temporary total disability (TTD)[6], 75% of a member's current daily compensation but not less than PhP70 per day for a maximum of 120 days in a year after exhausting all leave credits and an extension not to exceed a total of 240 days if more extensive treatment is required beyond 120 days; and 4) for non-scheduled disability or injuries or illnesses resulting in a disability not listed in the schedule of partial/total disability, the benefits are to be determined by the GSIS based on the nature of the disability (RA 8291, Sec. 15-19).

Separation Benefits. Members of the GSIS who separated from government service before the retirement age but have rendered at least 3 years of service and are below 60 years of age are entitled to separation benefits in the form of cash payments. For members who have rendered at least 3 years but less than 15 years of service, the cash payment is equivalent to 100% of the AMC for every year of service but not less than PhP12,000 payable upon reaching the age of 60 or upon resignation or separation,

[4] PTD arises when the likelihood of recovery from impairment is medically remote. Injuries resulting in any of the following are deemed as PTD: complete loss of both eyes; loss of two limbs at or above the ankle or wrist; permanent complete paralysis of two limbs; brain injury resulting in incurable imbecility or insanity; and such other cases as may be determined by the GSIS (RA 8291, Sec.16)

[5] PPD arises when there is functional loss of any part of the body, despite which gainful occupation can still be pursued. The following are disabilities deemed as PPD: complete and permanent loss of the use of any finger, any toe, one arm, one hand, one foot, one leg, one or both ears, hearing of one or both ears, or sight of one eye and such other cases as may be determined by the GSIS (RA 8291, Sec. 17).

[6] TTD arises when mental/ physical impairment can be rehabilitated or restored to normal function.

which ever comes later. For members who have served the government for at least 15 years, the cash payment is equivalent to 18 times the BMP payable upon separation plus an old age benefit pension for life starting at age 60. An unemployment or involuntary separation benefit, also in the form of a cash payment, is granted to permanent employees who have rendered less than 15 years of government service and have been paying contributions for at least one year but separated involuntarily due to the abolition of his/ her office or position, usually arising from reorganization. The cash payment is equivalent to 50% of AMC payable for a period of 2 to 6 months depending on the length of contribution, which ranges from one year to less than 15 years prior to unemployment or involuntary separation.

Life Insurance. All government employees except for members of the AFP and PNP are automatically covered by compulsory life insurance, in particular, a Life Endowment Policy (LEP) for those who entered the service prior to August 1, 2003 and an Enhanced Life Policy (ELP) for those who entered the service after July 31, 2003 and members whose policies have matured. The life insurance benefits include, among others, policy loans and annual dividends. The GSIS also offers its members an optional insurance and/ or pre-need coverage for life, health, hospitalization, education, memorial plans and such other plans as may be designed by the system with premiums payable by the insured or his employer and/or any person acceptable to GSIS.

Lending Program. The GSIS also provides service loans to its members and pension loans for retirees.

GSIS Mutual Fund Program. The GSIS Kinabukasan Fund is a balanced fund[7] managed by the Philam Asset Management Inc. (PAMI), a member of the Philam Group of Companies, starting in 1998. It was intended to provide affordable investment options for government employees. The minimum investment requirement is PhP1,000 for members and PhP5,000 for non-members (optional). The mutual fund registered an annual return on investment as high as 21.92 percent in 2007. As of February 2010, the year to date return is 1.58% (http://www.philamfunds.com.ph).

Status. In 2005, the estimated number of membership of the GSIS is 1.5 million and it is disbursing 32.4 billion in benefits.

[7] A type of mutual fund that combines a stock component, a bond component and sometimes a money market component in a single portfolio

3.2.2. Social Security System (SSS)

The SSS was established through the Social Security Act of 1954 (RA 1161) as amended by RA 1792 in 1957 after a series of deliberations and studies following a recommendation to Congress to enact a law to establish a social security system for wage earners and low-salaried employees in 1948. In September 1, 1957, the SSS commenced operations with only 211 employees covering all employees in private business and industry with 50 or more employees. Between that time and the current governing law, the Social Security Act of 1997 (RA 8282) which amended RA 1161, the SSS has been strengthened and enabled to expand its coverage, provide substantial increases in social security benefits, extend more loan privileges, and establish a voluntary provident fund for its members, among others.

Coverage. Coverage in the Social Security System (SSS) is compulsory for employers and all private sector workers not over 60 years old including private employees whether permanent, temporary or provisional; self-employed persons[8]; household helpers with a monthly income of at least PhP1,000; Filipino seafarers; and employees of a foreign government, international organization or their wholly-owned instrumentality based in the Philippines. Voluntary coverage is extended to separated members, non-working spouses of SSS members, and overseas Filipino workers (OFWs).

Contribution. The monthly contribution rate is equivalent to 10.4% of a worker's monthly salary credit (MSC), with the employee paying 3.33% (except for self-employed and voluntary members who pay the full amount) and the employer paying the remaining 7.07% effective January 1, 2007. The rate is applied to 29 MSC brackets which ranges from PhP 1,000 to PhP15,000 resulting in a corresponding monthly contribution which ranges from PhP 104 to PhP 1,560.

Social security benefits. The SSS provides the following social security benefits: retirement benefits, death and funeral benefits, permanent disability benefits, sickness

[8] Self-employed persons are individuals with an income of at least P1,000 a month and not over 60 years old, engaging in trade or professions including but not limited to self-employed professionals; partners and single proprietors of businesses; actors and actresses, directors, scriptwriters and news correspondents who are not under an employer-employee relationship; professional athletes, coaches, trainers and jockeys; individual farmers and fishermen; and workers in the informal sector such as cigarette vendors, watch-your-car boys, and hospitality girls, among others.

benefits, and maternity benefits. Solvency of the SSS is guaranteed by the Government of the Republic of the Philippines (RA 8282, Sec. 21).

Retirement benefits. Private sector employees and self-employed persons may take cash payments, either as a monthly pension[9] or lump sum as their retirement benefit (RA 8282, Sec. 12-B). Members who have paid at least 120 monthly contributions and have reached 60 years or have reached the age of 65 at retirement are eligible for a monthly pension for life with the option of receiving the first 18 monthly pensions in a lump sum discounted at a preferential rate of interest to be determined by the SSS. A lump sum benefit equal to the total contributions paid is available to members who are 60 years old at retirement but do not qualify for a monthly pension, provided he/ she has ceased employment and is not continuing payment of SSS contributions on their own.

Death, funeral and survivorship benefits. If an SSS member, retiree or a member with permanent total disability dies, his/her primary or secondary beneficiaries[10] shall receive a monthly pension or a lump sum benefit as death benefit. For a deceased member who has made 36 monthly contributions prior to the semester of death, the primary beneficiaries shall be given a monthly pension. In the absence of primary beneficiaries, a lump sum benefit is granted to the secondary beneficiaries. For a member who has not paid the required 36 months contributions, his primary or secondary beneficiaries shall receive a lump sum benefit. Aside from the death benefit, beneficiaries of the deceased are also entitled to other benefits such as the 13th month pension payable every December. A funeral benefit of PhP20,000 is also paid to the one who shouldered the funeral expenses of the deceased member or pensioner, regardless of whether he/ she has paid any contribution. Hospitalization benefits under PhilHealth are provided to survivorship pensioners prior to the effectivity of RA7875 on March 4,

[9] The monthly pension is based on the number of paid contributions and the years of membership with the amount set at PhP1,000 for members with less than 10 credit years of service (CYS), PhP1,200 for those with at least 10 CYS, and PhP2,400 for those with 20 CYS (RA 8282, Sec. 12 (a)). It is the highest of the following amounts: 1) PhP300 plus 20% of the average monthly salary credit (AMSC) plus 2% of AMSC for each CYS in excess of 10 years; 2) 40% of AMSC; or 3) PhP1,000 provided that the monthly pension shall in no case be paid for an aggregate amount less than 60 months. See also Templo (2002) for the pension formula.

[10] The primary beneficiaries are the legitimate dependent spouse until the person remarries and the dependent legitimate, legitimated, or legally adopted, and illegitimate children of the member who are not yet 21 years old. The dependent parents shall be the secondary beneficiaries, in the absence of primary beneficiaries. Any person designated by the member as beneficiary in the member's record shall be the secondary beneficiary, in the absence of all the foregoing. (RA 8282, Sec. 8-k)

1995. The minor children of a deceased member, up to a maximum of five children are also entitled to a dependents' pension, which is equivalent to 10% of the monthly pension or PhP250, whichever is higher. The dependent's pension is granted until age 21 and will terminate when he/ she is employed, married or dies.

Disability Benefits. An SSS member who suffers partial or total disability is granted either a monthly pension if he/ she has paid 36 monthly contributions prior to the semester of disability or a lump sum amount if the required 36 monthly contributions are not paid. A minimum of one monthly contribution paid qualifies a disabled member to receive a disability benefit. The monthly pension is granted for life to members with permanent total disability (PTD) and primary beneficiaries of a deceased PTD pensioner. The monthly pension is granted for a designated period only or may be given in a lump sum if it is payable for less than 12 months to members with permanent partial disability (PPD). Dependents of members with PTD, limited to five minor children, are also entitled to a dependents' pension. The monthly pension and dependents' pension are suspended when the member is re-employed or resumes self-employment, recovers from disability, or fails to present himself/ herself for examination at least once a year upon notice by the SSS. Aside from the cash benefit, a supplemental allowance of PhP500 is given to total or partial disability pensioners. Hospitalization benefits under PhilHealth are provided to total disability pensioners and their legal dependents prior to the effectivity of RA 7875. The SSS is currently implementing a new re-designed disability program, which aims to ensure the payment of the right cash benefit to deserving members. The new disability program adopts the World Health Organization's (WHO) definition[11] of disability and the International Statistical Classifications of Diseases and Related Health Problems Codes (ICD-10), includes medical and functional assessments and requires annual assessment of all pensioners except those with scheduled disabilities stated in RA8282, Sec. 13-A (f).

Sickness Benefits. A daily cash allowance is paid as sickness benefit to SSS members for the number of days that they are unable to work due to sickness or injury (RA 8282 Sec. 14 and 14-A). The sickness benefit is equivalent to 90% of a member's

[11] Disability is defined as any "restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered normal for a human being" while impairment is any loss or abnormality of psychological, physiological or anatomical structure or function.

average daily salary credit and can be granted for a maximum of 120 days in a year or 240 days in a single hospitalization. This benefit is available to employed, unemployed, self-employed or voluntary paying members who have paid at least 3 monthly contributions prior to illness and whose period of stay in a hospital or elsewhere with SSS approval is more than 3 days. A member, within a period of 5 days after the start of the sickness or injury, should notify the employer who must, in turn, notify the SSS within 5 days.

Maternity Leave Benefits. A daily cash allowance equivalent to 100% of the average daily salary credit for 60 days or 78 days in case of a caesarean section delivery for the first four deliveries or miscarriages is granted as maternity benefit to female SSS members unable to work due to childbirth or miscarriage. To be eligible, at least three monthly contributions within the 12-month period immediately preceding the semester of her childbirth or miscarriage must have been paid and she must have properly notified her employer about her pregnancy, or the SSS if she is a separated, voluntary or self-employed member.

Lending Programs. The SSS also extends salary, housing and business loans to its members.

Status. In 2007, the SSS has 28 million members and disbursed some 60.7 billion in benefits.

3.2.3. Employee's Compensation Commission (ECC)

The ECC was created in November 1, 1974 by virtue of PD 442 otherwise known as the Labor Code of 1975 and became fully operational with the issuance of PD No. 626 otherwise known as the Employees' Compensation and State Insurance Fund. The ECC, a quasi-judicial corporate entity attached to the Department of Labor and Employment was created to initiate, rationalize and coordinate the policies of the Employees' Compensation Program (ECP). The ECP, established under PD 442, Art 166-208A provides employees and their dependents a package of benefits in the event of work-connected contingencies such as sickness, injury and disability.

The ECC is composed of five ex-officio members, namely, the Secretary of Labor and Employment as Chairman, the GSIS Manager, the SSS Administrator, the Chairman of the Philippine Health Insurance Corporation, and the Executive Director of the ECC,

and two other members who are appointed by the President of the Republic to represent employees and employers. The GSIS Manager or the SSS Administrator is vested with the general conduct of the operations and management functions of the GSIS or the SSS under PD 626.

Coverage. Coverage in the State Insurance Fund (SIF) is compulsory for all employers and their employees, both in the public and private sectors, including Filipino employees working abroad who are not over 60 years old and paying contributions to qualify for retirement or life insurance benefit. Employers are obliged to pay monthly contributions to the SIF until such time as a covered employee dies, becomes disabled or is separated from employment. The amount is equivalent to 1% of an employee's monthly salary credit.

Benefits. The ECC is liable to pay the employee and his dependents compensation except for the following causes of disability or death: intoxication, willful intention to injure or kill himself or another, notorious negligence or otherwise provided under PD 626. The employee compensation (EC) benefits include: 1) medical benefits, 2) disability benefits, and 3) death and funeral benefits. The EC benefits are guaranteed by the Republic of the Philippines which likewise accepts general responsibility for the solvency of the SIF.

Medical Benefits. The System shall provide an employee with medical services and appliances immediately after contracting an injury or illness and during the subsequent period of disability. The medical benefits cover all fees and other charges for hospital services, medical care and appliances which shall not be higher than those prevailing in wards of hospitals for similar services to injured or sick persons in general. The medical benefits shall include payment of professional fees that are appreciably higher than those prescribed under the Philippine Medical Care Act of 1969 (RA 6111, as amended). The System also provides rehabilitation services, which consist of medical, surgical or hospital treatment, including appliances to injured and handicapped employees.

Disability Benefits. The System pays any employee with temporary total disability (TTD) an income benefit equivalent to 90% of his average daily salary credit provided the daily income benefit "shall not be less than PhP10 and not more than 20 days or more than PhP90 nor paid for a continuous period longer than 120 days, except as

otherwise provided by the Rules and the System shall be notified of the injury or sickness". For an employee with permanent total disability (PTD), the System pays a disability benefit equivalent to the monthly income benefit plus 10% thereof for each dependent child but not exceeding five children, guaranteed for 5 years subject to suspension once the pensioner is gainfully employed or recovers from his PTD, or whenever he fails to present himself for examination upon notice from the System. For an employee with permanent partial disability (PPD), the income benefit is equivalent to the income benefit for PTD for each month not exceeding a designated period for such disability. The System is also liable to pay income benefits to any employee under PPD who suffers another injury which results in a greater disability.

Death and Funeral Benefits. The System pays to the primary beneficiaries of a deceased member an amount equivalent to his monthly income benefit, plus 10% thereof for each dependent child, up to a maximum of five children, guaranteed for 5 years. In the absence of primary beneficiaries, the System will grant his secondary beneficiaries the monthly income benefit but not to exceed 5 years. The minimum death benefit is PhP15,000. For deceased PTD pensioners, their primary beneficiaries shall receive 80% of the monthly income benefit while their dependents' shall receive the dependents' pension. A funeral benefit of PhP3,000 is paid to beneficiaries of a deceased covered employee or PTD pensioner.

The ECC also implements a rehabilitation program for occupationally disabled workers (ODWs) which includes the ECC-QRT Program, the KaGaBay Program, and the ODW Friendly Employer Award. It also carries out advocacy on ECP, and industrial clinic programs, and a public assistance program.

Status. Since GSIS and SSS administer the ECC programs for the public and private sector workers, respectively, performance is usually included in the administering institutions.

3.2.4. Philippine Health Insurance Corporation (PhilHealth)

The PhilHealth succeeded the Philippine Medicare Commission in 1995 with the enactment of RA 7875 and assumed the responsibility of administering the Medicare program for government and private sector employees with its transfer and the turnover of the health insurance funds from the GSIS in October 1997 and from the SSS in April

1998.

Coverage. PhilHealth is mandated to provide universal coverage including all employees in the government and private sector, including household help and sea-based OFWs, and officers and uniformed and non-uniformed personnel of the AFP, PNP, BJMP, and BFP who entered the service after the effectivity of RA 8291; individually-paying members; indigent members paid for by Local Government Units; retiree-members; and dependents.

Benefits. PhilHealth provides its members with a wide range of personal health services consisting of in-patient hospital care, out-patient care; health education packages; emergency and transfer services; and such other health care services as may be determined by the PHIC. The in-patient hospital care package include allowances for hospital room and board fees from PhP300 to PhP1,000 per day for up to 45 days per year for each member and another 45 days to be shared by their dependents; drugs and medicines from PhP2,700 to PhP40,000 and allowances for x-ray and other laboratory exams from PhP1,600 to PhP30,000 per single period of hospitalization; use of the operating room complex; and professional fees for attending physicians. The other PhilHealth benefit packages include a maternity care package, day surgery benefit, out-patient TB package, dialysis, chemotherapy and radiation therapy, and out-patient benefits for the poor.

PhilHealth benefits are granted to the following: 1) an SSS or GSIS member who has paid premium contributions for at least 3 months within the 6 months prior to the 1st day of his or his dependents' receipt of benefit; 2) retirees and pensioners of the SSS and GSIS and their dependents prior to the effectivity of this Act; 3) members who reach retirement age and have paid at least 120 monthly contributions; and 4) enrolled indigents.

Status. As of March 2009, PhilHealth estimated it has covered at least 82%[12] of the population or about 77 of the 92 million populations when dependents are counted. It granted 17.4 billion worth of benefits in 2007.

[12] This is based on administrative reports. Other estimates show substantially lower coverage (Herrin, 2010).

3.2.5. Home Development Mutual Fund (HDMF)

The HMDF or Pag-IBIG[13] Fund was established in 1978 to address the need for a national savings program and an affordable source of finance for Filipino workers by virtue of PD 1530, as amended by PD1752 and RA7742. The Fund was initially administered by two agencies – the GSIS for the savings of government workers and the SSS for the savings of private employees. In 1979, administration of the mutual fund was transferred to the National Home Mortgage Finance Corporation (NHMFC). The funds from the government and private workers were also merged into what is now known as the Pag-IBIG Fund to make it more stable and viable. The signing of PD 1752 known as the HMDF Law of 1980 made the Pag-IBIG Fund independent from the NHMFC.

Coverage. Coverage was initially voluntary under PD 1530 and then made mandatory upon all GSIS and SSS members and their respective employers and voluntary only for those with a monthly compensation of less than PhP4,000 under PD 1752. The latter also extended the coverage to other working groups, with or without employer contributions. It became voluntary again in 1986 (EO 96) and back to a combination of mandatory and voluntary under RA 7742 in 1995. Under RA 9679 or the HMDF Law of 2009 membership to the Pag-IBIG Fund is mandatory for all employees covered by the GSIS and the SSS, including uniformed members of the AFP, BFP, BJMP and PNP and Filipinos employed by foreign-based employers. Voluntary membership is extended to spouses who devote themselves to managing the household and family affairs. Other working groups, with or without employer contributions may also be covered, as may be determined by the Board of Trustees. The term of membership is 20 years but may be terminated earlier for reasons of retirement, disability, insanity, death, departure from the country or other causes as may be provided by the Board of Trustees.

Contribution. The monthly contribution of employees to the provident Fund is one (1) percent for those earning below PhP1,500 per month and two (2) percent for those earning above PhP1,500 per month. All employers are required to pay the employer's counterpart of two percent (2%) of the monthly compensation of all covered employees.

[13] Pag-IBIG is an acronym for Pagtutulungan sa Kinabukasan: Ikaw, Bangko, Industriya at Gobyerno

For voluntarily-paying spouses, their monthly contribution is based on one half (1/2) of the monthly compensation income of the employed spouse. Contributions to the fund shall be based on a maximum monthly compensation of PhP5,000 the amount of which may be subject to change from time to time by the Board of Trustees taking into account actuarial calculations and rates of benefits. All the personal and employer counterpart contributions are credited to each member and are transferable in case of change of employment.

Provident claims. Under RA 9679, a member may claim the total accumulated value (TAV) of his/ her contributions after the 15th year of continuous membership provided the member has no outstanding housing loans. The TAV consists of the member's accumulated personal contributions, the employer's counterpart contribution, if applicable, and dividend earnings credited to the member's account. The dividend rate is 70% of the Pag-IBIG Fund's annual net income and is tax-free. Payment is made upon maturity of membership, retirement, death, disablement or emigration.

Other benefits. Housing loans are made available to members in good standing. The HMDF also provides its members with multi-purpose loans, calamity loans and special short-term loans. The multi-purpose loan is equivalent to up to 60% of the total accumulated value of a member's contributions. As with the benefits of the GSIS, SSS and ECC, the benefits prescribed under RA 9679 are guaranteed by the Government of the Republic of the Philippines.

Shelter Financing Programs. The HMDF is mandated to invest not less than 70% of its investible funds in housing. The HMDF implements four shelter financing programs, namely, end-user financing; the Expanded Housing Loan Program (EHLP), Others (folio 1, overhang, withdrawals prior to EHLP, UHLP); and institutional financing. The latter includes direct development loans; group land acquisition and development programs; Pag-IBIG City; medium/ high rise building; housing liquidity bond window; LGU Pabahay Program; credit facility for private developers/ interim financing; purchase of housing receivables; house construction financing line; and other development financing programs.

Status. As of 2007, the HDMF has 6.8 million members and disbursed some 4 billion in benefits for the same year.

3.2.6. Armed Forces of the Philippines Retirement and Benefit System (AFP-RSBS)

The AFP-RSBS was created by PD 361 issued in December 1973. Operations, however, started only in October 1976. It was created for "payment of retirement and separation benefits provided under existing laws to military members of the Armed Forces of the Philippines". It is administered by the Chief of Staff of the AFP. It is funded through appropriations and contributions; donations, gifts, legacies, bequests and others to the System; and all earnings of the System.

Coverage. It covers all officers and enlisted personnel in the active service of the AFP.

Contribution. Contribution to the System is mandatory except for officers or enlisted personnel of the AFP who were due for retirement or were optionally retirable and actually elected to retire within one year from its approval. The contribution rate is equivalent to 4% of a member's monthly base salary and longevity pay. The rate was later raised to 5% by PD 1656 in 21 December 1979. PD 1909 issued on March 22, 1984 required retirees who had retired prior to September 10, 1979 to contribute 5% of their monthly pensions to the scheme.

Benefits. The benefits include: 1) retirement and/ or separation gratuity payments or pensions for AFP personnel who were already retired at the effective date of this law and for those who were exempted from paying contributions and 2) a refund of all contributions to the System plus 4% interest for any officer or enlisted person who is separated from the service through no fault of their own and is not eligible for either retirement or separation benefits.

The scheme suffered several problems and had been subject to several congressional investigations. A bill (HB6929) was filed in Congress seeking dissolution of the program[14]. Finally, EO 590 was issued on 15 December 2006 de-activating the AFP-RSBS effective 31 December 2006. The EO specified the return of the member's contributions plus 6% interest upon retirement. Payment of obligations is guaranteed by the national government and implemented through the Department of National Defense.

[14] Source: **Jasmin Camero, MRS-PRIB "**Abolition of AFP Retirement and Separation Benefit System Sought" 10 November 2009 http://www.congress.gov.ph/press/details.php?pressid=3884

3.2.7. Overseas Workers Welfare Administration (OWWA)

The OWWA, an attached agency of the Department of Labor and Employment (DOLE), is mandated to deliver welfare services and benefits to overseas Filipino workers (OFWs) and their dependents and to ensure the build-up of capital and viability of the OWWA fund[15]. The creation of OWWA began with the creation of a "Welfare and Training Fund for Overseas Workers" in the Department of Labor through LOI 537 in May 1997. The LOI provided social and welfare services to OFWs including insurance coverage, social work assistance, legal assistance, placement assistance, cultural services, remittance services and the like. In 1980, PD 1694, as amended by PD 1809, formalized LOI 537 into the Welfare Fund for Overseas Workers (Welfund) and ordered fund transfer from all sources to Welfund to be administered by a Board of Trustees. Welfund was renamed OWWA under EO 126 (Sec. 19f).

EO 195 in 1994 provided a Medical Care (MEDICARE) Program for OFWs and their dependents who are not covered by the Philippine Medical Care Program of the SSS. The "Migrant Workers and Overseas Filipinos Act of 1995" (RA 8042) strengthened OWWA's mandate and services for OFWs and their dependents. In particular, Sec. 15 of RA 8042 provided for the repatriation of workers in cases of war, epidemics, disasters or calamities, natural or man-made, and other similar events, subject to reimbursements by the responsible principal or recruitment agency. In cases where the principal or recruitment agency cannot be identified, OWWA shall bear all costs attendant on repatriation. For this purpose, OWWA created and established the Emergency Repatriation Fund. The Re-placement and Monitoring Center (RPMC) for returning Filipino migrant workers was also established. A Migrant Workers Loan Guarantee Fund was also established to try to prevent unscrupulous illegal recruiters and loan sharks from taking advantage of workers needing a loan to finance the costs of overseas employment.

OWWA BOT Resolution No. 038 in 2003 established the Omnibus Policies of the OWWA. The DOLE Secretary was designated through EO 446 in July 2005 to oversee

[15] The OWWA fund is "a single trust fund pooled from the US$25.00 membership contributions of foreign employers, land-based and sea-based workers, investment and interest income, and income from other sources" (http://www.owwa.gov.ph/index.php?page=about-owwa).

and coordinate the implementation of the different initiatives for OFWs.

Contribution. A USD 25 membership contribution is collected from foreign employers and land-based and sea-based workers.

Benefits. The OWWA provides the following insurance and health-care program benefits for its members: 1) life/ accident insurance – a life insurance coverage of PhP100,000 for natural death and PhP200,000 for accidental death for the duration of employment contract; 2) disability and dismemberment benefits ranging from PhP2,000 to PhP50,000; 3) total permanent disability benefit of PhP100,000; and 4) burial benefit of PhP20,000.

OWWA also grants members, and their designated beneficiary, scholarships to education and training programs subject to a selection process and accreditation of participating institutions. It also implements social services and family welfare assistance programs such as the repatriation program, the reintegration program and the OWWA-NLSF LDPO Project. OWWA also provides loan packages such as the collateral loan window which has a loan ceiling of PhP200,000 for individual borrowers and PhP100,000 per group and a 9% interest rate per annum. The OFW Groceria Project is another loan assistance package extended to qualified OFW Family Circle beneficiaries in the form of merchandise goods worth PhP50,000 free of tax.

Status. As of 2007, the number of members of the OWWA schemes is estimated to be 1.2 million and benefits disbursed for the year amounted to 425.7 million.

4. Assessment

4.1. Coverage

Following Van Ginneken (2008), we discuss coverage in terms of three dimensions, namely (a) people, (b) contingencies, and (c) benefit levels. Assessment of the Philippine social protection system shows that coverage of people is low (under 50%) at best and while there are schemes developed for each of the contingencies, the coverage is expected to be even lower than that for pensions.

4.1.1. People

The Philippine Social Insurance programs virtually covers formal sector workers only (see of instance Manasan (2009b), ILO (1996), WB (1995)). Within the formal sectors, the public sector workers are well covered compared to the private sector workers. Table 7 shows the number of contributing SSS members by type from 2000-2009. It also shows the size of the approximate eligible population. By SSS law the eligible population includes private sector wage-workers, the self-employed and OFWs. Comparison of the number of contributing members with the eligible population shows that the coverage for the wage-workers ranges from 36 to 48 percent for 2000 to 2009. For own account workers,[16] the coverage is even lower ranging from 12 to 15 percent. Coverage of the OFWs is of similar magnitude (11 to 15 percent).

Table 7. Estimated SSS Coverage of Private Sector Workers

Year	Contributing SSS Members (000)			Workers (000)			Estimated Coverage (%)		
	Employed	Voluntary	OFWs	Private wage & salary workers	Own account	OFW Deployed	Private wage & salary workers	Own account	OFW Deployed
	[a]	[b]	[c]	[d]	[e]	[f]	[a]/[d]	[b]/[e]	[c]/[f]
2000	5,519	1,343	89	11,534	10,471	842	48	13	11
2005	6,054	1,463	112	16,438	12,263	989	37	12	11
2006	6,327	1,533	141	14,141	11,938	1,063	45	13	13
2007	6,592	1,573	158	14,580	12,290	1,078	45	13	15
2008	6,715	1,683	175	15,160	12,259	1,236	44	14	14
2009	6,850	1,833	197	18,874	12,240	n. a	36	15	-

Source of basic data: SSS and LFS, various years.

Even if the problem has been well recognized in the early 1990s (e.g. ILO, 1996 and WB, 1995), there is still no real progress with respect to the coverage of "irregular" workers. The current SSS law has expanded coverage to the self-employed, overseas workers and even household workers. Their enrolment, however, is expected to be low, given that enrolment of the primary eligible population - formal sector wage-workers - is low. Table 7 shows the coverage for the own account workers and OFWs is estimated to be only between 11-15%.

Another way of looking at coverage is to compare the computed number of

[16] Consisting of the self-employed and employers

pensioners and the eligible population aged 60 years and above. This also indicates low coverage. For instance, as of 2006 the recorded number of social insurance beneficiaries is 1.95 million for SSS and 0.136 million for the GSIS or a total of 2.08 million (Table 8). Relative to the estimated population of 60 years and above in 2006 (from the medium series projection of the NSO based on the 2000 Census) of 5.46 million, this implies a coverage rate of 38%.

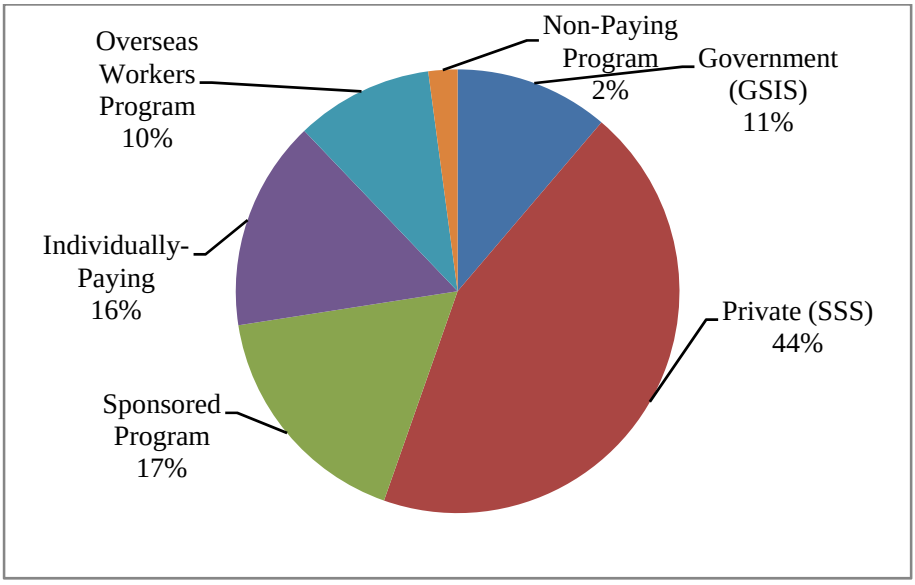
Table 8. Number of Beneficiaries, SSS and GSIS

	SSS	GSIS	Total	Estimated	Estimated
	Social Security	Social Insurance	Social Security Beneficiaries	Population 60 & above	Coverage (%)
2000	1,686,686	154,238	1,840,924	4,587,800	40
2001	1,775,995	167,749	1,943,744	4,713,081	41
2002	1,823,822	185,209	2,009,031	4,842,540	41
2003	1,858,917	127,143	1,986,060	4,976,334	40
2004	1,901,848	149,019	2,050,867	5,114,631	40
2005	2,022,110	135,633	2,157,743	5,257,600	41
2006	1,949,269	135,633	2,084,902	5,460,290	38
2007	2,036,440	n. a	-	-	-
2008	2,188,807	n. a	-	-	-

Source:
SSS : SSS Contributing Members.
NSO (LFS) : Private wage and salary workers, own account workers.
POEA : OFW Deployed

In terms of health insurance, the coverage is much better. The PHIC estimates 77 million (or 82%) of the 92 million are covered as of March 2009. There are, however, other estimates discussed below that indicate a much lower rate of coverage than what administrative reports indicate. Based on the 2007 data, the structure of its 15.8 million members is as follows: 11% government employees, 44% private sector employees, 17% sponsored programs, 15% individually paying members, 10% overseas workers, and 2% non-paying members (Figure 1). Comparing the number of members to the eligible population shows that 68% of government workers, 48% of private sector wage-workers and 20% of own-account workers are covered. The sponsored program is intended for indigents. The payment of the premium for this program is shared by the national and local governments.

Figure 1. Structure of PHIC Membership, 2007



Source: PHIC

The coverage discussed above refers to averages. It would be instructive to look at the profile of the covered population. Unfortunately, the profiles of those covered by the social security scheme are often not readily available. To give us an indication of this, we gauge the extent of the coverage using indirect measures, i.e., using data from household surveys. The Family Income and Expenditure Surveys (FIES) provide detailed data on income and expenditure of households. On the expenditure side, households paying insurance premiums can be identified. On the income side households receiving pension incomes can also be identified. The Annual Poverty Indicators Survey (APIS) also provides similar income and expenditure data. In addition, other useful information like households having at least one member who has health insurance from either the PHIC or other private health insurance is also provided.

Finally, the National Demographic Survey also provide data on health insurance coverage and the most recent round (2008) even asked for coverage information for individual members giving a more precise measure of coverage compared to the one used in APIS.

FIES expenditure data show that only 33% of households, on average, are paying an insurance premium (Table 9). What is more notable, although not very surprising, is the wide disparity of those paying insurance premiums across income groups. Only 2% for

the bottom decile pay insurance premiums while this is 80% for the topmost decile. The same survey also says that only about 24% of households whose head is 60 years and above received a pension income (Table 10).

Table 9. Pay Insurance Premium by Income Deciles, 2006

Income Deciles	Pays Insurance Premium
First Decile	0.02
Second Decile	0.04
Third Decile	0.08
Fourth Decile	0.13
Fifth Decile	0.21
Sixth Decile	0.32
Seventh Decile	0.42
Eigth Decile	0.58
Ninth Decile	0.67
Tenth Decile	0.80
Total	0.33

Source: Author's calculation using FIES 2006.

Table 10. Households with Heads of 60 Years and above who are receiving Pensions, 2006

Age of HH	With Pension Income	Mean Pension Income	Ratio Pen. Inc. Total Inc.	Mean Total Income	Mean per-capita Income
60 – 64	0.18	63,350	0.04	189,682	47,911
65 – 69	0.24	64,921	0.07	177,182	47,411
70 – 74	0.27	49,506	0.08	160,973	43,313
75 – 79	0.29	47,196	0.08	167,243	46,485
80 – 84	0.33	55,700	0.11	152,126	52,078
85 – 89	0.35	56,689	0.12	149,008	49,818
90 +	0.36	104,529	0.11	216,873	93,420
Total	**0.24**	**58,133**	**0.07**	**175,152**	**47,432**

Source: Author's calculation using FIES, 2006.
Ave per inc. : 41,911
Pov. Threshold: Min 11,591
Max 20,908

In terms of health insurance, APIS 2004 data shows that about 44% of households have at least one member who has health insurance (Table 11). Most of these are from the PHIC (42%). Considering that PhilHealth coverage include dependents (namely children below 21 and parents 60 and above), the population coverage was estimated to

be 52 to 62 percent (Herrin, 2010).[17] The recent survey estimate based on the 2008 National Demographic and Health Survey which asked for health insurance coverage at the individual level shows that 42% have a form of insurance plan of which 38% are covered by PhilHealth, 1.8% by GSIS and 11% by SSS.

Table 11. Health Insurance by Income Deciles, 2004

Income Decile	With any Health Insurance	With PHIC	With HMO	With Private Health insurance	With Other Health insurance
1	0.274	0.269	0.001	0.002	0.003
2	0.288	0.281	0.001	0.003	0.006
3	0.307	0.299	0.001	0.006	0.008
4	0.345	0.333	0.001	0.014	0.011
5	0.367	0.351	0.002	0.017	0.015
6	0.413	0.393	0.005	0.025	0.017
7	0.472	0.448	0.012	0.035	0.021
8	0.531	0.500	0.009	0.050	0.031
9	0.649	0.618	0.019	0.084	0.035
10	0.711	0.675	0.049	0.156	0.037
Total	0.436	0.417	0.010	0.039	0.019

Source: Author's Tabulation using APIS 2004

Across income groups, the health insurance coverage is 27% for the poorest decile and 71% for the richest (Table 11). PhilHealth coverage, being the dominant insurer has a similar distribution across income groups. Data from the 2008 NDHS show similar disparity with only 21% of the poorest wealth quintile covered while coverage for the richest quintile is 65%. Again PHIC, being the dominant provider, shows the same pattern of 20% in the bottom quintile and 57% for the richest quintile. Herrin (2010), citing the National Health Accounts estimates in Racelis et al, (2006), showed that PhilHealth benefit payments were also larger for richer households reflecting this difference in coverage. In terms of residence, there is a 14-percent coverage difference between urban and rural areas as expected.

4.1.2. Contingencies

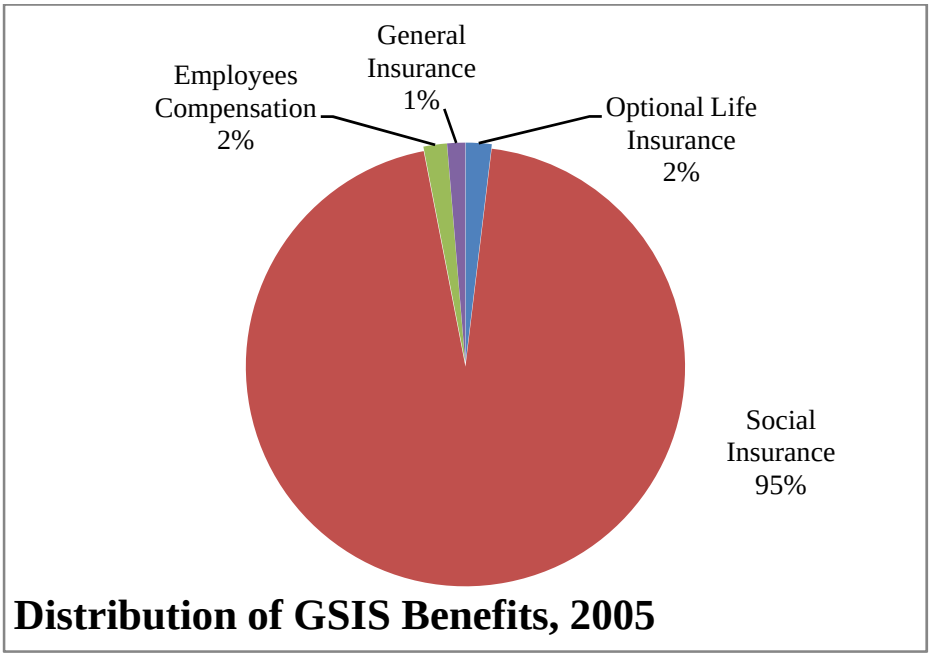
The review of programs above, summarized in Table 6 show there is at least one program that covers any conceivable contingencies, such as old age, work injuries, and

[17] Administrative reports of the PHIC claim the coverage is near universal at 85% (Herrin, 2010)

health problems. Short-term contingencies are addressed by general-purpose salary and policy loans. Even very specific risks, like calamities and economic crises, are covered with government often mandating social security institutions to provide for these specific contingences, presumably using reserves, in times of calamities and economic crises (see Manasan, 2009b). However, we already know the coverage problems.

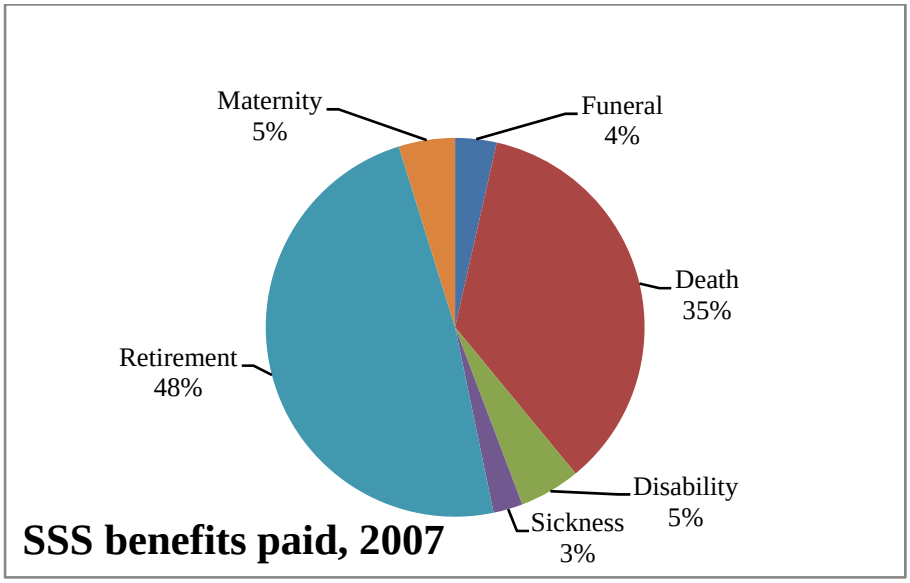
To gauge the importance of the schemes, we look at the distribution of benefits paid by the social security institutions. GSIS benefits are concentrated on social insurance, which accounts for 95% of the benefits in 2005. The other components are very small, e.g., 2% for employees compensation, 1% for general insurance, and 2% for optional life insurance (Figure 2). We have a less concentrated allocation of benefits for the SSS. While payment for pension (retirement) is still the biggest block (48%), there are considerable allocations for the other schemes: 35% for death benefits, 5% for disability, 5% for maternity, 4% for funeral and 3% for sickness (Figure 3).

Figure 2. Distribution of Benefits Paid by GSIS, 2005



Source: GSIS.

Figure 3. Distribution of Benefits Paid by SSS, 2007



Source: SSS.

4.1.3. Benefit Levels

Even if one is covered for specific contingencies in life, there is still the important question of whether the protection will be sufficient when the need arises. In this section we look at the replacement rates of pension schemes and the support value of health insurance coverage.

Using the applicable pension formulae, one can have an indication of the replacement rates of the schemes. The pension formula can be deduced from the applicable laws and has been described in earlier sections. Templo (2002) also provides the formula implied for computing SSS and GSIS pensions.[18] While eligibility is shorter for SSS (10 years) compared to GSIS (15 years), the proportion of credited salary returned is higher for GSIS (37.5%) compared to SSS (20%). In addition, a higher proportion is added for each additional year of service beyond the minimum. For GSIS this is 2.5% while for SSS this is only 2%. The pension formulas approximately will have a replacement value of 40% and 50%, respectively, for SSS and GSIS at 20

[18] For SSS, this is 300 + 0.2* AMSC +0.02 *(CYS-10) * AMSC where AMSC is the average of the last 60 monthly salary credits and CYS is the number of credit years of service. For GSIS, this is 0.375*RAMC+0.025*(YOS-15)*RAMC where RAMC is the re-valued average monthly compensation of the last three years and YOS is the number of years of service. Both are subject to a minimum which is adjusted from time to time.

years of service. The corresponding replacement rates at 30 years of service are 60% and 75%, respectively. It should be noted, however, that the fixed minimum of 300 pesos for SSS members allows for a higher replacement rate at lower salary values. This replacement rate is in line with the observation in Asher (2009) that pointed out that for the Asia-Pacific region the pension programs for government employees are, in general, more generous than those for the private sector workers.

Household income data indicates how important pensions are to households whose head is at retirement age. FIES 2006 data shows that pensions are a minor proportion of the income of households where the head of the household is 60 years and above. Table 10 shows that about 24% of the households are receiving some pension income. The average pension income for these households is 58,133. The average per capita income for these households is 47,432 which is above the population average per capita income of 41,911. It is even noteworthy that the average per capita income of these households is way above the poverty thresholds[19] (P11.6 to 20.9 thousand). However, it should be noted too that pension income is on average only 7% (from 4 to 12 percent) of household income. This implies that households whose heads are 60 and above are, on average, not really poor, although this cannot be attributed to their pension income. They have other important sources of income besides pension.

Analysis of benefits relative to medical expenditures provided in Banzon (2008) highlights the still substantial out-of-pocket costs incurred even by PhilHealth beneficiaries. An important observation is that the support value in private hospitals is quite poor. For instance, in 2006 the support value was 33% in private hospitals compared with 80% in government hospitals. This implies poor financial protection against illness even for PhilHealth members.

4.2. Governance and Management

Ross (2004) identifies the five core functions of a viable pension system to include: (1) reliable collection of revenues; (2) payment of benefits; (3) secure financial management and productive investment of assets; (4) maintaining an effective communications network including development of accurate data and record-keeping

[19] These are determined by province since 1997.

mechanisms to support collection, payment and financial management activities, and (5) production of financial statements and reports for effective governance, transparency, and accountability.

The social security institutions in the country, except perhaps for ECC, would fall under the category of full service social insurance institutions that handle all major functions including revenue collection and payment of benefits. As mentioned earlier, ECC is a policy making institution neither doing collection nor payment of benefits. Thus, any assessment on governance and management of most of the other social protection institutions would have to look at the five functions.

4.2.1. Collection of Revenues.

GSIS, in the main, has no problem collecting the contribution of its eligible population except for occasional arrearages with some government agencies. SSS, on the other hand, has an entirely different story. As mentioned earlier, the coverage of SSS has remained low up to now. One important reason is, of course, the nature of the eligible population. The employer of the GSIS is the government so there is rarely any problem with collecting contributions. The SSS, on the other hand, has to contend with almost 800,000 private firms more than 90% of which are small, having a workforce of less than 10 (Table 3). In addition, there are 12 million own-account workers to collect from, not to mention the overseas workers and housewives who have been recently considered eligible. For PhilHealth, contributions from employees are also collected via the employers as are those for GSIS and SSS. PhilHealth, a relatively young institution, however, has been able to build a membership base of about 16 million. The HDMF (Pag-IBIG) contributions are collected also in the same way as the GSIS and SSS contributions, i.e., by the employers who then remit these to HDMF. For OWWA, collection of contributions is made part of pre-departure procedures.

4.2.2. Payment of Benefits.

Most of the institutions have problems with delivering benefits on time. Like collection of contributions, efficiency in the delivery of benefits is also a function of the volume of transactions. Most of the institutions have already utilized the banking

system to deliver benefits. SSS, for instance, in its latest report claims that 98.4% of the monthly pensions, catering to 1.3 million pensioners, are delivered through the banking system and only 1.6% are through mailed checks. GSIS for its part uses its own e-Card co-issued with a commercial bank where benefits are credited. The e-Card can be used in the 6,000 Automatic Telling Machines (ATMs) nationwide. PhilHealth pays claims made through accredited health facilities. Since HDMF and OWWA do not make regular monthly payments like pensions, delivery of benefits is done through their offices.

4.2.3. Secure Financial Management and Productive Investment of Assets.

Most of the security institutions have problems in managing their finance and investment assets. The problem is partly due to the relationship between the governing boards and the government. For one thing, appointments to the governing boards are always viewed with suspicion as allegedly they are not based on technical expertise but on political favors. All social security institutions have been tainted with suspicions of granting behest loans to friends of those in power. The most serious case is the AFP-RSBS where the leadership was investigated by Congress and was recommended for prosecution by the Ombudsman[20]. The program was ultimately de-activated by the end of 2006.

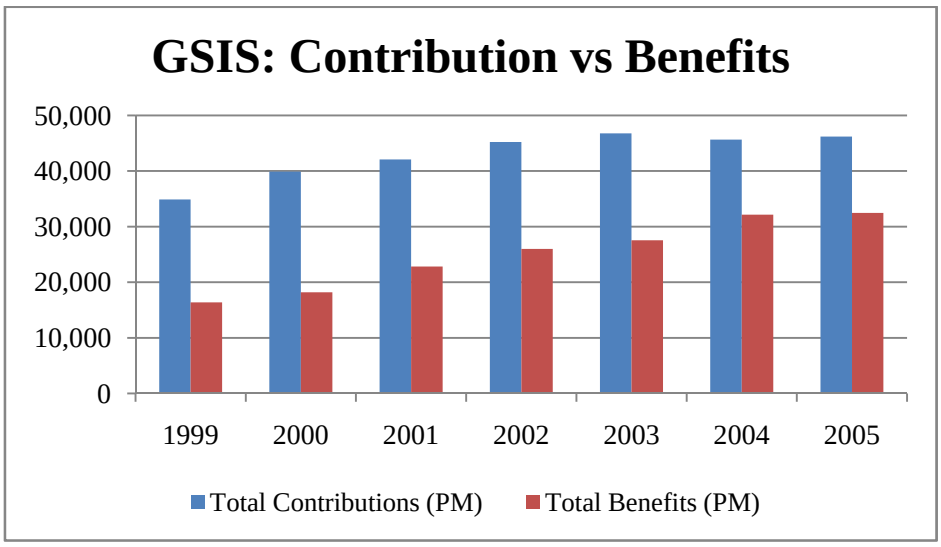
Against this backdrop, however, are promising developments. For instance, the GSIS, after being authorized in 1997 to invest in foreign assets, had engaged professional global fund managers to handle this aspect of their portfolio. The GSIS required a minimum annual US dollar return of 8% (net of fees) and a maximum portfolio volatility of 7% (GSIS 2008 Annual Report). Given the same authority in the same year, the SSS has not availed itself of this option even though this has been recommended in the actuarial valuation report released in 2007. Engaging professional fund managers with clear guidelines can increase the investment yield of the fund as well as help insulate the fund from political influence.

In a defined benefit system like that of GSIS and SSS, the key to sustainability is managing the flow of contribution and benefits. GSIS has kept contributions

[20] A court that tries graft and corruption charges for government officials.

comfortably higher than benefits (Figure 4). In recent years, the GSIS has also intensified collection of premium arrears of government agencies and improved its investment income. Consequently, the actuarial life of the GSIS reserve fund as of 2007 was up to 2055 (GSIS 2008 Annual Report), which was an improvement from the 1999 actuarial valuation that predicted the fund would be depleted by 2041 (Manasan, 2009a).

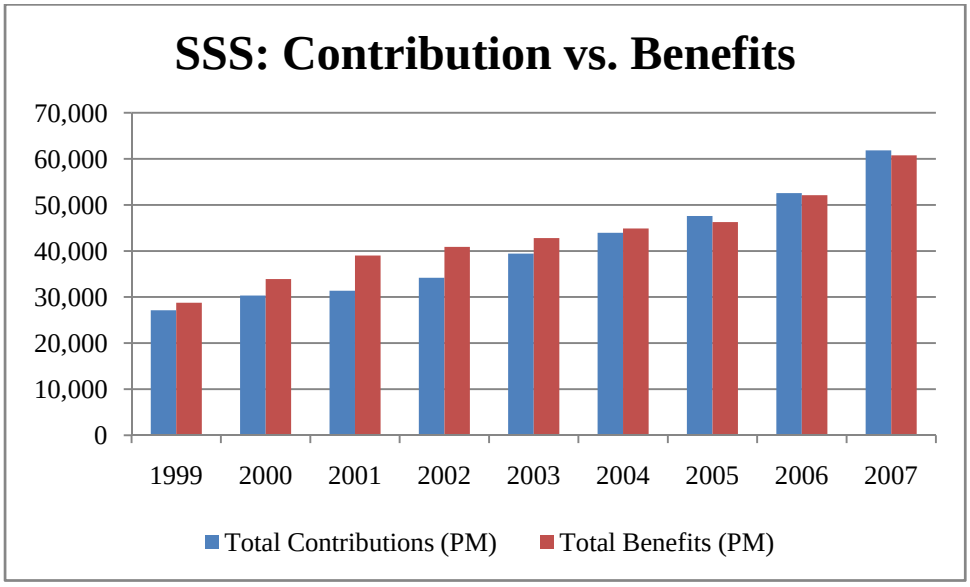
Figure 4. GSIS Contributions and Benefits, 1999-2005



Source: GSIS.

The case of the SSS is much more precarious as shown by the flow of contributions and benefits (Figure 5). From 2005-2007 contributions exceeded benefits, which compared favorably to 1999-2004 where benefits exceeded contributions. This turnaround was due to increasing contribution rates from 8.4% in 2002 to 9.4% in 2003 and 10.4% in 2007. There were also other parametric reforms introduced during the period including an increase in the maximum salary base, redefinition of credited years of service and some administrative measures. The latest actuarial report released in 2007 shows that the life of the fund is projected to last until 2031 which is an improvement compared to the 1999 actuarial valuation which projected the fund to last only until 2015.

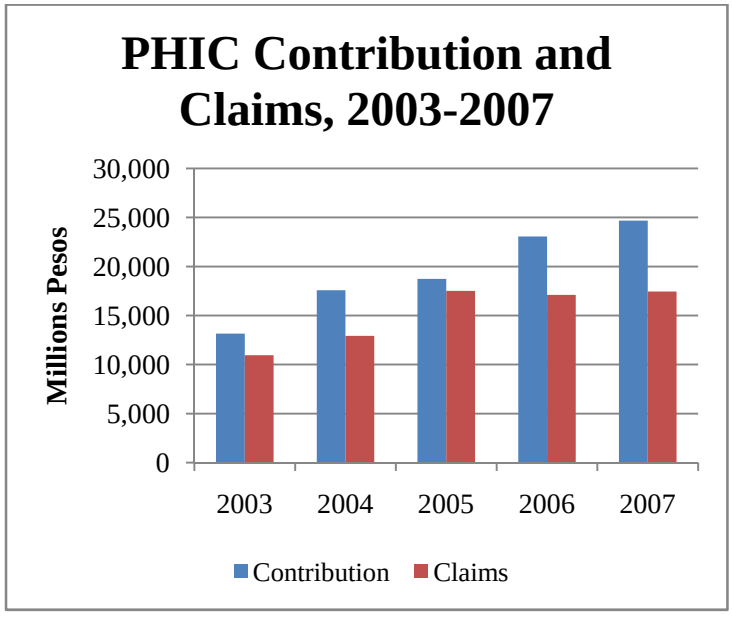
Figure 5. SSS Contribution and Benefits, 1999-2007



Source: SSS

The PhilHealth finances are far from being threatened as indicated in Figure 6. The problem is really its accumulation of surpluses. Its income and expenditure statements show a consistent and even rising net income. As a consequence, its assets have more than doubled in six years from 40.6 billion in 2002 to 90.1 billion in 2008 (Table 12).

Figure 6. PHIC Contribution and Benefits, 2003-2007



Source: PhilHealth.

Table 12. Balance Sheet and Income Statement, PHIC, 2002-2008

	2002	2004	2006	2008
Balance Sheet				
Assets	40,570,520,474	51,879,992,816	69,496,062,197	90,118,110,662
Liabilities	532,038,640	1,237,998,016	4,434,630,994	4,608,157,528
Net Worth	40,038,481,834	50,641,994,800	65,061,431,203	85,509,953,134
Income Statement				
Income	16,190,318,310	22,024,031,256	28,718,575,197	31,178,796,460
Premium Contribution	12,748,865,812	17,576,610,527	23,063,436,680	25,641,201,781
Interest and Other Income	3,441,452,498	4,447,420,729	5,655,138,517	5,537,594,679
Expenses	10,007,267,749	15,104,203,947	19,004,592,804	21,331,496,232
Benefit Payment	8,831,637,852	12,925,368,174	17,104,880,840	18,154,745,136
Personal Services	451,917,461	631,556,242	693,483,465	2,080,010,979
Maintenance and other operating expense	723,712,436	1,547,279,531	1,206,228,499	1,096,740,117
Net Income	6,183,050,561	6,919,827,309	9,713,982,393	9,847,300,228
Operating expense/ benefit	13	17	11	17
Operating expense/ contribution	9	12	8	12

Source: Commission on Audit, Annual Audit Reports.

The administration cost of both the GSIS and SSS can be lowered. Operating costs to benefit ratio for the GSIS ranges from 14% - 18% in 2002-2007 (Table 13). For SSS, on the other hand, the operating cost to benefit ratio ranges from 11% - 12% (Table 14). The corresponding operating cost to contribution ratio for the same years is 9%-14% for GSIS and 10%-13% for SSS. Holzmann and Hinz (2005) notes that these are among the highest in the region while Manasan (2009a) notes that these are very much higher than those observed in the mid-1990s.

Table 13. Balance Sheet and Income Statement, GSIS, 2002-2007

	2002	2004	2005	2006	2007
Balance Sheet					
Assets	230,417,529,880	293,732,766,405	332,607,602,100	337,187,026,533	410,502,191,637
Liabilities	26,674,048,161	4,268,798,891	9,121,762,185	7,526,917,210	6,716,107,053
Net Worth	203,743,481,719	289,463,967,514	323,485,839,915	369,660,109,323	403,786,084,584
Income Statement					
Income	57,458,840,865	68,413,687,732	74,668,162,740	70,705,105,102	77,832,254,432
Insurance	39,871,490,832	39,213,003,581	42,950,527,307	39,539,715,076	40,805,051,298
Social Insurance Contribution	*38,595,740,102*	*37,763,979,560*	*42,282,066,782*	*39,032,607,728*	*39,938,304,720*
Interest on Premium arrearages	*1,275,750,730*	*1,449,024,021*	*668,460,525*	*507,107,348*	*866,746,578*
Loans and Investment	16,529,513,023	26,299,437,745	28,900,438,393	33,201,439,154	32,614,445,334
Other Income	1,057,837,010	2,901,246,406	2,817,197,040	(2,036,049,128)	4,412,757,800
Expenditure	27,884,978,194	35,990,846,628	36,210,962,483	37,418,566,885	38,485,969,814
Claim and benefit paid	24,450,910,211	30,853,949,159	31,110,365,217	32,097,240,630	32,902,845,160
Personal Expenses	2,770,094,449	3,405,749,774	3,388,227,297	3,569,329,787	3,676,119,024
Miscellaneous and other operating expenses	663,973,534	1,731,147,695	1,712,369,969	1,751,996,468	1,907,005,630
Net Income	29,573,862,671	32,422,841,104	38,457,200,257	33,286,538,217	39,346,284,618
Operating expense/ benefits paid	14	17	16	17	17
Operating expense/ contribution	9	14	12	14	14

Source: Commission on Audit, Annual Audit Reports.

Table 14. Balance Sheet and Income Statement, SSS, 2002-2008

	2002	2004	2006	2008
Balance Sheet				
Assets	162,606,437,060	179,084,128,235	228,444,457,193	233,122,190,560
Liabilities	3,058,782,946	2,698,068,723	3,448,590,465	7,519,245,614
Net Worth	159,547,654,114	176,386,059,512	224,995,866,728	225,602,944,946
Income Statement				
Income	45,892,685,680	52,789,114,406	64,651,499,638	97,968,319,853
Member's Contribution	34,187,651,088	43,935,823,635	52,543,604,359	68,879,273,075
Investment and other income	11,705,034,592	8,853,290,771	12,107,895,279	29,089,046,778
Expenses	45,357,284,516	50,209,848,030	58,501,879,317	74,662,988,716
Benefit Payments	40,871,576,382	44,882,517,660	52,122,012,435	67,917,362,264
Operating Expenses	4,485,708,134	5,327,330,370	6,379,866,882	6,745,626,452
Personal Services	*3,008,967,965*	*3,388,881,680*	*4,138,468,608*	*4,605,567,109*
Maintenance and other operating expenses	*1,476,740,169*	*1,938,448,690*	*2,241,398,274*	*2,140,059,343*
Net Income	535,401,164	2,579,266,376	6,149,620,321	23,305,331,137
Operating expense/ benefit	11	12	12	10
Operating expense/ contribution	13	12	12	10

Source: Commission on Audit, Annual Audit Reports.

4.2.4. Maintaining Effective Communication Networks.

The large volume of transactions required to serve a large client base has made the security institutions the forerunners in computer processing applications in the bureaucracy. However, like any institution that has depended on mainframes for their computing needs, the fast shift towards more desktop and distributed processing and networking has created some problems for GSIS, particularly for some of their legacy software. In fact as this paper is being written, an advisory is still visible in the landing page of the GSIS website saying that the shift from IBM-DB2 to Oracle is currently ongoing and that this may disrupt some of its operations. The SSS has deployed the SSSNet using electronic data exchange (EDI) to automate the transfer of contributions from firms to the SSS and their respective banks.

For communicating with its clients and the public, the institutions have also used the Internet to deliver information about the institution, its programs and to provide downloadable forms and electronic copies of annual reports. GSIS has also used short-messaging technology to communicate with members particularly for alerts on payments made and even sending birthday greetings.

4.2.5. Production of Financial Statements and Reports.

Financial reports are always included in the annual report of the institutions. They are also required by law to submit audited financial reports to the Commission on Audit.

5. Recommendations

The recommendations listed here are not new. Many of these are recommendations that have been identified more recently by Manasan (2009b), Park (2009), Asher (2009), Sin (2009), Navarro (2004) and even much earlier by ILO (1996) and WB (1995). These are cast in themes as many are interrelated pieces.

Expansion of coverage. This should focus first on expanding coverage of the existing eligible population. This recommendation applies to SSS, which covers the bulk of the working population and yet continuous to have a relatively low coverage.

While this can be partly explained by the nature of its eligible population, one important question that should be answered is how was PhilHealth able to increase its membership, and collect from 16 million members - double that of SSS which only managed to collect from 8 million contributing members- when both institutions are virtually using identical methods of collection, i.e., through the employers. This is even more puzzling knowing that PhilHealth is younger than SSS. One promising model shown by PhilHealth is strong cooperation with local government units (LGUs). SSS can develop a program where LGUs can participate in expanding coverage. Once this problem is substantially solved, covering harder to reach population groups, e.g., informal sector workers, indigenous populations, can commence. The disparity in access to coverage across income groups as shown earlier should also be a cause for concern. It is the poorer segment of the population that needs more coverage.

Strengthening of the link between contributions and benefits. The SSS need to vigorously pursue the proposal of increasing their contribution rates.[21] Note that the total contribution rate for SSS members is currently at 10.4% when for GSIS members it is 17% (21% less the mandatory insurance premium of 4% which is not in the SSS scheme). While it would be understandable that private sector employers would resist paying what the government is contributing for its employees, it is difficult to understand why government employees can contribute 9% while private sector workers pay only 3.3% (Table 15). In addition, while the required number of contribution years to be eligible for a pension for GSIS is 15, it is only 10 for the SSS. The SSS actuarial valuation released in 2007 recommended a gradual rise in eligibility years to 12 years in 2011 and 18 years by 2017.

[21] The actuarial valuation report released in 2007 has proposed the increase to 11.4 in 2011 and 12.4 in 2016.

Table 15. Schedule of Contributions

Institution		Due to Institution Payable by		
		Employee	**Employer**	**Total Contribution**
Social Security System (SSS)		3.33% of salary base (see schedule)	7.07% of salary base (see schedule)	10.4% of salary base (see schedule)
Government Service Insurance Service (GSIS)		9.0% of gross basic monthly salary	12.0% of gross basic monthly salary	21.0% of gross basic monthly salary
Employee's Compensation Commission (ECC)	Public Sector		1.0% of basic salary or Php100.00 per month, whichever is lower	1.0% of basic salary or Php100.00 per month, whichever is lower
	Private Sector		0.2% of Monthly Salary Credit (MSC) for employees with MSC of at least Php15,000.00; fixed Php10.00 for employees with MSC of at most Php14,500.00	0.2% of Monthly Salary Credit (MSC) for employees with MSC of at least Php15,000.00; fixed Php10.00 for employees with MSC of at most Php14,500.00
Philippine Health Insurance Corporation (PHIC)		1.25% of salary base (see schedule)	(Same as employee contribution)	2.5% of salary base (see schedule)
Home Development Mutual Fund (HDMF or Pag-IBIG Fund)		1.5% of monthly compensation (COLA + base) if Php1,500 and less; 2.0% of monthly compensation if above Php1,500.00, or Php100.00, whichever is higher	(Same as employee contribution)	3.0 to 4.0% of monthly compensation (COLA + base) depending on amount, or Php100.00, whichever is higher
Overseas Workers Welfare Administration (OWWA)				USD25.00; effective upon payment until expiration of work contract, or up to two (2) years for voluntary members who register on-site
AFP – Retirement and Separation Benefits System (AFP-RSBS)		5.0% of basic monthly salary		5.0% of basic monthly salary

Source: Author's summary from relevant documents.

Building a stronger firewall around the social security funds. Like anywhere else, social security funds in the Philippines have been the object of political interference. This situation has often resulted in putting the fund under unnecessary stress. One specific form of political interference common in the Philippines is mandating social security institutions to use their reserves to finance emergency social programs. In the

majority of cases this is not the most productive use of the resources and neither is it in line with the long-term nature of the liabilities of the fund. Social programs must be financed by general taxes rather than social security funds. A corollary issue is the relationship between government and the governing boards of social security institutions. Sin (2009) recommends developing an arms-length relationship with the government. The sovereign guarantee clause has been time and again invoked to justify government interference in the allocation of the reserves of social security institutions. It should be understood that sovereign guarantee only means eventual financing by general taxes if need be, under extra-ordinary circumstances and that it is not a license to interfere in investment allocation decisions. Some recommended measures for building a stronger firewall around pension funds include publication of investment policy statements, greater transparency in appointments, and mandating a transparent process of evaluating investment opportunities (Sin, 2009).

Improving investment incomes. Allowing the system to engage professional fund managers with clear guidelines can improve the earning potentials of the fund.[22] Investment in foreign assets can help diversify the investment portfolio. Both the SSS and GSIS were authorized in 1997 to invest in foreign assets. However, up to now, only the GSIS had engaged a fund manager to manage their overseas investments. The SSS actuarial valuation report released in 2007 has also recommended the review of investments in salary and housing loans.

Reducing administration costs. The administration cost of the GSIS and SSS are among the highest in the region (Holzmann and Hinz, 2005). For Singapore, for instance, the administrative cost is only 0.5% of total contributions while for Malaysia it is only 2% of total contributions. This implies there is still room for improving efficiency in its operation. In the case of the SSS, there might have been more justification for its high operating cost if coverage had been extended further to reach the eligible population. This is hardly the case with the current low coverage. In addition, for SSS there is also a case for cleaning up its membership records, given an inordinately large number of members (28 million) less than 30% of whom are contributing members. Maintaining those records surely adds to its operating costs.

[22] This is also recommended for equity assets in the actuarial valuation report released in 2007.

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CHAPTER 9

Social Protection in Thailand - Current State and Challenges

SRAWOOTH PAITOONPONG*

AMONTHEP CHAWLA*

NIPANAN AKKARAKUL*

(Senior Research Specialist, Research Specialist and Researcher, respectively at Thailand Development Research Institute)*

This report reviews the current state and complexity of social protection (SP) in Thailand, and identifies critical challenges and possible solutions to ensure the sustainability and efficiency of the existing SP. It shows that the present SP system in Thailand is a multi-pillar system, with a few schemes to cover different sectors of the population. Examples of the SP schemes include the Government Pension Fund, the Social Security Scheme (SSS), the Workmen's Compensation Fund, Unemployment Insurance and the Provident Fund. For health care, the major SP is the Universal Health Care (30 baht) Program, also known as the "30 baht treat all" scheme.

Most of these SP schemes are imperfect due to their problems with regards to coverage, adequacy of benefits and management. In brief, there are 3 major challenges to the SP system of Thailand - aging population, a huge sector of informal workers who have not been covered by any income security system and a low rate of savings.

In response to these challenges, the government has initiated a National Savings Fund scheme to encourage people, particularly the poor and those who are not covered by the government pension fund or SSS or other formal SP system. A few public hearings have been held and a National Savings Fund Act has been drafted and is ready for consideration and approval by parliament.

1. Introduction

In Southeast Asia, the issues of social safety nets and social protection have emerged since the financial crisis in the middle of 1997. Apparently, it came with the conditionality of international organizations such as the International Monetary Fund (IMF), the World Bank, and the Asian Development Bank, that the crisis countries declare in a letter of intent a set of policies that give due consideration to the social impacts of the crisis[1]. In Thailand, the Asian crisis in 1997 was a major starting point for SP review and reform. Many SP schemes have been upgraded, strengthened or introduced. During the global financial crisis in 2008-9, a similar development has happened to SP in Thailand.

This paper has the following objectives:

1. To review the current state and complexity of SP in Thailand, focusing on the formal social protection system or social security system;
2. To identify critical challenges; and
3. To seek possible solutions to ensure the sustainability and efficiency of the existing SP (through an appropriate institutional design and modification of the SP establishment).

The paper consists of 3 major sections -- Current States and Challenges of SP; Main Critical Reforms of SP; and Policy Recommendation.

2. Current States and Challenges of SP

2.1. Overview of Current States

In 2009 Thailand had a population of 66.9 million with a labor force of 38.9 million. The total employment figure was 38.4 million with 41 percent involved in agriculture. More than 50 percent of those with jobs were self-employed and unpaid family workers. Thailand's population is aging rapidly. The number of older persons in 2010 was 7.5 million representing 11.8 percent of the total population. It has been

[1] For example, the Fifth Letter of Intent submitted to the IMF in 1998 (Bank of Thailand 1998).

forecast that in 2020, the number of older persons will rise to 11 million representing 17.2 percent of the total population.

The present SP system in Thailand is a multi-pillar one, with a few schemes to cover different sectors of employment as illustrated in Table 1. A 'zero pillar' scheme provides a minimum level of protection in the form of social welfare or social assistance; a 'first pillar' consists of a publicly managed, unfunded plan; a 'second pillar' is a mandatory privately funded plan; a 'third pillar' is a voluntary, privately funded plan; and a 'fourth pillar' is complementary provisions for the public and the poor (The World Bank, 2009).

Table 1. Multi-Pillar Pension System in Thailand 2006

Pillar	Characteristics (World Bank classification)	Thailand's Schemes	Funding	Participation*/	Benefit type
0	"Basic" or "Social pension," at least social assistance, universal or means-tested	Older persons allowance	Budget/general revenues	Universal or Residual (1,755,266 (2007))	Allowance
1	Public pension plan, publicly managed, defined-benefit or notional defined-contribution	Former Government Pension (before 1997)	Budget/general revenues	Mandated: Central civil servants (1,721,772) ; Government employees (221,553); Local civil servants (215,873)	Pension or lump sum
2	Occupational or personal pension plans, funded defined-benefit or funded, defined-contribution	Government Pension Fund (since 1997); Social Security Fund; Private school teachers Fund	Contribution	Mandated: Central civil servants (1,172,953); Private employees (8,537,801); Private school teachers (152, 576)	Lump sum
3	Occupational or personal pension plans, funded defined-benefit or funded, defined-contribution	Private employees (Provident Funds, since 1987); National Saving Fund (proposed 2010)	Contribution	Voluntary: Private employees (1,809,953)	Lump sum
4	Personal savings, homeownership, and other individual financial and non-financial assets	Retirement Mutual Fund (RMF); Private insurance; Welfare housing; low-cost housing	Personal savings (financial assets)	Voluntary	Return to investment

Source: Adapted from (Holzmann, R. *et al.*, 2004) and (Charndoevwit 2006).
Note: */Figures in parenthesis are number of members.

SP in Thailand can also be categorized into (A) Contributory transfer programs which consist of a statutory social insurance, an occupational security system and voluntary social protection and (B) Noncontributory (social assistance or welfare)

transfer programs which consist of Universal Health Care (30 baht) Program, Old Age Living Allowance, and short-term social assistance to mitigate the economic crisis.

2.1.1. Contributory Transfer Programs

a. Statutory Social Insurance

The statutory social insurance consists of social insurance or a social security scheme (SSS) which embraces the Social Security Fund, the Workmen's Compensation Fund and Unemployment Insurance, and the Private School Teachers Fund. Due to space constraints, only selected schemes are reviewed.

(i) Social Insurance or Social Security Scheme (SSS)

The SSS was set up under the Social Security Act B.E. 2533 (1990) to provide social insurance for private employees in firms with 20 or more workers. The SSS was started in March 1991, by providing four types of benefits - sickness, invalidity, maternity and death- for employees of enterprises with 20 or more workers.[2] From September 1993 the coverage was extended to enterprises with 10 or more workers. The registration of those enterprises has been enforced since June 1993. During this stage the Workmen's Compensation Act was passed in June 1994 and came into force on July 1, 1994. In September 1994, a voluntary insurance service was introduced under Article 39 of the SS Act. In December 1998, the old-age pension and child allowance schemes were implemented. Since April 1, 2002, the coverage has been extended to enterprises with 1 or more workers. Finally, unemployment benefit was introduced in January 2004. (http://www.asean-ssa.org/CP_Thailand.doc, accessed December 28, 2009). The SSS can be considered as the second pillar of the multi-pillar SP system (Table 1).

The SSS is administered by the SSO, presently a government department under the Ministry of Labor. The primary responsibility of the SSO is to manage the SSF and the WCF according to the Social Security Act 1999 (B.E.2533) and the Workmen's Compensation Act (B.E. 2537) (SSO 2008a).

[2] State enterprise employees who have their own schemes were in the program at the start but were withdrawn in October 1991 following changes in their legal status. Companies with superior employee benefit schemes already established as of September 1990 were granted exemption upon request from participating in any or all of the benefit schemes.

The SSF is now providing seven types of benefit, i.e., non-work-related sickness, maternity, invalidity, death, old-age and unemployment benefits, including a child allowance, to the persons insured under Article 33 of the Social Security Act 1999. As of December 2008, there were 8,779,131 insured persons under Article 33 (mandatory insurance) and 514,422 insured persons under Article 39 (voluntary insurance) (SSO 2008a). In 2008, the SSF covers 25.11 percent of the employed workforce of 37 million or 14 percent of population of 66.4 million.

The SSF is financed through employees, employers, and government contributions. The contribution rate for sickness, maternity, invalidity and death benefits, or package I, was 1.5 percent[3] of insured earnings (in the range of 1,650 and 15,000 Baht) during 1991-1997, the maximum rate established by law. During the financial crisis starting in 1997, the contribution rate was temporarily reduced to 1 percent of insured earnings in 1998. When the old-age benefit and child allowance, or package II, were included at the end of 1998, the total contribution rate for both packages was 2 percent in 1999. The contribution rate for the old-age benefit and child allowance later increased to 3 percent in 2003.

The contribution rate for unemployment benefit (package III) starting in 2004 is 0.5 percent each for workers and employers and 0.25 percent for the government. The total contribution to the SSF is, therefore, 5 percent each for workers and employers and 2.75 percent for the government. The Social Security Office (SSO) also collects contributions from the voluntary insured persons (Article 39) at the amount of 432 baht per month for 6 types of benefit: sickness, maternity, invalidity, death, child allowance and old-age pension. The government pays a contribution of 120 baht per month for them. Another type of voluntary insured person under Article 40 pays contributions of 3,360 baht per year. They have only 3 types of benefit: maternity, invalidity and death.

In 2008, the contribution from employers, employees and the government to the SSF was 106,909.39 million baht, an increase of 6.98 percent from 2007. The total benefits paid to claimants were 35,690.51 million baht which was an increase of 10.15 percent from 2007.

The SSF benefits are summarized in Table 2.

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[3] For each contributor.

Table 2. Social Security Fund Benefits

Type of Benefit	Eligibility Requirement	Benefits
Sickness benefits (non-work-related sickness)	Have paid contributions for 3 months out of the previous 15 months.	- Free in-patient and out-patient care in a registered hospital. - Sickness compensation of 50 percent of monthly wages upon physician's certification. The maximum compensation is 90 days per request, and 180 days per calendar year. The maximum compensation for chronic disease illness is 365 days. - 200-Baht reimbursement for dental care (extraction, filling and tooth cleaning), twice a year. - Reimbursement for prostheses and other related materials.
Maternity benefits	Have paid contributions for 7 months out of the previous 12 months.	<u>In-kind benefit:</u> - A lump sum payment of 6,000 Baht for each delivery, up to 2 pregnancies (eligible for both male and female insured persons). <u>Cash benefit:</u> - Maternity compensation, 50 percent of 3-month average wages for 90 days (only for female insured persons).
Invalidity benefits	Have paid contributions for 3 months out of the previous 15 months.	- A lifetime invalidity compensation, 50 percent of monthly wages. - Lifetime medical care reimbursement, maximum of 2,000 per month. - Reimbursement for prostheses and other related materials. - A funeral grant equal to 30,000 Baht, when the beneficiary dies. - Compensation equal to 1.5 times the monthly wages payable to relatives if the dead or invalid persons had paid contributions for 36-119 months, or 5 times the monthly wages if they had paid contributions for 120 months.
Death and survivors' benefits	Have paid contribution for 1 month out of the previous 6 months.	- A lump sum payment of 30,000 Baht for the funeral arrangements. - Compensation equal to 1.5 times the monthly wages payable to relatives if the dead insured persons had paid contributions for 36-119 months, or 5 times the monthly wages if they had paid contributions for 120 months.
Child allowances	Have paid contributions for 12 months out of the previous 36 months.	- Child allowance of 350 Baht per child aged 0-6 for a maximum of 2 children. - The child allowance eligibility status is not ended upon the death of an insured person.
Old-age benefits	Have paid contributions for at least 180 months, and had retired at the age of 55 or older.	- A pension equal to 15 percent of average of 60 months' wages received for it. - A one percentage point increase for every 12 months of additional contribution. - Compensation (10 times the monthly pension) payable to relatives if the pensioner dies within 60 months of retirement. - A lump sum payment equal to employee's contribution payable to the retiree (aged 55 and older) who has been contributing for fewer than 12 months. - A lump sum payment, equal to employee's and employer's contribution plus interest accrued from that amount, payable to the retiree who has contributed for more than 12 months, but fewer than 180 months. - A lump sum payment, in which the amount depends on the period of contribution and base income, payable to relatives of an insured person who dies before the age of 55.
Unemployment Insurance	Have paid contributions for 6 months out of the previous 15 months.	- For those who are involuntary unemployed (e.g., laid off), the replacement rate is 50 percent of the highest three-month average wages in the last nine months. The maximum duration to receive the benefit is 180 days in a calendar year. - For those who are voluntarily unemployed (e.g., quit work without just cause), the replacement rate is 30 percent of the highest three-month average wages in the last nine months. The maximum duration to receive the benefit is 90 days in a calendar year.

Source: Chandoevwit, Worawan (2006).

The SS Act is not applicable to:

- government officials and regular employees of the central administration, provincial administration and local administration except for temporary employees;
- employees of foreign governments or international organizations;
- employees whose employer's offices are in the country but the employee is stationed abroad;
- teachers or headmasters of private schools under the Private School Act;
- students, student nurses, undergraduates or apprentice doctors who are employees of schools, universities or hospitals;
- other employees as prescribed in the Royal Decree.

(ii) Unemployment Insurance

The Unemployment Insurance scheme (UI) is a part of SSS which has been enacted in the Social Security Act B.E. 2533 (1990) at the same time as the SSS (the 4 benefit package) and the Child Allowance and Old Age Pension scheme (the 2 benefit package). But the effective date of the UI program was not specified in the Act. According to the Act, the UI benefit would be provided to insured persons when the stakeholders, i.e., employee, employer, and government, are ready for their contributions, a maximum of 5 percent each.[4] On August 26, 2003, the SS Act was amended with a stipulation that the contribution for the UI benefit would be collected starting on January 1, 2004.

To be eligible for the UI, the insured persons must have paid contributions for a period of not less than six months within a period of 15 months. Additionally, a claimant must satisfy other conditions such as the termination of employment must not be a result of a job violation, a planned or premeditated criminal act against the employer, a serious act against the law, resulting in serious damage to the employer's business, or being imprisoned under a court order. The claimants must be employable, ready and willing to work, and cannot refuse to participate in any career-development or job-training programs etc.

[4] Currently 0.5 percent each from worker and employer and 0.25 percent from the government.

The eligible insured persons who are laid off will receive 50% of wages for not more than 180 days within 1 year. The insured persons who resigned from their jobs voluntarily will get 30% of wages for not more than 90 days and the accumulated days' benefits may not be more than 180 days within 1 calendar year. During the economic crisis in 2008, however, the coverage period was extended to 240 days for the insured persons who were laid off.

At the earlier stage of the UI implementation, from July 2004-April 2006, 227,862 people registered for the scheme with the Department of Employment (DOE), at an average of 10,357 people per month. The trend jumped in January of 2005 due to the catastrophe of the Tsunami in late December 2004.

Towards the end of 2008, the number of insured unemployed persons increased drastically due to layoffs as well as increasing awareness of the UI. In 2008, the number of UI beneficiaries increased from 59,214 persons in January to 71,951 persons in December. The laid off workers constituted only 30.47 percent of the beneficiaries (SSO 2008a, 40-41). The UI benefit payment in 2008 was 2,436.37 million baht increasing from 576.9 million baht in 2007.

b. Occupational Security System

The Occupational security system consists of the former Government Pension (GP), Government Pension Fund (GPF) and Pension for Employees of State Enterprises.

(i) Government Pension (GP) and Government Pension Fund (GPF)

The GP is the oldest pension system in Thailand founded during the reign of King Rama V (1853-1910) for the public sector by the enactment of the Pension Act in 1902. Under the reign of King Rama VII (1893-1941), the Act was amended and pension rights belonged to government officials only. In 1939, the Act was replaced by two new Acts; one for civil servants and the other for military servants. In 1951, the new Pension Act superseded the previous one and it was used for central government officials until about 1996 (Kanjanaphoomin, 2004). Since 1996, the GP has been transformed to the Government Pension Fund (GPF), a fully funded system.

Government employees (including civil servants, government employees, employees of state enterprises) are covered by many types of social security benefits, including old-age, health-care, and child-related benefits. All the benefits provided are

financed from general tax revenues. The health-care benefits provided to government officials are summarized in Table 3.

Table 3. Health-care and Medical Benefits for Government Officials

Compensation	Health-care and Medical Benefits
Coverage	- Government employees, parents, spouse and (up to three) children.
Public hospital	- For work-related sickness, all expenditures are covered subject to Ministry of Finance regulations. - For non-work-related sickness, all expenditures for medical treatment are covered; 600 Baht per day for hospital room and food expenditures are provided for a period not to exceed 13 days.
Private hospital	- For work-related sickness, health-care expenditures are covered on an emergency case basis only. - For non-work-related sickness, half of the health-care expenditures are covered, but not more than 3,000 Baht within 30 days.

Source: Chandoevwit (2006).

Prior to the introduction of the GPF, with regard to old-age pensions, a retired government official could choose between two forms of old-age income security, a lump sum payment, or a pension, based on criteria such as retirement age, length of service, and disability. The monthly pension for government officials was then calculated by the following formula:

$$\text{Pension} = [(\text{years of employment}) \times (\text{last salary received})]/50$$

The lump sum payment was equal to the last salary received multiplied by the number of years of employment. The government pension is transferable to their children or other relatives.

Since the 1990s, the "pay-as-you-go" system of the GP has caused a strain on the government budget. The number of retirees increased from 154,940 in 1990 to 217,733 in 1996. During the same period, government expenditure on old-age income security for government officials grew by about 20 percent annually from 6.6 billion Baht to 19.7 billion Baht (Phananiramai, 2003).

As a result, in March 1997, the GP was reformed and replaced by the GPF under the Government Pension Fund Act 1996. The GPF is a fully funded system with defined contributions for central government officials. It has[5] two major changes: (i)

[5] The date is based on (Kanjanaphoomin, 2004, 13).

the original pension benefit is reduced by using the average of a 60 month salary rather than the last month's salary and the ceiling may not be more than 70% of the replacement rate; (ii) the Act mandates the government to accumulate a reserve fund equal to 3 times of the fiscal budget for gratuity and pension payments, implying that pillar I is no longer a fully unfunded system.

The GPF is mandatory except for those who were in service before March 27, 1997 and chose to stay with the old pension scheme. If they chose not to join the GPF, they are eligible for a pension according to the Government Pension Act 1951 only. In December 2003, the GPF had 1.2 million members with a fund size of 230,000 million Baht (Kanjanaphomin 2004, 13-14). The number of GPF members decreased to 1.17 million in 2006.

Under the GPF scheme, the government and the GPF members each contribute an equivalent of 3 percent of the member's salary to the fund. For those government officials who had been employed before March 1996 and for those who voluntarily became members of the GPF, the government adds "seed money" equal to 2 percent of their accumulated salaries from the beginning of their employment. The government also provides an additional monthly contribution of 2 percent of the salary of voluntary members (Chandoevwit 2006, 11-13).

In 2006, there were 1,721,772 civil servants under the GP scheme and 1,172,953 civil servants under the GPF scheme.

Unlike civil servants, government (permanent) employees[6] were covered only by a gratuity (lump sum retirement payment) and a provident fund. In the case of the gratuity, the permanent employees receive a gratuity from the fiscal budget in accordance with the Ministry of Finance's Regulations on Employees' Gratuities in 1976. In the case of the Government Permanent Employees Provident Fund (GPEF), the fund is arranged according to the Provident Fund Act for permanent government employees who are not government officials. The permanent government employees make voluntary monthly contributions at a rate of 3% of their salary, and the government matches these contributions. In 2006, there were 221,553 government

[6] This category of government employees has been replaced by "government service employees" (in Thai พนักงานข้าราชการ) whose SP is covered by Provident Fund.

employees receiving gratuities. Local government officials are eligible for pensions or gratuities similar to the 1951 pension system of central government. However the system is a partially funded system with contributions coming from 1% of the local government fiscal budget every year. This fund is managed by the Ministry of Interior (Kanjanaphoomin 2004, 12). In 2006, there were 215,873 officials under this scheme.

(ii) Pension for Employees of State Enterprises

Presently, all state enterprise pension systems (defined benefit systems) have been transferred to the provident fund according to the Provident Fund Act, 1987. In 2006, there were 294,979 state enterprise employees covered by the provident fund with the fund reaching 118,968 million Baht (US$ 2,974.2 million). Under this scheme, the employees of the state enterprises will receive a lump sum from the provident fund when they retire.

c. Voluntary Social Protection

Thailand has 3 major voluntary defined contribution funds (Pillar III): the Provident Fund, the Retirement Mutual Fund (RMF)[7] and Private Insurance. There used to be a 500 baht health card scheme falling under this category, which later was incorporated into the 30 Baht Universal Health Care scheme.

(i) Provident Fund

The Provident Fund was enacted in 1987 to encourage private sector employees to save for retirement. The fund is a voluntary defined benefit scheme and is arranged upon agreements between employers and employees to set up a Fund Committee that oversees their provident fund. The committee is comprised of representation from the employer and elected representatives of the employees. The committee will then choose a fund manager. The scheme regulatory authority falls under the Securities and Exchange Commission (SEC). Employees' contributions must be at least 3 per cent of wages[8] but must not exceed 15% of wages. Employers' contributions must not be less than the employee's contributions. In Thailand, provident funds are always established in large and medium enterprises (Kanjanaphoomin 2004, 13).

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[7] GPF, on the other hand, should be considered as implicit mandatory defined contributions (Pillar II) (Kanjanaphoomin 2004, 5).

[8] Some reference (Duguay and Bubphawadee 2006) says 2 percent.

The employees receive lump sum proceeds at the time of their resignation or retirement. Segregation of the fund as a distinct legal entity from the company, the plan sponsor, is required. The contributions paid to the provident fund by employees and employers are tax deductible and the benefit payment is tax exempted.

At the end of 2008, 514 funds were registered with the Association of Investment Management Companies (AIMC), with net assets of 465.29 billion baht on behalf of 9,750 companies and 2.056 workers. As of March 2009, 519 funds were registered with the AIMC, with net assets of 471.3 billion baht for 10,028 companies and 2.06 million workers.

(ii) Retirement Mutual Fund (RMF)

The concept of the RMF has been established in Thailand with effect from the end of March 2001. This fund aims to provide a means for the public to make voluntary retirement savings. The fund manager will provide a few RMFs with different risk profiles. The investor can switch his/ her investment from one fund to another fund or even to another fund manager but cannot withdraw the fund until he/ she reaches the retirement age (55 years) after which a withdrawal can be made free from tax. As of December 2003, the total funds are 8,336 million Baht.

Tax benefits of the RMF include (i) tax deduction for investment up to 15 percent of annual income or a maximum of 300,000 baht; (ii) benefit payout or capital gain is tax-free as long as investors--buy investment units at least once a year; invest at least 3 percent of their annual income or 5,000 Baht, whichever is less; (iii) do not pause their investment for more than one year in a row; and, (iv) redeem the investment at the age of 55 or over after a continued investment period of not less than five years. (Thai Provident Fund 2010).

(iii) Private Insurance

Individual life insurance policies in Thailand can be basically categorized into 4 types, which are: Whole Life, Savings or Endowment, Term Life and Retirement or Regular Income (Thai Provident Fund, 2010).

Premiums paid to an insurance policy with a term of at least 10 years at an insurance company incorporated in Thailand are tax exempted for the amount actually paid but cannot exceed 50,000 baht per year. Benefits received from the life insurance policy are also tax exempted.

2.1.2. Noncontributory Transfer Programs (Health Care and Social Assistance)

Thailand's health insurance program consists of 3 major systems according to the profile of the insured: First, the Social Security Scheme (SSS) for private employees; Second, the Civil Servant Medical Benefit Scheme (CSMBS) for government civil servants; and Third, the Universal Coverage (UC), also known as the "30 baht treat all" scheme for the people who are uninsured by other schemes.[9] Table 4 shows the number of people covered by different health care schemes.

a. Universal Health Care (30 Baht) Program

This program started at the same time as the 7th National Economic and Social Development Plan (1992-1996), the UC was implemented in October 2001. The scheme has consolidated all of the existing health insurance schemes belonging to the Ministry of Public Health (MOPH), such as the Health Welfare Program for the Low Income and Disadvantaged (HWPLID) and the Health Card Scheme (the 500 Baht Health Card for Families). The UC's goal is to provide full health care coverage for all Thai citizens who do not belong to the Social Security Health Insurance Scheme (SSO) or the Civil Servants' Medical Benefit Scheme (CSMBS). Eligible persons have to register with the networks in order to obtain a free insurance card and pay a flat rate co-payment of 30 Baht for each out-patient visit or hospital admission but the co-payment was exempted in 2006.

The UC is financed from government revenue. For inpatients, the government pays fees to hospitals according to the types of diseases of the patients; this is called the Diagnosis Related Group, DRG. For outpatients, the government pays lump sum amounts to hospitals for the number of individuals who registered to receive services from such hospitals, this is called capitation.

The National Health Security Office (NHSO) was established in 2002 to supervise the universal health care scheme. The number of Thai people insured by the 30 Baht scheme increased from 45.35 million people in 2002 to nearly 47 million people in 2008. Those who are not insured by the UC are covered by other programs, such as SSO, CSMBS and others. The proportion of Thai people who are covered by any health

[9] Employees of state-owned enterprises are cover by the system similar to CSMBS.

insurance programs increases from 92.47 percent in 2002 to 99.15 percent in 2008 (Table 4).

Table 4. The Number of People with Different Health Care Coverage Schemes

	2002	2003	2004	2005	2006	2007	2008
UC	45.35	45.97	47.1	47.34	47.54	46.67	46.95
SSO	7.12	8.09	8.34	8.74	9.2	9.58	9.84
CSMBS	4.05	4.03	4.27	4.15	4.06	5013	5
Veteran	n. a	n. a	n. a	0.12	0.12	0.13	0.13
Private School Teachers	n. a	n. a	n. a	0.1	0.11	0.11	0.11
Population	61.12	62.45	62.54	62.81	62.39	62.41	62.55
Population with Coverage	56.52	58.08	59.71	60.45	61.04	61.63	62.02
% Population with Coverage	92.47	93.00	95.47	96.24	97.84	98.75	99.15

Source: Annual Report of National Health Security Office, 2009.
Note : Unit in million persons

b. Old Age Living Allowance (OAA)

The OAA is a social assistance or welfare transfer provided by the government. The program was initiated in 1993 to provide income for the poor elderly or the disabled elderly. In the first year there were 20,000 older persons that were granted an income of 200 baht per month per head. The number of OAA receivers increased to 400,000 persons in 2002 and the allowance was increased to 300 baht per month. In 2007, the number of receivers increased to 1,755,266 persons and the allowance was increased to 500 baht per month. In 2009 starting from April, the government has decided to make the scheme universal; however, the scheme will last for only 6 months as a trial period. The number of allowance receivers was 5,963,089 persons. In 2010 the number of older persons receiving the OAA was 5,559,374 resulting in a total amount of 32,218,122,400 baht (MSDHS, 2010).

The eligibility for the OAA includes having Thai nationality; living in the OAA administration area; being 60 years old or over; not receiving other forms of social protection; and not residing in a nursing home of the government or local government.

In addition to the various forms of SP discussed earlier, there are other short-term economic measures to mitigate the impact of the economic crisis, for example the SP1

or Stimulus Program, the so-called 6 Measures 6 months program, workers' loans, etc. They are, however, beyond the scope of this paper.

2.2. Challenges

Most of Thailand's SP schemes are imperfect, in transition or in the process of improvement due to their problems with regard to coverage, adequacy of benefits and management. For example, the SSS covers only private employees and does not cover those workers in the informal sector. The SSS also has problems with long-term financial stability and management. The UI is not yet working well -- the definition of the unemployed is broad, having also included the voluntarily unemployed. Even so, it presently covers only a fraction of the unemployed - in 2008, the number of UI beneficiaries increased from 59,214 persons in January to 71,951 persons in December.

On the health care side, there are some problems with the management of the UC. First, the government lacks sufficient funds to finance the entire universal coverage for all of the hospitals. The total health expenditure is estimated at about 3.7 percent of GDP (ILO 2004), of which about 70 percent is financed by the government. Despite a large portion of health expenditure financed by the government, the government could not allocate enough funds to finance inpatients and outpatients who registered in hospitals under the UC Scheme. Second, there is a problem of personnel redistribution to maintain public health services in remote areas. Some remote hospitals cannot recruit enough doctors and nurses to work in their hospitals. Third, the increased demand from patients leads to a poorer quality of service. For example, outpatients may need to wait in line for a considerable length of time in order to visit doctors.[10] Furthermore, there is a disparity problem among the 3 major health care systems. The best one is the CSMBS, followed by the SSS for private employees and the poorest system is the UC. (Thai Rath, November 21, 2009).

Because of space constraints, the authors limit their elaboration to only one income security scheme which has the biggest coverage but is being subject to reform at present; that is the SSS.

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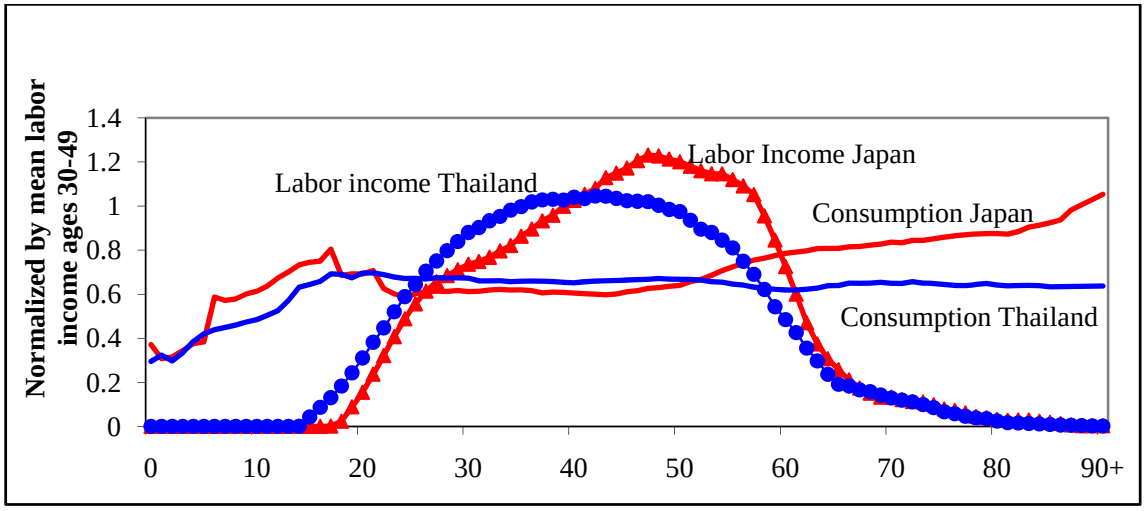
[10] For some more analyses of the 30 baht scheme see for example, (Adrian Towse, Anne Mills and Viroj Tangcharoensathien 2004; C. Suraratdecha, S. Saithanu and V. Tangcharoensathien 2009).

One of the main challenges of Thailand's SSS is the aging population. Population aging in Thailand is quite rapid demographically speaking and is the main challenge to a policy reform on the role of social protection for the elderly. In order to cope with the challenges, it is important to understand the pattern of consumption and how the elderly finance their consumption. For illustration purposes, we compare the pattern of consumption and financial consumption of the elderly in Thailand with Japan, a model of a rapidly aging society in Asia.

The method used to estimate consumption and consumption finance is adopted from the National Transfer Account (NTA), an accounting system that measures economic flows from one age group to another. For example, children and the elderly do not work and they receive economic flows from working adults to support their consumption. Economic flows could be in forms of transfers through the public sector, or the family, or reallocations through assets. Regarding social protection, the NTA can be used to measure the amount of public intervention, such as public transfers in various programs that target the elderly in Thailand. Methods and further references to the NTA can be found at (Mason, et al. (2006) and www.ntaccounts.org).

Consumption for the elderly in Thailand, as shown in Figure 1, is quite flat relative to the working ages, whereas consumption for the elderly in Japan increases rapidly relative to consumption by the working ages. One of the reasons for the Japanese consumption pattern is a rapid increase in consumption for health care and long-term care insurance in Japan (Ogawa, et al, forthcoming). Consumption for the elderly in Thailand seems to show a pattern of generational equity. The pattern of consumption in Thailand implies that even though the elderly do not work enough to support their consumption, the elderly still receive other sources of support to maintain a standard of living as good as their working age counterparts.

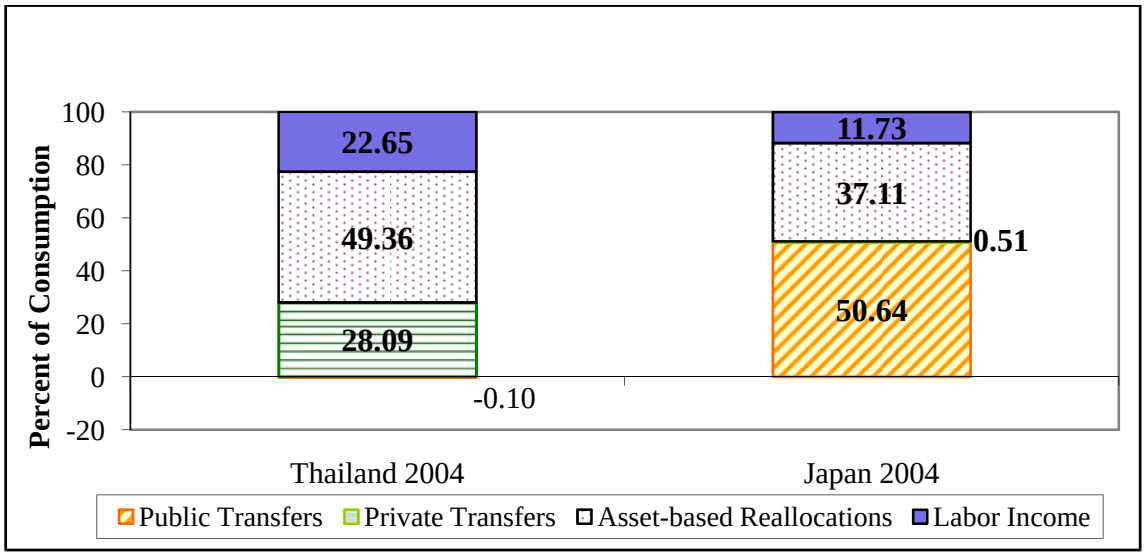
Figure 1. Per Capita Consumption and Labor Income, Thailand and Japan, 2004



Source: Ogawa (forthcoming) and Chawla (2008).

Based on the NTA method, there are generally four mechanisms the elderly may rely on to support their consumption: Labor income, asset-based reallocations, private transfers and public transfers. Figure 2 shows a comparison of how the elderly in Thailand and Japan finance their consumption. There are some important notes to consider. First, the elderly in Thailand rely more on labor income to finance their consumption compared to the elderly in Japan. Second, the major source of support for the elderly in Thailand is through asset-based reallocations, such as asset income and dis-saving. Next, in Thailand, the family plays a bigger and more important role in financing the elderly though private transfers. In Japan, the elderly rarely receive anything from their adult children. Finally, the role of public intervention to provide social protection for the elderly in Thailand is negligible or even negative (as the elderly pay taxes more than they receive benefits back from the government), where as public transfers in Japan are the major source of support for the Japanese elderly. It is thus a challenge to elaborate on the role of social protection provided by the government in Thailand.

Figure 2. Consumption Finance for the Elderly (65+) for Thailand and Japan, 2004



Source: Ogawa (forthcoming) and Chawla (2008)

Another major challenge to the SP, particularly the SSS, in Thailand is a huge sector of informal workers who have not been covered by any income security system. In Thailand, an informal worker is defined broadly as "an employed person who earns income but does not have an employer nor is under the protection of the Social Security Act" (Niratorn, Narumon et. al., 2007, 22) By this definition, based on the data in Table 1, the number of informal workers can be roughly counted as about 23.4 million workers. These workers and their families could be vulnerable to any form of shocks, such as an income shock due to a financial crisis or sickness. Furthermore, it is unlikely that these workers would have access to a source of funds to support their consumption during their retirement. At present, the role of the government in Thailand is very small in supporting the elderly. Thus, it is important that consideration is given on how to provide income security for the elderly in the informal sector.

The last major challenge to Thailand's SP (in the context of income security for retirement) is the low rate of personal savings in Thailand that will essentially lead to income insecurity in old age. As shown in Table 5, the proportion of personal savings to net disposable income was 6.8 percent in 2003 increasing to 12.4 percent in 2007. The level of personal savings per capita was 3,907 baht in 2003 increasing to 10,011

baht in 2007. Although the trend has been encouraging, the rate and level of personal savings are too low to sustain a living after retirement.

Table 5. Income and Saving in Thailand, 2003-2007

Year	2003	2004	2005	2006	2007
Disposable Personal Income					
- Total (Millions of Baht)	3,691,646	4,090,863	4,457,665	4,892,526	5,325,480
- Per capita (Baht)	57,698	63,394	68,475	74,611	80,639
Personal Outlay					
- Total (Millions of Baht)	3,441,650	3,771,332	4,128,926	4,468,994	4,664,356
- Per capita (Baht)	53,791	58,442	63,425	68,152	70,628
Personal Savings					
- Total (Millions of Baht)	249,996	319,531	328,739	423,532	661,124
- Per capita (Baht)	3,907	4,952	4,050	6,459	10,011
Percentage of Personal Savings to Disposable Personal Income	6.8	7.8	7.4	8.7	12.4
Net Savings (Millions of Baht)	867,530	984,320	1,038,276	1,352,612	1,626,971
Gross Domestic Product (GDP) (Millions of Baht)	5,917,369	6,489,476	7,092,893	7,841,297	8,493,311
Percentage of Net Savings to GDP	14.7	15.2	14.6	17.2	19.2

Source: National Account Bureau, Office of the National Economic and Social Development Board.

3. Main Critical Reforms of SP

In response to the challenges, the Ministry of Finance (MOF) has formulated 2 government policies aimed at ensuring that every Thai has sustainable income security in old age:

3.1. Policy on Mandatory Savings under Project on the National Pension Fund (NPF) which later has been renamed as the National Savings Fund.

With regard to this policy, the MOF had been trying to establish an NPF in pursuance of the Cabinet resolution of 25 April 2000. According to the resolution, the Cabinet had endorsed in principle that Thailand should have a Multi-Pillar system of SP and assigned the MOF to establish a mandatory savings fund (Pillar 2).

At the beginning, the MOF proposed that the fund should have a defined contribution of 3 percent of a worker's monthly wage each from the employer and the

worker. The range of the wage was fixed between 6,000 baht to 40,000 baht per month. For a worker with a wage lower than 6,000 baht per month, only his/her employer had to pay the contribution. Members of the fund would have individual savings accounts. The fund would be managed jointly by the Office of the NPF and a private management company selected by the Office of the NPF. The Office of the NPF would be a Public Organization. The NPF was expected to yield a pension of about 17 percent of the last month's salary. It was also expected that the fund would increase the country's long-term savings by 22,950 million baht in the first year and that the fund will increase long-term investment in the country's securities market. (Mitranont, Preeya et.al., 2009, 119-120).

3.2. Policy on Savings for Informal Workers.

Regarding this policy, the MOF had proposed 3 major alternatives of savings systems as follows.

(1) The NPF as discussed above in 3.1.;

(2) The extension of SSS coverage to the informal sectors; and

(3) The reform of area-based savings for retirement among informal workers such as Community Fund Institutions and Community Savings Groups into community welfare activities (Mitranont, Preeya et.al. 2009, 120).

These policies have been publicly reviewed a few times. For example, there was a national forum to develop the quality of life of older persons organized by the Thai Research Fund and National Public Health Foundation 2007 on "National Pension System for Older Persons in Thailand" in Bangkok on October 1, 2007 (National Public Health Foundation, 2007). Another national forum was organized by the Thailand Development Research Institute on "the Design of the National Pension Fund" at TDRI on April 21, 2009. In connection with the latter forum, a final report on "Thailand's National Pension System" was submitted by Charndoevwit *et.al.*, in September 2009 (2009).

After Charndoevwit's report, on 21 October 2009 the Cabinet approved a draft National Savings Fund Act B.E. as submitted by the MOF. The NPF's name has been changed to National Savings Fund (NSF) to reflect the integration of the 2 policies proposed by the MOF.

The NSF is a voluntary program that individuals may choose to save some part of their income in every month in order to guarantee that they will have some funds to support themselves during their retirement. The NSF is aimed at covering workers in the informal sector which accounts for the majority of the labor force in Thailand.

According to the draft National Saving Fund Act (Cabinet, 2009), the NSF will be established to promote savings in the country and to promote income security by ensuring pensions and other benefits to its members. The member must be of Thai nationality and not older than 60 years of age, and must not be a member of other social security schemes or the Government Pension Fund[11]. The membership expires when the member reaches the age of 60. Members must contribute to the fund with additional contributions by the government as stipulated by the Ministerial Regulation. In case a member is not able to make a contribution, his/her membership does not expire but the government will not pay a supplementary contribution. Members pay a contribution ranging from 100 baht to 1,000 baht a month. The government pays a counterpart contribution based on the age of the members. When the membership expires at the age of 60, a member is entitled to a pension from his/her contribution, the government's contribution and benefits accrued to the contributions until maturity.

The NSF Committee consists of 6 members appointed by agencies, 3 specialists from the legal, accounting and finance sectors respectively and 5 representatives from the members. The committee is chaired by the permanent secretary of the MOF with the Secretary General of the NSF as a committee and the secretary of this committee.

To ensure the sustainability of the fund, the government will provide compensation to the NSF if the fund's investment loses or receives a rate of return less than the 12-month time-deposit rate, based on the average of five major commercial banks and the Government Savings Bank and the Bank for Agriculture and Agricultural Cooperatives. The government will compensate for the loss from the government annual budget. The assets of the NSF shall be kept by asset management agencies who are certified by the Securities and Exchange Commission.[12]

From the draft NSF Act, it can be seen that the reform will answer a few questions on coverage, governance and management, and adequacy of benefits. First, on the

[11] This requirement will limit the participation of workers in the formal sector.
[12] More details of the NSF can be accessed from (Cabinet 2009).

coverage, the NSF is established to ensure that all of the population who are not government employees or insured by the SSS retirement benefit scheme will have old-age financial support. In addition to individuals' savings and return on the savings through this fund, the elderly can still receive the OAA of 500 baht per month. The fund plans to include members from various walks of life with a range of ages from 20 to 60 years old.

Second, the financial sustainability is, however, not promising at this stage. According to an estimate by Suwanrada and Chandoevwit (2009), each member needs to save adequately for a number of years to ensure their income security during old age. Members who save at an earlier age will receive a larger retirement fund than those who started to save later. For example, a member who saves 100 baht a month is expected to receive a monthly allowance, including OAA, of 877 baht if he starts to save at the age of 20, whereas he may receive 738 baht if he starts to save at the age of 30[13]. This amount of pension may not be adequate support during old age if members do not save enough. Given a poverty level of approximately 1,500 baht a month, those who are 20 years old may need to save about 300 baht a month in order to ensure a reasonable standard of living during old age, not counting inflation. The question is whether people have the ability to save enough every month.

Third, in terms of governance and management, the NSF will be established as an independent organization in order to guarantee less interference from bureaucracy. The NSF Committee includes a Board of Directors who supervises any investment activity of the fund. The Board of Directors is selected from various groups, such as investment specialists, members of sub-district authorities and members appointed by the MOF. The Board of Directors includes a number of sub-committees, namely the investment committee, audit committee; governance committee; human resources and compensation committee; and information management committee.

The management of the fund will be decentralized to the local level. The local level organizations such as the Tambon or Provincial Administrative Organizations will perform the function of the NSF at the local level which is to receive contributions from the members and provide pensions to retirees as depicted in Figure 3.

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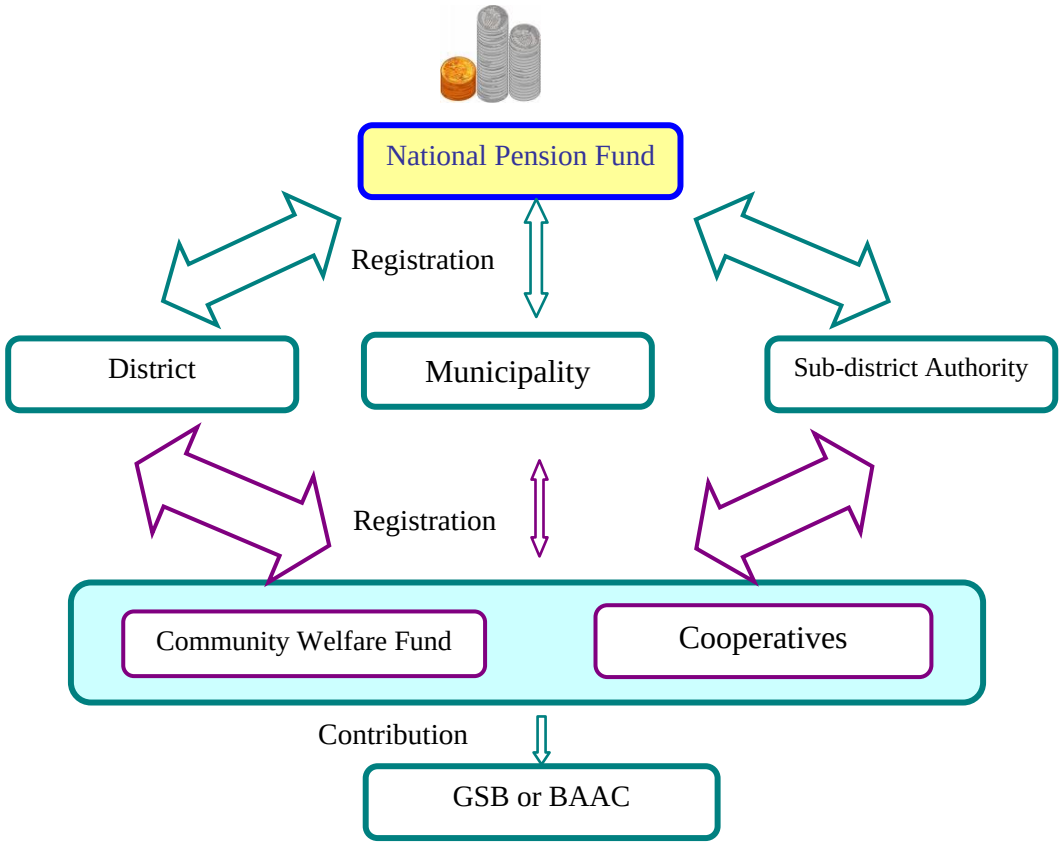
[13] Given a rate of return of 3 percent per year.

Figure 3. Organization Chart for Management of the National Pension Fund at the Local Level.



Source: Adjusted from Charndoevwit *et.al.* (2009)

It is too early to judge the success or failure of the NSF scheme. The MOF speculated that at first there may not be many members. It is anticipated that within 1-2 years, the membership will reach 7 million. Meanwhile, the draft NSF Act is still subject to the approval of parliament. It is hoped that the draft Act will be submitted for consideration and approval by early 2010. The MOF stated that it had not yet fully prepared for the establishment of the fund as it was not sure whether the draft act will pass through parliament (Matichon Daily November 16, 2009).

4. Policy Recommendations and Conclusion

4.1. Policy Recommendations

Based on the foregoing analysis, a few recommendations are offered:

1) The existing Multi-Pillar SP system needs constant and continued evaluation and reform. There have been problems of disparities among different schemes, inadequate coverage, and financing problems, while the country has become an aging society which demands better income security.
2) The SSS coverage is still low, particularly among employees of micro enterprises (employing 1-9 workers) and the voluntary insured persons (under Article 40 of the Social Security Act 2542) because of limited benefits. Although the former is mandatory under the SS Act, the compliance rate is low. The government should develop a policy and measures to increase the participation rate.
3) The UI has also not been effectively implemented. The application of UI to the voluntary unemployed should be reviewed and the coverage should be expanded to cover more of the laid-off and the unemployed who are unaware of their rights.
4) To reach the informal sector, through the NSF, the database system must be better prepared than those of the SSS or GPF to keep track of the fund members and fund administration.
5) At present the rate of personal savings is low and the reliance of the elderly on personal savings is also low (the proportion of the elderly having income from savings was 18 percent in 2002 and 38 percent in 2007 (NSO, 2002 and 2007). Although the government will provide joint contributions for members, it may also provide tax incentives for additional contributions to savings for retirement.
6) The role of the local administration should be emphasized with regard to their readiness, database and personnel to handle the implementation of the NSF scheme.

People's awareness and appreciation of the NSF is an important factor. Therefore, apart from providing an incentive to save, the government may need to develop public relation material and information on the importance of savings for all people.

4.2. Conclusion

In conclusion, the review has shown that Thailand's SP is a multi-pillar system which has been continuously developed. Many of the schemes are still young, while the older schemes are not appropriate for the current situation either in terms of coverage, adequacy of benefits or management. Both the young and the old schemes are in need of adjustment for a new environment with an aging society as a backdrop. Many challenges have been waiting in line for the SP in Thailand for some years. Thailand is now taking a giant step towards the informal sector by initiating a National Savings Fund to collect savings from informal workers. Considerable work has been done in the establishment of the Fund including a draft National Savings Fund Act B.E. to be submitted to Parliament for approval probably early next year. The mobilization of savings for retirement is a sound move but questions surround the implementation of the Act.

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CHAPTER 10

Social Protection in Vietnam: Current State and Challenges

GIANG THANH LONG

National Economics University, Vietnam

This chapter provides an analysis of the developmental path for, current state of, and challenges facing social protection in Vietnam, with a special focus on the social insurance and health insurance schemes. We reveal that Vietnam has achieved remarkable results in providing social protection to its citizens, particularly since Doi moi. At the same time, however, Vietnam also faces a number of challenges resulting from rapid changes in social, economic and health factors. Low coverage, poverty during old age and vulnerability, inefficient health care delivery and limited accessibility are some of emerging issues. To deal with these issues and to adapt to expected challenges such as an aging population, the chapter also provides some reform directions and proposals, such as transforming the current pay-as-you-go defined benefit (PAYG DB) pension scheme to a system of individual accounts via a notional defined contribution (NDC) scheme as a transitional step, and providing universal social assistance to the elderly to reduce incidences of poverty.

1. Introduction

After about 20 years of the implementation of *Doi moi* (renovation) programs, Vietnam has changed, since 2008, from one of the poorest countries in the world to a low middle-income country.[1] The average Gross Domestic Product (GDP) growth rate was about 7.4 percent during 1991-2009, which helped to increase GDP per capita to from $US 98 in 1990 to $US 1,064 in 2009. Thanks to this remarkable economic growth, the national poverty rate decreased significantly from 58.1 percent in 1993 to 14.5 percent in 2008. The poverty gap, measured as a percentage of the poverty line, was also substantially decreased from 18.5 percent in 1993 to 3.8 percent in 2006 (World Bank, 2007). In terms of region, incidences of poverty in all eight economic regions have been reduced over the course of time. Along with remarkable social and economic achievements, social protection system in Vietnam has been developing with considerable progress in terms of important aspects such as: poverty reduction, job creation and income maintenance for various groups of Vietnamese people. The country also has reached most of the Millennium Development Goals (MDGs) ahead of schedule (Gaiha and Thapa, 2007).

At the same time, however, such impressive economic growth has relied mainly on natural resources, capital and external financial resources (Nguyen and Giang, 2008). The areas, in which economic restructuring has been slower than expected, are within groups of the population, particularly ethnic minority people who are still living in disadvantaged conditions, and the inequality between areas and regions is widening, which is proving to be an emerging social concern. Along with this context and weak self-protection mechanisms, the most challenging policy issue is related to the fact that the social protection system in Vietnam has not been well developed and is characterized by a number of drawbacks, including a lack of coverage, insufficient funding sources and inefficient institutions. As such, the socio-economic development

[1] In 2008 GNI data, the World Bank classifies economies as follows: low income countries ($975 or less); low middle-income countries ($976-$3,855), upper middle-income countries ($3,856-$11,905); and high income countries ($11,906 or more). As such, in 2009, Vietnam was ranked as a low middle-income country.

of Vietnam in the near future may be facing more risks from changing economic, social and environmental conditions along with deeper regional and global integration.

As Vietnam enters the ranks of middle-income countries, it needs to lay the foundations to support a more dynamic and sophisticated economy, which in turn will result in new and more complicated challenges in developing appropriate policies. As such, without appropriate changes, the current social protection system may not be able to deal with new challenges, which in turn may have a negative impact on economic growth in the long-term.

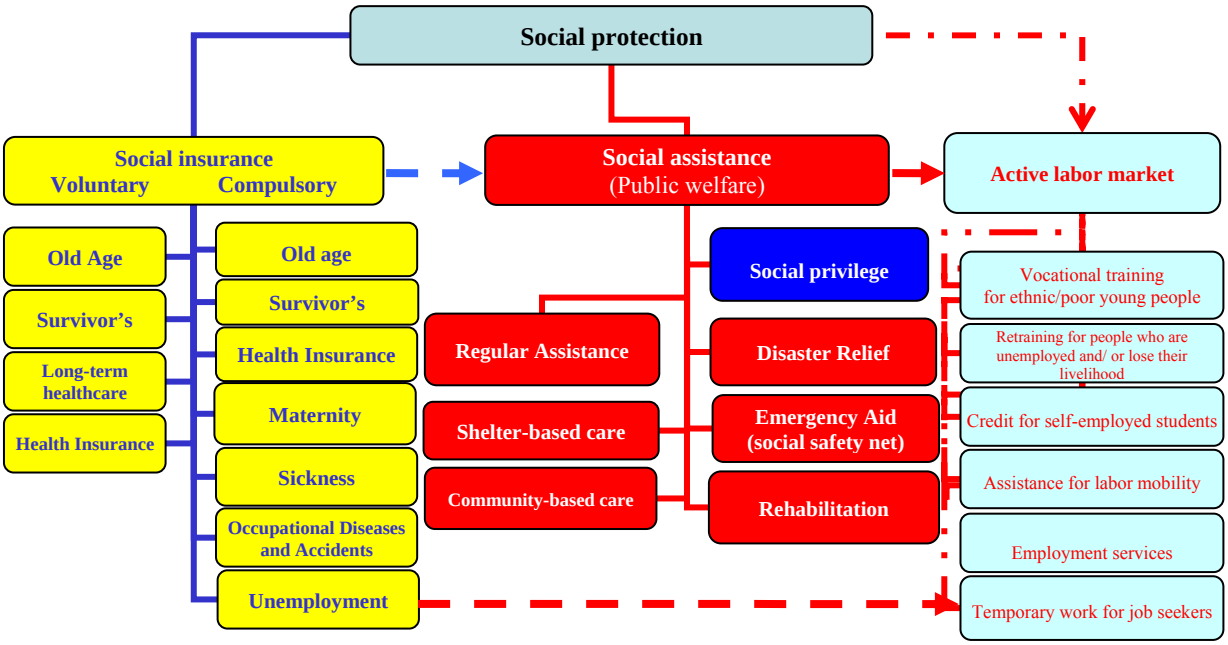
The main objectives of this chapter are to (i) provide an overview on the current state of development of the social protection system in Vietnam; (ii) point out challenges of these schemes during a time of swift socio-economic change in the country; and (iii) provide some policy suggestions to reform the current system which will help in adapting to the forthcoming expected changes. The paper is organized as follows: in the next section, we will provide information regarding the recent development and challenges of the social protection system in Vietnam with a special focus on social insurance and health insurance; along with these issues, reform proposals will be discussed. In the third part of the chapter, we will provide some concluding remarks for the chapter.

2. Social Protection in Vietnam: Development and Challenges

So far, the term "social protection" has not been well defined in Vietnam. Depending on the scope of policies and programs, this term is sometimes alternatively used with "social security" or "social safety net". According to the draft of the Social Protection Strategy 2011-2020, social protection in Vietnam includes three main pillars: (1) labor market; (2) social insurance and social health insurance; and (3) social assistance. These three pillars aim to deal with various risks which are present in a person's life. For instance, the labor market policies are to prevent risks; social insurance and social health insurance policies aim to mitigate risks once they occur;

while social assistance policies help people overcome their risks if they are unable to cope by themselves (Figure 1).

Figure 1. Structure of the Social Protection System in Vietnam



Source: Adapted from the draft of the Vietnam's Social Protection Strategy 2011-2020.

In this chapter, however, we will focus on social protection in Vietnam through two pillars (social insurance and health insurance) in order to see the current state of their development and challenges they may be facing in the coming time, as well as some policy proposals to reform the system.

2.1. Social Insurance Scheme

2.1.1. Current State

The social insurance scheme has been in operation since the early 1960s. Prior to 1995, social insurance only covered employees in the state sector and it was managed by different public agencies under the supervision of the government. The benefits were paid from a pooling fund, which was funded by contributions from employers and government subsidies. The fund was managed and guaranteed by the government. For about thirty years, the scheme contributed significantly to the income and living

standards of the insured people. However, dramatic changes in the economy and society along with the growing private sector resulting from the *Doi moi* (renovation) programs forced the government to reform the scheme. The reform led to the establishment of Vietnamese Social Security (VSS), which is responsible for administration of this scheme under the guarantees of the government. The social insurance scheme has taken a further step in development since 2007, when the first Social Insurance Law was put into effect. Under this Law, there are five mandatory components: sickness, maternity, occupational accidents, occupational diseases, and retirement and longevity. In addition, the scheme has also been diversified with a new voluntary social insurance covering retirement and survivorship with a special focus on people working in the informal sector.

With such changes, the current social insurance scheme includes both pre-1995 and post-1995 contributors and beneficiaries. The following discussion will mention only the post-1995 scheme.

Table 1. Number of Participants and Beneficiaries, 1996-2008

Year	Number of participants (1,000 persons)	Labor force (1,000 persons)	Participation rate (%)	Number of beneficiaries (persons)	Ratio contributor-beneficiaries
(1)	(2)	(3)	(2) : (3)	(4)	(2) : (4)
1996	3,231	35,866	9.0	1,769	1.8
1997	3,572	36,896	9.7	1,758	2.0
1998	3,765	37,207	10.1	1,752	2.1
1999	3,860	37,583	10.3	1,754	2.2
2000	4,128	37,610	11.0	1,761	2.3
2001	4,376	38,563	11.3	1,778	2.5
2002	4,445	39,508	11.3	1,801	2.5
2003	4,987	40,574	12.3	1,840	2.7
2004	5,820	41,586	14.0	1,890	3.1
2005	6,190	42,527	14.6	1,967	3.1
2006	6,747	43,339	15.6	2,058	3.3
2007	8,179	44,174	18.5	2,132	3.8
2008	8,539	44,916	19.0	2,205	3.9

Source: Own compilation from VSS reports (various years).
Note : The number of beneficiaries includes those belonging to pre-1995 scheme.

Table 1 shows that the number of participants of the social insurance scheme has increased over time. This expansion has been attributed to an increasing participation

from private sector institutions. However, the participation rate, measured by the number of participants as a percentage of the total labor force, has been small, at only 19 percent in 2008. Data from VSS (various years) show that the participants from the public sector account for a large proportion, meaning that many people from the private sector have not yet participated in the system.

At the same time, the number of beneficiaries has grown at a slower pace than the number of contributors. As a result, for the whole social insurance scheme, the contributor-beneficiary ratio has increased and reached about 4 in 2008. For the pension scheme alone, however, this ratio was about 17 in 2008.

Prior to 2007, benefits were adjusted in line with minimum wages. Since the first Social Insurance Law, benefits have been adjusted in line with the Consumer Price Index (CPI). In 2008, the average pension benefit (except those for armed-force pensioners) was about 78 percent of GDP per capita, and the average replacement rate was about 68 percent.

Table 2. Social Insurance Fund Balance and Accumulation, 1995-2008

Year	Previous year balance (VND billion)	Investment return (VND billion)	Revenue (VND billion)	Payments (VND billion)	Fund accumulation (VND billion)
1995	0	0	789	42	747
1996	747	18	2,597	383	2,968
1997	2,968	191	3,446	594	5,743
1998	5,743	473	3,876	752	8,888
1999	8,888	666	4,186	940	12,241
2000	12,241	824	5,298	1,334	16,285
2001	16,285	865	6,348	1,936	21,690
2002	21,690	1,606	7,777	2,960	26,507
2003	26,507	1,911	10,984	3,792	33,699
2004	33,699	2,604	12,520	4,866	41,353
2005	41,353	3,086	15,522	6,766	51,108
2006	51,108	4,081	20,290	11,045	61,838
2007	61,838	4,794	27,591	14,465	74,958
2008	74,958	7,357	30,939	21,360	91,522

Source: Own compilation from VSS reports (various years).
Note: These numbers include only those from VSS fund and exclude those from government budget. Numbers are rounded.

The expansion of the social insurance system has also resulted in a swift accumulation of funds. By 2008, the fund balance was about VND 9.6 billion (US$ 570 million) but the fund accumulation was VND 91,522 billion (or about US$ 5 billion, equivalent to 6 percent of GDP in 2008).

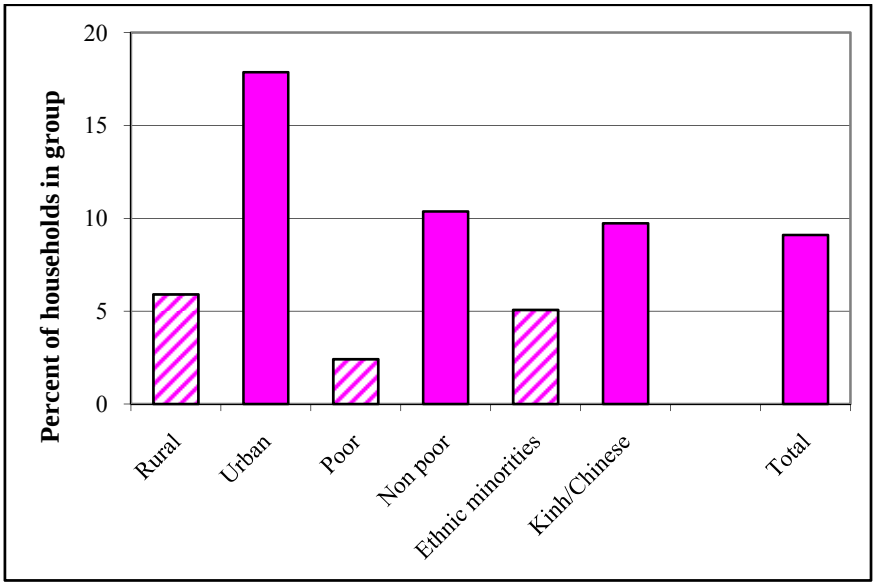
2.1.2. Challenges

The pension scheme is operating under a pay-as-you-go (PAYG) financing mechanism, in which benefits are pre-determined by given formulas based on the number of years of contribution and historical contributions. Under expected demographic and economic changes, as well as administrative capacity, the main challenges for the scheme result from the current design and implementation capacity.

First, the coverage rate of the scheme has been persistently low; particularly the coverage rate for the informal sector workers via the voluntary scheme is negligible. The main problems include: (i) regulations that focus mostly on formal sector workers; and (ii) it is difficult for the voluntary scheme to be articulated with the mandatory scheme, which in turn makes it difficult for workers to move between these two schemes.

In addition, among the mandated participants, the compliance rate (or active rate) has been low, especially for the private sector. In general, the compliance rate was only 65 percent in 2008 (meaning only 8.5 million out of 13 million workers made contributions to the scheme) while the compliance rate in the private sector was only 50 percent. There are a number of reasons for this; for instance, World Bank (2007) shows that low participation is mainly due to a lack of information and low incentives resulting from complicated regulations.

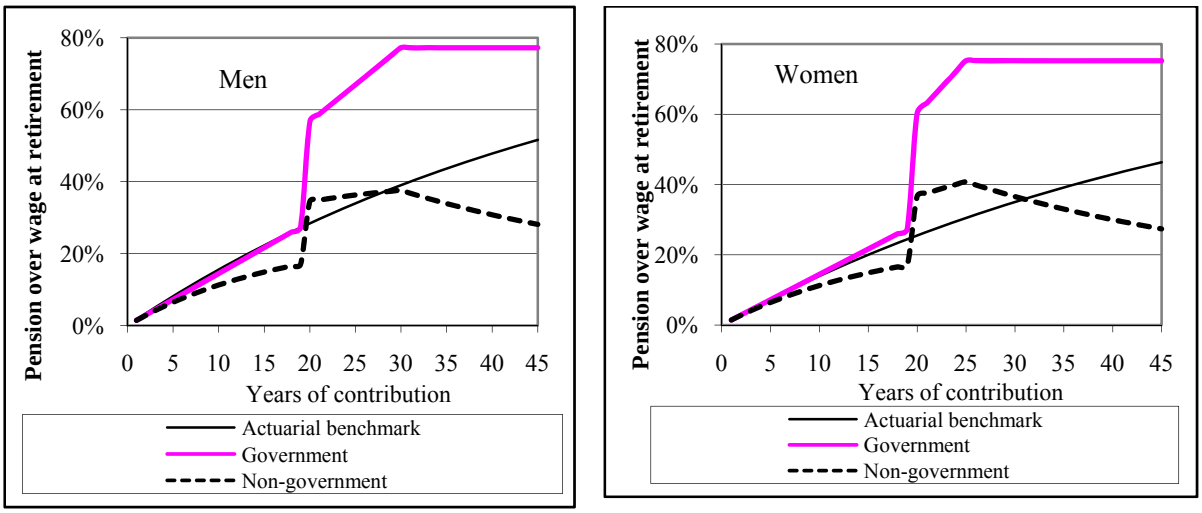
Figure 2. Large Participation Gaps in the Social Insurance Scheme



Source: World Bank (2007).

Second, in addition to the low coverage rate, Figure 2 shows that there have been wide participation gaps between rural and urban, between poor and non-poor, and between ethnic minorities and Kinh/ Chinese. The latter groups are usually more vulnerable to risks than the former, so that such a low participation may not be able to help them to mitigate risks since more than half of their income sources are mainly from household business or agricultural production (Evans *et al*., 2007). Recent estimates by the World Bank (2007) indicate that the social insurance benefits, especially pensions, are not pro-poor, since almost half of pension spending goes to the two richest quintiles, and only 2 percent go to the poorest. In fact, Giang and Pfau (2009a) show that there are only 35 percent of old-age persons receiving social protection benefits and most of them are from urban areas. This means that a great number of people, who are more vulnerable to poverty, are not covered by the current scheme.

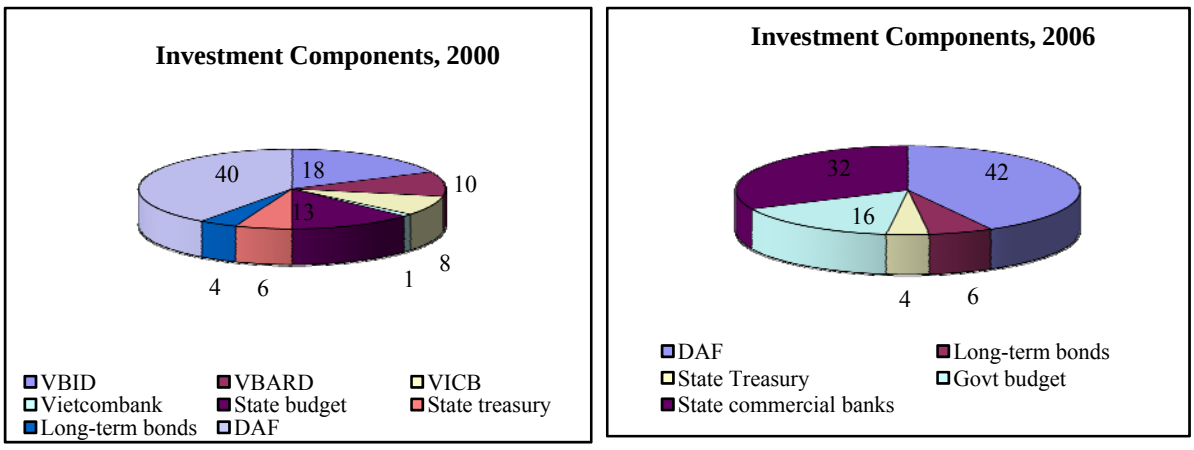
Figure 3. Unfair Benefits between the Public and Private Sector



Source: World Bank (2007).

Third, the current formulas to estimate benefits are unfair, particularly between males and females, and between the public and private sector. Figure 3 implies that workers in the private sector should not contribute for more than 28 years (for males) and 26 years (for females), since the expected additional benefits will be reduced overtime. Even with the same actuarial benefits, private sector workers may get lower levels of benefits, while those from the public sector may get higher levels of benefits. In addition, various reports from VSS show that the average pension benefit is only about 70-75 percent of GDP per capita, which is still low.

Figure 4. Investment Portfolio of the Social Insurance Fund



Source: Own compilation from VSS reports (various years).

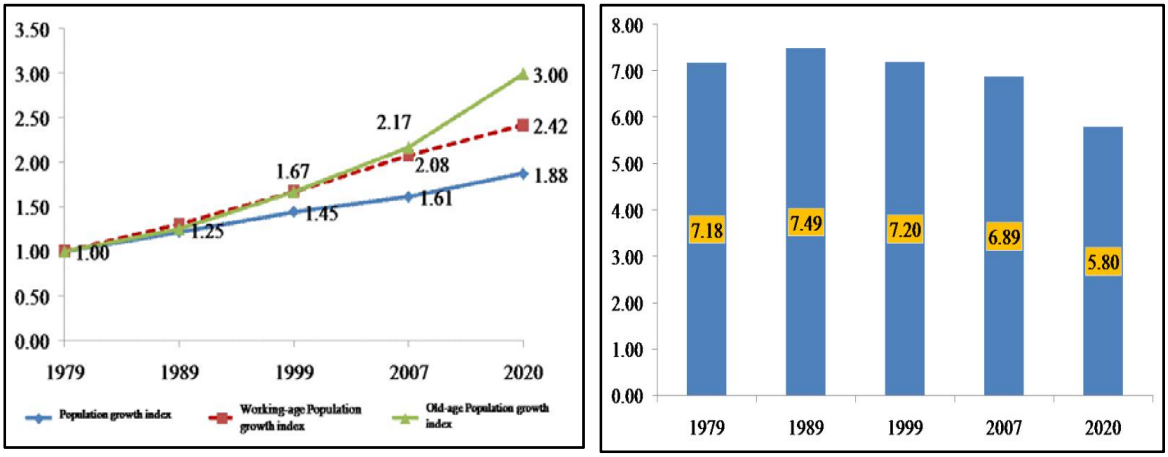
Table 3. Rate of Returns on Social Insurance Fund Investment

Year	NOMINAL				Inflation	REAL			
	T-Bill	Deposit	Lending	SI Fund		T-Bill	Deposit	Lending	SI Fund
1997	10.83	8.51	14.42	6.46	2.87	7.96	0.55	13.87	3.59
1998	11.44	9.23	14.40	8.23	7.30	4.14	5.09	9.31	0.93
1999	9.12	7.37	12.70	7.49	-1.80	10.92	-3.55	16.25	9.29
2000	5.42	3.65	10.55	6.73	-0.99	6.41	-2.76	13.31	7.72
2001	5.49	5.30	9.42	5.31	0.25	5.24	0.06	9.36	5.06
2002	5.92	6.45	9.06	3.76	2.96	2.96	3.49	5.57	0.80
2`003	5.83	6.62	9.48	4.53	2.06	3.77	2.86	6.62	2.47
2004	5.75	6.14	9.65	5.43	8.45	-2.69	8.84	0.81	-3.02

Source: Own estimates from IMF's financial statistics and VSS reports (various years).

Fourth, although the fund accumulation is getting larger, an important concern surrounds the low rate of returns on fund investment. The current reports by VSS show that over the years most of the social insurance fund investments are going to state financial institutions (Figure 4) and producing a lower rate of return that the market rate (Table 3). As discussed in Nguyen Tue Anh (2006) and Giang and Pfau (2009b), investments can be a crucial determinant in maintaining fund accumulation. As such, an improvement in the management of fund investment must be an urgent requirement in order to provide long-term stability of the fund in terms of finance.

Figure 5. Rapidly Aging Population and Potential Support Ratio



Source: Adapted from Nguyen Dinh Cu (2009).

Fifth, the long-term financial sustainability of the fund may be deteriorated by the aforementioned factors along with an expected rapidly-aging population. As indicated in a number of recent annual surveys by the General Statistics Office (GSO), the population in Vietnam has entered an aging phase in 2008 when the percentage of old-age persons (60 and over) accounted for 10 percent of the total population. Nguyen Dinh Cu (2009) shows that the growth rate of the old-age population has been much faster than those of the working-age population and the whole population (Figure 5, left). As such, we expect that the potential support ratio will decrease substantially in the future (Figure 5, right).

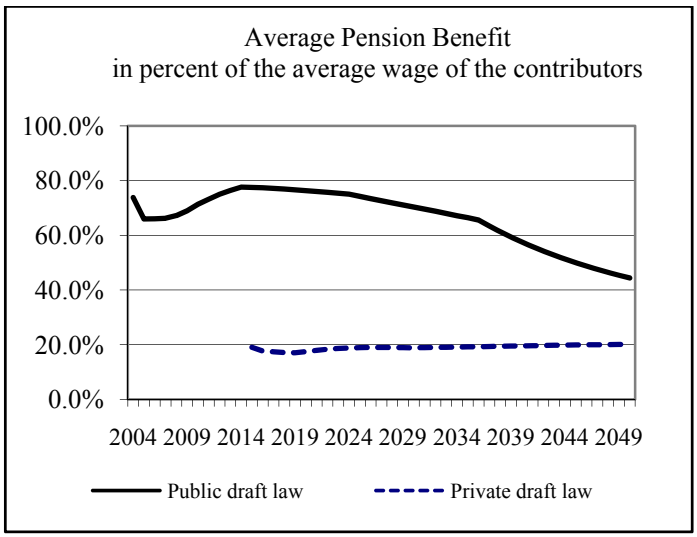
Assuming that the current social insurance regulations remain, the pension scheme dependency ratio (measured by the ratio between the number of beneficiaries and number of contributors) will increase swiftly. This ratio decreased from 34 in 2000 to 19 in 2004, and to 6 in 2020 (Castel and Rama, 2005).

Furthermore, as the population ages, life expectancy of elderly people at retirement will also increase. If the trend of early retirement for both males and females continues to persist in the future, then this will increase the number of years that benefits are paid. A recent report by VSS shows that the average actual retirement age is 53, of which males are 55 (compared with a normal retirement age 60) and females are 51 (compared with a normal retirement age of 55). In addition, the average life expectancy of retirees is 72.5 years, in which 71.1 years for males and 73.9 years for females. As a result, the average number of years for receiving benefits is about 19.5 years, in which 16.1 years are for males and 22.9 years for females. However, this report also indicates that a 28-year contribution can cover pension benefits for 10 years, meaning that the additional costs for the remaining 9.5 years of benefit receipts must be requested from the government budget or other sources. Otherwise, balancing the social insurance fund requires reducing replacement rates and/ or increasing contribution rates. Nevertheless, the current average pension is only $US 50-70 per month (Nguyen Thanh Tra, 2009) or the contribution rate must increase to 30 percent in order to balance the fund until 2045 (Giang, 2008). Both are infeasible under the current economic context.

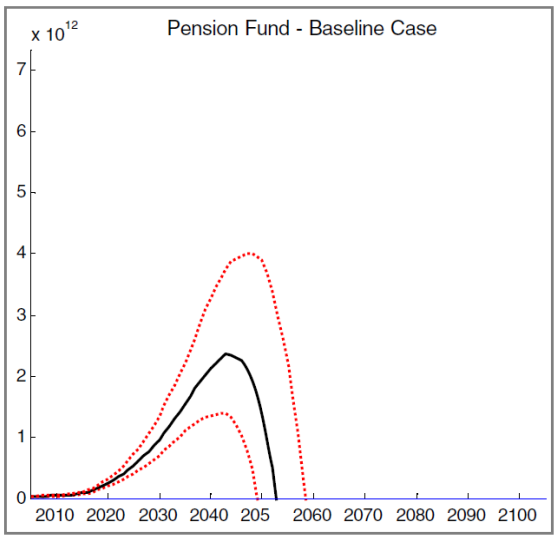
Overall, the current operation of the social insurance scheme in general and the pension scheme in particular, will not bring sustainability, as they will involve in both unsuitable benefits and financial instability. Castel and Rama (2005) show that the

replacement rate will be reduced significantly and the replacement rate for workers in the private sector will be substantially lower than that of workers in the public sector (Figure 6, left). Giang and Pfau (2009b), meanwhile, show that the pension fund will be completely depleted in about four decades (Figure 6, right).

Figure 6. Projections for Replacement Rate and Long-term Pension Fund Balance



Source: Castel and Rama (2005)



Source: Giang and Pfau (2009b)

2.1.3. Reform Proposals

These above challenges require Vietnam to reform social insurance, particularly the pension scheme, so as to achieve long-term sustainability. Following are some policy suggestions to reform the current social insurance scheme.

First, promoting the participation and accessibility to compulsory social insurance for employees in various types of enterprises. Under "demographic bonus", which will happen from 2010 onwards, job creation and promotion of participation in social insurance will ensure an increase in the number of contributors, so as to reduce the burden on contributions once the number of beneficiaries increases.

Second, clearly differentiate financial mechanisms for short-term and long-term social insurance. This will distinguish payments, investments, as well as the responsibilities of different parties in the social insurance system. One suggestion for the pension scheme is to transform the current PAYG DB scheme to a notional defined contribution (NDC) scheme as a step in moving closer to a scheme of individual

accounts. As discussed in Giang (2004, 2008), this transformation will help to avoid a huge amount of pension liabilities resulting from directly moving PAYG-DB to individual accounts. Given that the external debt reached 43 percent of GDP in 2007, moving directly from PAYG DB to individual accounts would add about 80-108 percent of GDP as pension debt[2] to the total government debt, which in turn would create substantial troubles for financial stability in the medium and long terms. In addition to such an expected advantage from NDC, reforming the PAYG alongside a rapidly aging population will also help Vietnam to remedy both intra-generational and inter-generational equity between participants.

It is worth noting that the social insurance scheme has covered a small part of the total population in general and the old-age population in particular, so that a social assistance scheme as a supplementary pillar is also needed. A research by Weeks *et al.* (2004) show that a universal pension scheme, which provides benefits to all old-aged persons from the age of 65 years and over, would cost less than 2 percent of GDP. Giang and Pfau (2009c) indicate that a universal pension providing benefits to all old-age persons in Vietnam that costs less than 3 percent of GDP, and, more importantly, provide benefits to rural and elderly females, who are persistently more vulnerable than other groups of people, will have high impacts on poverty reduction with lower costs.

Third, besides the mandatory social insurance scheme, policies aiming to promote participation in voluntary social insurance should be strengthened, including:

- Allow workers to buy the missing years in order to be eligible for social insurance benefits; flexible design of contributions and payments which reflect income to attract workers in the informal sector;
- Develop links between mandatory and voluntary social insurance in order to develop a common premium and benefit;
- Formulate a pilot support policy for vulnerable groups and ethnic minority people to participate in voluntary social insurance by sharing the social insurance premiums between the government and the participants to reduce the government budget burden for retired workers without pension benefits.

[2] For detailed discussion on how to measure pension liability/debt, refer to Holzmann *et al*. (2004) and Franco *et al*. (2004).

In addition to a formal social insurance scheme, it is also necessary to promote the development of a community-based and informal social protection model, in which families should be the core self-protection for people.

2.2. Social Health Insurance Scheme

2.2.1. Current State

The initial stages of the health insurance scheme in Vietnam involved a series of experimental local schemes in selected provinces in the late 1980s. In 1992, Vietnam introduced a mandatory scheme at national level as a means to raise funds for health care and to provide a mechanism against financial risks related to health. By 2008, about 47 percent of the populations were covered by the social health insurance scheme. The covered groups included formal sector employees, the poor, elderly persons, students and children under six years old. Nevertheless, the majority of social health insurance participants are those who cannot afford to make contributions or those who can barely make ends meet. The limited number of employed persons participating in the scheme results in a limited revenue, which in turn requires increasing governmental responsibility to maintain the balance of health care financing.

Table 4. Summary of the Vietnam Social Health Insurance Scheme, 2009

Schemes	Programs	Target groups	Financing
Mandatory	Social health insurance (SHI)	Formally employed	3% payroll tax (2% employers and 1% employees)
	Health care for the deserving people	Retirees, disabled (unable to work), the meritorious people, and others	3% of pension or state assistance, General government revenues and provincial resources
	Health care funds for the poor	The elderly, the poor, the ethnic minorities in mountainous areas, and inhabitants in disadvantaged communities	148,000 VND (per year)
	Free health care	All children under 6 years of age	Government revenue
Voluntary	Students	Students and school children	100,000-120,000 VND (per year)
	Other	Self-employed, informal sector workers, dependents of SHI members	300,000VND (per year)

Source: Adapted from Cha (2009).

There are two sub-schemes in the social health insurance system of Vietnam: the mandatory scheme and the voluntary scheme. Health insurance regulations, issued on 15 August 1992, provide mandatory health insurance for employees in enterprises, socio-economic organizations, civil servants, pensioners, early retirees due to loss of workability, and national devotees. The Vietnamese government has continuously included the specific target groups in response to their needs. In 2005, for example, all children under six years old became eligible for free health care in public health facilities (Giang, 2007). As such, the mandatory social health insurance scheme in Vietnam currently includes three different programs: (i) employment-based program; (ii) health care funds for the poor; and (iii) free health insurance program for children under six years of age. Table 4 summarizes the Vietnamese social health insurance system by sub-schemes, programs, ratios, target groups, and contribution levels.

Table 5. Coverage Provided by Social Health Insurance, 1993-2008

Year	Total participants (mil. persons)	Coverage rate (as % of total population)	Categorical participants (mil. persons)	
			Mandatory	Voluntary
1993	3.8	5.4	3.5	0.3
1998	9.7	12.5	6.1	3.6
2003	16.0	20.0	11.1	4.9
2004	19.0	23.1	13.6	6.4
2005	23.5	28.4	14.0	9.5
2006	34.5	41.0	25.0	9.5
2007	36.6	43.0	25.6	11.0
2008	41.0	47.2	30.0	11.0

Source: Own compilation from VSS (various years).

Table 5 shows the numbers and ratios of insured people in both mandatory and voluntary health insurance schemes. The government plans to expand the coverage up to 100 percent by 2015. As clearly shown in the table, the voluntary health insurance scheme will be diminished and eventually be obsolete by the end of 2014. It seems that the voluntary population groups will be mostly assigned to either the health care for the deserving poor or the health care funds for the poor.

The number of individuals insured through the voluntary scheme remains low. Most of the current insured participants in this scheme are school children who are strongly encouraged to purchase insurance by school authorities (Giang, 2007). By 2008, the voluntary scheme covered only 11 percent of the targeted population and school children were the primary focus of the voluntary scheme. There are a number of factors for such a low coverage figure, including low income; poor quality of public health services; poor marketing of the scheme; contribution levels and payment inflexibility; and aversion to collective state approaches (Cha, 2009).

Health Care Funds for the Poor was introduced in October 2002 to provide full health services for free to the poor. Initially, the government mandated all provinces to provide free health care to three groups: (i) households defined as poor according to the official government poverty standard; (ii) all households, regardless of their income, living in extreme disadvantaged communes; and (iii) ethnic minorities living in the mountainous provinces. The borderline poor people are also encouraged to join the scheme. The hardest task, however, is to identify the poor. The enrolment and screening procedures are so complicated that some groups of poor people, such as migrants, are obviously excluded from this package.

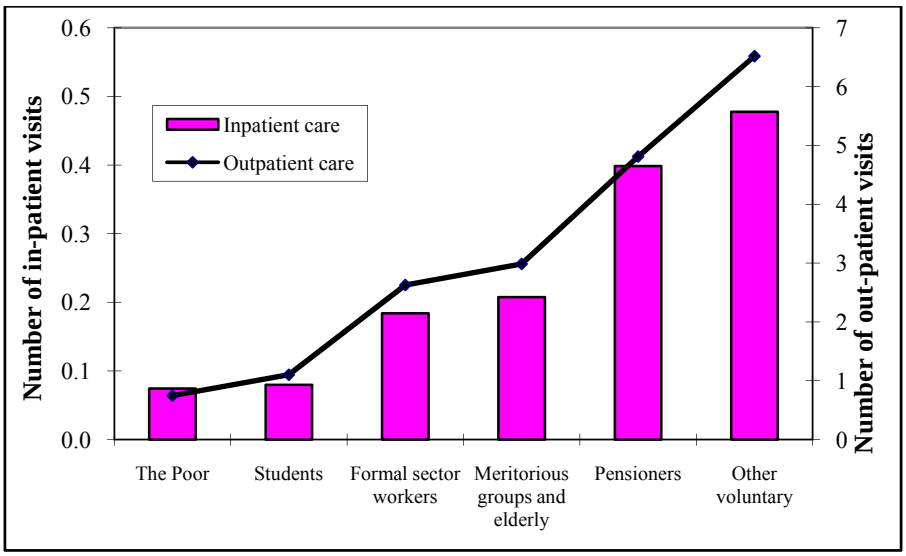
In terms of financing, as well as expanding the coverage, financing the programs is a critical issue within the current social health insurance scheme. In the case of a mandatory health insurance system, the social health insurance program is financed by 2 percent of employers' and 1 percent of employees' contributions. In addition to the employed, other population groups, such as retirees, the disabled and meritorious people, also have contribution rates of 3 percent either taken out of their pensions or the minimum government subsidies in the case that they receive social benefits.

The program for the poor is financed by central government funds. The funds are allocated to the provinces, which are also obligated to fund the balance by using their own resources. The program for the children under six years old is also financed by the central government funds mobilized from general revenues. In 2008, health insurance on average accounted for only 13 percent of the total health expenditure of a Vietnamese household.

2.2.2. Challenges

Given progresses in health insurance and health care services achieved in recent years, Vietnam will face a number of policy issues in reaching a state of universal coverage and financial stability for the social health insurance scheme.

Figure 7. Total Number of Inpatient and Outpatient Visits



Source: World Bank (2007).

First, the issue of limited accessibility for more vulnerable groups. Figure 7 provides a general overview of the average number of hospital visits, both inpatient and outpatient, according to their health insurance status and economic status. There should be caution in interpreting the outpatient hospital visits of the voluntary insures, because the majority of them (students and pupils) never received reimbursement for their treatment (Giang, 2007). As shown, however, hospital visits and admissions are disproportionate among health insurance participant groups. Although the number of hospital visits (outpatient) of the poor has increased over time, the poor made 60 percent less hospital visits than the mandatory participants in 2004. In terms of inpatient hospital use, the poor used 65 percent less than the mandatory participants in 2004. The significant lower hospital use, both inpatient and outpatient, is due to financial burden, difficulties in getting to hospitals in terms of distance and transportation, and distrust and attitudes of the service providers. A report by the United Nations (2003) shows that

hospital providers discriminate against people from whose fees are waived and those with free insurance cards and even sometimes against those who hold insurance cards.

In addition to the poor, another vulnerable group, i.e., rural-urban migrants, are also unlikely to be covered and able to access health services. World Bank (2007) shows that 87 percent of migrants, who were sick and treated at health facilities, had to pay for the cost of services and medications out of their own pockets; only 12 percent had the cost covered by their families and none of them had health insurance.

Table 6. Social Health Insurance Fund Balance, 2003-2008

Year	Participants (mil. persons)	Average cost (VND/person/year)	Healthcare fund (bil.VND)	Payments (bil.VND)	Balance (bil.VND)
2003	16.0	126.688	2,027	1,179	848
2004	19.0	136.842	2,600	2,133	467
2005	23.5	137.400	3,229	3,251	- 22
2006	34.5	125.507	4,330	5,805	-1,475
2007	36.6	162.630	6,224	8,124	-1,900
2008	41.0	230.000	9,000	10,400	-1,400

Source: Own compilation from VSS reports (various years).

Second, like many other developing countries, Vietnam has a strong commitment to extending access to a more comprehensive range of health services to a greater proportion of the population. In particular, universal coverage will be achieved by 2015. In this process, also the same as many developing countries, Vietnam may face various challenges to have financial viability for the health insurance scheme.

Table 6 presents the general collection and spending of social health insurance during 2003-2008. The debt accumulated since the beginning of the health insurance system is due to the lack of people contributing to the system, fixed contribution rates of 3 percent since 1992, and difficulties in collecting contributions.

The health insurance system in Vietnam has three funds: the social health insurance program, the health care for the poor and the voluntary health insurance fund. The major deficits occur in the free health care for the children under six and the voluntary health insurance fund. There are four main reasons for the deficit in the Vietnamese health insurance system: (1) relatively low health insurance fees; (2) frequent hospital

use; (3) abuse of the system by both providers and patients; and (4) inclusive health care packages. Cha (2009), however, provides careful analysis of these reasons. First, the current health care system has already proven to be burdensome to the poor. Therefore, increasing contribution levels and/ or the co-payment is unlikely to provide a solution to this problem and is against the purpose of implementing the pro-poor health policies. Second, the majority of the population groups, namely young children, in the voluntary health insurance scheme are usually the most frequent hospital users, except for the elderly. This means that voluntary health insurance is under a great deficit because it consists mainly of a target group that is prone to illness and hospital use. However, children are obviously an important part of the population from a policy and economic perspective of health care delivery and we cannot exclude them from the health insurance system. Third, there was some concern by health experts that abuse of the health insurance card was an eminent problem with respect to the health insurance fund. The average number of hospital visits per health insurance card was only about two times a year in 2008. A relatively and significantly lower rate of hospital use somewhat suggests that the abuse of the health insurance card by patients rarely happens. Lastly, developing an inclusive health care package is an on-going project of the Vietnamese government in order to protect the poor and the borderline poor from the financial shocks associated with severe illness. Needless to say, there was some concern expressed by health insurance experts that maintaining equilibrium between improving services to a satisfactory level and managing a sustainable health insurance fund would be a big challenge. However, there are great horizontal and vertical regional inequalities in terms of the allocation of the state budget for health insurance.

Third, without changing the current operation of the health insurance scheme, an aging population will create critical pressures on health care provision and financing. The World Health Statistics 2008 shows that Vietnam may become old before becoming rich, as the percentage of old-age persons (aged 60 and over) will reach 10 percent from 2010, while GDP per capita was just above $US 1,000. A research by Pham and Do (2009) also indicates that old-age persons in Vietnam are bearing “double health burdens” (both old and new diseases) and the average health care cost for an elderly person is 7-8 times that of a child. Such trends will obviously influence health insurance in coming times.

2.2.3. Reform Proposals

There are three key issues in sustaining a health insurance scheme in Vietnam, which aims to universally cover its citizens: efficiency (financial sustainability), effectiveness (access to and quality of care) and equity (health care status, fair financing and risk protection).

First, financial sustainability refers mainly to the long-term ability and potential to generate sufficient resources to support health while containing costs. The current scheme has faced significant financial challenges. There will be a range of possible responses, including further government subsidies, a reduction in reimbursable services and changes to the provider payment mechanism. However, considering the financial burden already imposed on patients coupled with the recent increase in the contribution rate from 3 percent to 4.5 percent (effective from 1 January 2010 by Decree 62), any possibility of a reduction in reimbursable services should be ruled out.

Second, to reach financial sustainability, policy makers should reduce supplier-induced costs by encouraging the providers to introduce a payment mechanism, which can share risks and rewards, as well as a monitoring mechanism to control under-utilization of services. Equally as important, policy makers also need to reduce consumer-induced costs by allowing consumer cost-sharing through deductibles and co-payments but while still having unlimited access to services with adequate financial protection.

Third, to make improvements in service delivery. An effective health system provides timely access to the full array of needed services, together with efficacious and safe care leading to an improvement in health, continuity of care and respect. To enhance accessibility to care and quality of care, Vietnam needs, firstly, to ensure the availability of health care by (i) increasing the number of physicians, nurses, and hospitals across all regions/ provinces; and (ii) requiring all private health care providers to join the social health insurance system. As such, patients can choose any health care services regardless of whether they are private or public. In addition, there is an urgent needed to monitor the quality of care via appropriate prescription guidelines, treatment

completion rates, re-admission rates, rate of avoidable hospitalizations and rate of follow-up visits, etc.

Fourth, equity should be promoted via improvements in resource mobilization and allocation to the extent that favors the poor and vulnerable groups. To reach equity, private health insurance should not be widely encouraged; rather, private health insurance can be supplementary to the mandatory health insurance scheme in order to reach the entire population. In addition to this initial policy direction, policy makers should also pay attention to (i) minimize adverse selection and encourage broader risk pooling via mandating insurance to all, encouraging collective enrolments, and creating incentives for low-risk individuals to join the insurance pool; (ii) minimize risk selection along with broader risk pooling; (iii) ensure financial stability with sufficient minimum capital and reserve requirements, and (iv) ensure that insurance packages provide adequate financial protection by defining a universal package for all people along with specific packages meeting demand.

3. Concluding Remarks

In this chapter, we review the developmental path, the current status, as well as challenges of the social protection system in Vietnam with a special focus and discussion on the social insurance scheme and the social health insurance scheme. We have shown that, along with notable socio-economic achievements from *Doi moi*, Vietnam has drawn a great deal of attention by providing social protection to all citizens, and some important social indicators are comparable with more economically advanced countries. However, at the same time, the chapter also implies that social protection policies have not been well adapted with swift changes in social, economic and health conditions, which in turn require comprehensive reforms of both schemes. Given such changes, the chapter also proposed some policy proposals, such as transforming the current PAYG DB pension scheme to a system of individual accounts via an NDC scheme, as well as providing a universal social assistance scheme to elderly people in order cope with a number of risks that could push them into poverty.

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CHAPTER 11

Social Protection in Cambodia: Toward Effective and Affordable Social Protection for the Poor and Vulnerable

VATHANA SANN
Deputy Secretary General,
Council for Agricultural and Rural Development,
Council of Ministers, Cambodia

Cambodians today still face many serious forms of vulnerability, notably regarding weather-dependent agriculture, idiosyncratic shocks and unemployment. Traditional social safety nets existed in the forms of sharing, mutual assistances, extended families and neighbor networks. However, these arrangements cannot be a substitute for a functioning government-provided safety net. Existing safety net interventions in Cambodia face several challenges related to implementation, institutional and financing issues. The coverage of existing social protection programs for the poor and vulnerable is very limited and the presence of important sources of vulnerability that remain poorly addressed leads poor households into further destitution.

Several poverty-reduction related-strategies have been developed. Several organic laws have been passed to codify some of the social protection related tenets of the Constitution. During the Cambodian Development Cooperation Forum in December 2008, aimed at promoting equitable growth in the near-to-medium term, an effective and affordable social protection system was put forward to help develop support for the poor and vulnerable in coping with major sources of vulnerability, while at the same time promoting human development. To prepare the strategy, in 2009 and 2010 the Council for Agricultural and Rural Development has convened meetings and held technical consultations with a broad set of stakeholders.

Using the lens of the lifecycle, a juxtaposition of risks and vulnerable groups against current program coverage highlights some key areas in which future support is needed. The strategy of social protection for Cambodia, therefore, has a vision to develop an integrated and sustainable system for the entire population, with particular focus on the poor and vulnerable. As the immediate objectives, three priorities have been designed including ensuring food security and basic needs, generating employment and income, and sustaining human capital and social welfare.

The programs to sustain human capital and social welfare through cash transfer would aim specifically to increase utilization of a pre- and post-natal care package that conforms to existing national policies and guidelines and international evidence-based best practices. Another important social protection instrument that has the potential to address the risk of seasonal unemployment during normal times, and the ability to respond to natural and economic crises, is a nationwide public works program.

1. Introduction

1.1. Overview

After emerging from three decades of instability, Cambodia has been remarked upon as having an impressive record of sustained growth and poverty reduction. Yet, Cambodians still face many serious forms of vulnerability, notably in regard to weather-dependent agriculture, idiosyncratic shocks, and unemployment. With the majority of the population engaged in single crop subsistence agriculture which is heavily dependent upon the weather, poor harvests and food insecurity are major sources of vulnerability, as are natural disasters. Illness and injury, and the high costs of treatment, are also critical factors in pushing households into poverty. For many of Cambodia's young and generally under-educated population now entering the workforce, unemployment or underemployment is equally an endemic risk and the recent crisis has shown that even those who have obtained jobs in export-oriented sectors of the economy (such as garment manufacture or tourism) remain vulnerable to job loss or drastically reduced earnings.

To promote equitable growth in the near-to-medium term, an effective and affordable social protection system should be developed that supports the poor and vulnerable in coping with major sources of vulnerability, while at the same time promoting human development. The coverage of existing social protection programs for the poor and vulnerable is very limited, and the presence of important sources of vulnerability (such as malnutrition, health shocks and poor quality of education) that remain poorly addressed leads poor households into further destitution. In the near future, priority should therefore be given to the development of effective and affordable social protection programs for the poor and vulnerable that supports them in coping with major sources of vulnerability, while at the same time promoting human development.

An effective social protection system also promotes equitable growth and the government's ability to reform. To the extent that it encourages prudent risk-taking and enhances opportunities for the poor, social protection can be beneficial for economic growth. Social protection can also help governments embark on reforms that have long-

term benefits in economic efficiency, but high short-term social and political costs, by providing effective compensation to those negatively affected by the reform.

1.2. Goal and Objective of the Proposed Research

The goal of this paper is to contribute to the integrated and systematic approach of social safety net policy and strategy development for Asia by addressing in particular on an analytical description of the current social safety net arrangements including key legislations and social security institutions in Cambodia and identifying the main challenges in progressing towards more robust and sustainable safety nets.

Subsidiary objectives are to:

- describe Social Protection activities in Cambodia and variations in perceptions and definitions of social protection;
- provide quantitative and qualitative information on existing social protection initiatives especially the traditional and informal social safety nets;
- assess the current state of social security system within the framework of voluntarily contributory system for civil servants and those under labor law;
- reassess the challenges and gaps in vulnerability and policy in social safety nets;
- identify institutional organization in place to implement programs and facilitate coordination among government agencies and donors.

2. Cambodia at a Glance

2.1. Brief History of Cambodia

Within the last 3 decades, Cambodia has changed its political regime more frequently than any of its neighboring countries. The societies, in particularly the formal and traditional systems have been reformed alongside the political regime. Emerging from a civil war of almost three decades, Cambodia was challenged with devastated physical and social infrastructure and human capital. The government did manage to stabilize the famine situation prevailing in 1979 and made slow but steady gains in reconstructing schooling and basic healthcare. The population was organized into “solidarity groups”. This collectivization ensured equal access to the scarce male

labor and draft animals available in 1979-80, but as the economy recovered it came to be seen as a hindrance to growth. Spontaneous de-collectivization, formalized through liberalization and land distribution in 1989, improved output and was welcomed by most, although vulnerable groups lost important forms of social security (Frings, 1993).

The great achievements in terms of infrastructure, human rehabilitation and development are tremendously significant. Cambodia embarked on a transition from war to peace, especially from one ruling party to multi-parties politics, and from an isolated and planned economy to a free market economy and principals, and being integrated into international trade. Since the Paris Peace Accord in 1991, free and fair elections have been conducted. Since 1993 Cambodia has transformed from a post-conflict society to a normal developing country.

2.2. Demography

The population structure of Cambodia reflects the impact of the Khmer Rouge regime between 1975 and 1979, during which mortality levels were high, particularly for men, and fertility levels decreased. In post-conflict times, a baby boom occurred which created a large proportion of people aged 20 years or less. Cambodia had a total population of 11.4 million according to the 1998 Census (NIS, 1998). It is projected to increase by two times to 20.3 million by 2021. The country had an average annual growth rate of 2.49 percent although a revision of the projection conducted after the census suggests a more moderate growth. Still, population growth in Cambodia is the highest among ASEAN nations, except for Laos.

Table 1. Cambodian Population Index and the Projection

Demographic Indicators	1970	1980	1990	2000	2010	2020	2030
Midyear population (*1000)	7,396	6,888	9,345	12,396	14,753	17,601	20,183
Growth rate (%)	-0.7	2.5	3.6	1.8	1.8	1.6	1.1
Total fertility rate (births/woman)	6.5	7.4	6	3.7	3	2.7	2.4
Crude birth rate/1000 population)	43	58	47	27	26	23	18
Life expectancy at birth (years)	38	37	52	59	63	66	69
Infant mortality rate/1,000 births	199	228	144	82	53	38	27
Under 5 mortality rate/1,000 births	274	327	185	104	67	47	33
Crude death rate/1,000 population	24	28	15	9	8	7	7

Source: DESA-UN (2008).

In 2008, from the total population of 13,395,682 people, only 4.39 % were employed by the government, and another 0.25, 0.07 and 0.24 % were employed respectively in state-owned enterprises, non-profit institutions and embassies or international institutions which later in this paper will be discussed within the framework of the social security system (NIS, 2008). Agriculture sector (including forestry and fishery) employed 72.29 % of the population where the proportion of employed women in this sector (75.11 %) is slightly higher than men (69.38 %).

3. Current State of, and Challenges Facing, Social Protection in Cambodia

3.1. Poverty and Vulnerability Profile of Cambodia

The last decade of development has been characterized by high rates of sustained economic growth at 7% GDP growth per year between 1997 and 2007. Per capita income doubled from US$285 to US$593. Such a growth pattern has raised living standards and resulted in reducing the rate of poverty, which fell from an estimated 45-50 percent in 1994 to 35 percent in 2004 and 30 percent in 2007. However, poverty incidence largely remains a rural phenomenon (Tab. 2, 3, 4 and 5). Despite impressive poverty reduction, one out of three individuals continues to live below the poverty line. While poverty rates decreased in both urban and rural areas, inequality and the urban-rural divide increased between 1993-94 and 2007.

Less than one percent of the population in Phnom Penh was deemed to be poor in 2007, compared to more than twenty percent in other urban areas and almost 35 percent in rural areas, where approximately 80 percent of the population lives. While inequality in Phnom Penh has decreased, it has increased in other urban and rural areas – leading to an overall increase in inequality from a Gini coefficient of 0.39 to 0.43 in only three years (Tab. 3). A large proportion of the population also remains near-poor and vulnerable to shocks that could push them into poverty.

Table 2. Profile of the Poor

	Quintile				
	Poorest	**Next Poorest**	**Middle**	**Next Richest**	**Richest**
Owned agricultural land is secured by a title (%)	15.6	21.6	24.5	25.3	28.6
Distance to nearest all-weather road (km)	5.2	3.7	3.3	3.1	1.9
Distance to permanent market (km)	10.8	9.6	8.1	7.1	4.2
Households with water pump (%)	3	8	9	12	13
Plots with access to irrigation in dry season (%)	6	10	12	13	12
Dependency burden (elderly and children in 100 economically active adults)	96.9	84.5	76.6	64.9	54.3
Literacy adults, age 15+ (%)	29.3	38.3	43.2	51.1	60.8
Education (average school grades completed by adults)	2.8	3.5	3.9	4.6	6.3

Source: NIS (2005).

Table 3. Poverty and Inequality Trends

	% Population	**Poverty Headcount (%)**			**Gini Coefficient**	
		1993/94	2004	2007	2004	2007
Phnom Penh	9.9	11.4	4.6	0.83	0.37	0.34
Other urban	10.2	-	24.7	21.8	0.44	0.47
Rural	79.8	-	39.2	34.7	0.34	0.36
Cambodia	100	47	34.7	30.1	0.40	0.43

Source: World Bank Cambodia Poverty Assessment (2006) for 1993/94 data.
Due to limited coverage of the 1993/94 survey, poverty data for Cambodia in 1993/94 have been extrapolated.

Table 4. Poverty Levels of Selected Population Groups

Group	**% Population**	**% Poor**	**Poverty Gap**
Elderly (65 years old or above)	4.3	25.9	5.5
Employed	53.3	28.3	6.6
Members of female-headed households	18.2	27.9	7.2
Members of male-headed households	81.8	31.2	7.5
Members of employed-headed households	91.1	31.0	7.5
People with disabilities	1.3	28.6	7.2
Ethnic minorities	2.2	36.1	10.0
Infants (Below 1 year old)	4.0	38.9	10.0
Children (Ages 0-14)	33.5	37.4	9.4
Cambodia	**100**	**30.5**	**7.4**

Source: NIS (2007).

Table 5. Major Sources of Vulnerability along the Lifecycle

Group	Main Sources of Vulnerability
Pregnant mothers	High Maternal Mortality Rates (MMR)
Infants and Children	High malnutrition rates Poor quality of education / High dropout rates Child labour and sexual exploitation
Youth	Poor quality of education / High dropout rates Low productivity
Working-age population	Low productivity Disability
Elderly	Inability to work
Entire lifecycle	Health shocks Natural disasters Food insecurity Economic and (food) price crises

Source: CARD and IWGSSN (Forthcoming).

The global financial crisis is affecting Cambodia through dramatic declines in external demand within Cambodia's key manufacturing and service sectors. Recession in the US and Europe in particular are affecting Cambodia's garment exports and tourism revenues; recession is also affecting FDI flows, particularly into real estate. The result is significant job losses and reduced earnings for Cambodians working in garment factories, tourism or the construction industry (Kang et al., 2009; CDRI, 2009). In the absence of safety nets system to provide them with subsistence income, these laid-off workers are at high risk of falling into poverty. These recent job losses exacerbate a more long-standing problem of pronounced youth underemployment: more than 200,000 young Cambodians currently enter the workforce every year, with many of them struggling to find adequate jobs.

The recent global economic shocks threaten to have a considerable negative impact on economic growth and poverty reduction. As of February 2009, rice prices remained about 60 percent higher than in January 2008. With food accounting for 60-70 percent of rural household expenditures and rice alone comprising 40-50 percent, the high cost of food has had a significant impact on rural households, who represent roughly 90% of all poor in the country. Overall, 82.7 percent of the households in Cambodia are net food consumers and 66.9 percent are net cereal consumers (Vu and Glewwe, 2009). An increase in the prices of rice would have negative impacts on two thirds of households. Poor and net food buying households are the worst affected and they generally reside in rural areas (CDRI, 2008).

Emerging evidence suggests that recent global economic shocks are starting to reverse the progress made in previous years. Estimates up to and including 2007 suggest that child nutrition and survival rates, while poor, were improving over time. However, the Cambodia Anthropometric Survey (CAS) in late 2008 suggests that the decline in child malnutrition and ill health has now stagnated and possibly started to reverse (CAS, 2008). It also draws attention to the differentiated effect of the crisis on child development, with widening disparities emerging between different groups in Cambodian society (CAS, 2008).

3.2. Background of Social Protection in Cambodia

Several organic laws have been passed to codify some of the social protection related tenets of the Constitution. The most relevant laws which have been adopted or are currently under consideration include:

- The Labour Law passed in October 1998, embodies most of the ILO conventions on core labor standards, all of which Cambodia has ratified
- The Insurance Law passed in June 2000, provides a legal framework for better regulation of insurance market activities. However, these insurance schemes will benefit only a small proportion of the population in the initial stages and most likely will not be accessible to the poor
- The Law on Social Security Schemes for Persons Defined by the Provisions of the Labour Law passed in September 2002. The law has been promulgated but not implemented since it requires a sub-decree on the National Social Security Fund (NSSF), which will cover employment injury insurance (EII), the pension scheme, and a short-term benefit system.
- A National Action Plan to Combat Violence Against Women has been developed, and is being implemented in accordance with the Law on the Prevention of Domestic Violence and Protection of Victims adopted in 2005
- The Law on Suppression of Trafficking in Humans and Sexual Exploitation, adopted in late 2007, consistent with the UN Palermo Protocol.

Table 6. Cambodia's Strategic Framework for Social Protection

Institutions	Dimension(s) of Social Protection and Social Safety Nets	Current Sectoral Policy / Strategy
RGC Institutions that are Mandated to Deliver Social Services to the Population and to Protect Specific Vulnerable Groups against Risks		
MLVT	• National Social Safety Fund for private sector employees • Vocational training • Child labour elimination programme	
MOSAVY	• National Social Security Fund for civil servants • Services for veterans • Services for homeless and destitute, victims of trafficking, children and youths, people living with disabilities • Emergency relief to those affected by natural disasters	Work Platform 2009-13
MOWA		
RGC Institutions that Implement Specific Safety Net Interventions		
MOH	• Health equity funds • Community-based health insurance for the poor and vulnerable	Health Strategic Plan 2008-2015 Strategic Framework for Health Financing 2008-2015 Master Plan on Social Health Insurance 2003-2005
MOEYS	• Scholarship for the poor program	Education Sector Strategic Plan 2006-2010
RGC institutions with complementary activities		
MAFF	• Food production, livelihoods	Strategy for Agriculture and Water 2006-2010
MPWT	• Implementation of national policy concerning all public works construction	
MRD	• Rural infrastructure works	
MOWRAM	• Rural infrastructure works	
MOP	• IDPoor Programme	Ministry of Planning Strategic Plan

Source: CARD and IWGSSN (Forthcoming).

Safety net interventions are scattered across several ministries. The Ministry of Social Affairs, Veterans and Youth Rehabilitation (MOSVY), the Ministry of Labour and Vocational Training (MOLVT) and the Ministry of Women's Affairs (MOWA) are all mandated with managing state social services for the wider population, and helping to protect specific vulnerable groups against risks. In collaboration with the WFP, the Ministry of Rural Development (MRD) and the Ministry of Water Resources and Meteorology (MOWRAM) are also implementing a food for work program.

Table 7. Social Safety Nets and Social Protection Activities in Various Ministries

Ministry	Major programme	Type	Eligibility
MoSVY	Emergency relief program to assist victims and vulnerable groups	Package of emergency relief assistance to the vulnerable and victims of emergency (includes victims of mines)	Victims of emergency
	Social cash cards (emergency-related)	3-month, 6-month social cash cards for emergency relief programs of victims	Victims of emergency
	Invalidity pensions and care services	Cash and food allowances; parents or guardians of deceased soldiers, spouses of the disabled, retirees and people who have lost their ability to work receive an allowance of 3,200 Riel (proposed to be raised to 6,000 Riel)	Veterans currently include guardians of the deceased, the disabled, retirees, and people who have lost ability to work
	Elderly persons 'association support and services	Support services	Membership in an elderly persons' associations
	Social insurance compensation	Cash benefit worth up to 12 months of total salary for the family of the deceased. If death by disease, 6 months of last total salary; if work accident, then 8 months of last total salary. The amount is transferred to the orphan on a monthly basis. 3,100 Riel (disease); 4,000 Riel (work accident) (2004 data)	Children up to 15 years of age are entitled. Over-age children, whether they study or not, do not qualify.
	Care services for homeless people	Social networks in communes / sangkats; reception and management of homeless people in state-managed shelters; temporary shelter, vocational training, and reintegration of homeless people into communities	
	Housing for poor and vulnerable		
		Social land concessions for the social purposes: - Provide land for residential purposes to poor homeless families - Provide land to poor families for family farming - Provide land to resettle families who have been displaced resulting from public infrastructure development - Provide land to the families suffering from natural disaster - Provide land to repatriated families - Provide land to demobilized soldiers and families of soldiers who were disabled or died in the line of duty	Besides being a Cambodian citizen with relatives in the household, the beneficiary should meet the financial criteria established by MoSVY and MoLVT, based on the comments of the National Social Land Concession Committee. The income guidelines shall take into consideration family size and age and health conditions of family members. The guidelines may be varied among regions and times in accordance with economic

(Table 7. Continued)

Ministry	Major programme	Type	Eligibility
		- Facilitate economic development - Facilitate economic land concessions by providing land to workers of large plantations for residential purposes or family farming - Develop areas that have not been appropriately developed	conditions and living standards. Special consideration is given to woman-head family, people with disability or demobilized soldier
	Alternative care services for orphans	Family and community-based care, kinship care, fostering and group homes.	Children under 18 who are orphaned
	Residential care for orphans	20 state-managed orphanages; support to 225 NGO-run orphanages in 2009	Children under 18 who are orphaned
	Child welfare and rescue an, rehabilitation and reintegration services for child victims of trafficking, sexual exploitation and abuse	Reception centre for victims of trafficking; provide education, healthcare and vocational training to female victims of human trafficking; provide repatriation support to victims of human trafficking; drop-in centre for victims of human trafficking	Children under 18 years of age, including abandoned infants, orphans, disabled children, street children, and children of trafficking, misconduct and drug abuse minors.
	Services for children in conflict with the law and drugs-addicted children	Case management of children (counseling, family tracing and assessment, reintegration and follow-up, continued care)	Children under 18 detained, convicted, in pre-trial detention, newly admitted, released, YCIM
	Assistance to victims and people affected by HIV/AIDS in communities	Social services and care to children and families of victims and people affected by HIV/AIDS	
	Physical rehabilitation centres / community based rehabilitation services for people with disabilities	11 Rehabilitation centres management will be taken over by MoSVY by 2011 and aids for people with disabilities provided; physiotherapy services for people with disabilities	People with disability of any age
	Civil servants and veterans retirement pensions	Cash benefit	
	Health insurance for civil servants and retired civil servants.	Health insurance services	

(Table 7. Continued)

Ministry	Major programme	Type	Eligibility
	Maternity related protection for formal sector employees and agricultural workers is covered by MOLVT (see next sheet MoLVT)		
MoLVT	HIV/AIDS workplace programme for garment factory workers	HIV/AIDS awareness, life skills support and referral services to female factory workers.	Female garment factory workers
	Maternity leave	Maternity benefits for all workers except domestic workers, civil servants, armed forces and police; 90 days maternity leave; pay at half salary covered by employer	All workers except domestic workers, civil servants, armed forces and police; 90 days maternity leave; pay at half salary covered by employer
	Maternity health protection	For the first two months after maternity leave the employee is expected to perform only light work (Article 182 of Labour Law); for one year following childbirth, breastfeeding mothers are entitled to one hour break (or 2x30 min) per day. Enterprises employing more than 100 women are required to establish nursing rooms and day care centres. Enterprises not able to establish such facilities are required to pay for the costs of childcare to their employees	All workers except domestic workers, civil servants, armed forces and police; 90 days maternity leave; pay at half salary covered by employer
	Family benefits for agricultural / plantation workers	All regular plantation workers are entitled to a daily allocation of rice for their wife and dependent minor children, legitimate or illegitimate, less than sixteen year old:	Family of agricultural / plantation workers for wife and dependent minor children under 16 years of age. To be entitled to family benefits, the wife must meet the following requirements: - She not be gainfully employed - She must live with her husband, either on the plantation if he is a regular resident worker or at home or in the husband's normal place of residence outside the plantation if he is a non-resident.

(Table 7. Continued)

Ministry	Major programme	Type	Eligibility
MoI	Commune transfers for emergency assistance	Emergency assistance cash and in kind assistance to communes to address poverty, vulnerability and insecurity: discretionary and non-discretionary funds.	Non-discretionary funds cover support towards achieving MDG 5 in particular. Discretionary funds cover support towards achieving all MDGs: cash for transportation of pregnant woman to hospital; in kind support, for instance bicycles for children to be able to attend school; cash assistance to poor families to enable them to send children to school; etc.
	Social services mapping	Support to identification of poor, vulnerable and insecure people in the commune for targeting purposes	
	Community pre-schools	Cash assistance for running community pre-schools	Community-pre-school teachers
MoEYS	Primary school scholarships	Cash benefit	Primary school age children of poor parents who require cash assistance to be able to attend school
	Secondary school scholarships	Cash benefit	Lower-secondary school age children of poor parents who require cash assistance to be able to attend school
	School feeding	All children of primary school age	All primary school age children
MoH	Health Equity Funds (HEF)	Exceptions from the payment of healthcare fees for patients identified through the IDPoor mechanism, implemented as a strategic purchasing mechanism in order to fund exemptions and reduce the burden of health-care costs on people on very low incomes.	Households identified as poorest and poor through the IDPoor mechanism
	Community-based health insurance (CBHI)	Community-based health insurance, where members contribute small monthly premiums on a monthly basis. It is also indirectly subsidized by a third party.	Registration is opened to everyone, without restriction on pre existing disease or age. Family coverage is usually mandatory.
MRD	Communes transfers for CLTS (community led total sanitation)	Cash support to communes for facilitating access of households to sanitation	Communes requiring support with implementing CLTS

(Table 7. Continued)

Ministry	Major programme	Type	Eligibility
MoP	ID-Poor	Support to identification of poor, vulnerable and insecure people in the commune for targeting purposes. The Equity Card provided to poor households: Helps to raise awareness of poor households that they can use the card to receive services or assistance; Provides positive identification through an unique household code that is linked to the database, and household photo.	
MoRC	Cash and in kind grants under BLI (Buddist Leadership Initiative)	Cash and in kind assistance and referral for HIV/AIDS infected and affected people: cash, supply of food, referral from village to RH, transportation costs for visits from village to pagoda for awareness raising session, etc.; food, school supplies etc. to children of families affected by HIV/AIDS	HIV/AIDS infected and affected people - voluntarily identified; and orphans and vulnerable children from families affected by HIV/AIDS are provided with life skills, training, awareness raising and assisted with referral

Source: CARD and IWGSSN (Forthcoming).

3.3. Social Security System in Cambodia

3.3.1. Background and Coverage of Social Security Systems

A Law on Social Security Schemes for Persons defined by the Provisions of the Labour Law was promulgated in 2002. At that time the governmental institution responsible was the Ministry of Social Affairs, Labour, Vocational Training and Youth Rehabilitation. Following a government reorganization, the Ministry of Labour and Vocational Training was established and is responsible for this legislation, whilst the Ministry of Social Affairs, Veterans and Youth Rehabilitation is in charge of the civil service social security system. The 2002 Law lays down the main principles of social security protection for persons covered by the Labour Law. The method of prescribing the detailed structure of schemes and their administration is through the promulgation of sub-decrees.

Persons covered by the Social Security Schemes in this law regardless of nationality, race, sex, belief religion, political opinion, national extraction, social origin, membership of trade union or act in trade union are:

- All workers defined by the provisions of the Labour Law, if those persons perform work in the territory of Cambodia for the benefit of an employer or employers,

regardless of nature, form and validity of the contract done or kind and amount of the wage received by the person thereof

- State workers, public workers and all personnel who are not governed by the Common Statute for Civil Servants or by the Diplomatic Statute as well as officials who are temporarily appointed in the public service
- Trainees, person who attend the rehabilitation centre and apprentice shall deem to be workers
- Persons working in a self-employed profession
- Seasonal or occasional workers

3.3.2. Benefits for Sickness, Accident at Work, Maternity and Death

a. Sickness

This contingency requires both medical care and cash payments, but presently the provisions for free medical care at public hospitals are not operative due to unofficial payments that are in force. There are no qualifying conditions for entitlements such as a minimum length of service.

Civil servants who fall sick are entitled to receive their full monthly salary, including location allowance, family and other allowances, whilst receiving medical treatment for a period of 3 months (if confined to hospital the patient is liable to pay for hospital food) but he/she continues to have the right to buy food and other goods from the State warehouse. From the 4th month, the amount payable is 90% of net monthly salary plus location, family and other allowances. The duration of this entitlement is related to the duration of service and cannot exceed 12 months. Persons who have still not recovered are entitled to apply for retirement or invalidity pension. For example, a civil servant that has 8 years service and if he/she is certified as incapable of working due to sickness he/she will receive a full monthly salary for 3 months and 90% of net monthly salary plus other allowances for the following 8 months. After a total of 11 months, if he/she is still not recovered he/she will be entitled apply for invalidity benefit.

b. Work-Related Accidents

Any civil servant who has an accident at work or while on a mission will be eligible to receive emergency care and treatment until he/she is completely recovered at the costs of his/her own department. However, the rules on meeting the costs of treatment are not now in force due to the current problems of obtaining personal health care under the practice of levying unofficial payments at medical facilities. Whilst undergoing treatment, he/ she receives his/her full monthly salary plus location allowance, family allowance and other allowances. The legislation appears to have no provision on a maximum duration. On recovery and discharge from hospital, persons with a residual disability will be evaluated by the Ministry of Health or the Provincial/ City Health Direction. The condition of his her disease or injury will be classified as indicated in Table 8.

Persons who are assessed as level 1 or 2 are eligible to apply for invalidity benefits. Those assessed as levels 3 and 4 who are still able to continue working will receive monthly cash support at 15 % and 10 % of monthly salary respectively of the injury or illness as an addition to his/her salary.

If a civil servant has lost most of his/her physical ability and is not able to continue his/her work, the Ministry of Health or the Provincial/ City Health Directorate will assess the condition of his/ her injury or illness again in order to determine whether or not he/she will eligible to receive the Maximum Invalidity Pension. If he/she is old enough for retirement, he/ she will eligible to apply for the Maximum Retired Pension.

The maximum invalidity pension is 65 % of the net final monthly salary and applies to civil servants who lose their professional ability due to accidents at work or on mission. The total pension includes allowances for location, health care and other allowances.

Table 8. Level of Disability and Cash Support Benefit

Level of Disability	Disability (%)	Cash support (months' salary)	Sick leave on full monthly salary (days)
Level 1	81 - 100	4	60
Level 2	61 - 80	3	45
Level 3	41 - 60	2	30
Level 4	20 - 40	1	15

Source: MoSVY and MoLVT (Personal communication).

c. Maternity

A pregnant civil servant is eligible for medical consultations and confinement care free of charge. There are no service qualifying conditions to be met. Maternity leave is 90 days which may be taken over periods before and after the confinement during which the employee is entitled to receive her full monthly salary. After giving birth or suffering a miscarriage, she will be eligible to receive a single payment of 200 Riels for each child born. For the first 12 months after giving birth, if the hospital has confirmed that she is sick or has no milk for breast-feeding the baby, she will be eligible to receive an additional cash support of 120 Riels per month for each child. For the first 12 months, during her working hours, a mother of a new born baby has the right to take 1 hour per day of her working time to feed the baby.

d. Death

In the case of a death, the payments due are as follows:

- On the death of civil servant by illness- 1,800 Riels for funeral costs and 6 months total salary plus monthly payments for a spouse of Riels 3,000 and for each eligible child Riels 3,100.
- On the death of a pensioner, 1,800 Riels for funeral costs and 6 months total pension and monthly allowances for the spouse and children.
- On the death of civil servant from an accident or on mission, 2,000 Riels for funeral costs and 8 months total salary plus monthly payments for a spouse of Riels 3,000 and each eligible child Riels 4,000.

Spouse payments are for life or until remarriage. Child payments are conditional on an age limit of 15 years, unless the child is over age 15 and at school without a government scholarship up to a maximum age of 21 or disabled when he/she is not subject to an age limit.

3.3.3. Pensions

The RGC pays a pension to an extensive number of its retired civil servants, military, police, disabled people and dependents of soldiers and military heroes. However these amounts of payment do not meet daily living standards. The private

sector, donors and NGOs also offer pensions to their employees in compliance with the Labour Law. This is normally in the form of withholding a percentage of a salary that will be paid as a lump-sum upon completion of contract or upon retirement. Civil servants of both sexes are required to retire by the age of 55 and / or have 30 years in the civil service in order to be eligible. This age limit may be extended from 55 to 60 years by the particular statute governing a body. Nevertheless, a civil servant having 30 years of civil service may request early retirement, before the age of 55, while still benefiting from his/her retirement pension.

In 2005, average payments by RGC through MoSVY to its civil servants, military, police, disabled people and dead and/or patriot-dead military, and for those who are their dependents, is estimated to be US$16.4 million, benefiting 120,000 persons (Tab. 9). It is interesting to note that dead civil servants and dead military - either patriot or natural dead - do not receive pensions but their dependents do, such as their children and their spouse and/or parents.

Table 9. Types of Pension Schemes and Beneficiaries

Type of pensioners	Estimated of total beneficiaries	Amount of Benefits (millions, US$)
Retired civil servants*	19,489	4.024
Retired military**	5,151	1.140
Disabled military (retired)***	31,121	7.010
Disabled civil servant (retired)****	5,151	1.125
Dependents of dead patriot military*****	54,895	2.400
Dependents of dead civil servants******	4,000	0.606
Total	**119,807**	**16.305**

Source: MoSVY and MoLVT (Personal communication).

Notes:

* *It also provide allowance to 13,364 spouse and 13,820 children, respectively*

** *It also provide allowance to 4,417 spouse and 12,132 children, respectively*

*** *It also provide allowance to 28,607 spouse and 91,328 children, respectively*

**** *It also provide allowance to 102,007 parents and 103,788 children, respectively*

***** *It also provide allowance to 4,000 children, respectively*

A civil servant having less than 20 years of service shall be entitled to obtain a refund of his/her pension deductions withdrawn from his/her salary as well as other state subsidies, in a lump sum payment. Moreover, a civil servant having between 20 and 30 years of civil service shall be entitled to benefit from a proportional retirement pension. No deductions for a retirement pension shall be made from salaries of a civil servant having more than 30 years of service while continuing his/ her duties in the service of the State. A civil servant who serves for less than 30 years and who continues his/her duties shall continue to bear retirement pension deductions. These provisions outline entitlement to full pensions after 30 years service or at age 55 but do not specify the rates of deductions from salaries, the establishment of a separate pension fund, or the rates of pensions. The civil servants who contribute for between 20 and 30 years may receive proportional pensions. When service is less than 20 years the retirees can receive a refund of the contribution deductions plus subsidies from the State.

The pension formula is as follows: Attainment of age 55 at least and completion of a minimum of 20 years service, but civil servants who complete 30 years service before age 55 are entitled to apply for RP. The pension calculation is as follows:

- 60 % of the final net monthly salary for 20 years service plus 2 % per year for additional years up to a maximum of 80 %, subject to a minimum of the minimum net monthly salary of their type, grade and rank
- Plus location allowance, health allowance, spouse and child allowance and any other approved allowances , excluding position allowance.

Example: In 2005, a civil servant with a service record of 25 years reaches pension age with a net salary of A3-13 (Tab. 10), calculated as follows: 340 * 345 Riels = 117,300 Riels.

- Net Pension = (60% + 10%) * 117,300 = 82,110 Riels
- The net minimum salary is A3-14 = 315 * 345 = 108,675 Riels
- Thus, his net monthly pension is 108,675 Riels

In summary, the Total Monthly Retired Pension = net monthly pension + location allowance + health allowance + spouse allowance + child allowance + other allowances (if any), but excluding position allowance. In addition, retirees are entitled to a lump

sum equal to 8 months of the total monthly salary paid by the employing office on the date of retirement.

Table 10. Net Salary Indicators (December 2001)

Type	Ranks														
		14	**13**	**12**	**11**	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**
A	1									436	457	482	506	528	550
	2					**361**	373	387	402	419	437	454	467	478	487
	3	315	323	331	340	349	359	369	380	390	399	407	414	420	425
B	1									**308**	324	344	360	374	385
	2					252	262	272	283	295	306	316	325	333	340
	3	220	225	230	236	243	251	259	266	273	279	284	289	293	297
C	1									212	223	235	245	254	262
	2					173	178	185	193	201	208	215	222	228	233
	3	150	154	158	163	168	174	179	184	188	192	195	198	200	202
D	1									141	149	157	164	170	175
	2					113	117	122	128	134	139	144	148	152	155
	3	100	102	104	106	109	112	116	120	123	126	129	131	133	136

Source: MoSVY and MoLVT (Personal communication).
Notes:

1 Each class has a unit price of 300 Riels. Since January 2005 the unit price is 345 Riels
Example: An official is entitled to a net salary A2-10 = 361, which is calculated as = 361 X 345 Riel = 124,545.00 Riels
2. The minimum net salary is the lowest class of each row. For example: In B1, the minimum net salary is B1-6 =308.
3. Under this scheme, the total salary comprises:
   - Net salary
   - The allowance for position (according to hierarchy for those in types A, B and C)
   - Benefit of occupational risk and survivor's allowance (Wife = 3,000 Riels and Child = 2,500 Riel)

Non-qualifiers who reach the age of retirement but have work seniority of less than 20 years are entitled to a single lump sum which is intended to be derived from salary deductions for pensions, and other allowances. Meanwhile, the lump sum is based on the number of service years multiplied by the total monthly salary, with a minimum of 4 months total monthly salary and a maximum of 10 months total monthly salary.

3.3.4. Social and Health Insurance

In the private sector, particularly workers from garment factories, insurance has to be applied in order to be a member of the Garment Manufacturers Association in

Cambodia (GMAC). This association, in collaboration with the International Labour Organisation (ILO) under a project entitled 'Better Factory in Cambodia' has been ensuring industrial harmony and promoting exports in Cambodia. GMAC helped its members to facilitate efficient discharge of bureaucracy and to co-operate with labor movement to ensure the observation of basic and core labor standards. In addition, GMAC has also worked closely with government ministries in order to promote and protect the interest of garment factories in Cambodia, and to work closely with the ILO in order to accredit labor standards. In 2005, there were 244 garment factories which employed around 278,310 workers and staff. To be a member of GMAC, garment factories are required to fulfill conditions imposed by GMAC, such as payment of membership fees for the GMAC and the ILO, insurance on workers compensation and fire. Notably, most large scale garment factories (those which employ more than 1,000 workers) still apply insurance for their own workers. A study revealed that the total health insurance or cost for all garment factory employees is estimated to be US$1 million per annum.

There has been some success in piloting Community Social Health Insurance schemes which have been recently operated and assisted by donors and NGOs. A few NGOs have operated this scheme which targets the rural poor and urban communities.

Currently in Cambodia a number of health reform proposals have been adopted, including official user fees, sub-contracting government health services delivery to non-governmental providers and Community Based Health Insurance (CBHI). These approaches have tended to reduce the burden of the poor on public health services. As a result of these reforms, Social Health Insurance policies (SHI), led by the Ministry of Health (MoH) are being devised. This policy includes developing legislative and guidance principals, with substantial technical support from various donors, including GTZ, the World Bank, the ADB and other development agencies. In addition, in terms of the development of a health insurance scheme for formal and non-formal sector workers, the sub-decree of the Social Security Law is yet to be approved by Council of Ministries (CoM). There are legitimate concerns in some quarters that a mandatory SHI scheme for the private sector may raise labor costs to the extent that they threaten or damage the competitiveness of economic sector.

3.4. Progress of Social Safety Nets Development

3.4.1. Scoping and Mapping Exercise on Existing Safety Net Programs

The Royal Government of Cambodia has made a firm commitment to the further development of social safety nets in Cambodia. During the Cambodian Development Cooperation Forum, government and development partners had noted that significant progress has been made in reducing overall poverty levels but at the same time recognized that significant parts of population remain vulnerable to various economic and social shocks pushing them into poverty and denying equal opportunities for participating in the economic growth. These risks have been exacerbated by the recent inflationary pressures and global financial crisis. To ensure the establishment and effective use of a social safety net system, which is an important part of a long-term growth strategy, there are a range of actions required at multiple levels: from the central government, at sectoral and sub-national levels.

Facing this challenge, the Royal Government of Cambodia agreed that the first step is to undertake a mapping exercise to determine the nature of existing safety net provision and to identify policy, institutional and capacity gaps for developing a more systematic and integrated safety net system.

3.4.2. Technical Consultation on Social Protection Strategy and Options

To prepare the strategy, in 2009 and 2010 CARD has convened meetings and held technical consultations with a broad set of national stakeholders, giving government representatives (national and sub-national), development partners, civil society representatives and other development practitioners the opportunity to explore in-depth the priorities and options for the Social Protection Strategy.

Table 11. Summary of the Consultation Process

Date	Activity / Event	Description	Paper / Outcomes
Dec 3-4 2008	Cambodia Development Cooperation Forum	Royal Government of Cambodia commitment to develop and implement an integrated national strategy for social safety nets.	
Jan-Jun 2009	Interim Working Group on Social Safety Nets (under the TWG on Food Security and Nutrition	Shared knowledge and consensus-building on the key concepts and broad direction for policy development, and inventory of ongoing Social Protection interventions.	
Jul 6-7 2009	National Forum on Food Security and Nutrition under the Theme of Social Safety Nets in Cambodia	Circa 400 participants (Government, development partners, civil society), with Prime Minister Hun Sen providing the closing address.	Social Safety Nets: Concept Note and Inventory
Oct 19-22 2009	Technical Consultation on Cash Transfers with a focus on addressing malnutrition	70+ participants from Government, development partners and civil society consulted during a day workshop in Phnom Penh. The core group (20 participants) also visited health and educational social protection activities and services, a commune council and the Provincial office in Kompong Speu. The consultation culminated in a brainstorming by key stakeholders to produce a 'Note on Cash Transfers'.	Note on Cash Transfers
Jan 12-14 2010	Technical Consultation on Public Works	80+ participants from Government development partners and civil society consulted during a day workshop in Phnom Penh. The core group (circa 30 participants) also visited sites of cash-for-work and food-for-work projects (ADB and WFP supported interventions) in Kampong Chhnang, including a consultation with representatives of a commune council and beneficiaries of the projects. The consultation culminated in a next steps meeting by CARD and core group of developments and the production of a 'Note on Public Works'.	Note on Public Works
Feb 3-4 2010	Technical Consultation on Education and Child Labour		
Feb - Mar 2010	Consultations on Draft Strategy		
Mar - May 2010	Bilateral stakeholder consultation on the draft strategy	CARD will lead the discussion on bilateral basics with distinguished development partners, civil societies, diplomat corps especially with line ministries in the RGC to have specific and sector comment on the draft strategy	Consolidated draft strategy
May 2010	Approving the strategy at Inter-ministerial meeting		
June 03 2010	CDCF meeting		

In addition to the limited availability of funds, a major constraint for the development of safety net interventions and for rapid assistance response in times of crises is the lack of a government body with a clear mandate to coordinate safety net interventions across ministries, and to implement cross-sectoral interventions. Since July, 2009, the first National Forum on Food Security and Nutrition under the framework of Social Safety Net in Cambodia was organized by the Council for Agricultural and Rural Development (CARD) in collaboration with the World Bank, WFP, UNICEF and various development partners. CARD was mandated to coordinate and facilitate the social safety net policy and strategy development for Cambodia.

3.5. Challenges and Gaps

Safety net interventions in Cambodia face several challenges related to implementation, institutional, and financing issues. Given the many sources of vulnerability faced by the poor of the country, safety nets ought to be a key component of social protection development. The experience of a social safety net is not new to Cambodia, but the term and understanding might be conceptually different. Cambodia has implemented many major-donor supported projects and programs to reintegrate, to rehabilitate, to improve food security, to effectively respond to emergency situations and to improve the livelihood of poor Cambodians but Cambodia still does not have an effective and affordable social safety net system in place.

Institutionally, many ministries and institutions involved in the development and the implementation of some kinds of social safety net programs and projects in the country, from emergency to recovery, rehabilitation and to development already exist. But neither an integrated system nor a sustainable program to respond to a crisis as it occurs has yet to be developed.

Existing safety net interventions exclude some important vulnerable groups. Urban areas are often left out of the current safety net interventions. While these groups are significantly less poor than rural ones, pockets of extreme poverty exist in urban settings too. Existing interventions also often fall short of providing assistance to those who have recently fallen into poverty, or are poor for a transient period, such as farmers during the lean season or victims of natural disasters. In order to address these gaps,

assistance could be provided by expanding and improving existing workfare programs in selected areas.

Cambodia has not yet made significant use of some types of safety net programs that have proved successful in other countries. Over the last decade, a growing number of countries have achieved considerable success with conditional cash transfers (programs which provide households with cash payments so long as they make use of public services). Cambodia has achieved good outcomes through the Scholarship for the Poor program, but only on a small scale. Learning from this success, it may be worth piloting incentive-based cash transfer schemes.

Existing interventions are largely food-based. These arrangements have the advantage of directly addressing shortages and providing households with a stable flow of food. However, in building a more comprehensive safety net system there may be potential for complementing this in-kind assistance with cash-based interventions which would help address the whole range of vulnerabilities faced by households (such as cash strapping or inability to satisfy non food needs).

Targeting has not yet been mainstreamed into safety net implementation, and even among safety net programs that make use of targeting, many still rely on ad hoc targeting procedures whose accuracy has not been investigated. Targeting of safety net interventions should be further promoted. A strong candidate for further development is the government's Identification of Poor Households targeting system (IDPoor). Nonetheless, while initial analyses have shown a good degree of satisfaction with IDPoor's accuracy, transparency, fairness and level of participation, a thorough study of the implementation procedures, the system's robustness in terms of governance risks, and the accuracy of the results obtained would be helpful to further assess strengths and identify opportunities for improvement, taking into account international best practice.

Most of the programs in place also have limited geographical coverage. Few programs have national coverage, and therefore neglect a considerable number of vulnerable poor. Furthermore, existing programs may not actually be covering regions that most need them. A geographically disaggregated analysis linking sources of vulnerability to program coverage may be useful, since it would allow better identification of coverage gaps and assist targeting of existing resources towards the most vulnerable regions.

Table 12. Coverage of Main Risks (Summary)

Age group	Main vulnerabilities	Progress to date	Gaps and challenges
Early Childhood (0-4 years)	• Stunted child development	• Some maternal and child nutrition programs are in place • Breastfeeding practices are improving	• Supply of services remains limited and of poor quality • Coverage is not universal
Primary School Age (5-14 years)	• High dropout rates • Poor quality of education • Child labour	• Scholarships and school feeding programs are improving attendance	• Quality of education remains poor • Coverage is not universal
Youth (15-24 years)	• Low productivity • Low human capital/skills • Underemployment	• Scholarships are improving attendance • Some programs in place to improve quality of education and of vocational training	• Quality of education remains poor • Low attendance • Coverage is not universal • Almost inexistent second chance programs to improve productivity of unskilled workers
Adults (25-64 years)	• Low productivity • Low human capital/skills • Underemployment	• Public works programs are providing some assistance during lean season or crises	• Limited coverage • Funding and assistance remains volatile, defying its safety net role
Elderly and disabled	• Low income • Underemployment	• Pensions for civil servants • Some donor assistance to the disabled	• No pensions for the poor outside of civil servants • Very limited assistance to the disabled
All groups	• Health shocks	• Health equity funds are financing health care for the poor	• Quality of health care remains poor • Coverage and access is not universal
	• Crises and natural disasters	• Public works have shown to be an effective and rapidly expandable safety net instrument during crises and natural disasters	• Limited coverage of existing public works programs • Coverage is not universal, and depends on funding

Source: CARD and IWGSSN (Forthcoming).

4. Social Protection Design

4.1. Proposed Steps for Social Security Reforms

The NSSF scheme will be implemented fully in 2011, whereas the insurance scheme is expected to fully cover all people by 2015. The development of an affordable, adequate and comprehensive social insurance system can be envisaged over the longer-term through a gradual process in relation to financial and administrative capacities. It is proposed that it collects contributions and provide benefits on full remuneration which is the cornerstone of any social security system. Restructuring and strengthening of the pension scheme within a sound financial and policy framework to provide an integrated system of retirement, invalidity and survivor pensions are

constituted as proportions of the full remuneration, which comprises salaries and all allowances, should be designed. This approach provides periodical payments, which are deemed to be the most effective method of long-term income protection compared with lump-sum payments and the introduction of survivor pensions primarily for widows and children to strengthen gender equity and can also contribute to policies for improving school enrollments.

4.2. Development of Social Protection Strategy for Cambodia

The development of social protection strategy for the poor and vulnerable in Cambodia is directed and guided by vulnerability and gaps in existing social safety net program. Using the lens of the lifecycle, a juxtaposition of risks and vulnerable groups against current program coverage highlights some key areas in which future support is needed. The analysis indicates in particular that greater support is needed for children and youths in terms of addressing malnutrition, improving education quality and attendance, reducing child labor and providing second chance education for out-of-school youths. Particular attention should be given to children and youths for several reasons. First, given the current demographics, children and youths represent the largest vulnerable group, while at the same time, given their young age, they have little voice and capability to express their needs and vulnerabilities. Moreover, children and youths represent the next generation of citizens participating in socioeconomic life. Failing to address their vulnerabilities would therefore put at risk future productivity growth and may also endanger social cohesion through growing inequality and social disparities.

Natural disasters also have a strong impact on poor households. Public works can be effective safety nets to help households cope with disasters but current coverage remains very limited and often more emphasis is put on building infrastructure than on the social protection role of public works. Finally, poor households remain particularly vulnerable during the lean season – a source of vulnerability that public works could also help address. If left unaddressed, these sources of vulnerability can lead poor households to adopt coping strategies with long-lasting consequences (such as selling land or pulling children out of school), and force them into vicious cycles of increased vulnerability and destitution.

Little support is also given to the disabled and the elderly poor, who rely on family support for survival. Whereas efforts are undergoing to develop a social security system for the formal sector, there is currently no allowance for the elderly poor who must rely on family support. A similar picture holds for the disabled poor. While family support remains one of the major sources of assistance for the elderly and disabled in most low- and middle income countries, it does represent a significant burden on the poorest families. Assistance given to the elderly poor could therefore be envisaged, for instance, in the context of a cash transfer program.

The programs to sustain human capital and social welfare through cash transfer would aim specifically to increase utilization of a pre- and post-natal care package that conforms to existing national policies and guidelines, and international evidence-based best practices. It was recommended during the Technical Consultation in August 2009 that while payment of the benefit would be subject to fulfillment of the conditionality, it would be advisable that the latter not be applied too strictly. The purpose of the conditions is not to move people off the register but to ensure meaningful behavioral change. For example, mothers showing sufficient evidence of behavioral compliance with the program, even if not perfect, should remain eligible for the program: a mother who attended two or three out of four recommended prenatal visits should be kept in the program. Similarly, an inability to deliver a child in a clinic should not exclude a mother from participation in the program; it may be possible to have a minimum of visits before and immediately after the birth that fulfills the recommendation. The consultation also highlighted the need to take supply constraints and the quality of service delivery into account. The impact of the cash transfer program in areas with poor quality of service delivery is likely to be minimal. More analysis will therefore need to be conducted to assess supply side capacity at the moment of choosing the pilot areas, and, once the pilot area is selected, on the specific constraints present there.

Another important social protection instrument that has the potential to address the risk of seasonal unemployment during normal times, and the ability to respond to natural and economic crises, is a nationwide public works program. Cambodia already has significant experience with public works, as various donor partners have been working with the Royal Government of Cambodia (RGC) in financing and implementing labor intensive public works programs. One of the main advantages of

public works is that it enables poor beneficiaries that are willing to work for slightly below the prevailing market wages to self-select themselves into the program, thus saving considerable program costs associated with administrative selection of potential beneficiaries. Such a feature makes public works a good complement to targeted cash transfers during crises and natural disasters, since poor beneficiaries (who may have fallen into poverty as a consequence of the crisis and therefore may not correspond to the chronically poor) do not need to be identified in advance. As shown in the discussion below, this role of public works as an emergency safety net has not yet been fully exploited in Cambodia.

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CHAPTER 12

Report on Social Protection in the Lao PDR

LEEBER LEEBOUAPAO
National Economic Research Institute, Lao PDR

In the Lao PDR, there are four formal social health-protection systems: the State Authority of Social Security (SASS), the Social Security Organization (SSO), Community Based Health Insurance (CBHI) and Heath Equity Funds (HEFs).

Coverage of social protection in the Lao PDR is limited. The ratio of health care fund contributors to the total population is only 2.9 %, and the ratio of pension beneficiaries and contributors to the total labor force is only 6.15 %.

The main challenges are: the majority of both labor force and population are in low-income groups, poor people and engaged in the informal sector; the population is ageing and there will be more old people due to the increasing life expectancy of Lao people; Government revenue is limited, and is insufficient for social assistance within the country.

The Lao government is planning to develop a new social protection scheme to increase the coverage of social protection by moving towards merging all social protection systems into a single authority, the National Social Security System, in order to strengthen technical capacity, maximize financial and personnel pooling, increase administrative efficiency, introduce new legislative tools and better inform the public.

To increase the coverage of social protection, the author makes four recommendations:

1 to promote economic growth and reduce poverty;

2 to establish social assistance funds for all poor people;

3 to promote more community social protection funds;

4 to promote Lao's traditional and cultural values

1. Introduction

1.1. Overview

The Lao PDR is a mountainous landlocked country in South East Asia with about 6,174 million people in 2010. Over the past decades, the Lao PDR has achieved remarkable economic growth at an average growth rate of about 7 % a year. Economic structures have changed remarkably, from the major share of agriculture in GDP of more than 50 % in 2000 to about 30% in 2010. However, the structure of the labor force has changed insignificantly during the same period. About 73.5% of the labor force is still engaged in the agriculture sector and most of them are subsistence farmers.

In parallel with this remarkable economic growth, significant improvements in major social indicators have been achieved over the last decade. The absolute poverty rate has fallen from 46% in 1993 to 25, 9% in 2008. From 2000 to 2005 the maternal mortality rate (MMR) has fallen from 530 to 405 per 100,000 live births; the infant mortality rate (IMR) from 104 to 70 per 1,000 live births, and life expectancy has increased from 50 to 59 for men and 52 to 63 for women from 1995 to 2005.

However, with an estimated GDP per capita income of about US$ 777 in 2009, the Lao PDR remains one of the Least Developed Countries (LDC) in the world. About 71% of the population lives on less than US$2 a day.

The Lao government's long term development vision is to free the country from Least Developed Country (LCD) status by the year 2020 and it is committed to achieving the Millennium Development Goals (MDG's) by 2015. One of the national Social Economic Development Goals, and the main goal of social protection, is universal health care.

After the independence and foundation of Lao PDR in 1975 until 1993, formal social protection in the form of pensions was eligible only for government employees. Pensions for government employees were fully paid by the government, without contribution. Health care was free for all Lao people. In 1993, the first social security fund for public employee pensions was established, based on 6% of their basic salaries. In 2001, the first Social Security Organization (SSO) for the private Sector, including state-owned and private enterprises, was established. In 2008, a new public social security scheme, called the State Authority Civil Servant Scheme (SASS), was

established. Beside this, there are some medical insurance systems for the informal and non-salaried sector providing health-care benefits, namely the Community-Based Health Insurance Scheme (CBHI) and Health Equity Funds (HEFs) covering. Apart from these, there are health care funds established by different organizations and private insurance companies.

Despite this development, the coverage of social protection in the Lao PDR is very limited; the ratio of health care fund contributors to the total population is only 2.9 % and the ratio of pension beneficiaries and contributors to the total labor force is only 6.15%.

So far, some studies related to social protection in Lao PDR have been carried out; however, many issues still remains critical and questionable. Hence, further study on social protection in the Lao PDR, which is supported by the Economic Research Institute for ASEAN and East Asia (ERIA) research project, is essential for the country.

1.2. Objectives

The main objectives of this report are:

1) to analyze the current state of social protection arrangements in the Lao PDR;
2) to identify the main critical challenges; and
3) to make policy recommendations toward more dynamic and sustainable social protection.

1.3. Research Methodology

The research approaches and methodology used to produce this report are based mainly on literature reviews, interviews and analysis:

1. Literature reviews:

Mr. Prasong VONGKHAMCHANH, Deputy Director General of Social Security Department, National Director of ILO Social Security Project, presented a discussion paper on Social Security Schemes, Pension and Elderly policy in the Lao PDR (2008). He described briefly the regulatory framework and system of social protection in the Lao PDR (social security schemes for the Civil Service and enterprises) and focused on welfare policy for vulnerable groups. The challenges facing social protection in the Lao

PDR are: the increasing number of elderly people, socioeconomic disparity between developed and developing parts of the country, insufficient health care provision and poverty reduction. Future plans to be implemented are to develop and manage innovative, culturally appropriate, cost effective, sustainable and repentant older people, to produce training manuals, resources, materials/ toolkits on home care and community care, and to share experiences, information and technical with ASEAN member countries and another country.

Mr. Padeumphone Sonthany, Deputy Director General of the Social Security Organization, under the Ministry of Labor and Social Welfare (2006) wrote a short paper on social security in the Lao PDR. He explained the Lao Government social security policy framework and the current health care system in the Lao PDR (social security for public sector employees and for enterprise employees), the health insurance system for informal sector and the medical care delivery system.

Dr. Saykham Voladet and Chongpraseuth Vilaylack (2004) wrote a paper on Social Protection Mechanism in the Lao PDR. They classified the existing social protection system in the Lao PDR as 2 main systems: First is the social protection system itself, including the Social Security Association for Government Officers, Social Security Association for (private) Enterprise Employees, Commune Social Security Association (Commune Health Care Security System and the Social Security Association of the Village); second are the social assistance projects. However, their explanation was contradictory. They emphasized the role of the Commune Social Security Association and the social assistance projects from which people in the informal sector and poor people can benefit. They stated that the problem with the social security system structure in the Lao PDR is the ineffective implementation of its regulations, thus, the majority (over 95%) of the population of labor force age is not covered by significant social security benefits (medical/ health-care benefit, sickness benefit, employment injury or occupational disaster insurance, retirement pension and invalidity benefit). Improving and increasing the coverage of the social security system are big challenges for Lao PDR. To improve and increase the coverage of the social security system, a "united social security organization" should be established.

ISSA (International Social Security Association) published an article on "Pursuing Universal health-care Provision in Lao People's Democratic Republic". It classifies the

social protection system in the Lao PDR as **four systems:** two compulsory contributory social security schemes, which provide health care alongside social security cash benefits: the Social Security Office (SSO), covering the private salaried sector; the State Authority for Social Security (SASS), covering the public salaried sector (and which is also set to include police and military personnel); the voluntary contributory social health-insurance scheme: Community-Based Health Insurance Scheme (CBHI), covering the informal and non-salaried sector (but providing only health-care benefits); and the non-contributory social assistance system: Health Equity Funds (HEFs), currently funded by bilateral donors and lending banks and implemented by external partners and non-governmental organizations, with the Ministry of Health stipulating that the funds be used to purchase CBHI membership for low-income families. It described the Lao Government's social protection system reform policy, and in particular, the merger of all social protection systems. Therefore, the rationale for merging the social health protection systems is to:

- Consolidate and increase technical capacity, to introduce new legislative tools and to better inform the public.
- Increase membership, with subsidies needed for the poor and near-poor population to reduce the risk of poverty as a result of paying for health care.
- Increase utilization to facilitate improvements in health, reduce unmet needs and facilitate the achievement of the Millennium Development Goals.

SSPTW, Asia and the Pacific (2004) explained the terms of the regulatory social protection framework of the Lao government on old age, disability and survivors, namely: coverage, source of funds, qualifying conditions, benefits and administrative organization.

2. Interviews

Interviews with government officials from the Ministry of Labor and Social Welfare and insurance companies.

1.4. Report Outline

The report consists of 4 major sections:

1) Introduction;
2) Current State and Challenges of Social Protection in the Lao PDR;
3) Main Critical Reforms of Social Protection; and
4) Conclusion and Policy Recommendations.

2. Current State and Challenges of Social Protection in the Lao PDR

2.1. Current State of Social Protection

2.1.1. The Government's Social Protection Regulatory Framework

a. Social Security System for Government Employees

After the foundation and independence of the Lao PDR from 1975 to 1986, social protection, in the context of health care, was fully financed by the government for all Lao people. During that period, there were two regulations on social protection for civil servants: Regulation No. 53 and No.54. Regulation No. 53 described the benefit for invalid persons and the payment for the families of government employees who sacrificed their life before and after independence in 1975. Regulation No. 54 determined the benefits for government employees who suffer social contingencies like sickness, maternity, death, death of spouse, loss of working capacity, old age and loss of child allowance.

In 1993, the Lao government adopted Decree No. 178, introducing a co-payment concept for social security expenditure. Government employees had to contribute 6% of their basic salary to the social security fund and the government, as an employer, had to contribute to the fund and guarantee social security entitlement for employees. The benefits covered by this scheme comprise old-age pension, disability benefit, incapacity benefit (loss of capacity), death benefit, survivor benefit, sickness benefit, maternity benefit, employment injury, child allowance and health care.

In 2006, the current decree, Decree No. 70/ PM, on social security for the public sector was adopted to replace Decree No. 178, determining users' contributions to the

social security fund. It states that employees' contribution is 8% of their basic monthly salary and the employers' contribution is 8.5% of payroll. The coverage is the same as the previous decree.

b. Social Security System for Enterprise Employees

In 1999, the first decree, the Decree of the Prime Minister No. 207/ PM, "Social Security Scheme for Enterprises" was approved and officially implemented in early 2001. It is a contributory and compulsory scheme. The insurable target groups are all employees who work for The State and for private enterprises. The scheme applies to all employers who have 10 or more employees. The total contribution rate is 9,5% of each employee's earnings, of which 5% comes from employers and 4,5% from employees. The minimum earnings for contribution and benefit purposes are 93,600 kip. The maximum earnings for contribution and benefit purposes are 1,000,000 kip. Exceptions are made for those who are working for: embassies; international organizations; companies that have a multinational network located in Laos for a period not exceeding 12 months; companies that have affiliates in other countries and who are sent to work abroad for 12 months or more, who work for the government such as civil servants, military, and police; and students. Benefits provided under this system include: old age pension, invalidity benefit, survivor benefit, sickness benefit, maternity benefit, medical care and work injury benefits. The scheme is administered by the social security organization (SSO), which is an autonomous body under the supervision of the Minister of MOLSW.

c. Health Insurance Policy for Informal Sector Population

In 2005, the Ministry of Health approved the Regulation No. 723/ MoH to promote Community Based Health Insurance (CBHI), which is available for the population in the informal sector, and is based on voluntary membership including family coverage. Benefit includes only health care (traffic accidents and cosmetic care are excluded).

The Sixth National Social Development Plan (2006-2010), identifies health as one of the four sectors for development and calls for full health-care coverage and equity of access by 2020.

The Lao Government is committed to achieving the Millennium Development Goals (MDGs) by 2015, with an emphasis on poverty reduction and health care, in particular for maternity, children and education for all children. The Lao government is planning to implement different development projects to achieve these Goals.

In 2009, the Prime Ministerial Notice was adopted to merge all social protection systems. This was in order to increase coverage and the revenue potential of prepayment and capitation methods for health-care providers.

2.1.2. Social Health-Protection Systems

There are four social health-protection systems: The State Authority of Social Security (SASS), Social Security Organization (SSO), Community Based Health Insurance (CBHI), and Health Equity Funds (HEFs). Table 1 below illustrates the current status and main characteristics of the four systems and their target populations.

Table 1. Four Social Health Protection Systems

	SASS	SSO	CBHI	HEFs
Target Population	Civil Servants and their dependents	Private-sector salaried workers and their dependents	Self-employed and informal-economy population	Families identified as below the poverty line
Estimated no. of people in target population	800,000	200,000	3,500,000 (including about 1,500,000 near-poor)	1,500,000
Dependency ratio	2.7	2.1	4.2	4.2
Legislative tool	Decree 70 (2006)	Decree 207 (2001)	Regulations Decree pending	MOH Regulations
Implementation date	2006	2002	2002	2004
Ministerial authority	MOLSW	MOLSW	MOH	MOH
Current scope of operation	All provinces	Vientiane capital and 3 provinces	18 cities in Vientiane capital and 8 Provinces	Selected provinces
Contributions for health care	4 per cent of salary shared by employer and worker	2.2 per cent of salary shared by employer and worker	Flat amount according to family size, with urban and rural rates	Same as CBHI, where merged amount spent varies by HEF
Health-care delivery	Contracts with providers; capitation and reimbursement	Contracts with providers; capitation with adjustment	Contracts with providers; capitation based on contributions	Capitation through CBHI for some reimbursement by free for service for others
Insured persons (August 2009)	300,000	85,000	65,000	15,000

Source: International Social Security Association, 07 Social Security Observer, Pursuing universal health-care provision in Lao People's Democratic Republic
MOLSW: Ministry of Labor and Social Welfare
MOH: Ministry of Health

a. Compulsory Contributory Social Security Schemes

There are two compulsory contributory social security schemes, which provide health care alongside social security cash benefits:

- The Social Security Office (SSO), covering the private salaried sector.
- The State Authority for Social Security (SASS), covering the public salaried sector (and which is also set to include police and military personnel).

b. Voluntary Contributory Social Health-Insurance Scheme

The Community-Based Health Insurance Scheme (CBHI) covering the informal and non-salaried sector, but providing only health-care benefits.

c. Non-Contributory Social Assistance System

Health Equity Funds (HEFs), currently funded by bilateral donors and lending banks, are implemented by external partners and non-governmental organizations, with the Ministry of Health stipulating that the funds be used to purchase CBHI membership for low-income families.

Collaboration between the MOLSW (Ministry of Labor and Social Welfare), the MOH (Ministry of Heath) and the major development partners – the International Labor Organization and the World Health Organization – resulted in all three contributory social insurance schemes having the same design features. All schemes provide coverage to the insured and his or her dependent family members. Health-care benefits cover ambulatory and in-patient care, without co-payment or limits on the number of contacts or services provided. In all the contributory schemes, capitation is the main provider payment method. The same classification codes are used in their information systems.

The main objective of assuring this compatibility was to facilitate, at a future date, the shift to universal coverage. In August 2009, the total number of persons covered by all four social protection systems was approximately 465,000, or 7.82 per cent of the total population of the Lao PDR of around 6 million.

Utilization of health care has increased significantly. Table 2 shows comparative data for health-care utilization through SSO and CBHI, alongside national estimates.

Table 2. Health-Care System Utilization (2008)

	National	SSO	CBHI
Out-patient visits/ person/ year	0.2	0.83	1.2
Hospital days/ person/ year	0.03	0.05	0.3
Hospital deliveries (childbirth)	10.8 percent	70.0 per cent	36.9 percent

Source: International Social Security Association, 07 Social Security Observer, Pursuing universal health-care provision in Lao People's Democratic Republic

There has also been a substantial increase in revenue coming into public health facilities from the insured population and a reduction in out-of-pocket payments, which typically predominantly go to unregulated private providers.

The weaknesses of each system are: In the SSO, compliance in registration and contribution collection is weak, with less than one-third of private-sector salaried workers covered. Membership is compulsory but the SSO's legislative tool (Decree 207) has no sanctions to enforce an employer to register workers and pay contributions regularly. To date, the SSO operates in the capital Vientiane and three provinces, which were selected since they have a large number of private-sector enterprises. The SSO is reluctant to expand to more provinces, because of the high operating costs incurred for a relatively small number of beneficiaries.

In the SASS, all civil servants are registered by the government (as the employer) and its operations are meant to extend to all provinces and districts. However, the scheme's legislative tool (Decree 70) has so far only been implemented in the capital Vientiane and in Vientiane Province, while the other provinces are still under the previous system of reimbursement for health-care expenses (which has higher actual expenditure per person compared with the population covered by the new capitation system).

In CBHI, low compliance is reflected by late payments and some families pay again when they need care. CBHI members do not represent the wealthier population in the informal economy. They are typically low-income families and many are near-poor families with income that is above the official poverty line but insufficient to pay contributions on a regular basis. The government has recognized that their contributions need to be subsidized because they are at risk of falling into poverty as a result of often having to pay high and unpredictable amounts for health care. The extension of

coverage in CBHI has been hampered by the scattered development of CBHI across the country, which has occurred without first reaching substantial coverage at the village and district level. In part, this situation is linked to a lack of trained staff to launch CBHI in new sites. However, a common problem is that all contributory schemes suffer from a lack of trained staff, particularly at provincial and district levels.

2.1.3. Social Security Fund

The Social Security Fund includes contributions from employers, employees and return on investment. The fund is guaranteed by the government.

The calculation of contributions or premiums draws on an individual employee's salary or wage. The total contribution rate is 9.5%. Of this, 5% comes from employer's contributions and the other 4.5% is from an individual employee, based on his or her monthly salary.

Contribution and benefits are summarised in table 3 below.

Table 3. Contribution To and Benefits from the Social Security Fund

Contribution rate (%)		Health-care benefits	Sickness, maternity and funeral benefits	Retirement, invalidity and survivor pensions	Working Injury or occupational diseases benefits
Employer	5 %	1.1%	0.65%	2.75%	0.5%
Employee	4.5%	1.1%	0.65%	2.75%	-

Source: Department of Statistics, MPI, Lao PDR (2007).

a. Coverage

Mandatory coverage includes all employees working in state-owned and private enterprises with 10 workers or more;

Voluntary coverage applies to enterprises with less than 10 employees.

b. Membership

As of 31 December 2008, there were 43,058 insured persons from 493 employing units who paid contributions to the Social Security Fund. Moreover, the total number of beneficiaries (including insured persons and their dependants) covered by the scheme was 85,854 persons.

c. Types of Benefits

There are 8 types of benefits, namely: Health care, sickness, maternity, funeral, working injury or occupational diseases, retirement, invalidity and survivors.

(i) Health-Care Benefit

Having paid contributions for at least 3 of the last 12 months, the insured person, spouse and children under 18 of age are entitled to medical treatment provided by his or her selected hospital which holds contract with SSO. The medical treatment services are free of charge and there are no limitations for admission. For insured persons who have stopped their contributions due to employment termination, the medical treatment is still offered to them for 3 months after their last contribution.

(ii) Sickness Benefit

Insured persons shall receive income replacement benefit due to sickness only when contributions have been remitted to the Social Security Fund for at least 3 months. Benefit will be equivalent to 60% of the insured person's average salary or wages during the 6 months prior to the incident. This sickness benefit is payable for up to 12 months.

(iii) Maternity Benefit

Having paid contributions to the Social Security Fund for at least 9 months, the insured person who is on maternity leave or miscarries after 6 months of pregnancy or adopts a child younger than 1 year old, is entitled to maternity benefit.

The maternity benefit is equal to 100% of the insured person's earnings and is effective for a period of 3 months. After 3 months, if the insured person is still unable to resume work for medical reasons, he/ she will be entitled to sickness benefit as described in number 4.6.2.

In addition, the insured person, who has contributed to the Social Security Fund for 12 months, shall be eligible for a birth grant equal to 60% of the minimum salary, determined by the government, per child.

(iv) Funeral Benefit

Death benefit is available for the family of a deceased person who contributed to the

Social Security Fund for 12 of the last 18 months before death. The death benefit (or funeral benefit) is equal to 6 months of the deceased person's monthly insured earnings.

If an insured person's spouse dies, the funeral benefit is equal to 3 months of the insured person's insured earnings. For the death of an insured person's child under 18, the funeral benefit will be equal to 2 months of the insured person's insured earnings.

(v) Working Injury or Occupational Diseases Benefits

An insured person suffering from a work-related accident or an occupational disease is entitled to receive employment injury or occupational disease benefits from SSO.

The benefit package in the employment injury or occupational diseases includes:

1. Medical care services.
2. Benefits for temporary loss of working capacity in the amount of 100% of the insured person's insured wage and effective for a period of 6 months. Should this period expire, but the insured person is still unable to resume his/her work, the rules for sickness benefit, as described in number 4.6.2, shall be applied.
3. Monthly benefits for permanent loss of working capacity (invalidity benefit) equal to 67.5% of his or her average insured earnings multiplied by the degree of his/her invalidity in % terms
4. Caretaker benefits are payable according to number of hours of service.
5. Funeral benefits equal to 6 months of the deceased person's insured earnings.
6. Survivors' benefits: The surviving spouse receives 50% of the deceased person's insured earnings. Surviving children under 18 years of age, or disabled children, receive 15% of deceased person's insured earnings per child, with a maximum of 60%.

(vi) Retirement Pension (Old-age Pension)

Generally, to receive a retirement pension an insured person must have continuously or periodically paid contributions to the Social Security Fund for at least 60 months and must have reached the age of 60. In special circumstances, insured people aged 55 to 59 years may also receive the retirement pension.

After reaching 60 years of age, a person disqualified from receiving a retirement

pension person shall be entitled to a lump sum from the SSO.

(vii) Invalidity Pensions

The insured person entitled to the invalidity benefit (invalidity pension) must satisfy the following prerequisites:

- Contributions have been made to the Social Security Fund for at least 60 months by the insured person.
- The insured person with poor health or physical disability is proved as invalidity (loss of working capacity).
- The insured person with poor health or physical disability is proved as invalidity (loss of working capacity).
- Such invalidity is neither caused by working injury nor occupational disease. However, the invalidity must occur either during the period of time that such insured person was a contributing member to the SSO, or during the period of being an SSO benefits recipient. (This condition is subject to determination).

(viii) Survivors Benefits

Conditions:

- Prior to death, the deceased insured person has paid contributions to the social security fund for at least 5 years or 60 months.
- The insured person died while being a contributing member of the social security organization; or
- The insured person died while receiving benefits from the social security organization; or
- The person died while being a retirement pensioner or an invalidity pensioner (with an invalidity degree of not less than 81%) to the social security organization;

For people to be entitled to survivors benefit (survivors pension), they must be the deceased insured person's legal spouse or children.

Survivors Benefit is divided into 3 Categories:

Adaptation Benefit: which is equivalent to 80% of the dead insured person's monthly

pension or insured salary averaged over the last 12 months and shall be paid for a maximum of 12 months.

Widow(er) Benefit: This equals 60% of the monthly pension received by the deceased pensioner, or of the assumed invalidity pension of the deceased spouse. This benefit is paid on monthly basis.

Orphans' Benefit: which entitles each surviving child under 18 to a monthly benefit equivalent to 20% of the monthly pension received by the deceased pensioner or of the assumed invalidity pension of the deceased insured person.

d. Taxation

All social security benefits and the Social Security Fund are exempted from taxation.

2.2. Challenges and Constraints.

The main challenges for improving and developing a well-functioning social protection scheme in the Lao PDR are:

1) The current coverage of social protection in the Lao PDR is limited; the majority of the population remains without health-care coverage. The ratio of health care fund contributors to the total population is only 2.9% and the ratio of pension beneficiaries and contributors to the total labor force is only 6.15%. More importantly, benefits from the social protection scheme are relatively low and not always sufficient for the needs of the beneficiaries. To increase the benefits and work towards full health care coverage, great efforts must be made through developing a relatively comprehensive social protection strategy including fund raising, establishment of social protection institutions, management, capacity building and pooling of human resources. Achieving this strategy will take a couple of decades.
2) The current administrative capacities of formal social security systems are limited. There is a need for improvement and further development.
3) The majority of the labor force and population is relatively poor underemployed people, working in the informal economy in rural and remote areas. It is difficult to increase coverage to the informal sector, both in terms of members and

contributions.

4) The population is aging and life expectancy at retirement is increasing. The duration of retirements, and therefore receiving benefits, is being extended. This will increase the burden on social protection funds.
5) Governments' revenues, as the main source for the social assistance, are limited and insufficient to cover, in particular, the very poorest people. These are the main critical challenges in the short and medium term.

3. Main Critical Reforms of Social Protection

3. 1. Increase Coverage

In response to these challenges, the Lao Government has formulated a strategy framework to extend the social health protection scheme to formal- and informal-economy workers, while developing mechanisms to cover the poorest through social assistance.

The National Health Development Plan of the Lao PDR determines:

- Targets for insurance of heath care:
  30% of total population by 2010, 50% of total population by 2015, more than 70% of total population by 2020.
- Expansion of the health care network through the public health care system reaching up to remote and mountainous areas to increase the health care utilization rate.
- Reduce financial barriers to health care services for the Lao people, especially the low income and poor people by decreasing user fee systems and increasing pre-payment systems through health insurance.

However, due to the challenges mentioned earlier, these coverage targets would probably not be achievable.

With a longer-term goal of realizing universal coverage, it is expected that the merging of the systems will lead to:

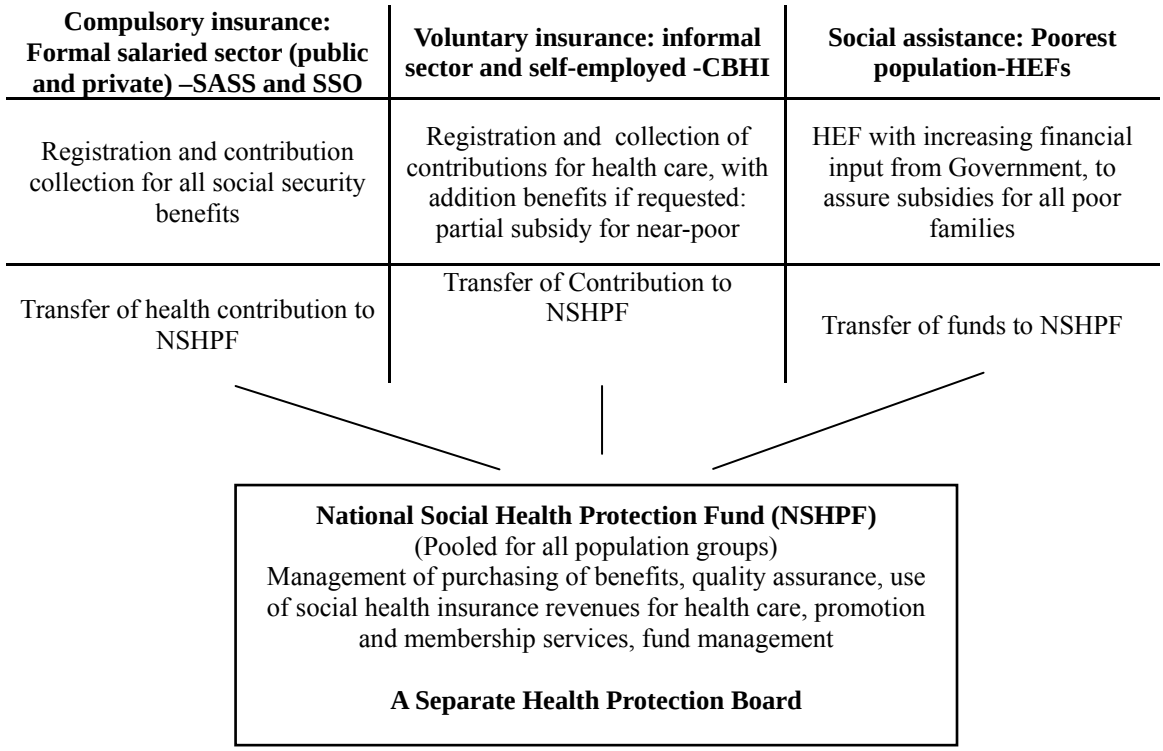
- Enhanced equity and solidarity among all population groups through maximized pooling of risks and social protection funds.
- Greater efficiency in the administration of social protection.

- The creation of one fund with adequate reserves and allocations for high-cost care, health promotion and prevention and appropriate research and documentation.
- The assurance of portability in social protection between public, private, self-employed and informal-economy workers.

In the proposed merger, a single authority, the National Social Security System, will be responsible for the registration of, and collection of contributions from, all population sectors (see Figure 1.). The National Social Health Protection Board will have a tripartite structure, compatible with the current Medical Boards of SSO and SASS, and will allow for appropriate representation of the informal sector, health-care providers and civil society. The MOH will retain responsibility for health-care policy development.

The new Social Security System is illustrated in Figure 1 below:

Figure 1. The National Social Security System



3. 2. Financing

Important prerequisites for the proposed merger are financial support, acceptance by health-care providers of improved quality of care, appropriate legislative tools, and adequate technical capacity through consolidation and strengthening of all professionals into a single institutional framework.

The salaried-sector schemes provide a broad range of cash benefits, as well as health care. The cash benefits include a retirement pension, income replacement for short-term sickness absenteeism, invalidity, maternity, and survivor's benefit and funeral grants. The comprehensive nature of these benefits will need to be maintained after any merger. It is hoped that, in the future, additional social protection benefits, such as old-age benefits and the funeral grant, will be available for all population sectors, including those in the informal economy.

Potential sources of revenue for subsidies include Health Equity Funds and additional government funds. Other potential revenue sources are an increase in the Vehicle Road Tax to support the treatment of road accident injuries, and revenue from fines imposed for the late payment of contributions.

4. Policy Recommendations and Conclusion

4.1. Policy Recommendations

To increase coverage of social protection for all Lao people, the author recommends the following:

1) Promote Economic Growth and Reduce Poverty

As explain earlier, low income, poverty of the Lao population and low government budget revenue are the critical challenges hindering an increase in the coverage of the social protection in the whole country, including the informal sector, where the majority of the labor force is engaged. So, at the macro level, great efforts must be made to achieve the government's National Social Economic Development Plan (NSEP), in particular to realize the target of gross domestic product (GDP) growth of no less than 8 percent per year, to realize the Millennium Development Goals (MDGs) by 2015, to reduce poverty by half according to the current poverty incidences, to increase GDP per capita to about US$ 1.700; to escape from having the status of a Least Developed

Country by 2020. Realizing those goals will create the basic conditions for extending the general coverage of social protection to more people, albeit not for the majority of the Lao people yet.

2) Establish Social Assistance Funds for the Poor

Poor people cannot afford fees for the social protection funds. So, the government should establish a social assistance fund to provide health care for all the poor in the whole country. So far, there are only a few social assistance projects for basic health care, and only for some remote areas with limited facilities and limited services.

3) Promote Establishment of Community Social Protection Funds

So far, there are some community health care funds which have been established and are functioning relatively well. This model should be applied to other groups of people.

4) Promote Lao Traditional and Cultural Values

Traditionally and culturally Lao people, by nature and in particular for relatives and villagers, help each other if any person gets sick, dies and has any trouble. Children take care of their parents when they get old. The majority of Lao people follow Buddhism, the pagoda of which is the venue for most funerals in the Lao PDR. These are the cultural and traditional values of Lao, which should be promoted.

The challenge that, as villages are urbanized and the economy grows, old people get more pensions for longer durations; Lao traditional and cultural values will be irreversibly changed.

4.2. Conclusion

Over the past 30 years, the social protection system in the Lao PDR has been developed gradually from a non- contributory social protection system exclusively for government employees to a contributory fee scheme, from state to private enterprise schemes, from voluntary to compulsory schemes, from formal to informal sector schemes and to social assistance schemes.

However, the coverage of social protection is very limited. The main challenges are: the majority of both the labour force and population are poor people in the low income groups who are engaged in the informal sector; the population is ageing and there will be more old people due to the increased life expectancy of the Lao people; Government revenue is limited and insufficient for social assistance within the country.

The Lao Government has made efforts to establish a more efficient social protection scheme to increase the coverage of social protection by moving towards merging all social protection systems into a single authority, the National Social Security System, in order to strengthen technical capacity, maximize financial and personnel pooling, increase administrative efficiency, introduce new legislative tools, and better inform the public.

The author makes the following recommendations to increase the coverage of social protection for the Lao people:

First is to promote economic growth and reduce poverty;

Second is to establish social assistance funds for all the poor;

Third is to promote more community social protection funds;

Fourth is to promote Lao traditional and cultural values.

Annex. Selected Socio - Economic Indicators

Table 1. Main Economic and Social Indicators

	2006	**2007**	**2008**	**2009**
GDP (%)	**8.7**	**6.8**	**7.5**	**7.6**
Inflation (%)	6.8%	4.5%	7.63%	0.03%
Population	5,312,631	5,423,266	5,536,206	5,651,497
GDP per capita (US$)	670.1	700.0	775.8	776.9

Source: Department of Statistics, MPI, Lao PDR (2010).

Table 2. Population Size and Growth

Age Group	Female	%	Male	%	Total	%
0-4	384.3	13.0	391.5	13.4	776	13.2
5-9	361.6	12.3	368.1	12.6	730	12.4
10-14	376.5	12.8	391.7	13.4	768	13.1
15-19	344.7	11.7	351.9	12.0	697	11.9
20-24	279.0	9.5	273.0	9.3	552	9.4
25-29	228.7	7.8	221.1	7.5	450	7.7
30-34	190.4	6.5	182.9	6.2	373	6.4
35-39	169.5	5.8	166.1	5.7	336	5.7
40-44	144.6	4.9	143.3	4.9	288	4.9
45-49	119.0	4.0	118.9	4.1	238	4.1
50-54	98.8	3.4	95.6	3.3	194	3.3
55-59	72.7	2.5	68.5	2.3	141	2.4
60-64	56.2	1.9	51.3	1.8	108	1.8
65-69	43.6	1.5	39.5	1.3	83	1.4
70-74	32.3	1.1	28.2	1.0	61	1.0
75+	43.2	1.5	36.8	1.3	80	1.4
TOTAL	2945	100	2929	100	5874	100

Source: Figure is estimated from the Population and Housing Census 2005, DoS, MPI.

Table 3. Natural Population Increase in 1995-2005.

Census Year	Census Population	Intercensal Increase		Estimated Number of Births, Deaths and Natural Increase during Intercensal Period			Estimated Net Migration 000	Natural Annual Growth Rate %
		Absolute Number 000	Annual Growth Rate %	Births 000	Deaths 000	Natural Increase 000		
1985	3 584 000							
1995	4 575 000	991	2.5					
2005	5 622 000	1 047	2.1	1 775	590	1 185	-138	2.5

Source: Department of Statistics, MPI, Lao PDR (2007).

Table 4. Age and Sex Distributions in 1995 and Population Censuses.

Age group	1995 Census			2005 Census		
	Females	Males	Total	Females	Males	Total
0 - 14	43	45	44	39	40	39
15 - 64	53	51	53	57	56	57
65+	4	4	4	4	4	4
Total	**100**	**100**	**100**	**100**	**100**	**100**

Source: National Statistics Centre, MPI, Lao PDR (1997); Dept. of Statistic, MPI, Lao PDR (2007).

Table 5. Fertility Measurements and Estimate in 1995-2020

Fertility Measurements	1995	2000	2005	2010	2015	2020
TFR	5.0	4.8	4.5	3.7	2.9	2.1
GRR	2.4	2.3	2.2	1.8	1.4	1.0
NRR	1.9	1.9	1.9	1.6	1.3	1.0
Mean age of childbearing	29.0	29.0	29.0	28.8	27.9	27.3

Source: Department of Statistics, MPI, Lao PDR (2007).

Table 6. Summary of Mortality Estimates

Mortality Measurements	1995 *(%)*	2000 *(%)*	2005 *(%)*	2010 *(%)*	2015 *(%)*	2020 *(%)*
Female LE	52.0	61.0	63.0	66.7	70.3	74.0
Male LE	50.0	57.0	59.0	62.7	66.3	70.0
Total LE	51.0	59.0	61.0	64.7	68.3	72.0
CDR per 1000	13.6	11.6	9.8	8.0	6.5	5.3
IMR	104.0	82.0	70.0	56.5	44.0	32.4
U5MR	170.0	107.0	97.6	76.4	57.2	40.5

Note: Crude Death Rate (CDR).

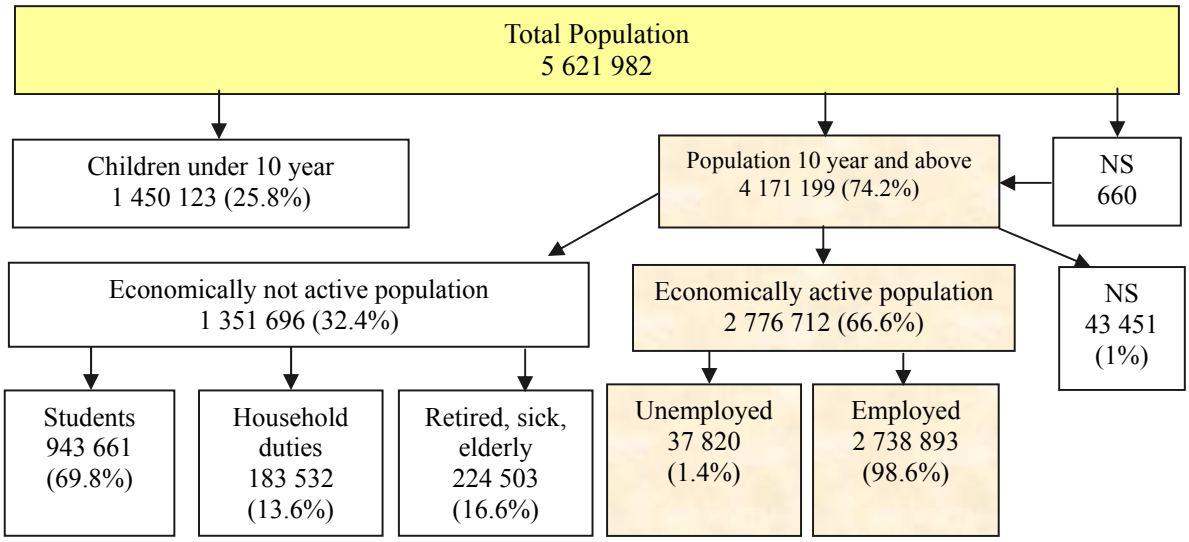
Table 7. Population Projection for Lao PDR from 2005 – 2020

Characteristic	2005 *(%)*	2006 *(%)*	2007 *(%)*	2008 *(%)*	2009 *(%)*	2010 *(%)*	2011 *(%)*	2012 *(%)*
Fertility								
Input TFR	4.2	4.3	4.2	4.0	3.9	3.7	3.5	3.4
GRR	2.2	2.1	2.0	2.0	1.9	1.8	1.7	1.7
NRR	1.9	1.9	1.8	1.7	1.7	1.6	1.6	1.5
Mortality								
Female LE	63.0	63.7	64.5	65.2	65.9	66.7	67.4	68.1
Male LE	59.0	59.7	60.5	61.2	61.9	62.7	63.4	64.1
Total LE	61.0	61.7	62.5	63.2	63.9	64.7	65.4	66.1
IMR	70.0	67.2	64.4	61.8	59.2	56.6	54.1	51.5
U5MR	97.6	93.0	88.6	84.4	80.4	76.4	72.4	68.4
Vital Rates								
CBR per 1000	34.7	33.7	32.6	31.6	30.7	29.9	28.0	28.1
CDR per 1000	9.8	9.4	9.1	8.7	8.4	8.0	7.7	7.4
RNI percent	2.5	2.4	2.4	2.3	2.2	2.2	2.1	2.1
Characteristic	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Fertility								
Input TFR	3.2	3.1	2.9	2.7	2.6	2.4	2.3	2.1
GRR	1.6	1.5	1.4	1.3	1.3	1.2	1.1	1.0
NRR	1.4	1.4	1.3	1.3	1.2	1.1	1.0	1.0
Mortality								
Female LE	68.9	69.6	70.3	71.1	71.8	72.5	73.3	74.0
Male LE	64.9	65.6	66.3	67.1	67.8	68.5	69.3	70.0
Total LE	66.9	67.6	68.3	69.1	69.8	70.5	71.3	72.0
IMR	48.9	46.4	44.0	41.7	39.4	37.1	34.7	32.4
U5MR	64.3	60.7	57.2	53.8	50.5	47.2	43.8	40.5
Vital Rates								
CBR per 1000	27.2	26.2	25.1	24.0	22.8	21.5	20.1	18.7
CDR per 1000	7.0	6.8	6.5	6.2	6.0	5.7	5.5	5.3
RNI percent	2.0	1.9	1.9	1.8	1.7	1.6	1.5	1.4

Source: Department of Statistics, MPI, Lao PDR (2008).

Table 8. The Labour Force in 2005.

Distribution of the Population by Main Activity:



Source: Department of Statistics, MPI, Lao PDR (2007).

Table 9. Number of Employed in the 2005 Census

Code	Categories	Employed	Females (%)	Males (%)
01	Government Employee	138 388	31	69
02	Parastatal Employee	11 446	33	67
03	Private Employee	121 786	40	60
04	State Enterprise Employee	19 486	27	73
05	Employer	7 210	31	69
06	Own Account Worker	1 149 906	32	68
07	Unpaid family Worker	1 260 671	71	29
	Total	**2 738 893**	**50**	**50**

Source: Department of Statistics, MPI, Lao PDR (2007).

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CHAPTER 13

Social Protection in China: Current Status and Challenges

ZHANG JUWEI*
Institute of Population and Labor Economics
Chinese Academy of Social Sciences
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This paper reviews the current state and challenges of social protection in China. After describing the administrative framework and institutional design of the social protection system in China, the paper mainly analyses the challenges facing social insurance schemes in terms of coverage, pooling and fiscal sustainability. As China is working hard to provide basic social protection for all at present, and many institutional reform measures are being implemented or will be implemented, this paper also summarizes up-to-date practices of the major reforms in improving and perfecting social insurance schemes in China. The paper concludes with some policy suggestions on how to realize the fundamental goal of providing basic protection for all in China.

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1. Introduction

China registered an annual average economic growth rate of 9.8% over the past 30 years, creating a miracle of economic takeoff. Despite the setback of the financial crisis worldwide since 2008, China's economy still experienced rapid growth momentum, with the GDP growth rate in 2009 reaching 8.7% and per capita GDP topping the 3,000 U.S. dollars mark for the first time (NBS, 2010). Currently, China is in a crucial period of economic and social development, and the establishment of a social security system covering urban and rural areas is an important task for this period. However, the special national situation determines that the difficulties and challenges of this task in China are far greater than those in any other country in the world.

China's unique situation is deeply rooted in two unique socio-economic systems: the household register system (the Hukou system) and the land system. These two systems have not only founded the basic economic and social order in China but also created a dual segmentation of China's economic and social systems. Starting from the *Regulations on Hukou Registration of the People's Republic of China* promulgated in 1958, the household register system is a legacy of the planned economy, which was designed mainly to restrict migration from rural to urban areas but later it evolved into a tool of separating the two areas. As various social policies and welfare systems became continuously attached to the household register system, people with urban Hukou and those with rural Hukou received different forms of social protection. China established a social security system for people with urban Hukou, while the rural population had the land, which is thus endowed with the function of guaranteeing their basic livelihood. The rural land system stipulated that land was collectively owned by the rural population but the peasants had rights of land use. This shows that under the planned economy system because of Hukou restrictions on population in urban and rural areas, they could not migrate, and therefore, they received different forms of social protection.

However, market-oriented reforms broke the economic and social order formed under the planned economic system. In urban areas, labor market reform destroyed scores of formal employments; substantial numbers of urban workers, who previously

had better protection under the planned economic system, lost their jobs, and, therefore, urban employment manifested a serious trend of informalization. Before the mid-1990s, there was a high proportion of formal employment in urban areas, and unit employment (approximate to formal employment) had been accounting for about 80% of urban employment. With the accelerating pace of labor market reform, this situation changed rapidly; the proportion of unit employment dropped sharply, and the absolute numbers also showed a decreasing trend. For example, total urban employment was 190.4 million in 1995, of which unit employment was 149.08 million, 78.3% of urban employment. Unit employment reduced to 117.13 million in 2006, only 41.4% of the total. On the other hand the amount and proportion of non-unit employment increased greatly; the number soared from 41.32 million in 1995 to 165.97 million in 2006, while its proportion leapt from around 20% to 58.5%. Non-unit employment increased by 124.65 million during the period from 1995 to 2006, while over the same period total urban employment increased by only 92.7 million; the increment in urban employment was less than that of non-unit employment, which means that not only all of the new jobs created came from urban non-unit employment, but also approximately 30 million people moved from unit employment into non-unit employment (Zhang Juwei, 2009). The informalization of urban employment means that more and more people lack basic social protection.

In rural areas, with the deepening of market-oriented reforms, the binding force of the household register system on population mobility has weakened, resulting in a lot of rural population shifting into urban areas. Without urban Hukou, the floating population cannot join the urban social security system, and thus became an important component of urban informal employment. It is generally estimated that rural population shifting into the urban areas were about 30 million in the mid-1980s, 50 million around the mid-1990s, and 140.41 million in 2008, which means that roughly 1/3 of the rural labor force are working in the urban areas at present (Cai Fang, 2009). On the whole, China's current social security system covers only those urban workers in formal employment, while most of workers, including the rural population, are still lacking basic social protection.

Theoretically, there are two approaches to providing basic social protection for all in China. One choice is to build a uniform social security system to cover all,

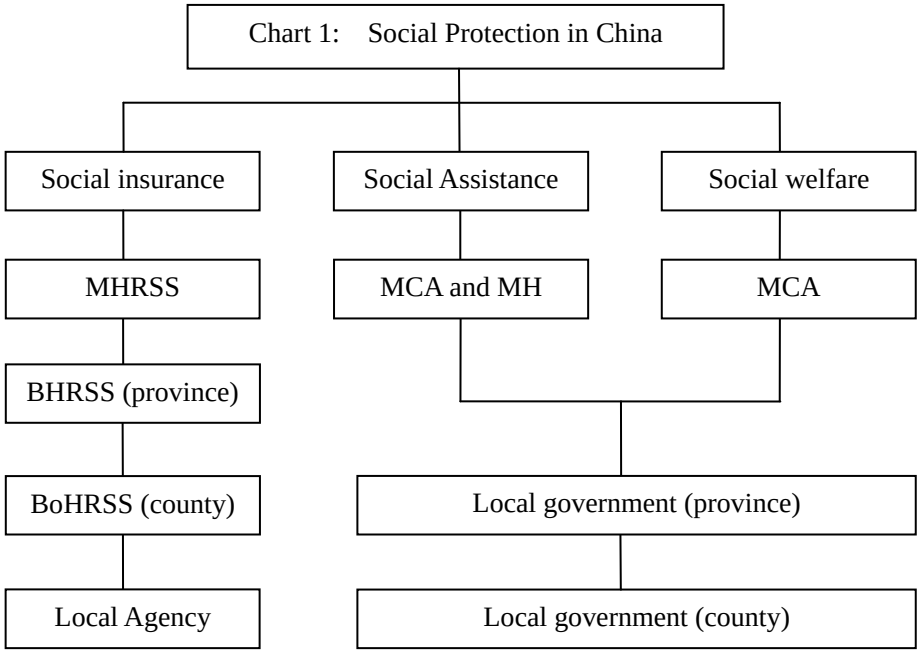
regardless of the rural and urban divide. That is, both rural and urban residents would be covered by the same system of rules. However, under the circumstance that Hukou and land systems still exist and continue to play their roles, the dual economic and social order will not disappear in the short term, so it can only be a "vision" to build such a system, which cannot be turned into reality. The remaining alternative is to set up different social protection systems for urban and rural areas respectively, which is mainly determined by China's basic national situation (Zhang Juwei & Zhang Shibin, 2010).

2. Current Status of China's Social Protection

The social protection model formed in China under the planned economy has been broken, and the social protection system adapted to the market economic system is currently under establishment and improvement. So far, the institutional framework of China's social protection has basically taken shape, and mainly includes three basic systems, namely, a social insurance system, a social assistance system, and a social welfare system. As mentioned earlier, because of China's large population size, coupled with the huge gap between urban and rural areas, none of the three basic systems is able to cover all people by applying identical rules, but the reality of division between urban and rural areas must continue to be recognized, and thus different treatment must be provided to urban and rural residents. The result is that, unlike most other countries, China cannot establish a social protection system identically applied to urban and rural areas, but must establish one that separately applies to urban and rural areas. Individually, the above-mentioned three basic systems can all be divided into two parts: a rural part and an urban part.

From the viewpoint of public administration, the three basic systems are organized and implemented by different government ministries. The Ministry of Human Resources and Social Security (MoHRSS) is mainly responsible for the social insurance system, including a total of seven insurance schemes: basic pension insurance for urban workers, basic medical insurance for urban workers, medical insurance for urban

residents, new rural pension insurance for peasants, unemployment insurance for urban workers, injury insurance for urban workers and maternity insurance for urban workers. The Ministry of Health (MoH) is mainly responsible for the new rural medical insurance scheme. The Ministry of Civil Affairs (MoCA) is mainly responsible for social assistance and social welfare schemes, including a minimum livelihood guarantee scheme for urban residents, a minimum livelihood guarantee scheme for rural residents, etc. The administrative framework of social protection systems in China is illustrated in Chart 1.



Note: MoHRSS: Ministry of Human Resources and Social Security; BoHRSS: Bureau of Human Resources and Social Security; MoCA: Ministry of Civil Affairs; MoH: Ministry of Health.

2.1. Social Insurance System

The social insurance system includes a total of 8 components, mainly: pension insurance (Old Age insurance), medical insurance, unemployment insurance for urban workers, injury insurance for urban workers, maternity insurance for urban workers, etc. (See Chart 2).

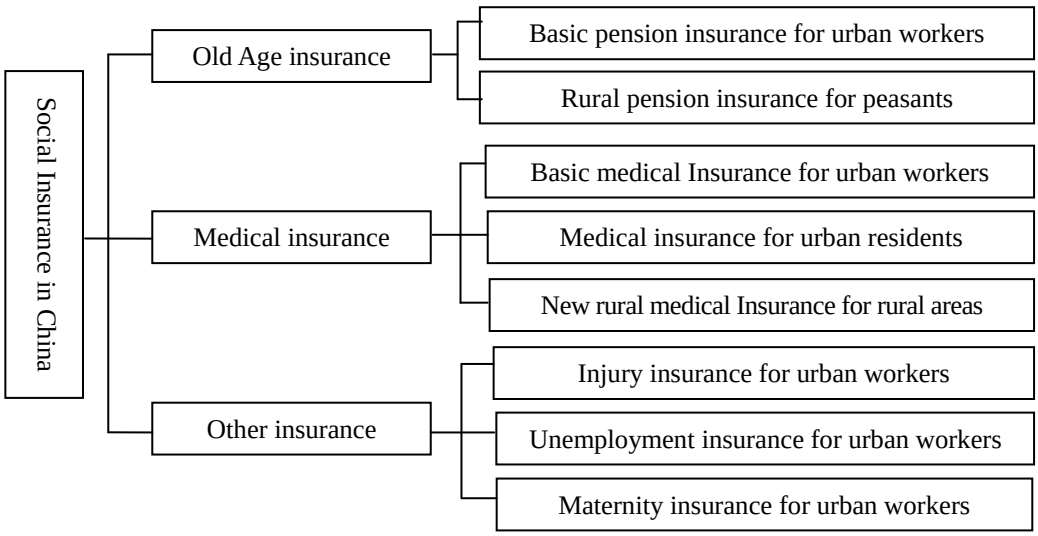


Chart 2: Social Insurance System in China

2.1.1. Pension Insurances

China's pension insurance system is divided into an urban pension insurance scheme and a rural pension insurance scheme, and the urban pension insurance scheme includes two types: one is the basic pension insurance scheme for urban workers and the other is an enterprise annuity scheme.

The basic pension insurance for urban workers is compulsory, i.e., all urban workers must participate in this scheme. Its basic model is a combination of social pooling with individual accounts, and the total contribution rate is 28% of payroll, of which 20% is contributed by the employer and goes into the social pooling account, and 8% is contributed by the employee and goes into the individual's account. Pension benefits are also have two parts, the basic pension allowance and the individual account pension allowance. The former comes from the social pooling account and the latter comes from the individual's account. Workers with accumulated pension contributions of more than 15 years are eligible for basic pension benefits on a monthly basis after retirement and workers with accumulated pension payments of less than 15 years can have a lump-sum payment of their individual accounts (State Council, 1997). A total of 218.91 million people participated in the basic pension insurance scheme for urban workers in 2008, of whom about 53.04 million were receivers of pension, who received

an average pension benefit about 1,100 Yuan per month, representing a replacement rate of 50% (pension benefit as a percentage of average wage before retirement) (NBS, 2009). The total income of the pension fund in 2008 was 974 billion Yuan, of which 801.6 billion came from contributions and 143.7 billion came from financial subsidies by all levels of government; the total expenditure was 739 billion Yuan and the accumulated year-end balance of the basic pension insurance fund was 993.1 billion Yuan (NBS, 2009).

The term "Enterprise Annuity" refers to a supplementary pension insurance scheme established by enterprises for employees in accordance with their economic strengths and implemented under national policy provisions and conditions, which is subject to national macro-guidance and to the internal decision-making of the enterprises. 33,000 Chinese enterprises had established enterprise annuity schemes by the end of 2008, with the number of participating workers at 10.38 million and the year-end balance of enterprise annuity funds at 191.1 billion Yuan. All the capital was managed by investment management companies and asset custodian companies that met relevant qualifications. Although the enterprise annuity system is developing rapidly, there are some problems. First of all, though the number of enterprises establishing annuity system increased rapidly, i.e. from 24,000 in 2006 to 33,000 in 2008, the increase in the number of people covered by the system did not significantly increase (from 9.64 million to 10.38 million in the corresponding period (NBS, 2009)). Second, the development of the enterprise annuity scheme is highly unbalanced; 90% of the enterprise annuity funds were accumulated from large state-owned enterprises, which are in industries with advanced economic performance, such as coal, electricity, petrochemicals and telecommunications industries, while small- and medium-sized enterprises which account for 99% of the total have accumulated less than 10% of the total enterprise annuity funds. The enterprise annuity system is actually widening income inequality among industries, among enterprises, as well as among different positions within enterprises. In addition, as relevant policies stipulate that in enterprises where an annuity scheme has been set up, 4% of the payroll can be deducted before tax, directly offsetting taxable income, the enterprise annuity system has thus been suspected of being a tool of tax avoidance in some of the enterprises.

In rural areas, people traditionally rely on family and land for security in old-age

and the social insurance system has been absent for a long time. China began to carry out a new pilot project of rural pension insurance for peasants in 10% of the counties (cities, districts) across the country as late as in 2009. The new rural pension insurance for peasants adopts a model that is a combination of social pooling with individual accounts and is designed to cover all rural residents from 16-60 years of age (non school students, peasants who do not participate in the basic pension insurance for urban workers). Its funds are raised by a model combining individual contribution, collective assistance and government subsidies, in which individual contribution can be classified into five levels, namely 100 Yuan / 200 Yuan / 300 Yuan / 400 Yuan / 500 Yuan per year. The value of pensions issued every month is one 139^{th} of the total value in a retiree's account. The government pays the full amount of basic pension allowance for peasants who are eligible for withdrawal and central government grants the full amount of subsidies for central and western regions and 50% of subsidies for the eastern region according to pension standards. The basic pension standard was 55 Yuan per person per month in 2009 (State Council, 2009a). At present, this system is still at the pilot stage.

2.1.2. Medical Insurance

For different types of people, China has established three kinds of medical insurance systems: basic medical insurance for urban workers, basic medical insurance for urban residents and a new rural cooperative medical insurance.

The basic medical insurance for urban workers is designed to cover urban employees. The employer and employee respectively contribute 6% and 2% of the wages and a model of combining pooled funds with individual accounts has been adopted. As for the requirements of payment, it is stipulated that the pooling fund pays medical spending when it is above the bottom line of payment, equivalent to 10% of average annual wage and that below the cap of payment equivalent to 4 times of the average annual wages while individual insurer needs to share a co-payment of 20% the spending. When the medical spending is below the bottom line payment, it will be totally paid by the individual account or by the insurers themselves (State Council, 1998).

The basic medical insurance for urban residents covers: primary and secondary

school students (including vocational high school, intermediary professional school and technical school students), teenagers and children, and other urban residents who are not employed and therefore are not covered by the basic medical insurance system for urban workers. The funds for the basic medical insurance for urban residents is collected from the contributions of insured people and from governmental subsidies, while giving special assistance to vulnerable groups. At present, the standard government subsidy is about 120 Yuan per person per year and it is managed in the same way as the basic medical insurance for urban workers. The basic medical insurance fund for urban residents is principally used for in-hospital and serious illness expenses of the insured people and the current reimbursement rate is around 60% of the total expense; some localities are gradually integrating outpatient medical costs on a pilot basis. The basic medical insurance scheme for urban residents started its national pilot in 2007 and 118.26 million urban residents had participated in the scheme by the end of 2008; university students were included into the scheme in 2009, pushing the number of people covered by the scheme to more than 150 million (MoHRSS and NBS, 2009).

In rural areas, the Chinese government initiated the new rural cooperative medical scheme (shortened as the "new rural cooperative") in 2003. The "new rural cooperative" is characterized by diversified sources of funding; through the main source, which is individual contributions and other sources like collective support and government subsidies, mutual assistance among peasants for "serious illness pooling" is being achieved. The new rural cooperative medical system covers all peasants and uses a funding mechanism combining individual contributions, collective support and governmental subsidies; current individual contribution fee is about 40-80 Yuan per person per year, government subsidy is 120 Yuan (Wen Jiabao, 2010) and the pooling is mainly done at the county (city) and township level. The rural cooperative medical system mainly pays for large medical expenses or in-hospital medical costs of the peasants who participate in the scheme with a current average reimbursement rate of 60% of the total expense. Up to the present, all county-level regions have already started implementing the new rural cooperative medical scheme and have achieved their target of full coverage.

2.1.3. Other Social Insurance Schemes

Unemployment insurance for urban workers is designed to cover urban workers in urban state-owned and collective enterprises, foreign-invested enterprises, urban private enterprises and other urban enterprises; the enterprise and the employee pay respectively 2% and 1% of the wages as unemployment insurance premiums and currently these contributions are mainly pooled at the county level. Unemployment insurance allowance is paid monthly; the standard and period are determined according to the duration of premium contribution. The benefit of unemployment insurance can last for 24 months and the allowance is lower than local minimum wage but higher than the urban minimum livelihood guarantee level (State Council, 1999).

Injury insurance for urban workers covers workers in all types of enterprises and hired workers in small industrial and commercial firms; all the injury insurance contributions are paid by the employer, and different contribution rates, ranging from 0.5% to 2.5% of the payroll, are applied to different industries based on the degree of risk. Payment by injury insurance includes: the cost of treatment of injuries, payroll, living allowance and some medical care costs during the period of treatment; the maximum period of benefit should not exceed 12 months (State Council, 2003).

Maternity insurance for urban workers covers women workers in government departments, public organizations, institutions and enterprises; insurance contributions are paid by the employer, at a rate between 0.5% - 1%, while individual workers do not need to pay and funds are currently pooled at the county level. Payment by the maternity insurance scheme includes: allowances during the period of maternity leave according to the average monthly wage of workers in the company in the previous year, women workers' examination fees, delivery fees, surgery fees, in-hospital fees and drug fees and medical expenses incurred women workers by illness following childbirth.

2.2. Social Assistance

China has accomplished the transformation from a traditional social relief system to a modern social assistance system and has preliminarily established a social assistance system with the following as its main contents: a minimum livelihood guarantee system in urban and rural areas, a five-guarantee scheme (a type of welfare scheme for widowed, disabled and orphans in rural areas, which provides those people with basic

livelihood and expense of their funeral) in rural areas, medical assistance systems in urban and rural areas, educational assistance, housing support, legal assistance and a relief system after natural disasters.

The minimum livelihood guarantee scheme for urban residents covers urban residents with non-agricultural Hukou, whose per capita income is lower than the local urban minimum living standard. Local governments integrate the minimum livelihood guarantee fund into government budgets and the civil affairs departments of local governments above the county level are responsible for this scheme. A total of 23.34 million urban residents were covered by the minimum living guarantee in China in 2008 with an average guarantee level of 205 Yuan, which is equivalent to 15.6% of the average disposable income of urban residents (Wu Hongxin *et al*., 2009).

The minimum livelihood guarantee scheme for rural residents covers all rural households whose per capita annual net income is below the local minimum living standard. Funding for the rural minimum livelihood guarantee scheme comes from local governmental budgets and central government grants appropriate subsidies to poor regions. Nearly 43 million people were covered by the rural "minimum livelihood guarantee" as of the end of 2008 with an average level of 82 Yuan per capita per month, which is equivalent to 20.7% of peasants' per capita net income (Wu Hongxin, *et al*., 2009).

Medical assistance covers families in rural areas suffering from serious illness affecting their basic livelihood, whose individual medical expenses are still unaffordable, even after accepting cooperative medical insurance. Medical assistance funding comes from government budgets and is managed by the local civil affairs departments. Medical assistance in rural areas was made available as many as 936 million times in 2008 (NBS, 2009). Urban medical assistance covers urban family members suffering from serious illnesses which affect their basic livelihood, and the assistance method combines direct relief aid payments with waiver of some medical costs.

2.3. Social Welfare

China has strengthened its legislation on social welfare and has successively passed the *"Law on Protection of Disabled Persons"*, *"Law on the Protection of Women's Rights"*, *"Law on Protection of the Rights and Interests of the Aged"* as well as the

"Welfare Donations Law" since 1990. By the end of 2008, there were about 2.35 million beds in various welfare institutions available for accommodation of helpless people and there are about 1.89 million of such people were actually accommodated; in cities and towns, some 109,000 community service facilities and 9,871 community centers have been established; annual sales of social welfare lottery tickets were 60.4 billion Yuan, raising public welfare funds of 21.1 billion; social donations of 48.2 billion Yuan were directly received. In 2008, the people covered by the five-guarantee scheme enjoyed governmental subsidy of 2,176 Yuan for those who were centrally supported and 1,624 Yuan for those who were supported individually (NBS, 2009).

3. Challenges Facing China's Social Protection

China continues to accelerate the construction of its social protection system for all and a number of schemes have been introduced in recent years. However, in general the coverage of social insurances is still low and the challenges are severe.

3.1. China's Population is Aging Rapidly but Most People are still not Covered by Any Pension Insurance

The huge population is China's basic national reality. With a total population of 1.33 billion and an urbanization rate of around 46%, more than half of the population was still living in rural areas in 2008. At present, 110 million people are above 65 years of age, accounting for 8.3% of the total population and this proportion will soar to 26.2% in 2050; such a pace of aging is rare in the world (Table 3.1). What's more, the shifting of rural working-age population to urban areas has greatly changed the distribution in age structure of urban and rural populations, so that the degree of aging in rural areas is much more obvious than in urban areas, and therefore, the rural areas face a more severe aging situation than urban areas.

Table 3.1. Population Projection in China: 2010-2050

Year	Total population (10 thousand)	Working age population 16-64 years (10 thousand)	The aged population 65 or above (10 thousand)	Degree of aging (%)	Support ratio
2010	133555	96961	11460	8.58	8.46
2020	139206	98708	17146	12.32	5.76
2025	140272	97757	19968	14.24	4.90
2030	139769	95335	23874	17.08	3.99
2035	138366	90730	28989	20.95	3.13
2040	136426	86048	32788	24.03	2.62
2045	133575	82573	33708	25.24	2.45
2050	129320	78668	33871	26.19	2.32

Source: Institute of Population and Labor Economics, Chinese Academy of Social Sciences.

The aging of China's population will lead to a decrease in the social support ratio, creating a labor burden as well as a cost. China's supporting ratio (the number of working age population divided by the number of the aged at 65 or above) was 9.81 in 2000 and will drop to 2.32 in 2050 but in sharp contrast to this, the pension insurance coverage is quite low (Table 3.2) and the vast majority of people still have not been covered by any form of pension insurance system.

In urban areas, since the mid-1990s, the Chinese government has continued to accelerate the construction of basic pension insurance for urban workers, vigorously expanded its coverage and the number of people covered has increased from 110 million in 1995 to 220 million in 2008. However, due to the growth of the urban working-age population in the same period, the rise in the coverage ratio of basic pension insurance for urban workers is not obvious. Though the proportion of people covered by that insurance compared to the urban working population has surged from about 46% in 1995 to 55% in 2008, yet from the perspective of the proportion of people covered by that insurance among the urban working-age population it has only increased from 40.6% in 1995 to 43% in 2008.

Table 3.2. Coverage of Basic Pension Insurance for Urban Areas

Year	Urban population above 16 years	Number of Employed workers	Total number of insured persons	Number of insured working persons	Coverage ratio for the employed persons	Coverage ratio for the working population above 16
1995	27062	19093	10979	8738	45.8	40.6
2000	38561	23151	13617	10447	45.1	35.3
2001	38453	23940	14183	10802	45.1	36.9
2002	40426	24780	14737	11129	44.9	36.5
2003	42707	25639	15507	11647	45.4	36.3
2004	44125	26476	16353	12250	46.3	37.1
2005	45939	27331	17488	13120	48.0	38.1
2006	48109	28310	18766	14131	49.9	39.0
2007	49504	29350	20137	15183	51.7	40.7
2008	50922	30210	21891	16588	54.9	43.0

Source: Based on relevant statistical data in *China Statistical Yearbook* in various years.
*Note :*Unit in ten thousand persons and percent

In rural areas, most people still have not been covered by any social pension insurance scheme (Table 3.3). China began to introduce a social pension insurance plan in the rural areas in the mid-1980s but because the government did not share necessary responsibility in the early period, coverage had stalled at around 10% for a long time, and, especially, the insured number declined after 1999. China began to establish a new social insurance scheme in 10% of the rural areas that were selected as pilot areas in 2009 hoping that the system will cover more of the rural population in the near future.

Table 3.3. Coverage of Rural Pension Insurance and Total Coverage for Rural and Urban as a whole.

Year	Urban population above 16 years	Total number of insured population	Coverage ratio for rural working age population	Total coverage ratio for rural and urban as a whole
1995	60210	5143	8.5	18.5
2000	57141	6172	10.8	20.7
2001	58173	5995	10.3	20.9
2002	58033	5462	9.4	20.5
2003	57182	5428	9.5	21
2004	57292	5382	9.4	21.4
2005	56595	5442	9.6	22.4
2006	53834	5374	10	23.7
2007	53966	5172	9.6	24.5
2008	53774	5595	10.4	26.3

Source : Institute of Population and Labor Economics, Chinese Academy of Social Sciences.
Note : Unit in ten thousand persons and percent

To sum up, it can be seen that, compared with the situation of rapid aging, China's pension insurance system lags far behind. If the populations covered by urban and rural social pension insurance are added together, the coverage ratio would just surpass 1/4, which means that about 3/4 of the population above the age of 16 are not covered by any pension scheme. This is currently one of the most serious social challenges for China; how to expand pension insurance coverage so that more people are covered by the pension insurance system.

3.2. The Level of Pooling is Low and the Different Benefits in Different Pools are Creating more Inequality

China's social insurance system is not only divided between urban and rural areas but also has too low a level of pooling, with the result that the system is often divided into thousands of pooling units. Social insurance policies are often determined by different departments according to different objectives to meet different needs at different times, while most are implemented separately, and the linkage of various policies is less considered. Different regions have different levels of social insurance contribution and there are a variety of levels of income and expenditure even within the same province, resulting in different forms of social security for the population with

different Hukou statuses and with a varied nature of jobs.

Of course, the low-level social insurance pooling is rooted in the imbalance of China's inter-regional economic and social development, which also is still further expanding (Table 3.4). From the perspective of income level, the national per capita income ratio between urban and rural areas jumped from 2.57:1 in 1978 up to 3.35:1 in 2008; in terms of per capita GDP, that of Shanghai was 8.2 times that of Guizhou, while Guangdong and Jiangsu provinces are 4.2 times that of Guizhou in 2008.

Table 3.4. Economic and Social Development of Urban and Rural Areas in Different Regions in 2008

Region	Per capita GDP (Yuan)	Per capita income of urban areas (Yuan)	Per capita income of rural areas (Yuan)
Beijing	63029	24725	10747
Shanghai	72553	26675	11385
Jiangsu	39083	18680	7357
Guangdong	37588	19733	6400
Guizhou	8824	11759	2797
Gansu	12110	10969	2725
Qinghai	17365	11648	3061
Ningxia	17892	12932	3681
Ratio of the highest over the lowest	8.2	2.4	4.2

Source: Statistical Communiqués issued by The Central Government and different regions in 2008.

The tremendous differences in economic and social development between urban and rural areas and among regions forced China to implement its social insurance plans at lower pooling levels (Table 3.5). Prior to the 1990s, China's urban pension insurance basically relied on enterprise pooling and even until now has not yet fully achieved provincial pooling. County-level pooling has been implemented in rural pension insurance, which means that China has more than 2,000 pooling units and the inter-regional contribution level and wage level are difficult to unify, leading to the "fragmentation" of the social insurance system. After years of development, each pooling level has formed its own unique interests and become an obstacle to pooling level elevation.

Table 3.5. Pooling Levels of Pension and Medical Insurance in China's Urban and Rural Areas in Different Periods

Period	Urban pension insurance	Rural pension insurance	Urban medical insurance	Rural medical insurance
From 1949 to the end of 1980s	Pooling at enterprise level	Village	Pooling at enterprise level	Village
From early 1990s to early this century	Pooling at city, county and industry level	County, city	Pooling at city, county and industry level	Township
Currently	Pooling at provincial level in most provinces	County, city	Pooling at city level	Township

Source: Compiled based on relevant governmental documents materials.

Pooling at a lower level will inevitably lead to greater differences in social insurance benefits among different groups. Take the pension insurance system as an example; the benefit of rural pension insurance for peasants is less than one-tenth of the basic pension insurance for urban workers, and is only equivalent to the minimum livelihood guarantee level in rural areas (Table 3.6).

Table 3.6. Average Monthly Pension Benefits by Urban and Rural Pensioners

Year	Average monthly pension of rural pensioners	Average monthly pension of urban pensioners	Ratio of rural pension to urban pension for workers	Ratio of rural per capita income to urban per capita income
2000	34	559	0.06	0.36
2001	39	576	0.07	0.34
2002	35	648	0.05	0.32
2003	61	674	0.09	0.31
2004	38	705	0.05	0.31
2005	56	758	0.07	0.31
2006	68	873	0.08	0.31
2007	82	1002	0.08	0.30
2008	90	1100	0.08	0.30

Source: The pensions under urban pooling are drawn from the *China Labor and Social Security Yearbook*; the rural pensions are calculated according to data from the *China Labor and Social Security Yearbook*; the urban and rural per capita income and their ratios are calculated according to data from the *China Statistical Yearbook*.

Note: Unit in Yuan / person, month

In urban areas, the average pensions for retirees from business enterprises are significantly lower than those of administrative departments and public institutions, at

only around 60% of the administrative departments' level (Steven Dunaway and Vivek Arora, 2007). In contrast, the ratio of enterprise workers' wages to those of administrative department workers' is about 0.9:1 or approximately equal. Therefore, the existing basic pension insurance scheme for urban workers has expanded the lifetime labor income inequality between enterprises and government organizations, and the pension insurance scheme has become a source of inequality (Table 3.7).

Table 3.7. Average Monthly Retirement Payments in Different Pools

Year	Enterprises	Administrative departments	Public institutions	Ratio of pension between enterprises and administrative departments	Ratio of average payroll between enterprises and administrative departments
2000	544	947	871	0.57	0.92
2001	556	940	894	0.59	0.86
2002	618	1077	1031	0.57	0.85
2003	640	1124	1091	0.57	0.86
2004	667	1223	1154	0.55	0.87
2005	719	1257	1208	0.57	0.86
2006	835	1364	1290	0.61	0.88
2007	947	1717	1576	0.55	0.84

Source : *China Statistical Yearbook* in various years.
Unit : in Yuan/ person, month

3.3. The 'Holes' in the Social Insurance System exclude Migrant Workers from the Protection of Social Insurance System

In theory, the on-going system of social insurance is still able to achieve universal coverage even with a separation of the system between rural and urban areas. However, the reality is that China's rapid urbanization and industrialization have led to a large number of people migrating in a constant flow from rural to urban areas. These people are difficult to incorporate into a suitable social insurance scheme. Without urban Hukou, the migrants can hardly participate in the urban social security scheme and even despite their accession to it, they will not only face the problem of dealing with the issue of rural land income but also the risk that on returning to the rural areas, they will be unable to receive off-site social security benefits. Meanwhile, though these migrants

have rural Hukou and land, in fact, they have become "urban people" and many are not likely to return to rural life in the future, so joining a rural social insurance system is not particularly meaningful to them.

This is exactly the reality. The size of China's rural migrant labor force reached 140.41 million in 2008 but the proportion of their participation in urban social insurance schemes is quite low (Table 3.8). The main focuses of such participation as they achieve are medical insurance and injury insurance for urban workers. In the same year, about 30.3% of rural migrant workers joined schemes for medical insurance for urban workers and approximately 35.4% of rural migrant workers joined schemes for injury insurance for urban workers but the proportion of participation in basic pension insurance schemes for urban workers was only 17.2%, less than half of injury insurance coverage ratio (MoHRSS and NBS, 2007, 2008). Owing to factors such as the difficulty of inter-regional transfer of pension insurance and the need for 15-years' accumulated contributions before receipt of post-retirement pension, the rate of insurance surrender of by rural migrant workers is very high; for instance, persons without Shenzhen Hukou have had access to pension insurance since 1987 but only about 100 people can truly enjoy the pension 15 years later. As a result, the pension insurance surrender rate of rural migrant workers reached 40% in eastern coastal areas and rural migrant workers always wait to surrender insurance in droves every New Year's eve before returning home (Zhang Meng, 2009).

Table 3.8. Participation by Rural Migrant Workers in Social Insurance

Year	Number of rural migrant workers	Pension insurance		Medical insurance		Injury insurance for urban workers	
		Number of participants	Coverage ratio	Number of participants	Coverage ratio	Number of participants	Coverage ratio
2006	11891	1417	11.9	2367	19.9	2537	21.3
2007	12609	1846	14.6	3131	24.8	3966	31.5
2008	14041	2416	17.2	4249	30.3	4976	35.4

Source: Calculated based on *Statistical Communiqué on China's Human Resources and Social Security Cause*.

3.4. The Nominal Social Insurance Contribution Rates are Too High and Contribution Evasion is a Serious Problem

Social insurance evasion is a common problem faced by developing countries. China is no exception. In China, if various social insurance contributions were all paid, the total contribution would amount to 39-42.5% of the payroll. Under the circumstance of high contribution, some employers, especially private companies, work out every possible way to evade contribution, leading to a rather high contribution evasion rate for social insurance; this proportion generally exceeded 60% before 2001. In recent years, due to gradual improvement of the contribution collection system, contribution evasion has significantly decreased, but even so, evasion still amounted to 27% in 2008 (see table 3.9).

Table 3.9. Contributions and Evasion of China's Social Insurance

Year	Nominal Social Insurance revenue	Real Contribution revenue	Total Evasion	Evasion rate
2001	4734	2696	2038	43.1
2002	5373	3581	1791	33.3
2003	6131	4332	1799	29.3
2004	7136	5142	1995	28.0
2005	8479	6306	2173	25.6
2006	10116	7661	2455	24.3
2007	12396	9619	2776	22.4
2008	15531	12209	3322	21.4

Source: Calculated based on *China Statistical Yearbook* in various years.

The high contribution rate is an important reason why rural migrant workers are unable to participate in the urban social insurance system. The social insurance contribution level for urban workers is calculated based on average wages, and the floor limit of the payment is 60% of the average wage and the cap is 300% of the average wage (Zhang Hongtao and Kong Jingyuan, 2008). The high contribution rates and low wages of rural migrant workers resulted in the consequence that their actual social insurance contribution rate is higher than their nominal rate (Table 3.10). In theory, if rural migrant workers all join all the urban social insurance schemes, the total contribution rate would be around 41% of their wages. However, as the average wages of rural migrant workers are generally less than 60% of the social average wage, the

actual social insurance contribution rate of rural migrant workers is obviously higher than the nominal contribution rate; for example, in 2007 the contribution of rural migrant workers involved in social insurance for urban workers was equivalent to 50% of their total average wage, far higher than the nominal contribution rate of 41%.

Table 3.10. Actual Contribution Rates by Rural Migrant Workers to Social Insurance for Urban Workers under the Current System

Year	Social average payroll	Average payroll of rural migrant workers	Proportion of rural migrant workers' payroll in social average payroll	Contribution standard of social insurance	Ratio between social insurance contribution and payroll of rural migrant workers
2003	14040	8424	60	3454	41
2004	16024	9360	58	3942	42
2005	18364	10332	56	4518	44
2006	21001	11352	54	5166	46
2007	24932	12180	49	6133	50
2008	29229	16800	57	7190	43

Note: China's current social average payroll is calculated according to the average payroll of workers in cities and towns and does not include rural migrant workers and the self-employed. It is assumed that the total social insurance contribution rate is 41% and employers pay 30% of the total employees' payroll as social insurance contributions.

4. Current Major Reforms

In order to expand the coverage of the social insurance system, China has speeded up the construction and reform of the social insurance system. The *Social Insurance Law (Draft)*, which is currently under third examination by the National People's Congress, has embodied the direction and practices of social insurance reforms and is expected to resolve many of the current problems after its passage. In summary, current reforms of social insurance system are mainly concentrated on the following aspects: first, improvement of the social insurance system and expansion of its coverage; secondly, elevation of the level of pooling and achievement of inter-regional pension insurance transfer; thirdly, standardization in the income, expenditure and management of social insurance funds.

4.1. Increasing Coverage of Social Insurance is a High Priority

In order to expand the coverage of social insurance schemes, the current main approach is to constantly strive to establish and improve the system. Expansion of the coverage of social insurance schemes has been made a key indicator of economic and social development in China's "Eleventh Five-Year Plan" to, and it has been set as a target that during the Eleventh Five-Year period, more than 10 million people per year should be added to the basic pension insurance scheme for urban workers and that the total should exceed 220 million at the end of the planning period. The *Guidance Opinions on Launching Pilot Work of New Rural Pension Insurance by the State Council* in 2009 clarified that, all peasants above 16 years of age (excluding school students) who do not join the basic pension insurance scheme for urban workers will be included into the rural pension insurance scheme for peasants, and proposed that before 2020 the system must achieve full coverage; to realize this goal, the central government will provide a basic pension of 55 Yuan per capita per month (State Council, 2009a).

Views on Solving the Issue of Rural Migrant Workers by the State Council in 2005 required that priority should be given to solving the problems of rural migrant workers' injury insurance and serious illness insurance and that pension insurance issues also should be gradually solved. The *Labor Contract Law* promulgated in 2007 stipulates that employers should establish labor relations with workers from the date of employment and must sign labor contracts with the workers, in which social insurance and labor protection should be included (NPC, 2007). *Social Insurance Law (Draft)* provides in legal form that urban workers should join the basic pension insurance scheme and that employers and employees should jointly pay contributions; small industrial and commercial businesses without employees and part-time employees are also eligible to join the basic pension insurance scheme, paying their own contributions (NPC, 2008).

The new rural cooperative medical insurance scheme began to be established by all levels of government in 2003 and it covered 833 million peasants in 2009, with a coverage rate of 94%; the medical insurance system for urban residents began to be established in 2007 and university students were integrated into the system in 2008; more than 150 million urban residents had joined the medical insurance system for urban residents by 2009. *Reform Plan for Deepening Medical and Health System* in

2009 clearly indicates that by 2011, a comprehensive coverage of the basic medical insurance system for urban and rural residents should be realized and that participation rates in basic medical insurance schemes for urban workers and the new rural cooperative medical insurance for rural residents should exceed 90% (State Council, 2007, 2009a; 2009b; 2009c).

4.2. Increasing Pooling Levels and Making Social Insurance Portable when Workers Move from One Place to Another

For a long time, China's various social insurances have been pooled at the county or city level, with the result that one insurance system is often split in thousands of pooling units, which has seriously hampered the development of the various social insurance schemes. The central government has always been committed to elevating the level of pooling but the lack of effective legal means has made such efforts ineffective. The *Social Insurance Law (Draft)* clearly lays down that the basic pension insurance scheme should be pooled at the provincial level and can be pooled at the country level when conditions are ripe; the time and steps for the pooling of other social insurance funds at the provincial level should be provided by the State Council. These articles of the *Social Insurance Law (Draft)* will undoubtedly provide a strong legal basis for elevating the pooling levels of social insurance, and when the law is passed, it will greatly promote the development of the various social insurance schemes.

To elevate the pooling level will be very helpful in the resolution of inter-regional pension insurance transfer issues. The *Social Insurance Law (Draft)* provides that when an employee pursues inter-regional employment, the basic pension insurance should be transferred with the employee, and on retirement, the basic pension should be calculated in accordance with the standards and period and places where contributions are paid and can be paid at the place of retirement. To this end, the State Council promulgated the *Interim Measures on the Transfer and Continuation of Basic Pension Insurance for Urban Enterprise Workers* at the end of 2009, which stipulates that from 2010 onwards, the insured employees, when transferring the basic pension insurance on an inter-provincial basis, they can transfer 12% of the money from the pooling account coupled with the total amount of the money from the individual account (State Council, 2009d). Meanwhile, the State Council also promulgated the *Interim Measures* on *the*

Transfer and *Continuation of Basic Medical Insurance of Rural migrant workers* at the end of 2009 (State Council, 2009e).

4.3. Better Management of Social Insurance Funds

It is known that the income, expenditure and management of social insurance funds in China are not up standard and often lead to scandals involving embezzlement of funds. To correct this, the *Social Insurance Law (Draft)* clearly defined the income, expenditure and management of social insurance funds. With regard to insurance contributions, the government has established a unified national individual social security number by using the identification number of every citizen. Employers must, within thirty days from the commencement of employment, apply for social insurance registration for employees to the social insurance institutions and pay social insurance contributions on behalf of the employees; small industrial and commercial firms or businesses without employees, and part-time workers, can apply directly to the social insurance institutions. In terms of administration and operations, the social insurance funds are administered in different accounts and managed by split accounting in accordance with the respective social security insurance; they should not overlap with or be transferred to each other and funds are earmarked; the funds can preserve value through investment and operations aimed at security, in accordance with the relevant provisions of the State Council. Governments above the county level must establish social insurance fund budgets according to the pooling level, achieve balance for social insurance funds and provide assistance when the social insurance funds develop deficits.

5. Suggestions

To some extent, the current reform measures will solve the problems of the social insurance systems' troubled development but cannot be an elixir for all problems. To the underlying problems of further expanding the coverage of social insurance, and in particular, settling the migrant population's participation in social insurance still require long-term hard work. In the long run, it is necessary to consider and cope with the following two issues for further reform of social insurance system.

5.1. Establishing a Social Insurance System with National Pooling

Important issues of social insurance are related to the low level of pooling; the implementation of provincial-level pooling will substantially mitigate the extent of the issues but will not fundamentally solve them. As inter-provincial transfer of social insurance is actually an adjustment of, and competition for, rights and responsibilities in respect of social insurance among the provinces, involving the distribution of benefits, it has an impact on the interests of both receiving regions and sending regions, and the problems cannot be solved under the current design of the system. Therefore, in the long run, establishing a social insurance system with national pooling is the fundamental way to solve the problem, which means that the central government will assume greater responsibility and give more financial input in the provision of social insurance services. At present, local governments are primarily responsible for China's social security system, while the central government has less responsibility and the social security expenditures of central government have been below 10 per cent of total social security expenditures, with a declining trend. The main reason lies in the fact that each social insurance scheme is based on local pooling. With the gradually enhanced fiscal strength of central government, it is possible for the central government to take on more responsibility and to implement a basic social insurance system with national pooling.

5.2. Accelerate the Reform of Houkou System and Explore an Effective way to Include Migrant Workers in the Social Insurance Schemes

Bringing migrants into the social insurance system has always been a crucial issue in expanding the coverage of social insurance. However, so far, there is still no effective approach to solving this problem. It is true that inter-regional transfers of pension insurance for urban workers and medical insurance for urban workers, introduced in 2009 would, to a certain extent, enable a "floating" population in cities and towns to actively participate in basic social insurance but this cannot fundamentally unravel the problem of migrants' insurance participation. Because of low income, unstable employment and short careers, migrant workers will face many difficulties and risks when joining the urban basic social insurance scheme. First, the over-high contribution rate of the urban basic social insurance scheme is unbearable for rural

migrant workers with low income levels. Secondly, in accordance with the current transfer approach, rural migrant workers can only draw the funds from their individual account and part of their pooling account, so social insurance rights have not been fully protected, and furthermore, they face a big risk in the loss of pension benefits if conditions cannot be met at the time of retirement. In the long run, in order to expand social insurance coverage, we must accelerate the reform of the household register system and eliminate the different treatment for people with different Houkou status. Specifically, rural migrant workers should be brought under management in cities and towns; just as the population with urban Hukou, they should enjoy the same public services and resources; some of the agricultural migrant population who meet relevant conditions should be allowed to pursue employment and settlement in urban areas; Hukou restrictions in medium- and small-sized cities and towns should be relaxed so that rural migrant workers can enjoy stable employment and life in cities and towns.

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CHAPTER 14

India's Social Security System: an Assessment

MUKUL G ASHER
Professor of Public Policy
Lee Kuan Yew School of Public Policy
National University of Singapore

and

AZAD SINGH BALI
PhD Student
Lee Kuan Yew School of Public Policy
National University of Singapore

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1. Introduction

India is a federal country comprising 28 States and seven Union Territories. It gained independence in 1947. After following relatively inward-looking economic policies for several decades since gaining independence, India adopted an open-economy- open-society strategy of economic growth in 1991, with the aim of integrating with the world economy in a market-consistent manner (Kelkar, 2004).

As India addresses the challenges of the twenty-first century and manages its rise globally, constructing and implementing a modern social security system represents one of its major imperatives. A modern social security system can enable India to cushion the burden on workers of restructuring public and private organizations; to increase the legitimacy of further reforms; and to encourage individuals and firms to engage in entrepreneurship and make creative career choices. All three are essential for India to emerge as a resilient knowledge-driven economy and society.

This paper analyzes India's social security system, with primary focus on pensions or retirement income arrangements. It also discusses reform themes which the policymakers and provident and pension fund organizations may consider in improving the sustainability, coverage and resilience to economic and other shocks of the current system. The paper is organized as follows. In section II, a broad overview of macroeconomic, demographic and labor market trends is provided. This is followed by a discussion of India's current social security system and its various components in section III. As social security related services must be provided by organizations, this section also provides suggestions for improving their effectiveness. Section IV provides a brief overview of India's healthcare financing system. The final section suggests five broad reform themes designed to transform the current system into a system more appropriate for meeting India's social security challenges in the 21st century.

2. Macroeconomic, Demographic and Labor Market Trends

Since initiating the open-economy, open-society paradigm in 1991-1992, India has exhibited fairly satisfactory macroeconomic performance (Table 1). India's real GDP growth rate has accelerated, while inflation has been moderate. The per capita GDP increased 3.2 times between 1991-92 and 2008-09. The savings and investment rates, which stood respectively at 37.7 and 39.1 percent of GDP in 2008-09, have increased substantially. India's total trade in goods and services increased from USD 48.1 billion in 1991-92 to USD 632.4 billion in 2008-09, while the current account balance remained manageable. India's foreign exchange reserves and foreign direct investment have also increased many times since 1991-92.

Table 1. India: Selected Indicators of Macroeconomic Performance

Indicator	1991-92	2001-02	2008-09
Nominal GDP (Rs. Billion)	7018	12675	53218
Growth in Real GDP (%) (base 1999-2000)	1.1	5.2	6.1
Per capita Nominal GDP (USD)	312	459	1000
Inflation			
Wholesale Price Index – All commodities (Inflation in %)	13.7	3.6	8.3
Consumer Price Index- Industrial Worker (Inflation in %)	13.5	4.3	9.1
Domestic Investment (2007-08)			
Gross Domestic Capital Formation (% to GDP)	22.1	22.8	39.1
Gross Domestic Savings (% to GDP)	21.5	23.5	37.7
Foreign Investment			
Foreign Exchange Reserves (USD billion)	5.6	51.0	252.0
Foreign Direct Investment (USD billion*)*	0.1	6.1	35.2
Total Foreign Investment Inflows (USD billion)	0.1	8.2	21.3
Trade			
Exports of Goods and Services (USD billion)	23.3	61.8	286.4
Imports of Goods and Services (USD billion)	24.8	70.0	346.0
Net Invisibles/ GDP (%)	0.7	3.1	7.7
Current Account Balance/GDP (%)	-0.3	0.7	-2.6

Sources: Calculated from RBI (2009).

The past satisfactory performance however was achieved from a relatively low base and the reforms needed to achieve them were relatively un-contentious. Sustaining this economic performance will be more challenging however. The external environment is not likely to be as favorable for medium-term economic growth, and prospects for world trade have diminished as a result of the global crisis. Internally, further reforms are likely to be difficult particularly those involving agriculture, labor markets, and administrative and governance reforms.

India is currently in a favorable demographic phase, with the share of working age population in the total population expected to increase from 56.2 percent in 2000 to 64.4 percent in 2025, and to 65.0 percent in 2050 (Table 2). This trend is favorable for higher savings and for growth, but it creates two major challenges.

The first is to generate livelihoods for the larger numbers of young people joining the labor force. This suggests that creating livelihoods that are sustainable and match rising expectations, rather than attempting to merely preserve existing jobs, should be the focus of labor market and education policies. As India's total workforce as a percentage of the total population in 2009 was only 38.3 percent and is expected to increase over time, this challenge is expected to be even more acute.

The second challenge arises due to the pattern of employment. In 2009, about 85 percent of the 460 million work forces were either self-employed or engaged in casual employment (Table 2). Traditionally, social security programs have been predicated on the basis of a relatively stable employer-employee relationship. As the share of such employment is low, and is not expected to increase, extending social security coverage would be a major challenge.

Table 2. India: Select Labor Force and Demographic Indicators

Indicator	Time Period		
Life Expectancy at Birth (Years)			
Male	2005-2010		63.2
Female			66.7
Life Expectancy at age 60 (Years)			
Male	2005-2010		16
Female			18
Total Fertility Rate *(No. of Children)	2005-2010		2.76
	2005	2025	2050
Population (million)	1103.0	1431.3	1613.8
Females (million)	537.5	696.3	793.1
Males (million)	565.7	735.0	820.7
Sex Ratio *(males per 100 females)*	2005		105.2
Population above age 60 (million)	2005		87.5
	2010		100.8
	2050		329.6
Old Age Dependency Ratio *(%)* **	2005		15.6
Working Age Population (million)	2000		619.7
	2025		921.5
	2050		1048.2
Employment by Sector			
	2009		As % of population
Total Work Force (million)	460		38.3
Self Employed	261		21.8
Casual Workers	133		11.1
Regular Workers	66		5.5

Sources: UNDESA (2009); Handique (2009).

Notes: * Total Fertility Rate is defined as the average number of live childbirths over a woman's lifetime.

**Old Age Dependency Ratio is defined as $\frac{(\textit{population above 60 years})}{(\textit{population 15-59 years})} \times 100$

India's favorable demographic phase notwithstanding, it will experience a sharp increase in its elderly population from 100 million in 2010 to 330 million in 2050. The sheer number of elderly will pose formidable challenges in designing, administering, and sustaining social security schemes and programs. Even if India sustains the high growth rates experienced in recent years, its per capita income will still be relatively low by 2050. This implies not only that India must pursue policies which sustain high growth, but that the distribution of income between the young and the old, and among the elderly will need to be given due weight. The social and political management of ageing will therefore acquire considerable significance.

The sheer number of ageing people suggests that flexibility to meet differing needs of such a large number of elderly, and reversibility to ensure that the design or other errors are not too costly, acquire greater importance in the Indian context.

India's rapid ageing is due to declining fertility, and longer life expectancy. The Total Fertility Rate (TFR), which was 2.76 during 2005-10, is projected to reach the replacement level by 2020. Indeed, variations in the TFR among different regions and groups in the country are high, with some states, such as Kerala and Tamil Nadu already experiencing TFR below the replacement level (Government of India, 2001).

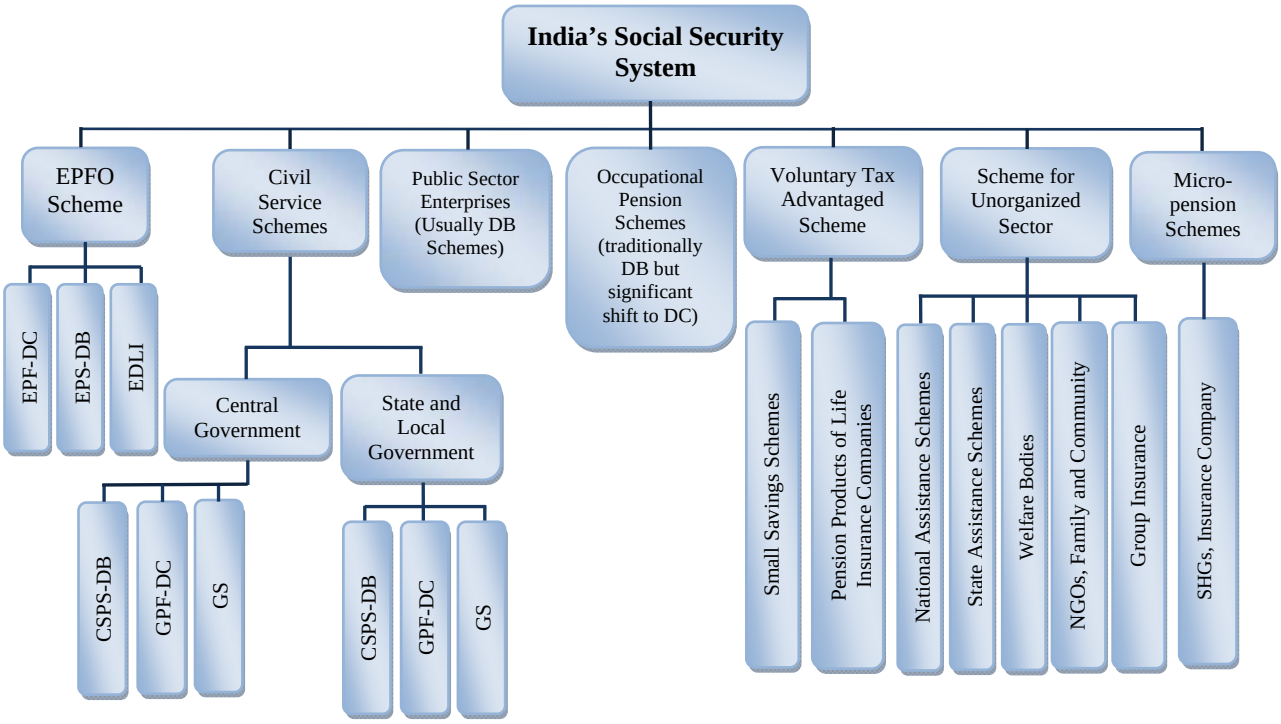
The life expectancy of people at age 60 between 2005-2010 was 16 years for males and 18 years for females respectively. This is expected to increase substantially. As women, as a group, have a longer life expectancy, feminization of the elderly, particularly those above 80 years of age, is anticipated. In conjunction with relatively low labor force participation, such feminization strongly suggests that the survivors' risks would need to be addressed.

The need for fiscal consolidation and flexibility constitutes another important reason for social security reform. Fiscal consolidation is essential to ensure that fiscal policies are consistent with macroeconomic and financial stability. India's combined public sector deficit exceeds 10 per cent of GDP, while total public debt, mostly internal rather than external, is around 85 per cent of GDP (RBI, 2009). This leaves very limited room for an expansionary fiscal policy to address social security needs. Fiscal flexibility requires that government expenditure and revenue raising methods and priorities be aligned to the prevailing economic strategies and goals. If a very large proportion of the expenditure is spent on items such as wages, pensions, and other current expenditure, there will less flexibility in reallocating expenditure towards growth and social cohesion-enhancing activities.

3. The Social Security System in India: An Overview

Since Independence in 1947, India has developed a fairly complex social security system.

Figure 1A. India's Social Security System



Source: Constructed by the author.

Note: From 1 January 2004, all newly recruited civil servants at the Centre (except for armed forces personnel) are on a DC scheme. Nineteen states have also issued notifications for a shift to the DC scheme, but their starting dates vary.

Abbreviations Used

DB	Defined benefit
DC	Defined contribution
EDLI	Employees' Deposit Linked Insurance Scheme
EPF	Employees' Provident Fund
EPS	Employees' Pension Scheme
GPF	Government Provident Fund
GS	Gratuity Scheme
CSPS	Civil Service Pension Scheme
NGO	Non-government organizations

Table 3. Multi-Pillar Pension Taxonomy of the World Bank

Pillar	Target Groups			Main criteria		
	Lifetime poor	**Informal sector**	**Formal sector**	**Characteristics**	**Participation**	**Funding/ Collateral**
0	X	X	X	"Basic or "Social pension," at least social assistance, universal or means-tested. Example: **Old Age Pension Scheme**	Universal or Residual	Budget/general revenues
1			X	Public pension plan, publicly managed, defined-benefit or notional defined-contribution Example: **Non-Contributory Scheme for Civil Servants**	Mandated	Contributions, perhaps with financial reserves
2			X	Occupational or personal pension plans, funded defined-benefit or funded, defined-contribution. Example: **EPFO**	Mandated	Financial assets
3	X	X	X	Occupational or personal pension plans, funded defined-benefit or funded, defined contribution. Example: **Occupational Plans, Public Sector Enterprises' Pension Plans, Beedi Fund**	Voluntary	Financial assets
4	X	X	X	Personal savings, homeownership, and other individual financial and non-financial assets. Example: **PPF, Micro pensions, Saving-Insurance products from LIC.**	Voluntary	Financial assets

Source: Holzmann and Hinz (2005).
Note: The size of x or X characterizes the importance of each pillar for each target group.

The current system is able to cover at best around 20 per cent of the labor force under at least one of the social security schemes. The challenges arising from the existing low coverage and rapid aging are considerable. Since state-intermediated pension systems cannot cope with this increase in the need for social security, private pension savings will become increasingly important. This will require new organizations and schemes, and product and technological innovations.

However, even as the need for inclusive growth has acquired greater urgency due to globalization, the need to maintain social cohesion and reform the social security system has not been accorded high priority by policy-makers, the bureaucracy and other stakeholders.

As a result, many elements of the social security system reflect India's current economic needs and priorities to a very limited extent. The paper will argue that there is a strong case for injecting greater professionalism in performing core functions, and for a thorough systemic overhaul, which integrates the various components of India's social security system.

3.1. Select Components of India's Social Security System

3.1.1. Employees' Provident Fund Organization (EPFO)

The Employees' Provident Fund Organization (EPFO) was set up under the 1952 EPFO Act. It is an unusual national provident fund in three respects. First, it administers two separate schemes: *(i)* a defined contribution scheme (EPF) and *(ii)* a defined benefit scheme (Employees' Pension Scheme). As the DB scheme was carved out of the DC scheme in 1995, the former specifies both the contribution rate and the final benefit. This is mathematically not possible.

The combined contribution rate for all EPFO schemes is 25.7 per cent of members' wages (EPFO, 2007), which is rather on the high side. The density of contributions (i.e. the ratio of actual to full working life contributions) of the EPFO members is not known. By 2009, after being in operation for 57 years, the EPF scheme covered 0.4 million establishments and had 44 million members, of whom about half (4.4 per cent of the labor-force) were active contributors.

There appears to be a large actuarial deficit in the EPS. The recent actuarial reports of the EPS, which have not been made public (but should be), suggest that the deficit is in the region of INR. 250 billion. As a result, ad- hoc changes are being introduced in the DB scheme, such as the recent decision to end the commutation of pensions (which permits lump sum withdrawal of future pension benefits, subject to a limit). These however have inconvenienced the members.

Second, the organization combines the role of provident and pension fund administrator with that of a regulator of funds that are exempted from the EPFO Act.

This however applies only to the EPF Scheme. Those corporations seeking exemption from the EPFO are usually large with above average wage rates. The EPFO has a conflict of interest in granting liberal exemptions as the exempted funds could provide competition in investment allocation and management, and in quality of services provided to members.

The EPFO, for example, requires that the exempted funds allocate balances in exactly the same manner as the EPFO; and that they provide at least the same rate of return to members as the EPF. Such requirements mitigate against innovations in asset allocation strategies which could benefit the members.

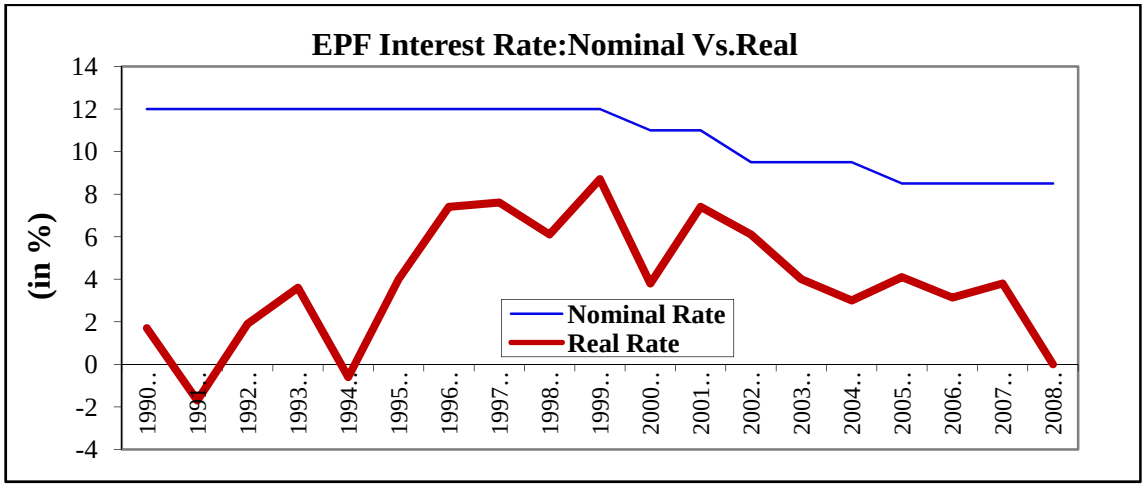
Combining the role of a major service provider and a regulator in one organization such as the EPFO is contrary to good governance practices. These roles need to be separated.

Third, EPFO is among the largest non banking-financial institutions (NBFIs) with assets of over INR 2,562 billion in 2007, equivalent to 5.4 per cent of India's GDP (INR 47,131 billion) (EPFO, 2007). While its absolute size is large, relative to pension assets as a percentage of GDP the size of EPFO is quite small.

EPFO has made limited progress in modernizing its investment policies and performance. Its assets are primarily in public sector debt instruments. It has begun trading in debt instruments, and is considering investing in passive index-linked equity products. It has no development investment management expertise in-house, and therefore continues to out-source investment activities. Recently, some contestability has been introduced as investment managers are now chosen through a bidding process. This has the potential to reduce investment management costs.

The nominal interest rate on EPFO balances has been relatively stable, and has generally exceeded the returns from bank deposits, and government securities (Asher, 2010). The real rate of return, as measured by the nominal rate minus wholesale price inflation, has shown less stability (Figure 2). Estimates based on Figure 2 suggest that for the 1989-2009 period, the simple average of the real interest rate paid by the EPFO was 3.7 percent per annum; the corresponding rate being 3.9 percent for the 2000-2009 period.

Figure 2. EPF Interest Rate: Nominal versus Real



Source: Calculated from EPFO (2007) and RBI (2009).

While no official or other projections are available, it appears that the expected replacement rates (ratio of pre-retirement to post-retirement income) for most of the members will be substantially lower than the 66 to 75 per cent recommended by the experts, even when both the EPF and EPS schemes are combined.

The main challenges facing the EPFO are summarized in Box 1. There is recognition among the policymakers of the above challenges faced by the EPFO. But the progress in addressing them has been slow.

Box 1: The main challenges facing EPFO are:

- An unwieldy governance structure (a 45-member board, with the Minister of Labor as Chairperson) and limited access to outside expertise.
- Poor design of its schemes (a substantial proportion of the time and energies of the EPFO's 19,000 employees are devoted to non-retirement-related issues).
- Lack of appropriate organizational and individual incentives.
- Outdated budgetary and record-keeping systems due to modest IT systems and an absence of appropriate investment in human resources.
- Inability to provide quality of service and retirement income security commensurate with the costs imposed on the economy.

3.1.2. Civil Service Pensions

The current civil service pensions at all levels of government require parametric, administrative and record-keeping and governance reforms. Civil servants are beneficiaries of pension schemes as well as being formulators and implementers of the schemes. This is against good governance principles; and predictably, transparency and accountability of civil service schemes have been low. Many current practices such as overly generous commutation benefits based on outdated morbidity and mortality data, linking pensions with wage revisions for current government employees, etc. Reflect the above arrangements.

The government's cash accounting system does not permit the recording of accrued pension (and health care) liabilities. In the private sector, accounting regulations already require companies to reflect such accrued liabilities in their profit and loss statements and in their balance sheets. Listed government enterprises will need to follow such practices. Moreover, for purposes of proper accounting, all government and quasi-government organizations must recognize such liabilities and clearly specify their plans for meeting them.

Currently, even the government provident fund (GPF) and gratuity contributions are not accumulated in separate funds; instead, they are paid from current revenues. This practice must be changed, and sinking funds arrangements must be instituted to meet future liabilities in an orderly manner. The current arrangements unduly encourage soft budget constraints at all levels of government. The fiscal capacities of different states vary greatly those with weak fiscal positions and those disinclined to undertake fiscal reforms will find it particularly challenging to meet their pension and other liabilities. If they do meet these liabilities, the opportunity costs, in terms of limited fiscal flexibility and lower growth, will be high.

To reform its civil service pension system, the Government of India introduced in January 2004 the New Pension Scheme (NPS)—a defined contribution scheme with distinct mandatory and voluntary components. The NPS architecture consists of a Central Record-keeping Agency (CRA), auctioning of investment mandates, and points of presence (PoP), which act as distributional and collection agents. The design and architecture of NPS are much more in tune with international pension best practices. However, the mandatory annuitization feature may require some reconsideration.

The mandatory component was made fully operational from 1 April 2008. Mandatory membership covers those central government employees (except armed forces personnel) who first commenced employment on or after 1 January 2004. The total contribution rate for mandatory NPS is 20 per cent of monthly earnings, split equally among the employee and the government (as employer). Members have a limited choice of investments, with life cycle funds as a default choice. Under mandatory NPS, pension is paid at age 60 and pre-retirement withdrawals are not permitted. At present, 22 states/union territories in India have introduced NPS type schemes. Mandatory NPS has the potential to cover 20 million civil servants in India.

The voluntary component of NPS is open to all citizens between the ages of 18 and 55. It became operational on 1 May 2009. Voluntary NPS has limited pre-retirement withdrawal provisions and flexible contributions. The 2010 budget has introduced an initiative called 'Swavalamban' under which the Central Government INR 1000 per year to each Voluntary NPS Account opened in financial year 2010-11. This applies to only those accounts where the minimum annual contribution is INR 1000, and maximum is INR 12000. This scheme will be available for three additional years, and will be managed by the interim Pension Fund Regulatory and Development Authority (PFRDA).

NPS offers well-considered investment choices, including a default option that automatically reduces the risk levels of asset class exposure with age. The equity exposure in all cases is only through indexed funds. The investment management is auctioned to the lowest bidders. In the latest round, the lowest bid by asset fund managers was only 9 basis points, or Rs. 9 for every Rs. 1,00,000 worth of assets under management. This is much lower than the average cost of a mutual fund of 2 per cent (Rs. 2,000 per year per Rs. 1,00,000) and 1.5 per cent (Rs. 1,500) for a standard unit-linked insurance plan (ULIP) (Halan, 2009).

3.1.3. Pension Plans of Public Sector Enterprises

The pension design for public sector enterprises varies widely. But, increasingly, they are also being subjected to NPS. The lack of transparency and accountability of the pension plans of these enterprises does make analysis difficult. However, it is highly probable that professional governance and administration, including the requisite

pre-funding and appropriate accounting procedures, need to be improved substantially. Currently, the Income Tax Department, in the union Ministry of Finance, is entrusted with approving such pension funds. But it does not have the required competence to supervise them subsequently. The PFRDA should be entrusted with supervision responsibilities.

3.1.4. Occupational Pension Plans

These plans currently lack proper supervision and clear guidelines. The proposed changes in India's AS (Accounting Standard) 15 will align it with FAS 87—Financial Accounting Standard No. 87 issued by the Financial Accounting Standards Board (FASB). FASB is the designated private sector organization in the United States that establishes financial accounting and reporting standards. This will significantly increase the disclosure requirements concerning un-funded pension and other retirement benefits liabilities. These plans also need to be regulated by a pension regulator (i.e., PFRDA). Regulatory gaps that provide arbitrage opportunities must be systematically addressed and plugged.

3.1.5. Other Retirement Income Schemes

These include such schemes as: voluntary tax-advantaged schemes, schemes for the unorganized sectors (which are essentially social assistance and social pension schemes), and micro-pensions. As there are a large number of such schemes, the discussion, which follows, is brief and selective.

Since the number of income tax payers in India is fairly low, tax-advantaged voluntary schemes such as the Public Provident Fund (PPF) have the tendency to become tax shelters for the top third of the income group. There are technical challenges to transitioning from the existing system to a uniform EET system for all pension products and providers. Politically, too, it will not be easy to move towards the EET (exempt contributions, exempt investment income, tax withdrawals at retirement) arrangement from the current EEE (exempt contributions, exempt investment income, exempt withdrawals at retirement) treatment accorded to EPFO, PPF and others. As NPS is subject to EET rules, its voluntary component, one of the important instruments to reach out to many of the self-employed, is perceived be at a relative disadvantage. In

addition, there are many administered interest rate schemes that receive favorable tax treatment.

Social assistance and social pension schemes such as the Old Age Pension (OAP) scheme, financed jointly by the Center and the states, but administered at the state level are usually means-tested. However, their coverage is fairly low (10 to 15 percent of the target population), and the benefit levels are also fairly low (Vaidyanathan, 2005). These schemes need to be strengthened, in terms of the delivery mechanisms, better targeting and larger level of benefits.

An encouraging recent development has been the introduction of co-contribution schemes such as the Abhayahastham for women members of Self Help Groups (SHGs) in Andhra Pradesh; and the Vishwakarma Unorganised Sector Pension Scheme for low-income unorganized sector workers in twenty occupations in Rajasthan. Under these schemes, a member's contribution is matched, within limits, by the state. It is projected that under the Vishwakarma pension scheme a co-contribution INR 1,000 per annum for a member contributing an equal sum over a period of 25 years could result in a monthly pension of INR 1,275 per month which is significantly higher than the present Rs.400 paid under the tax-financed national old age pension scheme.

These schemes are utilizing more modern pension management practices, such as not permitting pre-retirement withdrawals; and electronic-based service delivery systems. As these are largely targeted at women members, they also help address the survivors' benefit and gender issues.

The efficacy of the social assistance and pensions as well and co-contribution schemes depends on the fiscal capacity of the Center and the states, and the efficiency with which individual state governments can deliver pension benefits. Thus, fiscal and public sector governance reforms are intricately linked with the broader use of this component.

3.2. Schemes for the Unorganized Sector

In 2006, the National Commission for Enterprises in the Unorganized Sector (NCEUS) published a Report which advocated a comprehensive social insurance-based, government run program covering health benefits (hospitalization, sickness allowance, maternity benefits, life insurance, and provident fund, with provision for non-

contributory pensions for poor elderly workers).The Report set an ambitious task of covering 300 million workers over 5 years, that is, 60 million individuals per year. The NCEUS Report has been criticized for its limited appreciation of the administrative tasks involved in covering such a large number of individuals in a short period; a lack of detailed actuarial projections of various insurance schemes; and the vague nature of financing sources, and their sustainability (Asher, 2010).

Parliament passed the Unorganized Sector Workers Social Security (USWSS) Bill in 2008. The Bill provided only a broad framework and substantially limited the coverage. It also did not provide funding sources. The progress in effective implementation of the Bill is expected to be gradual and limited. To supplement social protection to the unorganized sector plans to establish a National Social Security Fund (NSSF) with an initial allocation of INR 10 billion was announced in the 2010-11 Budget.

India has also experimented with various welfare funds, which provide social security benefits, organized by occupations. The Beedi[1] Workers' Welfare Fund Act passed by the Parliament in 1976 covering around 4 million workers is among the most prominent of such welfare funds.

3.2.1. Micro-pensions

There has also been progress in developing micro-pension schemes (Shankar and Asher, 2010). A typical micro-pension scheme is based on voluntary savings, accumulated over a long period and intermediated through financial and capital markets by a professional fund manager. The total amount accumulated depends on contributions (less permitted pre-retirement withdrawals), and investment returns net of administrative, investment management and other expenses. At an agreed-upon withdrawal age (usually 58 or 60 years), the accumulated balances can be withdrawn in a lump sum, a phased withdrawal, annuity or a combination of these methods

Their combined membership of these schemes is around two hundred thousand. In contrast, it is estimated that about 35 million individuals have benefited from micro-finance schemes, primarily through self-help groups (SHGs). While the short-term

[1] Beedis are indigenously hand rolled cigarettes.

nature of SHG activities, and relatively short life span of most SHGs are not directly comparable to the long-term nature of the micro-pension schemes based on individuals, the members of the SHGs are potential customers for micro-pension schemes. The pension scheme involves contributions ranging from Rs. 50 to Rs.100 per month per member.

The contributions must be made until age 55 and the pension payments begin after age 58. The savings are pooled by the Bank and transferred to UTI Mutual Fund for investment management. Each member has a pension account with the SEWA Bank, which regularly provides information about the pension accounts. It appears that the accumulated amounts will be insufficient for substantial annuity purchases. Therefore other options such as phased withdrawals may need to be considered.

Micro-pensions have the potential to play a limited role as one of the methods for financing old-age. The extent of their potential will depend on the following factors.

First, in the accumulation phase, minimizing the transaction costs associated with record-keeping, payment of benefits, communication to members, and investment policies and management should be given due emphasis. Second, in savings-based micro-pension schemes, investment, macroeconomic and other risks are borne by the individual. Risk-sharing arrangements have therefore been often advocated, although longevity and inflation risks will have to be addressed. Third, arrangements during the pay-out phase need to be carefully considered while 40% lump-sum withdrawal of the accumulated funds appears realistic. Fourth, micro-pensions represent a long-term financial contract, with potential for significant agency problems, and systemic risk to the financial system.

To make micro-pensions more attractive, considerable innovation which enables provision of goods and services to the poor at a fraction of the cost to the middle and high-income groups should be applied to micro-pensions. This will require that organizations involved in the micro-pension industry are able to benefit from economies of scale and scope.

3.2.2. Reverse Mortgage

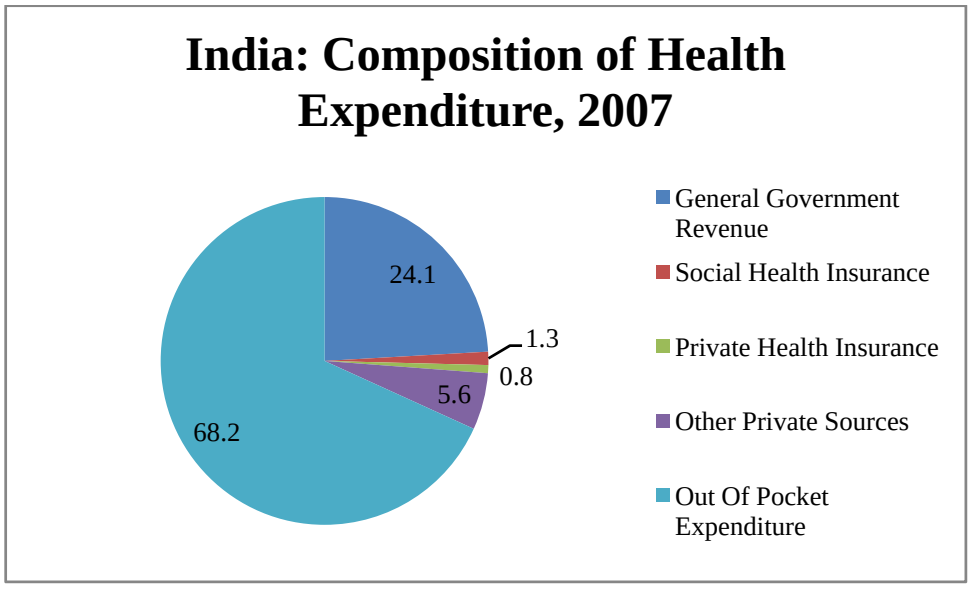
A commercial bank in India has introduced a reverse mortgage loan annuity (RMLA) product, which combines annuity with simple reverse mortgage and thereby

addresses longevity risk (Sarang and Bhaskaran, 2009). However, the response to this scheme has been relatively limited.

4. Health Schemes: A Brief Overview

Healthcare in India is largely financed by private out of pocket expenditure. In 2007, more than 70 percent of health expenditure was financed out of pocket, while private and social health insurance accounted for only two percent of total health expenditure (Figure 3). Gupta and Trivedi (2005) estimate that in 2005 health insurance covered roughly 85 million individuals, or approximately 20 percent of India's labor force. Even this limited coverage does not adequately reflect the limitations of India's health schemes. This is because the range of illnesses covered is limited, and the quality of healthcare for many individuals is relatively low.

Figure 3. Composition of Health Expenditures in India, 2007



Source: Calculation by authors based on data from WHO (2009).

The Employees State Insurance Scheme (ESIS) is a health insurance scheme for workers employed in the formal sector. The ESIS was set up in 1952. Members contribute 1.75 percent of their basic wage, and employers 4.75 percent. As of March

2006, ESIS provided healthcare protection to approximately 35 million beneficiaries, or roughly three percent of India's population. The quality of healthcare facilities managed by the ESIS is perceived to be in need of substantial improvement. This limits its ability to extend coverage and provide competition to private sector healthcare providers.

There have been several initiatives to extend the coverage of community-based health insurance in rural India. These include the National Rural Health Mission (NRHM) implemented in 2005, and the Rashtriya Swasthya Bima Yojna (RSBY) implemented in 2008. RSBY covers expenditure associated with secondary care, whereas the NRHM covers basic illnesses and primary care.

The NRHM, launched in 2005, aims to improve (i) Infant Mortality Rates, (ii) Maternal Mortality Rates, and reduce the (iii) Total Fertility Rate. The NHRM has focused on increasing rural public health spending to improve infrastructure, train and skill requisite professionals, and decentralize the delivery of primary healthcare in rural India (Desai, 2009). These measures may bring about greater choice and contestability in the health sector.

The RSBY is a government financed health insurance scheme for families identified as being below the poverty line (BPL). Households enrolled in RSBY are eligible for healthcare benefits at accredited public and private healthcare providers of up to INR 30,000 each year. As of March 2010, 13 million BPL households have enrolled in the scheme.

Relatively low reach and quality of services in the public sector remains a major constraint on accessibility, and in managing costs through effective competition for the private sector providers. Limited health insurance coverage by the insurance companies has contributed to a continuing large proportion of national health expenditure being financed out of pocket by households.

5. Reform Themes

Many of the specific reform measures concerning EPFO, civil service pensions and other components are implicit in the preceding discussion. It is suggested that social security reforms in India be organized into the following five reform themes. Such reforms will enable India to gradually transform its current social security system, which is characterized by low coverage and inadequate replacement rates, into a more broad-based system with improved and more secure replacement rates.

First, there is a strong case for viewing social security systems as an integral part of the overall economic, social, human resources and political management in India. This will require a change in the mindset of provident and pension fund organizations, and of the Labour and other Ministries from a welfare orientation to a professional-technocratic service provider orientation.

The need for effective management and application of the principles of pension economics and finance in social security policy-making and administration must receive much greater recognition than is the case currently. An unpredicted increase in the longevity of members by one or two years, for example, could disproportionately affect the financial viability of the pension and health care schemes. The second theme concerns the need for viewing social security arrangements as a system rather than focusing on individual components. Different components of the social security system in India have evolved, over time, in isolation. As a result, there is limited coordination amongst different schemes, such as those for civil servants and private sector workers. For a systemic perspective, it is imperative that the PFRDA Bill, which has been languishing for several years in Parliament, be passed in the budget session beginning in February 2010.

There is also a need to understand the systemic risk, as the ultimate contingent liability of nearly all social security schemes in India is on the state and, therefore, borne by taxpayers. This is illustrated by the recent press reports that Mahanagar Telphone Nigam Limited (MTNL), a public sector telecom firm, has requested that the government bear the pension costs of its employees. Many public sector financial institutions are also likely to be constrained in meeting the pension and health care

promises made to their employees. Recent changes in accounting practices will require all companies to reflect their accrued pension and health care liabilities in their profit and loss accounts and balance sheets. As a result of cash accounting, organizations such as the Indian Railways and India Post, who do follow these accounting rules, end up providing an inaccurate picture of their financial position.

There is a strong case for a multi-tiered social security system under which an individual obtains retirement income not from just one scheme but from a variety of sources. This permits risk diversification for the individual and for society as a whole. A multi-tiered approach can help balance the retirement risks borne by individuals and by society; and develop a different mix of financing from taxes, contributions and other methods. Each scheme need no longer be devised to provide full retirement benefits. In India, retirement income transfers, partly or fully financed from the budget, will be needed as one of the tiers. The extent to which this tier can be developed will depend on the fiscal capacity of the government and on the efficacy of government service delivery systems. The existing network of strong micro-finance institutions and community organizations can be utilized to reach relatively low-income and self-employed workers, particularly women, through micro-pension products (Shankar and Asher, 2010). There are two aspects of a systemic approach to social security arrangements in India that are worth considering. The first is the need for an overall National Social Security Council (NSSC) for strategic policy direction and coherence among different components of the social security system. The second is the need for a pension regulator to ensure that the provident and pension fund organizations undertake their core functions with the requisite professionalism, and that their governance structures meet international best practices. The composition of most of the provident and pension fund boards in India, in both the public and the private sectors, reflects insufficient expertise, autonomy, transparency and accountability in their operations. This needs to be urgently addressed by NSSC and a pension regulator.

There is also a need to begin graduate-level courses in social security policy and management. The role of the National Academy of Training and Research in Social Security (NATRSS) ought to be reconsidered. The tendency of almost exclusively relying on current and retired civil servants to be faculty members and resource persons at such institutions must be urgently reviewed.

India has an opportunity to develop the pension sector as a significant component of its overall financial sector, and secure opportunities to turn the expertise to its economic advantage through the export of pension-related services.

The third theme highlights that effective social security reform requires complementary reforms in areas such as labor markets, fiscal policies, civil service, financial and capital markets, and family policies. Thus, any increase in social pensions financed from the budget will require reallocation of expenditure priorities, progress towards fiscal consolidation and better delivery mechanisms. This suggests that to be in favor of more robust social pensions and to simultaneously be against fiscal reforms is to be inconsistent.

A provident fund that invests nearly all of its assets in gilts (a specialized type of investment offered by the government which pays a fixed rate of interest and is considered low-risk) and does not take advantage of trading opportunities will forego opportunities to benefit its members by more professional portfolio management. This may lead to a reduction in national savings to the extent that such a practice may weaken the government's fiscal discipline due to the availability of cheap funds. This defeats the main purpose of mandatory saving, which is to intermediate these savings into productive investments that, in turn, can up the trend rate of economic growth. Only when this is done can pensions be regarded as fully funded (Barr and Diamond, 2009).

The fourth theme concerns the health sector. The key goals should be accessibility, affordability, managing costs, and reforming public sector health institutions to enable them to provide effective competition to the private and not-for-profit sectors. As with pensions, health insurance schemes need to be sustainable for a prolonged period, and avoid falling prey to the tyranny of small numbers where by a seemingly minor change in parameters can significantly affect the financial viability of the scheme. The need for greater professionalism in designing health policies and managing health institutions is an imperative for India.

The fifth theme concerns the need for more empirical, evidence-based social security policies, particularly in pensions and health care, which require sophisticated price-discovery mechanisms. It calls for developing indigenous analytical capacities

and professionals; building robust databases; and establishing professional programs relating to pensions, health policy and management, and actuarial sciences.

Each of the above five themes is of relevance for constructing more robust, sustainable, professionally managed and regulated social security systems in India. It is often far easier, politically, to increase the demand for pension or health care services. But, if there is no commensurate increase in supply and in the fiscal, institutional, and organizational capacities, the outcomes will be limited. Careful planning and homework is required before introducing new social security schemes or reforming existing ones.

There is a case for revamping the recruitment policies and the organizational and governance structures of major provident and pension organizations in India, such as the Employees Provident Fund Organization and the Employees State Insurance Scheme (which is responsible for the delivery of health care services). The country also needs to put an end to the practice of using the provident fund of government employees to finance current expenditure. India must establish sinking funds to systematically meet the future health care and pension obligations of its public sector organizations. India has a favorable demographic profile and the capabilities to harness this potential opportunity and make measurable progress towards its professed goal of constructing and implementing a modern social security system; one that is sustainable and covers most of the population. However, progress will not be easy. Sustained focus and efforts will be required. Moreover, pension economics literacy of the stakeholders, particularly of policy-makers and the managers and trustees of provident and pension fund organizations, will have to be substantially improved.

For substantive sustainable social security reform in India, a change in mindset from provider-producer interest dominance to consumer/customer/citizen-centric procedures and attitudes is essential. Different components of India's social security system are likely to move in this direction at an uneven speed and with varying levels of effectiveness.

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