Data Collection Survey on Social Security Sector in Asia
Final Report
Country Report

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Mitsubishi UFJ Research and Consulting Co.Ltd.

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Abbreviation

【Common】

ADB	Asian Development Bank
CCT	Conditional Cash Transfer
DRG	Diagnosis Related Group
UC	Universal Coverage
FFS	Fee For Service
WHO	World Health Organization
GIZ	
ILO	International Labour Organization
MOU	Memorandum of Understanding
NGO	Non Governmental Organization
WB	World Bank
AusAID	Australian Government Overseas Aid Program
UNESCAP	United Nations Economic and Social Commission for Asia and the Pacific
JETRO	Japan External Trade Organization

【the Philippines】

4P	Pantawid Pamilyang Pilipino Program
AHA	Aquino Health Agenda
AMC	Average Monthly Compensation
BMP	Basic Monthly Pension
CYS	Credited Years of Service
DepEd	Department of Education of the Philippines
DILG	Department of the Interior and Local Government
DOH	Department of Health
DOLE	Department of Labor and Employment
DSWD	Department of Social Welfare and Development
ECOP	Employers Confederation of the Philippines
F1	FOURmula One for Health
GSIS	Government Service Insurance System
HSRA	Health Sector Reform Agenda
IRA	Internal Revenue Allotment
KALAHI-CIDSS	Kapit-bisig Laban sa Kahirapan –Comprehensive and Integrated Delivery of Social Services
KaSAPI	Kalusugang Sigurado at Abot-Kaya sa PhlHealth Insurance
LGU	Local Government Unit
NAPC	Nationa Anti-Poverty Commission
NEDA	National Economic Development Authority
NHIP	National Health Insurance Program
NHTS-PR	National Household Targeting System for Poverty Reduction
OSCA	Office of Senior Citizens' Affairs
Pag-IBIG/ HDMF	Home Development Mutual Fund

【Indonesia】

AAJI	**Indonesia's Life Insurance Association**
AAJI	Indonesia's Life Insurance Association
ASKESOS	Social Welfare Insurance
BAPEPAM-LK	The Capital Market and Financial Institution Supervisory Agency
BAPPENAS	Indonesian National Development Planning Agency
BLT	Bantuan Langsung Tunai
BPJS	Social Security and Administrating Bodies
BPS	Central Agency on Statistics
DJSN	National Social Security Council
JAMKESDA	Public Health Security System by Local Governments
JAMKESMAS	Public Health Security System for Low-Income Population
JAMSOSTEK	Jaminan Sosial Tenaga Kerja
JHT	Corporate Old-Age Savings
JK	Life Insurance Program for Employees
JKK	Workers Compensation Insurance
JPK	Employee health security
JSLU	Social Cash Transfer for Elderly
JSPACA	Social Cash Transfer for Severely Disabled
MOF	Ministry of Finance
MOH	Ministry of Health
MoMT	Ministry of Manpower and Transmigration
MoSA	Ministry of Social Affairs
MOSE s	Ministry of State-Owned Enterprises
PBI	Penerima Bantuan Iuran
PKH	Program Keluarga Harapan
PKSA	Social Cash Transfer for Disadvantaged Children
PNPM Mandiri	Program Nasional Pemberdayaan Masyarakat Mandiri
PODES	Village Potential Statistics
PPLS	Data Collection for Targeting Social Protection Programs
PSE	Socio-economic Population Survey
RASKIN	Beras Miskin
SJSN	National Social Security System
SUSENAS	National Socio-Economic Survey
THT	Old-Age Savings Program for Government Officers
TKLHK	Social Insurance Program for Workers in Informal Sectors
TNP2K	The National Team for the Acceleration of Poverty Reduction

【Laos】

AGL	Allianze General Laos
CBHI	Community Based Health Insurance
CRC	Convention on the Rights of the Child

DDF	District Development Fund
DO	District Field Office of Finance
DOS	Department of Statistics
HEF	Health Equity Fund
LECS	Lao Expenditure and Consumption Survey
MOF	Ministry of Finance
MOH	Ministry of Health
MOHA	Ministry of Home Affairs
MOLSW	Ministry of Labor and Social Security
MPI	Ministry of Planning and Investment
NGPES	National Growth and Poverty Eradication Strategy
NSEDP	National Socio-Economic Development Plan
PO	Provincial Field Office of Finance
PRF	Poverty Reduction Fund
SASS	State Authority of Social Security
SSO	Social Security Office
VAT	Value Added Tax

【Malaysia】

CWC	Central Welfare Council, Peninsular Malaysia / MAJIS PUSAT KEBAJIKAN SEMENANJUNG MALAYSIA
E-Kasih	E-Kashih
EPF/ KWSP	Employee Provident Fund／ Kumpulan Wang Simpanan Pekerja
ICU	Implementation Coordination Unit／ Unit Penyelarasan Pelaksanaan
JPA	Public service department of Malaysia／Jabatan Perkhidmatan Awam Malaysia
KPWKM	Ministry of Women, Family & Community Development ／ Kementerian Pembangunan Wanita, Keluarga dan Masyarakat
LIAM	Life Insurance Association of Malayisa ／ Persatuan Insurans Hayat Malaysia
MOH	Ministry of Public Health ／ Kementerian Kesihatan Malaysia
MOHR	Minister of Human Resource
NIAM	National Insurance Association of Malaysia / Persatuan Insurance Kebangsaan Malaysia
1 Malaysia	One Malaysia ／ Satu Malaysia
SOCSO/ PERKESO	Social Security Organization ／ Pertubuhan Keselammatan Sosial
Wawasan 2020	Vison 2020 ／ Wawasan 2020

【Vietnam】

DOLISA	Department of Labour, Invalids and Social Affairs
DRG	Diagnosis Related Groups
DSS	District Social Security
GIZ	Gesellschaft fur Internationale Zusammenarbeit
HSPI	Health Strategy and Policy Institute
ILSSA	Institute of Labour Science and Social Affairs
ISSS	Insititute for Social Security Science
MOF	Ministry of Finance
MOH	Ministry of Health
MOLISA	Ministry of Labour, Invalids and Social Affairs
PPC	Provincial People's Committee
PSS	Provincial Social Security
VASS	Vietnam Academy of Social Science
VGCL	Vietnam General Confederation of Labour
VSS	Vietnam Social Security

【Thailand】

BAAC	**Bank of Agriculture and Agricultural Cooperation**
BMN	Household Basic Minimum Needs
CGD	Comptroller General's Department
CSMBS	Civil Servant Medical Benefit Scheme
CTOP	The Project on the Development of a Community Based Integrated Health Care and Social Welfare Services Model for Older Persons in the Kingdom of Thailand
CUP	Contract Unit for Primary Care
DHO	Dirtrict Health Office
GPF	Government Pension Fund
GSB	Government Saving Bank
HSRI	Health System Research Institute
IHPP	International Health Policy Program
MOF	Ministry of Finance
MOL	Ministry of Labour
MOPH	Ministry of Public Health
MSDHS	Ministry of Social Development and Human Security
NHSO	National Health Security Office
NSF	National Savings Fund
NSFO	National Saving Fund Office
OPP	Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups
PCU	Primary Care Unit
PHO	Provincial Health Office
RMF	Retirement Mutual Fund
SEC	Securities and Exchange Commission Thailand
SRM	Strategic Route Map

SSF	Social Security Fund
SSO	Social Security Office
SSS	Social Security Scheme
TAO	Tambon Administration Organization
THIF	Tambon Health Insurance Fund
THPF	Thai Health Promotion Fund
TPF	Thailand Provident Fund
UC	Universal (health) Coverage
WCF	Workman's Compensation Fund

【Cambodia】

CABDIC	Capacity Building of people with Disabilities in the Community
CARD	Council for Agricultural and Rural Development
CBHI	Community Based Health Insurance
CCT	Conditional Cash Transfer
CPA	Complementary Package of Activities
C/SDP	Commune/Sangkat Development Plan
C/SF	Commune/Sangkat Fund
C/SIP	Commune/Sangkat Investment Program
DFT	District Facilitation Team
DPLA	Department of Local Administration
ESSP	Education Sector Support Project
HCP	Health Coverage Plan
HEF	Health Equity Fund
HEFI	Health Equity Fund Implementer
HEFO	Health Equity Fund Operator
HP	Health Post
HSP	Health Strategic Plan
HSR	Health Sector Review
HSSP	Health Sector Support Project
JFPR	Japan Fund for Poverty Reduction
JPA	Joint Partnership Arrangement
JPIG	JPA Development Partner Interface Group
MOEF	Ministry of Economic and Finance
MOH	Ministry of Health
MOI	Ministry of Interior
MOLVT	Ministry of Labour and Vocational Training
MOP	Ministry of Planning
MOSAVY	Ministry of Social Affairs, Veterans and Youth Rehabilitation
MPA	Minimum Package of Activities
MPSP	Ministry of Planning Strategic Plan
NFV	The National Fund for Veterans
NSDP	National Strategic Development Plan
NSPS	National Social Protection Strategy
NSSF	National Social Security Fund

NSSF-C	National Social Security Fund for Civil Servants
OD	Operational District
ODO	Operational District Office
PBCRG	Planning and Budgeting Committee Representative Group
PFT	Provincial Facilitation Team
PRC	Physical Rehabilitation Center
SFHF	Strategic Framework for Health Financing
SUBO	Subsidy Operator
SWiM	Sector Wide Management
VRG	Village Representative Group

Chapter I Philippines

1. Social Security Overview

1.1. Social security in the constitution

The current constitution of the Philippines was established on February 2, 1987. For social security, it is provided in Section 9 of Article 2 that "The State shall promote a just and dynamic social order that will ensure the prosperity and independence of the nation and free the people from poverty through policies that provide adequate social services, promote full employment, a rising standard of living, and an improved quality of life for all."[1] Additionally, for the rights of citizens to health, it is provided in Section 15 of Article 2 that "The State shall protect and promote the right to health of the people and instill health consciousness among them." Section 11 of Article 13, which concerns social justice and human rights, provides that "The State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. There shall be priority for the needs of the under-privileged, sick, elderly, disabled, women, and children. The State shall endeavor to provide free medical care to paupers to prescribe measures for people in the low-income bracket, etc.

1.2. Current state and basic direction of government policy for social security

In the Philippines' social security system, the Philippines Health Insurance Corporation (PHIC) or "PhilHealth" exists for health insurance, the Government Service Insurance System (GSIS) for pensions and benefits for government officers, the Social Security System (SSS) for the pensions and benefits for employees of private companies, and the Home Development Mutual Fund (HDMF) or the "Pag-IBIG" for savings and housing loans. As the fact that the GSIS and SSS were established in 1936 and 1954, respectively, suggests, the social security system of the Philippines has a long history and was arguably developed ahead of other Asian countries.

Despite the country's long-established system, however, it is hard to argue that the Philippines has a sufficient social security system. Especially, universal coverage has not yet been achieved although such completion had been recognized as a challenge for the Philippines for many years. Social security for the poor and the informal sector is also a major issue.

To overcome this situation, the government of the Philippines has made several social security strategies such as the Health Sector Reform Agenda (HSRA, 1999 to 2004), FOURmula One (F1, 2005 to 2010), and the Aquino Health Agenda (from 2010). Every one of these strategy positions universal coverage or the spread of social security to the poor and the

[1] The translation of the Philippine constitution (1987) is based on the work of Yoshio Hagino, Hiroyuki Hata, and Kazuo Hatanaka (2004) in the *Selection of Asian Constitutions*, Akashi Shoten.

informal sector, and the current Aquino administration has explicitly promised to actively tackle these challenges.

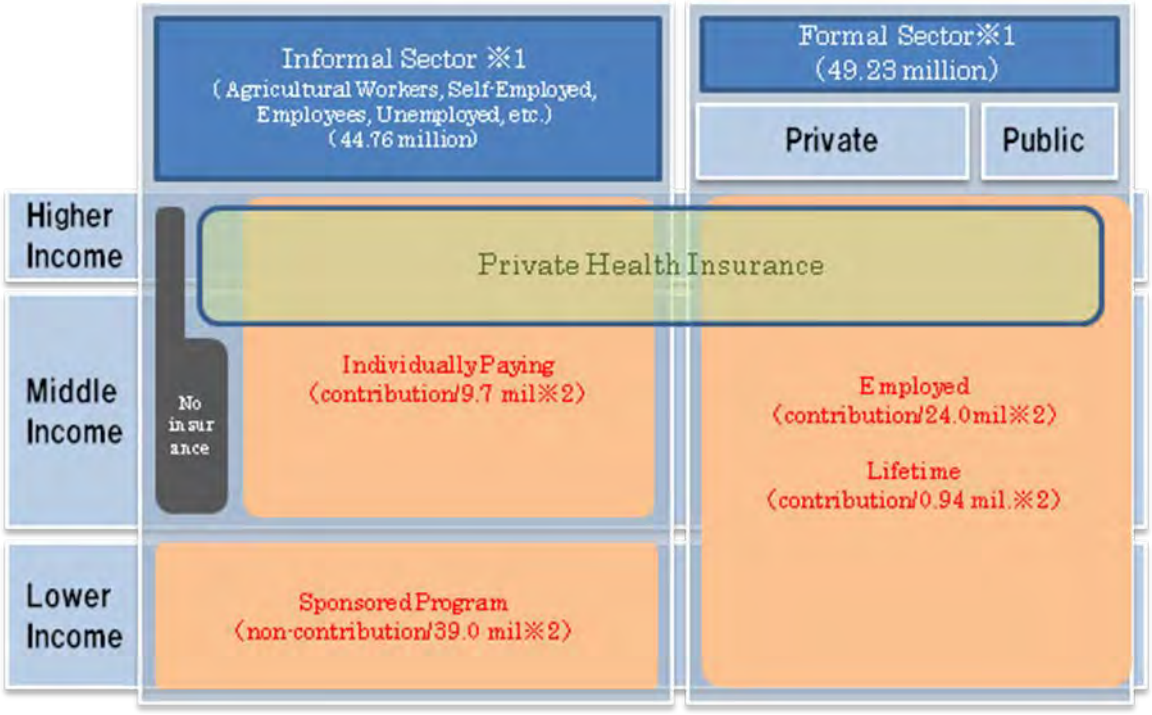
Additionally, an unemployment insurance system has not been in place in the Philippines, and the Department of Labor & Employment (DOLE) and other authorities are attempting to introduce such a system. However, as the ideas regarding desirable unemployment insurance differ among government ministries and agencies, as well as between employers and employees, it is likely to take further time to put an unemployment insurance system in place.

1.3. Outline of the social security system

In the Philippines, PhilHealth takes charge of the health security system. Prior to the establishment of PhilHealth in 1995, separate social security institutions were in charge, specifically, the SSS for the employees of private companies and the GSIS for government officers. However, the systems have been integrated under PhilHealth.

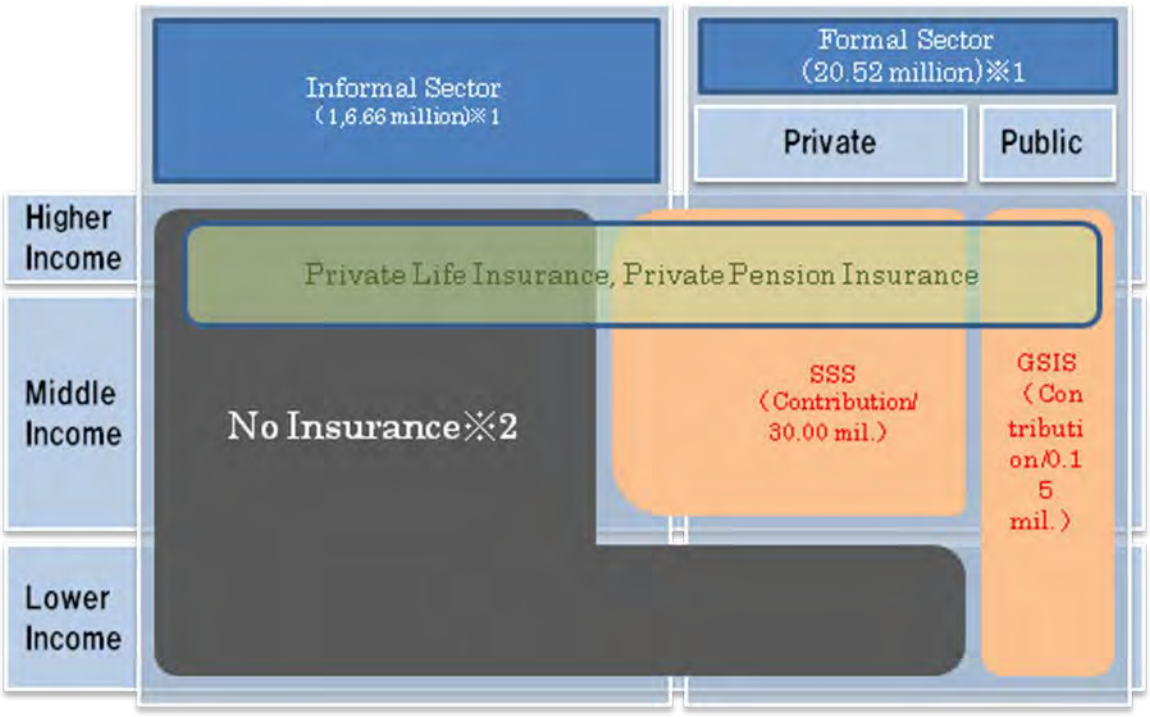
For social security for employees, such as old-age pensions and workers' compensation (income security), the SSS and GSIS serve the employees of private companies and government officers, respectively. The services they provide are almost the same, and both institutions provide services including retirement pensions, survivorship pensions, disability benefits, and sickness benefits. On the other hand, income security for the informal sector is insufficient. Informal-sector employees can join the SSS, which admits voluntary subscriptions, but only a few of them can actually subscribe to the SSS, as the contributions are unaffordable for them. Note that, although it is not a pension system, the Pag-IBIG provides a savings fund and a loan system that are affordable for low-income earners, thus functioning as a social security institution for the informal sector to a certain extent.

Figures I-1 Outline of the Philippines' health security system



※1Ratio of formal sector population and informal sector population in 2008 in Philippines is 1.1 to 1. The number of each sector population in 2011 (total population is 94 million) is calculated according to the above ratio.
Ref. World Bank, World Development Indicators & Global Development Finance
※2The coverage ratio of PhilHealth is 82% in 2011 according to PhilHealth. However, some researchers estimates the coverage ratio at 30% or so.
Source: Compiled by Mitsubishi UFJ Research and Consulting

FiguresI-2 Outline of the Philippines' income security system



※1 Population of each sector are limited to the labor force. According to estimates by National Statistics Office, Employee of the year 2011 is 37,191,000. Among total employees, wage and salary worker accounts for 55.2%, own account accounts for 33.2%, unpaid family worker accounts for 11.6%. For own account and unpaid family workers corresponds to the informal sector, the informal sector in Philippines is 17,660,000 people (44.8% of the total employees). Regarding the definition of the informal sector, see footnote 2 of this chapter..
※2 Note that, although not shown in the figure, the Pag-IBIG exists as a savings and loan institute for both the formal and informal sectors. Non-security include people who are using the system of Pag-IBIG. For the small amount of compensation, those people are not included in the figure.Source: Compiled by Mitsubishi UFJ Research and Consulting

2. Organizations Involved in Social Security

2.1. Department of Health (DOH)

The DOH governs the field of public health, provides basic public health services, and regulates the providers of health-related equipment and services. The DOH's major roles are: (1) playing a leading role in the health-related field, (2) supporting competence development, and (3) managing and supervising services in specific fields.[2]

DOH is composed of Bureau of Health Devices and Technology (develop policies and regulations for health and health-related devices and technologies ; develop regulations and conduct licensing and accrediation of health and health related devices and technology, and so on), Bureau of Health Facilities and Services (develop and disseminates standards for regulation of health facilities and services ; conduct licensing and accrediation for health facilities, and so on), Bureau of Local Health Development (provide the standards and procedures about local health system development ; Strengthens regional capacities to support and assist local health systems), Bureau of International Health Cooperation (develops standards, mechanisms and procedures for international health cooperation ; provides services related to mobilization, coordination, management and assessment of externally supported health projects and initiatives, and so on), Bureau of Quarantine and International Health Surveillance (formulates and enforces quarantine laws and regulations, and so on), and so on. DOH also has authority to manage DOH hospitals.

As an objective to be accomplished by 2030, the DOH has stated that it will establish a competitive health system that supports good health, meets the needs of people, and attains equal health finance.[3] Furthermore, the DOH has stated as its duty that it will secure continuing as well as equal, quality health for all Philippine people including the poor, and will play a leading role to achieve a good health system.

2.2. Department of Social Welfare and Development (DSWD)

The DSWD takes charge of social welfare for the poor and for the socially handicapped persons, households, and regions. The roles of the DSWD are described below.[4]

- Making policies: Makes policies for agents and policy enforcers in charge of social welfare and development
- Program development: Develops and expands programs for children & the young, females, families, regions, single people, the elderly, and the PWD
- Registering, licensing, and authorizing persons: Gives licenses and authorizations to

[2] DOH website, http://www.doh.gov.ph/node/97 (accessed in March 22, 2012)
[3] DOH website, http://www.doh.gov.ph/Mission_Vision (accessed in March 22, 2012)
[4] DSWD website, http://www.dswd.gov.ph/index.php/about-us (accessed in March 22, 2012)

persons and institutions engaged in social welfare and development; also sets standards and monitors the state of conformity to those standards

- Supporting the development of techniques and competence: Supports agents in developing techniques and competence
- Supporting local government units (LGU): Supports the provision of social security and social welfare services to the poor and to vulnerable, handicapped sectors

DSWD has developed and improved the National Household Targeting System for Poverty Reduction (NHTS-PR), which was developed for identifying the beneficiaries of poverty reduction program.

DSWD is composed of Office of the Secretary Group, Operations and Programs Group (Social Technology Bureau, Poverty Reduction Programs Bureau, and Protective Services Bureau), Policy and Plans Group (Policy Development and Planning Bureau, Information and Communication Technology Management System, National Household Targeting Office), Institutional Development Group (Capacity building Bureau, Human Resource Development Bureau, Standards Bureau, Resource Generation and Management Office) and so on.

2.3. Department of Labor and Employment (DOLE)[5]

DOLE makes and implements policies and plans in the field of labor and employment. Stating the full employment of all Philippine people, the realization of decent work, and the achievement of productive employment as its objectives, DOLE provides opportunities for paid employment, develops human resources, protects employees, improves employee welfare, and maintains balance in the industrial sector, as its duties.

2.4. Social Security System (SSS)[6]

The SSS is a government-managed social insurance institution mainly for the employees of private companies. The SSS is put under the management and supervision of the Social Security Commission (SSC), an institution superior to the SSS. The SSC is composed of nine members: three representatives of employers, three representatives of trade unions, and three other members including the Minister of DOLE.[7] The president appoints the chairman.

The SSS provides: services for paying pensions, such as retirement pensions, survivorship pensions, and disability pensions; services for providing benefits such as maternal benefits and sickness benefits; and lending services such as salary loans, emergency loans, and housing loans. The SSS also conducts asset management. As its financial resources, the institution depends on social insurance contributions and profits made through investments and asset management

[5] DOLE website, http://www.dole.gov.ph/secondpage.php?id=57 (accessed in March 22, 2012)
[6] Refer to the SSS website; http://www.sss.gov.ph/sss/index2.jsp?secid=759&cat=3&pg=null, etc. (accessed in March 22, 2012)
[7] Interviews with the SSS

(such as lending).

2.5. Government Service Insurance System (GSIS)[8]

The GSIS is a government-managed social insurance institution for government officers. The GSIS is put under the management and supervision of the board of trustees of the GSIS, an institution superior to the GSIS, in which members are appointed by the president.

The GSIS provides services including pension payment services, various insurance services, services based on the employee compensation program, and lending services. Like the SSS, the GSIS conducts asset management.

The GSIS depends on contribution from both employers and employees as its financial resources. The total revenue of 2009 was about 93.4 billion PHP[9], while total expenditure was 44.8 billion PHP. In addition, contribution revenue was 53.7 billion PHP (57.5% of total revenue), while pension expenditure was 39.7 billion PHP (88.6% of total expenditure).

Currently, the SSS, the GSIS, PhilHealth, and the Pag-IBIG are trying to communize the insured person number and are preparing to introduce the unified multi-purpose ID (UMID). Originally, the SSS was expected to take the initiative in developing the UMID system. However, the SSS now lags behind in system development and the GSIS plays a leading role in introducing the system.

2.6. Philippines Health Insurance Corporation (PHIC or PhilHealth)[10]

PhilHealth is an institution for operating and implementing the public health insurance system, established by integrating the health insurance benefit units of the SSS and GSIS. The foundation of this institution is based on the Philippine Medical Care Act of 1969 (Republic Act 6111, established in 1969), by the Marcos administration, and the National Health Insurance Program (Republic Act 7875, established in 1995), by the Ramos administration, etc.

Based on the Philippine Medical Care Act of 1969, the Philippines Medical Care Commission (PMCC) was established as an organization to supervise the implementation of the medical care program. As a higher-quality insurance program that meets people's needs is required in the 1990s, the Ramos administration developed the National Health Insurance Program in 1995, and PhilHealth was established as an institution for operating and implementing the health insurance system. Authorities concerning health insurance were gradually transferred from various institutions; the health insurance authority of each institution was transferred to PhilHealth from the GSIS in 1997, the SSS in 1998, and the Overseas Workers Welfare Administration in 2005. Section 14 of the Republic Act No.7875 provides that PhilHealth is a

[8] GSIS website, http://www.gsis.gov.ph/default.php?type=main&id=28 (accessed in March 22, 2012)
[9] 1 peso（PHP）=1.903 JPY(JICA transaction rate as of May 2012 as reference)
[10] PhilHealth website,
http://www.philhealth.gov.ph/about_us/history.htm (accessed in March 22, 2012)

tax-exempt government corporation attached to the DOH.

2.7. Home Development Mutual Fund (HDMF or Pag-IBIG)[11]

The Pag-IBIG, an institution established in 1978, provides small-sum savings services and housing loans. Originally, for the savings program, the GSIS and SSS were in charge of government officers and the employees of private companies, respectively, but their authorities were transferred to the National Home Mortgage Finance Corporation (NHMFC) in 1979. After the HDMF law (PD1752) was established in 1980, the Pag-IBIG was born as a spun-off independent institution from the NHMFC.

2.8. Public Employment Service Office (PESO)[12]

PESO, an institution established in 1999 based on the PESO Act (Republic Act 8759), states the full employment of the Philippine people and the provision of equal employment opportunities as its purposes. To promote employment, PESO provides free-of-charge services such as: matching jobseekers and employers, providing information on life-based programs, supporting overseas employment, holding profession understanding programs, and providing counseling prior to employment, etc. PESO is operated by various entities including national universities, local governments, NGOs and community bases. DOLE and the local offices of DOLE cooperate with PESO and provide technical advice to PESO.

2.9. LGUs[13]

By the Local Government Act 1991, the authority on Social Security in the Philippines has been transferred to the (LGU) local governments. About the role of each local government on health and social security, the Local Government Act 1991 stipulates as follows,

- Barangays: providing health and social welfare service, including the maintenance of day-care center, barangay health centers
- Municipality: the implementation of programs and projects for primary health care, maternal and child care, anti-infectious diseases and lifestyle-related diseases, access to second and tertiary health services, purchase of pharmaceutical and medical equipment ; welfare service for children and youth, families, welfare service of community, welfare for women, wlefare for the elderly and the disability, rehabilitation program for street children, youth deliqunency, and drug addicts ; anti-poverty programs for poverty, nutrition program ; family planning, and so on.street children, youth delinquency, for drug addicts, and other nutrition programs, such as family planning welfare youth welfare, family, community, women and children and the elderly implementation.

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[11] Pag-IBIG website, http://www.pagibigfund.gov.ph/abouthdmf.aspx (accessed in March 22, 2012)
[13] Yamashita Shigeru (2010) , *Comparative local government*, Gyousei, pp.234-239.
[13] Yamashita Shigeru (2010) , *Comparative local government*, Gyousei, pp.234-239.

- Province : Provision of health services including hospitals and other tertiary health services ; Implementation of social welfare programs and projects for refugees and armed forces members, humanitarian assistance, and development of residents : Implementation of programs and projects related to low-cost housing.
- City : City has the authority to conduct the all the health and social welfare services and services concerning the facilities.

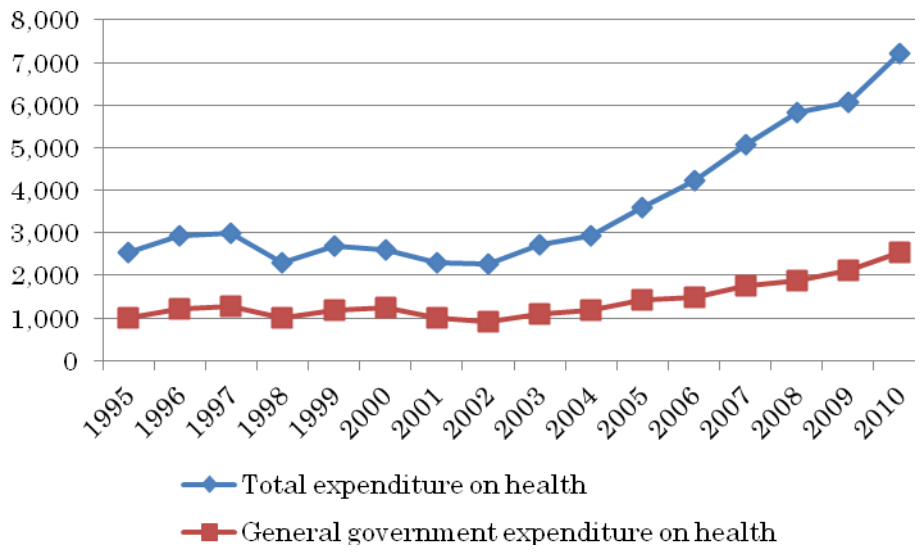
3. Social Security Budgets

3.1. Health budget

Affected by the financial crisis in 1997, general government health expenditure significantly declined in 1998, but largely increased in the 2000s. General government health expenditure, which was 1.237 billion dollars in 2000, almost doubled to 2.549 billion dollars in 2010. However, considering that the growth rate of the entire health expenditure almost tripled in the same period, the growth rate of the general government expenditure was said to be moderate.

FiguresI-3 Trends in health expenditure (1995–2010)

Unit: Million U.S. dollars



※2 General government expenditure on health includes all levels of government. For a definition, See http://www.who.int/healthinfo/statistics/indhealthexpenditure/en/index.html.
Source: Compiled by Mitsubishi UFJ Research and Consulting based on the Global Health Expenditure Database according to WHO

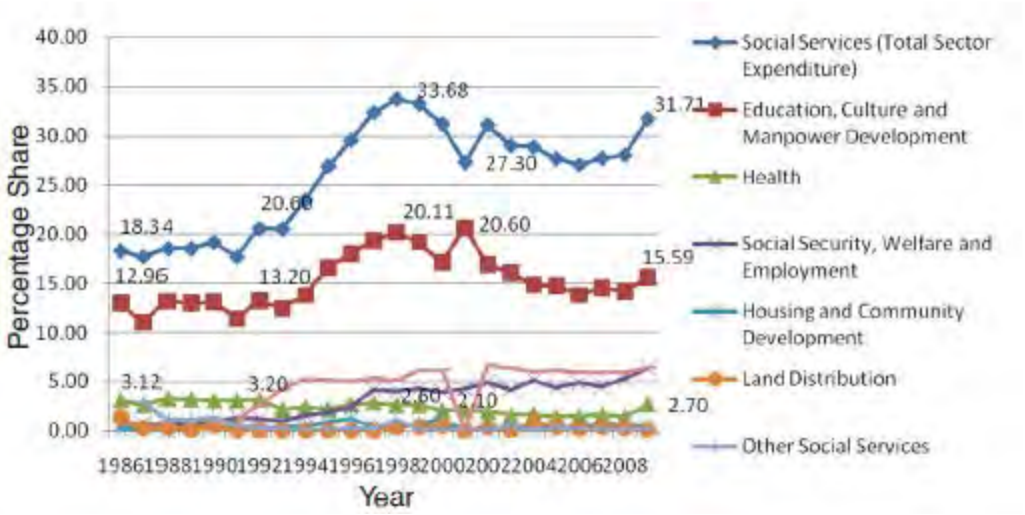
3.2. Social welfare budget

Figure 4 shows a graph that relates the trend in the proportion of the health and social security expenditure in the budget. While the proportion of the expenditure for all social aspects including education is arguably and largely on the rise, and while it reached around 32% of the budget in 2008, the 1997 Asia currency crisis led to a one-time large dip in the proportion.

Regarding the breakdown, the areas of education, culture, and human development accounted for almost half of the expenditure regarding social aspects in 2008. The proportions of the health-related field and social security/social welfare in the total expenditure were about 3% and

6%, respectively—smaller than the proportion of the education field in the expenditure for the area regarding social aspects.

Figures I-4 Trends in the proportion of health and social security expenditures in the budget (1986–2008)



Source: Excerpts from p. 234 of the Philippines Development Plan 2011–2016

3.3. LGU budget

Figure 5 is a chart showing the breakdown of budget LGU.Total budget has increased by 15% between 2010 and 2012. On the other hand, the budget of social service has been increased by 29%, which exceeds the growth rate of the total budget at the same time period.

Figures I-5 Breakdown of LGU expenditure (2010-2012)

billion PHP

	2010				2011				2012			
	Mun.	City	Prov.	Total	Mun.	City	Prov.	Total	Mun.	City	Prov.	Total
Total	96.39	107.42	64.36	268.16	103.39	123.30	69.69	296.38	107.57	126.58	73.82	307.97
General Services	55.75	47.95	26.60	130.30	58.99	53.56	27.58	140.14	61.57	55.35	29.33	146.26
Economic Services	19.20	25.42	17.00	61.62	19.31	27.12	16.53	62.96	19.87	27.38	17.59	64.85
Social Services	14.66	20.78	15.11	50.55	16.86	26.25	18.16	61.27	18.43	27.38	19.51	65.32
Debt Services	6.77	13.28	5.65	25.70	8.23	16.37	7.41	32.01	7.70	16.46	7.38	31.54

※1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)

Source : Department of Bugdet and Management, SUMMARY OF RECEIPTS AND EXPENDITURES OF LOCAL GOVERNMENT UNITS, FY 2010-2012

4. Health Security

4.1. National plans for the health security sector

As a national plan for the health security sector, the National Objectives for Health are set every six years. National Objectives for Health summarizes the six years of the achievements and challenges for health policy of the previous government and establishes the goals and strategies of the next six years. Health Sector Reform Agenda, Formula One and other policies have been developed as a framework for implementation.

Since the authorities concerning the health security sector were transferred to local governments based on the 1991 Local Government Code, coordination with local governments is required to carry out health security policies. Under FOURmula One for Health (F1), each local government develops the "Province-wide Investment Plan for Health (PIPH)."[14]

4.1.1 Health Sector Reform Agenda (HSRA, 1999 to 2004)[15]

The HSRA is an agenda developed for the purpose of improving the performance of the health sector in 1999. Setting the expansion of the coverage of the health program at the national and local levels, the enhancement of accessibility to public and private health services especially for the poor, the fulfillment of universal coverage, and a reduction in the load of household health costs as its priority fields, the HSRA states the six items shown below for the health sector reform.

- Local health system reform: Improve the city-, municipality-, village-, and province-level health system
- Hospital system reform: Improve the financial and operational independence of government hospitals
- Health program reform: Strengthen the leadership of the DOH regarding sickness prevention, etc.
- Health laws and regulations reform: Strengthen the DOH's competence concerning the implementation of regulations related to health products and equipment, etc.
- Social health insurance reform: Improve PhilHealth coverage and benefit units.
- Health-related financial reform: Realize universal coverage.

4.1.2 FOURmula One for Health (F1, 2005 to 2010)[16]

As a successor of the HSRA, F1 was made in June 2005. As its objectives, F1 states better quality health services, a health system satisfying need, and the achievement of equal health

[14] WHO (2011), Philippines, p. 344
[15] http://erc.msh.org/hsr/index.htm (accessed in March 22, 2012)
[16] WHO/WPRO website, http://www.wpro.who.int/countries/phl/PHL.pdf (accessed in March, 2012)

finance. The four priority areas of reform in F1 are shown below.

- Provision of health services: Develop health facilities, eradicate infectious diseases and sickness such as malaria and filariasis, and prepare against natural disasters and pandemics.
- Laws and regulations in the health-related field: Rationalize and adjust licensing regulations, establish the unified certification of health products, and enhance accessibility to essential medicine for the poor.
- Health finance: Reform health finance and expand the National Health Insurance Program.
- Good governance of the health-related field

4.1.3 Aquino Health Agenda (AHA, 2010 to 2016)[17]

The AHA is an agenda that was introduced based on administrative order 0036 for the purpose of improving, rationalizing, and promoting the results achieved by the HSRA and F1. The AHA states the achievement of universal coverage as its priority issue. The expansion of health services to the poor is also one of its priority issues. Under the AHA, the National Health Insurance Program is developed to attain objectives such as protecting the poor against financial risks, modernizing/securing the sustainability of health facilities, and improving public health services to achieve the millennium development goals. As shown in FiguresI-3, the expanding government health expenditure continues to grow due to the development of the AHA without changes after the establishment of the Aquino administration.[18]

4.2. Salient features of health care delivery systems[19]

In the Philippines, around 1,800 hospitals have been set up, comprising approximately 700 public hospitals and approximately 1,000 private hospitals. While the proportion of private hospitals is large in terms of the number of hospitals, the proportions are almost equal in terms of the number of beds.

[17] WHO (2011), *Philippines*, pp. 342–343
http://www.wpro.who.int/countries/phl/26PHLpro2011_finaldraft.pdf (accessed in March 22, 2012)
[18] Interviews with PhilHealth
[19] Kawahara Kazuo(2008), *Health situations and the medical insurance system of the Philippines in Journal of health care and societ,y vol. 18, no.1, pp. 192–194*

Figures I-6 List of health facilities (2007–2010)

	2007	2008	2009	2010
Hospitals	1,781	1,784	1,795	
Public	701	711	721	
Private	1,080	1,073	1,074	
Bed capacity	92,561	94,199	95,991	
Public	47,141	47,889	48,349	
Private	45,420	46,310	47,642	
Bed-populatoin ratio (per 10,000 population)	10.4	10.4	10.4	
Barangay health facilities(*Barangay* health facilities)			16,191	16,219

※1 Barangay health facilities treat first aid, maternal and child care, social disease, and so on. In 2009, given that there are 41,984 barangays, there is one barangay health center per one barangay on average.
Source: Compiled by Mitsubishi UFJ Research and Consulting based on National Statistics Office (2012), *Philippines in Figures 2012*, pp. 49–50.

4.3. Basic structure of the health security system

In the Philippines, the health insurance benefit units of the SSS and GSIS were integrated in 1995 and institutions for operating the public health insurance system were unified into PhilHealth. However, as shown in the figure below, although institutions for operating the public health insurance system were unified into PhilHealth, the public health insurance system can be divided into programs for overseas employees, the voluntary insured persons, the targets of poverty programs, government officers and the employees of private companies, and the lifetime insured persons, and each program is implemented based on a different model.

While the contribution system of PhilHealth is basically defined-contribution system, with respect to low-income earner, insurance premium is subsidized by National Government and LGU.

PhilHealth depends on contribution from insured persons and subsidies from the central government and the LGU. The PhilHealth contributions vary depending on the program. The annual contribution for overseas employees is 1,200 PHP while that for the voluntary insured persons is 1,200 PHP for those with a monthly salary credit 25,000 PHP or less. It is 2,400 PHP for those with a monthly salary credit 25,000 PHP or more. For the government officers and employees of private companies, both the employee and the employer incur the contribution

costs. For the poor, a program for the poor has been set up, and the central or local government incurs the contribution costs in place of PhilHealth sponsor members. The target of this program is the poor, which account for about 35% of the population. For a grasping of the numbers of the poor, the National Household Targeting System for Poverty Reduction (NHTS-PR), developed by DSWD, is used (details of the NHTS-PR will be described later).[20]

Figures I-7 Outline of PhilHealth

	National Health Insurance				
Year of establishment	1995				
Related Act	the Philippine Medical Care Act of 1969 (Republic Act 6111) the National Health Insurance Act of 1995(Republic Act 7875)				
Administrative agency	PhilHealth				
Program	Overseas Worker	Individually Paying	Sponsored Program	Employed	Lifetime
Model	contributory	contributory	non-contributory	contributory	contributory
Contribution (year)	1,200PHP	Professionals or more than 25,000PHP estimated monthly family income: 2,400PHP 25,000PHP and below : 1,200PHP	Public expenditure	2.5% of monthly salary Employee share : 1.25% Employer share : 1.25%	
Condition of membership	voluntary	voluntary	voluntary	Compulsory	voluntary
Target group	OFWs with registration of POEA	Self-employed, Self-earning professionals, Professional athletes,	indigents belonging to the lowest 25% of population	workers in the government and private sectors	former employees of the government/private sectors who have paid at least 120

[20] Interviews with PhilHealth

		Farmers, Fisherfolks, workers in the informal sector, separatee etc.			monthly premium contributions etc.
Coverage to population（Total）（As of September, 2011 ）	78.31million				
Coverage to populatoin（by program）	5 million	9.71million	38.94million	23.73million	0.94 million
Payment system for OP	payment by results				
Payment system for IP	payment by results				
copayment	medical expenses which exceed the limit of insurance benefit				
Annual health expenditure（Total）（As of 2010）	30.5 billion PHP				
Annual health expenditure（by program）（As of 2010）	0.95 billion PHP	4.42 billion PHP	6.63 billion PHP	16.54 billion PHP	1.97 billion PHP
Exclusions	・Fifth and subsequent normal obstetrical deliveries ・Non-prescription drugs and devices ・Alcohol abuse or dependency treatment ・Cosmetic surgery ・Optometric services ・Other cost-ineffective procedures as defined by PhilHealth				

※1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)
Source: Compiled by Mitsubishi UFJ Research and Consulting based on the PhilHealth website http://www.philhealth.gov.ph/members/, etc. (as of April 9, 2012)

4.4. Coverage

4.4.1 The insured persons of each program

Although people are legally obliged to subscribe to the public health insurance system, universal coverage has not yet been achieved in the Philippines. According to the announcement by PhilHealth, the enrollment figures were 78.31 million and the coverage reached 82% as of September 2011.

Note that, since the enrollment figures are value estimates calculated by multiplying the number of registered (in most cases the head of the household) by five, the average number of household members in the Philippines, the actual coverage is expected to be below this value.[21]

Furthermore, the National Demographic and Health Survey in 2008 conducted by the National Statistics Office estimates the coverage to be 38%. Additionally, some experts point out the coverage is just over 30%.

The insured persons can be broken down into five categories based on the employment relationship, etc.

Figures I-8 Enrollment figures in PhilHealth (as of September 2011, unit: million persons)

Program	Registered Members	Dependents	Total
Government-Employed	2.00	3.94	5.94
Private-Employed	8.61	9.17	17.79
Sponsored Program	9.73	29.21	38.94
Regular	4.77	12.71	17.48
DOH	0.68	1.83	2.51
NHTS-PR	4.28	14.67	18.95
Individually-Paying	4.22	5.49	9.71
Lifetime Members	0.57	0.37	0.94
Overseas Workers Program	2.52	2.48	5.00
Total	27.66	50.66	78.31

Source: PhilHealth, Stats & Charts 3rd Quarter 2011
http://www.philhealth.gov.ph/about_us/statsncharts/snc2011.pdf (Accessed on March 22, 2012)

4.4.2 Policies for expanding the coverage

Under the Aquino Health Agenda (AHA), the DOH tackles the strategic areas of priority shown below to achieve universal coverage.[22]

- Protection from financial risks: Attempt to improve the benefit delivery ratio of the

[21] PhilHealth admits possible overevaluation of the coverage. According to PhilHealth's estimate, the actual coverage is in the latter half of the 70% ranges. This is based on interviews with PhilHealth and various experts.
[22] WHO (2011), *Philippines*, p. 342

National Health Insurance Program (NHIP) through registration in the NHIP and the expansion of benefits, and protect the poor from the financial burden of using health services

- Quality hospitals and the improvement of accessibility to health facilities: Enhance the competence of national hospitals and enhance the quality of services to achieve millennium development goals (MDGs) and make it possible to cure and treat injuries and other emergencies, adult diseases, and complications
- Achievement of health-related MDGs: Reduce the maternal/child death ratio and the disease/death ratio of tuberculosis and malaria, take measures against emerging infectious diseases, and prevent and manage adult diseases.

For the national strategy concerning universal coverage, the six strategic measures shown below are prioritized.[23]

- Health finance: In order to strengthen the financial protection of the poor and vulnerable, make the allocation and utilization of resources as used for health more effective
- Service provision: In order to deal with how to use the health services and changes in effectiveness, reform the health service provision system
- Development of policies, standards, and regulations: Secure equal access to health services, essential medicines, technologies with secured quality, availability, and safety
- Health governance: Establish a mechanism pursuing efficiency, transparency, and accountability, while preventing fraud
- Securing of health human resources: Secure access to health specialists for all Philippine people
- Information on health: Provide prompt and efficient health services, improve the health system management on the local level, and establish a modern information system so that the basis of policy-making and program-forming will be provided.

4.4.3 Issues/challenges and obstacles in expanding the coverage

As one of the causes of insufficient coverage in the Philippines, the side effect of decentralization can be pointed out.[24] Problem can be divided into two. The first is that the LGU has arbitrarily selected the subject of the PhilHealth sponsored program, the second is that in some cases improvement of the quality of health services is prevented.

For the first problem, according to Manasan, beneficiary household exceeded poor household that originally selected as beneficiary from 2007 to 2009 in 23 to 44 provinces. Also in 2010, beneficiary household exceeded the original number in 56 provinces.

[23] WHO (2011), *Philippines*, pp. 342–343
[24] WHO (2011), *Philippines*, p. 343

Although the lack and shortage of identifying system of LGU for selecting beneficiary households is the one of the cause for arbitrary selection, the problem that politicians in LGU use the poverty program as a political means to gain the support of the residents has also been pointed out. As described later, this issue has been gradually solved since NHTS-PR(National Household Targeting System for Poverty Reduction)was developed, has been prevailed nationwide, and utilized across ministries and agencies. NHTS is to eliminate "the political poor" and to capture the low-income earners based on the unified criteria in order to provide the health security for them. Insurance premium of the beneficiaries identified by NHTS is funded by the central government since 2011. However, even after the development of NHTS, LGU can identify and select the beneficiaries based on its own standards, in which case, public expense is paid by LGU.The second problem is that adequate health services cannot be provided in financially insufficient LGU. In order to receive support from the IMF and the World Bank, the Philippines promoted decentralization based on the structure adjustment programs from both institutions and has established the Local Government Code (LGC) in 1991.

After the LGC was established, the authorities of the DOH were transferred to the LGUs, resulting in a considerable reduction in the DOH's authorities. While the DOH holds specialty hospitals, local hospitals, and medical centers, provincial governments manage provincial hospitals and area hospitals, while cities, municipalities, and villages manage rural health units (RHU) and the health stations in the *barangays*. As a result of the transfer of regional health services to the LGUs, the central government, when trying to improve health services across the country, cannot achieve its purposes without obtaining cooperation from the LGUs. Additionally, as operational bodies vary, differences in how to provide health services and in the service quality are generated.

Furthermore, while the expenditure for national public health services increases, the LGUs' expenditures have not increased; or rather, they have declined.[25] Only a few LGUs have enough financial power, and some LGUs even use the budget originally assigned to health services for other fields.[26]

4.5. Contribution rates

As described above, the PhilHealth contributions vary depending on the programs. The contribution for overseas employees is 1,200 PHP, while that for the voluntary insured persons is 1,200 PHP for those with a monthly salary credit 25,000 PHP or less. It is 2,400 PHP for those with a monthly salary credit of 25,000 PHP or more. For government officers and the employees of private companies, the contribution is 2.5% the monthly salary credit, and both

[25] WHO (2011), *Philippines*, p. 345

[26] The matter is slightly different from the relationship between the central government and the LUG, but one of the relative successes of the SSS in increasing the enrollment figures can be that the structure of the SSS is "centralized," where local offices obey orders from the central government. This is based on interviews with the SSS.

the employee and the employer incur 1.25% each. For the poor, a program has been set up and the central government or the LGU incurs the contribution costs in place of the insured person.

Figures I-9 Contribution rates for the employee program

Salary bracket	Salary Range	Salary Base	Total Monthly Premium	Employee Share	Employer Share
1	4,999.99 and below	4,000.00	100.00	50.00	50.00
2	5,000.00–5,999.99	5,000.00	125.00	62.50	62.50
3	6,000.00–6,999.99	6,000.00	150.00	75.00	75.00
4	7,000.00–7,999.99	7,000.00	175.00	87.50	87.50
5	8,000.00–8,999.99	8,000.00	200.00	100.00	100.00
6	9,000.00–9,999.99	9,000.00	225.00	112.50	112.50
7	10,000.00–10,999.99	10,000.00	250.00	125.00	125.00
8	11,000.00–11,999.99	11,000.00	275.00	137.50	137.50
9	12,000.00–12,999.99	12,000.00	300.00	150.00	150.00
10	13,000.00–13,999.99	13,000.00	325.00	162.50	162.50
11	14,000.00–14,999.99	14,000.00	350.00	175.00	175.00
12	15,000.00–15,999.99	15,000.00	375.00	187.50	187.50
13	16,000.00–16,999.99	16,000.00	400.00	200.00	200.00
14	17,000.00–17,999.99	17,000.00	425.00	212.50	212.50
15	18,000.00–18,999.99	18,000.00	450.00	225.00	225.00
16	19,000.00–19,999.99	19,000.00	475.00	237.50	237.50
17	20,000.00–20,999.99	20,000.00	500.00	250.00	250.00
18	21,000.00–21,999.99	21,000.00	525.00	262.50	262.50
19	22,000.00–22,999.99	22,000.00	550.00	275.00	275.00
20	23,000.00–23,999.99	23,000.00	575.00	287.50	287.50
21	24,000.00–24,999.99	24,000.00	600.00	300.00	300.00
22	25,000.00–25,999.99	25,000.00	625.00	312.50	312.50
23	26,000.00–26,999.99	26,000.00	650.00	325.00	325.00
24	27,000.00–27,999.99	27,000.00	675.00	337.50	337.50
25	28,000.00–28,999.99	28,000.00	700.00	350.00	350.00
26	29,000.00–29,999.99	29,000.00	725.00	362.50	362.50
27	30,000.00 and up	30,000.00	750.00	375.00	375.00

※1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)
Source: PhilHealth website,
http://www.philhealth.gov.ph/partners/employers/report.html (accessed in March 2012)

4.6. Benefit Packages[27]

Benefit packages basically depend on inpatient costs, such as the room fee, food cost, medicine cost, and practice cost, as well as the outpatient costs, such as medicine cost, practice cost, and cost for preventive services, etc.

Figures I-10 PhilHealth revenue (2004–2010)

(unit : million PHP)

	2004	2005	2006	2007	2008	2009	2010
Premium Contribution	16,516	18,274	22,580	23,727	25,641	25,981	29,088
Interest and Other Income						6,458	6,280
Interest	4,429	5,072	5,615	5,387	5,507		
Other Income					30		
Total	20,968	23,366	28,223	29,138	31,179	32,439	35,368

※1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the PhilHealth Annual Report

FiguresI-11　PhilHealth expenditure (2004–2010)

(unit : million PHP)

	2004	2005	2006	2007	2008	2009	2010
Benefit Payment	12,953	17,519	17,201	18,451	18,155	24,310	30,513
Operating Expenses	2,160	1,761	1,916	2,387	3,176	3,598	3,809
Total	15,113	19,280	19,117	20,838	21,331	27,908	34,322

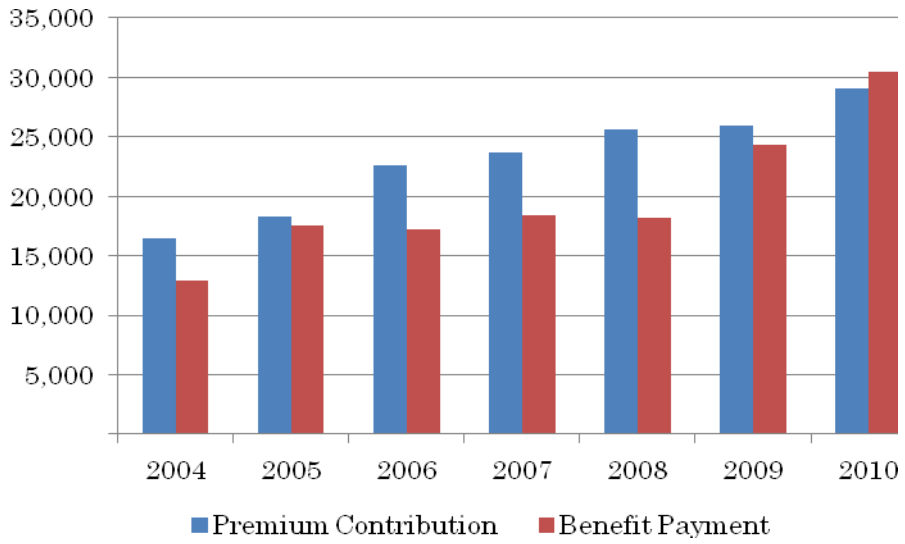
※1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)

Source: Same as the above

[27] PhilHealth website, http://www.philhealth.gov.ph/members/employed/coverage.html (accessed in March 22, 2012)

FiguresI-12 Trends in PhilHealth contribution and payment (2004–2010)

(unit: million PHP)



Source: Same as the above

FiguresI-13 Breakdown of benefit payment (2009 and 2010)

(Unit: million PHP)

	2009 年	2010 年
Employed		
Private Sector	9,360	11,083
Government Sector	4,688	5,459
Indigent Program（IP）	3,331	5,626
Indigent Program（Capitation）	684	1,008
Overseas Workers Program	756	949
Individually Paying Program	3,745	4,419
Non paying Program	1,745	1,969
Total	24,310	30,513

※1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)

Source: Same as the above

Benefits are provided using the in-kind benefit method, and the cost exceeding the benefit payment is incurred by the insured person.[28] While the system adopts the in-kind benefit method, it is practically similar to a cash benefit, as PhilHealth benefit payment is limited to a certain level. Additionally, since the PhilHealth maximum benefit payment is set low, the

[28] Kawahara (2008)

self-pay ratio of patients is as high as about 80%.

To receive benefit paymentfrom PhilHealth, the conditions described below shall be met.

FiguresI-14 PhilHealth benefit payment requirements

Members	Requirements
Overseas Filipino Worker	・ Within the validity period of OFW's PhilHealth Member Registration Form (PMRF) ・ 45 days allowance per year for hospital room and board
Individually Paying	・ Payment of at least three monthly premiums within the immediate six months prior to month of confinement. For pregnancy-related cases and availment of the newborn care package, dialysis, chemotherapy, radiotherapy etc., payment of nine monthly premium contribution within the last 12 months(except for those enrolled under the KASAPI program) ・ Confinement in an accredited hospital for at least 24 hours due to an illness or injury ・ Attending physicians must also be PhilHealth-accredited. ・ Within the 45 day allowance for room and board
Sponsored Program	・ Within the validity period of PhilHealth card ・ Confinement in an accredited hospital for at least 24 hours due to an illness or injury ・ Attending physicians must also be PhilHealth-accredited. ・ Within the 45 day allowance for room and board
Employed	・ Payment of at least three monthly premiums within six months prior to the month of confinement ・ Confinement in an accredited hospital for at least 24 hours due to an illness or injury ・ Attending physicians must also be PhilHealth-accredited. ・ Within the 45 day allowance for room and board
Lifetime	・ Confinement in an accredited hospital for at least 24 hours due to an illness or injury ・ Attending physicians must also be PhilHealth-accredited. ・ Within the 45 day allowance for room and board

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the PhilHealth website, etc.;
http://www.philhealth.gov.ph/members/overseas_workers/condition.html (as of April 22, 2012)

FiguresI-15 List of health insurance benefits

(PHP)

	Level 1 hospitals (primary)		Level 2 hospitals (secondary)			Level 3 hospitals (tertiary)			
Benefit Item	Case Type		Case Type			Case Type			
	A	B	A	B	C	A	B	C	D
Room and Board	300	300	400	400	600	500	500	800	1,100
Drugs and Medicine	2,700	9,000	3,360	11,200	22,400	4,200	14,000	28,000	40,000
X-ray, Laboratory and Others	1,600	5,000	2,240	7,350	14,700	3,200	10,500	21,000	30,000
Operating Room	500	500	below RVU 30 = 750			below RVU 30 = 1,200			
			RVU 31- 80 = 1,200			RVU 31 - 80 = 1,500			
			RVU 81 - 600: RVU x PCF 15			RVU 81 - 600: RVU x PCF 20			
			(minimum = 2,200 maximum= 7,500)			minimum = 3,500			
Professional Fees									
a. Daily Visits									
General Practitioner(Groups 1, 5, & 6)									
Per Day	300	400	300	400	500	300	400	500	600
Maximum per confinement	1,200	2,400	1,200	2,400	4,000	1,200	2,400	4,000	6,000
Specialist(Groups 2, 3, & 4)									
Per Day	500	600	500	600	700	500	600	700	800
Maximum per cofinement	2,000	3,600	2,000	3,600	5,600	2,000	3,600	5,600	8,000
b. Surgery(for Case Type A and B)									
						RVU 500 以下		RVU 501 以上	
	Surgeon	Anesthesiologist	Surgeon	Anesthesiologist		Surgeon	Anesthesiologist	Surgeon	Anesthesiologist
General Practitoiner	RVU x PCF 40=PF1	40% of surgeon's fee (PF1)	RVU x PCF 40=PF1	40% of surgeon's fee (PF1)		RVU x PCF 40=PF1	40% of surgeon's fee (PF1)	RVU x PCF 40=PF1	40% of surgeon's fee (PF1)
1st Tier (Group 1)			maximum : 3,200	maximum : 1,280		maximum : 3,200	maximum : 1,280	maximum : 3,200	maximum : 1,280
2nd Tier (Group 5 and 6)	RVU x PCF 48=PF2	48% of surgeon's fee (PF1)	RVU x PCF 48=PF2	48% of surgeon's fee (PF1)		RVU x PCF 48=PF2	48% of surgeon's fee (PF1)	RVU x PCF 48=PF2	48% of surgeon's fee (PF1)
Diplomate/Fellow 3rd Tier (Group 2, 3 and 4)	RVU x PCF 56=PF3	56% of surgeon's fee (PF1)	RVU x PCF 56=PF3	56% of surgeon's fee (PF1)		RVU x PCF 56=PF3	56% of surgeon's fee (PF1)	RVU x PCF 80=PF4	40% of surgeon's fee (PF4)
	Maximum of 2,000 per confinement	Maximum fee computed as percentage of 2,000							

1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)

*RVU: Relative Value Unit

PF: Professional Fee

PCF: Peso Conversion Factor

Source: Compiled referring to the PhilHealth website, http://www.philhealth.gov.ph/members/overseas_workers/coverage.htm, etc.

4.7. Role of private health insurance systems and recent trends[29]

In the Philippines, PhilHealth provides public health insurance. However, the coverage of PhilHealth is only around 20% of the medical costs, and the remaining 80% is incurred by users themselves. Therefore, to reduce self-pay burden, people need to subscribe to private health insurance. However, the contribution of private health insurance is too expensive for many people, thus only 2% of the population subscribe to a private health insurance plan.[30] In the Philippines, those subscribing to a private health insurance is arguably a wealthy person, but since some companies have corporate accounts in private health insurance companies as part of fringe benefits, the employees of those companies can subscribe to private insurances.

Thus, with those insured by private insurance, including wealthy persons accounting for only 2% of the population, private insurance is now less represented in the Philippines health insurance system. However, private insurance companies expect the market size to expand[31]. t

[29] Descriptions on private health insurance systems are mainly based on interviews with private insurance companies.
[30] The annual PhilHealth contribution is 1,200 PHP. Meanwhile, the annual contribution of the 40-year-old standard plan of the private insurance company interviewed is 26,000 PHP.
[31] Interviews with private insurance companies

5. Pension and other income security scheme

5.1. Social insurance system for employees: Social security systems for employees (SSS)

5.1.1 Legal basis

The SSS was established through the Social Security Act of 1954 (RA 1161). The act was amended in 1957 and 1997, with the 1997 amendment leading to improvements such as expanded coverage, an increase in benefits, an extension of loan privileges, and the establishment of a voluntary provident fund for members.

5.1.2 Benefit packages

The SSS provides pension services (such as retirement pensions, survivorship pensions, and disability pensions) as well as sickness benefits and indemnity benefits in the event of injury or sickness(cash benefit). Medical benefit is not provided by SSS because authority of medical benefits based on benefits in kind are integrated into the Phil health since 1993[32]. Retirement pensions, survivorship pensions, and disability pensions are a defined benefit pension plans.

(1) Retirement pensions[33]

Those eligible for a retirement pension include: the retiree SSS insured aged 60 and above who have paid at least 120 monthly contributions before the six-month period in which the pension is first paid out; or the SSS insured aged 65 or over who paid at least 120 monthly contributions. Miners aged 55 or over who have worked underground for at least five years are also eligible. Retirees who have not paid at least 120 monthly contributions can receive a lump sum payment of all the contributions and interest on the contributions paid by the insured person themselves and their employer. On the other hand, if a person aged less than 65 resumes employment, pension payments are suspended until they reach 65.

Pension payments are made 13 times a year. Monthly benefits are calculated based on: the amount of contributions paid by the insured party; the number of underage dependents the insured party is responsible for; and the length of contribution payments. Based on the insured party's average monthly payments in the 60 months before retirement, the insured party is eligible to receive whichever amount is greater from among the calculation methods listed below.

- 300 PHP + 20% of the insured person's average monthly covered earnings + 2% of the insured person's average monthly covered earnings for each credited year of service (CYS) exceeding 10 years

[32] Interviews with the SSS
[33] SSS website, http://www.sss.gov.ph/sss/index2.jsp?secid=73&cat=4&pg=null (accessed in March 22, 2012).

- 40% of the insured person's average monthly covered earnings
- The minimum monthly pension is 1,200 PHP or 2,000 PHP (1,200 PHP when the CYS is 10 years or more but less than 20 years; 2,000 PHP when the CYS is 20 years or more).

The members also receive a 13th-month pension, with an extra month's payment paid each December. Furthermore, the dependents of a pension beneficiary who are under the age of 21 (up to a maximum of five children, from the youngest upward) are entitled to a dependents' supplement equivalent to 10% of the monthly pension amount. The upper age limit of 21 is removed if the dependent child suffers from a disability, but the supplement ceases once a child starts work or gets married. As a general rule, pension benefits are paid on a monthly basis, though the beneficiary also has the option of receiving the first 18 monthly pensions in a lump sum, subject to some deductions.

In the event of the death of the beneficiary, the total pension amount is then paid to the beneficiary's legal spouse, etc.

(2) Survivorship pensions[34]

When an insured party dies before the commencement of pension payment and when the insured party had paid at least 36 monthly contributions before the six-month period in which the death occurred, the relatives of the deceased are entitled to a survivorship pension. Eligible survivors are the surviving spouse and any children under the age of 21. As in the case of retirement pensions, the upper age limit of 21 is removed if the child suffers from a disability, but the supplement ceases once a child starts work or gets married. The spouse's benefits also cease when he or she remarries. In the absence of a spouse or dependent children, the benefit is paid to the deceased's parents and so on, though the benefit period is capped at 60 months. If the deceased party had paid less than 36 monthly contributions, a survivor grant will be paid to the applicable surviving relatives.

Pension payments are made 13 times a year. Monthly payments are determined by whichever amount is greater from among the calculation methods listed below.

- 300 PHP + 20% of the insured person's average monthly covered earnings + 2% of the insured person's average monthly covered earnings for each credited year of service (CYS) exceeding 10 years
- 40% of the insured person's average monthly covered earnings
- CYS of less than 10 years = 1,000 PHP; CYS of more than 10 years but less than 20 years = 1,200 PHP; CYS of 20 years or more = 2,400 PHP

In addition to the survivorship pension, dependents can also receive a dependent's

[34] SSS website, http://www.sss.gov.ph/sss/index2.jsp?secid=792&cat=4&pg=null (accessed in March 22, 2012)

supplement equivalent to 10% of the deceased's pension or 250 PHP, whichever figure is greater.

Furthermore, when the deceased party has paid at least one monthly payment before death, a lump sum of 20,000 PHP is paid to the organizer of the funeral to cover funeral costs.

(3) Disability pensions[35]

Those eligible for a disability pension are mainly the SSS insured persons with a permanent physical disability. In order to receive the disability pension, the beneficiary needs to have paid at least 36 monthly contributions before the six-month period in which the disability first occurred and must be assessed as having a permanent disability. A lump sum benefit is paid to those insured who have not paid at least 36 monthly contributions. Total disabilities include the loss of sight in both eyes, the loss of both legs, and paralysis. The disability pension is suspended if the beneficiary returns to employment or recovers from the disability. The pension is paid in 13 monthly installments, with the beneficiary entitled to receive the following amounts based on the length of contribution payments.

- CYS of less than 10 years: 1,000 PHP
- CYS of 10 years or more but less than 20 years: 1,200 PHP
- CYS of 20 years or more: 2,400 PHP

When the disability is permanent and total (PTD), dependents can receive a dependent's supplement equivalent to 10% of the insured party's pension or 250 PHP, whichever figure is greater.

The beneficiary can choose to receive monthly payments or a set lump sum benefit.

(4) Maternal benefits[36]

Maternal benefits are paid to women who are no longer able to work due to childbirth. In order to receive the benefit, the beneficiary needs to have paid at least three monthly contributions within the 12-month period immediately preceding the birth. Miscarriages also qualify for the benefit. A beneficiary can receive benefit payments for the first four deliveries or miscarriages. A daily cash allowance equivalent to 100% of the average daily salary credit is granted for 60 days in the case of delivery/miscarriage and 78 days in case of caesarean section delivery.

(5) Sickness benefits[37]

This benefit is paid to insured parties who are unable to work for a set period of time due to

[35] SSS website, http://www.sss.gov.ph/sss/index2.jsp?secid=791&cat=4&pg=null (accessed in March 22, 2012)
[36] SSS website, http://www.sss.gov.ph/sss/index2.jsp?secid=53&cat=4
[37] SSS website, http://www.sss.gov.ph/sss/index2.jsp?secid=147&cat=4&pg=null (accessed in March 22, 2012)

illness or injury. In order to receive the benefit, the beneficiary needs to have paid at least three monthly contributions within the 12-month period immediately preceding the occurrence of the injury or illness. The beneficiary also needs to have stayed in a hospital for four days or more, or have difficulties living a normal life at home. The benefit can be granted for a maximum of 120 days in a single year. However, it cannot be granted for 240 days or more for the same illness or injury. Unused days cannot be carried over. The sickness benefit is equivalent to 90% of a member's average daily salary credit. The minimum monthly benefit is 1,000 PHP, while the maximum 15,000 PHP.

5.1.3 Eligibility for enrollment and contribution rates[38]

Enrollment in the SSS is compulsory for employers and all private-sector employees 60 years old and under. Self-employed persons or household helpers (maids, drivers, etc.) 60 and under with a monthly income of at least 1,000 PHP are also obliged to join the SSS. Voluntary enrollment is also recognized and is extended to: (1) the insured persons who have separated from employment, (2) overseas Filipino workers (OFWs), and (3) spouses of the SSS insured persons.

The monthly contribution rate is equivalent to 10.4% of a worker's monthly salary credit (MSC), with the employer paying 7.07% and the employee 3.33%. Self-employed members and voluntary members must pay 10.4% of their salary. The MSC is divided into 29 brackets of 500 PHP each,[39] ranging from 1,000 PHP to 15,000 PHP, based on the aggregate of the employee monthly salary and all allowances received (overtime, commuting allowance, dependents allowance, and meal allowance, etc.)

5.1.4 Funds and operational bodies

The SSS has adopted the fee for servicesystem. The SSS has over 180 offices, with 13 of these located overseas. Most offices within the Philippines are located in urban areas.

5.1.5 Enrollment figures

As of September 2011, SSS membership stood as follows: employers at 889,892; employees at 19,990,465; the self-employed at 5,834,015; voluntary members at 3,344,299.[40] As mentioned above, ① separated member, ② Overseas Filipino Workers (OFWs), and ③ non-working spouse can join voluntary coverage. Labor force in the Philippines as of January 2012 is 57,390,000, SSS covers approximately 52% of the labor force.

5.1.6 Actual benefit payments

FiguresI-16 shows the SSS revenue and expenditures for 2009 and 2010. Insurance

[38] SSS website, http://www.sss.gov.ph/sss/index2.jsp?secid=108&cat=2&pg=null (accessed in March 22, 2012)
[39] SSS website, http://www.sss.gov.ph/sss/index2.jsp?secid=111&cat=2&pg=null (accessed in March 22, 2012)
[40] SSS website, http://www.sss.gov.ph/sss/index2.jsp?secid=845&cat=6&pg=null (accessed in April 12, 2012)

contributions, pensions, and benefit payments are all on an upward trend. Payments for retirement pensions and survivorship pensions account for the bulk of expenditures, with the two pensions accounting for around 85% of all pension and benefit payments.

FiguresI-16 SSS revenue and expenditures (2009 and 2010)

Unit: Million PHP

	2009	2010
Revenue	95,336.51	107,120.75
Premium contribution	72,350.89	79,272.86
investment and other income	22,985.62	27,847.89
Expenditures	79,124.55	84,288.57
Retirement	35,126.49	38,226.76
Death	25,962.63	27,648.69
Maternity	3,589.16	3,634.83
Disability	3,253.75	3,362.39
Funeral Grant	2,377.40	2,488.20
Sickness	1,703.78	1,777.59
Medical Services	36.65	35.56
Rehabilitation	0.82	0.12
Management expenses	7,074.59	7,114.41

1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the *SSS Annual Report 2010*, p. 29

5.2. Social security for government officers: GSIS

5.2.1 Legal basis

This is a retirement plan established under the Republic Act (RA) 8291. Other retirement plans have been established under RA660 and RA1616, etc.

5.2.2 Benefit packages

GSIS provides a variety of pensions and benefits service to government officers, such as retirement pensions, survivor's pensions, disability pensions, unemployment benefits. GSIS also provides insurance services, such as life insurance. Retirement pension, survivor's pension, and disability pension are defined benefit pension plans.

(1) Retirement pensions[41]

Eligibility for a GSIS retirement pension is essentially based on age and the length of employment. In other words, the beneficiary needs to have reached the voluntary retirement age

[41] GSIS website, http://www.gsis.gov.ph/default.php?id=2 (accessed in March 22, 2012)

(60), the retirement age (65), or have worked for at least 15 years.

Based on the insured party's length of service (years) and the average monthly salary received during the three years prior to retirement, monthly benefits are determined according to the formulas listed below.

- If the length of service is 15 years or more: Basic Monthly Pension (BMP) = 0.025 × (RAMC* + 700 PHP × Length of Service)
- If Length of Service is less than 15 years: BMP = 0.375 × RAMC

* Revalued Average Monthly Compensation: 700 PHP + AMC**

** Average Monthly Compensation (AMC): Total Monthly Compensation received during the last 36 months of service divided by 36

However, when the benefit payments calculated according to the aforementioned formulas exceed 90% of the AMC, the monthly payment will be set at 90% of the AMC.

In the event of the death of the beneficiary, a survivorship pension will be paid to the beneficiary's legal spouse, etc.

(2) Survivorship pensions[42]

When an insured party passes away, a survivorship pension is paid to his or her relatives. Eligible parties include the spouse of an insured party who had served for at least 15 years (including de facto spouses) or any underage, unmarried dependents of the insured party. Payment is discontinuedwhen the spouse gets remarried. A spouse is entitled to monthly payments equivalent to 50% of the insured party's Basic Monthly Pension (BMP) at the time of death, with up to five children each entitled to a monthly payment equivalent to 10% of the deceased's BMP.

Survivors of the deceased GSIS insured are also entitled to a 20,000 PHP funeral benefit.[43]

(3) Unemployment benefits[44]

When a government officer loses his or her job, they can receive a benefit from the GSIS equivalent to 50% of average monthly compensation (AMC) for a period of up to six months. However, this system is rarely used because not many government officers are aware of it.[45] As discussed below, though the Philippines does not have unemployment insurance, there is a perception that government officers do have employment insurance because of the existence of this system. However, there is opinion that this system cannot be regarded as the same as

[42] GSIS website, http://www.gsis.gov.ph/default.php?id=45 (accessed in March 22, 2012)
[43] GSIS website, http://www.gsis.gov.ph/default.php?id=44 (accessed in March 22, 2012)
[44] GSIS website, http://www.gsis.gov.ph/default.php?id=43 (accessed in March 22, 2012)
[45] Axel Weber (2010), *Social Protection in Case of Unemployment in the Philippines (Draft for Discussion)*, p. 13

unemployment insurance, it is more like a form of compensation.[46]

FiguresI-17 Unemployment benefit payment schedule

Contribution payment years	Benefit duration
1 - 3 years	2 months
3 – 6 years	3 months
6 – 9 years	4 months
9-11 years	5 months
11 years or more	6 months

Source: GSIS website, http://www.gsis.gov.ph/default.php?id=43 (as of March 22, 2012)

(4) Disability pensions[47]

A disability pension is granted to a GSIS member who has seen a decrease in or a total loss of earning capacity due to a physical or mental disability. Disability levels are divided into the following categories: (1) Permanent Total Disability (PTD), Permanent Partial Disability (PPD), and (3) Temporary Total Disability. Different benefits systems are applied to the insured who have served at least 15 years and to those who have served less than 15 years. The pension benefit amounts are listed below.

- Permanent Total Disability (PTD)
  - ・At least 15 years service: Basic Monthly Pension (BMP) or a cash paymentof 18 times the BMP
  - ・Less than 15 years service: BMP
- Permanent Partial Disability (PPD)
  - ・If the beneficiary is working: Cash benefits equivalent to BMP × the number of PTD months(based on GSIS medical evaluator)
  - ・If the beneficiary is not working but has paid 36 monthly contributions within the last five years immediately prior to the disability, or has paid at least 180 monthly contributions: Cash benefits equivalent to BMP × the number of PTD months(based on GSIS medical evaluator)

(5) Insureance[48]

The GSIS insured who entered service from January 31, 2003 onward are automatically

[46] Interviews with the ILO
[47] GSIS website, http://www.gsis.gov.ph/default.php?id=41 (accessed in March 22, 2012)
[48] GSIS website, http://www.gsis.gov.ph/default.php?id=1 (accessed in March 22, 2012)

enrolled in the Enhanced Life Policy. The GSIS insured who entered service before this can enroll in the Life Endowment Policy. Life Endowment Policy also provides coverage against death due to natural or accidental causes, permanent total disability. Members of GSIS life insurance policy can avail policy loan program.

5.2.3 Eligibility for enrollment

All national and regional government officers are obliged to enroll in the system.[49] However, members of the judiciary, constitutional commissions, the armed forces, and the police force (including members of the Bureau of Jail Management and Penology and the Bureau of Fire Protection) have their own separate, independent pension funds and as such are outside the scope of the GSIS. Furthermore, contractual employees are not classed as full-time employees and as such are also outside the scope of GSIS insurance.

5.2.4 Contribution rates

The contribution rate is equal to 21% of the member's monthly salary credit, with the employer paying 12% and the employee 9%.

5.2.5 Funds and operational bodies

The GSIS is a government-run institution. The governing body of the GSIS is the board of trustees of the GSIS, whose members are appointed by the President of the Philippines.

The GSIS currently has 15 regional offices, 25 branch offices, and 18 satellite offices.[50]

5.2.6 State of coverage

The system had around 1.5 million members as of 2009.[51] Coverage rate is approximately 82%.

5.3. Home Development Mutual Fund: HDMF/Pag-IBIG[52]

The Pag-IBIG was established in 1978 to provide all employees[53] with a savings program and a source of financing. Unlike the SSS and the GSIS, the Pag-IBIG is not a pension program. Rather, it functions to give low-paid employees access to a small-sum savings and financing system.

5.3.1 Legal basis/Eligibility for enrollment

The eligibility for enrollment in the Pag-IBIG is divided into mandatory and voluntary. Coverage of mandatory membership is private employee, household helper earning at least

[49] GSIS website, http://www.gsis.gov.ph/default.php?type=main&id=28 (accessed in March 22, 2012)
[50] GSIS website, http://www.gsis.gov.ph/default.php?type=main&id=28 (accessed in March 22, 2012)
[51] National Statistics Office (2012), *Philippines in Figures 2012*, p. 51
[52] Pag-IBIG website, http://www.pagibigfund.gov.ph/# (accessed in March 22, 2012)
[53] More specifically, all employees with monthly incomes of 1,000 PHP or more, which includes virtually every employee; based on interviews with the Pag-IBIG

P1,000.00 a month, seafarer, uniformed members of the Armed Forces of the Philippines, the Bureau of Fire Protection, the Bureau of Jail Management and Penology, and the Philippine National Police, OFWs, and Filipinos employed by foreign-based employers. On the other hand, coverage of voluntary membership is non-working spouses of registered the Pag-IBIG members, Filipino employees of foreign government or international organization, employees of an employer who is granted a waiver or suspension of coverage by the Pag-IBIG, leaders and members of religious groups, member separated from employment or ceased to be self-employed, and public officials or employees who are not covered by the GSIS.

The eligibility for enrollment in the Pag-IBIG changes frequently due to legal amendments. Enrollment was voluntary when the system was first established, but the signing of PD1752 made it compulsory for the insured/users of the GSIS or SSS to enroll in the Pag-IBIG, with voluntary enrollment limited to employees earning 4,000 PHP or less a month. The system became voluntary again with the signing of EO96 in 1986, but it then switched to a system of both compulsory and voluntary enrollments with the signing of RA7742 in 1995. Enrollment became compulsory again for GSIS and SSS members under the HMDF Law of 2009, with Filipinos employed by foreign-based employers also obliged to join.[54]

Though the Pag-IBIG is a government financing bank, it does not receive financing from the government.[55] Furthermore, at least 70% of Pag-IBIG financing must be invested in housing.

5.3.2 Benefit packages

After 15 years in the system, members with no outstanding housing loans can claim the Total Accumulated Value (TAV) of his or her contributions.[56] The TAV is composed of the insured contributions, employer contributions, and dividend earnings credited to the insured's account. The dividend amount is 70% of the Pag-IBIG Fund's annual net income and is paid as a lump-sum payment.[57]

In addition to the savings program, another key Pag-IBIG function is the provision of housing loans. Members can also utilize a multi-purpose loan equivalent to up 60% of the TAV. The system also provides calamity loans for use in the event of a disaster.

5.3.3 Contribution rates[58]

The term of membership in the Pag-IBIG is 20 years, but this can be extended if the insured

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[54] Pag-IBIG website, http://www.pagibigfund.gov.ph/benpromembership.aspx (accessed in March 22, 2012)
[55] Interviews with the Pag-IBIG
[56] Pag-IBIG website, http://www.pagibigfund.gov.ph/benproprovident.aspx
[57] The SSS is also examining the introduction of a voluntary savings system, so this may overlap with the Pag-IBIG's activities; based on interviews with the Pag-IBIG and "Philippines: New SSS saving window to increase members' retirement benefits," *ASSA NEWS* vol. 24, 2011 http://www.asean-ssa.org/cs/groups/public/documents/document/mdaw/mda1/~edisp/wcm012034.pdf (accessed in May 2, 2012)
[58] Pag-IBIG website, http://www.pagibigfund.gov.ph/benpro.aspx# (Accessed in May, 2012)

person so desires.

Contributions are 1% of the monthly salary for employees earning less than 1,500 PHP per month and 2% of the monthly salary for employees earning above 1,500 PHP a month. Employers are obliged to pay 2% of the monthly earningof employees. However, contributions are calculated based on a maximum monthly salary of 5,000 PHP, so the maximum amount of the insured person and employer contributions is capped at 100 PHP a month. The contribution rate of spouses of registered mandatory member is half the amount of their employed spouse.

5.3.4 Funds and operational bodies

The Pag-IBIG is governed by a board of trustees.

5.3.5 Enrollment figures (extension of coverage to workers in informal sectors)

The Pag-IBIG had 7.47 million insured members as of 2009.[59] It is expanding its presence in each region on the back of an increase in the insured numbers.[60] As of February 2012, the Pag-IBIG had 37 offices within the Philippines and 18 desks established in embassies primarily throughout Asia and the Middle East. The branches within the Philippines employ around 100 people, with each branch responsible for 10 cities, five regional government districts, and 100 *barangay*s. The Pag-IBIG is aiming to reduce staff numbers at each branch to 5–10 people at the same time as establishing branches in every regional government district.

The Pag-IBIG is also planning to expand its coverage to include middle-income earners.[61] The Pag-IBIG's ultimate goal is to provide a system for saving and financing to people who cannot borrow from commercial banks, but it is planning to expand its financing services to encompass middle-income earners, who are capable of meeting financial obligations.

5.4. Unemployment insurance

Though unemployment insurance has not been introduced in the Philippines, the government has made clear its intention to introduce such a system, with unemployment insurance being incorporated into the Philippines Labor Plan. The ILO is also pushing for the introduction of unemployment insurance. In 2010, it conducted a comprehensive examination of unemployment insurance and produced a report containing (1) proposals for an unemployment insurance bill and (2) an analysis of the obstacles impeding the introduction of such a system.

[59] National Statistics Office (2012), *Philippines in Figures 2012*, p. 51
[60] Interviews with the Pag-IBIG
[61] Interviews with the Pag-IBIG

Column: The ILO Unemployment Insurance Proposal

The ILO, in cooperation with DOLE, is working toward the introduction of a system for unemployment insurance in the Philippines. As part of a research study into the introduction of unemployment insurance, the ILO asked Alex Weber, social security specialist at the ADB, to prepare a research report on the topic. Released in February 2010, the report (1) discussed the reasons why unemployment insurance has not been introduced in the Philippines and (2) made some tentative proposals for an unemployment insurance system. These proposals are outlined below.

- Membership: All formal sector employees (SSS and GSIS members); the GSIS would include contract workers in addition to permanent employees. As a first step, membership would be compulsory for all employees in establishments with 10 or more staff. After five years, enterprises with 10 staff or less would also be obliged to join the system. If all employees in establishments with 10 or more staff were enrolled in the system, this would see 68% of all employees covered by unemployment insurance, with this figure rising to 85% when employees in establishments of 10 staff or less are also included.
- Financing: Insurance contributions, initially set at 2%, to be shared by employer and employee
- Benefit packages: 50% to 60% of a member's personal Average Monthly Salary Credit (AMSC) over the last 12 months, up to a ceiling of 15,000 PHP; the member would need to be registered as unemployed in order to receive the benefits.
- Duration of payments: Up to a maximum of 10 months
- Qualifying criteria: Registration with PESO, payment of insurance contributions
- Administration: The system would be administered by PESO, TESDA, and the SSS/GSIS.

Source: A. Weber (2010), *Social Protection in Case of Unemployment in the Philippines*, pp. 21–25.

The report outlines the following obstacles and challenges standing in the way of the introduction of an unemployment insurance system: the lack of any consensus about unemployment insurance among different government agencies, employers, and employees; and the large informal sector.[62]

There are huge differences of opinion among concerned parties when it comes to the introduction of unemployment insurance. The Employers Confederation of the Philippines

[62] A. Weber (2010), *Social Protection in Case of Unemployment in the Philippines*, pp. 16–19

(ECOP) is proposing a non-contributory, limited unemployment assistance scheme. However, ECOP has stated that it would support the introduction of a contributory unemployment insurance system if it fulfilled certain criteria (for example, if the law was revised to make it easier to dismiss employees).[63]

Trade unions agree on the whole with the idea of an unemployment insurance scheme, but they are opposed to the imposition of any new contributions and are calling for the state to foot the bill. They are also naturally opposed to the idea of revising the law to make it easier to dismiss employees.

There is no shared consensus among government agencies as well. DOLE supports the introduction of an unemployment insurance scheme, but other agencies are unconvinced of the need to enroll government officers in any such scheme. Furthermore, though the GSIS supports the idea of including government officers in any unemployment insurance scheme, the GSIS and SSS differ when it comes to contributions and benefit packages (GSIS contributions are equal to 21% of a member's salary whereas the figure is 9% for the SSS), thus the GSIS insists that mutual coordination is necessary.[64]

Unemployment rate of the Philippines in 2011 is 7%, relatively higher than other Asian countries (Ex. Vietnam : 4.5%, Malaysia : 3.2%). Though judging from high unemployment rate it follows that introduction of unemployment insurance is important in the Philippines, improvement of working environment is recognized as more important issue than unemployment insurance because working environment in the Philippines is in poor condition. According to the ILO, labor law and working environment in the Philippines has not reached the international standards.

Though the report recognizes the need for an unemployment insurance system in the Philippines, it also recognizes that the employment situation itself presents more of a pressing challenge at this moment in time.[65] The country's labor laws and employment situation are not up to international standards, and the ILO has repeatedly asked the Philippine government to revise labor laws, improve the situation of household employees, and promote freedom of association, in order to meet international labor standards.[66]

There is also some skepticism about whether the introduction of unemployment insurance in accordance with the Philippines Labor Plan is the best way forward. For example, the Philippines Labor Plan envisages unemployment insurance being administered by PESO, but PESO is nothing more than a coordinating institution and could find it difficult to run any

[63] Interviews with the SSS
[64] Interviews with the GSIS
[65] Interviews with ILO and the GSIS (February, 2012)
[66] Interviews with ILO; though the Philippines has signed the ILO treaty on freedom of association, violations of the treaty are common.

unemployment insurance scheme.[67]

[67] Interviews with the SSS

6. Social Welfare System and Community-based Assistance Schemes

6.1. Development of databases to identify low-income populations: National Household Targeting System for Poverty Reduction (NHTS-PR)

6.1.1 Outline of databases

The National Household Targeting System for Poverty Reduction (NHTS-PR) is a data management system that aims to identify who and where the poor are. This identification helps the authorities to gain a picture of which people should be the beneficiaries of social security programs.

Social security budgets are limited, thus it is vitally important to avoid any unnecessary expenditures. By making it possible to identify who and where the poor are in a clear and simple manner, the introduction of the NHTS-PR is expected to reduce the leakage (the inclusion of non-poor people) or under-coverage (the exclusion of poor people who should be beneficiaries) that occur in the implementation of anti-poverty programs.

A NHTS-PR household survey was conducted between March 2009 and March 2010, with the next survey scheduled for 2013.[68] The first NHTS-PR targeted 10.9 million households. The number of individuals is calculated by multiplying the number of households with the Philippine median household size (five people).

The household survey first selects poor regions based on the Philippine National Statistics Office's Family Income and Expenditure Survey (FIES) and the National Statistical Coordination Board's Small Area Estimates (SAE). A survey of poverty rates in provinces and municipalities is then conducted in order to gain a more accurate picture of priority areas.

In the second stage, a list of municipalities with poverty rates of 50% or more is prepared. Some municipalities with poverty rates of 49% or less still have areas with high poverty rates (poverty pockets), thus poverty assessment surveys are conducted based on 10 key indicators in order to gain an understanding of these areas.

The survey uses a Household Assessment Form (HAF)—a questionnaire with 34 headings. The HAF adopts the Proxy Means Test model to estimate the income of a household based on the replies to the 34 questions. These calculated household incomes are used to classify households into poor and non-poor based on provincial poverty thresholds.

6.1.2 Range of database utilization

The DSWD used the NHTS-PR to select target areas for the second KALAHI-CIDSS(Kapit-bisig Laban sa Kahirapan – Comprehensive and Integrated Delivery of Social Services) project. Before now, the government had to rely substantially on LGUs when

[68] Interviews with the DSWD

identifying beneficiary households. However, it has been pointed out that the central government's selection of beneficiary households often differs from the selection of LGUs, with only around 20% of households appearing on both lists and 80% not overlapping.[69] The NHTS-PR enables the central government to identify beneficiaries without having to rely on LGUs. It also reduces leakages through improvements in the accuracy of surveys. In this respect, it would be fair to say that the introduction of NHTS-PR is a groundbreaking event in the area of Philippine social security policy formation.[70]

The NHTS-PR is also used by the Department of Energy, the Department of Health, the Department of Agriculture, the National Economic and Development Authority (NEDA), the National Anti-Poverty Commission (NAPC), and PhilHealth.[71]

6.1.3 International cooperation

The World Bank has offered technical support for the development of the NHTS-PR. US $ 645 million has been allocated for the initial development of infrastructure and information management system of NHTS-PR from Social Welfare and Development program funded by World Bank. In 2010, the trust fund of AusAid also provided the fund for improvement of efficiency and enlargement of NHTS-PR.

6.2. Social assistance systems

The Philippines has no public assistance program for providing poor people with regular economic support. However, there is a Philippine Conditional Cash Transfer (CCT) program in the form of the Pantawid Pamilyang Pilipino Program (4P). 4P is a scheme that aims to improve health, education, and nutrition. Its main targets are children (aged zero to 14) and pregnant women who live in extreme poverty.

Budget of 4P in 2011 is 21. 19 billion PHP. While entire national budget in 2011 is 1, 65 billion PHP social security, social welfare, and employment-related expenditures amounts to 94. 15 billion PHP. 4P budget is equivalent to approximately 22% of social security, social welfare, and employment-related expenditures.

[69] Interviews with the DOH and ADB
[70] Interviews with the DSWD
[71] Interviews with the DSWD; PhilHealth has been using the NHTS-PR since 2009. The introduction of the NHTS-PR has made it possible to expand coverage for the poor and avoid the problem of the politically oriented selection of beneficiaries by the LGUs; based on interviews with PhilHealth.

FiguresI-18 Approved Budget per GAA and. Estimated Actual Budget Requirement（2011）

Unit : PHP

	Approved Budget for GAA : (General Appropriation Act RA 10147)	Estimated Actual Budget Requirement
Grants	17,137,864,333	18,948,566,880
Operational Cost	4,056,252,667	4,202,530,637
Total	21,194,117,000	23,151,097,517

1PHP=1.903 JPY(JICA transaction rate as of May 2012 as reference)
Source : DSWD, Pantawid Pamilyang Pilipino Program : Status Report on the Implementation for the Second Quarter of 2011, p.4.
http://www.dswd.gov.ph/index.php/pantawid-pamilya-accomplishment-report（as of May 28, 2012）

6.2.1 Target beneficiaries

Target beneficiaries for 4P are people who meet the following criteria. Beneficiary households are selected using the Proxy Means Test.

- They live in the poorest municipalities as stated in the 2003 Small Area Estimates (SAE).
- The household's economic status falls below provincial poverty thresholds.
- The household contains a pregnant woman or children between the ages of zero and 14.
- The household agrees to meet 4P conditions.

6.2.2 Standards for benefits and benefit amounts

Each household receives 6,000 PHP per year or 500 PHP per month for health and nutritional needs. Every household also receives 3,000 PHP per year or 300 PHP per month per child for 10 months for educational expenses, to a maximum of three children per household. At the same time, a household with three qualified children receives 1,400 PHP/month or 15,000 PHP for the school year. 4P benefits can be received for a maximum of five years. Benefits of 4P accounts for approximately 20% of the income of beneficiary households on average though the ratio is different depending on configuration of beneficiary households. The conditions for 4P benefits are outlined below.

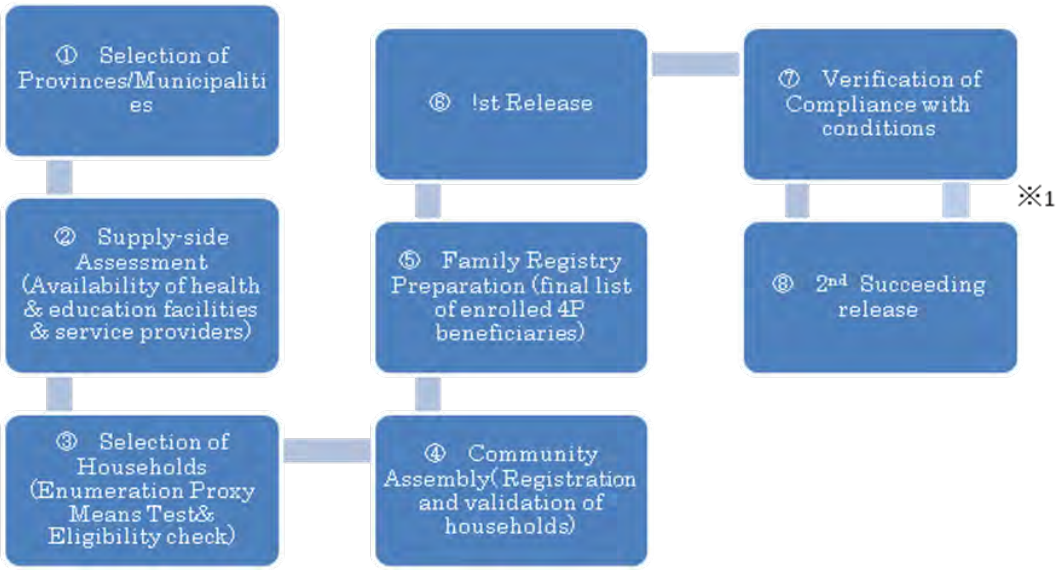
- Pregnant women must use pre- and post-natal care and be attended to during childbirth by a trained health professional.
- Parents must attend Family Development Sessions.
- Children aged zero to five must receive regular preventive health check-ups and vaccines.
- Children aged three to five must attend day care or pre-school classes at least 85% of the time.
- Children aged six to 14 must enroll in elementary or high school and must attend at least 85% of the time.

・ Children aged six to 14 must receive deworming pills once or twice a year.

To verify that beneficiaries comply with the conditions, CVS (Compliance Verification System) has been introduced. School and health facilities record the non-compliance of conditions on the check sheets prepared by government, then, 4P office of national government update the information to judge the discontinue and modification of payment based on check sheets.

According to the report of the World Bank, while the compliance rate of beneficiary household who are attending school is between 80% to 90% in 2010, that of health conditionalities is between 50% to 70%. The World Bank indicates that factors that cause the difference of compliance rates is that complying the health conditionalities burdens on parents too much because parents are required to visit health facilities many times for vaccination and health examination. In addition, there are not enough health facilities which can conduct vaccination and health examination.

FiguresI-19 4P Implementation Process



※1 Subsequent cash payment and verification of compliance are carried out repeatedly.
Source : DSWD

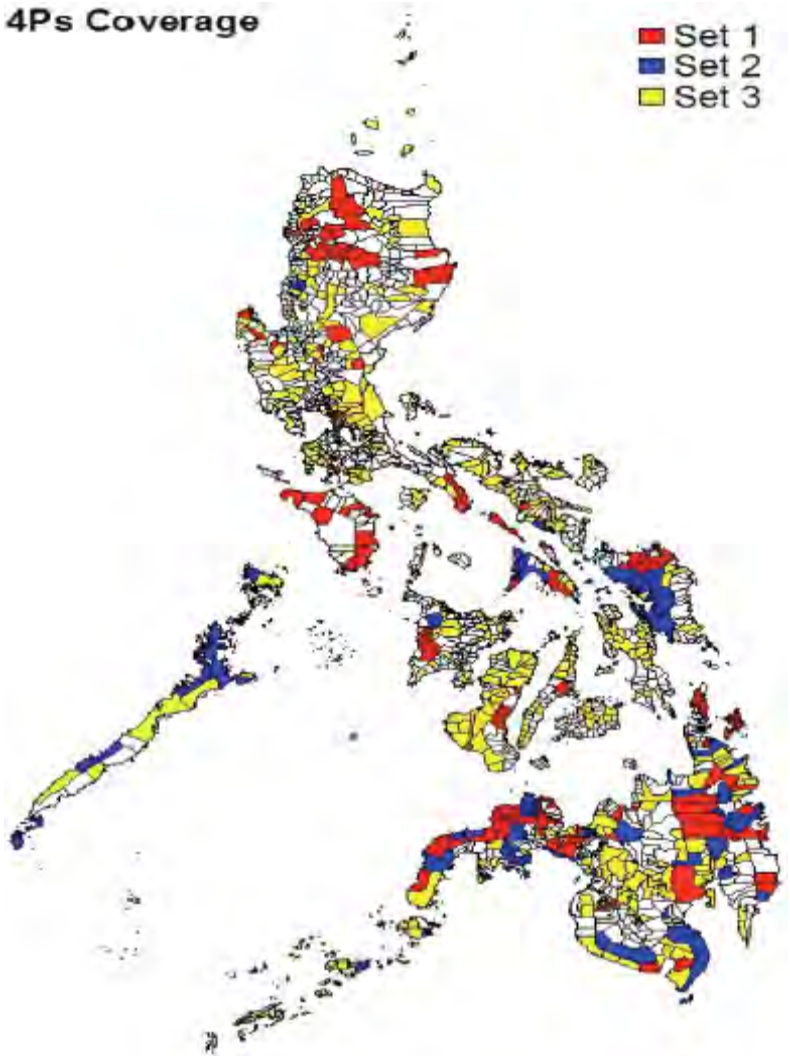
6.2.3 Actual benefit payments

FiguresI-20 4P actual benefit payments

	No. of Beneficiary Households	Period of Expansion	Geographic Coverage	Selection Criteira
Pilot	4,459	September to December 2007	3 regions, 3 Provinces, 2 districts	・2 poorest provinces・Accessible municipalities to monitor pilot testing
Set 1	333,281	March to December 2008	17 region, 33 provinces, 4 districts, 170 municipalities/ cities	・Poorest municipalities in 20 poorest provinces ・Poorest provinces in other regions
Set 2	288,192	March to July 2009	11 regions, 28 provinces, 140 municipalities/cities	・Poorest municipalities (poverty incidence above 60 percent)
Set 3	412,901	October 2009 to December 2010	17 regions, 77 provinces, 472 municipalities/cities	・Individual selection of municipalities
Total	1,038,833		782 municipalities	

Source: World Bank (2011), Overview of the Philippines' Conditional Cash Transfer Program: The Pantawid Pamilyang Pilipino Program (Pantawid Pamilya), p. 3

FiguresI-21 4P Coverage of each set



Source : World Bank (2011), Overview of the Philippines' Conditional Cash Transfer Program: The Pantawid Pamilyang Pilipino Program (Pantawid Pamilya), p.4.

FiguresI-22Benefit Payament（As of December 31, 2011）

Unit: US $

Conditionality	Benefit Payment
Health	152,722,916.19
Education	149,590,272.45
Total	302,313,188.64

※1USD=81.07JPY（JICA transaction rate as of May 2012 as reference）
Source: DSWD date

6.2.4 Implementing bodies[72]

4P is run cooperatively by the DSWD, the DOH, the Department of Education (DepEd), the Department of the Interior and Local Government (DILG), and the Land Bank. The day-to-day management of the program is run by the Pantawid Pamilya National Project Management Office (NPMO), an organization established by the DSWD. Deworming pills are provided by the DOH, with the DepEd distributing the pills to its regional branches. Nurses are stationed in the regional branches to administer the pills. One nurse is usually in charge of four to five regional government districts (around 20 to 40 schools).[73]

6.2.5 Impact of 4P

According to the World Bank simulation analysis, 62% of the population in the municipalities is covered by 4P. With regard to potential impacts on poverty reduction, the World Bank estimates that 4P could reduce poverty incidence by 2.6% point, income gap by 5.3% point, poverty severity by 4.3% point, and increase per capita income by 12% point.

6.2.6 Issues and challenges[74]

4P faces a shortage of staff and material resources. In particular, the preparatory stage before the introduction of 4P was quite short, thus there was not enough time to secure sufficient staff numbers. The DSWD was originally supposed to survey more than twice the number of beneficiary households, but it wasn't able to secure enough staff members, IT equipment, or funding necessary for the survey. The target area of 4P has been expanded, but the DSWD has not been able to secure enough human, material, or financial resources to cope with the expansion. Though the NPMO was established with the introduction of 4P, this was run using existing DSWD employees—there was no increase in employee numbers.

Local structures for providing benefits are also insufficient. Some of the regions selected for aid do not have enough health care facilities or schools, thus it is difficult to dole out 4P benefits. There are also not enough nurses, and each nurse is responsible for multiple schools.[75]

6.3. Community-based assistance schemes

KALAHI-CIDSS (*Kapit-bisig Laban sa Kahirapan* – Comprehensive and Integrated Delivery of Social Services)

6.3.1 Outline of schemes

The KALAHI-CIDSS is a community-driven development aimed at alleviating poverty and

[72] World Bank (2011), *Overview of the Philippines' Conditional Cash Transfer Program: The Pantawid Pamilyang Pilipino Program (Pantawid Pamilya)*, p. 2
[73] Interviews with the DSWD
[74] World Bank (2011), *Overview of the Philippines' Conditional Cash Transfer Program*, p. 11
[75] Interviews with DepEd

helping the socially vulnerable.[76] The KALAHI-CIDSS is controlled and implemented by the DSWD with the help of the World Bank. The development aims to alleviate poverty and social vulnerability by tackling: (1) the lack of capability and resources at the local level; and (2) cases where local governments are not meeting the needs of the local area.

As of 2002, the KALAHI-CIDSS was rolled out in the 42 provinces in which the poverty rates exceeded the national average of 33.7%. Projects are usually implemented for three years.

FiguresI-23 KALAHI-CIDSS target regions

Phase	Period	Provinces	Barangays
1	January to June 2003	11	201
2	June 2003 to December 2006	56	1,291
3A	October 2004 to December 2007	34	883
3B	January 2006 to December 2008	29	727
4	August 2006 to July 2009	54	1,127
KC Expansion	February 2010 to May 2011	16	354
Total		200	4,583

Source: DSWD (n.d.), Department of Social Welfare and Development: KALAHI-CIDSS, p. 2

[76] The difference between this and 4P is that the 4P scheme is implemented on a household basis whereas KALAHI-CIDSS is implemented on a village or *bangaray* basis. As a scheme targeting the entire community, the KALAHI-CIDSS aims to provide public funds in a way that benefits many households, with the funds specifically used for the improvement and maintenance of schools, roads, water supplies, and bridges, etc. There is a roughly 70–80% overlap in the areas covered by KALAHI-CIDSS and 4P. This information is based on interviews with the DSWD.

FiguresI-24 Loan Utilization ending September 2010 (cumulation) Million US $

Project Catogory	Allocation	Utilized until September 2010	Unutilized
Barangay Grants	90.6	78.24	12.36
Goods	1.00	0.95	0.05
Consultants' Services	4.84	4.50	0.34
Incremental Operating Cost	2.56	2.35	0.21
Front End Fee	1.00	1.00	0.00
Total	100.00	87.04	12.96

※1USD=81.07JPY（JICA transaction rate as of May 2012 as reference）
Source： DSWD, THIRD Quarter 2010 project Accomplishment Report
http://kalahi.dswd.gov.ph/old/index.php?option=com_content&view=article&id=61&Itemid=22（As of May 28, 2012）

6.3.2 State of international cooperation

The KALAHI-CIDSS is an anti-poverty program carried out with the support of the World Bank. The project is also supported by the U.S. Millennium Challenge Corporation, Japan Social Development Fund, and the Australian Agency for International Development (AusAID), etc.

FiguresI-25 State of international cooperation (partial list)

Organization	Project Name	Project brief	Target
World Bank	KC Additional Financing Project	The amount of 49.8 billion PHP to 184 municipalities	・ 2,069 barangays in 91 municipalities ・ Funded a total of 1,324 community sub-projects amounting to 1,507 billion that will benefit approximately 153,600 households in 1,370 barangays
Millennium Challenge Corporation	KALAHI-CIDSS Millennium Challenge Corporation Project	・ 164 municipalities with poverty incidence of at least 33% ・7,80 billion PHP	・ 1,730 barangays in 77 municipalities ・ 630 community sub-projects amounting to 500 million PHP that will benefit approximately 26,620 households.
Japan Social Development Fund		approximately 3,750 households in 75 urban poor communities in Metro Manila, Cavite etc.	・ Piloted in 6 urban poor communities
AusAid		・early childhood learning and development activity ・ construction and/or rehabilitation of day care centers and school buildings	・On-going preparatory activities

※1PHP=1.903JPY（JICA transaction rate as of May 2012 as reference）
Source : DSWD

7. Care and Welfare for the Elderly

7.1. Policy initiatives and framework for the elderly

Productive age population/aging population ratio of the Philippines in 2010 is 6% and elderly population over 60 is estimated to be 14. 32 million, only 11% of the total population in 2030. From this, it follows that measures for the elderly is not pressing issue in the Philippines because youth population ratio in the population structure is large.

The Philippines has a relatively high proportion of young people, thus the ageing of society is not a pressing challenge at this moment in time.[77] However, a gentle ageing of the population is also expected in the Philippines over the long term, while the country also faces the challenge of elderly poverty, thus the "Philippines Plan of Action for Senior Citizens" was formulated as a national policy (first stage: 1999 to 2004; second stage: 2006 to 2010).[78] The plan identifies the following as major areas for action: (1) elderly persons and development; (2) advancing the health and well-being of the elderly; and (3) ensuring an enabling and supportive environment for the elderly[79]. Specific goals include: the establishment of the Office of Senior Citizens' Affairs (OSCA) in all LGUs; the development and strengthening of databases on the elderly; the development and strengthening of laws related to the elderly; the development of anti-poverty programs; the provision of accessible micro-credits to the elderly; and the holding of workshops, etc[80].

The policy toward the elderly is stipulated in the Senior Citizen Act (RA 9257, established in 2003) and the Expanded Senior Citizens Act of 2010 (RA 9994, established in February, 2010).[81] Based on these laws, elderly people aged 60 and above can receive special privileges including: a 20% discount on medicine, public transport and accommodation or a VAT exemption; exemption from paying income tax providing the senior citizen is considered a minimum wage beneficiary in accordance with RA9504; exemption from training fees in socio-economic programs; and free medical services, etc.

In 2011, the DSWD spent 694 million PHP on programs aimed at indigent elderly, with 126,558 people receiving support. In 2012, over 1.2 billion PHP will be allocated to help 185,914 elderly people.[82] In particular, indigent elderly people aged 77 or over will be provided

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[77] According to the 2007 census, the median age of the Philippine population is 22 years old. National Statistics Office website, http://www.census.gov.ph/data/pressrelease/2010/pr10162tx.html (accessed in April 13, 2012)

[78] The second plan of action can be obtained from the DSWD website. http://www.dswd.gov.ph/index.php/downloads (accessed in April 13, 2012)

[79] *Philippines Plan of Action for Senior Citizens 2006–2010: Building a Society for All Ages*, p. 1

[80] *Philippines Plan of Action for Senior Citizens 2006–2010: Building a Society for All Ages*, pp. 21–31

[81] DSWD website, http://www.dswd.gov.ph/index.php/downloads/category/3-2010 (accessed in April 6, 2012)

[82] DSWD website, "DSWD Has P.1.2 Billion For Pension of Poor Seniors For 2012," February 28, 2012 http://www.dswd.gov.ph/index.php/component/content/article/1-latest-news/2545-dswd-has-p12-billion-for-pension-of-poor-seniors-for-2012 (accessed in April 10, 2012)

with a social pension. The aforementioned NHTS-PR will be used to identify beneficiaries.

FiguresI-26 Population projection

1,000 population

Age	2020	2025	2030
0-4	11,546.1	11,512.7	11,374.3
0-14	33,834.5	34,383.2	34,386.7
15-59	68,208.2	73,919.3	79,395.4
60-	9,741.9	11,922.0	14,327.9
Total	111,784.6	120,224.5	128,110.0

Source: National Statistics Office (2012), *Philippines in Figures 2012*, p.25.

7.2. Pension System

With regard to pension system of retirees, refer to "Pension and other income security scheme .".

7.3. State of elderly care facilities and services

Senior Citizen Centers are being established in each municipality in accordance with RA7876 (established in 1995) as facilities for the elderly. Free residential facilities for elderly people with no other means of support are being established in the Manila metropolitan area, Davao, and Zamboanga.

7.4. Issues for the future of elderly policy

As mentioned above, the Philippines has a relatively high proportion of young people and as such is not troubled by the problem of an ageing society. However, the population is forecast to grow older in the long term. In relation to this, the second plan of action identifies the following key challenges in the area of elderly policy: (1) the full implementation of the 2003 Senior Citizen Act (RA9257); (2) the strengthening of databases and statistics related to the elderly; (3) understanding the issues and challenges that an elderly population brings to society; (4) the preparation of the populace for an ageing society; (5) the development and improvement of services, institutions, and the environment in order to meet the needs of the elderly; and (6) the delivery of social and human services needed by the increasing elderly.[83]

[83] Other challenges have also been identified, such as the abuse of the elderly; *Philippines Plan of Action for Senior Citizens 2006–2010: Building a Society for All Ages*, pp. 18–19

8. Issues Facing Social Security in the Philippines

8.1. Issues facing the health security system

8.1.1 PhilHealth's "pension mind" and improvement of "out of pocket" ratio[84]

PhilHealth's maximum benefit amount is set too low, thus patients have to pay substantial medical expenses out of their own pockets when using medical services. Furthermore, it is left to the doctor's discretion as to which medical services to provide, thus patients sometimes end up paying excessive fees due to doctors providing expensive services. In 2008, the percentage of health care costs shouldered by the individual (out-of-pocket costs) stood at 82.5%.[85]

PhilHealth was originally meant to tackle the problem of high out-of-pocket ratio through the expansion of benefits, but up to now PhilHealth was actually quite prudent when it came to expanding benefits, despite possessing a large amount of accumulated funds.[86] It has been pointed out that the reason PhilHealth has been reluctant to expand benefits is because it has developed a "pension mindset." Even PhilHealth top officials have admitted that PhilHealth has slipped into this "pension mindset."

Generally speaking, health insurance is a short-term form of insurance, thus if managed in an appropriate way, it wouldn't be that necessary to build up reserves to pay for benefits over a several-year period, unlike in the case of long-term insurance, as typified by pension benefits.

Legally speaking, PhilHealth is allowed to keep funds equivalent to two years' worth of benefit payments, but in actual fact, PhilHealth aimed to save more than this amount. Newly-installed PhilHealth president Dr. Eduardo P. Banzon has lowered this amount of reserve funds and, as a part of efforts to improve benefit packages from now onward, is targeting benefit payments of 100 billion PHP by 2016 (the figure stood at around 34 billion in 2011).[87] This direction chimes with the government's active financial policies in the health sectors since the Aquino administration assumed power, thus further improvements can be expected in the future.

8.1.2 Insufficiency of medical resources

Though the Philippines is "export" country of nurses and doctors, medical staff within the country is not sufficient especially in rural area. However, despite the lack of medical staff in rural areas, unemployment rate of medical staff is high because there are few medical staffs who desire to work in rural areas.

Demographic challenges faced by the Philippines is not decreasing birthrate and aging population but population growth. In 2030 the population is expected to be 128.11 million.

[84] WHO (2011), *Philippines*, p. 345
[85] WHO (2011), *World Health Statistics 2011*, p. 133
[86] WHO (2011), *Philippines*, pp. 345–347
[87] Interviews with PhilHealth

Current medical services system has not kept up with population growth. Bed to population ratio is approximately 1 per 1,000 population, this figure is lower than other Asian countries, such as China (2.6 per 1,000), Thailand (2.2 per 1,000). In addition, as large hospitals with many beds are mainly located at big cities, beds in rural areas is not sufficient.

8.2. Issues surrounding employee social security

8.2.1 Collection of contributions

The Philippines is a nation of many islands. For this reason, one pressing issue is how to establish an efficient method of collecting contributions from far-flung islands or remote regions. A further challenge is how to collect contributions from difficult-to-identify workers in the informal sector.

The SSS has 170 branches, but most of these are located in urban areas, thus it is difficult to collect contributions from the insured living in remote areas or far-flung islands.[88] Therefore, the SSS also relies on banks and private payment centers for contribution collections.

The Pag-IBIG faces the same kind of problem. With the cooperation of employers, it is easy enough to collect contributions from full-time formal-sector workers and from government officers, but collecting contributions from the informal sector is no easy task. In order to collect contributions from the informal sector, the Pag-IBIG has carried out a number of initiatives, including: working with Metro Bank and Land Bank to enable people to make payments through these entities; enabling people to pay contributions at buyer centers or payment centers; and enabling people to pay with credit cards.[89]

In recent years, the SSS and Pag-IBIG have tried to tackle this issue by introducing a method of collection that utilizes various cooperatives established in many areas. The SSS introduced such a collection method in 2011.[90] Around 65,000 cooperatives are registered with the SSS, including many market, transportation, and labor cooperatives.

The Pag-IBIG also adopted a similar collection method in the latter half of 2010, with various cooperatives able to collect contributions from housekeepers or workers in the transportation sector (such as Jeepney drivers), for example, sending the funds to the Pag-IBIG.[91]

Only around one year has passed since both institutions introduced this system of contribution collections through cooperatives, thus it is still unclear whether this new method has improved collection rates (as of February 2012).[92] However, cooperatives often include

[88] Interviews with the SSS; the issue of how to collect contributions from members in remote regions or far-flung islands is also pertinent to the GSIS and PhilHealth. When it comes to collecting insurance contributions, however, there is no cooperation between the institutions.
[89] Interviews with the Pag-IBIG
[90] Interviews with the SSS
[91] Interviews with the Pag-IBIG
[92] The cooperative method of the SSS and Pag-IBIG resembles that of PhilHealth's KASAPI, though it cannot be confirmed whether KASAPI's methods are being adopted by the two institutions. However, the institutions do discuss

low-paid workers or informal-sector employees, therefore a further challenge would be how to identify these people and collect different rates of contributions from them in an efficient manner.

8.2.2 Financial sustainability

When comparing the SSS and GSIS, there is a large difference in financial sustainablity between them. As GSIS premium income has greatly exceeds the amount of benefit payment, GSIS has sufficient assets to sustain its services until 2055 as of 2007. On the other hand, the amount of net revenue of SSS is smaller than that of GSIS. As of 2007, SSS asset is limited to sustain its services until 2031. However, it can be said that condition has improved since SSS was predicted to be financially sustainable until 2015 as of 1999.

8.2.3 Database management and the introduction of common reference numbers

Another issue for the Philippine social security system is the insufficient management of data pertaining to the insured persons. Each institution is working to create a database to ascertain the details of the insured and to improve the efficiency of services. For example, the SSS is currently in the middle of trying to introduce a database system for the details of the insured. It has taken on more employees for this purpose.[93]

The Unified Multi-purpose ID (UMID) system is being introduced to enable the SSS, GSIS, PhilHealth, and Pag-IBIG to share a common reference number for each member. The idea is that, by sharing a common reference number and database, the four institutions will be able to improve the efficiency of service provision. However, the introduction of the UMID has not gone smoothly. The introduction is taking place under the guidance of the SSS, but the SSS itself is running behind schedule.[94] In fact, the GSIS is taking the lead in this respect. PhilHealth is also running behind schedule and has introduced a different ID number from the one used by the GSIS.

Furthermore, each institution has different opinions when it comes to UMID data headings. For example, the GSIS data management system is only concerned with ascertaining the numbers of government officers, with the system not grasping spouses. PhilHealth, though, requires data for each individual person, thus it needs a database that includes not just member details but also the details of their spouses and dependent family members.[95]

It would not be efficient for each institution to have its own separate database, thus, in this

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insurance contribution collection methods with each other (based on interviews with the Pag-IBIG), thus, if the effectiveness of the cooperative method is proven, this method could spread and become more relevant.

[93] Interviews with the SSS

[94] Interviews with the GSIS

[95] Interviews with PhilHealth; the PhilHealth database currently records data on a household basis, but many members want to see the registration of each individual person. When data is recorded on a household basis, it is not possible to ascertain a picture of the individual members comprising the household, thus even if dependent family members use PhilHealth insurance cards, they cannot claim back medical expenses.

respect the introduction of UMID is vital, but at this moment in time, progress toward a shared ID and database system is not going smoothly at all.

8.2.4 Coordination and cooperation between pension funds

The SSS and GSIS are the major pension funds in the Philippines, but there are actually 16 systems when small-scale pension funds are included in the equation. For government officers in particular, there are a number of pension funds besides the GSIS, catering specifically to the judiciary, for example, or for the police force or armed services. These pension funds were originally supposed to be integrated into the GSIS, but the judiciary and armed forces, etc., desired better pension schemes and split off from the GSIS as a result. Some argue that these pension funds should be integrated again, but each scheme differs when it comes to retirement age, benefits packages, and benefit calculation methods, for example, thus integration would be no simple matter.[96]

8.2.5 Introduction of unemployment insurance and improvement of labor problem

While the introduction of unemployment insurance has been recognized not only as one of the goals of social security but as one of the challenges in the Philippines, to tackle the more general problem that labor law does not conform to international standards, which is pointed out by ILO, is also the urgent need.

As ILO has asked repeatedly the Philippine government to improve the circumstances of domestic workers and revise labor law in order to meet the international standards, improvement of general system for labor circumstances takes priority over the introduction of unemployment insurance.

8.3. Issues surrounding social welfare system [97]

Regional decentralization is underway in the Philippines, thus it is up to the LGUs to decide whether to conduct social security services.Some of the LGUs with enough funds have set up adequate programs, such as in Quezon City and Makati City, but regional governments with insufficient budgets cannot be expected to do likewise. In addition, up to now, central government depends on LGUs in identifying beneficiary household to carry out its anti-poverty measures. However, LGUs identify beneficiary households arbitrarily, it has been recognized as problem that beneficiary households identified by LGUs standard differs significantly from those by national standard.

However, moves are afoot to overcome this problem.. As mentioned above, the DSWD has developed the NHTS-PR, the data management system to identify the poor household.. DSWD

[96] Interviews with the GSIS
[97] Interviews with the ILO

could use this system to reach out to the poor without bypassing LGUs.

DOH, Department of Energy, Department of Agriculture, NEDA, NAPC, and PhilHealth also utilize the NHTS-PR. The introduction of the NHTS-PR has made it possible for PhilHealth to expand coverage for the poor and avoid the problem of the politically-oriented selection of beneficiaries by the LGUs.[98] The NHTS-PR has only recently been introduced, but it can be expected to help overcome the detrimental aspects of regional decentralization.

Hereafter, to reduce the time lag in the data updates will become more important to identify actual beneficiary household. In addition, in the present, CCT is the only social welfare benefit program, but it is necessary to develop the unconditional cash payment program (social welfare system) in future.

8.4. Issues surrounding elder care

As speed of aging of the Philippines is slowest in the ASEAN countries, it can be said that the priority of the elder care is low.

[98] Interviews with PhilHealth

9. Prioritized Issue for cooperation in Philippines

9.1. Substantial reduction of out of pocket ratio

Defined-contribution mechanism which emphasizes social insurance principle has been adopted as health insurance system in the Philippines. While financial condition of PhilHealth is stable, health insurance system in the Philippines has many practical problems from the point of view that out-of-pocket ratio of patient is significantly high. Though it is important to expand coverage ratio to reduce medical expenses of citizens, it is also important to raise benefit of public health system and extend the range of medical practice and disease covered by benefit payment.

To increase the number of health care staff and health institutions is also important. At present, to expand the coverage and financial input and to increase the health resources, human resources and institutions, at the same time are priority matter. However while with regard to benefit expansion newly-installed president Banzon is expected to proceed it, measures to solve the problem of health care resources is not provided so far.

As the health insurance of the Philippines is not similar to that of Japan in that the latter is benefits in kind system but the former is just to cover a small part of health care cost, it is not easy to transfer the Japanese system to Philippines. However, as Japan and Philippines has in common in that the number of private health institutions is higher than that of public ones, it is possible to share the knowhow of Japan with the Philippines to manage the health expenses and to regulate the private health institutions.

9.2. Improvement of labor environment and introduction of unemployment insurance

Development of income security system for workers in the Philippines has long history, and it can be said that income security system has reached a certain level as the fact that GSIS and SSS coverage ratio is over 60% respectively shows. On the other hand, as ILO has asked the Philippine government to improve the labor environment repeatedly, the Philippine government has to improve labor safety and occupational health. It is possible that Japan can help the Philippines government to solve that problem. And with regard to introduction of unemployment insurance, it is also possible that Japan can support the Philippines government effectively by providing academic findings about system design of unemployment insurance.

9.3. Support for the development of social assistance system

Regarding social assistance system as due to nationwide CCT implementation and introduction of NHTS-PR, poverty situation has improved at a certain level. International donors such as the World Bank has already provided large amount of support, there is almost no room for Japan to provide direct support to CCT development and implementation. In addition,

it is not clear that the Philippines government wants to introduce permanent guaranteed minimum income (social assistance) system other than CCT, cooperation needs is not high in this field. Cooperation needs in the social security for the elderly is also not high since the speed of aging of the Philippines is slow.

Chapter II Indonesia

1. Social Security Overview

1.1. Social Security in the constitution

The 1945 Constitution of the Republic of Indonesia stipulates social security for its people in Chapter XA "Human Rights," Article 28H.

> Chapter XA "Human Rights"
> Articles 28A–28G (Skipped)
> Article 28H
> (1) Every person shall have the right to live in physical and spiritual prosperity, to have a home and to enjoy a good and healthy environment, and shall have the right to obtain medical care.
> (2) Every person shall have the right to receive facilitation and special treatment to have the same opportunity and benefit in order to achieve equality and fairness.
> (3) Every person shall have the right to social security in order to develop oneself fully as a dignified human being.
> (4) Every person shall have the right to own personal property, and such property may not be unjustly held possession of by any party.

1.2. Current state and basic direction of government policy for social security

1.2.1. National Medium-term Development Plan (2010–2014)

It was after the Asian economic crisis in the 1990s when poverty reduction became considered a matter of national priority in the national development plan of the country. Currently in Indonesia, medium-term development plans are being implemented under the Long-term Development Plan covering the period from 2005 through 2025, divided into four five-year terms. Before the Asian economic crisis, however, poverty reduction was not deemed a key strategy in the medium-term development plans of the government. In the second Medium-term Development Plan currently underway (2010–2014), poverty reduction is ranked higher than in preceding plans. The cut in fuel subsidy since 2005 as a result of the appreciation of oil prices has imposed tremendous economic burden on the poor, the government presented the directions for assisting the poor.

In the Medium-term Development Plan (2010–2014), 11 priority items are enumerated (reform of the bureaucracy and administration; education; health; poverty reduction; food

security; infrastructure development; investment in the business sector; energy; environment and natural disaster management; initiatives for left-behind, underdeveloped, most outer, and post-conflict regions; culture, creativity and technological innovation), and the measures taken in the health and poverty reduction sectors are as mentioned below.

1.2.1.1. Health

In the health sector, emphasis is placed on the prevention of illness, while a goal is set to increase the average life expectancy from 70.7 years (in 2009) to 72.0 years (in 2014) through the action programs including the enhancement of the public health infrastructure. A concept of national health security providing universal coverage to all people is also being introduced.

1.2.1.2. Poverty reduction

The program to reduce poverty included in the National Medium-term Development Plan aims at reducing the absolute poverty rate, which equals to 2,100 calorie per capita per day for the food component plus basic non-food consumption such as housing, clothes, education, transportation, from 14.1% in 2009 to the level of 8–10% in 2014, along with improving income distribution through social protection. Major action programs in the poverty reduction sector include the direct provision of: cash benefits as a social protection program, food assistance, social security regarding health, scholarships for low-income families, and the expansion of the Family Hope Program (PKH: Program Keluarga Harapan) and a poverty-reducing project on a community participation basis (PNPM Mandiri: Program Nasional Pemberdayaan Masyarakat Mandiri). A policy to organize a poverty-reducing team and to develop a database to determine the poverty-reducing program target is also included in the program.

As for the poverty-reducing team, the National Committee for Reducing Poverty has been in existence since its establishment in 2010. For details regarding the poverty reducing team, see “2.2 TNP2K: The National Team for the Acceleration of Poverty Reduction”

1.2.2. Actions for the universal coverage of social security

1.2.2.1. Law on National Social Security System

The unification of social security systems has been in progress in Indonesia, and the “Law No.40 of 2004 on National Social Security System” (SJSN Law) was enacted in October 2004 for ensuring that all citizens are able to provide for their minimum basic life needs in Indonesia where there are lot of uninsured citizens.

The application of the SJSN Law is defined in the five social security programs of: health insurance, workers compensation insurance, pensions, old-age savings, and life insurance. The SJSN Law is the “framework law” for social security in Indonesia, and the rules and regulations used to set registration procedures for the insured, benefit packages, rates and amounts of

contributions, contents of medical benefits, amounts of benefits for respective programs, and the detailed management and investment of accumulated contributions—all of which are required to implement the law—will be entrusted to the Presidential Decree and government regulations to follow.

1.2.2.2. Law on the Social Security and Administrating Bodies (BPJS)

In October 2011, the Indonesian parliament passed a bill concerning the Social Security and Administration Bodies (BPJS), and the law was enacted on November 25.

In more concrete terms, the law is meant to establish agencies to implement the five programs under the SJSN Law (medical benefits, workers compensation benefits, old-age benefits, pensions, and life insurance).

For transition, the existing four organizations will be unified under the BPJS: PT.ASKES, the operational body for health insurance for government officers; PT.JAMSOSTEK for social security for corporate employees; PT.TASPEN for pension program and old-age savings for government officers; and PT.ASABRI for health insurance for military officers. Existing programs also integrated in the BPJS; JAMKESMAS, public health security system for low-income population operated and financed by government; and JAMKESDA, public health security system by local governments run by local governments.[1]

The business of the BPJS includes, among others, the registration of the insured, collection of insurance contributions from the insured and employers, acceptance of government subsidies for insurance contributions, management of social security funds, collection and management of the data of the insured of social security programs and the payment of benefits thereto, and the provision of information on social security programs.

1.2.2.3. Unification processes

The transition process of BPJS comprises two stages, namely BPJS-I for health security programs and BPJS-II for income security programs for employees, both of which are scheduled to transit from the existing organizations to the BPJS-I and BPJS-II programs in 2014.

While BPJS-II for pension and other income security is generally recognized to be unified in 2015, systematically, it will be reorganized and unified in 2014 concurrently with the health security programs. Practical reform including amendment to the benefit package, however, will take place in 2015 and after.

The direction of the reform of the pension schemes for government officers and armed forces is still under study. A decision on the reform of the pension for government officers is to

[1] Based on a hearing on the MOH in February 2012. Transition of JAMKESDA is not stipulated in BPJS Law.

be postponed until 2029.

1.2.2.4. Reorganization of existing social security administering bodies

Outline of the reorganization of the existing social security administration bodies under the BPJS Law is as mentioned below.

Figures III-1 BPJS transition, reorganization policy and outline of each division

	BPJS- Ⅰ	BPJS- Ⅱ
Domain	Health security	Income security for employees
Leading organization for transition	PT.ASKES	PT.JAMSOSTEK
Reorganized program*	・PT.ASKES ・MOH (JAMKESMAS) ・MOD (Health service program for military officers) ・PT.JAMSOSTEK (Health sector)	・PT.JAMSOSTEK (Income security program sector) ・PT.TASPEN ・PT.ASABRI
Scope of transformation	・all assets and liabilities as well as the legal rights and obligations of PT. ASKES ・assets and liabilities, and the rights and obligations of health care security program of PT. JAMSOSTEK	・assets and liabilities as well as the legal rights and obligations of PT. JAMSOSTEK
Board membership in transition process	Board of Commissioner and Board of Directors of PT. ASKES become the Board of Supervisors and Board of Directors of BPJS- Ⅰ for a maximum period of 2 years.	Board of Commissioner and Board of Directors of PT. JAMSOSTEK become the Board of Supervisors and Board of Directors of BPJS- Ⅱ for a maximum period of 2 years.
Provision concerning Employees after transition	・All employees of PT ASKES become employee of BPJS- Ⅰ.	・All employees of PT JAMSOSTEK become employee of BPJS- Ⅱ.
Transition Process		
January 1, 2014	BPJS- Ⅰ will start to operate health insurance programs.	PT. JAMSOSTEK will transform into BPJS- Ⅱ.
July 1, 2015		・BPJS- Ⅱ will conduct program of work accident insurance, old age benefits, pensions benefits, and death benefits operated by PT. JAMSOSTEK. ・BPJS- Ⅱ will start to operate programs of work accident insurance, old age benefits, pension benefits, and death benefits that have been organized by PT. TASPEN and PT. ASABRI.
2029		・The transfer of Social Security programs by PT. TASPEN and PT. ASABRI to BPJS- Ⅱ will be completed.

*For details regarding existing programs implanted by each organization, see “4.Health Security” and “5.Pension and other income security schemes ”

Source: compiled by Mitsubishi UFJ Research & Consulting based on BPJS Law

1.2.2.5. Structure of social security programs

Individual programs defined in the unified social security system are as mentioned below.

(1) Health security

Health insurance is operated by BPJS- I and commonly defined as a program to provide health services (including medicaments and medical supplies) for stages from prevention through rehabilitation, and the insured as well as their family members (up to five persons) are eligible to receive services at the public and private medical facilities that are in contract with the social security service organizations. (Family members in excess of five persons may receive the service against the payment of additional contribution.) Payment is made to the medical facilities by the organizations, and the amounts to be paid are determined based on the agreements between the organizations and associations of local medical facilities. The insurance contribution for wage workers is shared by the employees and their employers at a fixed rate, while the insured other than wage workers bear a fixed amount by themselves.

As to the public medical assistance available in JAMKESMAS provided by the central government and in JAMKESDA provided by local governments, the former is generally considered more substantial regarding benefit packages than the latter in many cases. In such a situation, however, there are cases where people who belong to the low-income group are not deemed eligible for the benefits of JAMKESMAS due to problems in the database to control the low-income group and thus receive the less-substantial benefits of JAMKESDA.[2] Once the programs are unified into the BPJS, the database of the low-income group will be improved and the target groups of the respective public medical assistance programs will be controlled unitarily.

The levels of benefits after the unification will be made equivalent to those of the most massive programs available under the current public health security system so that the benefits under the unified system will not fall below the benefits currently guaranteed.[3]

Exemption from participation in JAMSOSTEK (opting out), which has been permitted when an alternative to offer better medical benefits is available, will no longer be permitted under the universal coverage system.

(2) Workers compensation insurance

This is a program to provide work injury victims with medical services and cash benefits. The victims can receive services at the public and private medical facilities that enter into an agreement with the BPJS, while the cash benefits are provided according to the degree of the victims' injury or in a lump sum at the time of their death. In the areas where medical facilities are not yet developed, the insurance carriers are obliged to provide compensation. Insurance

[2] Based on a hearing on JAMKESDA held in Depok City in February 2012

[3] Based on a hearing with the MOH conducted in February 2012.

contribution for wage workers is determined at a fixed percentage of their wage (depending on the risk of their work environment) and is borne in full by employers, and the contribution for other insured persons is at a fixed amount and borne in full by the insured.

(3) Old-age savings

Although named a "pension," this is actually a program to provide a lump-sum amount when the insured reach a retirement age, decease, or suffer injury. The program is based on a defined contribution system, and the insured receive a payment of the accumulated amount of their contributions with the premium of the management reflected. After participation for 10 years, the insured may remove their contributions up to a fixed limit. The contribution for a wage worker consists of an amount equivalent to a fixed percentage of the wage, which is shared by the employee and their employer, while the contribution for the other insured is borne by the insured through their payment of a fixed amount.

(4) Public pensions

This is a defined benefit-type program meant for employees, in which they receive pension payments when they reach their retirement age, decease, or suffer injury. In this program, old-age benefits are provided when the insured reaches retirement age and until death, a disability pension is paid when the insured becomes injured and until death, a pension for the surviving spouse is paid until the spouse gets married again or deceases, a pension for surviving children is paid until 23 years of age or until they get a job or get married, and a pension for parents is paid to the parents of the insured for a fixed period when the insured is unmarried at the time of their death. The minimum period of participation is 15 years, but even when the insured deceases before they complete the minimum period, their heir succeeds to the right to receive the benefit. Contribution is made by the employee and their employer, who jointly pay an amount equivalent to a fixed percentage of the insured's wage or a fixed amount.

(5) Life insurance

This is a program that provides the payment of a lump-sum to the insured's heir upon the insured's death. Contribution for a wage worker is made by the employer solely paying an amount equivalent to a fixed percentage of the worker's wage, while the contribution for other insured persons is made by the insured, who pays a fixed amount.

1.2.2.6. Penalty

After the unification, employers are required to register themselves and their employees as participants to BPJS, providing proper data of themselves, their employees, and families to BPJS. If one violated the provisions, it will be subject to administrative sanctions. Administrative sanctions are in form of 1)written warning, 2)fines, and/or 3) not providing particular public services (business license and proof of ownership of land and building are exemplified). The first and the second sanctions are carried out by BPJS, but the last one is carried by the government or local

governments upon request of BPJS.

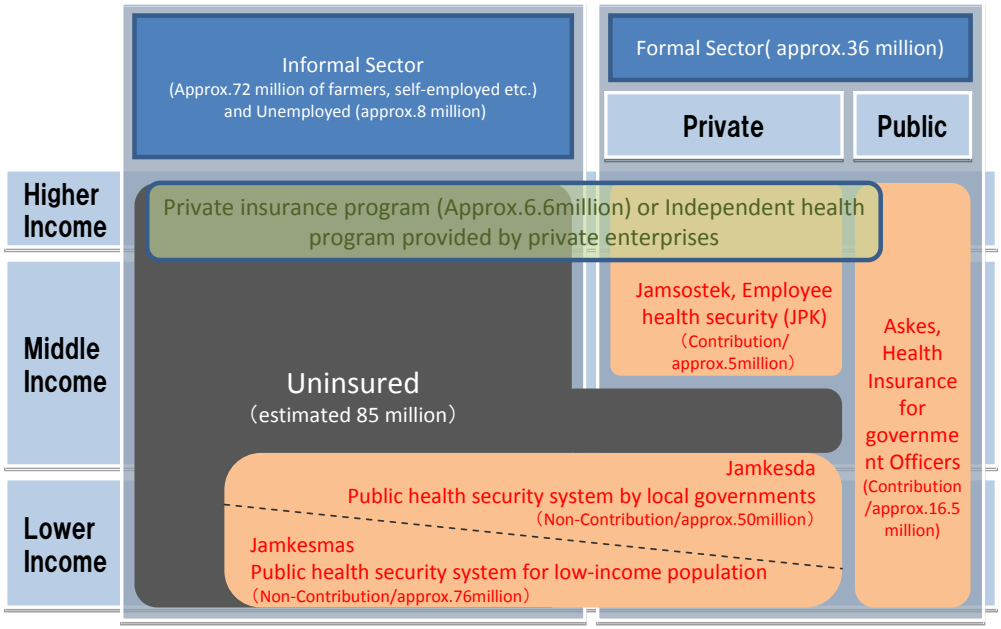
1.2.2.7. Current Coverage

Regarding coverage, ASKES has approximately 1.65 million insured, ASABRI has 1.16 million, JAMSOSTEK has 9 million (5 million insured for health insurance), JAMKESMAS has 76 million, JAMKESDA has 50 million, and private health insurance carriers have approximately 6.6 million insured, respectively.[4]

Exact coverage is difficult to grasp. In JAMKESDA, for instance, the database of its insured lacks accuracy, and cases where a single insured person has more than two IDs are reported. Accordingly, estimates of the number of the insured made by different researchers and organizations are actually different from one another.

[4] Based on a hearing conducted in February 2012 and on existing research by JICA; the values for Askes and ASABRI are based on each Annual Report 2010.

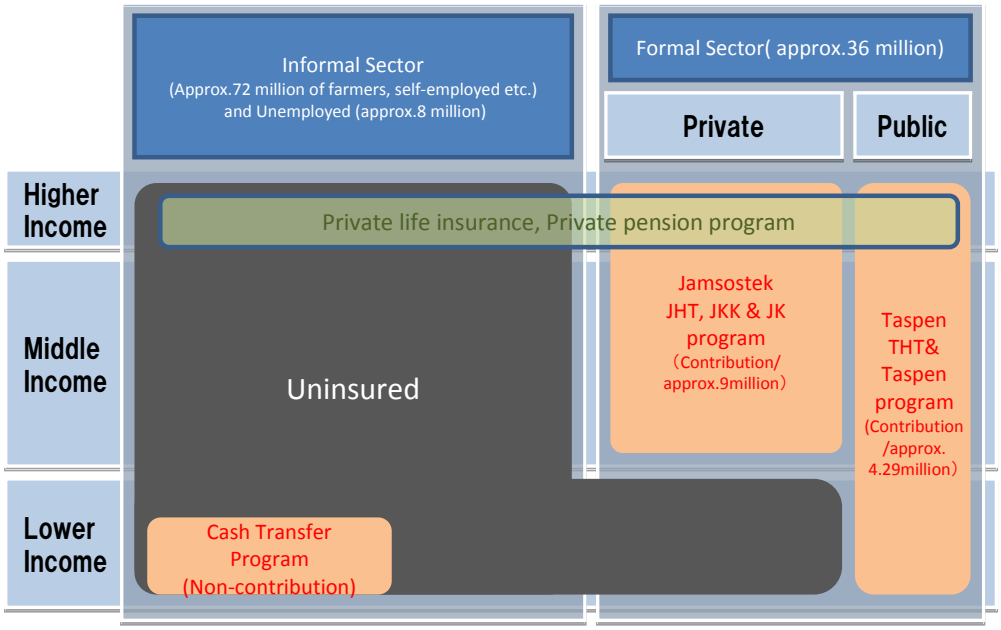
Figures III-2 Outline of the health security system



※The number of participants includes employees' dependents

Source: compiled by Mitsubishi UFJ Research & Consulting (The number of each sector's population is based on the JAMSOSTEK Annual Report (2010))

Figures III-3 Outline of the social security system



※The number of participants does not include employees' dependents

Source: compiled by Mitsubishi UFJ Research & Consulting (The number of each sector's population is based on the JAMSOSTEK Annual Report (2010))

2. Organizations Involved in Social Security

2.1. MOH: Ministry of Health

The MOH is an administrative organization of the Indonesian government. It is in charge of health care, and is responsible for the development and implementation of public health insurance policies.

Currently, the MOH is responsible for the policy development and operation of JAMKESMAS (which was managed by PT. ASKES until 2008) and is also the supervisory authority of operating programs of PT. ASKES, a state-owned enterprise.

2.2. TNP2K: The National Team for the Acceleration of Poverty Reduction

The TNP2K, established in March 2010, is an independent organization with approximately 70 staff members under the direct control of Vice President Office. The organization is aimed at smoothly solving the problems among the relevant government agencies in implementing poverty reduction programs. It studies problems in working groups under the advice of learned persons from universities and other experts, and it identifies and researches the current status and problems actually arising in the poverty reduction projects and communicates them to the respective agencies to accelerate the respective projects.

AusAid provides the TNP2K with comprehensive assistance in its operation (with the exception of a part of the TNP2K receiving assistance from the GIZ).

2.3. Coordinating Ministry for People's Welfare

Coordinating Ministry for People’s Welfare coordinates the various agencies of the Indonesian government in their development and implementation of policies in the areas of welfare and poverty reduction. In the current situation where different projects to reduce poverty are conducted by different government agencies, the ministry is responsible for removing, coordinating, and improving the negative effects of bureaucratic sectionalism.

Different from the TNP2K, which identifies and analyses the current status of the project sites and provides advice from an independent position, Coordinating Ministry for People’s Welfare mainly coordinates and monitors actual programs in their day-to-day operation according to certain guidelines, in order to prevent injustices.

The ministry is directly involved in the operation of projects as a supervisory authority of PNPM Mandiri.

2.4. MoMT: Ministry of Manpower and Transmigration

The MoMT is an administrative agency of the Indonesian government and is in charge of labor administration.

As the supervisory authority of PT.JAMSOSTEK, the operating organization of health

insurance and old-age benefits for private enterprises, the MoMT currently develops policies in the areas related to the social security system for employees.

Through PT.JAMSOSTEK, the MoMT also assists (subsidizes the payment of contributions) the workers of the informal sector by participating in JAMSOSTEK.

2.5. MOF: Ministry of Finance

The MOF is an administrative agency of tax practice, administration of state finance, and management of state owned properties.

The Capital Market and Financial Institution Supervisory Agency (The BAPEPAM-LK) is one of the departments of the MOF, the BAPEPAM-LK is the supervisory authority of the nonbank financial sector in Indonesia including state-owned enterprises. Nonbank financial sector includes insurance companies and pension program.

MOF is also the supervisory authority of state-owned enterprises (PT. ASKES, PT. TASPEN, and PT. JAMSOSTEK, etc.) with aspect of financial performance. When a state owned enterprise decides to change its management, Ministry of State-Owned Enterprises (MOSEs) is required to apply for approval of candidates to MOF and obtain its approval.

2.6. MoSA: Ministry of Social Affairs

Areas related to social assistance and social welfare for females, the elderly, homeless children, and the PWD are within the responsibility of MoSA. The ministry is actually running facilities for homeless children, the poor, regular children, the PWD, and the elderly. (Similar facilities are run by local governments in some cases.) The major item of the social welfare policies currently promoted by MoSA comprises the CCT program of the PKH and social welfare insurance for the informal sector (ASKESOS).

2.7. MOSEs: Ministry of State-owned Enterprises

The scope of MOSEs' supervision is not limited to social security issues. Matters related to state-owned enterprises are within the responsibility of MOSEs regardless of their lines of business. As a matter of fact, the ministry is promoting businesses related to reform, management & operation, and the supervision of the management personnel of the state-owned enterprises.

MOSEs supervises the Pertamina, state-owned oil and natural gas mining company. The company own the medical institutions as subsidiary, which provide medical services.

When MOSEs intends to appoint directors of the state-owned enterprises, it is required to apply for approval of candidates to MOF and obtain its approval.

2.8. Bappenas: Indonesian National Development Planning Agency

Bappenas is responsible for the formulation of long-term (20 years), medium-term (five

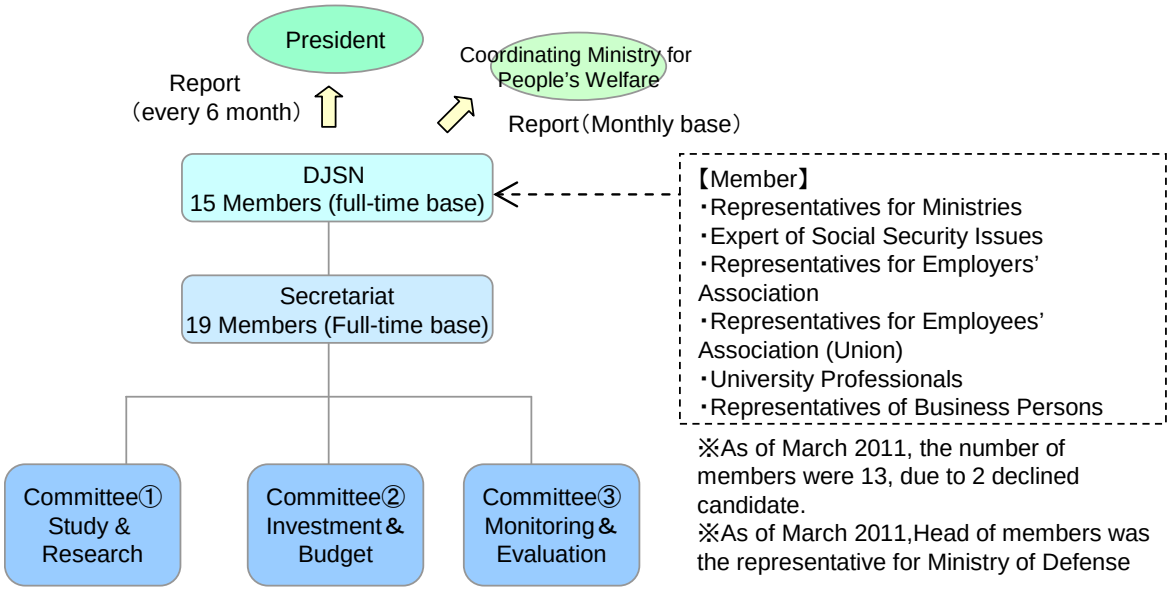
years), and annual development plans under the National Development Plan (Social and Economic Development Plan) of Indonesia, along with the examination and operation of the development budget and economic assistance matters such as poverty reduction and the comprehensive adjustment of macroeconomics.

2.9. DJSN: National Social Security Council

The DJSN is an organization established under Chapter 4 of the SJSN Law. Its responsibilities include conducting research and studies concerning social security, making policy suggestions related to the implementation of social security, and making suggestions concerning the social security budget.

DJSN is under the direct control of President. Placed under the DJSN are committees for research & studies, investment & fiscal operation, and the monitoring & assessment of social security.

Figures III-4 Organization of DJSN



Source: JICA

2.10. PT. JAMSOSTEK

PT. JAMSOSTEK is a state-owned enterprise established in 1992 under the "Law No.3 of 1992 on Social Security for Employees" (Jamsostek Law) for the purpose of providing the employees of private enterprises with a corporate old-age savings program (JHT), a health insurance program (JPK), workers compensation insurance (JKK), and a life insurance program (JK).

The major supervisory authority of PT. JAMSOSTEK on financial affairs is the MOF, on

administration of state-owned enterprise is MOSEs, and on implementation of social security program is the MoMT.

PT.JAMSOSTEK will be the successor to BPJS-Ⅱ after the transition to BPJS.

2.11. PT. ASKES

PT. ASKES is a state-owned enterprise established in 1968 under the "Presidential Decree No.230 of 1968 on Insurance for National Government Officers and Benefits for Their Families" for the purpose of providing government officers with health security.

Until 2008, PT. ASKES was the operator of the health security system for the low-income group (ASKESKIN), but the system has already been transferred to the MOH and was renamed "JAMKESMAS." Even after the transfer, PT. ASKES has been entrusted with the partial operation such as issuing membership cards of JAMKESMAS and JAMKESDA (a public health security program run by local governments)[5]. It also owns a subsidiary to sell private insurance products such as life insurance and health insurance products. Under Government Regulation No. 6 of 1992 the public company status was changed into (state-owned) limited liability company. Since then, PT.ASKES became more independent entity from the government and was permitted to sell private health insurance. Since the 2004 decision to unify the social security programs under the SJSN Law, the PT. ASKES division selling private insurance products has been spun off as its subsidiary (Inhealth). Inhealth is expected be reorganized into a state-owned enterprise and will fall under the control of the Indonesia government after the transition to the BPJS.

The major supervisory authority of PT. ASKES on financial affairs is the MOF, on administration of state-owned enterprise is MOSEs, and on implementation of social security program is MOH.

PT.ASKES will be the successor to BPJS-Ⅰ after the transition to BPJS.

2.12. PT. TASPEN

PT. TASPEN was established in 1963 as an organization to provide old-age savings for government officers under " Government Regulation No. 10 of 1963 on Civil Servants' Saving and Insurance." Later, a pension for government officers was introduced under the "Law No.11 of 1969 on the Forms of State Companies," and these two programs for government officers were unified in 1981.

The major supervisory authority of PT. TASPEN on financial affairs and implementation of social security program is MOF, and on administration of state-owned enterprise is MOSEs.

[5] PT.ASKES 2010 Annual Report

2.13. Local Administration

2.13.1. Administrative boundary

Indonesia consists of 33 provinces under the central government, and the provinces are subdivided into cities (*kota*) in urban area and regencies (*kabupaten*) in rural area, both cities and regencies are the same administration level as districts. Districts (cities and regencies) are divided into sub-districts (*kecamentan*) as internal administrative structure of districts, and sub-districts are further divided into villages (*desa* or *kelurahan*)

2.13.2. Decentralization and health system

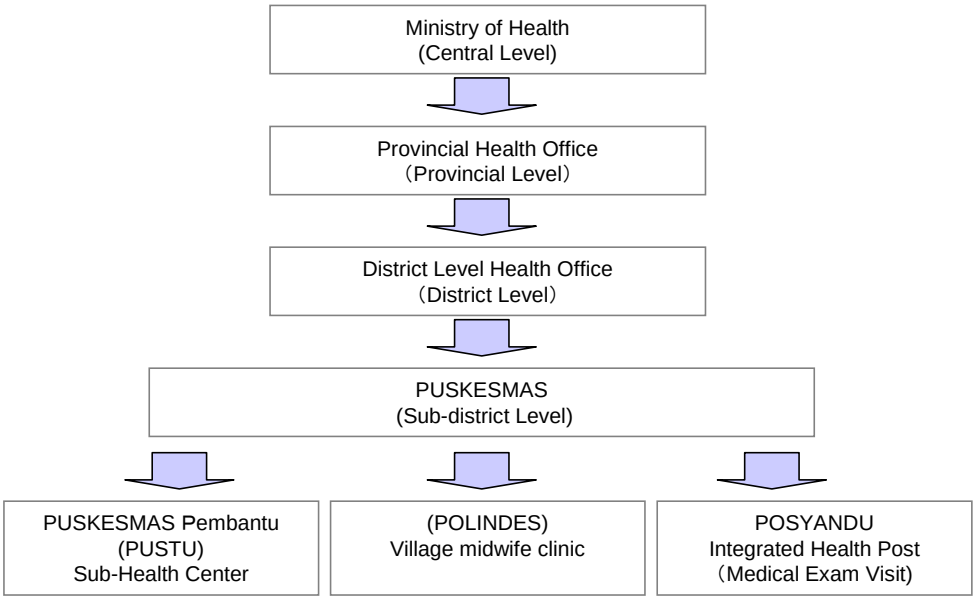
Under the Asian Financial crisis, the Suharto regime had collapsed in 1998, and newly established Habibie regime started to reform the system of local government. The regime enacted the " Law No.22 of 1999 on local government". After the enactment of the law, local governments expanded their authority, however, the structural reforms and development of human resources were left behind. Rapid decentralization caused confusion in local governments, consequently the government conducted the review of excess decentralization with amendment of the "Law No.32 of 2004 on local government".[6]

Since decentralization, province-level health offices have mainly been responsible for training and coordination efforts as well as oversight of provincial hospitals, but they have limited resource allocation responsibilities.

In contrast, districts have major responsibilities for delivering health services and allocating resources. At the sub-district level, Puskesmas (health centers) have been the key organizations of basic health services and primary care, while district-level hospitals are the main providers of curative care.[7] Puskesmas are funded by the government, and operated by local governments.

[6] Council of Local Authorities for International Relations (2008), *Local Government in Indonesia*
[7] WB, *Health Financing in Indonesia, A Reform Road Map* (conference edition)

Figures III-5　MOH Level from Central to peripheral level



Source: compiled by Mitsubishi UFJ Research & Consulting based on WHO, Country Health System Profile

3. Social Security Expenditure

The social security-related expenditure of Indonesia is as mentioned below. In addition to the national budget related to social security, there is also a project budget contributed to by international organizations.

3.1. Health Expenditure

The fiscal expenditure of the Indonesian government, which was 440 trillion IDR in 2006, sharply increased to 965 trillion IDR in the 2012 budget. The health expenditure included therein, which was 12 trillion IDR in 2006, increased to 16 trillion IDR in the 2012 budget. The percentage of health expenditure in total expenditure has gradually declined.

Figures III-6 Changes in the health expenditure and the percentage

（IDR in billions）

	2006	2007	2008	2009	2010	2011	2012
TOTAL	440,031	504,623	693,356	628,812	697,406	908,243	964,997
HEALTH	12,190	16,005	14,039	15,743	18,793	14,815	15,565
Medical product, appliances, and equipment	924	885	1,389	1,275	1,329	1,787	2,538
Individual public health services	4,839	8,070	8,781	9,765	12,086	8,705	8,714
Society public health services	4,152	3,348	1,716	2,712	3,166	922	1,098
Population and Family planning	329	434	480	624	795	2,506	2,594
R & D	145	198	199	134	258	414	342
Other health related expenditure	1,800	3,070	1,476	1,233	1,160	482	279
Percentage of Health Expenditure in Total Expenditure (%)	2.8%	3.2%	2.0%	2.5%	2.7%	1.6%	1.6%

※1IDR＝0.00885 JPY(JICA transaction rate as of May 2012 as reference）

※Items shown in 2012 are budget.

Source: MOF, Budget Statistics 2006-2012

3.2. Social Protection Expenditure

The social protection expenditure was 2.3 trillion in 2006, increased to 5.6 trillion IDR in2012.

Figures III-7 Changes in the social protection expenditure and the percentage

（IDR in billions）

	2006	2007	2008	2009	2010	2011	2012
TOTAL	440,031	504,623	693,356	628,812	697,406	908,243	964,997
SOCIAL PROTECTION	2,303	2,650	2,986	3,102	3,342	4,585	5,578
Sickness and disability	-	-	-	-	-	260	308
Old age	-	-	-	-	-	109	146
Protection and Social Services for Family	27	-	-	-	-	-	-
Family and children	72	720	680	716	755	484	511
Women empowerment	93	116	96	84	111	122	143
Counseling and social guidance	29	480	481	539	542	-	-
Housing	-	-	-	-	-	-	-
Social Security	691	1,149	1,547	1,563	1,736	77	33
R & D	65	87	65	74	70	244	250
Other social protection related expenditure	1,326	98	118	127	127	3,289	4,187
Percentage of Social Protection Expenditure in Total Expenditure （%）	0.5%	0.5%	0.4%	0.5%	0.5%	0.5%	0.6%

※1IDR=0.00885 JPY(JICA transaction rate as of May 2012 as reference)

※Items shown in 2012 are budget.

Source: MOF, Budget Statistics 2006-2012

4. Health Security

4.1. National plans for the health security sector

In recent years, efforts have been made to reform the health security system in Indonesia.

The pillar of the reform is the realization of universal coverage based on the SJSN Law, and the bill was presented to the Peoples Representative Council in January 2004 and was adopted in September 2005. The law is aimed to provide the entire Indonesian population with social security for medical services, work accidents, old-age, pensions, and death.

In addition, according Strategic Plan of Ministry of Health for the Year(2010-2014), the MOH set the goal of 100 percent of health insurance coverage by 2010, including all poor population.

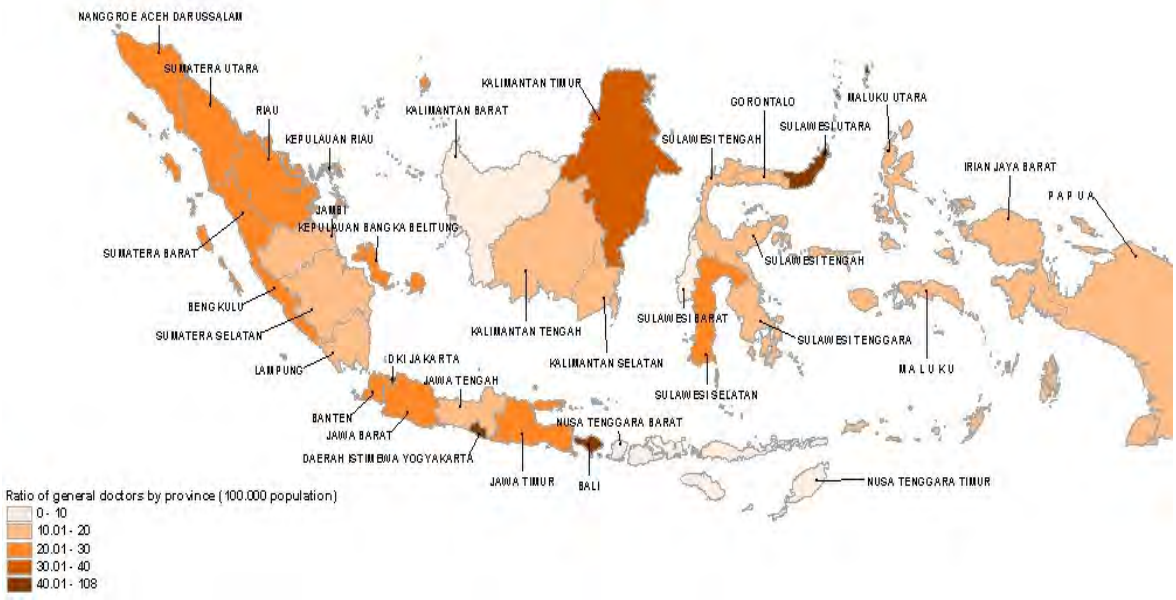
4.2. Salient features of health care delivery systems

In Indonesia, the employment and placement of doctors and other key health care workers in local areas still remains under the control of the MOH in the situations where the decentralization of power has been promoted. Health care in local areas, in particular, is mainly covered by the MOH, while the budget is allocated by MOF based on the record of budget execution in the preceding fiscal year.

A health center (Puskesmas) is established by the MOH in each 24-km^2 area in Indonesia, as the primary care provider, and each center provides health services to the people living in each respective location. More than 8,000 Puskesmas centers have been established in Indonesia, and approximately 31% of them are equipped with inpatient facilities. In addition, approximately 20,000 sub-centers and 6,000 mobile health centers are organized under these Puskesmas. The Puskesmas centers have been developed on the premise that each of them will provide health services to 30,000 people, but they are subject to regional disparity in quality although they meet the required standard in quantity.[8]

[8] WB, *Health Financing in Indonesia, A Reform Road Map* (conference edition)

Figures III-8　Ratio of general doctors by province (100,000 population)



Source: World Bank (2010) Indonesia's Health Sector Review

The table below shows changes in the number of medical institutions in each jurisdiction except specialized hospitals.

Figures III-9　Changes in the number of medical institutions in each jurisdiction

	1995	1997	2000	2003	2005	2006
MOH	15	15	14	14	13	13
Local Government	323	327	328	339	365	377
Armed Forces or Police	110	111	110	110	110	110
Other ministry or state-owned enterprise	73	69	68	71	71	71
Private	329	351	390	432	436	441
Total	850	873	910	966	995	1012

Source: WB, Health Financing in Indonesia, A Reform Road Map (conference edition)

In addition, the state of having 53.37 beds per 100,000 people is underdeveloped in comparison with neighboring countries, and the service is not necessarily accessible to the entire population due to the country's geographical characteristic of being comprised of a large number of islands.

Figures III-10 Changes in the number of beds in medical institutions by their form of ownership

	1995	1997	2000	2003	2005	2006
MOH	9,023	9,610	9,173	8,858	8,483	8,784
Local Government	40,069	40,824	42,109	43,761	46,798	48,209
Armed Forces or Police	10,752	10,874	10,811	10,718	10,814	10,842
Other ministry or state-owned enterprise	7,246	6,881	6,928	6,758	6,827	6,880
Private	33,298	35,697	38,516	42,284	43,364	43,789
Total	100,388	103,886	107,537	112,379	116,286	118,504
Beds per 100,000	51.55	-	52.42	52.62	53.05	53.37
Bed occupancy rate	-	-	-	56	56	59

Source: WB, Health Financing in Indonesia, A Reform Road Map (conference edition)

4.3. Basic structure of the health security system

The health security system in Indonesia is composed mainly of the following systems.

Figures III-11 Basic structure of the health security system

	ASKES : Health insurance for government officers	JAMSOSTEK : Employee health security (JPK)	JAMKESMAS : Public health security system for low-income population	JAMKESDA Public health security system by local governments	Health insurance program based on the SJSN Law
Established Year	1968	1992	2008	2008	2004 : SJSN Law enactment 2014 : BPJS establishment (expected)
Legal Basis	Presidential Decree No.230 of 1968 on Insurance for National Government Officers and Benefits for Their Families	Law No.3 of 1992 on Social Security for Employees (Jamsostek Law)	Health Minister's Decree No. 112/Menkes/II/2008 on Management of Participation in People's Health Security Program	－	Law No.40 of 2004 on National Social Security System" (SJSN Law)
Supervisory Authority	MOH MOF MOSEs	MoMT MOF MOSEs	MOH	Local governments (250 out of 440 cities or regencies)	To be determined (under consideration among MOF, MOH, MoMT, TNP2K etc.)
Implementing Organization	PT.ASKES	PT.JAMSOSTEK	MOH (directly operated by local government or entrusted by PT.ASKES)	Local governments (directly operated by local government or entrusted by PT.ASKES)	BPJS All of programs mentioned at the left column will be unified.
Model	Contribution (Paid by employee 2% and paid by the government 2%)	Contribution (Paid by employer: single 3%, married 6%)	Non-Contribution The government paid 5000IDR per capita per month.	Non-Contribution (Paid by local government)	Contribution (public health security system for poor is non-contribution)
Membership Obligation	Compulsory	Private companies with 10 or more employees or with total salaries of at least 1 million IDR per month are compulsory (Exemption (opting out) is available if company provides more favorable benefits.)	JAMKESMAS is the public medical assistance by the government for the poor or near poor who meet the criteria.	JAMKESDA is the public medical assistance by local governments for the poor or near poor who meet the criteria (Duplicated receipts with JAMKESMAS are not allowed).	Compulsory
Target Groups	Civil Servants Retired Civil Servants Retired Military Personnel	Employees of private company or state-owned company	Poor and Near Poor	Poor and Near Poor (Resident of relevant local government, Not member of other health security program,	all Indonesian nationals

	ASKES : Health insurance for government officers	JAMSOSTEK : Employee health security (JPK)	JAMKESMAS : Public health security system for low-income population	JAMKESDA Public health security system by local governments	Health insurance program based on the SJSN Law
				Meet the requirement of asset or life environment.)	
The Number of Members	Approx. 16.5 million (including family members)	Approx. 5 million (including family members)	Approx. 76 million (including family members)	Approx. 50 million (including family members)	230million (all Indonesian nationals)
Payment System	-Primary care : Capitation -Secondary and tertiary care : Fee for Service	-Primary care : Capitation -Secondary and tertiary care : Fee for Service	-Primary care : Capitation -Secondary and tertiary care : Fee for Service	Schemes can vary according to local governments.	To be determined
Referral	implemented	implemented	implemented	implemented	To be determined
Copayment	-Primary care : None -Secondary and tertiary care: Patients pay the balance between the amounts billed by hospitals and the amounts set in the ASKES system. -Medicine : Out-of-pockets.	-Primary care : None Secondary and tertiary care: Patients pay amounts in excess of the reimbursement amounts determined by PT.JAMSOSTEK according to duration of hospitalization and class of bed	-Primary care : None (practiced at Puskesmas) -Secondary and tertiary : None	Schemes can vary according to local governments.	To be determined
Capitation Budget	N/A	5,500IDR per month	5,000IDR per month	Schemes can vary according to local governments.	To be determined
Uncovered Medical Practice	HIV/AIDS, Sexual diseases, Alcohol addiction, Cosmetic treatments	Cancer, Hemodialysis session, Suicide, HIV/AIDS, Cosmetic treatments, Routine Medical Checkup, Fertility treatments	Suicide, HIV/AIDS, Cosmetic treatments, Routine Medical Checkup, Fertility treatment	Schemes can vary according to local governments.	To be determined
Remark			In principle, secondary and tertiary cares are free, however practically medical institutions sometimes ask for payments from the insured in the name of medical supply costs, etc.		BPJS consists of BPJS-Ⅰ and BPJS-Ⅱ, BPJS-Ⅰ will manage and supervise health security affairs.

※1IDR=0.00885 JPY(JICA transaction rate as of May 2012 as reference)

Source: compiled by Mitsubishi UFJ Research & Consulting

4.4. Health insurance for government officers (ASKES)

ASKES is the compulsory health insurance system for government officers, and it provides health services to central and local government officers, retired government officers, and veterans of the armed forces and their families. (The number of family members eligible for the service is limited.) The ASKES system is run by PT. ASKES, a state-owned enterprise, and government officers pay an amount equivalent to 2% of their basic wage as contribution, while the government contributes the same amount as their employer. Medical benefits for primary care are provided by the registered medical institutions and by public hospitals for secondary and tertiary care. As for hospitalization, different levels of hospital rooms (first class to third class) are available according to different professional ranks, and payments are made using a capitation system for primary care. In secondary and tertiary care, payments are made using a prospective payment system for regular examinations, inspections, and injections, while daily amounts fixed for respective diseases are paid for other health care services. The balance between the amounts billed by hospitals and the maximum amounts set in the ASKES system is borne by the insured, which is estimated to be approximately 40% of the medical expenses incurred. [9]

In 2010, the premium revenue of PT.ASKES was 7.9 trillion IDR, and health expenditure was 5.3 trillion IDR. [10]

4.5. Employee health security (JPK)

This scheme is run by PT. JAMSOSTEK, a state-owned enterprise. It has the four divisions of employee health security (JPK), workers compensation insurance (JKK), old-age benefits (JHT), and life insurance (JK).

Employee health security (JPK) is an insurance system for private employees (including the employees of state-owned enterprises). It is compulsory for businesses with 10 employees or more (or with employees with a total monthly wage of one million IDR or more) to provide medical benefits to the insured and their families. It is provided, however, that employers can be exempted from participation in this system (opting out) when the company is in a position to provide more favorable benefits. Contribution for health insurance, which is equivalent to 3% of the insured's remuneration when they are not married and 6% when they are married, is paid solely by the employers. Primary care is provided by approximately 2,900 private clinics across the country, and they operate under a contract with PT. JAMSOSTEK, while secondary and tertiary care is provided by public and private hospitals. The scope of available health care, however, is less extensive than in other systems, and cancer treatment, cardiac surgery, artificial dialysis, and the treatment of inborn diseases, etc., are excluded from the coverage for benefits. Payments are based on a

[9] WB. *Health Financing in Indonesia, A Reform Road Map* (conference edition), p. 31
[10] 1IDR=0.00885 JPY(JICA transaction rate as of May 2012 as reference)

capitation system (5,500 IDR per month per insured) for primary care and on a fee for service basis for secondary and tertiary care, and any amounts in excess of the reimbursement amounts determined in the negotiation between PT.JAMSOSTEK branches and local medical institutions are borne by the insured. Payments under this program seldom exceed their budget, as the number of beds available for inpatients is limited.

A problem of this system is that employers pay contributions for approximately 2.2 million employers (5 million beneficiaries) only, while the total number of eligible people is said to be approximately 30 million. This is, however, due to the facts that: a large number of employers elect not to participate in this health insurance scheme in the situation where the companies tend to employ more delegated and temporary workers than regular workers under the country's labor legislation designed more favorable to the employees; and that they are exempted from the duty to participate in the health insurance scheme (opting out) so long as the companies are in a position to provide alternative medical benefits. With respect to the amount of contribution, the maximum amount of monthly wages used as a basis of calculation, which has been frozen at one million IDR for a considerable period, is scheduled to be raised to three million IDR in 2012 to reflect an increase in the prices of goods. [11]

In 2010, the premium revenue of employee health security (JPK) was 1.1 trillion IDR, and health expenditure was 0.813 trillion IDR. [12]

4.6. Public health security system for low-income populations (JAMKESMAS)

JAMKESMAS is the health security system for the poor, its target has been expanded for not only the poor but also near poor since 2007. [13] JAMKESMAS is fully financed with public funds and which was run by PT. ASKES as ASKESKIN until 2008. This system has been transferred to the MOH and is currently run by the ministry. The target of this system is the poor, and certificates for benefits are issued to those eligible based on an examination of their income and assets. Currently, the system covers approximately 76 million people, who receive benefits from Puskesmas for primary care and from the public medical institutions for secondary and tertiary care. The scope of health care provided is similar to that of ASKES, and the lowest class of hospital rooms is provided when hospitalization is required. The payment is based on a capitation system for primary care and on a DRG system for secondary and tertiary care, but the amount of payment greatly differs among the districts. The MOH allocates to each province an amount of 1,000 IDR per insured per month for primary care and 5,000 IDR per insured per month for secondary and tertiary care, which are used for payments to hospitals and clinics.

Problems lie in the facts that: (1) the medical institutions have low incentive to secure quality health care and are not trusted by the insured, (2) medical institutions sometimes ask

[11] Based on a hearing with P.T. JAMSOSTEK conducted in February 2012
[12] 1IDR＝0.00885 JPY(JICA transaction rate as of May 2012 as reference)
[13] WB(2012) "JAMKESMAS Health Service Fee Waiver"

for payments from the insured in the name of medical supply costs, etc., (3) the insured must be attended to by their families when they are hospitalized, (4) and access to the hospital is not easily available particularly in insular areas, all of which results in low medical examination rates. (The medical examination rate in JAMKESMAS is 20% that of ASKES.)[14] A problem in operation is that JAMKESMAS' data is based on the data of the BPS (Central Agency on Statistics), but those who are not registered in the data are not eligible for benefits even when they actually fall under the poor demographic of society.

In 2010, the health expenditure of JAMKESMAS was 4.8 trillion IDR.[15]

4.7. Public health security system by local governments (JAMKESDA)

JAMKESDA is the form of public medical assistance provided by local governments, which covers the poor and near poor not covered by public medical assistance under JAMKESMAS. The operation methods and benefit packages of JAMKESDA vary among the local governments. The mechanism of JAMKESDA in the text is based on the Depok City's case. (In Depok City, for example, the maximum amount of benefit is 100 million IDR per person per year. The maximum amount of benefit varies among local governments, and some have a maximum of two million IDR while others have no upper limit.[16]) Systematically, in Depok City, new insured are registered when openings are created through the out-migration or the death of the existing insured.

In Depok City, a person who wishes to receive the benefits of JAMKESDA has to satisfy the following three requirements: namely, (1) they must be a resident of Depok City, (2) they must neither be registered with JAMKESDA nor covered by other health security programs including JAMKESMAS or JAMSOSTEK, and (3) they must meet at least nine requirements out of the 14 listed below as the criteria necessary to be considered a low-income household.

The 14 items listed below are the basic items of the Socio-economic Population Survey (PSE2005) conducted by the BPS.

Figures III-12 Standard items to determine eligibility for JAMKESDA benefits

	Variables	Criteria
1	Floor area of the residence	Less than 8 ㎡ per person
2	Type of floor in the residence	Soil/ bamboo/ cheap wood/ low quality cement
3	Type of wall	Bamboo/ sago palm branch/ low quality wood/ wall without plaster
4	Bathroom	Don't have/ using public toilet/ connected with neighbors
5	Main source of lighting	Not electricity
6	Source of drinking water	Well/ wellspring/ river/ rainwater
7	Cooking material	Wood/ charcoal/ kerosene
8	Consumption of meat/ milk/ chicken, per week	Never consume/ Only once a week

[14] Based on research conducted by JICA in February 2011
[15] 1IDR＝0.00885 JPY(JICA transaction rate as of May 2012 as reference)
[16] Based on a hearing with JAMKESDA at Depok City conducted in February 2012

	Variables	Criteria
9	Buy new clothes for every family member in a year	Never buy/ Only buy one set of clothes in a year
10	Eating in a day for every family member	Only one time/ Twice a day
11	Ability to pay for treatment in health community center (Puskesmas) or clinic	Cannot afford to pay
12	Job of head of household	Farmer with land area < 0.5 Ha or farm worker, fisherman, construction worker, temporary worker, unemployed
13	Education of head of household	Do not have school background/ not completed elementary school/ elementary school
14	Asset ownership	Do not have saving/ assets that are easily sold with minimum value of 500,000IDR, such as motor cycle, gold, livestock, motor ship, etc.

Source: Depok City

In receiving JAMKESDA benefits, the recipients have their data screened to avoid possible duplicated receipts with JAMKESMAS benefits. The recipients of JAMKESMAS benefits have to be registered in the BPS data in the first place. When they are not registered with JAMKESMAS, they may receive the benefits by registering themselves with JAMKESDA.

4.8. Role of the private health insurance system and recent trends

As for health care services aside from the public health insurance system, health insurance services provided by private health insurance carriers and health care services provided by enterprises to their employees by running their own hospitals or cooperating with other hospitals are currently available. Pertamedika, or the subsidiary of Pertamina (national oil company) is a major example of privately owned hospital. In lieu of public health insurance (opting out), some private enterprises provide their employees with the above kind of private health insurance programs and health care services provided by medical institutions.

Some hospitals are operated by non-governmental private organization, Islamic network, Muhammadiyah and its sister organization Aisyiyah have clinics and hospitals, mostly concentrated on Java. Muhammadiyah and Aisyiyah accept ASKES and JAMKESMAS patients.[17] In addition to Muhammadiyah, Nahdlatul Ulama (NU), and its sister organization Muslimat; Perdhaki (Association of Voluntary Health Services); and Bidan Delima, a network of quality-certified midwives are major private hospitals. Unlike Muhammadiyah and NU facilities, which tend to target the middle class but still serve a significant number of poor and near-poor patients, the perception in many areas is that the Catholic hospital is more expensive and so does not tend to attract the poor or near-poor.[18]

[17] USAID(2009) "Private Sector Health Care in Indonesia"
According to Division of Religion and Philosophy, St. Martin College, UK, The Muhammadiyah (followers of Muhammad) was founded in Jogjakarta, Java, in 1912. A woman's organization was started in 1914 and named the Aisiyah (after an influential wife of the Prophet).
(http://www.philtar.ac.uk/encyclopedia/indon/muham.html)

[18] USAID(2009) "Private Sector Health Care in Indonesia" USAID indicated these medical institutions as high potential partners among private hospitals in terms of larger network.

4.8.1. Private insurance products

4.8.1.1. Private insurance market trends

The total revenues of Indonesian life and health insurance market was expected to increase by 30% to approximately 144 trillion IDR in 2012, from approximately 94 trillion IDR in 2011. [19]

With the rapid market expansion of insurance industry, the Capital Market and Financial Institution Supervisory Agency (BAPEPAM–LK) at MOFA began placing gradual capital requirements on insurance companies until 2014, for the purpose of strengthening the management of each companies. These trend influenced the reorganization of insurance companies. [20]

4.8.1.2. Health insurance industry organization

The AAJI (Indonesia's Life Insurance Association) is an industry organization for life insurance carriers in Indonesia with 46 members (four of them being reinsurance carriers). Besides the AAJI, the General Insurance Association of Indonesia (AAUI) and the Indonesia Islamic Insurance Association (AASI) represent insurance carriers in Indonesia as their industry association.

4.8.1.3. Major private insurance programs

Private health insurance consists mainly of the programs sold to middle- to high-income groups as group insurance for enterprises. The insurance is currently divided into the programs of two types: (1) a program to provide comprehensive medical benefits and (2) a program to provide benefits additional to the fundamental benefits of JAMSOSTEK and other programs. The major programs of private health insurance in Indonesia consist of insurance to compensate actual damage. [21]

From now on, private insurance carriers will sell programs to provide additional benefits (as such will no longer be permitted under the introduction of the universal coverage system), in order to replace public health security with private insurance programs—even when the latter can provide better medical benefits.

At present, however, AAJI sees that the health insurance market in Indonesia (which is in its growth stage) is expanding and that the impacts made by private insurance programs shifting to additional types will be limited. [22]

4.8.1.4. Microinsurance

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[19] Jakarta Post "Life Insurance Industry expects 30 percent increase in revenues" on March 12, 2012

[20] Based on a hearing with AAJI and Inhealth conducted in February 2012

[21] Fujino Fukuoka (2010), Health Security System in Indonesia and its Challenges, Study of Social Security Outside Japan, Vol. 170, p. 76

[22] Based on a hearing with AAJI and Inhealth conducted in February 2012

An increasing number of insurance carriers are currently handling microinsurance (insurance with low premiums and low coverage limits) although it has not become a major private health insurance product just yet. Around five carriers are selling microinsurance as of February 2012, and the Life Insurance Association of Indonesia is studying a model for a contribution and benefit package in cooperation with the World Bank and the GIZ. This insurance targets near-poor group, which is engaged in agriculture and fisheries in insular areas in the eastern part of Indonesia, where the network of life and health insurance brokers is not yet developed or is diffused.

BAPEPAM–LK at MOFA designed "the Capital Market and Non Bank Financial Industry Master Plan 2010-2014", and demonstrated the policy of encouraging development and promotion of insurance products that support family for risk management, and encouraging the development and promotion of products of microinsurance for mitigating risks of middle and low income population. However, it is not clear how the government will position the microinsurance in its process of unifying health security. In 2011, AAJI demanded that MOF implement efforts to introduce microinsurance that included the introduction of reduced brokerage costs paid by brokers to the AAJI for diffusing microinsurance products. [23]

Allianz led other insurance carriers in selling microinsurance in Indonesia, and an outline of its program is as mentioned below.

Figures III-13 (Reference) Example of microinsurance (Allianz's product, named "Tamadera")

	Weekly	
Premium	10,000 IDR (Min.)	100,000 IDR (Max.)
Payment & Insured Duration	Approx.5years(250 week)	
Life Insurance Benefits	2.5 million IDR	25 million IDR
Critical Illness Benefit	2.5 million IDR	25 million IDR
Maturity benefit after 5 years (if no claim)	2.5 million IDR	25 million IDR

* 1IDR=0.00885 JPY(JICA transaction rate as of May 2012 as reference)

* The products of Allianz comprise life insurance and health insurance, which cover serious diseases of cancer, apoplexy, heart attack, renal failure, and heavy burns, while the insured must be aged between 17 and 50. Premium Paying period and insurance term is 5 years. These programs consist of group insurance and can be purchased through cooperatives, employers with a large number of blue collar workers, associations, funds, and NGOs. [24]

[23] Global Business Guide Indonesia (2011), *The Prospects for Indonesia's Insurance Industry*
[24] Allianz's website (http://www.allianz.co.id/AZLIFE/English/Products/Group+Insurance+Indonesia/Allianz+Microinsurance.html)

5. Pension and other income security schemes

With regard to social security for employees, PT. TASPEN, an organization that provides social insurance for government officers, offers pensions for government officers (TASPEN) and old-age savings for government officers (THT). (There is also "ASABRI," a system for military officers similar to those for government officers.)

For private companies, PT. JAMSOSTEK offers corporate old-age savings (JHT), as well as workers compensation insurance (JKK), employee health security (JPK), and life insurance (JK). The corporate old-age savings is an old-age lump sum payment, and there is no system to provide monthly pension payment.

Besides, there is pension and other income security scheme for informal sectors that is partly sponsored by the state through the MoMT and provided by JAMSOSTEK, and ASKESOS, a social welfare insurance system provided by MoSA.

Figures III-14 Types and summaries of pension and other income security schemes

System	Target	Benefit Package	Contribution rate	Implementing organization
TASPEN	Civil Servants	Pension program for government officers (TASPEN)	4.75%	PT.TASPEN
		Old-age savings program for government officers (THT)	3.75%	
JAMSOSTEK	Private Companies	Corporate old-age savings (JHT)	5.7%	PT.JAMSOSTEK
		Workers compensation insurance (JKK)	0.24～1.74%	
		Life insurance program for employees (JK)	0.3%	
		Employee health security (JPK)*	3%(Single) 6%(Married)	
	Informal Sector	Social insurance program for workers in informal sectors (TKLHK)	Based on each JAMSOSTEK program.	MoMT PT.JAMSOSTEK
ASKESOS		Social welfare insurance (ASKESOS)	5,000IDR per month	MoSA

* For details regarding employee health security (JPK), see "4. Health Security."

5.1. TASPEN's Income Security Program

5.1.1. Pension program for government officers (TASPEN)

5.1.1.1. Legal basis

PT. TASPEN is a state-owned enterprise and the operational body that offers pensions for government officers (TASPEN) and old-age savings for government officers (THT). The enterprise was established as an institution to provide pensions and old-age savings for government officers based on "Government Regulation No. 10 of 1963."

Pension program for government officers (TASPEN) is based on the President Regulation No.56 of 1974.

5.1.1.2. Benefit packages

The monthly sum of the pensions for government officers is 2.5% of the last paid monthly salary multiplied by the number of years in service. The upper limit of the amount of monthly pension payment is 80% of the last paid monthly salary, and the pensions are provided from the age of 56–60. Pensions for government officers are combined with survivor's pensions and thus they can be paid either to the insured or to the surviving family of the insured, i.e., the spouse, children, or parents (in the case the insured does not have a spouse or a child).

The spouse of the insured is qualified for benefits until death or remarriage, and the children of the insured are qualified for benefits until the age of 25.

Although pensions used to be partly paid by the reserve fund,[25] the current pension program has been fully based on the pay-as-you-go system since 2008.

5.1. 1.3. Eligibility for enrollment and contribution rates

Government officers as well as the employees of state-owned enterprises, excluding military personnel, are eligible to enroll in the pension plan and the old-age savings plan for government officers; and enrollment in and full contribution to the plans is compulsory.

The insured are to pay 4.75% of their monthly salary as a contribution to the pension plan for government officers in order to qualify for the benefits after their retirement. Although the pensions are provided from the age of 56–60 (depending on the status), those who have contributed to the plan for 20 years or more are qualified to receive pensions before reaching the eligible age in the case of resignation at the age of 50 or above. Those who resigned before fulfilling the conditions to receive pensions are entitled to withdraw the total value paid as contribution as well as the outcome of investment management.

5.1. 1.4. Funds and operational bodies

The pension program (TASPEN) is managed by PT. TASPEN under a separate account from that of the old-age saving program (THT).

5.1. 1.5 State of coverage

The history of the number of the insured and beneficiaries of PT. TASPEN is shown below.

Figures III-15 History of the number of the insured and beneficiaries of TASPEN

	2009	2010	2011
Insured	4,328,831	4,612,684	4,685,048
Beneficiaries	2,172,945	2,238,351	2,291,201

Source: PT.TASPEN 2011 Annual Report

[25] According to Isa, Rachmatarwata (Ministry of Finance) (2004) *Indonesia Pension System: Where to Go?*, as of the time of survey in 2001, TASPEN was under-financed and the program was expected to be fully supported by the government from 2008.

5.1.2. Old-age savings program for government officers (THT)

5.1.2.1. Legal basis

PT. TASPEN is a state-owned enterprise and is the operational body that offers pensions for government officers (TASPEN) as well as old-age savings for government officers (THT). The enterprise was established as an institution to provide pensions and old-age savings for government officers based on "Government Regulation No. 10 of 1963."

Old-age savings for government officers (THT) is based on Government Regulation No.25 of 1981.

5.1.2.2. Benefit packages

The old-age savings for government officers is a system operated by PT. TASPEN, a state-owned enterprise, to provide a lump sum payment at the time of retirement, and enrollment is compulsory for government officers. The amount of the payment is 60% of the last paid monthly salary multiplied by the number of years in service.

The old-age savings program for government officers includes a lump sum payment to the insured (or the surviving family of the insured) as well as life insurance.

The lump sum payment is made when the insured reaches the eligible age, and in the case of the death of the insured before reaching the eligible age, the payment is made to the surviving family of the insured.

5.1.2.3. Eligibility for enrollment and contribution rates

Government officers as well as the employees of state-owned enterprises, excluding military personnel, are eligible to enroll in the pension plan and the old-age savings plan for government officers, and enrollment in and full contribution to the plans are compulsory.

The insured are to pay 3.75% of the total amount of their monthly salary as well as spouse and child-care allowance as a contribution to the old-age savings program for government officers, in order to qualify for the payment at the time of their retirement.

5.1.2.4. Funds and operational bodies

The old-age savings program for government officers (THT) is managed by PT.TASPEN under a separate account from that of the pension program for government officers (TASPEN).

5.1.2.5. State of coverage

For the history of the number of the insured of PT. TASPEN, see the section on the pension program for government officers (TASPEN).

5.2. JAMSOSTEK's Income Security Program

5.2.1. Corporate old-age savings (JHT)

5.2.1.1. Legal basis

PT. JAMSOSTEK provides corporate old-age savings (JHT), employee health security (JPK), workers compensation insurance (JKK), and life insurance (JK) based on the " Law No.3 of 1992 on Social Security for Employees " (the Jamsostek Law).

5.2.1.2. Benefit packages

Under the corporate old-age savings program (JHT), employees are to pay 2% of their base salary while employers are to pay 3.7% as contribution to the program, and the employees receive the total value of their contribution with interest at the time of their retirement. Although the payment is made in the case of retirement at the age of 55 or above in principle, employees are equally entitled to withdraw the total amount of their contribution and the outcome of investment management after five years of contribution, even if they resign before reaching the age of 55. The program thus functions also as an unemployment benefit, and 86.78% of the total cases of payment in 2008 fall under this category. [26]

5.2.1.3. Eligibility for enrollment

The corporate old-age savings program is for private employees (including the employees of state-owned enterprises), and enrollment is compulsory for the employees of enterprises with 10 employees and above or for employees who have a total monthly wage of 100 million IDR and above—as is the case with the health insurance program explained above.

5.2.1.4. Contribution rates

Employees are to pay 2% of their base salary, while employers pay 3.7% as contribution to the program. The minimum length of enrollment is five years, and employees receive the total amount of their contribution and interest at the time of their retirement.

5.2.1.5. Funds and operational bodies

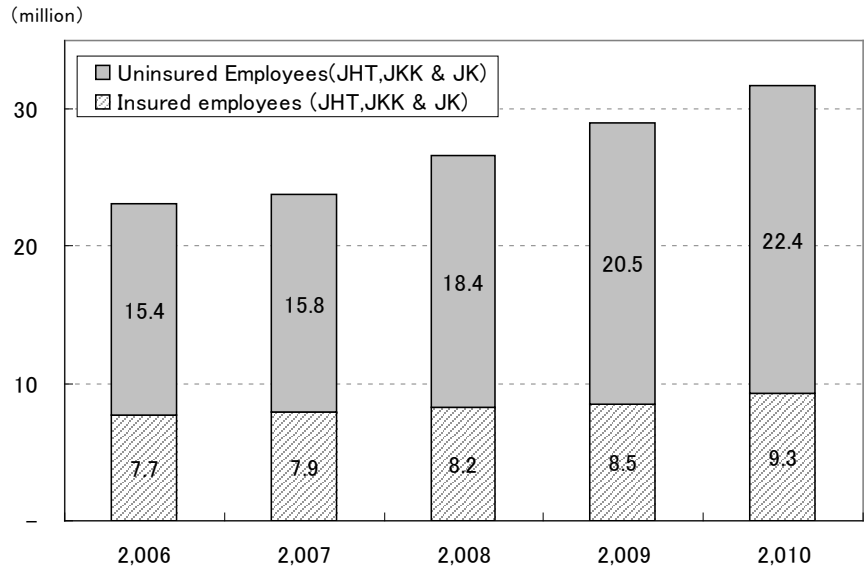
The capital of the corporate old-age savings program of JAMSOSTEK consists of deposits as well as investment profits, and there is no state contribution to the program.

5.2.1.6. State of coverage (extensions to workers in informal sectors)

The numbers of payers and non-payers among the insured of PT. JAMSOSTEK (the number of the insured regarding old-age benefits, health insurance, workers compensation insurance, and life insurance) are shown below.

[26] P.T. JAMSOSTEK 2008 annual report

Figures III-16 History of the number of the insured of JAMSOSTEK (the numbers of payers and non-payers)



	2,006	2,007	2,008	2,009	2,010
Insured employees	7,719,695	7,941,017	8,219,154	8,495,732	9,337,423
Uninsured employees	15,361,672	15,788,933	18,407,661	20,534,941	22,408,877
Total employees	23,081,367	23,729,950	26,626,815	29,030,673	31,746,300
Ratio of Insured employees	33%	33%	31%	29%	29%

Source: PT.JAMSOSTEK 2010 Annual Report

5.2.2. Workers compensation insurance (JKK)

5.2.2.1. Legal basis

The workers compensation insurance program is operated by PT. JAMSOSTEK and provides old-age benefits, health insurance, workers compensation insurance, and life insurance based on the "Law No.3 of 1992 on Social Security for Employees" (the Jamsostek Law).

5.2.2.2. Benefit packages

PT. JAMSOSTEK provides a workers compensation insurance program (JKK). The program provides insurance against accidents that may occur between the time employees leave home and the time they return home, as well as covering work-related illness, accidents, impairment, and death. The amount of compensation is determined according to various conditions, such as severity of the impairment.

Figures III-17 Benefits and compensation included in the workers compensation insurance program

Category	Benefit Package
Medical treatment benefit	The maximum amount of benefit for medical expenses : 1.2 million IDR
Compensation for temporary disability	Benefit package for temporary disability is as follows. ・First 4 months : 100% of wage ・Next 4 months : 75%of wage ・Further months during rehabilitation or until the degree of disability is determined : 50% of wage
Compensation for disability	Details of disability benefit are as follows. Partially-Disabled ・80 months×wage（based on the stipulation of degree of disability Totally-Disabled ・80 months×wage×70%(Lump sum base) ・24months×0.2 million IDR(monthly base)
Death Benefit for employees	Details of death benefit for employees are as follows ・80 months×wage×60%(Lump sum base) ・24months×0.2 million IDR(monthly base) ・Compensation for funeral expenses 2 million IDR
Other	・Transportation Costs (Land : 0.4 million IDR, Sea : 0.75 million IDR, Air : 1.5 million IDR ・Rehabilitation costs for prosthetic feet and wheel chairs

Source: PT.JAMSOSTEK 2010 Annual Report and the JAMSOSTEK website

5.2.2.3. Eligibility for enrollment

The workers compensation insurance program is for private employees (including the employees of state-owned enterprises), and enrollment is compulsory for the employees of enterprises with 10 employees and above or for employees who have a total monthly wage of 100 million IDR and above—as is the case with the health insurance program explained above.

5.2.2.4. Contribution rates

Employers are fully liable for contributions for the workers compensation insurance. The contribution rate is determined by the degree of risk involved in the profession, and there are five levels: 0.24%, 0.54%, 0.89%, 1.27%, and 1.74%.

5.2.2.5. Funds and operational bodies

Employers are fully liable for contributions for the workers compensation insurance program provided by PT. JAMSOSTEK, and there is no state contribution to the program.

5.2.2.6. State of coverage

For the number of the insured of PT. JAMSOSTEK, see the section on the JHT.

5.2.3. Life insurance program for employees (JK)

5.2.3.1. Legal basis

The life insurance program for employees is operated by PT. JAMSOSTEK and provides

old-age benefits, health insurance, workers compensation insurance, and life insurance based on the“ Law No.3 of 1992 on Social Security for Employees ” (the Jamsostek Law).

5.2.3.2. Benefit packages

PT. JAMSOSTEK provides employees with life insurance (JK) that is not part of the workers compensation insurance program. A death benefit of 14.2 million IDR as well as funeral expenses of 2 million IDR are paid to the surviving family at the time of the death of the insured, and a monthly benefit of 200,000 IDR is paid thereafter for the duration of 24 months.

5.2.3.3. Eligibility for enrollment

The life insurance program for employees is for private employees (including the employees of state-owned enterprises), and enrollment is compulsory for the employees of enterprises with 10 employees and above or for employees with a total monthly wage of 100 million IDR and above—as is the case with the health insurance program explained above.

5.2.3.4. Contribution rates

Employers are fully liable for the contributions of the life insurance program for employees. The contribution rate is 0.3% of the base salary of their employees.

5.2.3.5. Funds and operational bodies

Employers are fully liable for the contributions of the life insurance program provided by PT. JAMSOSTEK, and there is no state contribution to the program.

5.2.3.6. State of coverage

For the number of the insured of PT. JAMSOSTEK, see the section on the JHT.

5.2.4. Social insurance program for workers in informal sectors provided by JAMSOSTEK (TKLHK)

5.2.4.1. Legal basis

The MoMT operates the TKLHK as a pilot project through PT. JAMSOSTEK, based on “Decree of the Minister of Labor and Transmigration, No. 24 of 2006.”

5.2.4.2. Benefit packages

The benefit packages are generally in accordance with the benefits provided by JAMSOSTEK.

5.2.4.3. Eligibility for enrollment

In order to receive the benefits, workers must be under the age of 50, must not be unemployed, and they must not receive public health security provided by JAMKESMAS or JAMKESDA, nor be recipients of other benefits for workers in informal sectors. Workers in

informal sectors with a monthly wage of a certain level as well as individual business owners are eligible for enrollment.

The MoMT defines those who work outside formal sectors (LHK) as "Workers that work outside an employment relationship and workers who perform their own activities without any assistance from another person." Workers in informal sectors constitute the majority of those who are eligible for the benefits. In general, according to MoMT, the characteristics of their work include: micro-scale operations with small capital, the use of simple and low technology, the production of goods and services of low quality, a non-permanent place of business, highly mobile operations, irregular working hours, and relatively low and instable income.

5.2.4.4. Contribution rates

The contribution rate of the TKLHK is 0.3% of the monthly wage for life insurance (JK), 1% for workers compensation insurance (JKK), 2% or higher for old-age savings (JHT), 3% for health insurance for single workers, and 6% for health insurance for married workers. The contribution rates are generally in accordance with those of insurance for workers in formal sectors provided by JAMSOSTEK.

The MoMT operates a pilot project to subsidize the insurance contribution of individual business owners and workers in informal sectors for the duration of eight months. Workers are required to pay their own contribution after the eight months have passed. [27]

5.2.4.5. Enrollment figures

A total of 553,663 workers enrolled in the program between 2004 and 2010. The number of new insured in 2010 was 142,065.

Figures III-18 History of the number of the insured of the TKLHK

(Unit: individual insured)

Year	2004	2005	2006	2007	2008	2009	2010	Oct.2011
Insured workers	5,164	43,555	28,403	71,415	105,285	157,775	142,065	108,888

Source: MoMT (2012), Employees Social Security Program (JAMSOSTEK)in Indonesia

Among these, more than 20% of the total figure, are located in Java—the central part of the country where there are many workers in informal sectors.

5.3. Social welfare insurance (ASKESOS)

5.3.1. Legal basis

MoSA operates a pilot project to provide microinsurance for low income workers in order to prevent them from falling into poverty due to illness, or accident, based on "Decree of the Minister of Social Affairs No. 51 of 2003 on Social Security Programs for Poor and

[27] MoMT (2012), *Employees Social Security Program (JAMSOSTEK)in Indonesia*

Vulnerable People."

5.3.2. Benefit packages

Under the program, the insured are to pay 5,000 IDR every month for three years in order to receive a lump sum refund after the three years (there is also an option to continue paying to increase the total amount of contribution), as well as to receive benefits in case of illness or accident during the covered period. A total of 300,000 IDR is paid in case of illness or accident, while 400,000 IDR is paid as an insurance payout in case of death in the first year after enrollment, with 600,000 IDR in case of death in the second year and 800,000 IDR in case of death in the third year.

5.3.3. Eligibility for enrollment

To be eligible for enrollment, workers must be heads of households between the age of 21 and 60 with a monthly income of 300,000 IDR or more. MoSA selects communities with 200 insured or more and operates the program on the community level.

5.3.4. Contribution rates

The insured are to pay 5,000 IDR every month for the duration of three years.

5.3.5. Funds and operational bodies

The fiscal budget of 2010 was 40 billion IDR. [28]

5.3.6. Enrollment figures

The number of the insured in informal sectors was 280,800 in 2010. [29]

5.4. Unemployment insurance

5.4.1. Liquidation of corporate old-age savings

In Indonesia, the unemployment insurance system is underdeveloped, while there are dismissal allowances.

In principle, under the corporate old-age savings program (JHT) provided by PT. JAMSOSTEK, the insured are entitled to receive payment in the case of retirement at the age of 55 or above. However, the program functions practically as unemployment insurance, as the insured are equally entitled to withdraw the total amount of their contribution and the outcome of investment management even when they resign from work under the age of 55—as long as they have paid contributions for at least five years.

[28] ILO Jakarta (2011), *SPF Assessment Matrix*
[29] ILO Jakarta (2011), *SPF Assessment Matrix*

6. Social Welfare System and Community-based Assistance Schemes

6.1. Development of databases to identify low-income populations

6.1.1. Outline of databases

6.1.1.1. Outline of the current databases

In order to understand the status of the low-income classes in the country, the Indonesian government uses the existing databases of PSE2005(Socio-economic Population Survey 2005) and PPLS2008(Data Collection for Targeting Social Protection Programs 2008), provided by the BPS. However, the reality is that those databases currently do not necessarily show accurate figures concerning the low-income classes, as there are a large number of people in poverty that are not included in the databases, while a certain number of households have been lifted out of the poverty classes thanks to the benefits of economic development.

6.1.1.2. Outline of the databases under development [30]

(1) Integrated database for social protection (PBI: Penerima Bantuan Iuran)

The development of an integrated database is included in the National Medium-term Development Plan (2010–2014), and the TNP2K is currently developing the PBI with the support of the WB and through an alliance with various ministries, including the BPS, in order to enhance the accuracy of the current databases.

The PBI is a database that is based on the figures collected in the surveys carried out in 2011 by the BPS (PPLS2011). The PBI is a database that combines the PPLS2011 figures and data on the characteristics of villages, the economic and social state of citizens, figures collected by various ministries, and information on medical and educational facilities.

The cost to collect the PBI database is estimated to be 560 billion IDR. This is equivalent to 1% of the total budget allocated to the rice subsidy program (Raskin) and JAMKESMAS—the programs offered in 2010—as well as the direct cash transfer (BLT: Bantuan Langsung Tunai) offered between 2005 and 2006.

(2) PPLS2011 used in the PBI

PPLS2011 has been remarkably improved from PPLS2008 both in terms of methodology and the number of samples. It is estimated that 40% of the total population in Indonesia is in a state of poverty. The PPLS figures are renewed every three years, and PPLS2011 covers 25 million households, which accounts for 40% of the total number of households, whereas PPLS2008 covered only 19 million households.

With regard to the selection and examination of samples, PPLS2011 is the result of a

[30] WB (2012), *Targeting Poor and Vulnerable Households in Indonesia*

full examination of the current figures instead of a partial modification of the PPLS2008 figures, reflecting the addition of households that have recently become part of the low-income classes as well as the removal of households that are no longer counted in the low-income classes thanks to economic development.

PPLS2008 was a database that combines 39 SUSENAS indices on living environment and standard of life, 12 PODES indices on village location and convenience of life, and 24 PPLS2008 indices (six indices on individuals' educational background and profession, and 18 indices on households' standard of life). In addition to the data used in PPLS2008, PPLS2011 also uses household data collected in the 2010 census. In building the actual PPLS2011 database, the TNP2K collected and examined the data by setting up opportunities to exchange opinions with local leaders.

6.1.2. Range of database utilization

The current databases (PPLS2008 and PSE2005) are widely used for social assistance and CCT programs. For example, they are used for JAMKESMAS provided by the MOH, JAMKESDA provided by local governments, PKH (which is a CCT program provided by MoSA), PNPM provided by Coordinating Ministry for People's Welfare, Raskin, and other scholarship programs. In reality, however, these programs are still operated based on old database (PSE2005), and it cannot be said that the databases are used in an integrated manner. The improved databases are thus expected to support these programs more efficiently when utilized in an integrated manner.

6.1.3. International cooperation

The WB is assisting the TNP2K in developing the databases. AusAid is comprehensively supporting the TNP2K's activities including payment of the rent for the TNP2K's office.

6.2. Cash benefit program for the disabled, the elderly, and the youth [31]

6.2.1. Summary of the cash transfer program for the disabled (JSPACA), the elderly (JSLU), and the youth (PKSA)

As an social welfare policy, MoSA is currently operating a pilot cash transfer program for the disabled (JSPACA : Social Cash Transfer for Severely Disabled) and the elderly (JSLU: Social Cash Transfer for Elderly) introduced in 2006, and (PKSA : Social Cash Transfer for Disadvantaged Children) introduced in 2009.

Overviews of JSPACA, JSLU and PKSA are as follows.

Figures III-19 Overviews of JSPACA, JSLU and PKSA

	JSPACA	JSLU	PKSA
Implementing organization	MoSA	MoSA	MoSA
The number of implemented provinces	31 provinces	29 provinces	24 provinces
Beneficiaries (2010)	17,000	10,000	4,187(estimated)
Benefit package	0.3 million IDR per month	0.3 million IDR per month	1.3 - 1.8 million IDR per year
Public expenditure(2009)	4.6 trillion IDR		
Administrative cost per beneficiary	522,169IDR	576,390IDR	199,882IDR
Coverage(2010)	4% poor and disabled	1.4 % poor and vulnerable elderly	1.6 % poor and neglected children
Roles of local governments	Socialization, card distribution, monitoring and evaluation	Socialization, card distribution, monitoring and evaluation	Socialization, card distribution, monitoring and evaluation

※1IDR=0.00885 JPY(JICA transaction rate as of May 2012 as reference)

Source: WB (2012), JSLU, JSPACA, PKSA: Cash and In-kind Transfers for At-risk Youth, the Disabled, and the Vulnerable Elderly

[31] Information on the JSPACA, JSLU and PKSA program is based on WB (2012), *JSLU, JSPACA, PKSA: Cash and In-kind Transfers for At-risk Youth, the Disabled, and the Vulnerable Elderly*, unless otherwise stated.

Conditions for the eligibility for JSPACA, JSLU and PKSA are as follows.

Figures III-20 Conditions for the eligibility for JSPACA, JSLU and PKSA

	JSPACA	JSLU	PKSA
Conditions for the eligibility	・ Severely disabled who depend on others to support their daily activities. ・ Without fixed income support. ・ Prioritized for disabled who are poor and/or not members of care institutions. ・ Are not currently receiving other assistance from government.	・ 70 years or older ・ 60 years and older if chronically ill & depending on others for support in daily activities ・ Bedridden. ・ Do not have fixed income support. ・ Not a disabled or person who received a permanent assistance from government. ・ Other PMT criteria. [32]	・ Abuse victims, abandoned by the parents/family, vulnerable street children. ・ In violation of law, being processed judicially, or serving a criminal sentence. ・ With physical and/or mental disabilities. ・ Victims of trafficking/ exploitation, from minority/ Isolated groups, or HIV/AIDS positive, or drugs abusers.

Source: WB (2012), JSLU, JSPACA, PKSA: Cash and In-kind Transfers for At-risk Youth, the Disabled, and the Vulnerable Elderly

6.2.2. Issues and challenges for the JSLU, JSPACA, and PKSA program

At the moment, the coverage of each program is extremely low.

It is pointed out that the current BPS data is not precise enough to identify those who are eligible for the program. [33]

6.3. Social assistance systems: Family Hope Program (PKH)

After the cut in fuel subsidy in 2005 as a result of the appreciation of oil prices, the Indonesian government introduced a compensation program in order to mitigate impact on the low-income classes. Thereafter, the government has been providing the low-income classes with enhanced health services, elementary education, small-scale infrastructure, and cash benefits, etc. The PKH is a social assistance program also available to those with such backgrounds.

6.3.1. Target beneficiaries

MoSA is also operating a pilot CCT program targeting mothers and children. The targeted households include those categorized in the low-income classes based on the BPS databases with children between the ages of six and 15, children under the age of 18 that have not finished elementary education, children between the age of zero and six, and pregnant or lactating mothers.

6.3.2. Standards for benefits and benefit amounts

In order to be eligible for the cash benefit, beneficiaries are required to fulfill the conditions concerning health care and education. The benefits are paid through local post offices. The details of the conditions for eligibility as well as the payment models are shown

[32] The PMT standard is a standard used to evaluate the vulnerability of living conditions of the elderly such as PWD or those lacking any relatives.
[33] ILO Jakarta (2011), *SPF Assessment Matrix*

below.

Figures III-21 Conditions for eligibility for PKH

Sector	Indicators
Health	(1) Four prenatal care visits for pregnant women at health institutions
	(2) Taking iron tablets during pregnancy
	(3) Delivery assisted by a trained health professional
	(4) Two postnatal care visits
	(5) Complete immunizations (BCG (Tuberculosis), DPT (Diphtheria, Whooping Cough, Tetanus), polio, measles, and Hepatitis B and additional immunizations for children aged 0-11 and 12-59 months
	(6) Ensuring of monthly weight increases for infants
	(7) Monthly weighing of children under three and bi-annually for under-fives
	(8) Vitamin A twice a year for under-fives
Education	(9) Enrolment of all children aged 6 to 12 years in primary school
	(10) Minimum attendance rate of 85 per cent for all primary school-aged children
	(11) Enrolment of all children aged 13 to 15 years in junior high school; and
	(12) Minimum attendance rate of 85 per cent for all junior secondary school-aged children

Source: PKH documents published by MoSA

Figures III-22 PKH payment models

Transfer Scenario	Transfer Amount per Poor Family per Year (IDR)
Fixed transfer	200,000
Transfer for poor families who have:	
a. Children aged under 6 years	800,000
b. Pregnant/lactating mother	800,000
c. Primary school aged children	400,000
d. Junior high school aged children	800,000
Average transfer per poor family	1,390,000
Minimum transfer per poor family	600,000
Maximum transfer per poor family	2,200,000

1IDR=0.00885 JPY(JICA transaction rate as of May 2012 as reference)

Source: PKH documents published by MoSA

Beneficiaries are provided with a beneficiary card as well as a “JAMKESMAS” card. The eligibility for the CCT program is determined based on the current database of the BPS (PPLS2008). The PPLS database is due to be revised according to the results of the 2011 surveys.

facilitators are sent to local communities by MoSA. The responsibilities of facilitators include verifying statistical data and the actual living conditions, as well as monitoring the level of services at medical institutions and the education given to the beneficiaries during the period covered by the program.

6.3.3. Actual benefit payments

The PKH is implemented in all 33 provinces, provided benefits for 1,116,000 people in 2011.[34] MoSA plans to increase the number of beneficiaries in the times ahead, to cover three million people by 2014.[35]

6.3.4. Implementing bodies

The PKH program is operated by MoSA. The adoption of the PKH program is not compulsory, and local governments need to make a request for participation to the central government to obtain an approval. There are also conditions for participation, and local governments are liable for a part of the program expenses including costs for coordination at the time of introduction, as the operation cost is not fully covered by the central government.

The GIZ provides technical assistance such as mobile banking system for MoSA in operating the PKH program.

6.3.5. Issues and challenges

6.3.5.1. Evaluation

World bank compared the average values of pre-PKH households to post-PKH households, and evaluated the PKH's impacts on beneficiaries' health and education-related behaviors.[36] As a result, in terms of health related behaviors, beneficiaries' behaviors such as pre and post natal visits and public health facility outpatient visits demonstrated 5- 15% improvement. In terms of education, the PKH impacts on "any wage work last month" demonstrated 20% decrease, however, impacts on most indices such as the rate of enrollment and attendance demonstrated no significant change.

6.3.5.2. Challenges

One of the challenges that the PKH faces is the difficulty to access health care and education in remote rural areas.

With regard to health care, the lack of doctors and hospital beds has been a problem in Indonesia, and the problem is more severe in rural areas including small islands, as there is often no medical institution in the commutable area. In poor communities, it is often the case that midwives assist childbirth, but it is difficult for midwives to provide support in such remote areas. Furthermore, there are cases in which there is no infrastructure to provide the electricity and water necessary for support even if midwives are available.

With regard to education, it is often the case with poor communities that there is an insufficient number of educational institutions within the accessible area. For the low-income classes in remote rural areas, in particular, the situation is more severe, as there

[34] ILO Jakarta (2011), *SPF Assessment Matrix*
[35] Based on a hearing with MoSA conducted in February 2012
[36] WB(2012) "PKH Conditional Cash Transfer"

is no available transportation or as long-distance travel expenses become a financial burden. There are cases in which children have to travel long distances or must swim across a river, which can result in the interruption of education because of a children's declining motivation to study after a long commute. (Commuting long distances can be a severe burden, especially for children who cannot afford to have breakfast.) Furthermore, there is difficulty in securing a sufficient number of the qualified teachers and facilities necessary for education (essentials for educational environment such as appropriate school buildings and a sufficient number of books)—even in cases where children can actually go to school.

The objective of the PKH is to stop poverty from spreading and to develop human resources for the next generation. However, as was explained above, there are more challenges in providing support for the low-income classes in remote rural areas than in urban areas. Under the current circumstances, the success of the PKH depends on the accessibility to appropriate human resources and institutions that are necessary for health care and education. [37]

6.4. Community-based assistance schemes

After the cut in fuel subsidy in 2005 as a result of the appreciation of oil prices, the Indonesian government introduced a compensation program in order to mitigate its impact on the low-income classes. As is the case with the PKH program, PNPM Mandiri is a state-level project introduced in 2007 along with the compensation program in order to empower poor communities through community participatory efforts for the eradication of poverty and for employment creation.

6.4.1. Outline of schemes

PNPM Mandiri is a local resident participatory program that provides benefits for residents in poor communities directly to each community (a unit smaller than a village; there are generally multiple communities in one village) so that community members can decide by themselves how the benefits should be used by identifying the necessary infrastructure and then by building it.

The PNPM Mandiri program is operated by Coordinating Ministry for People's Welfare. The main objectives of the program include enhancing the income level, achieving the participation of women and marginalized groups in community activities, achieving the participation of the low-income classes in economic activities (to improve accessibility to financial capital, markets, information, and innovation), and ameliorating the organizational capability of local governments through the PNPM Mandiri among others.

The ministry is engaged in operating the program efficiently, not only to take action against poverty but also to correct the vertically segmented system among government ministries—as

[37] *Social Protection in Asia,* (2009) *Problems and Challenges for the Indonesian Conditional Cash Transfer Programme-Program Keluarga Harapan (PKH)* (2009), pp. 10–14

well as to prevent fraud in local governments.

The government pays the benefits directly to each community, and the involvement of a local government is confined to the selection of facilitators. Accounts used to implement the budget are also created under the community names. This is due to the fact that there were increasing cases of fraud when local governments were responsible for the implementation in the past. A total of 42,000 facilitators are allocated communities throughout the country by the ministry in order to implement the PNPM Mandiri program.

Communities participate in the participatory planning and decision-making process for projects through workshops, facilitators provide various supports program of providing information for communities, promoting participation, providing trainings, and technical assistances. Some communities where residents are mainly women are commonly found in Indonesia, after men leave communities and go overseas in order to work as migrant workers. Under the facilitation of PNPM Mandiri, many women in communities work for construction of bridges and roads as paid workers.

In 2010, PNPM disbursed over 900 million USD in block grants, overview of implemented project are as follows. [38]

- 18,279 km of farm/rural roads
- 2,147 bridges
- 3, 447 irrigation systems
- 2,053 clean water facilities
- 26,000 km of small roads
- 7,100 km of drainage
- 170,000 units of solid waste and sanitation facilities
- 13,000 community health facilities
- other 946 infrastructures in disadvantaged areas

According to the evaluation made by Coordinating Ministry for People's Welfare, the financial burden for the government has been reduced by around 40% in the cases where local residents directly build roads and bridges—compared to the cases where an outsourced construction company is used. [39]

[38] PNPM Support Facility (http://pnpm-support.org/sske-outcomes)
[39] Based on a hearing with Coordinating Ministry for People's Welfare carried out in February 2012

The following table shows the state of the implementation of the PNPM Mandiri program.

Figures III-23 State of the implementation of the PNPM Mandiri program [40]

Year	Project location (sub-district level)	Total amount of allocation (trillion IDR)
2007	2,803	2.8
2008	3,999	5.9
2009	6,408	11.0
2010	6,321	11.8
2011	6,622	10.3
2012(estimated)	6,680	9.9
Total	32,833	51.8

※1IDR=0.00885 JPY(JICA transaction rate as of May 2012 as reference)

Source: Coordinating Ministry for People's Welfare (2012)PNPM Mandiri and PNPM Generasi

6.4.2. State of international cooperation [41]

The state of international cooperation is as follows.

Figures III-24 Implemented international assistance for PNPM

(USD in millions)

	2008	2009	2010	Total
Australia	6.2	3.1	14.9	24.2
Denmark	2.7	4.5	4.3	11.5
Netherlands	14.7	4.5	0.8	20.0
UK	-	5.6	2.3	7.9
USA	-	-	64.7	64.7
EU	-	-	3.4	3.4
Total Amount	23.6	17.8	90.4	131.7

※1USD=81.7 JPY(JICA transaction rate as of May 2012 as reference)

Source: PNPM Support Facility (2010) PSF Progress Support

6.4.3. Issues and challenges

The ministry implements the program not only to take action against poverty but also to coordinate interests among different government ministries, the central government, and local governments, as well as to correct the vertically segmented system. In reality, however, the situation has not yet been properly functioned. It has also been pointed out that there are persistent cases of inappropriate use and procedures regarding the community fund as well as political intervention in the poverty eradication programs. [42]

From a technical point of view, the ministry plans to allocate 150,000 facilitators. [43]

[40] Coordinating Ministry for People's Welfare (2012), *PNPM Mandiri and PNPM Generasi*
[41] Based on a hearing with Coordinating Ministry for People's Welfare carried out in February 2012
[42] Coordinating Ministry for People's Welfare (2012), *PNPM Mandiri and PNPM Generasi*
[43] Based on a hearing with Coordinating Ministry for People's Welfare carried out in February 2012

However, there has been a constant shortfall in human resources, as those who possess expertise tend to prefer working in urban areas. In rural area, it sometimes happens that inexperienced facilitators are allocated. Facilitating, which is mostly related to the effort to invite, persuade, and motivate requires special skills that mostly develop from one's long experience. The challenge for the program has thus been securing facilitators with professional and practical skills. [44]

[44] SMERU Research Institute,(2011)*A Qualitative Study on the Impact of the 2010 PNPM-Rural in East Java, West Sumatra, and Southeast Sulawesi*

7. Care and Welfare for the Elderly

According to the World Bank, in Indonesia in 2010, total fertility rate was 2.12 %, the ratio of aging population to productive age population was 8.2%, life expectancy at birth was 68.9 years-old, the birthrate has been reducing, and the population has been aging for 20 years.

As the changes observed in Indonesian families, the size of households has been gradually reducing, and younger family members tend to migrate to bigger cities, or to other countries, it is predicted that it is getting more difficult for family members to support personally and directly for the elderly. Consequently, it is also predicted that supports for the elderly have been increasingly shifting from care by family members, to more impersonal and institutional system of care from outside family.[45]

7.1. Policy initiatives and framework for the elderly

The "Law No. 13 of 1998 on Elderly Welfare" as well as the "Government Regulation No.43 of 2004 on the Implementation of the Efforts to Increase Elderly Welfare" have been enacted as legal systems concerning welfare for the elderly.

In Indonesia, MoSA is responsible for policies concerning welfare for the elderly.

7.2. State of elderly care facilities and services

In Indonesia, family ties remain strong even in urban areas, and still now, the responsibility for elderly care is generally left to mainly family members, and friends and neighbors. On the other hand, however, the educational standard for the elderly tends to be lower than that of the working generation, and thus, the elderly are left behind by economic development. As the government places low priority on elderly support, it can be said that the conditions are most severe for the elderly who do not have family support or who have disabilities.

Most of elderly Indonesians are still unwilling to enter nursing homes, long-stay elderly care facilities are not widespread in Indonesia. Third-party infrastructure provided by both the public sector and the private sector available to support elderly Indonesians is still underdeveloped,[46] most elderly care facilities are based in urban areas and there is no alternative care for older people in rural settings.[47]

The government considers that family members are responsible for elderly care.[48]

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[45] SMERU(2006)Public Policy Towards the Elderly in Indonesia：Current Policy and Future Directions

[46] SMERU(2006)Public Policy Towards the Elderly in Indonesia：Current Policy and Future Directions

[47] Global Health Action
（http://www.globalhealthaction.net/index.php/gha/article/view/2125/6070#CIT0014 ）

[48] UNESCAP (2007), *Country Statement Indonesia*

7.2.1. State of long-stay elderly care facilities and services

Even though elderly care facilities are provided by MoSA, provincial governments, and private companies, users are asked to pay a fee according to their income level. Thus, the facilities are free for the elderly with no income, but those who are economically affluent and have no relatives have to pay a fee in accordance with their economic level.[49]

Long-stay elderly care facilities in Indonesia provide shelter, health care, and social activities, including recreational as well as religious events. In general, these facilities mainly target the elderly without relatives and those with disabilities.

Figures II-25 Number of elderly care facilities and users in 2004[50]

	Number of care facilities	Numbers of users		
		male	female	total
Government	2	68	114	182
Local government	69	1,853	3,102	4,955
Private	164	1,598	4,662	6,260
Total	235	3,519	7,878	11,397

Source: NCOP Indonesia

7.2.2. State of other services for the elderly[51]

Day care services for the elderly include home care for poor households and the elderly without relatives, protective institutions for the elderly, day care services on a community basis (Pusaka), elderly welfare centers, medical examination visits organized locally for the elderly (Posyandu), and educational programs for family members to support the elderly, among others.

In Indonesia, the concept of Posyandu service was initially developed to address maternal and child issues, based on communities, in cooperation with Puskesmas. Posyandu was later expanded to cover the ageing population,[52] providing medical checkup and health promotion. Issues on Posyandu are within the responsibilities of the MOH.

7.2.3. State of support provided by non-governmental organizations, etc.

There are various non-governmental organizations in Indonesia. For example, there are non-profit organizations that consist of veterans and retired government officers. Such organizations have a number of branches throughout the country.

In addition to these organizations for veterans and retired government officers, the

[49] Ministry of Health, Labour and Welfare, *The Health, Labour and Welfare in the World 2003*, p. 275

[50] Based on materials provided by the NCOP (http://asiaforum.tsaofoundation.org/pdfDownloads/Day1/free_papers/Housing%20Option%20for%20Older%20Persons%20in%20Indonesia.pdf)

[51] UNESCAP (2007), *Country Statement Indonesia*

[52] Global Health Action (http://www.globalhealthaction.net/index.php/gha/article/view/2125/6070#CIT0014)

Indonesian Gerontology Association (Pergeri) was established in 1985. Pergeri provides community-based support for the elderly and health care support, and conducts various surveys.

Any individual or organization can establish a Pusaka, or day care service for the elderly on a community, provided they have sufficient funding for the activities.

The majority of Pusaka funds come from private sources including individuals, social organizations, foundations, companies and communities. Some are operated as informal organizations, others are operated as accredited official organization. In order to become an official Pusaka, care workers operating such a centre for the poor elderly should be active for at least two years before their activities can be evaluated and accredited with the status of Pusaka by the Coordinating Body for Welfare (BK3S).

The benefits for accreditation by BK3S are a modest subsidy, access to training in the management of home care, supervision and networking. In turn, accredited Pusaka have to submit progress reports quarterly and annually to BK3S, the local authorities and relevant donors. Otherwise, Pusaka are free to manage and run their activities and programs as they design. Pusaka provide free daily welfare services for elderly such as meals, basic health services, teaching handicrafts, recreation opportunities, and religious activities. These activities are carried out mainly by local women in communities. The criteria for eligibility for support by Pusaka are: aged 60 and over; widowed and from a poor family; holding residence card (KTP) and letters of recommendation from the head of the village and relevant association; living within walking distance of the home of caregivers. [53]

7.3. Issues for the future of elderly policy

According to the National Commission for Older Persons Indonesia (NCOP), there are three challenges in the field of elderly welfare that Indonesia faces as the elderly population sees a gradual rise. The first challenge is for the government to allocate a budget for elderly care, as community-based support is not sufficient to support the elderly due to financial shortages. The second challenge is to overcome the shortage in training for the managers of social welfare facilities. The third challenge is to respond to the growing need of education for caregivers. [54]

7.4. State of international cooperation

From 2003 to 2006, the UNESCAP introduced a community-based home care pilot project for the elderly without relatives in Tegal Alur, poor sub-district of Western Jakarta.

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[53] Kim Dung Do-Le and Yulfita Raharjo (2002) “Community-Based Support for the Elderly in Indonesia : The Case of PUSAKA” According to the study, revenues of Pusaka markedly decreased after the economic crisis.

[54] Based on the material provided by the NCOP Indonesia (http://asiaforum.tsaofoundation.org/pdfDownloads/Day1/free_papers/Housing%20Option%20for%20Older%20Persons%20in%20Indonesia.pdf)

The overview of project is that volunteer care workers were recruited from the community and trained in basic care giving skills. Care givers are mostly women, and working on voluntary basis. After the project ended, the UNESCAP interviewed the elderly, family member of the elderly, family care givers, voluntary based care workers, community and related governmental officials. The result of the interview, they concluded the project was successful with a high level of interviewees' satisfaction with the voluntary care. In addition, the UNESCAP suggested undertaking of futures as follows.

- Community-based service should be offered to more older people in the community as well as be replicated to other regions in Indonesia.
- The local governments should coordinate and make use of existing networks to ensure sustainability of the service.
- There may be a need for continuing to educate the community on older people issues. It could also facilitate acceptance by the elderly of help from outsiders.
- Volunteers need more training in psychosocial issues so that they could be more helpful to the elderly in accepting and dealing with the process of ageing.
- In order to further use volunteers for providing services, a more objective in-depth study of the volunteers' experience need to be conducted. This knowledge will help in designing training volunteers, providing support to volunteers and motivating community to volunteer in caring for the elderly.

8. Issues Facing Social Security in Indonesia

8.1. Issues in the health security system

8.1.1. Issues in institutional design

8.1.1.1. Issues on National Strategy

In Indonesia, there are many ministries and governmental organization, and they separately implemented their projects on health security system. Consequently, there is no leading organization that makes active efforts to introduce the universal coverage, it is difficult for the government to formulating strategies across the office and ministries.

8.1.1.2. Issue accompanying expansion of health care system

Under the present circumstances, there is a significant gap between urban areas and rural areas in the health care system including the number and level of medical institutions and health care providers. It is often the case that the residents of areas short of medical institutions are reluctant or unable to use medical institutions, and the amount of medical cost per person varies according to accessibility to a medical institution. For this reason, it has been pointed out that the cost of health security per person in Jakarta is almost twice as much as that in the rest of Indonesia.[55] Although it is necessary to improve the health care system, keeping quality of the health care system and curtailing the health security expenses are problems that need to be overcome.

8.1.1.3. Issue regarding private hospitals' transition to universal coverage

Private hospitals have been providing private health services, different from the public health services. After the introduction of universal coverage, private hospitals become providers of mixed service system, the combination of public health insurance and privately paid treatment. Political and institutional challenges remain in incorporating such private hospitals into an integrated system in the times ahead.

8.1.1.4. Difference in accounting systems between public hospitals and private hospitals

The difference between public hospitals and private hospitals lies in the fact that the accounting system of the former is conducted on a cash basis, while the latter is conducted on an accrual basis. Thus, their systems of payment are also different. Private hospitals are expected to be providers of the mixed service system after universal coverage. In order to design and update DRG system, it is necessary to properly keep track of capital and health cost .

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[55] Yves Guerard, Mitch Wiener, Claudia Rokx, George Schieber, Pandu Harimurti, Eko Pambudi, and Ajan Tandon (2011), *Actual Costing of Universal Health Insurance Coverage in Indonesia*

8.1.2. Issues in operation of system

8.1.2.1. Opposition of trade unions and trade associations

Reactions from industry groups include opposition from the State Enterprise Workers Union (FSBUMN), the National Workers Union (SPN), and the Indonesian Employers Association (Apindo), against the unification of social security systems by the BPJS. While trade unions are opposing the introduction of a new system that would increase financial burden for employees, employer's associations are opposing the fact that extension to workers in informal sectors would increase financial burden for employers compared to the current system. [56]

Under the new system, the value of the benefit is to be set at the highest level of the current system so that health security will not fall below the currently secured level. As a result, a certain increase in the value of contributions is expected. As the value of contributions would increase for both employees and employers, the labor costs in informal sectors are expected to rise and the non-payment of contributions would not be tolerated for either employees or employers, both of which are considered to be sticking points for the opposition. Due to such opposition, it has been difficult to set the value of insurance contributions, which may result in a delay in the unification process.

8.1.2.2. Issue of coverage in informal sectors

In the times ahead, the government need to identify the target, to collect date of targets such as profession, residential mobility, and to secure collecting insurance contributions in the informal sectors that had thus far not been insured. In particular, workers in informal sectors in remote rural areas have a low level of income and their jobs are not stable. Furthermore, as they live far from hospitals and health care centers, there is no strong incentive for them to subscribe to insurance to receive benefits.

8.1.2.3. Issue of the coverage of non-payers

As there are currently a large number of non-payers of insurance contributions, a framework is needed to collect contributions from non-paying business owners and to apply penalties in case of non-payment. It has been pointed out by MOF officials that the framework for applying different collection methods based on individual tax systems is not practical, as it is difficult to gain a consensus among various political parties. [57]

8.2. Issues regarding pension and other income security schemes

8.2.1. Issue of expanding coverage

The coverage of pension and other income security schemes is currently low, not only in

[56] Jakarta Post, *Workers, Employers to Challenge BPJS Law at Constitutional Court*, issued on October 31, 2011

[57] Based on a hearing with MOF carried out in February 2012

informal sectors but also in formal sectors.

An upcoming challenge for the government is to identify the target, to secure collecting insurance contributions in the informal sectors that had thus far not been insured, to develop system of penalty imposition on those in arrears, and to develop system of labor legislations for expanding income security system for employees.

8.2.2. Liquidation of corporate old-age savings

As there is no unemployment insurance in Indonesia, the benefit of the corporate old-age savings program provided by JAMSOSTEK (JHT) is often withdrawn under the age of 55, and thus the program is not functioning as "old-age savings" as was originally intended.

8.3. Issues regarding the social welfare system

8.3.1. Issues regarding the accuracy and usage of the databases used to identify the low-income classes

There has been a problem in the accuracy of the databases currently used to identify the low-income classes for ongoing programs such as JAMKESMAS, JAMKESDA, the rice subsidy program (Raskin: Beras Miskin), the direct cash transfer (BLT), and CCT, etc.

Programs for health security and social assistance are currently provided individually, and it is difficult to say that the low-income classes are efficiently identified as the recipients of support in an integrated framework. It is also often the case that multiple programs with the same standard for eligibility end up with different beneficiaries. For example, while Raskin, BLT, and JAMKESMAS all target the low-income classes in the bottom 30% of society, only less than one third of such households received benefits from all three programs.[58]

8.3.1.1. Issues caused by the absence of integrated data and delays in program revision[59]

Although the BPS databases are mainly used to identify the low-income classes in order to carry out the current programs, such as JAMKESMAS, JAMKESDA, Raskin, BLT, and CCT, etc., it is not necessarily the case that the identical database is used in an integrated manner.

For example, since 2011, JAMKESMAS has been using collected data based on the surveys in 2008, which are the latest surveys carried out by the BPS (PPLS2008: Data Collection for Targeting Social Protection Programs), in order to carry out its social security programs.[60] However, JAMKESDA in Depok was using PSE2005 as of February 2012.

While PSE2005 is a collection of only 14 indices that show the conditions of households,[61] PPLS2008 incorporates 39 indices based on the National Socio-Economic Survey (SUSENAS), 12 indices based on the Village Potential Statistics (PODES), and 24

[58] WB (2012), *Targeting Poor and Vulnerable Households in Indonesia*
[59] WB (2012), *Targeting Poor and Vulnerable Households in Indonesia*
[60] WB (2012), *Targeting Poor and Vulnerable Households in Indonesia*
[61] See the section on JAMKESDA; and according to WB (2012), *Targeting Poor and Vulnerable Households in Indonesia*; PSE2005 is used in the Raskin program.

PPLS2008 indices (six indices on individuals and 18 indices on households). It can therefore be said that PPLS2008 is more advanced than PSE2005 to a certain degree.

There are thus cases in which updates to the latest data are delayed or data is not used in an integrated manner, resulting in different degrees of accuracy in providing benefits for appropriate recipients and making it difficult for the central and local governments to carry out effective and efficient support programs. Such issues need to be dealt with.

8.3.1.2. Issues regarding the accuracy of the current database [62]

The BLT program is a cash benefit program introduced after the fuel subsidy cut in 2005 in order to mitigate impact on the low-income classes and those vulnerable who may fall into poverty. When the program was introduced, it was required that data be collected over a short amount of time to identify the low-income classes. Although there were many methods of data collection considered, in the end, potential recipients were, in practice, listed by the head of each village without any clear criteria for doing so. With this method, if the head of the village fails to list an eligible household as part of the low-income classes, that household would not be considered as a potential recipient.

The database is revised every three years, and there are two PPLS databases—one from the 2005 survey and the other from the 2008 survey. Although the current 2008 database is based on revised data from the 2005 data, it is mostly the case that the data missing in the 2005 database is also missing in the 2008 database.

8.3.1.3. Issues regarding the process used to identify the benefit recipients (the poor and vulnerable classes) [63]

Despite the fact that the JAMKESMAS program targets the poorest 30% among the population, some relatively wealthy people are also included in the program. While recipients are selected based on the database in some areas, in other areas, Puskesmas staff members use their own judgment when selecting recipients. Furthermore, there are people who are not included in the JAMKESMAS program while actually fulfilling the conditions for eligibility, due to the fact that their records are not included in the database. In order to evaluate the accuracy of recipient selection, the level of correspondence between those who are actually eligible to receive the medical assistance of the JAMKESMAS program and those who are currently receiving the benefit was calculated as a score [64] based on random sampling. The score obtained by the JAMKESMAS program was 16.

Such issues are observed in other programs as well. In the Raskin program, the recipients

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[62] WB (2012), *Targeting Poor and Vulnerable Households in Indonesia*
[63] WB (2012), *Targeting Poor and Vulnerable Households in Indonesia*
[64] If none of the eligible people are receiving the benefit, the score would be zero, while if all the eligible people are receiving the benefit, the score would be 100. However, as it is not easy to identify the low-income classes and provide them with benefits, 50 is considered to be a high score.

of subsidized rice are to be determined after verifying the list on the database at a community-level meeting. However, the actual process of selecting recipients varied depending on the community, and the meeting was held in some cases while it was not held in other cases. In those communities, the priority was on equal distribution rather than distribution to the eligible low-income classes, as they hoped to avoid friction among households. Consequently, the score of the Raskin program was 13—lower than that of the BLT program and the JAMKESMAS program. The score obtained by the BLT program was 24.

8.3.1.4. Issues in using the current database [65]

A problem lies in the fact that the current database is missing a large number of the records of the low-income classes. Data on the low-income classes and vulnerable people who may fall into poverty needs to be extracted more accurately.

In identifying appropriate recipients (the low-income classes and vulnerable people who may fall into poverty), it is essential for the records of eligible people to be included in the database. In other words, the accuracy of the database is the key. The next step is for the eligible people to be correctly extracted, but in reality, guidelines for identifying the eligible people are not appropriately distributed and the staff members do not share the necessary knowledge and understanding on them, which is also preventing appropriate recipients from being identified.

Furthermore, under the current circumstances, coordination among implementing organizations is not sufficient, which is another problem in executing the programs. For example, programs such as the PKH and JAMKESMAS can expect a synergistic effect if their promotion campaigns and procedures are combined, but at the moment they are carried out individually.

9. Issues Facing Social Security in Indonesia and Cooperation by Japan

9.1. Issues facing the health security system

In Indonesia, for achieving the universal coverage and poverty reduction, several efforts have been now under implementation by international organizations. Under such situation, providing training programs at universities and/or sharing information through seminars on individual health system such as designing hospital accounting system and medical service fee can be pointed out as the highest priorities.

9.2. Issues facing the elderly welfare system

In Indonesia, it is predicted that the population continue to age, efforts to develop human resources for elderly welfare have yet to be adequately implemented. To grasp potential

[65] WB (2012), *Targeting Poor and Vulnerable Households in Indonesia*

needs of the elderly welfare and to support human resource development in elderly welfare sector can be the highest priorities.

Chapter III Laos

1. Social Security Overview

1.1. Social security in the constitution

In the Constitution in 1991, health and medical policies are prescribed in Article 25 which was added upon the amendment. Article 25, Paragraph 1 provides, "The State attends to improving and expanding public health services to take of the people's health." In addition, Article 28 amended from Article 20 of the old Constitution sets forth social welfare policies as follows, "The State and society attend to implementing policies on social security, especially towards national heroes, soldiers, retired civil servants, disabled people, [and the] families of those who have sacrificed their lives for the revolution and who have contributed extensively to the nation."[1]

1.2. Current state and basic direction of government policy for social security

One of the priority policies presented in the 6th National Socio-Economic Development Plan (NSEDP) (2006-2010) is health care, and the "Health Strategy for the Year 2020" was formed in 2000, which set up the basic four targets: 1) Universal coverage of health care services and equality, 2) Development of integrated health care services, 3) Demand-based health care services, and 4) Self-help and financially-self-sustained heath care services. The Strategy also clearly stated improvement of the health management and health financing structure in Laos, and support for the poverty in the health sector[2].

Currently, the 7th NSEDP (2011-2015) approved by the National Assembly in 2011 has set the following four targets: 1) Secure stable economic growth (GDP growth: 8%, GDP per capita: USD1,700[3]), 2) Achieve the MDGs by 2015, graduate from a least development country (LDC) by 2020, 3) Achieve cultural and social development, preserve natural resources, ensure sustainable economic growth accompanied by environmental conservation, and 4) Maintain political stability, peace and social order, improve a roles in the international community[4]. Especially for the MDGs in 2), the indicators relating to mother and child health (MDG4: Reduce child mortality and MDG5: Improve maternal health) which are currently at a lower level are emphasized[5].

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[1] Source: "Constitutions of Asia", 'Lao People's Domestic Republic' translated by Hiroyuki Seto (2004)

[2] Thome JM, Pholsena S(2009) Lao People's Democratic Republic: health financing reform and challenges in expanding the current social protection schemes. In *Promoting Sustainable Strategies to Improve Access to Health Care in the Asian and Pacific Region*. United Nations Economic and Social Commission for Asia and the Pacific, p.74
http://www.unescap.org/esid/hds/pubs/2529/2529_Chapter%203%20P71-102.pdf

[3] 1USD=81.07JPN(as of May 2012 JICA internal rate)

[4] Source: Ministry of Foreign Affairs' country databook (2011)
http://www.mofa.go.jp/mofaj/gaiko/oda/shiryo/kuni/11_databook/pdfs/01-11.pdf

[5] For the current figures and changes in MDG4 and MDG5, refer to the UNDP's website.
http://www.undplao.org/newsroom/publication/MAF%20Report_Lao%20PDR_September%202010.pdf

1.3. Outline of the social security system

In Laos, the scope of coverage is different between health security system and pension and other income security schemes.

The current health security system consists of the following four schemes: (1) Civil Servants' Scheme (CSS) established in 1993 as the social security scheme for government officers which has been redesigned as a social insurance system based on the traditional pension scheme for government officers, (2) Social Security Scheme (SSS) which is a compulsory employee social security scheme for the employees of the formal sector[6] (employers having at least 10 employees), (3) Community Based Health Insurance (CBHI) which is a voluntary health insurance scheme for the informal sector, and (4) Health Equity Fund (HEF), a free health care service system for low-income persons, which covers not only medical cost but also transportation cost, and play an important role in providing health care services in remote rural areas.

The benefits and operational costs for the CBHI and the HEF have been deeply dependent on development assistance and resources from international/bilateral donors since their introductions, but the financial and human resources are gradually transferring to the Ministry of Health (MOH). In the regions where the CBHI has been implemented, the CBHI and the HEF have been operated as a single scheme while the HEF is paying the contribution.

In addition to the above four schemes, the mother and child health benefit scheme (cash benefit support in connection with the Nam Theun Dam Project) implemented in Luang Phrabang, Xieng Khouang, Bolikhamsai, Khammouane and Vientiane) has been introduced[7].

On the other hand, the social security system (pension and other income security schemes) is covered only with CSS and the SSS, and there is not social security system for workers in the informal sector. According to the national population census of 2005, the working population consists of 7,000 of business owners, 1.15 million of self-employed and 1.26 million of domestic workers. Among them, the number of insured of the SSS is limited to 0.12 million. The issue is that most of the nation is not entitled to social security.

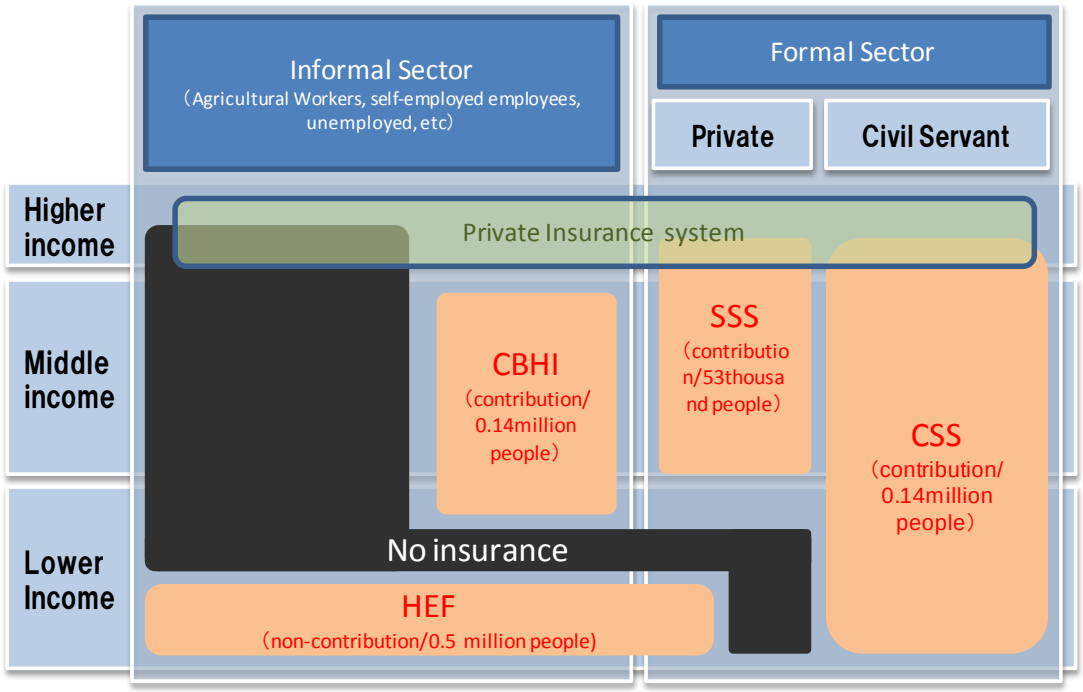
It is planned to phase in the Lao National Social Security System and the Lao National Social Security System from 2015 to 2020 throughout the country[8].

Local administrative structure in Laos is consisted of 15 provinces and 1 municipal area (Vientiane) and 143 districts and 10.9 thousand villages belong to each province and municipal area[9]. Each ministry's department is located under the province (for example

[6] The informal Sector in this paper is defined as people, who do not participate neither CSS nor SSS.
[7] The mother and child health benefit scheme was suddenly started. Some criticized that it is an ad hoc measure to achieve the MDG targets.
[8] Based on the interview from Ministry of Labor and Welfare (MLSW).
[9] Souknilanh (2012) [Economic Geography Data in Laos (Laos no Keizaichiritoukei data)] in Japanese
http://www.ide.go.jp/Japanese/Publish/Download/Report/2011/pdf/206_ch9.pdf,

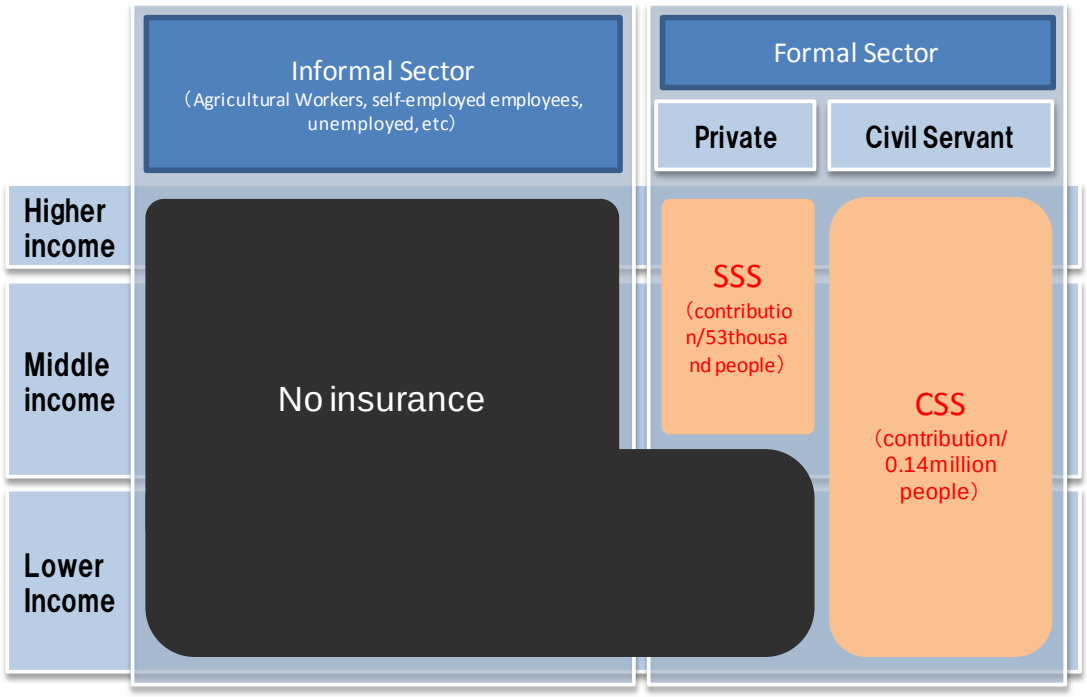
Department of Health under MOH is located under the provincial People's Committee[10].

Figures III-1 Coverage of the social security system in Laos (Health security)



Source: Compiled by Mitsubishi UFJ Research and Consulting.

FiguresIII-2 Coverage of the social security system in Laos (Pension and other income security)



Source: Compiled by Mitsubishi UFJ Research and Consulting.

[10] Yamada (2011)"Establishment of Lao People's Revolution Party" in Institute of Development Economy "*Building of State-Nation in Lao PDR (Laos ni okeru Kokumin Kokka Kensetsu)* "in Japanese.

2. Organizations Involved in Social Security

2.1. Ministry of Health (MOH)

The MOH has the six departments and one Cabinet and, which are Department of Hygiene and Prevention (DHP), Department of Planning and Budgeting (DPB), Food and Drugs Department (FDD), Department of Organization and Personnel (DOP), Department of Curative Services (DCS) and Department of Inspection (DOI)[11], and is responsible for supervising the domestic health services as well as all public hospitals including central hospitals (4 central hospitals and 3 special hospitals) in the country. The Provincial Offices of Health are in charge of province-level public hospitals (5 regional hospitals and 13 provincial hospitals), and the District Offices of Health are in charge of district-level hospitals (127 district hospitals) and health centers (750 health centers) respectively[12].

2.2. Ministry of Labor and Social Welfare (MLSW)

The MLSW which was established in 1993 is a relatively new ministry, and has the Department of Inspection, the Department of Organization and Personnel, the Department of Labor Management, the Department of Social Welfare, the Department of Skill Development and Employment, the Department of Social Security and the Department of Pension, War Invalid and Disabled People. The MLSW's main roles are social welfare and assistance policies mainly for the elderly, children and PWDs, labor affairs and social security system of CSS and SSS.

2.3. State Authority of Social Security (SASS)

The SASS was established under the control of the MLSW in 2008 as an autonomous body based on the Decree of the Prime Minister No. 70/2006, for the purpose of development of social security for government officers.

The SASS currently has 34 officers (11 officers who have worked since the establishment are paid by the central government, and the remaining 23 officers are paid from the administration fund of the social security fund), most of whom were transferred from the Social Security Organization (SSO). The SASS has 17 provincial offices each of which has about 10 officers (2 to 3 officers paid by the central government, and the remaining 5 to 6 officers paid by the administration fund).

2.4. Social Security Organization (SSO)

The SSO was established an autonomous body based on the Decree of the Prime Minister No. 207/1999 in 2000 under the control of the Social Security Agency of the MLSW, and in June 2001 the social security system for the employees of the private sector was introduced.

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[11] There are nine departments and one cabinet after the organizational change in April 2012.
[12] Thome JM, Pholsena S(2009), p.75

The SSO currently has 73 officers (7 officers of the Head Office and 7 heads of regional offices are employed by the MLSW, the remaining are paid by the administration fund of the SSO), and 7 regional offices (Bolikhamsai, Champasak, Sayabouly, Xieng Khouang, Bokeo, Savannakhet and Khammouane). Operational expenses are restricted to not exceeding 10% of the fund.

The SSO is mainly in charge of providing health insurance benefit and social security benefit to the member of the SSS.

3. Social Security Expenditure

3.1. Health Expenditure

In Laos, the amount of expenditures in the health sector is increasing year of year, as shown in the following figure. The government expenditure in the health sector dropped in 1999, remained stable until 2007, and recovered to the level of 1997 in/after 2008.

The notable points in the expenditures per capita in the health sector are an increase of out-of-pocket expenditure.

FiguresIII-3 Amount of expenditures per capita in the health sector in Laos (Unit: USD)

	1995	2000	2005	2006	2007	2008	2009
Expenditure in the Health Sector (total)	15	19	33	31	32	34	35
Governmental Expenditure in the Health Sector	7	6	6	6	6	6	7
Public Expenditure in the Health Sector	8	13	28	25	26	28	28
Out-of-pocket expenditure	7	12	21	19	20	21	22

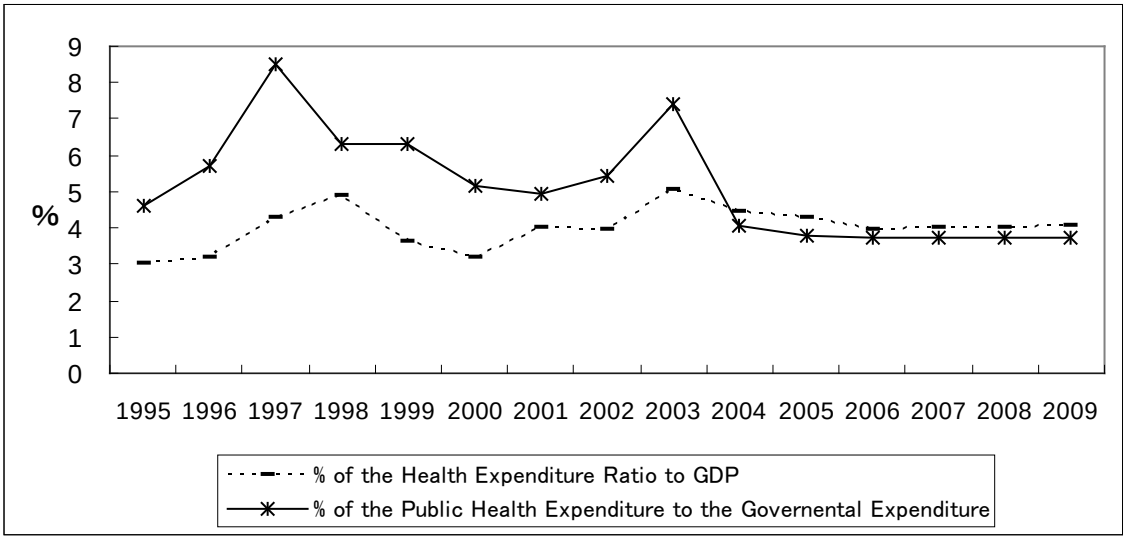
Note: 1USD=81.07JPN(as of May 2012 JICA internal rate)
Source: Extracted from WHO (2011) *Health Financing Country Profile 1995-2008*, p.50.

FiguresIII-4 Amount of expenditures in the health sector in Laos (Unit: USD1 million)

	General government expenditure on health			Expenditure to the public insurance	Out-of-pocket Expenditure	Expenditure through NGOs
		Expenditure of MOH	Expenditure to the Social Security Fund			
1995	44	22	0	0	26	3
1996	50	22	0	0	33	3
1997	64	27	0	0	42	4
1998	36	15	0	0	42	4
1999	17	7	0	0	34	3
2000	20	7	0	0	34	3
2001	20	6	1	0	35	15
2002	19	6	1	0	36	15
2003	26	7	2	0	55	18
2004	19	6	2	0	69	22
2005	15	6	1	0	76	24
2006	18	8	2	1	88	28
2007	20	6	2	1	109	35
2008	58	41	3	1	133	42
2009	68	48	3	1	121	49
2010	95	67	5	1	146	43

Source: Complied by Mitsubishi UFJ Research and Consulting based on the Global Health Expenditure Database of the WHO.

FiguresIII-5 Amount of expenditures per capita in the health sector in Laos (Unit: USD)



Source: World Bank (2011) World Development Indicators & Global Development Finance

The percentage of financial resources from international and bilateral donors to the total health expenditure in Laos is 15.1% in 2010 and the dependency ratio is the second highest in the Southeast Asia, following to Cambodia [13].

3.2. Social welfare budget

The MLSW expenditures of the year 2003/2004 amounted to 132.2 billion Kip (here after LAK [14]), 47% of which (62.5 billion LAK) for adjustment and technical support expenses (including pensions, social security benefits and technical support) and 45% for human capital investment (including salaries for government officers).

Supports from international institutions and foreign aid organization accounted for 52% of the social security-related expenditure amount from the year 2000/2001 to the year 2003/2004. From 2001 to 2005, the social security-related expenditure amount amounted to 4,581.4 billion LAK, 78% of which was allocated to UXO victim support, orphan support, and benefits to children with disabilities and natural disaster victims.

The expenditures in the social welfare (assistance) sector is increasing year by year (2007: 400 million LAK, 2008: 500 million LAK, 2009: 1,200 million LAK), most of which used for emergency support during disasters.

As above, the social security budgets largely depend on international supports. Current issues would be unstable financial resources, insufficient financial resources and inconsistency between working plans and actual supports [15].

[13] World Bank , Health Nutrition and Population Statistics
[14] 1 Kip (LAK)=0.01 JPN (as of May 2012 JICA internal rate)
[15] Lorphengsy (2011) Country Report Lao PDR 2011, p.10

4. Health Security

4.1. National plans for the health security sector

Under the National Health Financing Strategy (2011-2015), Laos is targeting to extend the coverage of health services to 50% of the total population by 2015 and achieve universal coverage by 2020. The government's health security budgets are increasing year by year, supported by higher economic growth (7 to 8%). The Lao government has recently promoted supports to infrastructure development according to the Master Plan based on the National Health Financing Strategy to improve the social security system. More specifically, the projects in progress/under consideration include the reform of the Social Security Law after the integration of the CSS and the SSO (research of the social security systems in Vietnam, China and Thailand), and the improvement of the social security services (including the CSS and the SSO) (e.g. evaluation and audit of the social security benefit payments in provinces and districts, inspection of the quality of hospitals).

4.2. Salient features of health care delivery systems

Most hospitals in Laos are public, including 5 central hospitals, 4 regional hospitals, 12 provincial hospitals, 130 district hospitals and 828 health centers. In addition to them, there are the National Research Center, the Health and Prevention Promotion Unit and the Food and Drug Quality Management Unit [16].

FiguresIII-6 Changes in the number of beds by hospital in Laos (1976 to 2009)

	Central Hospitals	Curative Centers	Regional hospitals	Provincial hospitals	District hospitals	Dispensaries	Total
1976	465	…	…	1,295	2,675	1,743	6,178
1980	540	…	…	2,180	3,080	4,050	9,850
1985	660	…	…	2,125	3,168	3,870	9,823
1990	750	…	…	2,025	2,989	4,600	10,364
1995	852	…	…	1,937	2,291	1,596	6,676
2000	620	238	932	940	2,350	1,241	6,321
2005	660	160	907	985	2,366	1,658	6,736
2007	940	140	675	1,559	1,304	2,337	6,955
2008	810	120	675	1,559	1,845	2,106	7,115
2009	825	120	675	884	1,845	2,076	6,425

Source: Lao Statistics Bureau (2011) Statistical Year Book 2011
http://nsc.gov.la/index2.php?option=com_content&view=article&id=41&Itemid=43&lang=en

In Laos, lack of health care professionals is a long-standing issue. The number of health care professionals has not increased from 1998 (12,481 person) to 2009 (12,422 person). Lack of medium- and high-level health care professionals in rural areas has caused the gap in

[16] Ministry of Health (2011) Health Personnel Development Strategy By 2020, p.6

health services between urban areas and rural areas. Other issues include lack of budgets for the health sector, non-sustainability of development and operation of health organizations, limited and unfair budget allocation at a district level, limited management capabilities of the provincial and district offices of health, lack of supports to mother and child health and nutrition, and lack of infectious disease management programs [17].

4.3. Basic structure of the health security system

The Lao health security system consists of the five schemes respectively for government officers, private sector employees, the informal sector, the low-income group, and mother and child. Among them, the CSS, the SSO, the CBHI and the HEF is operated based on a registration system, while the mother and child health benefit scheme does not require registration but apply to all mothers and children in the targeted area.

FiguresIII-7 Health Security System in Laos

	CSS	SSO	CBHI	HEF	The mother and child health benefit scheme
Year of establishment	1993	2001	2002	2004	2010
Related act	The Decree of the Prime Minister No. 178 The Decree of the MLSW No.2282 (Implementation Guideline) The Decree of The Prime Minister No. 70/2006	The Prime Minister No. 207/1999	The Decree of the MOH No.723/2005 (there was no legal basis for the system since it began as a pilot project)		
Administrative agency	MOF	MLSW	MOH	MOH	MOH
Implementing Agency	SASS	SSO	Community-Based Health Insurance Division, Dept. of Planning and Finance	Lao Red Cross/Swiss Red Cross and MOH	
Model	contribution	contribution	contribution	Non-contribution	Non-contribution
Entry obligation	obligation	obligation	option	Approved by community	All eligible in the targeted area
Target Group	Civil Servants	All private companies and employees having not less than 10 employees	Self-employers, workers in formal sector	Approved households under the poverty line	Mothers having under 5 years-old child in the targeted area
Number of beneficiaries	0.14million (including family member	796 institutions 53thousand (including	0.14million	0.50million	

[17] *Ibid.*

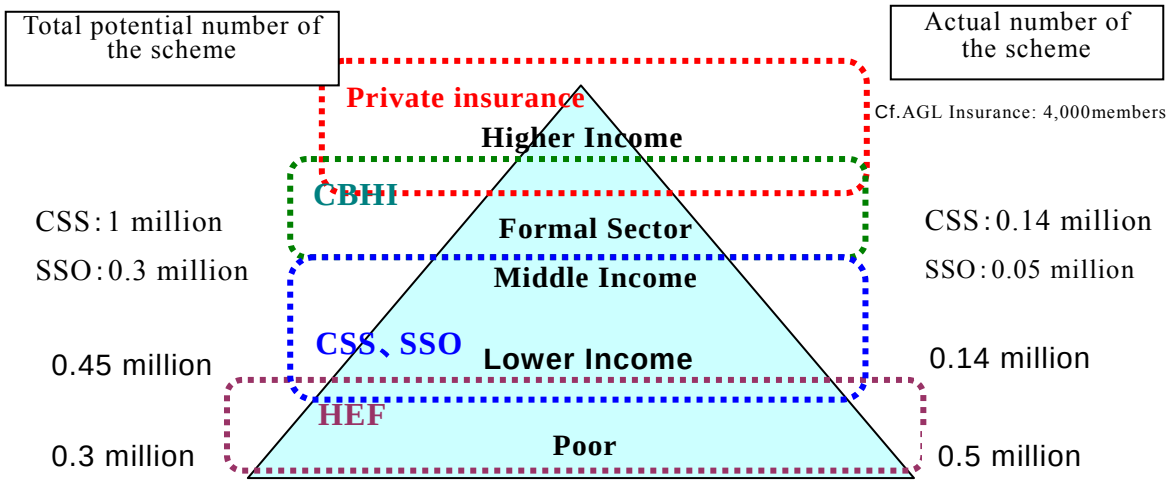
	CSS	SSO	CBHI	HEF	The mother and child health benefit scheme
	0.45 million)	family member 0.12 million)			
Payment System for OP(out-patient)	Capitation	Capitation	Capitation	Capitation	Capitation
Payment System for IP(hospitalized)	Capitation	Capitation	Capitation	Capitation	
Payment System for expensive service		Patients with chronic disease can pay the different system Reimbursement for the expense medical survives can be paid by DRG-RW			
Out-of-pocket	2%	2.2%	different from households	n.a.	n.a.
Capitation budget per year	85,000LAK (Vientiane) 75,000LAK (Other area)	85,000LAK	65,000LAK (Urban area) 60,000LAK (Rural area)	3USD	
Annual Health Expenditure		3.6billion LAK(2006)	75million LAK(2006)		

Note: 1 USD=81.07 JPN (as of May 2012 JICA internal rate) and 1 Kip (LAK)=0.01 JPN(as of May 2012 JICA internal rate)
Source: Complied by Mitsubishi UFJ Research and Consulting based on field work, Howell and Aviva (2008), etc.

The MLSW has drafted the Decree of the Prime Minister to integrate the existing five health security scheme (i.e. the CSS, the SSO, the CBHI, the HEF and the mother child health benefit) under the same fund, which is under review by the Ministry of Justice and expected to be officially issued as the National Health Insurance Decree. The proposed changes in the draft decree include shifting the CBHI to a compulsory system, and injecting the contribution by the government.

Meanwhile, the Social Security Act is in the process of drafting to integrate the employee social security schemes such as pension, which is not yet finalized. It is proposed to maintain the current separate funds while operation of the social insurances is integrated.

FiguresIII-8 Health security schemes in Laos and their insured



Source: Complied by Mitsubishi UFJ Research and Consulting based on Howell and Aviva (2008), field work, etc.

4.4. Civil Servants' Scheme

The social security fund for government officers was established in 1993 based on the Decree of the Prime Minister No. 178, which was controlled by the Department of Social Security of the MLSW. In 2008, to enhance the social security system for government officers, the SASS was set up as an autonomous body based on the Decree of the Prime Minister No. 70 under the control of the MLSW. The social security funds consist of (1) Long-term benefit fund (pension and sickness allowances), (2) Short-term benefit fund (retired soldiers, maternity allowance, survivor allowance, childbirth allowance and child allowance), (3) Worker's compensation fund, (4) Health insurance fund, and (5) Administration fund.

Upon the shift from the Decree of the Prime Minister No. 178 to No. 70, the contribution rates of the government and government officers were increased to 8.5% and 8% (from 6%) respectively.

However, due to financial difficulties and an increase of the total contribution amount following the expansion of benefits, the government contribution is currently at most 3 to 4% [18].

The social security funds are in a deficit and the SASS reviews the budget plan every six months and requests the government to increase the allocation of the budget.

Upon the expiration of 4-year term of the 1st Social Security Fund Committee, the 2nd Social Security Fund Committee (chaired by the Ministry of Finance (MOF)) has been organized since 2012, which completed the annual meeting and workshops in provinces [19]. Prime Minister Thongsing commented in a workshop that it would be required to review the

[18] Based on the interview to the CSS.
[19] As of the end of February 2010.

policy for managing the fund in compliance with the Decree of the Prime Minister No. 70. However, the contribution amount from the government is still limited to half of the amount required. In addition, computerization of the operation should be promoted since most procedures at the fund, such as the issue of SSS cards, are operating basically manually.

It is difficult to quantify the ratio of the government's contribution. The SASS submits data based on budget review every six months to the MLSW for review and approval, and then requests the Department of Accounting, MOF to allocate the budgets.

In the era of the Decree of the Prime Minister No. 178, the CSS members had to pay the medical bill in advance from out-of-pocket at a medical institution and submit an application to the MLSW for reimbursement, which took for a long time to receive averagely 30% of the bill (according to the ILO's estimate). On the other hand, since the enactment of the Decree of the Prime Minister No. 70, the CSS members are not required to pay out-of-pocket anymore, despite an increase in the contribution amount.

Through the reform which started in 2005 as a pilot project, the health insurance for government officers has covered their dependents since 2008, whereby social security scheme cards are issued to all of the insured and their dependents.

The social security funds have engaged 131 district hospitals and 17 provincial hospitals. District hospitals have health centers under their networks.

The capitation unit cost per capita is 85,000 LAK in Vientiane and 75,000 LAK in other provinces. The budget calculated by multiplying the applicable capitation unit cost by the population is allocated to each province, and then the ratio of allocation between a provincial hospital and district hospitals (e.g. 50:50, 80:20) will be discussed and determined.

Each district hospital is reported by health centers the number of patients and the cost per patient, based on which it allocates the budget to each health center.

Any medical institution which receives a patient with referral from a central hospital in Vientiane bills to a provincial hospital through the SASS. With any appeal, the Medical Board of Directorate consisting of the head of the SASS and medical experts will be held for discussion, which has never been exercised.

The agreed amount billed by a central hospital to a provincial hospital is deducted from the budget of the following month to be allocated by the SASS to the provincial hospital, and paid by the SASS to the central hospital.

4.5. Social Security Scheme (SSS)

The SSS is a mandatory scheme for state enterprises and private companies having not less than 10 employees, which covers these employees and their spouses and children under the age of 18. The benefits under the SSS include (1) condolence allowance, (2) medical allowance, (3) sickness allowance, (4) maternity allowance, (5) worker's compensation allowance (injury and sickness), (6) disability allowance, (7) retirement pension, (8) survivor

allowance, (9) child allowance, and (10) unemployment allowance. The contribution (premium) rate is determined based on the salary or wage of an employee. The social security contribution rate is 9.5% of a salary, consisting 5% of employer's contribution and 4.5% of employee's contribution.

The capitation unit cost per capita is 85,000 LAK. Before introducing the capitation system Fee for Service (FFS) was adopted and averagely 30% of the bill was reimbursed. The SSO pays the invoiced amount for each hospital based on the calculation from hospital.

SSO insurance contribution is collected basically by electronic withdrawal from the bank account; however the voluntary members can pay the contribution by cash at the local SSO office. There are no special punishments to the companies where does not pay the contribution [20].

4.6. Community Based Health Insurance (CBHI)

The CBHI is a public health insurance scheme in which any person who is not covered by any scheme of the CSS and the SSO, such as farmers and the self-employed, and their spouses and families, and workers in the informal sector, may enroll voluntarily. The CBHI is under the control of the MOH.

The CBHI started to be designed in 2001 and had been tentatively implemented in Vientiane and other two provinces from 2002 to 2004. After the evaluation of the pilot project in the three provinces in 2004, Phase 2 projects had been implemented in 2005 and 2006 to extend to other provinces [21].

The regions where the CBHI has been implemented are limited, 25 districts (out of 143 districts throughout the country) as of February 2012. The number of the insured is only 140,000, which accounts for only 5% of the target groups. The budget scale of the CBHI is also smaller than other schemes.

The CBHI suffers from adverse selection due to its voluntary system and is less effective. Some members, who should be a member of CBHI, join the HEF because HEF does not require the contribution payment.

To extend coverage, it is crucial to shift to a compulsory system. However, due to lack of employer's contribution, the contribution rate would need to be set higher. It would be extremely difficult to extend coverage without putting public (tax) resources.

In addition, it is required to clarify differences in the eligibility of enrollment with the HEF which is a tax-based system. However, the target low-income group has not yet been listed up.

The CBHI depends financially on international development institutions. Since the

[20] Based on the interview of SSO.
[21] The CBHI has been given assistance by Japan through UN Trust Fund since its introduction, including the capacity building support in the health filed from 2007 to 2009. Due to financial difficulties, the Japanese government has suspended contribution to UN Trust Fund since 2009.

suspension of funding from UN Trust Fund, the CBHI has been financed by WHO (4 districts) to maintain each projects and by French Development Agency (AFD: Agence Française de Développement,) (6 districts including Savannakhet).to implement the training course. The CBHI budget is fully financed by the contribution at a local government level, without any subsidiary from the central government. Administrative cost (operation of the fund) are basically limited to under 10% of the fund amount.

The contribution is fixed according to the number of household members and region, which may be paid on a monthly, quarterly or yearly basis. The monthly contribution amounts are as follows.

FiguresIII-9 Contribution of the CBHI (Annual)

Household size	Urban area	Rural area
single	14,000LAK	12,000LAK
2 to 4 person	28,000LAK	24,000LAK
5 to 7 person	30,000LAK	28,000LAK
more than 8 person	33,000LAK	30,000LAK

Note: 1 Kip (LAK)=0.01 JPN(as of May 2012 JICA internal rate)
Source: Complied by Mitsubishi UFJ Research and Consulting based on the interview to the MOH.

4.7. Health Equity Fund (HEF)

The HEF is a free medical service scheme for the low-income group supported by the Lao Red Cross, the Swiss Red Cross, the ADB (where supports in the North region), the World Bank (where supports in the South region), Luxemburg (where supports in the Central region), etc., following the scheme implemented in Cambodia.

While the scope of medical services is limited due to a low capitation unit cost (USD5), the HEF covers not only medical cost but also transportation cost, and is expected to play an important role in providing health care services in remote areas.

While the responsibility to maintain funding is transferring to the MOH, the benefit payments under the HEF is still supported by donors in almost all regions, not like other health security schemes. The ADB plans to cease supports in the North region at the end of 2013, and the government is required to strongly commit to secure the budgets.

The number of the poverty is estimated based on its definition under the Decree of the Prime Minister No. 285. At a province or district level, the data relating to the poverty such as the number of poor households, names of households' heads, address (village) and the number of children is collected, which is submitted to the central government.

The Decree of the Prime Minister No. 285 defined the poor as the person having their income under 240,000 LAK (Urban area) and 192,000LAK (Rural area). The Lao/Swiss Red Cross, who has been supported HEF since its establishment, also adopted the geographical approach, where takes into population distribution and access to the medical institutes, as well as recognition of the village head.

In some regions where the CBHI has been implemented, the CBHI and the HEF have been

operated as a single scheme while the HEF is paying the contribution on behalf of an individual. The MOH views that it is possible for the CBHI and the HEF to operate a single scheme under separate fund management, promotion and education projects [22].

The unit cost per capita in the HEF is about USD3 per year. While in an emergency the insured of the HEF may be transferred to Vientiane, the CBHI cannot afford to such an arrangement due to lack of the budgets. Another difference between the two schemes is that; hospitals manage the funding and accounting in the CBHI, on the other hand, provinces and districts manage that in the HEF. This should be taken into account in integrating the two schemes [23].

The Lao and Swiss Red Cross both are not in line with these MOH's policies,as they view the HEF as multilateral initiatives including insurance and health education for community people, dissemination and management improvement of HEF, rather than a simple support to the public health finance.

4.8. Coverage

4.8.1. CSS

The number of eligible government officer is currently 140,000. The number of beneficiaries is 450,000.

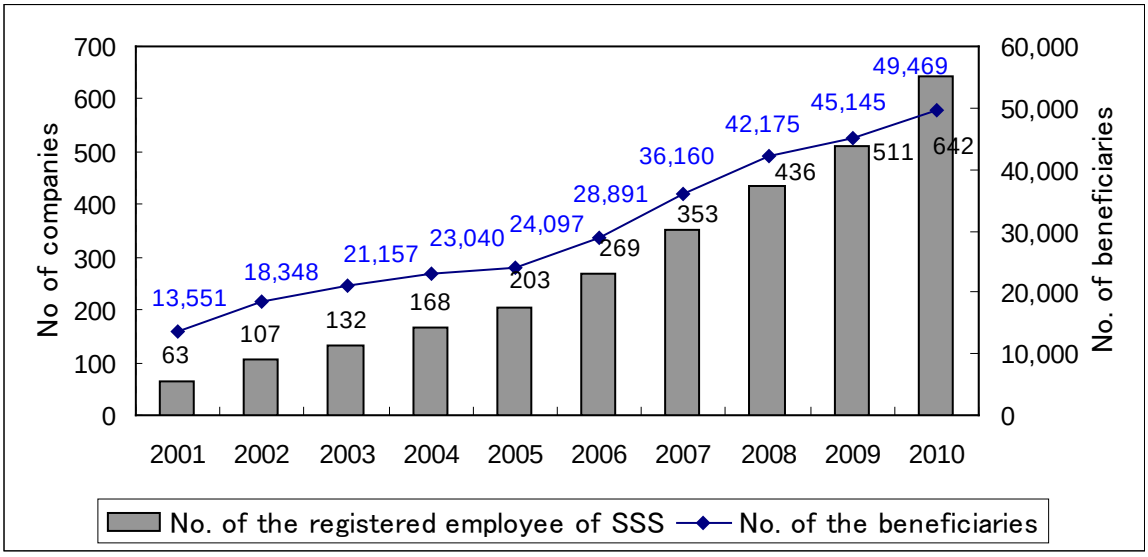
4.8.2. SSS

The number of the registered companies is 796, and the number of the insured is approximately 53,000. The number of beneficiaries is 120,000 (as of the end of 2011).

[22] Based on the interview to the MOH. Some officers commented that funds and accounts should be separated. While the CBHI has different contribution amounts according to the number of household members, the issue is that it has not collect premium costs effectively.

[23] Based on the interview to the MOH. Some officers commented that the integration of the CBHI and HEF schemes would cause confusion at hospitals due to different capitation cost and some hospitals may not comply with the Decree of the Prime Minister.

FiguresIII-10 Changes in the numbers of the registered employers and beneficiaries in the SSS (2001-2010)



Source: Complied by Mitsubishi UFJ Research and Consulting based on the SSO's data.

4.8.3. CHBI

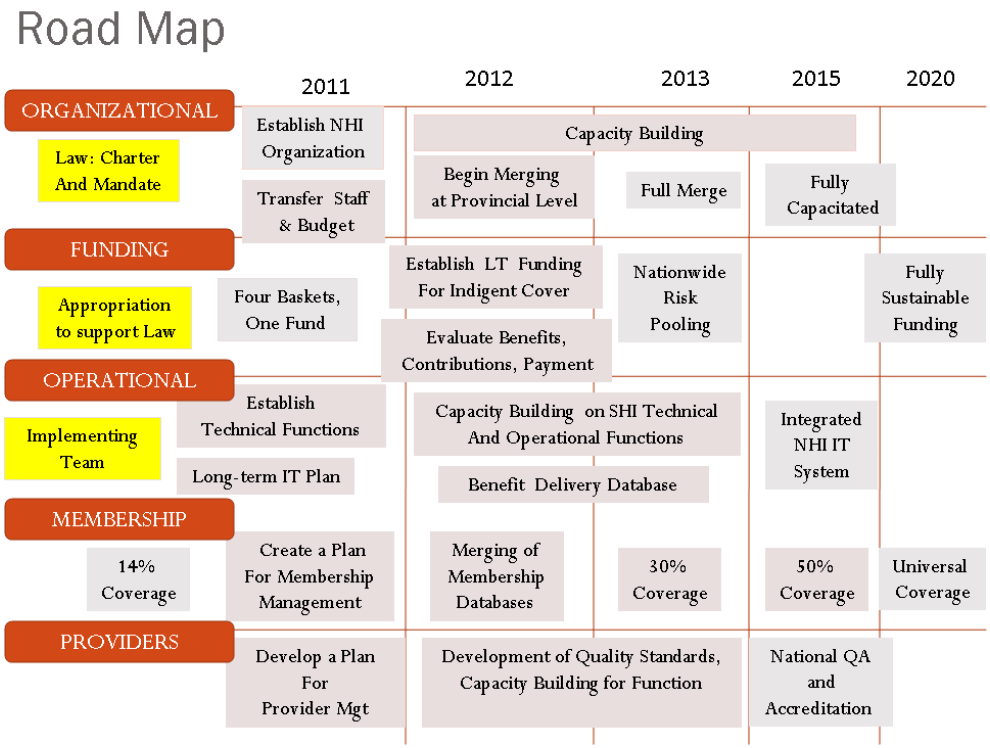
The pilot projects have been currently implemented in 25 districts out of 143 districts in the country, and the number of the insured is approximately 140,000. Given about 3 million persons mainly in the informal sector are eligible, the coverage is still 5%.

The Lao government is targeting to extend the coverage to 50% (3 million persons) of the total population by 2015 and achieve universal coverage in the health security system by 2020. The CBHI has been newly implemented in 1 district by February 2012 and will be extended to other 2 districts through 2012 [24].

There is still a wide gap between the target coverage and the current number of the insured. The MOH has prepared the following roadmap to achieve 50% of coverage by 2015 and universal coverage by 2020.

[24] The MOH requested the extension to 4 districts in the year 2011, but only 2 districts have been approved (Based on the interview to the MOH).

Figures III-11 CBHI roadmap towards 2020



Source: MOH's data.

Due to delay in collecting the contribution from the insured, allocation of the budgets to medical institutions are also delayed. Collection of the contribution is concerned especially in local areas. As the insured that has not paid the contribution for three months will be disqualified from the CBHI, most insured has not paid the contribution for almost to the limit three months.

One of the reasons of delayed collection is that a collector who is assigned to each village is volunteer and less motivated to collect money. At a district level, one to two paid cashiers are assigned.

Under the current system and framework focusing on the gate keeper function, many patients have to visit district hospitals where the quality of services is relatively low due to the referral system, while prefer to visiting central hospitals. A lower capitation unit cost has prevented improving the quality of services. Proposed changes in the medical insurance scheme reform include increasing the capitation unit cost allocated to medical institution to the same level as the SSS, offering two options of the contribution in the course of integration of the medical insurance system (CBHI and HEF), and providing another package with a higher contribution in response to the needs of the CBHI users who prefer to visiting central hospital [25].

[25] Based on the interview to the MOH.

4.8.4. HEF

The HEF is basically managed by the MOH with the financial and operational supports from the World Bank, Luxemburg, the ADB, the Red Cross and other donors. As of 2012, the HEF covers 63 districts and 500,000 of the poverty (400,000 in the North region and 100,000 in the South region). The number of the poverty in Laos is estimated to be 1.2 million.

4.9. Role of private health insurance systems and recent trends

There are five leading private insurance companies in Laos, among which Allianze General Laos (AGL) is largest and oldest. Due to foreign capital control in the insurance sector, AGL started business in 1992 by setting up a joint venture with the MOF. Other private insurance companies are also joint ventures: A Malaysian insurance company and the Ministry of Justice.

Before 2006, Lao people were not familiar with the concept of a “private insurance”, and most of those who enroll in private insurances were Lao staffs working in ODA projects by international organizations, bilateral donors (e.g. JICA) and international NGOs. The number of the insured of private insurances is sharply increasing since 2006, in step with increasing large-scale projects (e.g. Nam Theun Dam).

For an instance of the AGL, AGL currently has 4,000 customers most of which have enrolled as part of welfare of private enterprises. Some people who are entitled to the SSS have purchased insurances from AGL to have better medical services.

Medical fee may be reimbursed either of the SSO and AGL. If medical fee is not fully covered by the SSO, a hospital will contact AGL to ask pay the excess, i.e. basic medical fee is covered by the SSS and high-cost services are reimbursed by AGL.

AGL currently provides life insurance products (e.g. health insurance, worker’s compensation insurance, travelling insurance and car insurance) and non-life insurance products in Laos. No pension insurance is available. The most popular product is health and accident insurances, and the percentage of the insured of the package including these two product accounts for 35%. A corporate contract is more popular than an individual contract. The number of the insured of a death insurance (insurance is paid on the condition that a premium has been paid for at least three years) is not increasing.

In Laos, more and more people buy private insurances to have medical services in Thailand. The advantages of the AGL’s insurance products are cashless (no redemption required) medical services in leading hospitals in Thailand and contracted clinics in Laos. As for travelling costs to Thailand, ambulance cost in an emergency case is covered, but transportation by helicopter not (transportation by helicopter was popular a few years ago due to lack of transportation means, but transportation by car is now available upon development of road infrastructure).

The annual insurance premium of the AGL’s most popular product is 1,363,000 LAK

(equivalent to 13,630 Yen) for male customers and 1,772,000 LAK (17,720 Yen) for female customers. The insurance does not cover HIV, childbirth and bird flu, but is applicable to cancers hernia and tuberculosis in case of development six months after the contract.

Private insurance companies are recently advertising their health and accident insurance products to not only private enterprises but also students. The private insurance market is expected to be expanding in Laos which is achieving remarkable economic growth.

Following deregulation of private hospitals in 2011, many foreign companies and hospitals are active in investments in Laos. All hospitals in Laos are currently managed by the government. Along with an increase of private hospitals, some may not prefer to engage with the SSO [26].

[26] Based on the interview to private insurance companies.

5. Pension and other income security scheme

5.1. Social Security Scheme (SSS)

5.1.1. Legal basis

Decree of the Prime Minister No. 207/1999.

5.1.2. Benefit package

Funeral allowance, medical allowance, sickness allowance, childbirth allowance, worker's compensation, sickness allowance, retirement allowance, survivor allowance, child allowance, unemployment allowance.

5.1.3. Eligibility of enrollment and contribution rates

The SSS is a mandatory scheme for state enterprises and private businesses having not less than 10 employees, which covers these employees and their spouses and children under the age of 18.

The contribution rate is 9.5% of a salary, consisting 5% of employer's contribution and 4.5% of employee's contribution.

In addition to the above, the voluntary insured includes 363 of those who were the compulsory insured and 912 of those who work for an employer having less than 10 employees including the informal sector (2011 data). The contribution rate of the voluntary insured is 9.0% (lower than the compulsory insured, due to the exclusion of the workmen's compensation).

5.1.4. Funds and operational bodies

The SSS's fund is managed by the SSO established in 2001 under the control of the MLSW.

5.1.5. Enrollment figures (extension of coverage to workers in the informal sector)

The number of the registered employers is 796, the number of the insured is approximately 53,000, and the number of beneficiaries is 120,000.According to the national population census of 2005, the number of work force consists of 7,000 of business owners, 1.15 million of self-employed and 1.26 million of domestic workers[27]. The SSS coverage is still low.

While most major companies have registered in the SSS, the coverage of SMEs in local cities and rural area is still low. Even if the coverage is extended to SMEs in local cities and rural area, the total contribution amount would not significantly increase due to a small scale of business and a lower salary of employees. Given that more and more costs to expand the coverage and operate the fund in local and rural areas will be required, it is worth integrating the SSO with the CSS having offices in local areas for cost reduction purpose.

[27] JICA (2010) "Poverty profile in Laos", p.46

While a responsible organization after the integration is still under consideration, it is likely to use the name of the SSO. How to manage the database after the integration is also discussed[28].

The database complied by the Tax Department of the MOF for tax collection may be used to identify the state of enterprises and encourage them to enroll in social security. There is no penalty against failure to pay the contribution.

The SSO intends to set up its regional offices in all provinces (currently, 7 provinces) to expand the coverage. Considering several factors such as the population, the number of employers, the number of hospitals and facility capacity, next offices will be located in the South and North regions.

Regarding demarcation between the CBHI and the SSO, where these two schemes have been implemented as one scheme in some regions, it is difficult for any provinces which have no SSO's regional office to divide their role clearly, even though it is stated in the Decree of the Prime Minister. Some employers having 10 or more employees must be SSS members but they are using the CBHI to avoid paying the SSS contribution. Despite the increasing number of employers, who should be registered in the SSS scheme, especially hotels and guesthouses following the growing tourism, many employers have not paid the employee's contribution (since they regard their workers as part-time farmer or they declare they are in financial difficulties)[29].

5.1.6. Actual benefit payments

The actual benefit payments by the SSO are increasing year of year as shown in the following table. The amount of the maternal allowance has higher proportion.

FiguresIII-12 Actual social security benefit payments by the SSO (2001-2004)

(Unit: No. of cases and million LAK)

	2001		2002		2003		2004	
Kind of benefits	No. of cases	amount	No. of cases	amount	No. of cases	amount	No. of cases	amount
Sickness	10	41.3	127	65.4	249	102.6	415	145.6
Maternity	0	0.0	174	169.9	528	587.8	1,345	768.0
Death	0	0.0	19	4.9	50	141.6	44	151.4
accident at the workplace	1	0.4	19	16.0	29	21.8	145	36.2
pension	0	0.0	0	0.0	0	0.0	31	37.9
total	11	41.7	339	256.1	856	853.8	1,980	1,139.2

Note: 1 USD=81.07 JPN (as of May 2012 JICA internal rate) and 1 Kip (LAK)=0.01 JPN(as of May 2012 JICA internal rate)

Source: Complied by Mitsubishi UFJ Research and Consulting based on the SSO's Annual Report.

5.1.7. Others

The SSO has been provided technical assistance by the ILO, Belgium and Luxemburg for

[28] Based on the interview to the SSO.
[29] Based on the interview to the SSO.

a long time.

For the integration of the SSO and the CSS in coming 2013, the ILO and the WHO has decided to provide assistance to Laos.

While the Insured of the SSS is issued the SSS card, the family book, which is distributed for each household with name, age, gender and other information of each family member, is more common in local areas. While the CSS card is used to each individual, the insured and their spouse and families, one SSS card is provided to each household (insured, spouse and children of the age below 18).

FiguresIII-13 SSS card (Sample)

The coverage of the CSS is often overlapped with that of the SSS (based on the household survey in 2006). For example, in the case where a husband is a government officer (eligible to the CSS) and a wife is an employee in the private sector (eligible to the SSS), a wife tends to be covered by the CSS. The SSO views that this would be solved by the integration of the social security schemes in 2013.

5.2. Civil Servants' Scheme: CSS

5.2.1. Legal basis

Since the independence in 1975 until the establishment of the MLSW in 1993, government officers may receive free medical services under the Regulation No. 53 (government officer pension and allowance for surviving family of government officers) and the Regulation No. 54 (sickness allowance, childbirth allowance, death allowance, survivor allowance, unemployment allowance, and elderly and child allowance for government officers) enacted in 1986. Following the establishment of the Social Security Fund for Civil Servant under the Decree of the Prime Minister No. 178/1993, the contribution rate to the Fund was prescribed in the Decree of the Prime Minister No. 70/2006. The SASS to maintain and manage the Fund was organized in 2008 based on the Decree No. 70.

5.2.2. Benefit package

The benefits of the Social Security Fund include sickness benefit, maternity benefit, death benefit, survivor benefit, pension, disability benefit, PWD care benefit, incapacity benefit

and child benefit, the details of which are described below.

FiguresIII-14 List of benefits of the Social Security Fund for Civil Servants in Laos

kind of benefit	amount of benefit
Sickness Benefit	Sickness Benefit is payable for 3 months with an amount of full salary for each month and after that if an employee still can not return to work the benefit is reduced to 80% of salary and payable for 12 months.
Maternity benefit	Maternity benefit comprises two forms of payment. A lump sum payment equals to 60%of basic salary for each child and a monthly payment equals to a full salary for 3 months.
Death Benefit	Death Benefit is a payment to the family of deceased employees or persons who are in charge of organizing traditional funeral ceremony. The payment is a lump sum equal to 10 months of his/her last salary or pension. For the invalidity pensioners who are living outside invalid centers, the benefit is equal to 12 months of his/her pension.
Survivor benefit	A lump sum payment for the family members of deceased persons. The payment is divided into four categories as follows: A lump sum amount equal to 6 months of deceased person salary for those who served for 3 years and less An amount of 8 months of salary for employees working more than 3 to 10 years An amount of 12 months of salary for employees working more than 10 to 20 years An amount of 15 months of salary for employees working more than 20 years. Each surviving child shall be entitled to a monthly payment equal to 10% of salary or pension of the deceased.
Old age pension	Old age pension is payable to employees who reach 60 years of age for men, 55 years for women, and 25 years of service. Qualified persons will receive 75% of salary. And each additional year of service, 1% will be added. The maximum rate of pension is 90%. In addition to a monthly pension, a pre-retirement lump sum will be paid equivalent to 15% of salary multiplied by the number of service years. For employees who do not qualify for a monthly pension they will be entitled to a lump sum benefit. The benefit equals to 75% of the last salary and multiplied by the number of years of service.
Invalidity benefit	Invalidity benefit is a monthly payment payable to two groups of persons. One is the group of invalidity persons who are working in any government organizations and who are not working but living in any invalid centers. Another is the group of the invalidity persons who are not working and not living in any invalid centers. The benefit is paid as follows: Working invalid and invalid living in centers: benefit for special category: 100% of salary and 100% minimum salary; category 1: 40% of minimum salary category 2: 30% of minimum salary category 3: 20% of minimum salary category 4: 10% of minimum salary The invalid living outside centers: special category: 150% of minimum salary category 1: 100% of minimum salary category 2: 80% of minimum salary category 3: 60% of minimum salary category 4: 40% of minimum salary
Invalidity caretaker benefit	Invalidity caretaker benefit is also available for those invalid persons who can not help themselves in normal daily life. The benefit is 100% of minimum salary.
Incapacity benefit	Incapacity benefit is payable to persons who can not continue to work due to their health status and they are not considered as invalidity persons. The payment of this monthly benefit equals to 70% of concerned persons' salary.
Child allowance	Child Allowance is available for employees who have a child whose age less than 18 years old. The amount of child allowance is referred to real living conditions in each period.
Workers injury	In case employees suffer an employment injury or occupational diseases, they shall be entitled to employment injury benefits. The benefits include

kind of benefit	amount of benefit
	medical care, sickness benefit, invalidity, death benefit, survivor benefit and invalidity caretaker benefit.

Source: Complied by Mitsubishi UFJ Research and Consulting based on ILO Sub regional Office for East Asia (2006) Asian Decent Work Decade: Social Security Extension Initiatives in East Asia, pp.5-6.

5.2.3. Eligibility of enrollment

Government officers, including soldiers and police officials.

5.2.4. Contribution rates

Upon the revision from the Decree of the Prime Minister No. 178 to No. 70, the contribution rates of the government and government officers were increased to 8.5% and 8% (from 6%) respectively. Compared to the CSS (employer: 5%, employee: 4.5%), the contributions rates of CSS are high (the government: 8.5%, government officer: 8%). This is because the contributions are partly used to pay the benefits to pensioners (who did not pay any contributions).

5.2.5. Funds and operational bodies

The Fund is managed by the SASS, which was established under the control of the MLSW in 2008 as an autonomous body based on the Decree of the Prime Minister No. 70/2006, for the purpose of development of social security for government officers.

While 90 to 95% of the benefit package is common between the CSS and the SSS, the CSS offers some better benefits (for example, government officer may have vaccination for poisonous snake bite, but the SSS users have to pay half of out-of-pocket). Since 2005 or 2006, the Social Security Card has been started to issue, and the capitation system has been introduced.

5.2.6. State of coverage

The number of eligible government officers is currently 140,000, and the number of beneficiaries if 450,000.

While the SSS card is issued to all beneficiaries (including family), the actual number of the SSS cards issued is 360,000, against the number of beneficiaries of 450,000[30]. In local areas, the family book is more commonly used as an ID.

The insured that changes their address is required to notify to the relevant CSS office in a province. In the case where the insured needs to have medical treatment or be hospitalized in any different province, the CSS will coordinate with a hospital.

20 billion LAK is deposited from the social security fund to the Bank of Agricultural Development each year. The fund has more than one bank account but does not involve in investments. Purchasing foreign currency bonds are under consideration.

[30] In Vientiane, Luang Phrabang, Hua Phan and Xieng Khuang, a photo is attached to the SSS card.

5.3. Unemployment insurance

In Laos, there is neither unemployment insurance nor discussion of its introduction.

6. Social Welfare System and Community-based Assistance Schemes

6.1. Development of databases to identify low-income populations

6.1.1. Outline of databases

In the National Growth and Poverty Eradication Strategy (NGPES) announced in 2004, the following poverty standards has been set to support local government in monitoring changes in poverty and have better understandings on the poverty situation at a household, village and district level.

FiguresIII-15 Poverty standards in Laos

unit	criteria
Household	・ Monthly household income per capita income under 85,000LAK (Urban area: under 100,000LAK, Rural area: under 82,000LAK)
Village	・ More than51% households are under the poverty line in a village ・ There is no school in or next village ・ There is no health center nor drug store in a village, or it takes more than 6 hours to reach a hospital ・ There is no access to a road in a village
District	・ More than 51% villages are under the poverty line in a district ・ More than 40% villages without school in or next village in a district ・ More than 40%villages without health center nor drug store in a district ・ More than 60%villages without access to road in a district ・ More than 40%villages without access to safe water in a district

Source: Lao PDR (2004) "National Growth and Poverty Eradication Strategy", p.30

Based on the above definitions, in 2003 the number of poverty households, villages and districts amounted to 160,000 households (50.4% of the total households), 4,000 villages (76.7% of the total villages) and 72 districts (out of the total 142 districts in the country). The poverty districts are given the priority, e.g. "first prioritized district", "second prioritized district", etc. Prioritized districts are mainly located along the border with Vietnam and in the North region [31].

According to the latest poverty survey by the government in October 2011 (provided in the Decree of the Prime Minister dated October 13, 2011), 18 districts in 10 provinces fall in the poverty district, 798 villages (72.3%) out of 1,108 villages in the 18 poverty districts fall in the poverty village, and 43,070 households (46.03%) out of 93,575 households fall in the poverty household in 2011 [32]..

[31] JICA (2010) "Poverty profile in Laos", p.20

[32] Source: Local newspaper "Vienchamai" dated February 29, 2012. The districts having the most number of the poverty villages are Kuwa, Sam Nua and Mai. The districts having the most number of the poverty households are Sai, Sam Nua, Sanaam Sai, Kuwa, Asaporn, Mai, Bunthai, Sonburi and Et (Japanese translation is cited from the website of the Japanese Chamber of Commerce of Laos (President: Mr. Yamada)). http://laotimes.exblog.jp/17443277/ (Accessed in April 2012)

According to the statistics of the Committee for Planning, the Naional Statistics Center and the World Bank, the poverty population in Laos amounted to 655,000 in 2003[33].
The household surveys to be used the base of poverty standards in Laos include the Lao Expenditure and Consumption Survey (LECS) which is conducted by the Department of Statistics (DOS) (the former National Statistical Center (NSC)) of the Ministry of Planning and Investment (MPI) every four years since 1992 and the Population and Housing Census which is conducted every ten years.
The LECS has been conducted four times so far and the latest one (LECS IV) was in 2005[34].

6.1.2. Range of database utilization

As described later, the initiatives of public social welfare (social assistance) supports, which is not depend on external resources (e.g. assistance from ODA and NGO), are quite limited in Laos. In this regard, there is no need to identify the poor for the purpose of providing public social assistance. The results of the above surveys which identify the poverty are not used to set the targets of the HEF, but used for perceiving current poverty circumstances and support for the local government or rural development..

6.1.3. International cooperation

In connection with the above poverty surveys, the World Bank, Sweden (SIDA), etc. have provided financial and technical assistance to the MPI.

6.2. Social assistance systems

The Social Welfare Department of the MLSW has provided social assistances mainly with external funds. The limited project budgets are used to monitor these social assistances performed by external funds[35]. The major projects are below;

6.2.1. Child protection support

The child protection projects are implemented in five provinces (Udom Xai, Vientiane, Savannakhet, Champasak and among others). Lao-speaking experts dispatched by the UNICEF and World Vision provide information relating to the Convention on the Rights of the Child (CRC) and child protection, and perform training to prevent, raise awareness of

[33] Committee for Planning and Investment, National Statistics Center, and World Bank, "Lao PDR Poverty Trends 1992/93-2002/03", (2004), p.35, Table 5
[34] Swiss National Center of Competence in Research North-South and International Food Policy Research Institute, *"The Geography of Poverty and Inequality in the Lao PDR"*, p.7
[35] The budgets are allocated to project management (child support and research project) (30 million LAK, equivalent to 300,000 Yen) and welfare and vulnerable support (1.2 billion LAK, equivalent to 12 million Yen, but not in cash but in kind, e.g. rice, supplied by the MOF). Separately, there is the so-called "counterpart fund" provided via the Japanese Embassy, i.e. "2KR", which is a collateral fund from sales of rice (50 million LAK, equivalent to 500,000 Yen) (the 2KR collateral fund is an excess fund in domestic currency from ODAs which an beneficiary government may reserve and use for the economic and social projects or procurement of goods upon discussion with the Japanese government through each Japanese embassy). In the first 2KR assistance, rice was supplied free of charge. In the second 2KR assistance, rice was sold to public companies and the money is deposited in a bank account and utilized as the counterpart fund.

and improve capacities to prevent human traffic, domestic violence (children and women) (e.g. training in Vientiane, lecture in the National University of Laos), in collaboration with community leaders.

Another child support project is the SOS Village which is supported by the Save our Soul (SOS), an NGO based in Innsbruck, Austria. This project intends to provide educational and health supports to orphans at a community level. Currently, 6 SOS villages are set up in Laos, where 150 orphans are taken care of. The Lao government pays USD5,000 of the annual membership to SOS, whereby it subcontracts orphan support to the NGO.

6.2.2. Human traffic victim support

Two temporary shelters are provided in Vientiane and Savannakhet having the capacity of 20 persons, which is managed by a French NGO engaging the MOU with the MLSW.

A victim sheltered will stay in a shelter for about one week and be interviewed by experts from the MOH, the Ministry of Education or NGOs. Subsequent supports vary case by case (e.g. the Ministry of Education to support educational matters if an expert deems necessary and a victim wishes to do so, provincial or district officers to accompany to go home if a victim wishes to do so, the Ministry of Public Security to investigate if a case is serious or involves money).

The International Organization for Migration (IOM) and World Vision also committed to human traffic victim support. World Vision is in charge of three provinces (Savannakhet, Salavan and Champasak), and the government is responsible for the others. The IOM used to take care of all provinces, but their supports now do not cover all provinces due to lack of the budgets.

6.2.3. PWD support

According to the joint survey by Handicap International, an international NGO, and the National Rehabilitation Center in 1999, the number of PWDs in Laos is estimated to be approximately 40,000, including paralysis (14%), polio (13%), visual and auditory disabilities (11%), physical disabilities (amputation) (9%) and learning disabilities (9%). According to the similar survey in 2003, disabilities are due to inherent (52%), sickness (30%) and accidents (12%).

Most PWDs may have free medical services at public hospitals and be provided prosthetic devices at state-owned rehabilitation centers. A job training school in Vientiane provides various term training courses for 6-12-month to 2-3 year. For disabilities due to an accident during work, the disability benefit is also paid by the CSS and the SSO[36].

6.2.4. Target beneficiaries

Orphans, victims of domestic violence and human traffic, etc.

[36] Lorphengsy (2011) Country Report Lao PDR 2011, p.9

6.2.5. Standards for benefits and benefit amounts

The standards for benefits and benefits amounts by item are set by the MLSW [37].

6.2.6. Implementing bodies, social workers

While the MLSW is responsible for social assistance, in practice external organizations such as international organizations and NGOs are playing a key role in operating and managing projects and financing.

6.2.7. Issues and challenges

The annual social development budget (health, education and information) is about 20 to 30% of the total budget, most of which is for education (mainly, primary education). The issue is that the budget related to social welfare is very limited [38].

6.3. Community-based assistance schemes

In Laos, the UNDP has established the District Development Fund (DDF), which is a large-scale program covering five provinces (Xieng Khouang, Udom xai, Saravanh, Sekong and Attapeu) with the capacity of USD10.65 million (financed by the United Nations Capital Development Fund (UNCDF), the UNDP, Luxemburg, Switzerland and the World Bank). In this program, people will submit a project proposal such as infrastructure or school construction to a district and any project which the community deems necessary will be implemented. The DDF intends to reinforce capabilities of counterpart staffs in the district office of the Ministry of Home Affairs (MOHA) to be able to manage the project efficiently.

There is another similar project which is the Poverty Reduction Fund (PRF) by the World Bank to implement a project by district offices. The PRF focuses on projects for poverty reduction with the counterpart of the Rural Area Development Department of the Office of the Prime Minister.

6.4. Other social welfare practices

6.4.1. Natural disaster support

In Laos, provinces along the Mekong River are hit by floods in the rainy season almost every year. In addition, over 400 households, exceeding 2.5% of the total households, suffered any natural disaster such as drought, storm and landslide in 2011 [39].

In 2011, the Lao government invested 5 billion LAK (equivalent to 50 million Yen) for providing rice for supporting 429,000 victims of natural disasters (e.g. floods, storm and typhoon) throughout the country, mainly to Luang Namtha Province heavily affected. This assistance was financed by Japanese assistance (2KR). The 19 billion LAK scale-flood relief measures were also taken, whereby provinces supplied goods (e.g. food, clothing and farm

[37] Data of actual benefit payment is not available.
[38] Based on the interview to the MLSW.
[39] Lorphengsy (2011) Country Report Lao PDR 2011, p.8

equipment) to flood victims. No cash support was included even in emergency disaster support measures. International NGOs such as the WFP and the FAO have also provided assistance to natural disaster victims [40].

6.4.2. Urban poverty support

The adult poverty in urban areas, e.g. homeless people, is taken care of by the Social Welfare Section of the Vientiane City. Meanwhile, the MLSW plans to discuss the measures to eliminate homeless people with the Vientiane City for the ASEAM Summit to be held in Vientiane in the end of 2012. In this regard, MLSW and Vientiane city plans to provide a joint support to the homeless people, Given the total budget amount of the Vientiane City is only 1 billion LAK (equivalent to 10 million Yen), supports to the people in this group would be difficult.

6.4.3. Retired soldiers and war victim support

The current supports by the government for 4,282 war victims include the provision of state-owned residence and residential land, the construction of villages for those who has not house, and the establishment of centers for PWDs (due to war) throughout the country. These initiatives are prescribed in the Decree of the Prime Minister No. 343/2007 [41].

[40] *Ibid*.
[41] *Ibid*, p.9

7. Care and Welfare for the Elderly

7.1. Policy initiatives and framework for the elderly

There are few initiatives by the government for care and welfare for the elderly, and elderly care is left to each household. The elderly population (over 60-years) in Laos is currently 400,000 (7% of the total population) and is estimated to increase to 600,000 through 2020[42]. Under the Decree of the Prime Minister No. 18 published in June 1995, the National Committee for the elderly was organized to support the elderly under the Decree. The Decree of the Prime Minister No. 156/2004 also states the national policies for the elderly.

7.2. State of elderly facilities and services

According to the household survey in urban areas, 49% of the elderly are supported by their children or relatives, 5.2% by the community and 2.2% by international organizations or NGOs, while 42% of the elderly answered they have no support. In rural areas most of the elderly are supported by families or relatives[43].

7.3. Issues for future of elderly people

The major concern is the poverty of the elderly in urban areas. They have no physical and financial support from their families. Experience and information in elderly support are also insufficient.

7.4. State of international cooperation

International cooperation in the elderly support sector includes those from the APEC, the UNFPA and South Korea. A pilot project for home care is in place[44].

[42] *Ibid.*
[43] *Ibid.*
[44] *Ibid*, p.10

8. Issues Facing Social Security in Laos

8.1. Issues facing the health security system

8.1.1. Financing support

The financial resources in the health sector are largely dependent on international donors. According to the estimate by the WHO and the ILO, the expenditure amount per capita in the health security system in Laos is approximately USD11 (for the poverty, USD5), consisting of 60% of out-of-pocket, 30% of donors and 10% of the government (from tax revenues)[45]. One of the main purposes of the social security system would reallocate the wealth of a county to people. From a perspective of sustainability, the social security system dependending on external financial supports would not last even in a short term. Despites the government's commitments to the HEF and the CBHI, stable dissemination and expansion of the system would not be expected, unless sustainable financial resources are secured.

8.1.2. Modernization of administrations

The major issue in the CBHI is delayed payments of the contribution. Some households have not paid the contribution in two months where a notice will be sent[46]. The following table shows the ratio of delayed payments of the contribution to the CBHI in some pilot villages (data of 2007)[47].

Village	Ratio of delayed payments (%)
Sisathanak	69
Nambak	28
Champasak	82
Hatxayphong	65
Viengkham	46

Another issue for the CBHI is over-prescribing of drugs. At average 4 to 5 drugs are supplied to one prescription, and the drug cost amounts for over 30% of the total cost of hospitals. Especially, antibiotics, Diclofenac, Valium and vitamins tend to be over-prescribing. This is partly due to "under the table" by health professionals[48].

8.1.3. Promotion of health and insurance education

In rural areas, education and dissemination initiatives on utilization of the health system are also major challenges. Most people in rural areas having few health care resources tend

[45] Howell and Ron(2008)Developing Social Protection in Lao PDR, ILO&WHO http://www.google.co.jp/url?sa=t&rct=j&q=fiona%20howell%20aviva%20ron&source=web&cd=1&ved=0CDEQFjAA&url=http%3A%2F%2Fwww.ilo.org%2Fgimi%2Fgess%2FRessFileDownload.do%3FressourceId%3D3557&ei=rvBzT-SsI4bKmQWa4sT5Bw&usg=AFQjCNGeECO6b14_0TAN8jdnU13XOlUtPA

[46] Howell and Aviva (2008) p.22 and the interview to the MOH.

[47] Howell and Aviva (2008) p.22

[48] Howell and Aviva (2008) p.24

not to be familiar with the heath care service system under the CBHI and the HEF, as a result which some suffer serious conditions unintentionally[49]. In addition, people tend to hesitate to pay future expenses in advance, especially in rural areas where the money economy is not fully working, whereby the system is not disseminated.

It is thus important to carefully educate people on how to utilize the health care services and the significance of social insurances.

8.2. Issues facing the pension and other income security scheme

8.2.1. Lower coverage and establishment of the social security system for the informal sector

The major issue in the employee social security system is lower coverage in the private formal sector and the informal sector, except for government officers covered by CSS and private sector employees covered by the SSS. In Laos, while most of the working population is farmer and the self-employed, there is little social security system for these people in the informal sector. Most of the nation is out of the current public social security system. Future challenge would be the establishment of the social security system for the informal sector, the encouragement of enrollments to it and the collection of the contribution.

8.2.2. Lack of target setting and database system

As described in 6.1., in Laos, data obtained from public surveys to identify the poverty is not complied nor effectively used for set the target beneficiaries of the CBHI and the HEF.

The SSO has established the database of the insured, which covers only part of the working population due to its lower coverage. It would be required to establish the database to extend the social security system to SMEs and the informal sector.

[49] Based on the interview to the ADB (Laos Office).

9. Issues Facing Social Security in Laos and Cooperation by Japan

9.1. Assistance for quantity and quality for the medical services

In Laos, integration of CSS and SSS by 2013 and integration of CBHI and HEF will be implemented toward Universal coverage (hereafter UC) by 2020 (though the HEF and CBHI have already been operated as one scheme in some region). However as mentioned above, it might be premature to promote UC under the situation where each scheme covers only few percent of the target population.

In recent years, the number of the urban high-income class has been increased according to the rapid economic growth in Laos and the wealthy prefer to the Thai medical service not Lao service. The number of private health insurance subscribers has also increased following to the demand above.

Rather to promote UC scheme (of course it is surely important), it would be much important to improve the quality and quantity of medical services (increase of the number of doctors, nurses, beds and so forth) first in Laos and it is also crucial for us to continue to support for expanding and enhancement of medical insurance system- in order to establish the sound system in Laos. As a result, Lao medical system would be attractive enough for the wealthy and it would contribute to the increase of the coverage rate of each scheme. JICA has already been conducting a number of technical assistance in health sector in Laos, and there are several projects implemented [50].Is also expected to inhibit the cross-border medical visitors to Thailand by middle and high income class by promoting stead support for the establish sound medical system [51].

On the other hand, from the point of social and income security, there are not necessary for JICA to providing assistance in this field of labor and employment, since ILO decided to support for integration of SASS and CSS.

Also, the issues for assistance to the elderly have not been in the stage of discussion.

[50] For example, Senior Nurse and and Midwife Training Project, (November 2008 - November 2012) , Strengthening Capacity Development Project for Project Management in Health Sector Phase 2 (December 2010 to December 2015),Strengthening Integral Service for Maternal and Child Health Project (May 2010- May 2015), and Maternal and Child Health Care Human Resource Development Project (February 2012 to February 2016).

[51] On the other hand, some experts from Thailand suggested that JICA can support a Triangular Cooperation among Laos, Thailand and Japan through the medical training course that Thai hospital accepts the Lao doctors and nurses and provide Thai medical skill training. Lao doctors and nurses can easily visit Thai hospital when it locates opposite to the Mekong river, even they do not need to overstay in Thailand Japan can provide the cost of the training expences.

Chapter IV Malaysia

1. Social Security Overview

1.1. **Social security in the constitution**

The Constitution of Malaysia enshrines the basic rights and obligations of the people, including religious freedom, civic rights, and physical freedom. However, it does not contain specific provisions concerning social security.

1.2. **Current state and basic direction of government policy for social security**

The Malaysian government is known for its negative attitude regarding the term "social safety net" as a form of social protection.[1] The consistent idea behind the economic policy and social policy of Malaysia is that the greatest social security is provided by the expansion of employment opportunities through the expansion of the economy, not through passive forms such as a social safety net. Therefore, an important policy issue concerning social security expenditure is how to finance social security expenses through economic growth. Thus, their policy is unique in that it does not aim at a mere increase in social security expenditure.

1.3. **Outline of the social security system**

1.3.1. Health security

In Malaysia, health care services are provided through a tax-based system, and there is no public health security system operated by social insurance scheme. . Therefore, there is no specifically named social security scheme.

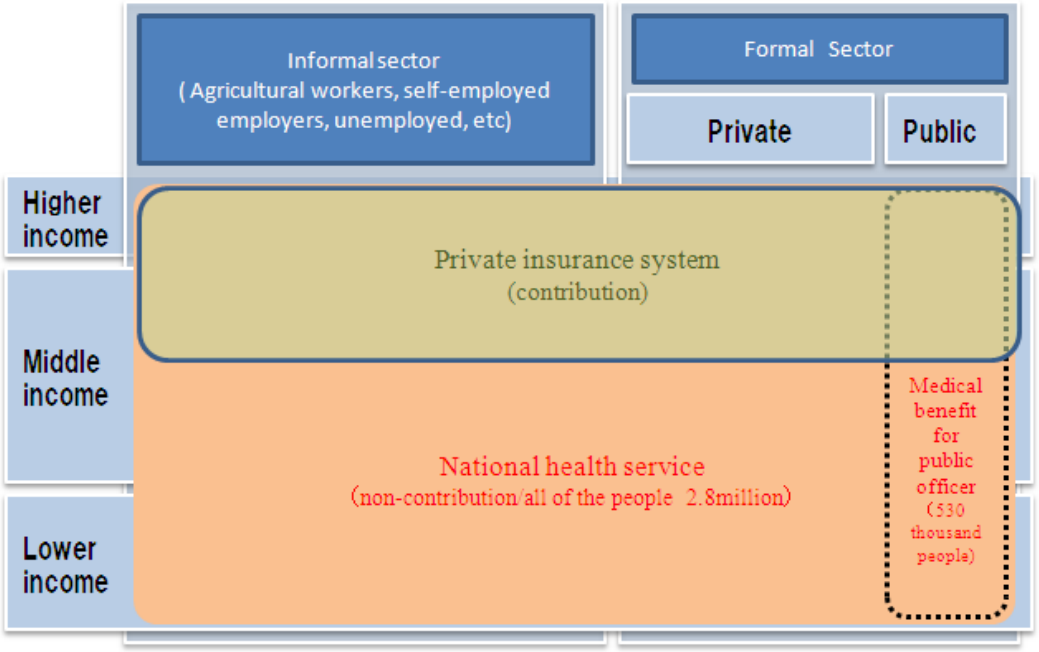
While health care services are available extremely-limited own expenses, private health insurance systems play an important role, as they are often used by the wealthy classes (including some types of government officers) that can afford them. At present, the government is considering the creation of a national health insurance scheme based on a social insurance system, and careful discussion is underway, taking into account the potential significant impacts that such a scheme may have on the private health insurance market and the operation of private medical institutions.

Even in basically the free health care services, patients need to pay for some medical practice and must shoulder a heavy cost burden. . In this regard, the free services are virtually not free. On the other hand, there exists a gap between the above-described system and that for government officers, because health security system for government officers covers the expenses of medical practice that is not covered by public medical services. This indicates that, although a health security system with universal coverage is formally in place,

[1] According to an interview with the Ministry of Finance

there are many issues that need to be improved.

Figures IV-1Outline of the health security system in Malaysia



Source: Compiled by Mitsubishi UFJ Research and Consulting

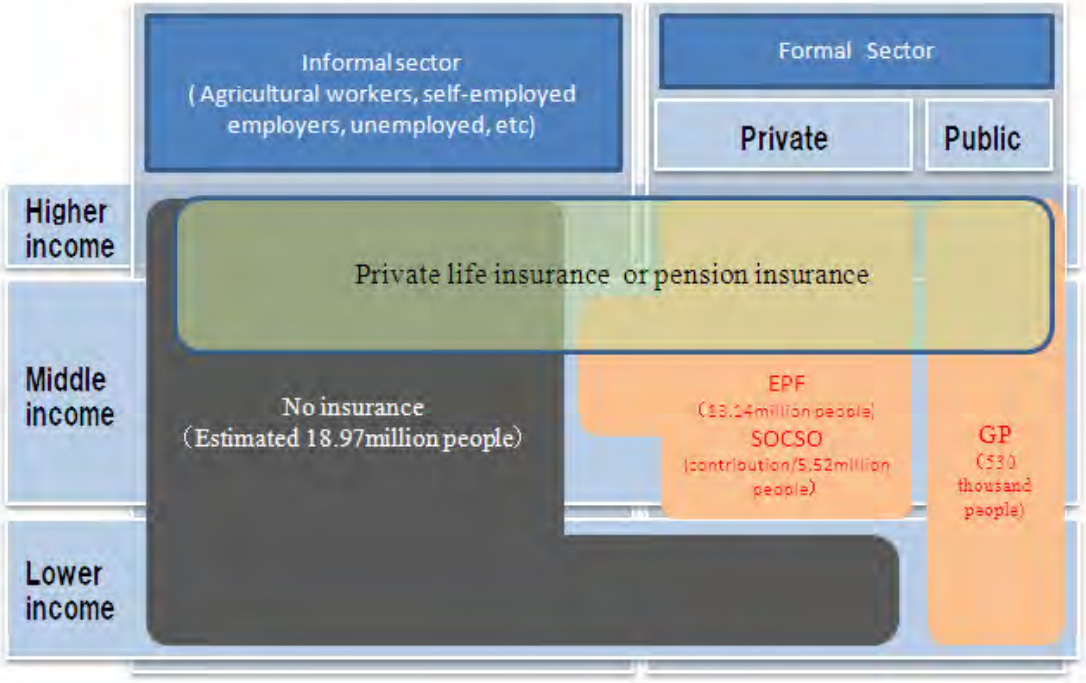
1.3.2. Pension and other income security schemes

The income security system consists of the GPF (operated by the JPA), which is a social security scheme for government officers, and the EPF and SOCSO, which is for the employees of private companies.

The EPF is a compulsory funding scheme in which employees and employers contribute a prescribed portion of wages and in which employees receive benefits when retiring. Employees can also draw on some funds when they buy houses or receive health care, or when their children go on to higher education, etc.

SOCSO mainly pays for the workers' compensation pension for bereaved families, disability pension, and education loan benefits, etc. Malaysia does not have an unemployment insurance scheme.

Figures IV-2 Outline of pension and other income security schemes in Malaysia



※1:Overlapped members are included.
※2:According to “SOCSO annual report ”, The number of registered employees is approximately 13.83 million. it is the number of the workers registered with SOCSO from the beginning.
Source: Compiled by Mitsubishi UFJ Research and Consulting

2. Organizations Involved in Social Security

The responsibilities for social security policy are divided among the Ministry of Health (health security and public health measures), the Ministry of Women, Family & Community Development (social welfare measures), Jabatan Perkhidmatan Awam Malaysia (Public Services Department) (pension benefits for government officers), and statutory authorities, etc.

2.1. **Ministry of Health (MOH)**

The MOH is also referred to as "Kementerian Kesihantan Malaysia" (KKM) in Malaysian. The MOH is responsible for the planning and development of health security strategies, the implementation of policy measures, and the operation of the service delivery system. The tax-based medical service is provided by public medical institution and they are under the jurisdiction of MOH. Its objectives are to maintain the good health of the people and to realize and maintain a productive economy and social system by promoting effective, efficient, and appropriate services and by providing preventive measures, health care, and rehabilitation services.

2.2. **Ministry of Women, Family & Community Development**

This ministry is responsible for the planning and development of social welfare measures for low-income people, the elderly, children, and women, etc.

It was established following the Fourth World Conference on Women held in Beijing in 1995 as the platform for the protection of women's rights and the improvement of their status. It was launched in January 2001 as the "Ministry of Women Affairs."

As its roles and functions expanded, it changed its name to the "Ministry of Women and Family Development" (KPWK) in February 2001. Under the KPWK, the Department of Women Affairs (HAWA) and the National Population and Family Development Board (LPPKN) were established.[2]

After the general election in 2004, the role of the ministry was expanded, and its name was changed to the current name. Following several rounds of reorganization, four departments are now placed under the ministry: the Department for Women Development (JPW), the Social Welfare Department of Malaysia (JKMM), the National Population and Family Development Board (LPPKN), and the Social Institute of Malaysia (ISM).

With the aim of achieving the national objectives known collectively as "Wawasan 2020,"[3] the ministry is working to promote social welfare and realize a caring and developed society.

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[2] HAWA was reorganized into the current Department for Women Development (JPW) after several rounds of restructuring.

[3] "Vision 2020": This is an initiative proposed by former Prime Minister Mahathir in 1991 aiming to join advanced countries by the year 2020.

2.3. Public Service Department of Malaysia (Jabatan Perkhidmatan Awam Malaysia [JPA])[4]

The JPA is responsible for health security and the pension scheme for government officers.

In order to improve organizations and promote the development and management of human resources in public services, the JPA aims to: (1) engage in human resource management in the public service sector and in advisory services for government agencies, (2) restructure or enhance the organization and develop high-quality, competent, and innovative personnel, (3) manage labor management relations to realize harmonious workplace environments, and (4) improve the system and work processes through the use of ICT.

There are three pillars of its function: planning, development, and management. In the planning aspects, the JPA: determines the roles of the public sector, studies the size and structure of public institutions, studies the pension scheme, etc., for government officers, defines the roles of the private sector and the public sector, and constructs strategic networks, etc. The development function includes the formulation of organizational development policy, the provision of career paths, and the determination of training policy, etc. The management function involves: the appointment and assignment of personnel; the management of remuneration, promotion, retirement benefits, work conditions, labor management relations, education, and the human resource database; the evaluation of the target achievement level; and monitoring activities.

2.4. Ministry of Human Resources (MOHR)[5]

The MOHR has jurisdiction over labor administration. With the objective of developing productive, useful, disciplined, caring, and adaptable human resources, it strives to achieve and maintain a harmonious environment in industry by settling labor disputes between employees and the management and by helping negotiate labor agreements. MOHR is also responsible for securing health & safety and improving the ability of workers.

The introduction of an unemployment insurance scheme is being discussed under the purview of the MOHR.

2.5. Employee Provident Fund (EPF)

This is known as “Kumpulan Wang Simpanan Pekerja” (KWSP) in Malaysian. Established in 1951, the EPF has been operating a retirement benefit scheme under the EPF (Preliminary) Rules 1969 and now under the Employees Provident Fund Act 1991 (Act 452) (EPF Act 1991).

This scheme of the EPF is a compulsory funding scheme in which employees and employers contribute a prescribed portion of wages and in which employees receive benefits

[4] http://www.jpa.gov.my/index.php?option=com_content&view=article&id=246&Itemid=26&lang=en
[5] http://www.mohr.gov.my/index.php?option=com_content&view=article&id=699&Itemid=420&lang=en

when retiring. The EPF falls under the Ministry of Finance.

2.6. **Social Security Organisation (SOCSO)**

This is referred to as "Pertubuhan Keselamatan Sosial" (PERKESO) in Malaysian. SOCSO is in charge of a social insurance scheme in the private sector covering workers' compensation, disability, and bereaved families. This system provides social security by providing health care services, adaptive equipment, and cash benefits, etc., in the event that a work-related accident occurs or if an employee becomes disabled, thereby reducing the burden and anxiety of the employee and their family. SOCSO was established under the Employees' Social Security Act 1969 and the Employees' Social Security (General) Regulations 1971 as a subsidiary organization of the MOHR.

2.7. **National Insurance Association of Malaysia (NIAM)**[6]

This is referred to as "Persatuan Insurance Kebangsaan Malaysia" in Malaysian. NIAM was established as an industry organization in 1973 under the Societies Act 1966.
At present, it has 34 members, including 14 general insurance companies, four multiple-line insurance companies, five life insurance companies, seven Takaful companies,[7] and four reinsurance companies. The objectives of the association are the furtherance and protection of the profits of its members, the promotion of its collaborative activities, and the enactment of laws and regulations, etc. NIAM is different from LIAM, which described below, in that its members are composed of locally based companies (including foreign-affiliated joint venture companies).

2.8. **Life Insurance Association of Malayisa (LIAM)**[8]

This is referred to as "Persatuan Insurans Hayat Malaysia" in Malaysian. LIAM was established as an industry organization with the objectives of: raising people's awareness regarding life insurance, promoting various awareness-raising and educational activities, making suggestions to the policy section for the sound development of industry, and establishing internal control regulations, etc. At present, 17 life insurance companies including foreign-affiliated companies are members of this association.

2.9. **Administrative system of Malaysia**[9]

The administrative division system of the Federation of Malaysia is defined in the supreme law of the Federal Constitution. At the first level, the federation is divided into 11 states in Malay Peninsula, two states in North Borneo (Sabah and Sarawak), and three

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[6] http://www.niam.org.my/niam.html
[7] "Takaful" is an insurance system based on the teachings of Islam. It is established under the rules prescribed by the Bank of Negara (the central bank). No incentive is provided by the government. Takaful is often provided for by JVs with foreign companies. All Takaful companies except for the 1–2 locally based companies consist of joint ventures with foreign companies.
[8] http://www.liam.org.my/index.php?option=com_content&view=article&id=54&Itemid=84
[9] *Local Autonomy in Malaysia*, (Japanese) Council of Local Authorities for International Relations (Singapore

federal territories (Kuala Lumpur, Labuan, and Putrajaya). At the second level, these 13 states and three territories are further divided into 137 administrative districts.

Each state of Malaysia has a different history—some were independent kingdoms and others were British Crown colonies. Today, differences remain among the state in terms of the head of the state, legislative authority, and the administrative system used.

The heads of nine states out of 11 states in the Malay Peninsula are the hereditary rulers of Islamic countries and are referred to as "sultans," and those of other four states are referred to as governors appointed by the king. Each state has nation-like status with its own constitution. The head of the nation, the king, is elected to a five-year term by and from among the nine states headed by the sultans.

In 11 states in the Malay Peninsula, the federal government has strong power over the state governments, while Sabah and Sarawak are granted different authorities from other states based on the agreement reached when Malaysia was formed. In the federal territories, the Ministry of Federal Territory of the federal government was established, and administrative services are provided by independent local autonomous governments and public corporations.

Office)

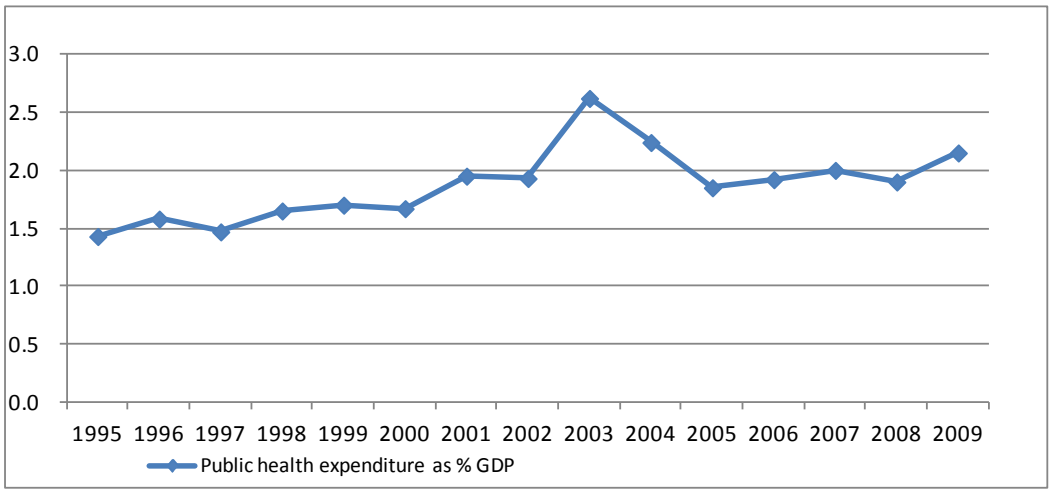
3. Social Security Expenditure

3.1. **Health Expenditure**

The percentage of the public health expenditure shows the rate of increase of around 6 percent annually. This trend is expected to continue in the future. The ratio to GDP has been around 2%level..

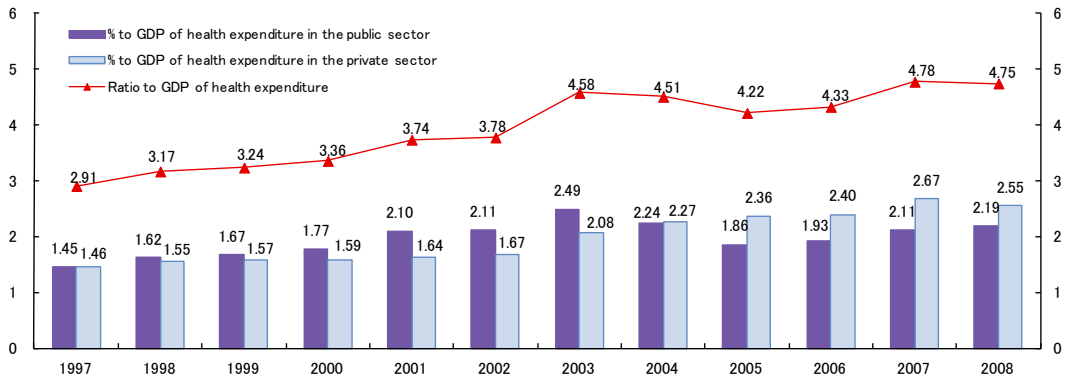
The ratio to GDP of health expenditure in the public and private sectors had been nearly the same until 1997, and since then the ratio had been slightly higher in the public sector than in the private sector until 2003. After this tendency was reversed in 2004, more expenditure has been used in the private sector than in the public sector.

Figures IV-3 Public health expenditure as % GDP



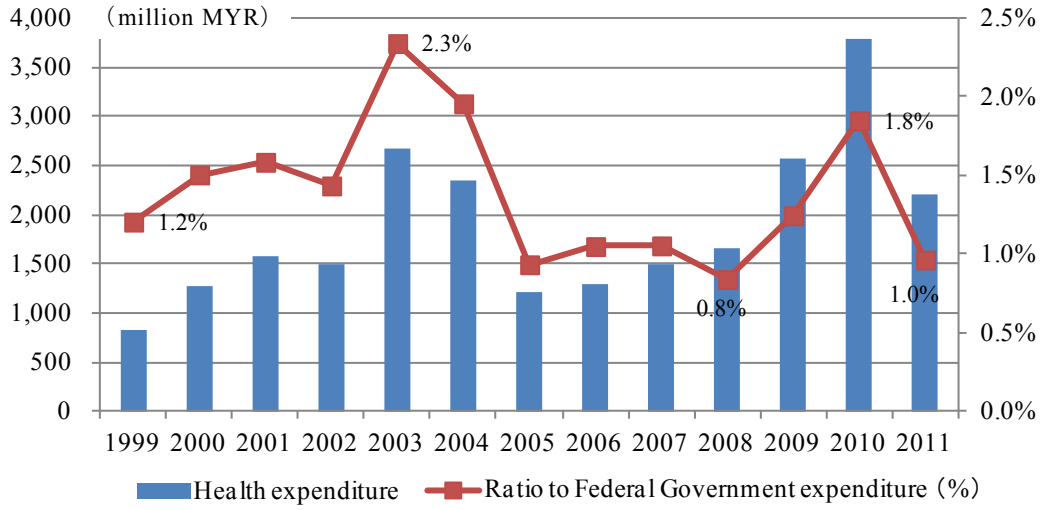
Source: Institutionalization of national health accounts in Malaysia (Oct. 2010)

Figures IV-4 Ratio to GDP of health expenditure in the public/private sector



Source: Institutionalization of national health accounts in Malaysia (Oct. 2010)

Figures IV-5 Ratio of health expenditure to Federal government expenditure



Source: Compiled based on the data of the MOF; the figures for 2012 are based on budget appropriation.

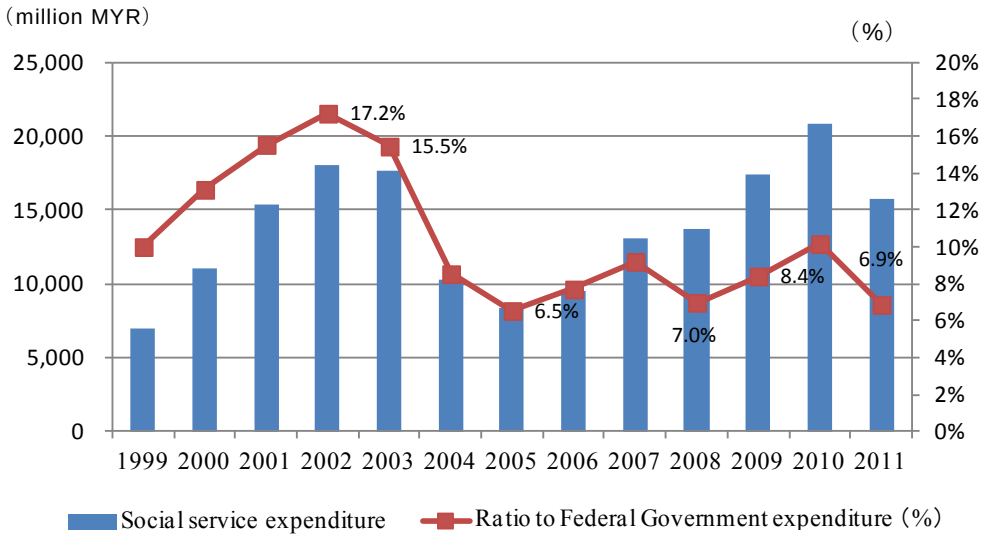
3.2. **Social welfare expenditure**

Figure 6 is the graph showing the percentage of social services expenditure for the federal budget. Social services include health, education and training, housing and others. With respect to its share in federal government budget in the first half of 2000, social services accounted for 15-16% of government budget, but since 2004 its share has declined to around 10%. This is because Prime Minister Abdullah appointed in October 2003 is concerned about the budget deficit, decided to cut the development budget, including the social sector.

However, the development budget has been increased again after the 9th Malaysia Five Year Plan (MP9: 2006 to 2010) was adopted. Social service expenditures in terms of monetary amount has increased five consecutive years since 2006, exceeded 200 billion MYR in 2010.

As the economy has recovered after 2011, the amount of social service expenditures has decreased.

Figures IV-6 Ratio of social service expenditure to Federal government expenditure



Source: Compiled based on the data of MOF; the figures for 2012 are based on budget appropriation.

4. Health Security

In Malaysia, where health care services are provided by public medical institutions almost free of charge, universal coverage has been formally realized. In reality, however, people in the middle and upper classes purchase private health insurance and receive health care services of higher quality—a situation which is causing health disparities. The government is also aware of the limits of providing services by the tax-based system modeled on U.K.'s NHS (National Health Service) and is now seeking a shift to a social insurance system.

4.1. **National plans for the health security sector**

As a national plan for the health security sector, Malaysia develops a "Country Health Plan" every five years. Currently, the *10th MALAYSIA Health Plan* (10MP) is in effect. Malaysia also set forth "Vision 2020" as a key policy, under which the country sets the target to become an advanced country by 2020 and is now working on the improvement of the health security system to meet the standard of advanced countries, all under the slogan of "1 Care for 1 Malaysia."

Figures IV-7 Key policies of the *10th MALAYSIA Health Plan (2011–2015)* by the Ministry of Health

【The main key result area by MOH】 (1) health sector transformation towards a more efficient& effective health system in ensuring universal access to healthcare (2) Health awareness & healthy lifestyle (3)Empowerment of individual and community to be responsible for their health
【Strategy】 Strategy (1)Establish comprehensive healthcare system and recreational infrastructure Strategy (2)Encourage health awareness & healthy lifestyle activities Strategy(3)Empower the community to plan or implement individual wellness programme (responsible for own health) Strategy(4)Transform the health sector to increase the efficiency and effectiveness of the delivery system to ensure universal access

Source: Compiled based on *Country health plan 10th Malaysia Plan* by the Ministry of Health Malaysia

4.2. **Salient features of health care delivery systems**

4.2.1. Salient features

The health care system of Malaysia is based on the NHS of the former colonial power of the U.K., under which all public medical institutions provide health care almost free of charge. In principle, there is reference system.

In general, most people only visit public medical institutions for cost reasons. At such public medical institutions, many people must wait to see a doctor, and the quality of health care is considered to be low. Private medical institutions provide relatively higher-quality

health care and have less patients waiting. However, those who use the services of private medical institutions have to pay all the expenses or must purchase private health insurance. Therefore private medical institutions are used only by the middle- and higher-income classes that can afford to pay the cost of health care services or purchase private health insurance, while most people visit public medical institutions.

Medical institutions in Malaysia include public medical institutions and private or NGO-operated medical institutions. While there is a nationwide network of public medical institutions operated by the MOH, private hospitals also assume an important role in delivering health care mainly in urban areas.

Figures IV-8 Medical institutions in Malaysia [10]

		Government	Private
Hospitals		131	217
	Number of beds	33,211	13,186
Clinics [11]		2,833	6,442
Placement ratio of doctors		Approximately 50%	Approximately 50%
The ratio of patients		Approximately 75%	Approximately 15%

* The ratio of patients shown is the ratio to the entire population, as based on an interview with a person in charge at the MOH. It is estimated that the remaining 10% of patients is treated by traditional medicine rather than medical institutions.

Figures IV-9 Public medical institutions in Malaysia

Medical institutions		Number	Number of beds (official)
Under MOH			
	Hospitals	131	33,211
	Special Medical institutions	6	4,582
	Special institutions[*1]	15	-
	National institutions of health	6	-
	Dental Clinics[*2]	34	341
	Mobile Dental Clinics[*2]	25	42
	Health Clinics[*3]	2,833	-
	Health Clinics (1 Malaysia)	53	-
	Mobile health Clinics& Teams	165	-
	Mobile health Clinics& Teams (1 Malaysia)	3	-
	Flying Doctor stations	13	-
Not under MOH			
	Hospitals	8	3,690

[*1] One national blood center, four public health research institutes and 10 food quality research institutes
[*2] The number of beds is the number of dental chairs.
[*3] Including community clinics/Klinic Desa, mental clinics, and maternal & child health clinics
Source: Compiled based on Health Facts 2010 by the Ministry of Health Malaysia

In total across the country, there are 131 hospitals with 33,211 beds under the jurisdiction of the MOH, eight government-affiliated hospitals with 3,690 beds outside the jurisdiction of

[10] Compiled based on *Health Facts Malaysia 2010* (MOH)
11 Including community clinics/Klinik Desa and maternal & child health clinics; according to a person in charge at the MOH, there are about 800 medical

the MOH, and 217 private hospitals with 13,186 beds (as of 2010).

As for the institutions providing basic outpatient care and public health services, the MOH operates community clinics/Klinik Desa (which provide maternal and child health services, treatment for minor injuries, and first aid in the community), maternal & child health clinics (specialized in maternal and child health services), mobile clinics, and health clinics (which provide a wide range of health services to local residents in wider areas).

Figures IV-10 Private medical institutions in Malaysia

Facilities		Number	Number of beds (official)
Licensed			
	Hospitals	217	13,186
	Maternity Homes	22	97
	Nursing Homes	12	263
	Hospice	3	30
	Ambulatory Care Centre	36	125
	Blood Bank[*1]	5	-
	Hemodialysis Centre[*2]	191	2,195
	Community Mental Health Centre	1	9
Registered			
	Medical clinics	6,442	-
	Dental clinics	1,512	-

[*1] Four cord blood stem cell banks, one stem cell bank, and one regenerative medicine research center
[*2] The number of beds is the number of dialysis chairs.
Source: Compiled based on Health Facts 2010 by the Ministry of Health Malaysia

Figures IV-11 Number of inpatients and outpatients

Type of medical institution			Admissions	Outpatient attendances
Government	Under MOH			
		Hospitals	2,121,923	17,550,603
		Special Medical Institutions	8,640	102,944
		Public Health Facilities	_	27041,812
	Not under MOH		132,010	2,070,036
Private [12]			869,833	3,174,124

Source: Compiled based on *Health Facts 2010* by the Ministry of Health Malaysia.

4.3. **Basic structure of the health security system**

Figures IV-12 Basic structure of the health care system in Malaysia

	Public healthcare service	**Medical benefits of GP**	**Private insurance**
Started	--	1980	--
Basis laws	--	Pension Act 1980	--
Competent authority	MOH	JPA	Central Bank of Malaysia、MOH
Administration organization	MOH	JPA	Private insurance companies

clinics.

[12] Based on the result of a survey conducted with private health organizations and facilities (response rate: 98.44%)

Scheme	Non-contribution scheme	Contribution scheme	Contribution scheme
Target group	All the people	Public officers and their families	Voluntary （Upper and middle income group）
Apply to Dependents (family members)	Yes	Yes	Based on a contract
The number of the members	Approximately 28 million	Approximately 530 thousand	Estimates approximately 8.4million （30％of the population）
Referral system	Yes	N.A.	None
Out of pocket	・Outpatients pay about 1 MYR per visit ・Inpatients pay almost free of charge .	・ benefits are paid for treatment of specific diseases in private hospital which is not treated in public hospital,	・Patients cover all expenses. ・ Some private companies purchase insurance program for companies as a welfare program for employee
Annual medical expenditure 13	13,546 million MYR (Public expenditure on health,2007）	--	16,682 million MYR （ Private expenditure on health,2007）
Requirement to receive benefit and medical practice to be excluded	・To receive benefit the insured has to be treated in public hospitals. ・The expensed for purchasing specific medical equipment is not covered.	・ This covers the expenses for medical equipment and extra bed charge that is not covered by public healthcare service.	・Depends on the contract with insurance company. ・Extra charge for high cost medical services that exceeds the limit of benefit is not covered, because there is limit in total amount of insurance benefit in lifetime.
Others	--	--	.Regarding private health insurance plan, there is the regulation of MOH and the Central Bank that individuals can receive tax deduction when they take out insurance.

Note 1:
Annual medical expenditure: MOH “Country Health Plan 10th Malaysia Plan 2011–2015”
Source: Compiled by Mitsubishi UFJ Research and Consulting based on an interview with the persons concerned, etc.

4.4. **Public health security (non-contributory health security)**

In Malaysia, primary care services are provided by public medicals institution for little or no charge, and thus a health security system with universal coverage is formally in place. This system is a tax-based non-contributory system funded by taxes under which 98% of total medical costs of public medical institutions are covered by public funds. Usually, patients pay approximately 1MYR per visit for primary care. As for secondary and higher lever care, too, basically free services are the standard for the most part, and patients need to pay only for specific types of health care services.

However, due to long wait times and the low level of public health care services, people in the middle and upper classes purchase private health insurance and, as a result, health disparities do exist. In order to improve the current situation, the government is looking to

[13] MOH’s *Country Health Plan 10th Malaysia Plan 2011–2015*

improve the service quality of public medical institutions. At the same time, the government is aware of the limits of non-contributory health security systems from a sustainability perspective, and the MOH is now seeking a shift from a tax-based health care delivery system to a social insurance system.

4.5. **Medical benefit of the government officers pension scheme**

Government officers can receive specific types of medical care also for free, as part of the medical benefit under the government pension scheme. In addition, they can receive medical care that is not available at public medical institutions but that is available only at private medical institutions if they have a letter of reference or a prescription issued by a government medical officer. Details of this system are described below in "5. Employee Income Security (1) Government Pension (GP)."

4.6. **Private health insurance**

4.6.1. Attitudes toward private health insurance

In Malaysia, private insurance products are purchased mainly by middle- and higher-income people, it is estimated that the number of enrollment account for approximately 30% of the total population.[14] Some purchase a medical insurance policy only, while many of them purchase health insurance as a supplement to their life insurance policy. In general, companies above a certain size tend to provide coverage to employees as part of their welfare program. In this case, however, it is difficult for employees to keep the same coverage option of insurance for corporation when they retire.. So, employees purchase insurance products on an individual basis before retirement in order to prepare for life after retirement.

In addition, a fairly large number of government officers also take out private health insurance since they can chose insurance coverage option based on their individual circumstances..

On the other hand, a certain group of people do not see much need for private health insurance. Even without health insurance, the medical costs charged by private medical institutions are only 40–50MYR per visit or 70–100MYR in urban areas. Therefore, some middle-income people are skeptical about the benefit of paying for private insurance.

4.6.2. Procedure for private health insurance

When a patient presents the insurance card for private health insurance, the "Medical Card," to a medical institution, a health insurance benefit is paid according to the coverage of the insurance product that the patient is receiving. When a patient not holding any private

[14] This figure is not the actual number of the insured persons but the number of policyholders of private insurance companies including both health and life insurance. Considering that many people take out more than one insurance policy, the accurate number of the insured is unknown.

health insurance is hospitalized in a private medical institution, the patient usually needs to deposit about 3,000MYR prior to hospitalization. This deposit is not necessary if the patient presents the Medical Card to the medical institution. The costs of medical care are paid by the insurance company to the extent covered by the insurance package.

In Malaysia, where private health insurance is frequently used, it is important to be able to confirm quickly that the patient is covered by private health insurance in promoting the sale of insurance products. Therefore, Managed Care Organizations (MCOs) are established as organizations that confirm the validity, etc., of the Medical Card. MCOs are financed jointly by insurance companies, each of which provides data to an MCO on those insured, including their name, the insured number, the validity of the Medical Card, and the type of insurance coverage held. When an insured person visits a medical institution, the medical institution confirms the validity of the Medical Card via an MCO portal site.

Presently, there are more than 10 MCOs in Malaysia (including three major companies). In some cases, major insurance companies such as ING operate MCOs for themselves.

Figures IV-13 Major insurance-related associations in Malaysia

Name of association	Missions	Number of members
National Insurance Association of Malaysia (NIAM)	・To promote and safeguard the interests of members in all their activities. ・To promote or undertake any project which will enhance or contribute to the standing and reputation of its members in society ・ To secure and support the promotion of Bills in Parliament which will protect the interests of or be advantageous to its members	34 companies Comprising 14 general insurance companies, 4 composite insurance companies, 5 life companies, 7 takaful operators and 4 reinsurers.
Life Insurance Association of Malaysia (LIAM)	・To promote public understanding and appreciation for life insurance ・To enhanc e the professionalism of staff and agents through continuous training and education ・To formulate rules and guidelines to instill good business practice ・To improve the image of the life insurance industry through self-regulation.	17 life insurance companies (Include foreign companies)

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the websites of NIAM and LIAM.

4.6.3. Market outlook for the future

The private insurance market in Malaysia is still in the development stage. Although health insurance is widely known by the citizenry, the necessity of such insurance is not fully recognized. This seems to be because, while public health security services form the important basis of health care services in Malaysia and are trusted by the users, to some extent, the fact that it is difficult to receive advanced care only by using the public health

care services has not been widely recognized [15].

In addition, the insured persons under private health insurance that are registered through a corporate contract do not fully understand that they have to surrender their insurance policy under a corporate contract after retirement and that it is difficult to take out a health insurance policy on an individual basis. [16] In particular, the younger generations tend to have a weak sense of crisis regarding the preparation for life after retirement.

[15] According to an interview with NIAM.
[16] Therefore, a large number of employees who are insured under a corporate contract also take out insurance on an individual basis.

5. Pension and other income security schemes

5.1. **Government Pension (GP)**

Figures IV-14 Types and summaries of pension and other income security schemes

System	GP	SOCSO	EPF
Target	government officer	Employees for Private companies	Employees for Private companies
			Informal sectors （voluntary）
Benefit scheme	Gratuity, pension, medical benefit, derivative benefit etc.for government officers	Employment Injury Scheme/ Invalidity Pension Scheme	Saving for the aged, withdrawals for the purpose of medical treatment, disability, housing, education , etc.
Administration organization	JPA	SOCSO	EPF

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the materials provided by JPA, EPF and SOCSO.

5.1.1. Legal basis

From the viewpoint of securing capable human resources, the Government Pension scheme has been administrated by the JPA under the Pension Act 1980, etc. The pension scheme was revised under Act 662 (Retirement Fund ACT 2007) and Act 238 (Pension Adjustment Act 1980).

5.1.2. Benefit packages

In the case of the death on duty or after retirement, this system provides the lump-sum distribution or monthly allowance, And, this system also provides the cash benefit according to the number of non-excercised paid vacation days. In addition, when a person entitled to receive pension dies, this system provides pension for the widow and the unmarried children under the age of 21..

The medical benefits of this scheme are available not only to government officers but also to their spouses and unmarried children (up to 21 years of age), who can receive the most health care services free of charge. The medical benefit is provided even after the government officers retire from service. As for the officers themselves, the medical benefit covers expensive care for specific diseases. Starting from May 2011, government officers

who chose to join the EPF are also entitled to a similar medical benefit. [17]

5.1.3. Eligibility for enrollment

Government officers are eligible for the government pension, including teachers, judges, federal officers, state government officers, railway officers, and police officers, etc.

Military personnel, who are eligible for another pension scheme, are treated as government officers and join GP when they are promoted to captain or higher. When they become treated as government officers, pension portability is allowed and they can carry over the contributions that they have paid.

Among those eligible for GP, the government officers, etc., employed after the revision of the act in 1991 and 1992 (Act A793 and Act A823) can choose either the EPF or the pension scheme for the public sector as a result of the revision (Section 6A). However, the pension scheme for the public sector is definitely more favorable than the pension provided by the EPF, and therefore only a few officers are actually expected to choose the EPF. [18]

5.1.4. Contribution rates

The public institutions that employ the beneficiaries contribute 17.5% of their salaries (Section 12 B).

5.1.5. Funds and operational bodies

GP is operated by the JPA and funded by the federal government (appropriated from the national budget, including taxes). The retirement benefit is to be ultimately taken over by the retirement allowance fund.

Figures IV-15 Breakdown of pension enrollment and beneficiaries (as of February 2012)

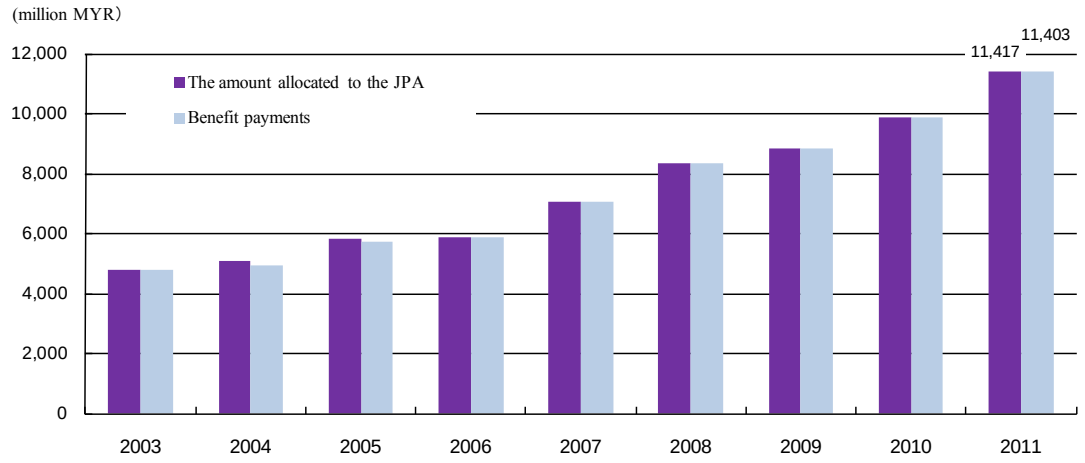
Category of pensioner and pension recipients	Total pensioner and Pension recipients
Federal public service	343,561
State public service	68,386
Statutory authority	87,886
Local authority	27,726
Members of parliament & Members of federal administration	1,038
Political secretaries	130
Judges	90
Total	528,817

Source: Compiled by Mitsubishi UFJ Research and Consulting based on the materials provided by JPA

Figures IV-16 Changes in the amount allocated to the JPA and benefit payments

[17] According to the person in charge at the JPA, the introduction of a hybrid scheme combining the public and private insurance is being considered.

[18] According to *Old Age Income Security System in Malaysia* by Hironobu Sugaya (2012) (Japanese)



Source: Public Service Department Malaysia, *Overview of Pensions Policy in Malaysia*

In the public sector, employees are entitled to receive a retirement pension equal to 20–60% of the last pay drawn according to the length of service. A sliding pay scale system has been introduced since 1981. The basic calculation formula is 1/600 x the months served x the last pay drawn. The number of months served is limited to a maximum of 360 months. As a retirement allowance, 7.5% of the amount calculated by multiplying the last pay drawn and the number of months served is paid (Pension Regulation 1980 Sec.4). The pension is paid to those who retired for the reasons listed below (Section 10–Section 12A).

Figures IV-17 Eligible reasons for retirement for pension benefits

＊Attaining age of 60(effective from January 2012) ＊Health reasons ＊Abolition of office ＊Reorganization of department ＊Obtaining foreign citizenship (whether it is a government system does not matter) ＊Optional retirement(upon attaining age of 40) ＊In the case of transfer to other organizations with officer's agreement (whether it is a government system does not matter)

In the case of optional early retirement, the pension benefit commences at the age of 45 or 50. The commencement age of 45 applies to female employees, firefighters, police officers and prison officers below a certain rank, and male nurses at mental hospitals, and the commencement age of 50 applies to male employees other than those mentioned above. In the case of transfer to other organizations,[19] the pension benefits commence when the employee reaches the age of 50 for male and 45 for female, if the transfer takes place before the employee reaches such age, and it commences when the employee reaches the age of 55 if the transfer takes place before the employee reaches the above specified age. If an

[19] Transfer to other organizations (whether it's a government subsidiary or not) with the consent of the government

employee dies before reaching these ages, a survivor's pension is paid.[20]

Since the current tax-based pay-as-you-go system entails a heavy financial burden, the JPA intends to make a shift to a defined contribution scheme from a sustainability perspective.

Figures IV-18 Benefit packages of the GP scheme

Benefit packages		remarks
①Retirement benefits Gratuity (lump sum)	7.5% ×months of reckonable service(月)×last drawn salary	＊w.e.f:1 st January 2009(i.e. maximum at 30 years (360months) of service)
②Retirement benefits Pension (monthly)	1/600×months of reckonable service×last drawn salary (but not more than three - fifths of last drawn salary)	＊w.e.f:1 st January 2009(i.e. maximum at 30 years (360months) of service)
③Cash in lieu of leave	1/30×up to a maximum of 150 days of vacation leave not taken due to exigencies of service × total monthly emolument	＊Total monthly emolument includes salary and fixed allowances.
④Medical benefits	Free or subsidized medical benefits: ・Specified medical treatment and medication without charge for pensioner, spouse and minor children available at government hospitals and clinics. ・Medical treatment in private hospitals and medication purchased from private providers/suppliers not available from government hospitals upon recommendation/ prescription by Government medical officers. ・Medical treatment overseas upon recommendation by government medical officers and decision by Board of Officers.	
⑤Derivative benefits	・If the government officer dies in service, the bereaved families can receive retirement allowance, survivor's pension, and medical benefits. ・Regarding to the retirement allowance, his (her) parents can receive allowance as well as widow(er) and children.. e. ・Even if member himself(or herself) dies after retirement, the bereaved families can receive survivor's pension and medical benefit.	

[20] According to *Old Age Income Security System in Malaysia* by Hironobu Sugaya (2012) (Japanese)

⑥ Disability/Dependent's pension	・Paid in addition to pensions/derivative pensions. ・When retirement or death is caused by -injury due to a mishap in the performance of official duty or from a disease contracted in the line of duty or due to a travel accident but not resulting from the personnel's carelessness or wrongdoing, not the injury or disease aggravated by the personnel.	

Source: Public Service Department Malaysia, *Overview of Pensions Policy in Malaysia*

Figures IV-19 Breakdown of the amount allocated to the JPA and benefit payments (2011)

	the amount allocated to the JPA		Benefit payments	
	Amount(MYR)	(%)	Amount(MYR)	(%)
Cash in lieu of leave	263,760,800	2.3	262,165,698	2.3
Compensation	—	0.0	—	0.0
Pension	8497,155,900	74.4	8494,017,149	74.5
Gratuity	2653,262,900	23.2	2643,613,695	23.2
Allowance	2,861,700	0.03	2,834,368	0.00
Total	11,417,041,300	100.0	11,402,630,911	100.0

Source: Public Service Department Malaysia, *Overview of Pensions Policy in Malaysia*

5.2. **Employee Provident Fund (EPF)**

5.2.1. Legal basis

The retirement benefit scheme is operated under EPF (Preliminary) Rules 1969 and the subsequently enacted EPF Act 1991—Employees Provident Fund Act 1991 (Act 452).

This is a compulsory contribution fund to which employees and employers contribute a prescribed percentage of salaries. Under this saving-type provident fund system, employees withdraw the saved amount upon retirement.

Members of the fund are mainly private-sector employees, and this includes those who have no eligibilities for the pension benefit for government officers described above. Government officers are allowed to depart from GP and join the EPF.

5.2.2. Benefit packages

Benefits are granted upon retirement or the inability to work. There are two types of individual savings accounts of members: Account I, which accounts for 70% in terms of the amount of contribution and dividend, and Account II, which accounts for 30%. Account I is used to prepare for retirement from which the entire balance of savings can be withdrawn when the member reaches the age of 55. Members are allowed to manage part of the balance themselves. From Account II, savings can be withdrawn for down payment for a home purchase or loan repayment, or for the purpose of paying for the education of dependent children or for medical expenses, etc.

Figures IV-20　Benefit packages of the EPF

Type of withdrawals	Packages
Retirement withdrawals	・Age　55 years withdrawal (1)Lump-sum (2)monthly (3)anytime & any amount (4)combination
Pre-retirement withdrawals	・Age 50 years withdrawal ・Housing withdrawal ・Healthcare withdrawal ・Education withdrawal ・Members' investment choice
Other withdrawals	・Death withdrawal ・Incapacitation withdrawal ・Leaving the country ・Pensionable Employees Withdrawal ・Millionaire Withdrawal
Additional benefits	・Incapacitation benefit（5,000MYR） ・Death benefit（2,500MYR）

Source: Compiled based on the materials provided by EPF Malaysia

Figures IV-21 Types of withdrawals & benefits of EPF

Types of withdrawals & benefits	Conditions and withdrawal pattern
Retirement withdrawals	・Age　55 years withdrawal (1)Lump-sum (2)monthly (3)anytime & any amount (4)combination
Pre-retirement withdrawals	・Age 50 years withdrawal ・Housing withdrawal ・Healthcare withdrawal ・Education withdrawal ・Members' investment choice
Other withdrawals	・Death withdrawal ・Incapacitation withdrawal ・Leaving the country ・Pensionable Employees Withdrawal ・Millionaire Withdrawal
Additional benefits	・Incapacitation benefit（5,000MYR） ・Death benefit（2,500MYR）

Source: EPF Malaysia

5.2.3. Withdrawal for the purpose of paying medical expenses

The system of withdrawal for the purpose of paying medical expenses was introduced in 1994. It covers medical expenses for the members and their spouse, parents (including parents in law, stepmother, and stepfather), children (including stepchildren and adopted children), and siblings. The disease must be specified in the application. Eligible disorders were expanded from 36 to 55 covering wide-ranging disorders including cancer, cardiovascular system disorders, gastrointestinal and digestive system disorders, urogenital

system disorders, blood system disorders, and mental disorders.

When selecting eligible disorders, advice from a doctor who is a board member and opinions from experts are sought. In addition, the Malaysia Medical Association (MMA) provides cooperation.

5.2.4. Eligibility for enrollment and contribution rates

It is compulsory for employees to join the EPF, and a voluntary system is applied to workers in the informal sector[21] includes the self-employed, agriculture and fishery workers and foreign employees, etc. Since their income is unstable and paid at various times, they pay the contributions on a voluntary basis on the condition that "at least 50MYR must be paid at a time."

Formerly, those over 55 years of age pay the contributions on a voluntary basis. However, with the increase in those who continue working beyond the age of 55, it became compulsory for these people to pay the contributions in 2008, though the employee's share of the contribution rate is half of that for those under 55.

Figures IV-22 Current contribution rates

Target		contribution percentage (%)		
age	Wage	employee	employer	Total
Above 55	Above 5,000 MYR	5.5	6	11.5
	Below 5,000 MYR	5.5	13	18.5
Below 55	Above 5,000 MYR	11	12	23
	Below 5,000 MYR	11	13	24

Source: Materials provided by EPF Malaysia; effective from January 2012

5.2.5. Funds and operational bodies

The board members of the EPF consist of a chairman, five government representative (including deputy chairman), five representatives of the employees, three professional representatives including a doctor, and a CEO. The current chairman is Mr. Tan Sri Samsudin Osman.

The Investment Panel is composed of seven members: a chairman, a representative of the Ministry of Finance, a representative of the central bank, three professional representatives specialized in finance and investment, and a CEO. The Investment Panel is responsible for the investment and management of the fund.

The handling of the investment fund is provided for in Section 18 (2) of EPF ACT1991. It is stipulated that the investment fund shall be deposited in the specified financial institutions including Bank Negara Malaysia, and shall be invested in the shares of the companies listed on the stock exchange in Malaysia and the debentures of public companies, etc.

In member management, computerization has been going on since the 1980s. However, many members have not yet been familiarized with computers. The younger generations who

[21] The informal sector defined by the EPF include the self-employed, agriculture and fishery workers, artists, specialist sole proprietors, household helpers, and those without a regular occupation, etc..

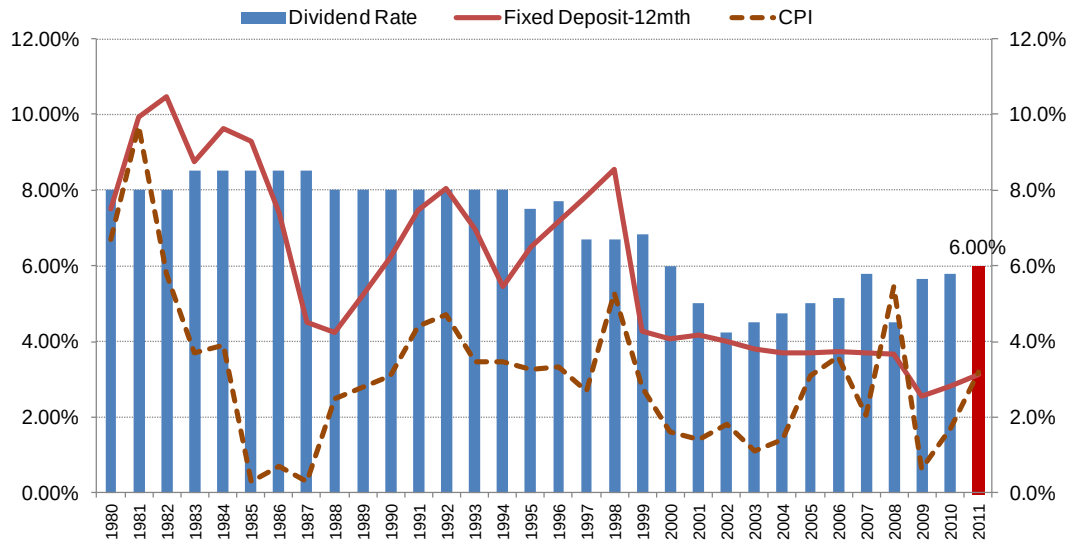
can access the Internet are less interested in the balance of pension savings. Thus, the database system has not been fully utilized. [22]

Figures IV-23 Changes in annual contributions to and withdrawals from the EPF

	2009		2010		2011	
	Billion MYR	Billion USD	Billion MYR	Billion MYR	Billion USD	Billion MYR
Annual contributions	33.47	11.10	35.76	11.86	41.43	13.74
Annual withdrawal	24.71	8.1	26.41	8.76	30.03	9.96
Accumulated asset	375.46	124.54	445.85	147.88	476.53	158.10
Investment income	17.26	7.72	24.41	8.10	27.24	9.04
Dividend rate	5.7%		5.8%		6.0%	

Source: Materials provided by EPF Malaysia

Figures IV-24 Changes in the EPF's dividend rate



Source: Materials provided by EPF Malaysia

5.2.6. Enrollment figures

As of 2011, a total of 13.14 million members are enrolled. Among them, those who are paying contributions ("Active Members") account for only about half of the total, or slightly above 6.26 million. Other members are retirees or those who have their own accounts but who currently are not accumulating savings due to unemployment.

Since 2010, the enrollment of eligible informal sector workers has been promoted. As of the end of 2011, 48,452 informal sector members have enrolled. Under the slogan "1 Malaysia [23] Retirement Saving Scheme (SP1M)," the EPF established a voluntary savings system for informal sector workers. The minimum contribution is 50MYR at a time, and

[22] According to an interview with the EPF.
[23] "1 Malaysia" is the slogan set forth by Prime Minister Najib with the hope that Malaysia as a multi-ethnic nation will "unite and develop" to achieve the goal of joining advanced countries by 2020.

contributions may be paid at any time and frequency. The advantages of membership include entitlement to the dividend payment at a rate of 2.5% per annum, the death grant of 2,500MYR, and a tax credit of up to 6,000MYR a year (for life insurance). Members can also receive incentives such as a matching contribution, which is a system where 5% of the government expenditures is credited to Account I with the upper limit of 60MYR (2010–2014).

The EPF is seeking to grasp the number of eligible people in the informal sector. In addition, as the databases of the member information are not linked, the EPF is planning to integrate the databases into one, obtain data on eligible people in the informal sector, estimate the funds necessary for post-retirement life, and consider how to contribute the funds.[24]

Figures IV-25 Breakdown of members in the informal sector (2011)

	(%)	Number of members
Housewives	16.76	8,120
Agriculture & fishing	6.25	3,028
Professionals agents, direct sellers artists etc	6.51	3,154
Pensionable employees	2.48	1,202
Services & transportation	6.92	3,353
Business	34.84	16,881
Others	26.24	12,714
Total	100%	48,452

Source: Materials provided by EPF Malaysia

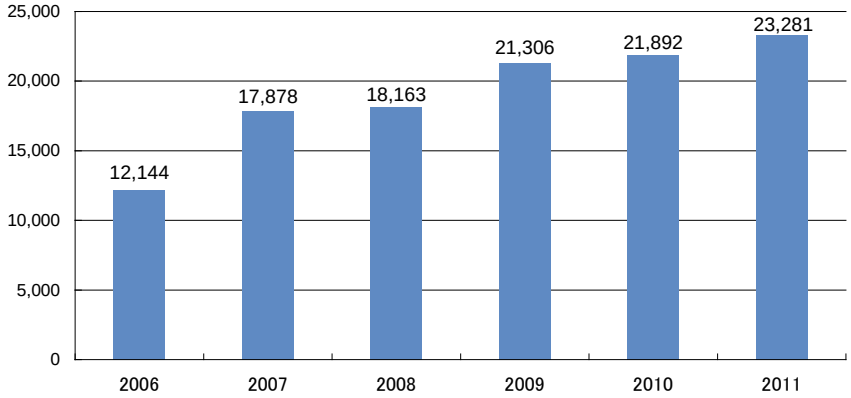
For the future, the EPF set the goal of: 1) setting upper-limit wages that are to be against the contribution amount, and 2) realizing a compulsory contribution system for all employees and, for that purpose, collecting contributions along with the contributions to SOCSO and the health insurance by the MOH.

5.2.7. Actual benefit payments

The annual total withdrawals have been increasing, while the amount withdrawn for the purpose of paying medical expenses has been decreasing since 2009. By method of withdrawal at the age of 55, the ratio of lump sum withdrawals is on the decrease, while that of monthly or partial withdrawal or a combination thereof is on the increase.

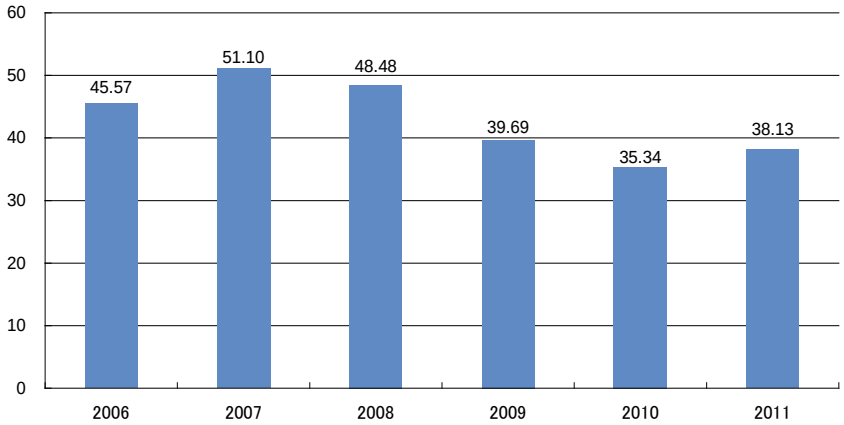
[24] According to an interview with the EPF

Figures IV-26 Annual withdrawals from the EPF (excluding withdrawals by members for investment purposes; unit: million MYR)



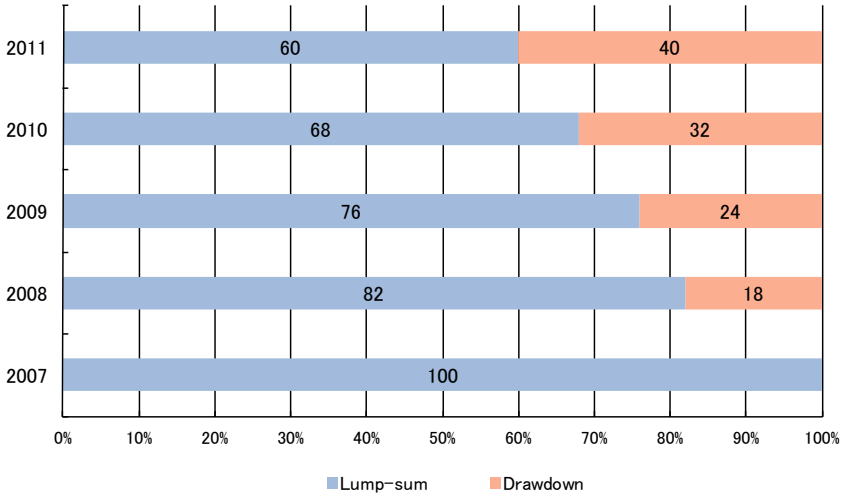
Source: Materials provided by EPF Malaysia

Figures IV-27 Withdrawals from the EPF for the purpose of paying medical expenses (Unit: Million MYR)



*Amount approved on applications for annual medical benefits
Source: Materials provided by EPF Malaysia

Figures IV-28 Changes in the method of withdrawal at the age of 55 (%)



※Note1:"Drawdown" includes "Monthly", "Partial" and "Combination of monthly & partial".
Source: Materials provided by EPF Malaysia

Figures IV-29 EPF operational locations by function

Type of branches	Functions	Total
Type1	Receipting, Services and Enforcement	15
Type2	Services and Enforcement	30
Type3	Receipting and Services	1
Type4	Services only	17
Type5	Enforcement only	3
Total		66

Source: Materials provided by EPF Malaysia

5.3. **Social security system for employees: Social Security Organisation (SOCSO)**

5.3.1. Outline of SOCSO [25]

The Social Security Organisation (SOCSO, or PERKESO in Malayan) is an extra-governmental organization under the jurisdiction of the MOHR. It was established in 1971 as the Social Security Department of the government under the Employees' Social Security Act, enacted in 1969. It aims to provide work-related accident compensation and now functions as a provider for accident compensation, invalidity pension funds, and educational loan benefits. At present, its fund stands at 18–19 billion MYR (approximately 6 billion U.S. dollars).

Regarding invalidity pension scheme, SOCSO provides financial support to low-income employees whose income decreases due to total disability or not curable disease even not

25
http://www.malaysia.gov.my/EN/Relevant%20Topics/Employment%20and%20Training/Citizen/EmployeeBenefitsContributions/Pages/EmployeeBenefitContributions.aspx

caused by work-related accident[26]. However, such support amounting to 300MYR per month is not enough to support their living and only plays a supplementary role.

5.3.2. Schemes of SOCSO

Under the labor laws, companies with one or employees are obliged to join SOCSO at the time of business registration. As of the end of 2010, the number of effective employees who pay contributions at least once a month is about 5.52 million, which accounts for approximately 44.2% of the working population of 12.5 million, and the number of effective employers is 348,000 companies.[27]

It is compulsory for employees who earn less than 3,000MYR and their employers to join SOCSO, while self-employed people, foreign employees, etc., are not eligible. Employees who earn over 3,000MYR join SOCSO on a voluntary basis based on agreement with their employers. If the monthly wage of an employee exceeds 3,000MYR after joining SOCSO, such employee is obliged to continue the payment of contributions.

SOCSO's schemes are classified into two categories according to the benefit packages. The first category covers the Employment Injury Insurance Scheme and the Invalidity Pension Scheme, to which employees under 55 years of age pay contributions jointly with their employers. The second category covers the Employment Injury Insurance Scheme only, and contributions are paid by employers only—not by employees. This category applies to employees aged 56 or older, those who joined SOCSO for the first time after reaching 50 years of age, or those whose income has been reduced to one-third due to employment injuries.

Employees who earn over 3,000MYR per month and who have never joined SOCSO, government officers, household employees (including cooks, gardeners, household helpers or housekeepers, security guards, and drivers), the self-employed, and foreign employees are not eligible for these schemes.

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26 SOCSO employer's Guide, Ministry of Health, Labour and Welfare of Japan Reporting foreign affairs 2009-2010. It is necessary to satisfy the requirements such as examination of Medical Board examination.

27 SOCSO *Annual Report 2010*

Figures IV-30 SOCSO's schemes and eligibility

category	Scheme	eligibility	Contribution
First category	Employment Injury Scheme And Invalidity Pension Scheme	For employees below 55 years of age.	The contribution is paid by both the employer and employee.
Second category	Employment Injury Scheme only	・For employees above 55 years of age and still working. ・For employees above 50 years of age when first registered and contributed to SOCSO. ・For an Insured Person receiving Invalidity Pension who is still working and receiving wages which is less than 1/3 of the average monthly wage before invalidity.	The contribution is paid by the employer only.

Source: Compiled based on the website of SOCSO [28]

5.3.3. Contributions

The amount of contributions is determined based on the monthly wage of the employee. The monthly wage for this purpose includes the base pay, overtime pay, fees, and various allowances, such as the allowance for working on a holiday, housing allowances, and incentives, etc. The annual total of the contribution payments has been increasing in the last three years.

[28] http://www.perkeso.gov.my/en/socso-contribution1.html

Figures IV-31 SOCSO contributions

Monthly wages(MYR) (Exceed-but not exceed)	First category (Employment Injury Scheme And Invalidity Pension Scheme)			Second category (Employment Injury Scheme)
	Employer's contribution(MYR)	Employee's contribution(MYR)	Total contribution (MYR)	Total contribution by Employer only (MYR)
30	0.40	0.10	0.50	0.30
30–50	0.70	0.20	0.90	0.50
50–70	1.10	0.30	1.40	0.80
70–100	1.50	0.40	1.90	1.10
100–140	2.10	0.60	2.70	1.50
140–200	2.95	0.85	3.80	2.10
200–300	4.35	1.25	5.60	3.10
300–400	6.15	1.75	7.90	4.40
400–500	7.85	2.25	10.10	5.60
500–600	9.65	2.75	12.40	6.90
600–700	11.35	3.25	14.60	8.10
700–800	13.15	3.75	16.90	9.40
800–900	14.85	4.25	19.10	10.60
900–1,000	16.65	4.75	21.40	11.90
1,000–1,100	18.35	5.25	23.60	13.10
1,100–1,200	20.15	5.75	25.90	14.40
1,200–1,300	21.85	6.25	28.10	15.60
1,300–1,400	23.65	6.75	30.40	16.90
1,400–1,500	25.35	7.25	32.60	18.10
1,500–1,600	27.15	7.75	34.90	19.40
1,600–1,700	28.85	8.25	37.10	20.60
1,700–1,800	30.65	8.75	39.40	21.90
1,800–1,900	32.35	9.25	41.60	23.10
1,900–2,000	34.15	9.75	43.90	24.40
2,000–2,100	35.85	10.25	14.10	25.60
2,100–2,200	37.65	10.75	48.40	26.90
2,300–2,400	39.35	11.25	50.60	28.10
2,400–2,500	41.15	11.75	52.90	29.40
2,500–2,600	42.85	12.25	55.10	30.60
2,600–2,700	46.35	13.25	57.40	31.90
2,700–2,800	48.15	13.75	59.60	33.10
2,800–2,900	49.85	14.25	64.10	34.40
2,900 以上	52.65	14.75	66.40	35.60

Source: Compiled based on the SOCSO *Employers Guide*

Figures IV-32 Changes in enrollment in SOCSO

year	Employer		Employee		Annual contributions (million MYR)
	Registered ('000)	Active ('000)	Registered ('000)	Active ('000)	
2008	684	389	12,603	5,670	1834.66
2009	724	327	13,278	5,311	1867.16
2010	770	348	13,832	5,519	2007.87

Note 1: The number of registered companies (employees) shows the number of members registered since the establishment of SOCSO.
Note 2: The number of effective companies (employees) shows the number of employers or employees who pay contributions at least once a month.
Source: Compiled based on the SOCSO *Annual Report 2010*

5.3.4. Issues for the future

While there has been the discussion of raising the retirement age, the retirement age for

government officers has already been raised from 55 to 60. The intention is to, by extending the service years of the elderly, help increase savings and reduce the unwaged period from retirement to the end of life. The government recommends that the private sector adopt the same policy.

When an employee becomes unemployed due to a work-related injury, etc., income security is provided through SOCSO. Therefore, some discuss that SOCSO should also assume the function of unemployment insurance. However, it is not easy because the systems are different.

5.4. **Unemployment insurance** [29]

Malaysia does not have any unemployment insurance system. SOCSO and the EPF play a supplementary role in this area.

5.4.1. Discussion concerning unemployment insurance

The discussion concerning unemployment insurance in Malaysia began after the Asian currency crisis in 1997. It started around 1998 with a discussion concerning unemployment insurance by labor unions. Initially, it was requested that the Retrenchment Fund be established to provide laid-off employees with a fund to cover living expenses costs during the laid-off period, though it was not realized because of strong objection from the employers' side. This event triggered active discussion on the necessity of unemployment insurance in Malaysia.

The unemployment insurance schemes need to be considered separately for government officers, the employees of private companies, and informal sector workers (self-employed, farmers and fishers, household helpers, etc.). Foreigners are not eligible for these schemes.

Figures IV-33 Current discussion situation regarding unemployment insurance

Target	Current discussion situation
Private sector	・Discussion on Unemployment insurance have begun after Asian financial crisis in 1997, but still on study phase.
Public sector	・Welfare for civil servants have been established by the JPA. ・This scheme also includes workers working in government.
SOCSO	・SOSCSO is under the jurisdiction of MOHR. Its objective is Employment Injury Scheme and Invalidity Pension Scheme. ・SOSCO works as complementary income security covering decreased income due to employment injury, etc.

Note 1: The Malaysian government is positively accepting foreign employees. Malaysia has 2.32 million foreign residents, accounting for 8.2% of the population (2010).
Source: Compiled by Mitsubishi UFJ Research and Consulting based on an interview with the MOHR.

The purpose of establishing an unemployment insurance system is to strengthen the safety net for employees. Its realization requires the study on the sustainability of the system and

[29] This section is mainly based on an interview with the MOHR.

the agreement by the employers' and employees' sides. The MOHR has been studying examples of unemployment insurance in Japan, South Korea, Vietnam, and Thailand, etc., from an academic perspective (including JICA's training program). When designing the system, the unique factors of Malaysia, such as it being a multi-ethnic nation, its culture and religions, and its racial diversity, need to be addressed; and, therefore a cautious approach is required.

The current issues is that people are not fully aware of the significance of unemployment insurance and complain it is not fair that unemployment benefit would be paid from the contribution fund to employees who are not enrolled in any scheme.

5.4.2. International cooperation

The MOHR is now conducting a research study on unemployment insurance with the support of ILO. In this research study, which is scheduled to be complete in September 2012, extensive research is being conducted covering the industrial/trading field and various associations, organizations, and unions, etc. By accepting the opinions of experts and promoting diversified discussion, the MOHR is to consider an appropriate way for Malaysia and to lay out its policy. [30]

[30] Whether or when the report of this study will be published has not been decided.

6. Social Welfare System and Community-based Assistance Schemes

6.1. **Development of databases to identify low-income populations** [31]

6.1.1. Outline of databases

In Malaysia, a database called E-KASIH [32] has been established since 2007 for the purpose of grasping and managing accurate information on low-income households and providing appropriate assistance.

This system was developed by the Implementation Coordination Unit (ICU) affiliated with the Prime Minister's Office. The ICU develops and manages the database that contains information about each household and individual, provided by each ministry. For example, if the Ministry of Education (MOE) provides a scholarship or assistance benefit to a low-income student, the student is registered on the list of E-KASIH. In addition, if any ministry provides financial assistance, the name of the recipient individual or household is registered on the list and the list of low-income persons is shared by ministries and agencies. When the assistance is provided, the identification card (ID) is checked to verify identity.

6.1.2. Background

When the Federation of Malaya was founded in 1957, [33] nearly 70% of the population lived in poverty, and a budget for poverty reduction was allocated to each ministry to implement separate programs. However, with the increase in those who receive assistance from more than one ministry at the same time, a concern arose that the assistance may not reach all those who are really in need. In view of such situation, it was realized that, in order to distribute the limited resources properly, a unified system to grasp the information on eligible persons was necessary and thus it was decided to introduce this system.

6.1.3. Range of database utilization

In E-KASIH, about 1.5 million persons, or about 330,000 households are registered, which accounts for about 4% of the population (as of 2010). The list includes the "poor" and the "very poor," who are eligible for assistance in Malaysia.

Figures IV-34 Definition of the poor

Type	Definition
Hard core Poor	Monthly household income below 440MYR
Poor	Monthly household income below 750MYR

Source: Complied based on the materials provided by the ICU; the definition is as of 2007.

Note 1: According to the person in charge at the ICU, the definition has been changed: Monthly income less

[31] This section is based on an interview with the person in charge at the ICU and on the materials provided.

[32] *Kasih* means "love" in Malayan.

[33] In 1957, the Federation of Malaya attained independence as a member of the Commonwealth. In 1963, Malaysia was formed with Sarawak, the British territories in North Borneo (current Sabah), and Singapore, and Singapore separated and became an independent nation in 1965.

than 100MYR/person for the very poor, with monthly household income less than 180MYR/person for the poor.

In 2007, Malaysia set the targets of reducing the percentage of the very poor from about 0.7% to 0%, and that of the poor from 3.6% to 2.8%. As a measure to achieve these targets, site visits and interview surveys are conducted targeting the households below the poverty line (monthly household income 1,500MYR in urban areas and 1,000MYR in rural areas) to determine who are eligible for assistance.

In Malaysia, the low-income population is defined as those who fall into the low 40% range from the poorest. Today, approximated 10 million persons fall into this group. The monthly household income of this group used to be assumed at around 1,500MYR. As for the income levels now, with the rise of income levels, the definition was changed to those with a household income of 2,300MYR/month.

6.1.4. Issues for the future

The method with which to identify those who should receive public assistance and the appropriate update of their information and data (while ensuring sustainability) are some of the issues to be addressed. How to raise awareness among the recipients who are not willing to work is another issue. In this regard, the government is endeavoring to improve their attitude by providing education and training mainly to the younger generations, who are relatively adaptable.

6.2. **Social assistance systems**

6.2.1. Target beneficiaries

The social assistance systems cover a broad range of beneficiaries, including the low-income, the elderly, children, and PWD, etc. The assistance includes not only livelihood assistance but also assistance for school expenses and preparation for school attendance, such as the purchase of school uniforms as well as assistance for the purchase of supportive devices for PWD.

6.2.2. Standards for benefits and benefit amounts

The standards for the benefits and benefit amounts are shown in the figure 35.

Figures IV-35 Major social assistance systems

No	Type of Assistance	Objective	Eligibility	Amount
1	Financial Assistance for Children	・ To assist underprivileged, needy children so they could continue living with their family and get affection, care and attention. ・ To nurture and strengthen the family institution so that parents can become independent and continue to provide proper care for their children.	・ For families who are taking care of their children; ・ Children of the age 18 and below; ・ Children who are orphans; and ・ Children with parents /guardians who are incapable to care for them or who have lost their source of income due to weakness, disabilities, diseases or imprisonment.	Min: MYR100 for each person , monthly Max: MYR 450 for each family with more than 4 children.

2	Financial Assistance for the Older Persons	• To support the poor elderly so that they continue to live and lead a normal life with care, concern and support from their local community.	• Elderly, age 60 and above; • Those with no source of income; and • Those with no family or family members who can provide or contribute to them.	MYR300 for each person, monthly.
3	Financial Assistance for Foster Care Children	• To encourage children to continue living in their community and not be admitted into any welfare institutions; • To place children from welfare institutions into foster families so that they can experience the attention and affection of a healthy family environment, and live in a societal surroundings; • To recognize the rights of the child for protection and assistance when living with foster families; and • To recognize the role and responsibility of foster families who are entrusted to take care of the children	• Children of the age 18 and below; • Children who are orphaned; • Children who are staying with foster families; • Children who are not placed under the Child Adoption Act 1952; and • Children who are placed under the Foster Care Scheme • No fixed income limit for foster families	Min: MYR250 for each child, monthly Max; MYR500 for each family who cares for 2 or more children, monthly
4	Incentive Allowance for Disabled Workers	• To sustain an income to meet the basic needs for Persons with Disabilities (PWD's) • As an incentive to encourage PWD's to be employed, independent and be a productive member of the community • To improve the standards of living of PWD'S in the community	• Those who are registered with the Department of Social Welfare; • Those who are self-employed or an employee; • Those with a monthly income not more than MYR1200,excluding family income; • 16 years old and above • Those who are not a resident in any institution that provides shelter, food and clothing.	MYR300 for each person, monthly
	Financial Assistance for PWD's who are incapable of work	• To help sustain an income for PWD's who are incapable of work. • To increase their quality of life especially for Persons with Disabilities who are incapable of work. • To avoid or minimize their admission into welfare institutions.	• Citizen of Malaysia, residing in the country; • Those with individual source of income not more than the eligible criteria for financial assistance. The source of income refers to all individual income including pensions, PERKESO, monthly assistance, insurance, etc; • PED's who are registered with Department of Social Welfare; • Those with disabilities which are not clearly defined will have to be certified by the medical officer; • Those who are not recipients of the financial assistance scheme of the Department of Social Welfare;	MYR150 for each person, monthly
6	Public Assistance (for the Federal Territories of Kuala Lumpur, Labuan and Putrajaya)	• To give assistance to the targeted group of the Department of Social Welfare who are underprivileged, in order to temporary lighten their financial difficulties or until they become self-reliant.	• Each state has it's own Public Assistance and eligibility requirements. Allocation of funds also varies in each state. • Assistance will be given to underprivileged families who are needy	The amount for the Public Assistance differs in each state as the following; From 50-450MYR/Month
7	Financial Assistance for Carers of Bed-Ridden Disabled and Chronically ill	• To help reduce the financial burden of family members of Persons with Severe Disabilities/Chronically ill • To encourage better care for PWD's/Chronically ill • To improve the quality of life of this targeted group • To avoid or minimize their admission into welfare institutions • To strengthen family relationships.	• Applicant has to be the family member providing care to the PWD's/Chronically ill; • Citizens of Malaysia, residing in the country; • Those who are currently providing full time care to the PWD's/Chronically ill; • Those who have a family income of less than MYR3,000 a month; • Families who are needy and poor.	MYR300 for each person, month

8	Launching Grant	・ To provide financial assistance to the target group who are keen and have the potential to be enterprising or to be involved in small businesses ・ To encourage financial assistance recipients to be independent and to improve their quality of life, and not to be dependent of the government's assistance.	・ Recipients (or family members) who receive monthly assistance; ・ Persons with Disabilities who are currently receiving services from the department; ・ Former trainees of welfare institutions; ・ Cases under supervision or on probation.	MYR2,700 (one-off)
9	Financial Assistance Artificial Aids/Assistive Devices	・ To help PWD's who cannot afford artificial aids such as artificial legs and arms, calipers, crutches, wheelchairs, special glasses, special shoes, and other support tools that are recommended by the doctors of specialists. ・ To assist PWD's to improve their capabilities and to be self-reliant.	・ PWD's who are registered with the Department of Social Welfare; ・ Persons who are recommended by doctors and specialists; ・ Those who are needy and cannot afford their own artificial aids/support tools.	The actual price of the artificial aid/Assistive Devices
10	School Aid	・ To give assistance to children of poor needy families so that they can continue with their schooling. ・ To endure that all children be given their rights to get primary and secondary school education, minimizing school dropouts.	・ Underprivileged children, orphans and PWD's; ・ Children of parents who are needy, temporary unemployed, weak due to disability or disease, or under imprisonment or in detention; ・ The monthly income of parents/guardian is below the eligibility criteria for financial assistance.	The actual price: ・ School Fee ・ Exam Fee ・ Work books/exercise books ・ Transportation fee ・ Other assistance such as work books and exercise books ・ School uniform
11	Immediate Assistance for Those in Need	・ To help clients who are in dire need of immediate assistance, and unable to wait for the normal process of payment assistance. They need urgent basic daily needs including food, clothing, shelter and related supplies such as electricity, water, health care, etc.	・ Malaysian citizen; ・ Underprivileged families that require immediate assistance for their basic daily needs; ・ Those who are unable to wait for the normal process of payment assistance.	Maximum of MYR300 lump sum
12	Immediate Federal Assistance Scheme for Parliamentarians. Note; This scheme is channeled straight to the Parliamentarians.	・ To help the poor that require immediate assistance.	・ For groups who are needy and underprivileged; ・ For families with an income less than MYR1,000 a month.	According to Situation
13	Financial Assistance for Victims of Disaster	・ Short term: To provide immediate assistance at relief centers such as mats, blankets, dried food and kits. ・ Long term; To provide relief in terms of financial assistance for disaster victims to start anew due to property damage.	・ Victims of disaster	The amount varies accordingly to states; From150-450 MYR/Household

Source: Compiled based on the materials provided by the KPWKM

6.2.3. Actual benefit payments

In Malaysia, both the amount of the social security benefits paid and the number of households that received benefits have been increasing since 2006. Particularly in 2009, these figures almost doubled, partly due to the impact of the financial crisis in late 2008.

Figures IV-36 Number of recipient households of social security benefits and the amount paid (2006-2011)

	2006	2007	2008	2009	2010	2011
Number of Recipients(household)	180,000	210,000	222,000	354,000	425,000	460,000
Amount (million MYR)	242.2	322.4	371.2	760	1,100	1,180

Source: Materials provided by the Socioecomic Development and Financial Assistance Division, Jabatan Kebajikan Masyarakat Malaysia

6.2.4. Public assistance for the elderly

Financial assistance is provided to the low-income elderly so that they can continue living in their home and community. Financial assistance of 300MYR a month is provided to eligible elderly persons who are aged 60 or older with no regular income and who have no relatives or family who assist them. For the elderly who cannot afford to buy welfare equipment or supportive devices, financial assistance is provided to cover the purchase price, subject to recommendation by the person in charge of medical care.

6.2.5. Implementation bodies

Social welfare measures of Malaysia are implemented mainly by the Social Welfare Department of the KPWKM. They are engaged in welfare for the elderly, welfare for PWD, child/family welfare, the strengthening of local communities, and volunteer development. Public benefits and the services of public welfare facilities, which mainly target low-income persons, are unique in that emphasis is place on the facilitation of self-reliance through education and training to enhance the earning capacity of the beneficiaries and in that NGOs and private voluntary organizations play an important role in the provision of welfare services. [34]

6.3. **Community-based assistance schemes**

No such scheme was identified in this survey.

6.4. **Other social welfare practices, community-based activities**

One of the notable social welfare activities of private organizations including NGOs is the microcredit program operated by Amanah Ikhtiar Malaysia (AIM). AIM, the largest microcredit institution in Malaysia, was founded in 1987 with the goal of supplementing the poverty reduction measures.

In addition, there are some projects operated by government-affiliated organizations using the funds raised from the public. One such example is the program in which the federal or state government provides assistance to the poor for living expenses, educational expenses, insurance, and business start-up costs, etc., using the funds raised in Islamic society. Islamic

[34] Ministry of Health, Labour and Welfare, *Report on Conditions Overseas 2009–2010* (Japanese)

contributions such as *Zakat* or *Fitrah* are eligible for tax credits, such as a tax refund.[35]

[35] ASEAN-JAPAN CENTRE, *Taxation System of Malaysia* (Japanese)
(http://www.asean.or.jp/ja/asean/know/country/malaysia/invest/guide/3.html)

7. Care and Welfare for the Elderly [36]

7.1. **Policy initiatives and framework for the elderly**

In February 2010, the KPWKM announced a new policy initiative for the elder, known as the "National Action and Plan for Elderly/Dasar Dan Pelan tindakan Warga Emas Negara," and the new action plan for the elderly was formally approved in 2011 as national policy. [37]

In a bid to achieve success in the national policy for the elderly, the Malaysian government is making efforts to promote understanding toward the improvement in welfare and the understanding of the elderly by individuals and households in the wide context of education and employment, as well as in wide areas including local communities.

Figures IV-37 Outline of the action plan under the DWEN national policy for the elderly

Malaysia is capable of becoming a nation that is united and tolerance, with a society that is self-confident, moral and ethical, progressive and prosperous as well as able to play the role of ensuring the well-being of all social groups.

To achieve this goal, it is necessary to mould a society that is caring and considerate with a social system that emphasizes on universal needs, that is, to enhance and strengthen continually the welfare of each citizen centered on a strong and established family system.

STRATEGIES

（1）Education - Education and training are to be made available for the elderly to develop their potential to the optimum. The school curriculum is to include education on the family to enable the younger generation to understand and appreciate the elderly,

（2）Employment – The elderly are encouraged to continue contributing to national development through employment according to their respective experience and skills. In this way, they are able to be independent with respect to income and their well-being,

（3）Participation in society – The elderly are encouraged to involve themselves in family and societal activities to enable them to play their role in their family and society besides interacting among themselves,

（4）Recreation - Suitable facilities are to be provided for the elderly to carry out recreational activities in housing areas, recreational parks and sport centers,

（5）Transport – The public transport system is to provide suitable facilities to enable the elderly to move comfortably from one place to another,

（6）Housing - Existing and future houses should include facilities suitable for the elderly to live comfortably,

（7）Support system for the family - To ensure that the elderly can continue to live with their family, a support system for the family need to be established in housing areas to assist the family in caring for the elderly. Certain incentives need to be introduced to enable family members to continue caring for their elderly members,

（8）Health – Health and medical facilities appropriate and specific to the elderly are to be provided to ensure that their health is well taken of,

（9）Social security - A comprehensive social security scheme is to be provided to secure the future of the elderly,

（10）Media - The print as well as electronic media are to play active roles to increase the society's awareness of the elderly,

（11）Research and development - Studies are to be carried out to obtain information to enable better planning for the senior citizens. The Social Welfare Department under the Ministry of Women, Family and Community Development has been identified as the agency responsible for the coordination of the implementation of the action plan.

Source: Compiled based on the website of the KPWKM [38]

[36] This section is based on an interview with the Ministry of Women, Family and Community Development.
[37] The action plan is based on the previous policies: *National Policy for Older Persons 1995* and *Plan of Action for Older Persons 1998*.
[38] http://www.jkm.gov.my/index.php?option=com_content&view=article&id=86&Itemid=874&lang=en

7.2. **State of elderly care facilities and services**

The Social Welfare Department of KPWKM provides the elderly with financial assistance and institute services. The eligibility for and contents of the services are detailed below.

7.2.1. Financial assistance

As mentioned in "6. Social Welfare System and Community-based Assistance Schemes," "6.2 Social Assistance Systems," and "6.2.4 Public assistance for the elderly" above

7.2.2. Institute services

As part of measures to ensure well-being and a certain level of living, nine homes for the elderly have been established and operated for the purpose of providing care and protection to the low-income elderly. Conditions for the eligible residents include that the resident is aged 60 or older and free of infectious diseases, has no relatives or guardians, has no home to reside in permanently, and is unable to look after him/herself, etc. About 2,000 elderly live in each home on average.

7.2.1. Day care center: Activity Center for the Elderly (PAWE)

The main objective of day care centers is to help the elderly live an independent life with their family, etc., in the community. A total of 17,014 users are registered as of May 2011.

The day care centers provide mental support, recreation and rehabilitation opportunities, and financial assistance to elderly persons aged 60 years or older, and also function as a place for the elderly to share their expertise and experience. Day care centers open from 7:30 to 17:30 every day except Sunday, national holidays, and local holidays. Users can visit the center anytime during opening hours and participate in various activities. Each center is managed by the Day Care Center Committee or a government organization, and a manager and two assistants are always stationed.

7.2.2. Home help services

Usually one care worker takes care of five elderly persons. Home visits are made at least once a week for one hour for each home.

7.2.3. Use of NGOs

Although the KPWPM drew up the public welfare policies for the elderly, the actual services are implemented not by the government organizations but by NGOs. These NGOs receive subsidies from the government and operate day care centers (PAWE), home help services, and elderly care units (UPWE). The KPWPM supervises the NGOs' activities and provides them with guidance.

Figures IV-38 Subsidies to NGOs (2010)

State	Number of NGOs	Amount (MYR)
MANAGEMENT GRANT	3	2,099,568
PERLIS	-	-
KEDAH	-	-
PULAU PINANG	3	701,384
PERAK	2	188,048
SELANGOR	3	245,280
KUALA LUMPUR	2	62,780
NEGERI SEMBILAN	-	-
MELAKA	1	58,400
JOHOR	1	85,848
PAHANG	1	32,120
TERENGGANU	1	122,640
KELANTAN	1	2,000
SABAH	-	-
SARAWAK	1	53,144
TOTAL	**19**	**3,651,212**

Source: Materials provided by the KPWPM

One of the NGOs engaging in such activities is the Central Welfare Council, Peninsular Malaysia (CWC). The CWC has more than 60 years of history since its establishment in 1946. Initially, it was established as a subordinate body of the government, as there was no such organization as an NGO at that time, and in 1986, it was reorganized as an NGO. Its activities are still under the supervision and guidance of the government through the KPWKM and the National Registration Department (Jabatan Pendaftaran Negara Malaysia), under the Ministry of Home Affairs. The CWC, which has 78 branches in 12 states in Malaysia, operates 17 day care centers and 102 elderly care facilities, and carries out a home visit service program (covering about 1,000 persons). One volunteer worker takes care of 3–5 elderly persons a day and visits each home every day to once a week. In addition to the government subsidy amounting to 3 million MYR a year, it receives contributions from the private sector, though the amount is small.

In Malaysia where elderly persons are respected according to the traditions of Islamic culture, communities and volunteers are likely to function well. Recently, there is a growing issue such that those who are working in cities cannot look after their parents in rural areas, and therefore, the assistance by the government and the formation of communities are becoming more important.

Figures IV-39 Activity programs of the CWC (2011)

STATE	SERVICE CARE PROGRAM		DAY CARE CENTRES FOR THE ELDERLY		CARING UNITS TRANSPORTATION PROGRAMS		HOSTELS FOR NEEDY STUDENTS		ENVELOPE WORKSHOPS	
	VOLUNTEERS	CLIENT	CENTRE	REGISTERED MEMBER	VEHICLE	MEMBER	HOSTEL	STUDENT	WORKSHOP	TRAINER
PERLIS	16	75	-	-	1	17	-	1	-	-
KEDAH	10	39	2	453	1	24	-	-	-	-
PERAK	12	59	1	743	1	15	-	-	-	-
PENANG	3	15	-	-	1	14	-	-	-	-
SELANGOR	16	75	2	160	1	9	3	97	-	-
K. LUMPUR	2	5	-	297	-	-	-	-	-	-
PAHANG	12	66	3	1362	2	51	2	105	-	-
KELANTAN	19	75	1	72	1	7	8	515	-	-
T'GANU	9	45	4	339	1	5	4	123	-	-
N. SEMBILAN	6	34	1	88	-	-	-	-	-	-
MELAKA	2	22	2	35	1	18	-	-	-	-
JOHOR	-	-	1	885	1	-	-	-	1	50
SABAH	3	183	-	-	-	-	-	-	-	-
SARAWAK	6	33	-	-	-	19	-	-	-	-
TOTAL	116	726	18	4434	11	179	19	840	1	50

Source: Material provided by Central Welfare Council, Peninsulae Malaysia (CWC)

7.3. **Issues to be addressed and development for the future**

At present, the elderly care facilities under the supervision of the KPWKM provide various programs such as those related to sports, group making, playing instruments, singing, and other forms of recreation. However, rehabilitation or training programs are not available, and the introduction of these programs is an issue to be addressed. In addition, offering computer classes for the elderly at day care centers is being considered.

7.4. **State of international cooperation**

Malaysia received support from the International Federation on Ageing (headquarters located in Toronto, Canada) in 2011. The KPWKM is interested in the history and system of home visit care services in Japan and is planning to study the elderly support systems and measures of other countries and apply them in Malaysia.

The KPWKM has also conducted a research study on the social network for the elderly, jointly with the World Bank. For the future, it is seeking opportunities to share the experiences of international and overseas organizations through training.

8. Issues Facing Social Security in Malaysia

8.1. **Issues facing health security** [39]

Although a tax-based system of universal coverage is already in place, there is a disparity between public and private medical institutions. In addition, while the government anticipates the financial limitations of maintaining the current NHS scheme, it hesitates to introduce a social insurance system.

8.1.1. Disparity between public and private medical institutions

Public medical institutions, which provide most health care services free of charge, are so crowded that the quality of services has been declining. While the number of doctors working at public institutions is almost the same as those working at private medical institutions, 75% of all patients visit public medical institutions while 15% visit private medical institutions. Public medical institutions are also facing the issue of the "brain drain" of doctors. Doctors tend to transfer to private hospitals where they are better paid, after gaining experience at public medical institution. In addition, the above-described situation where doctors at crowded public institutions need to work hard accelerates the transfer of doctors from public to private medical institution and results in further doctor shortages and crowding at public institutions. Thus, a vicious circle arises.

As it is generally recognized that private medical institutions provide better health care services than public institutions, more than a few people choose private medical institutions even though they need to pay for the services. As result, a larger proportion of people purchase private insurance than in other ASEAN countries. Thus, there are some cases where low-income persons who cannot afford private insurance spend all their savings to receive medical care at private institutions and then fall into poverty. They can withdraw savings from Account II of the EPF to pay for medical costs, though the amount available is limited. Usually the funds are allocated to savings for old age and home purchase costs, etc.,[40] with little left over for medical costs.

The government intends to work on the improvement of the quality of services provided by public medical institutions in a bid to redress the disparity between public and private medical institutions. However, under the current system of free services, there is a concern that public institutions will become more crowded, as more patients will concentrate in such institutions.

8.1.2. Issues facing the introduction of social insurance systems

Arguments about the provision of public health security services through the introduction

[39] This section is based on an interview with the MOH.

[40] The persons concerned at each organization say that the shift of the EPF to health insurance is unlikely. This is probably because they strongly recognize that the EPF basically functions as an old-age benefit system to prepare for retirement.

of a social insurance system have already begun from the viewpoint of securing a source of revenue. However, the government maintains a cautious stance for the reasons described below.

The government thinks it will be difficult to obtain people's understanding over the significance of paying consultation fees or insurance contributions, as they have been receiving public health care services almost free of charge. The method of collecting contributions from the low-income bracket and informal sector workers, such as the self-employed, farmers, and fishery workers, and the amount of contributions are also at issue.

Substantial changes in private insurance services will be also required. At present, private insurance products, mainly blanket insurance, are taken out by some people. If a social insurance system is introduced, it would be inevitable for private insurance companies to review the contents of their products and the terms of the payment of insurance contributions. Although private insurance companies show a willingness to flexibly respond to the government policy, a considerable burden is expected for them during the transition period.

The private insurance market is still in the development stage. As a system change would be more difficult to carry out when the market expanded, the government recognizes the necessity of introducing a social insurance system at an early date. [41]

8.1.3. Expected international cooperation

The MOH acquires a program budget from WHO every two years to conduct research study (including seminars and the dispatch of experts abroad) concerning the fields that require assistance. The operating cost is shared by WHO and the government of Malaysia. Recent activities include the observation of the JLN system (learning network) in Taiwan and the on-site inspections of the social security system in the U.K.

According to a person in charge of MOH ,the economic level of Malaysia has improved to such a level as to virtually lift the country out of the status of an aid-receiving nation. At the same time, however, it has lost opportunities to work with overseas organizations. Today, foreign experts are invited, and studies on foreign systems are conducted with the financial assistance of the World Bank. Even though the country ceased to receive international aids, international cooperation is expected, as the cost of inviting experts from overseas imposes a heavy burden.

8.2. **Delay of social safety network**

Malaysia, in which the elderly population accounts for around 6% of the total population, has not reached a stage in which it must look toward the issue of an aging society. Therefore, there is no medical institution that only accepts elderly patients, and government agencies

[41] According to an interview with the MOH

have not actively discussed the issue of elderly care so far.
In reality, is dependent on the support of volunteers, such as local communities and NGO. In addition, the delay can be seen even for the public social assistance.

The Malaysian government is skeptical about public social assistance and basically believes that the creation of employment through economic growth will solve the problems of unemployment and poverty.[42] It also takes the stance that, even if the social safety net to provide relief to the underprivileged were strengthened, problems would not be essentially solved and moral hazards may occur, as people seek to receive benefits without making efforts.

The government believes that what is required to assist the unemployed or the poor is not the improvement of the social safety net but economic development, and that economic development will lead to the creation of employment; and as a result, that the problem of poverty will be eliminated. Although the government provides assistance to the poor, such assistance plays only a supplementary role and is insufficient to support their livelihoods.

8.3. **Issues surrounding employee social security**

The EPF does not have sufficient funds, as the members paying contribution account for less than half of all members enrolled and as its savings are not enough to cover the money necessary for post-retirement life. Therefore, the system of the EPF needs to be strengthened through an increase in the contribution rate of employees, etc.[43] Since enrollment in the EPF is voluntary for self-employed persons, informal sector workers including household helpers, and foreign employees, how to have these people enrolled is an issue to be addressed. Another issue is the absence of a system equivalent to the National Pension System of Japan.

As for GP, the current tax-based pay-as-you-go system carries a heavy financial burden, and the government intends to make a shift to a defined contribution scheme.

[42] According to interviews with the KPWPM and ICU
[43] JETRO (http://www.jetro.go.jp/world/asia/my/biznews/4f5592bc96e10)

9. Priority issues to be addressed in Malaysia

In Malaysia today, there are mainly two priority issues that need to be addressed. The first issue is the introduction of a social insurance system in health security. The disparity between public and private medical institutions has already become obvious. It is difficult to maintain the current non-contributory system while improving the quality of the services of public medical institutions. In addition, several issues remain to be solved in connection with the introduction of a social insurance system in health care, including the relief of low-income persons, the balance between social insurance and private insurance, and the method of collecting insurance contributions, etc.

The second issue is the establishment of a social security system for the elderly. As the aging of the population is not a serious problem, with a population aging rate of around 6%, the elderly people are supported by care by family members and the volunteer activities of community groups, charitable organizations, NPOs, and local communities, etc.

In Malaysia, the elderly population is going to increase gradually, and the rate of elderly people as of 2020 will be 8.9%. However in the middle and long term, it is likely that people would expect higher quality service for the elderly because of the further improvement of income level. As the issues of livelihood support, long term care, and income security for the elderly are expected to come to the fore in the near future, the government is required to promptly establish a mechanism of welfare provision for the elderly.

Chapter V Vietnam

1. Social Security Overview

1.1. Social security in the constitution

In the constitution of the Socialist Republic of Vietnam, statements related to social security are included in Articles 39 and 40 of Chapter Three, “Culture, Education, Science and Technology” and in Articles 61, 65 and 67 of Chapter 5, “Basic Rights and Obligations of Citizens”.

Article 39 The State invests in, develops and ensures the unified administration of people's health protection, harnesses and organizes all social forces to build and develop a prevention-oriented Vietnamese medicine; combines disease prevention with treatment; develops and combines modern with traditional medicine and pharmacology; combines the development of public along with popular health care; ensures health care insurance and creates favorable conditions for all people to enjoy health care. The State grants priority to the implementation of the health care program for mountain inhabitants and ethnic minority people. Illegal medical treatment production and sale of medicines detrimental to the people's health by organizations of individuals are prohibited.

Article 40 The State, society, the family and all citizens have the obligation to give protection and care to mothers and children and to implement the population and family planning programme.

Article 61 Citizens are entitled to health care. The State determines provisions on hospital fees as well as exemption from or reduction of hospital fees. Citizens have the obligation to comply with regulations on disease prevention and public hygiene. Illegal production, transportation, sale, stockpiling and use of opium and other narcotic drugs are strictly prohibited. The State provides for compulsory treatment of drug addiction and certain dangerous social diseases.

Article 65 The State, society and the family are responsible for the protection, care and education of children.

Article 67 The State grants preferential treatment to war invalids, sick soldiers and families of fallen combatants, creates conditions for the rehabilitation of disabled soldiers' working ability, to help them find employment suited to their health conditions and lead a stable life. Persons or families who have rendered services to the country shall be commended and rewarded and shall receive proper attention. Old people, disabled persons and orphans with no family support are entitled to assistance from the State and society.

1.2. Current state and basic direction of government policy for social security

In Vietnam, one-party dictatorship has been carried out by the Communist Party of Vietnam. According to the constitution, Vietnam's National Assembly is the highest organ of state power and has the rights to enact the constitution, the legislative power and the authority to elect a prime minister/president. However, the actual bill decided at the National Assembly would require the approval of the Central Committee of Communist Party of Vietnam for final decision.

Subdivisions which have taken a three-class system in Vietnam are divided into provinces, counties (townships), and communes (towns). Provincial level consists of 58 province and

five municipalities. With the revision of April 2011, five municipalities are Hanoi, Ho Chi Minh, Da Nang, Hai Phong, Can Tho.

Vietnamese are approximately 90% of Viet people and the remaining 10% is made up of 53 ethnic minorities.

Since adopting a free market economy under Doi moi, the Vietnamese government has worked to improve social services in order to achieve both economic development and well-balanced social development. However, because the majority of citizens are engaged in agriculture, physical access to social services has limited the effects of these improvements, and a gap has begun to form between urban and agricultural areas. In addition, with the increase in life expectancy and decline in birthrate, the population is expected to age rapidly. However, there has been a noticeable delay in social security coverage in the informal sectors as well as a change in the traditional community that can be associated with the advancement of industrialization and urbanization. Because of this, the social infrastructure supporting the elderly is very fragile. Therefore, the development of social services such as health insurance and social assistance, the introduction of related laws and securing financial resources to maintain these systems are all urgent issues.

The establishment of the Social Protection Strategy of Vietnam 2011-2020 as a national plan that specifies the direction for the entire social security system has progressed, but the final version has not been released because even though it has been approved by the Parliament, the examination by the Central Committee of the Communist Party is not yet completed. The ministry in charge of the plan is the Ministry of Labour, Invalids and Social Affairs (MOLISA). However, as the social protection covers a wide range of areas, discussions and adjustments are being carried out with the commitment of the Ministry of Health (MOH), the Ministry of Education and Training (MOET) and the local governments, as well as the Ministry of Finance (MOF) and Ministry of Planning (MPI) for financial matters. As each supporting institution also believes that this social protection strategy indicates the future direction of social security in Vietnam as a whole, support within the social security area in the country is expected to take shape after the approval of the strategy.

1.3. Outline of the social security system [1]

The most noticeable feature in Vietnam that cannot be observed in other Southeast Asian countries and developed countries is the consolidated operation of the social health insurance, social insurance and unemployment insurance, which are being centrally managed and operated by the Vietnam Social Security (VSS). Another noticeable feature in the social security system not found in other Asian countries is that the systems of public and private operators have already been consolidated. In addition, the Vietnamese social security system

[1] Izumi(2005)"Social security in Vietnam and Cambodia",『Social security in Asia』, University of Tokyo Press, pp305 -317.

is characterized by many groups (25 groups), which are divided by occupation and age into categories such as government officials, private business operators, low-income earners and children.

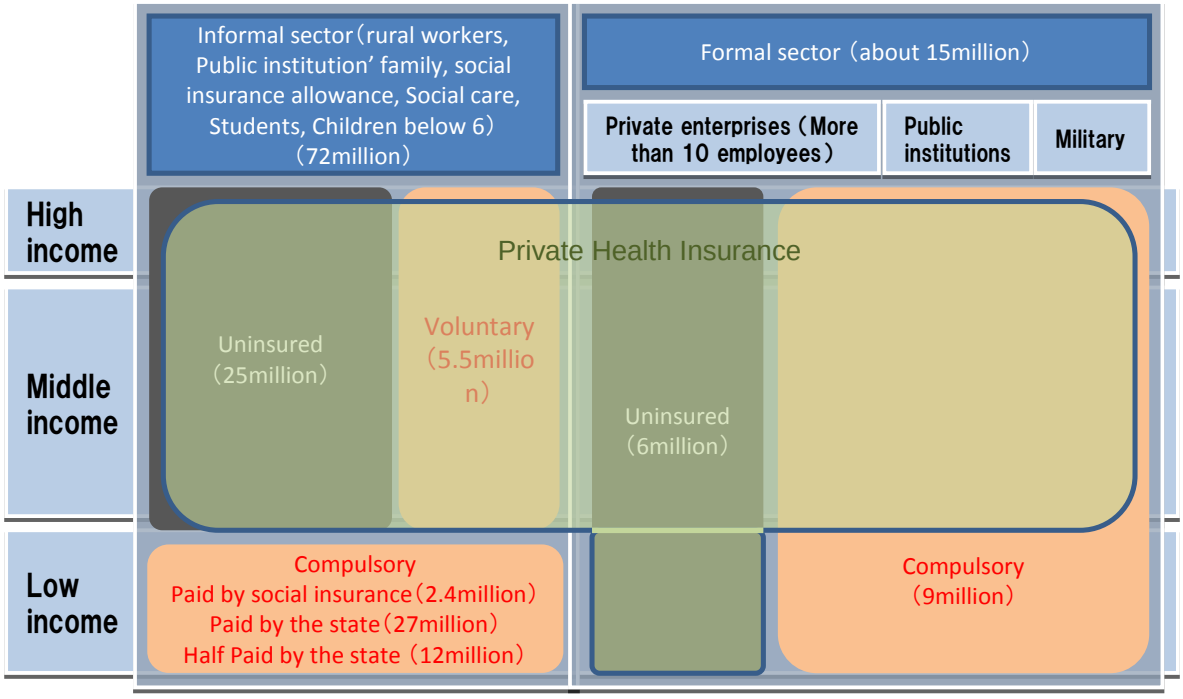
The model for the health insurance system was developed in 1992. After the establishment of the health insurance regulations in November 2008, the range of persons who are eligible for enrollment has been expanded gradually. The government has developed policies to accomplish the goal of the universal coverage (UC) by 2014 through the integration of the compulsory and voluntary insurance systems and tax cuts that reduce or exempt contribution payments for low-income earners.

It can be deemed that the current social insurance system actually began in 1995 when the non-contributory pension system for government officials, employees of government-affiliated companies and military, which started in 1961, was introduced to general private companies as a contributory social insurance system. While the government has made efforts toward universal coverage of social insurance similar to those made for health insurance, the progress in expanding access has not been as good as in health insurance. A big challenge is the sustainability of the system as the Vietnamese population ages.

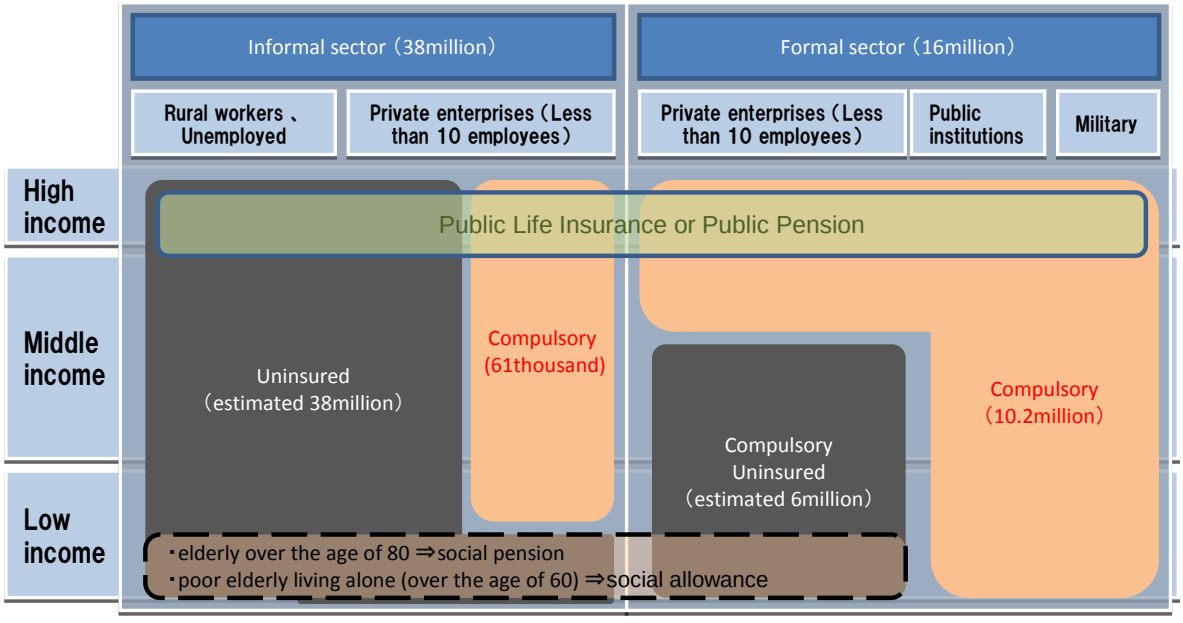
Furthermore, in 2009, Vietnam introduced the most advanced unemployment insurance system among ASEAN countries.

The development of social assistance for low-income earners has not been fully implemented. However, it is being developed gradually. For example, the age at which old-age benefits can be received has been lowered year by year for low-income elderly persons who have no relatives.

Figures V-1 Basic concept of the coverage of the social health insurance system in Vietnam



Figures V-2 Basic concept of the coverage of the social security system in Vietnam (income security scheme)



2. Organizations Involved in Social Security

While Vietnam's social security system is practically managed and operated by a single institution in an integrated fashion, the policies are decided separately by MOLISA and MOH. As each ministry lacks internal cooperation and has a vertically divided decision-making structure, their inability to present strategic approaches is an issue.

2.1. MOH (Ministry of Health)

MOH formulates policies, controls investigations and conducts research related to overall health security. It also manages and operates medical institutions. While the Department of Health Insurance (DOH) is in charge of developing policies related to the health insurance system, the Department of Planning and Finance (DPF)is in charge of managing medical fees. In addition, VSS collectively manages and operates the practical affairs concerning health insurance, and the Health Strategy and Policy Institute (HSPI), a research institution under MOH, collects practical data related to insurance medical policies and provides specific analysis for the formulation of policies.

2.2. MOLISA (Ministry of Labour, Invalids and Social Affairs)

MOLISA formulates policies, controls investigations and conducts research related to social insurance and social assistance. While the VSS collectively manages and conducts the collection of contributions, registration of new individuals and management of benefit payments concerning social insurance, Department of Labor, Invalids and Social Affairs (DOLISA), which is a regional organization of MOLISA, manages social assistance, such as the payment of old-age benefits.

MOLISA manages unemployment insurance in a manner equivalent to the management of social insurance. With regard to investigations and research, the Institute of Labour, Science and Social Affair (ILSSA) has been established within the ministry, and it conducts research necessary for the formulation of policies as well as prepares various government documents.

2.3. VSS (Vietnam Social Security)

In Vietnam, MOLISA used to manage the practical operations, such as levy of insurance premiums, insurance benefit and management of administrative procedures, of long-term social insurance (e.g. old-age pension and survivor pension), and the Vietnam General Confederation of Labor[2] (VGCL) used to manage short-term social insurance (e.g. workers compensation insurance and maternal benefits). However, in 1995, the operations of both institutions were integrated into the operations of VSS. Furthermore, in 2002, the practical operations, such as levy of insurance premiums, insurance benefit and management of administrative procedures, of health insurance, which were previously handled by MOH,

[2] VGCL is originally a coalition of labor unions in Vietnam and currently considered to direct involvement in social security.

were also integrated into the operations of VSS. Since then, VSS has collectively managed all the practical operations related to social security.

Since 2009, VSS has also been managing the newly introduced unemployment insurance. VSS does not belong to either MOH or MOLISA[3]. Rather, it manages the practical operations as an institution directly controlled by the government. It also manages the social insurance fund as well as the payment of social insurance benefits.

In addition to the headquarters in Hanoi, which controls all of the branch offices, VSS has 63 branches (PSS: Provincial Social Security Offices) in the provinces and 656 branches (DSS: District Social Security Offices) in the counties. It has about 20,000 employees including employees in the county branch offices and has about 12,000 branches at the commune level which is below the county level[4].

VSS has established an internal research institution, the Institute for Social Security Science (ISSS), which analyzes policies and conducts other work. However, because it has no pension actuary, there are capacity issues; for example, it cannot provide prospective analysis for government use, such as future estimates for pension financing.

2.4. MOF (Ministry of Finance)

With regard to social security in Vietnam, while the system is designed based on the principle of social insurance, some or all of the contributions are reduced or exempted through the injection of tax revenue. Therefore, MOF has a big impact on the system design. Government officials, who currently account for about half of the insured persons in the social insurance system, can be deemed to be one of the largest stakeholders as they pay contributions as employers. The finance minister chairs the Management Board of the social insurance fund (The deputy chairman is the director-general of VSS).

Under the current system, old-age benefits are paid to elderly persons who are ineligible to receive a pension through the injection of tax revenue. Therefore, there are many social security measures to which MOF must pay attention, such as maintaining financial sustainability until the pension system matures.

[3] VSS is made up as an independent organization which does not belong to the Ministry. Approval of the Treasury Department is not required to HR top of VSS, but has been determined by the approval of the Communist Party of Vietnam Central Committee employee.
[4] The interview for social health insurance officer in VSS.

3. Social Security Budgets

3.1. Health budget

The health budget for 2012 is 51.1 trillion VND[5] and accounts for 6.0% of the total national budget in Vietnam. The budget has increased rapidly in the last decade and is now 13 times the health budget in 2002, which was valued at 4.46 trillion VND. The percentage of the health budget in terms of the total budget is 6.0% in 2012, which represents about a two-fold increase from 3.3% in 2002. The health budget, as well as its proportion of the total budget, is expected to continue to grow similar to the other developed countries when the aging progresses in Vietnam in the near future. The future challenge will be reducing the growth rate of the health budget for maintaining the social health insurance fund.

Figures V-3 Vietnamese state budget in 2002 and planned budget for 2012

	budget (Billion VND※1)		Proportion of the budget (%)	
Items	2002	2012	2002	2012
Total balance expenditures	133,900	852,760	100.0	100.0
Social expenditures	70,880	651,060	52.9	76.3
Education and training	17,615	135,920	13.2	15.9
Health	4,460	51,100	3.3	6.0
Social security	12,260	85,560	9.2	10.0
Salary reform expenditures		59,300		7.0
Population and Family planning		970		0.1

※1 1VND=0.0038yen

Source: MOF website

3.2. Social welfare budget

The social welfare budget is divided into social security, salary reform and population and family planning as shown in the figure3. The social welfare budget for 2012 is 145.83 trillion VND in total and is about 12 times the social welfare budget in 2002, which was valued at 12.26 trillion VND. The proportion of the social welfare budget in the overall budget is 17.1% in 2012, which represents about a two-fold increase from 9.2% in 2002. The social welfare budget and its proportion of the overall budget have increased at almost the same rate as the health budget over the last decade. Also, as the social welfare budget will tend to increase in the future, the challenge will be to reduce the growth rate.

As shown in the figure4, 21.711 trillion VND was allocated for the social assistance budget[6] under the estimated budget in 2008. The breakdown was 2.036 trillion VND for daily life protection, 4.762 trillion VND for disaster assistance, 1.301 trillion VND for social services and 13.613 trillion VND for military pensions[7]. In addition, the budget for the National Targeted Program on Poverty Reduction (NTPPR) and the Program for Socio-Economic Development in Communes Facing Extreme Hardship in Ethnic Minority

[5] 1VND=0.0038JPY(JICA transaction rate as of May 2012 as reference)
[6] Social assistance budget in Figure 4 are included in the social security budget in Figure 3.
[7] Paulette(2010)「Fiscal space for social protection policies in Viet Nam」.

and Mountainous Areas (P135) was 4.564 trillion VND in 2008.

Figures V-4 Budget associated with social security in 2008 (Estimated value)

Items	budget (Billion VND※1)	Proportion of the budget※2 (%)
Social assistance	21,711	5.44
Monthly cash benefits	2,036	0.51
Aid to natural disaster victims	4,762	1.19
Social services	1,301	0.33
Benefits to people with national merit	13,613	3.41
NTPPR and P135-Ⅱ, 2006-2010	4,564	1.14

※1 1VND=0.0038yen

※2 Proportion is calculated as the Nation budget (2008) of 398,980(billion VND)from PLAN OF STATE BUDGET BALANCING EXPENDITURES FY 2008 in MOF website.

Source: Paulette (2010) Table.1 [8].

[8] Paulette(2010)「Fiscal space for social protection policies in Viet Nam」.

4. Health Security

4.1. National plans for the health security area

The Vietnamese government's greatest concern in the health insurance area is UC. The current target is to achieve UC by 2014 based on the road map drawn up by the government[9].

4.2. Salient features of health care delivery systems

Health insurance covers a relatively a wide range of medical care, including outpatient and inpatient care at all medical institutions. With regard to individual medical procedures, X-ray diagnostic imaging, biological tests, hemodialysis and open chest surgeries are covered. In terms of pharmaceuticals, those items registered in the pharmaceutical list prepared by MOH are covered.

For beneficiaries of social welfare benefits, low-income earners, persons near poverty and children under six to whom the referral system is applied who need to be transferred to a higher-level medical institution, the transfer cost can be covered by insurance.

In Vietnam, as shown in Figure 5, approximately 1,000 hospitals, 750 polyclinics and 11,500 health stations have been established. Private hospital has 83 facilities and 5,429 beds, but the proportion of private hospitals is considerably less of the total hospital.

Medical services covered by insurance are provided by 961 hospitals, including private hospitals, and 10, 866 communal health stations nationwide.

Vietnam is also characterized in that the medical health care facilities compared to urban, suburban and rural health care quality is low[10].

Figures V-5 Medical facilities and hospital beds

	medical facilities(institution)	number of hospital bed (bed)
・Hospital	961	159,558
General hospital	774	115,923
Special hospital	136	28,560
Traditional medicine hospital	51	6,501
・Polyclinic	752	8,761
・Others	180	9,907
・health station	11,576	45,994
communal health station	10,866	45,994
Others	710	0
Total	13,506	211,695

Source: Health Statistics Yearbook 2008

4.3. Basic structure of the health security system

4.3.1. System structure and persons eligible for enrollment[11]

The Vietnamese social health insurance can be classified based on the enrollment

[9] Although initially UC was set in 2010, there were circumstances to extend the goals to prospect difficult to achieve.
[10] Nguyen(2011)「Social Protection Reforms in Vietnam –Experiences and Challenges-」.

obligation and financial methods. With regard to the enrollment obligation, it can be divided into compulsory and voluntary insurance systems. With regard to the financial methods, it can be divided into three types: contributory, non-contributory and half-contributory. Citizens are divided into 25 groups based on attributes such as occupation and age. Currently, 20 of these groups are obligated to enroll in the compulsory insurance system.

The persons who are eligible for enrollment in the contributory-type compulsory health insurance system include government officials and employees of public, private and foreign companies [12]. Social welfare recipients and Unemployment insurance benefit recipients, who are eligible for enrollment in the compulsory insurance system, are fully funded from social insurance. The poor, ethnic minorities, the disabled and children under six, etc. must enroll in the compulsory insurance system. However, their enrollment is actually financed from tax revenue, so they do not need to pay contributions.

In 2010, students were transferred to the compulsory insurance system from the voluntary system. Then students are eligible for enrollment financed from tax revenue until then, but their enrollment has been changed to the half-contributory type financed 1/3 from tax revenue.

Persons who are eligible to enroll in the voluntary insurance system are self-employed persons, farmers and dependents of persons who are required to enroll in compulsory insurance, etc.

4.3.2. Contributions [13]

Compulsory insurance contributions are paid by employees and employers, and the contribution rate is 4.5% in total. The contribution rate of social welfare recipients and Unemployment insurance benefit recipients is 4.5% of social welfare allowance or unemployment allowance. The contribution rate of poor, ethnic minorities, the disabled and children under six, etc. has been 4.5% of minimum salary funded in full by the government. The contribution rate of near poverty and students has been 3% of minimum salary, but households of near poverty has been adopted the diminishing premium method according to the number of subscribers.

Contributions under the voluntary insurance system are fixed at 4.5% of the minimum monthly salary.

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[11] The documentations provided by VSS, 「VIETNAM SOCIAL SECURITY(january,2010)」.

[12] When the system was launched, companies subject to the contributory-type compulsory health insurance were limited to companies with 10 or more employees. In 2005, this rule was abolished and all private companies became subject to the system.

[13] According to the documentations provided by VSS, 「VIETNAM SOCIAL SECURITY(january,2010)」.

Figures V-6 Social health insurance in Vietnam and its summary

	Social health insurance				
Founding year	1995				
Law	1993, Decree 43/ND-CP 1995, Decree 19/CP				
Executing agency	VSS				
Program	Paid by employer and employee	Paid by social insurance	Paid by state	Paid by 1/3 state	Voluntary type
Model	Social insurance method		Taxation method	1/3 taxation method	Social insurance method
Health premiums (per year)	4.5% of salaries or remuneration	4.5% of social welfare benefit or Unemployment insurance benefit	4.5% of Minimum salary	3%of Minimum salary	4.5% of Minimum salary
Enrollment obligation	Compulsory				voluntary
membership	Public institutions, Enterprises (Dependants of them are not included in voluntary type)	Social welfare allowance, Unemployment allowance	Officers who receive allowance from the state, Revolution contributors, War veterans, The Assembly, People's Committee Members, Social Care, Poor, minority people, Military, Public Security, Important Service families, Children below 6, Overseas students	Near poverty, Students, pupils	Farmers, self employed workers, Dependants of formal sector's employees
Number of subscriber (total)(2011) [14]	55.93 million				
Number of subscriber (by program) [15]	8.95 million	2.42 million	27.15 million	11.88 million	5.53 million
Payment (outpatient) [16]	60% fee-for-service payment + 40% capitation payment (Payment operation may vary by local authorities, and rules are not clearly distinguished. Basically, the primary health care facilities are a capitation payment. But as medical facilities become more sophisticated from secondary medical facilities to tertiary medical facilities, payment operation become fee-for-service. Especially high proportion of foreign population is fee-for-service payment. As a matter of policy, the government is thinking about moving to pay medical treatment fees by capitation payment in order to reduce health care costs.)				
Payment (inpatient)[13]	60% fee-for-service payment + 40% capitation payment (Payment operation may vary by local authorities, and rules are not clearly distinguished. Basically, the primary health care facilities are a capitation payment. But as medical facilities become more sophisticated from secondary medical facilities to tertiary medical facilities, payment operation become fee-for-service. As a matter of policy, the government is thinking about moving to pay medical treatment fees by capitation payment in order to reduce health care costs.)				
Contribution	contribution	contribution	Not- contribution	contribution	contribution
Copayment	—	Copayment exemption		—	—
Referral system	Structure of the health system is divided into each stage of top-level hospital, Hospital Ministry, county hospital, health center and community applications. By referral system of visits to county hospitals, hospital-saving, top-level hospital, treated as medical insurance, medical expenses can be low. On the other hand, if you ignore referral system, top-level hospital is required the cost of expensive burden. Currently, residents' trust against the low-level hospital is thin, so many residents visit to the upper hospital. Referral form prescribed by the country has not been used much and referral information is often not reaching the lower health care facilities [17].				

[14] The documentations provided by DOH.
[15] The documentations provided by DOH.
[16] CBEH Vietnamese group(2010)「Review of piloting capitation payment method for Health Insurance -based healthcare in some provinces of Vietnam」.
[17] Itoh (2010)「The current state of medical health in Vietnam」.

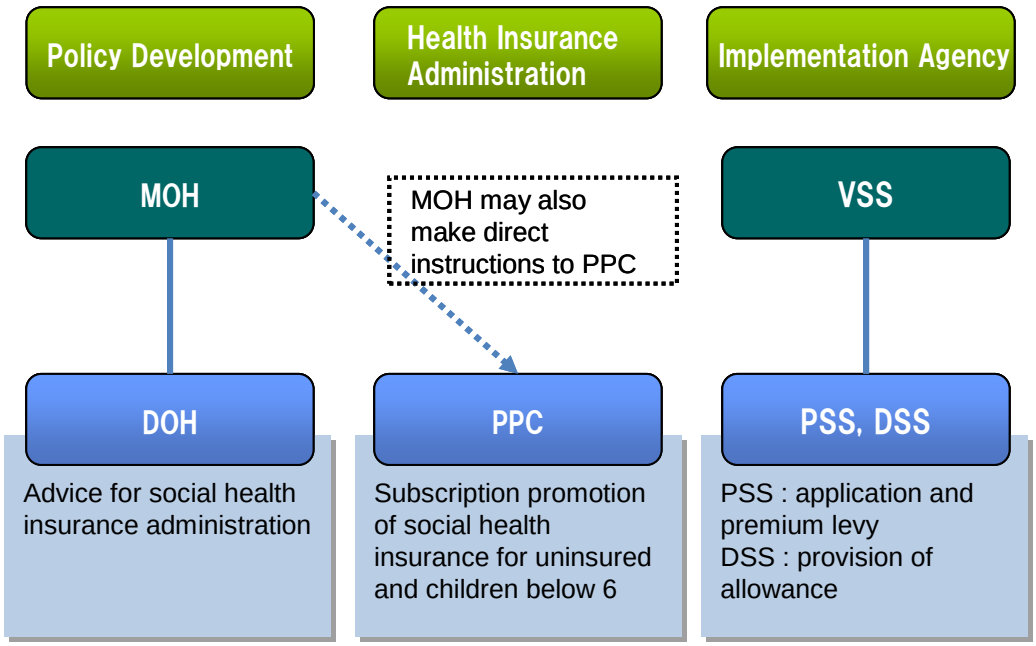
Annual spending on health (total) (2010)	7,280 million US$ [18]

※1 1USD=81.07JPY(JICA transaction rate as of May 2012 as reference)
Source: Mitsubishi UFJ research & consulting make based on the documentations provided by VSS,「VIETNAM SOCIAL SECURITY(january,2010)」

4.3.3. Operation

In the practical health insurance operations, insurance application and premium levy are managed by PSS, and provision of allowance is managed by DSS. The Provincial People's Committee (PPC) in each ministry is in charge of promoting measures for health insurance and encouraging children under six to enroll in social health insurance. DOH functions as an advisory institution for PPC on the administration of the health insurance system.

Figures V-7 Jurisdictions over the administration of the health insurance system



4.3.4. Coverage [19]

As shown in the figure.8, the number of subscribers and the coverage ratio in health insurance was 56 million people and 63.71% as of 2011.

Coverage of the type of compulsory contributions is 100% of civil servants and 51.37% of private sector employees. Coverage of private sector employees is low, but as a measure to expand it, the government prepares a draft provision on penalties for non-payment and non-subscription of compulsory memberships.

Coverage of social welfare recipients is 100%. As shown in the Figure.9, coverage of Unemployment insurance benefit recipients may be 0, because benefit of unemployment insurance was started in 2010 and statistical data for recipients of unemployment insurance

[18] Health Nutrition and Population Statistics.
[19] Hearings with persons in charge at DOH.

is not collected at the time of the 2011.

Coverage of the compulsory insurance system funded in full by the government is 91.8% as a whole, and any category has become a high coverage. But one of the main factors that impede 100% coverage is that children under six are often not enrolled. Parents neglect to complete the registration procedures even though the government has established a compulsory insurance system financed entirely from tax revenue for children under six. Education of the social health insurance must be required for their parents. In addition, the coverage ratio for persons who receive social assistance is low because MOH has been unable to identify all of the persons who are eligible to enroll in this system. One of the reasons for this is that the information in the list of persons who receive social assistance, which is prepared by MOLISA, is not shared with MOH. Some persons are classifiable into several of the 25 groups subject to health insurance based on the health insurance regulations, there is a possibility that one person can have two or three health insurance cards, which means that one person may become enrolled in multiple health insurance systems. But MOH has not still taken any measures. It will be necessary to prepare a list of persons registered in health insurance systems in cooperation with MOLISA. Persons associated with MOH have shown a recognition that MOH needs to make efforts to expand the coverage through a cross-sectional approach between MOF and MOLISA and that strong initiatives at the prime minister level are necessary.

The number of subscribers and the coverage ratio for the voluntary insurance system is 5.5 million people and 26.01%.

Figures V-8 Coverage of Health Insurance in 2011

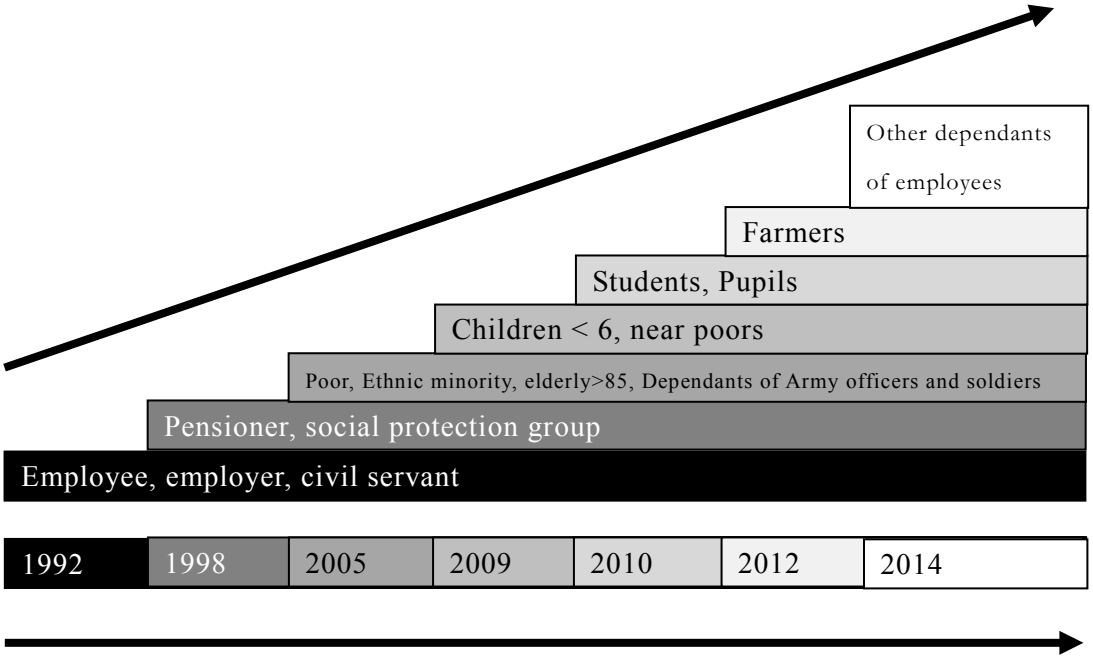
	Targeted people	Number of subscribers	% subscribers
Ⅰ.Mandatory health insurance	66,529,387	50,399,870	75.76
1.Paid by employees and employers	15,211,486	8,948,041	58.82
Enterprises and other organizations [20]	12,822,328	6,618,041	51.37
Public institutions [21]	2,329,158	2,329,158	100.00
2.Paid by social insurance	2,420,000	2,419,914	100.00
Pension, social insurance allowance	2,420,000	2,419,914	100.00
Unemployment allowance	0	0	0
3.Paid by the state	29,579,063	27,152,414	91.80
Officers who receive allowance from the state	41,431	38,809	93.67
Revolution contributors	1,851,245	1,851,245	100.00
War veterans	421,330	401,949	95.40
The Assembly, People's Committee Members	124,294	109,033	87.72
Social Care [22]	916,916	695,442	75.85
Poor, minority people	14,374,981	14,116,231	98.20
Military, Public Security, Important Service families	1,633,240	1,633,240	100.00
Children below 6	10,209,304	8,300,143	81.30
Overseas students	6,322	6,322	100.00
4.Self paid or subsidized by the state	19,318,839	11,879,501	61.49
Near poverty	6,400,000	1,616,912	25.26
Students, pupils	12,812,221	10,262,589	80.10
Ⅱ.Self-paid health insurance	21,251,318	5,527,577	26.01
TOTAL	87,780,706	55,927,447	63.71

Source: Provided Documentation by Department of health insurance, MOH

Coverage has been expanded gradually since the launch of the system in 1992. After the not-contribution system was adopted for children under six and low-income earners, coverage expansion became a matter of financial sustainability, and the barrier for practical operations, such as the collection of contributions, seems to be low. However, as farmers are still eligible to enroll in the voluntary-type contributory insurance system, in order to transfer this group to the compulsory system, it is necessary to make citizens in rural areas realize the benefits of health insurance and persuade them to make contribution payments from their cash income. Therefore, there may be many issues in expanding coverage into the informal sectors, including farmers. Furthermore, some have commented that it is not realistic to apply penalties to farmers who are delinquent in their payments or who do not enroll as stated above.

[20] Here, dependents of enterprises and other organizations employees are not included, any dependents are included in the Self-paid health insurance.
[21] Here, dependents of public institutions are not included, any dependents are included in the Self-paid health insurance.
[22] Here include who are recipients of social assistance benefits such as old age welfare.

Figures V-9 Road map towards universal coverage of health insurance



Source: Nghiem Tran Dung (2010) Social Health Insurance in Viet Nam, Health Insurance Dept, Ministry of Health.

In order to achieve the target of UC in the future, it is necessary to enroll most persons in the informal sectors who have only limited opportunities to earn cash income. However, as the government currently has a policy not to adopt a health insurance system for all sectors that is financed entirely from tax revenue, the department forecasts that the coverage ratio will be limited to; 70% in 2014 and 73% in 2015.

4.3.5. Payment mechanism [23]

Payment system for Medical services in Vietnam is not the form of each medical facility to apply for reimbursement to VSS. It is done that the officials of VSS or PSS or DSS station in a large hospital and they visit small hospitals two or three times a week regardless of the public and private in charge of the business application of medical fees. They then report the medical fee invoices to VSS on a quarterly basis. There are two reasons why VSS officials handle the invoicing of medical fees instead of hospitals: 1) the officials need to know the details of the patients' health insurance benefits, including the types of benefits they can receive, and 2) the officials need to prevent hospitals from submitting false claims for medical fees. This payment system can be persisted in condition of current 13,000 medical facilities, but when the number of medical facilities in Vietnam will increase, it is expected to be difficult to persist.

With regard to the methods of paying for medical fees, the ratio of fees for services is 60%

[23] Hearings with persons in charge at DOH

and the capitation payment is 40%. Operation in local government is different about what to adapt either of capitation payments and fee-for-service system. There are not rules that are clearly distinguished. But basically the primary health care facilities adapt the capitation payment and advanced medical care facilities such as the secondary and the third tend to adapt the fee-for-service system. Especially outpatient care tends to adapt capitation payment.

While price lists have been established for medical treatment, such as technical services, tests, drugs and material costs, such lists for surgeries have not been prepared under the Vietnamese fee-for-service system. Hospital employees accumulate medical fees based on the price lists and submit them to VSS or PSS or DSS officials. In principle, there is a cap on service fees in Vietnam, but fees that submitted can be paid to a hospital if a senior VSS official judges during an audit that the amount of the hospital claim is reasonable.

Under the Vietnamese capitation system, a budget of 500 thousand VND is allocated to the hospital for each person registered, and that amount is deemed as the total amount of medical the fees at the hospital. Price lists similar to those for fee-for-service have been established for capitation. As under the capitation system, because 20% of the remaining budget allocated to the hospital is paid to the hospital as revenue, it is expected to lower medical fees. The budget allocation that is standardly used for the capitation system is determined as 1.1 times the total medical fees for patients registered to a hospital in the previous year[24].

As a matter of policy, the government is thinking that the methods of paying for medical fees will be unified to capitation system to reduce health care costs.

4.3.6. Role of private health insurance systems and recent trends[25]

Private medical insurance is a product to join the following four cases.

①The low-income earners that don't have social health insurance, join it by the employer burden.

②The low-income earners that don't have social health insurance, join in order to reduce the cost of hospital treatment when they were suffering from a disease that requires hospitalization.

③Regardless of whether they have social health insurance, middle-income earners join in order to reduce the cost of hospital treatment in outpatient, pregnancy and dental treatments that its' insurance is not adapted.

④High-income earners want to get medical practice outside the social health insurance adaptation and to get advanced medical practice abroad.

Medical insurance product ①is a product had been sold as an option, when companies of life insurance and casualty insurance sell insurance products for the enterprise. Then they

[24] Hearings with persons in charge at DOH
[25] Hearings with persons in charge at private insurer Prevoir.

sell medical insurance products alone, so it had sold more than expected in that cheap premium. But, because of that cheap premium, they were huge losses. Today many private insurance companies do not sell.

Many people take out medical insurance product ②, when they discover that they require hospitalization after outpatient visits. Therefore the subscriber's billing rate is high and medical service fee is expensive, so medical insurance product ②has become a deficit in a lot of private insurance companies. So many private insurance companies do not sell.

Unlike medical insurance products ①or ②, profitability is not so low in medical insurance products ③that middle-income earners join. But there is no profit in products ③to consider the cost of enterprise management, so many private insurance companies has been withdrawn from sale for this product.

Profitability of products ④for high-income earners is high. Because medical facilities that they use are often foreign-owned hospitals for foreigners.

For these reasons, in Vietnam, private medical insurance system has been positioned as a medical insurance system for the current high-income earners. For these reasons, in Vietnam, private medical insurance system has been positioned as a medical insurance system for the current high-income earners. Therefore, the high-income earners, have joined forces to social medical insurance system if they belong to the enterprise. They are using private health insurance without the use of social medical insurance system.

Private Vietnamese insurance companies have thin margins, and many post losses. According to the Association of Vietnam Insurers (AVI) [26], the loss ratio of non-life insurance companies was 45% as of September 2011. The reason for this high loss ratio of health insurance products is thought to be that hospitals falsely claim medical fees higher than the actual fees. In Vietnam the number of medical facilities is far less for the number of patients, patient has become excessive demand. So in return for preferential medical treatment, they are accepting expensive fraudulent claims that have not even carried out. In addition, if private insurance companies request an audit of claims for reimbursement of public medical facilities, it does not get accepted. So they are major factors does not eliminate fraudulent claims.

People must be modifying the approach to medical insurance. People must recognize that medical insurance is mutual aid. Government must improve the coverage of social health insurance. Otherwise, private medical insurance is not approved as a commercial product.

[26] http://www.avi.org.vn/

5. Pension and other income security schemes

In terms of a public system, Vietnam has a social insurance system (not including health insurance) that includes old-age pension and in which enrollment is compulsory for all workers in the formal sector. However, as the system is technically limited to businesses with ten or more employees, it is worth noting that the state of the social insurance system differs from the current state of the health insurance system for the formal sector. In addition, the actual rate of enrollment in this system is lower than the rate of enrollment in health insurance.

5.1. Legal basis

Social insurance was defined through the issue of DECREE No.12-CP ON THE 26th OF JANUARY 1995 ISSUING THE REGULATION ON SOCIAL INSURANCE and was subsequently amended in 2003 by DECREE No. 01/2003/ND-CP OF JANUARY 9, 2003 AMENDING AND SUPPLEMENTING A NUMBER OF ARTICLES OF THE REGULATION ON SOCIAL INSURANCE, ISSUED TOGETHER WITH GOVERNMENT DECREE No. 12/CP OF JANUARY 26, 1995. Moreover, the specific methods of implementing the social insurance system were articulated in CIRCULAR No. 07/2003/TT-BLDTBXH OF MARCH 12, 2003, which provided guidelines for implementing the social insurance system.

5.2. Benefit packages

The benefit package is divided into long-term insurance and short-term insurance.

Long-term insurance includes old-age pension and survivor pension while short-term insurance includes illness benefits, maternal benefits and workers compensation insurance for occupational diseases and accidents.

Pension has been operating in pay-as-you-go system. In principle, males aged 60 or older and females aged 55 or older with contribution periods of over 20 years are eligible to receive old-age pension; however, males and females working in certain occupations designated by MOLISA and MOH as dangerous or otherwise are eligible for benefits from ages 55 and 50, respectively. Although there is no actual “disability pension” under the social insurance system, males aged 50 or over and females aged 45 or over who have lost 61% or more of their capacity to work are eligible to receive early old-age pension as long as the they have a contribution period of more than 20 years or have been engaged in a profession designated as dangerous by MOLISA and MOH for at least 15 years.

The replacement rate of the old-age pension based on a 15-year contribution period has been set at 45% of standard wages, and the system has been designed so that with each additional year of contribution, the replacement rate rises by 2 points for males and 3 points for females to a maximum 75%.

Funeral grant, monthly survivors’ benefit and lump-sum survivors’ benefit are given in

survivor's pension. The funeral grant is equivalent to 10 months of the common minimum wage. His/her close relatives shall be entitled to monthly survivors' benefit right in the month after the insured persons die, if he/she is one of the following cases.

1) Having paid social insurance premiums for at least 15 years.
2) Having paid received monthly old age pension.
3) Deceased because of employment injury and occupational disease.
4) His/her children have not reached 15 years of age.
5) His/her children are still going to school and below 18 years of age.
6) Legal spouse reaches 60 years of age for a man and 55 years of age for a woman.
7) The father, mother, father-in-law and mother-in-law / custodians who reach 60 years of age for a man and 55 years of age for a woman.

The monthly survivors' benefit for each dependent of the deceased employee is entitled to 50～70% of the common minimum wage by the earnings of the relatives (shall not exceed four persons).

If his/her condition does not apply to the above-mentioned monthly survivors' benefit, his/her relatives shall be entitled to a lump-sum survivors' benefit. The lump-sum survivors' benefit shall be computed based on multiplying the period of paying social insurance premiums (at least 3 years or more) by average monthly wage. In case that the deceased employee has received monthly old age pension, the lump-sum survivors' benefit shall be computed based on multiplying the period of paying social insurance premiums (at least 3 years or more) by half of monthly old age pension.

An amount equal to 75% of the employee's wages is paid out as illness benefits during his/her absence from work while employees of the Vietnam People's Army are paid 100%. There is no waiting period before starting to receive these benefits payments.

Maternity benefits include coverage for leaves of absences to undergo check-ups during pregnancy, a lump-sum payment at childbirth and maternity leave after childbirth.

Workers compensation insurance for occupational diseases and accidents cover accidents and injuries that are suffered on the way to and from work as well as those that occur during working hours at the place of work or areas out of the workplace but to which the guidance and supervision authority of the workplace extends. Illnesses caused by the work environment are also covered by this insurance. Either a lump sum or a monthly benefit is paid depending on the condition of the illness or accident.

5.3. Eligibility for enrollment and contribution rates

Workers eligible for the compulsory program include:

1) Vietnamese laborers working under a fixed-term employment contract or an employment contract lasting at least 3 months.
2) Civil servants and employees of public organizations.

3) Employees of the Vietnam People's Army and law enforcement organizations.

4) Non-commissioned officers and career officers of the Vietnam People's Army.

5) Vietnamese laborers who had paid the compulsory insurance premiums, are supposed to be working abroad under a fixed-term employment contract.

6) Employees of public administration agencies, the Vietnam People's Army, political associations, social and political organizations, overseas organizations, international organizations active in Vietnam, enterprises and cooperative associations.

Workers eligible for the voluntary program include self-employed workers and rural workers who are between the ages of 15 and 60 for males and 15 and 55 for females. In addition, those workers must not be eligible for the compulsory program.

Figures V-10 Compulsory Social Security Contribution

Contribution	Retirement and Survivorship fund	Work Injury-Occupational diseases fund	Sickness and Maternity fund	Total
2007-2009				
Employer	11%	1%	3%	15%
Employees	5%	-	-	5%
Total	16%	1%	3%	20%
2010-2011				
Employer	12%	1%	3%	16%
Employees	6%	-	-	6%
Total	18%	1%	3%	22%
2012-2013				
Employer	13%	1%	3%	17%
Employees	7%	-	-	7%
Total	20%	1%	3%	24%
2014-				
Employer	14%	1%	3%	18%
Employees	8%	-	-	8%
Total	22%	1%	3%	26%

Source: Vietnam Social Security (2010) Vietnam Social Security

The insurance system is funded by contributions from both the employer and employee. The contribution rates are set to correspond to a worker's base salary, and they increase annually. The contribution rates for each fund are indicated in the figure below.

5.4. Funds and operating organizations

Although VSS is responsible for operating the Social Insurance Fund (long-term insurance), its decisions must be sanctioned by the Board. The role of the Board is to give advice to the Prime Minister, who then guides and supervises the Director of VSS. As of the time research was being conducted for this report, the members of the Board were as follows. The members of the Board are determined on the basis of each position and appointed every five years by the Prime Minister.

Figures V-11 the Governing Body of Social Security

	Post
Chairman	Minister of Finance
Vice Chairman	Vice Minister, Director General of VSS
Member	Vice Chairman of General Confederation of Labor
Member	Deputy Minister of MOLISA
Member	Vice Chairman of Cooperative Alliance
Member	Director of Employers' Representative Office Vietnam Chamber of Commerce and Industry
Member	Vice Chairman of Farmers' Association
Member	Deputy Minister of Home Affairs
Member	Deputy Minister of Health

Source: Vietnam Social Security (2010) Vietnam Social Security

5.5. Enrollment figures (extension of coverage to workers in the informal sectors) [27]

As of the end of 2010, 10.2 million workers were enrolled in the compulsory program, which accounted for approximately 19.0% of the total workforce of 54 million persons. Among the number of workers who were insured under the compulsory program, approximately 4.49 million were civil servants and government employees and 4.05 million were workers belonging to other sectors. This means that approximately 60% of the workforce of 16 million persons in the formal sector is enrolled in the compulsory program.

Meanwhile, enrollment in the voluntary program has been extremely low, and 0.12% of the roughly 30 million workers of the informal sector, only around 61,000 are covered. In particular, the fact that males aged 45 or older and females aged 40 or older cannot enroll in the voluntary program for the informal sector due to their inability to satisfy the minimum contribution period for the social insurance by the time they reach the designated retirement age has become a major obstacle for expanding coverage.

5.6. Actual benefit payments [28]

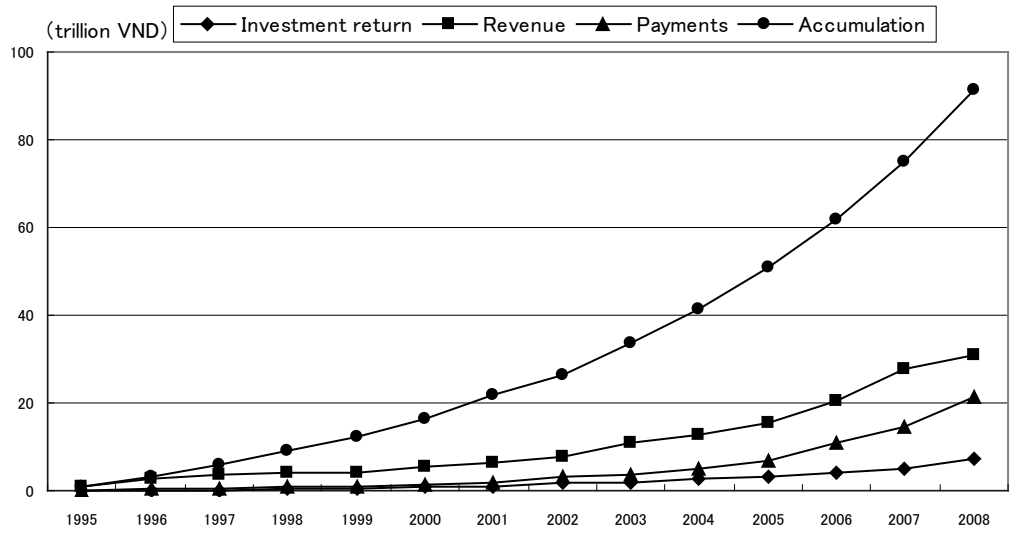
The figure11 is a graph of the amount of investment return, revenue, payments and fund accumulation of the Social Insurance Fund. It has been created based on data compiled from VSS reports. Social Insurance Fund revenues have grown in conjunction with the growth in the number of participants and reached VND 30,939 billion in 2008, and payments also reached VND 21,360 billion. Fund accumulation was VND 91,522 billion as of 2008.

A philosophy of social insurance benefits is that low benefits are received against of contributions as little as 4% of gross household income. But 40% of the social insurance fund has been funded by high-income earners of 20% and 20% of low-income people who Insurance premiums have not contributed, have received 7% of the total benefit amount and

[27] Nguyen(2011「Social Protection Reforms in Vietnam –Experiences and Challenges-」.
[28] Nguyen(2011「Social Protection Reforms in Vietnam –Experiences and Challenges-」.

contributions from the governments are small. So high-income earners have a sense of unfairness.

Figures V-12 Social Insurance Fund Balance and Accumulation, 1995-2008



Source: Modified by Mitsubishi UFJ research & consulting based on VSS reports.

In Vietnam, it is said that the population bonus[29] is from 2010 and 2018, and the era of aging from 2040. And the Social Insurance Fund is expected to fall into a major deficit by 2030 as the population ages and the workforce dwindles due to the current situation where women retire at the age of 55. In addition, in Vietnam, it is pointed out that despite the maximum amount of old-age pension benefits which has adopted a defined benefit type stipulated by the government decree is specified 75% of average salary for the past few years, only 40% of average wages is actually being paid out in benefits at this time.

[29] Labor force growth rate is higher than the population growth rate with the variation of population composition, fertility rate and mortality, and economic growth rate is increased.

6. Unemployment insurance [30]

With the enforcement of the Labor Law in 2009, Vietnam introduced the most advanced unemployment insurance system among ASEAN countries. The scheme is based on a system where contributions are shared by three parties: the employer, the employee and the government. The unemployment rate in Vietnam in 2010 was 2.9%.

In addition, as part of its labor market policies, the National Employment Promotion Fund has given preferential credit to SMEs since 1992, thereby creating approximately 300,000 jobs annually. Moreover, since 2009, the government has been conducting vocational training programs aimed at maintaining the employment of 10,000 rural workers annually. The government has also established labor market information centers in rural areas to serve as employment agencies, and as part of the labor export program, it has implemented policies to promote migrant workers in the 63 of the poorest rural districts.

6.1. Legal basis [31]

Unemployment insurance is provided for in the same Labor Law, which serves as the basis for social insurance and is based on the view of ensuring income security. However, on the view that unemployment insurance benefit and promoting employment such as job placement should be managed by the same law, debate has been exchanged by the National Assembly with respect to whether unemployment insurance should be incorporated into employment law. But social insurance office wants to leave the unemployment insurance labor law and it manages as far. And employment office wants to transfer the unemployment insurance to employment law and capture the unemployment insurance budget. So they have a tug of war over the management of unemployment insurance. Currently, the National Assembly is adjusting the claims of the two ministries.

6.2. Benefit packages [32]

Regulations stipulate that in order for a participant to receive unemployment benefits, he/she must be enrolled for at least 12 months. Unemployment insurance benefits will be benefits if the new job is not found within 15 days of unemployment. Benefit payments have become 60% of the (monthly) average salary for 6 months before unemployment. The first benefit payments were made in 2010. For contribution periods of 12 to 24 months, the participant is entitled to receive benefits for a maximum of 3 months. For contribution periods of 24 months to 36 months, the participant will receive benefits for 6 months, for contribution periods of 36 to 72 months, the participant will receive 9 months of benefits and for contribution periods of over 72 months, the participant will receive 12 months of benefits.

[30] Nguyen(2011)「Social Protection Reforms in Vietnam –Experiences and Challenges-」.
[31] Based on interviews with PPC.
[32] Based on interviews with PPC.

In order to receive these benefits, the participant must register as unemployed at a job placement center within seven days of becoming unemployed and must also submit the documents required for job placement to the center within 13 days. The participant must also submit documents for new employment within one month from the time the center refers him/her to another employer.

6.3. Eligibility for enrollment

According to the Labor Law, all employees of enterprises and organizations with ten or more employees are eligible to enroll in unemployment insurance.

6.4. Contribution rates

Since 2009, the employer, the employee and the government each contribute 1% of the salary income (monthly).

6.5. Funds and operation bodies

As was the case with social insurance and health insurance, VSS is responsible for managing and operating the unemployment insurance. PSS and DSS conduct the benefit management.

Until 2010, an unemployed person had to first submit the necessary documents to the PPC, and after screening by the PPC, that person had to then register at the job placement agency under the jurisdiction of the PPC and receive unemployment benefits from PSS or DSS. From 2011, it has become possible to register directly with the job placement agency and receive unemployment benefits from PSS or DSS without having to submit documents to PPC. Some have noted that these changes to the application and registration procedures have caused confusion in the implementation of the insurance system, but at the present time, much of the confusion seems to have been resolved.

However, as there are limited days out of each month when unemployed persons are able to register for unemployment benefits, and as the unemployed person is required to register at the job placement center within 7 days from becoming unemployed as stated above, overcrowding of the job placement center has become a problem.

6.6. Enrollment figures

As of the end of 2010, 7.05 million workers (there are thought to be approximately 15 to 16 million workers in the formal sectors) were enrolled in the scheme, and in the one year and four months since the inception of the scheme, a total of 220,000 persons have received unemployment benefits. According to data from 2010, unemployment insurance coverage was 13.9%.

6.7. Issues surrounding the unemployment insurance system

As was the case with social insurance and social health insurance, unemployment

insurance also faces the problem of non-enrollment by the businesses for which this system is intended, and there have been cases where the business does not conclude an employment contract with the laborer as well as cases of fraud, including workers who have quit after the minimum enrollment period of 12 months just to receive benefits. In addition, there have been cases where businesses deduct unemployment insurance premiums from workers' salaries but do not pay the premiums to the fund. However, these businesses have been penalized, which suggests that unemployment insurance, which had previously been left to the moral prerogative of the enterprise, has reached the stage of compulsory collection of premiums [33].

Two years have already elapsed since the unemployment insurance system went into effect, and the implementation status thereof will be analyzed and evaluated. At the same time, as the system reaches a crucial crossroad, a decision will have be to made as to which direction will be taken in the future, whether to revise the system as part of the revision to the Social Insurance Law by 2014 or to integrate the system into the Employment Law by 2013 [34].

[33] Based on interviews with PPC.
[34] Based on interviews with PPC.

7. Development of databases to identify low-income population [35]

As part of NTPPR(2006-2010), MOLISA and MPI had been instructed by government to build a database in order to grasp the situation of low-income assistance for the purpose of preventing low-income earners who receive ministerial financial support from receiving duplicate benefits. However, currently they have not been able to build a database.

[35] Homepage of the Communist Party of Vietnam, Introduction page of "NTPPR"(http://english.tapchicongsan.org.vn/Home/Vietnam-on-the-way-of-renovation/2011/260/Implementation-of-policies-on-poverty-reduction-in-Viet-Nam.aspx).

8. Social assistance systems [36, 37, 38]

8.1. Target beneficiaries

In Vietnam, various projects have been implemented as part of the nation's poverty reduction programs. These projects are conducted in accordance with laws including the "Law on the Protection of Public Health (1989)," the "Law on Child Protection, Care and Education (1991)," the "Primary Education Universalization Law (1991)," the "1992 Constitution of the Socialist Republic of Vietnam," the "Ordinance on Flood and Storm Control (1993)," the "Vietnam Labor Code including Regulations on Disabled Workers and Child Labor (1994)," the "Ordinance on Disabled Persons (1998)" and the "Ordinance on Elderly People (2000)".

The government, in accordance with the above laws, conducted the Hunger Eradication and Poverty Reduction program (HEPR) (1998-2005) from 1998 to 2005. In addition, by further implementing NTPPR, the government has been supporting low-income households and the economic development of poor areas. These programs provide low-income households with access to financial support, health insurance, education, housing, drinking water and agriculture promotion services, as well as develop infrastructure for communities in the poorest areas. Moreover, in addition to the above projects, the government has conducted programs geared toward the social and economic development of ethnic minorities and extremely poor communities in the mountainous areas (P135-I (1999-2001), P135-I (2002-2004) and P135-II (2006-2010)) as a means of providing funds to poor areas and developing infrastructure and social policies.

These efforts, despite being conducted as part of NTPPR, are, in effect, functioning as social assistance programs for the low-income population in Vietnam.

8.2. Standards for benefits and benefit amounts

Social assistance benefits are divided into regular assistance, emergency assistance and the elderly assistance. Regular assistance refers to assistance given to 11 groups (the poor, ethnic minorities, residents of remote areas, residents of mountainous areas, rural workers, laborers in the informal sectors, the unemployed, the disabled, orphans, the elderly and the sick) in accordance with Decision 13/2010/NĐ-CP while emergency assistance refers to assistance given to persons facing difficulties due to the effects of natural disasters or the impact of economic/social risks. Staff of PPC in each commune surveys and comprehends the circumstances on the target persons of regular assistance. In addition, in the 63 poorest districts, many poverty reduction programs have been carried out, such as NTPR managed by

[36] Izumi(2003)「Social security in Vietnam and Cambodia」『Social security in Asia』, University of Tokyo Press, pp305 -317.
[37] Paulette(2011)「Fiscal space for social protection policies in Viet Nam」.
[38] Nguyen(2011)「Social Protection Reforms in Vietnam –Experiences and Challenges-」.

MOLISA and P135 managed by association of the ethnic minorities. So situation of the poor are always grasped. Benefit criteria is the salary of less than $ 2 per day (poverty line) set by the government. The amount of benefits is set at half of the minimum wage, regardless of regular assistance and emergency assistance.

As cash benefit systems in support of the elderly, welfare benefit system for the elderly over 85 has been developed. Under this system, regardless of the family presence and income, the target persons shall be entitled. Benefit amount is set to 18 million VDN, equivalent to about 20% of the minimum wage. Age to receive benefits was over the age of 90 in the beginning of the system, but it was reduced to 85 years old in 2008. Currently, considering the financial balance, the proposal[39] that age to receive benefits is further reduced up to the age of 80 was approved by the parliament and is discussed in the Central Committee of Communist Party[40].

8.3. Actual benefit payments

Beneficiaries increased from 416,000 in 2005 to 6 million in 2010 . The reason for the increase in their social assistance benefit is because the subject has increased emergency assistance. Many of the current social assistance benefits have been used to support the victims of natural disasters.

8.4. Implementing bodies, social workers

The Social Protection Bureau of MOLISA is responsible for implementing social assistance. In regards to social workers, the National Proposal on Social Work and Integration of Social Work Functions is being implemented with cooperation from the Asian Social Institute[41] (ASI) during the period from 2010 to 2020 for the purpose of enhancing the quality of social workers[42].

8.5. Issues and challenges

Problems of social assistance is that the government does not know for sure the exact number of social assistance 1.14 million people that are said to account for 1.3% of the total population of Vietnam. In particular, poverty situation of poor people who emigrated to urban areas from the poorest district, geographically difficult area residents who have access to administrative services, and , orphans is not out of the grasp.

[39] The proposal described in 「Social Protection Strategy of Vietnam (2011-2020)」.
[40] Based on interviews with the Social Protection Bureau of MOLISA.
[41] Private graduate school at the Institute of Manila in the Philippines, studying in economics, sociology, social work, social services, development studies.
[42] Based on interviews with the Social Protection Bureau of MOLISA.

9. Care and Welfare for the Elderly [43, 44]

9.1. Policy initiatives and framework for the elderly

Vietnam is getting closer to the end of demographic transition represented by three characteristics, such as decrease of birthrate, decrease in mortality and increase in life. As a result, the population of children reduces, and productive-age population and aging population increases. According to General Statistics Office (GSO), the average life expectancy is 71.3 years old in 2006, the elderly population (over 60) [45] is 10% of the total population in 2017, and will reach 17% in 2029. The aging index [46] will be 35.5 in 2009 and will increase to more than 100 in 2032. According to the definition [47] of World Health Organization (WHO), society has exceeded 7% of the population over the age of 65 is an aging society. So it is believed that Vietnam has entered the aging society within 10 years.

In 2006, breakdown of the cost of living of the elderly has become 19.2% pension, 60% social assistance, 30% self-income, 49% support from their children and the community (Including duplicates).

4,206 Social Protection Center across the country have been providing community service for the elderly.

As support elderly health care, health insurance card has been distributed to 363 thousand elderly people and copayment of 9.1 thousand people, 67% over the age of 90 are exempted.

9.1.1. Law on the Elderly

A welfare system for the elderly has been devised and is currently being operated by MOLISA. However, the system is limited and has not necessarily been sufficiently developed from a long-term perspective.

Following the issuance of the ORDINANCE ON ELDERLY PEOPLE [48] on April 28, 2000, policies for the elderly were formulated by MOLISA in collaboration with the Vietnam Association of the Elderly (VAE) and work began on drafting the Law on the Elderly. The nine areas of clothing, food, housing, mobility, health, culture, education, information and exchange where identified as the key areas during the drafting of the law. Although the payment of old-age welfare benefits has been administered pursuant to Decree No. 23, 2000,

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[43] UNFPA(the United Nations Population Fund)(2011), THE AGING POPULATION IN VIETNAM.

[44] Nguyen(2006), Country Report Current situation and future perspective for ageing society, MOLISA.

[45] As defined by the WHO, many countries have been defined that elderly age is 65 at a global point of view, but Vietnam has been defined that elderly age is 60.

[46] In Vietnam, percentage of the population under 15 years of age divided by the population over 60 years of age.

[47] A population is classified as “aging society” when the persons aged 65 and over account for 7% of the total population; it is classified as “aged society” and “very aged society” with percentages of 14% and 21%, respectively.

[48] ORDINANCE ON ELDERLY PEOPLE, No. 23/2000/PL-UBTVQH10 of April 28, 2000

the Law on the Elderly[49] only became law after being approved by the parliament on November 23, 2009 and enacted on July 1, 2010.

9.1.2. National Action Plan on the older people

MOLISA has devised national action plans on the older people (2005-2010 and 2010-2020)[50]. There are six targets and ten activities in this plan as follows.

Six targets

1) Older people improve material and spiritual life.
2) Older people receive medical treatment and care from their families and communities. Poor older people receive free medical examination and treatment.
3) Lonely older people without income get social allowance every month and entitled to free medical care.
4) Older people over 85 without pensions and other social allowances are provided with monthly social allowance and free medical insurance cards.
5) No older people live in slum housing.
6) 80% of the communes have funds to provide care for older people.

Ten activities

1) Promote the role of older people.
2) Promote awareness on ageing.
3) Promote activities to prepare younger people for active ageing.
4) Improve livelihood of older people and their families
5) Improve health status of older people.
6) Promote activities to improve cultural and spiritual life of old peoples.
7) Encourage and assist the establishment of funds to care for older people at commune level as prescribed by law in the National Plan of Action on Ageing.
8) Improve the capacity of the Older People Associations to develop and implement effective and appropriate activities to improve the health and livelihood of older people and their communities.
9) Organize studies, researches, and evaluations on programs and policies relating to older people.
10) Enhance international cooperation in ageing issues to improve the health and livelihood of older people in Vietnam.

9.2. State of elderly care facilities and services

9.2.1. Elderly care facilities

Anyone aged 80 or over may enter into an elderly facility by applying to the local People's

[49] Law on the Elderly No: 39/2009/QH12
[50] Based on interviews with the Social Protection Bureau of MOLISA.

Committee. Residents of these facilities are not required to pay living expenses, which are covered entirely by tax revenue. In provinces such as Hanoi, which have large budgets, such expenses are covered by the budget of the City of Hanoi, while funds are appropriated from MOF to provinces with smaller budgets. In addition to the elderly care facilities under the jurisdiction of local government, there are a number of facilities around the nation under the jurisdiction of MOLISA in the ministry of large budget such as municipalities. In principle, the government's policy is to cover the expenses of these social protection facilities with the local budget [51].

Although MOLISA has laid down uniform operation standards (e.g. number of staff, budget per person, etc.) for elderly care facilities throughout the nation, some facilities do not meet these standards, and in most cases, the facilities are run according to their own standards, which are often different from those prescribed by MOLISA.

9.2.2. Cash benefits system

Regarding cash benefits system for the elderly, refer p.30.

9.3. Welfare for the elderly

9.3.1. Main organizations providing welfare for the elderly

The Vietnam Association of the Elderly (VAE) was founded by former Head of State Ho Chi Minh in 1945 as an association for providing mutual assistance between the elderly, and it was initially run through voluntary funds without funding from the government. Since May 1995, VAEs have been established throughout the country, and at present, in addition to the Central Office, organizations exist at each level of Province, City (63 organizations for Provinces and Cities taken together), District (700 organizations), and Commune (11,000 organizations). Although the elderly account for 10% of the Vietnamese population, total membership in VAE is 7.6 million, or 86% of the nation's elderly population. The objective of VAE is to provide welfare for the elderly in cooperation with the government [52].

VAE has taken the lead in forming funds for mutual assistance (General caring Fund、Older association fund、Fund for caring parents and grand-parents etc.) in each region. Enrollment in these funds requires an initial payment of VND 10,000, and when faced with economic hardship, the participant may borrow living expenses from the fund with interest. By these funds, activities to repair the residence of the elderly and construct a new dwelling have been carried out.

In addition, an auxiliary fund for the elderly has been created pursuant to the Law on the Elderly, which is run by contributions collected by VAE from private-sector enterprises [53].

[51] Based on interviews with the Social Protection Bureau of MOLISA
[52] Based on interviews with VAE.
[53] Based on interviews with VAE.

9.3.2. State of welfare for the elderly [54]

VAE has taken the initiative in utilizing government subsidies to promote the following types of welfare measures for the elderly:

1) Execute renovation programs for the elderly living in old housing through the use of government subsidies, contributions from private enterprises and donations from Association members

2) Conduct programs to collect donations of clothing and distribute them to the elderly poor; and other similar programs.

In certain regions, community support for the elderly is being implemented under the sponsorship of VAE. Examples of such support include these assistances such as the following:

1) Visits by VAE members to elderly persons who are sick (to provide physical and mental care)

2) Operating cultural and sports clubs for the elderly for the purpose of maintaining their health

3) Holding lectures that providing information from around the world and information on children's education for the purpose of maintaining their mental health

4) Holding leisure activities and travel events for the elderly

5) Providing opportunities for the elderly to participate in the local community (arranging for former physicians to conduct physical exams of young people, former teachers to provide education and instruction to children).

At TV broadcast stations, channels dedicated to the elderly have been established that broadcast programs on hobbies and leisure as a means of preventing dementia among the elderly.

9.4. State of international cooperation [55, 56]

International cooperation for elderly assistance has been obtained from HelpAge International and International Federation on Ageing (IFA).

Help Age activity in Vietnam has a wide variety of activities such as elderly income improvement, elderly health maintenance activities, establishment of community self-help club for the elderly and elderly working support. In 2010, Help Age has been involved in the establishment of 160 community self-help club. The current efforts are to receive old-age pension by the elderly more, increase the income of the elderly and their families, provide home care for 20,000 elderly per year and implement measures against natural disasters. HelpAge are doing activities for the elderly in partnership with VAE and Center for Ageing Support and Community Development (CASCD). In addition, the HelpAge is carrying out a

[54] Based on interviews with VAE.
[55] Based on interviews with VAE
[56] HelpAge International homepage(http://www.helpage.org/)

program request for nursing human resources, including other ASEAN countries in the backup of the South Korean government. Vietnam Has also received support since 2003.

Activities of the IFA are the exchanges of information and personnel with NPO and NGO working on issues related to aging, and to hold an international conference, a forum. So IFA is going to support the elderly.

In addition, few years ago, physical exams for 1,200 elderly people were conducted through cooperation and funds provided by Japan's Toyota Motor Corporation and VAE.

10. Issues Facing Social Security in Vietnam

10.1. Issues Facing Social Health Insurance

10.1.1. Reforms to the healthcare financing system

In order for health insurance to be sustainable, measures for managing healthcare costs, including methods for the payment of medical costs, are important issues even in the medium- to long-term. Operating a health insurance system is financially difficult, and the health insurance fund recorded deficits from 2005 to 2009 during which time it took out loans from the social insurance fund. Contribution rates are low (4.5% of wages), and the fund is faced with the problem of not being able to fully cover basic medical costs such as pharmaceuticals and other medical materials.

In regards to the payment methods, the Department of Planning and Finance of MOH has reexamined the current system of fees for services and has been promoting a new pilot project with an aim of introducing payment by capitation or Diagnosis Related Groups (DRG). However, it has not necessarily clarified the direction it will take in the management of medical costs. In addition, the government is receiving academic support from the Thai government in order to consider capitation or DRG, but a researcher from the Thai government who is involved in the project said that Vietnam's current capitation scheme is being developed more as a tool for cutting back on costs rather than as a scheme based on measurements of the actual costs that will be required.

Moreover, in terms of coverage, there has been discussion on whether to include physical check-ups in the scope of coverage. Furthermore, in regards to the management of medical costs, discussions are being held on whether to apply an independent accounting system to public medical institutions. Issues regarding the level of independence also need to be addressed in the future.

10.1.2. Issues facing universal coverage

Vietnam has been promoting the development of its social security system in line with its Doi Moi policies by commencing the development of its social security system in the 1990's and promoting the centralized management and operation of the system during the 2000's. Over the past few years, efforts toward achieving universal coverage in the social and health insurance systems have gained momentum and a roadmap toward universal coverage in health insurance has been prepared.

However, many officials note the lack of specific measures required for realizing universal coverage as well as insufficient capacity in terms of formulating and carrying out the necessary measures, and thus, many issues remain both on the policy and technical levels.

Improving medical institutions and raising public awareness can be cited as specific obstacles toward realizing universal coverage in health insurance. Among the health

insurance products offered by private sector health insurance companies, insurance products intended for the middle- to lower-classes, in particular, are unlikely to become profitable as those persons who are insured are more prone to injuries and illness. In Vietnam, health insurance policies are not purchased for peace of mind but as a way of receiving inexpensive medical treatment, and it has also been noted that unless the concept of "paying insurance premiums in advance" is embedded in the minds of the population, it will be difficult to expand the public health insurance system.

10.2. Issues surrounding employee social security

10.2.1. Policies to expand the application of social security to the entire population

Similar to health insurance, regarding universal coverage in social insurance, the expansion of coverage to the information sector is a particularly crucial policy. However, the non-enrollment of rural workers and the self-employed as well as SMEs with fewer than 10 employees, which would normally be classified as belonging to the formal sector, is another major issue. In order to incorporate the over 400,000 SMEs that are said to exist into the social insurance system, the ability for the employers to make the contributions is a prerequisite, and this, in turn, would require various measures such as stabilizing the management of SMEs and improving the access to credit. Not only employers but the employees, too, are reluctant to enroll, and the expansion of enrollment is even weaker compared to health insurance because of the assumption that a bigger take-home pay is better.

As future measures, the government is considering to: (1) increase the coverage of the formal sector, (2) implement a pilot voluntary social insurance program for SMEs and the informal sector that is partially subsidized by the government, (3) gradually transfer the pension scheme from defined benefits to defined contribution in order to increase the financial sustainability of the pension fund and (4) further reduce the current eligibility age (80 years old) of the non-contributory social pension for the elderly[57].

10.2.2. Monitoring income and contribution rates

The majority of employee wages are paid in cash, which makes it difficult to monitor income, and this, in turn, leads to difficulty in accurately calculating contribution rates. In addition, as contributions are determined by multiplying the basic salary by the contribution rate, in principle, a trend has been seen where the employers pay bigger benefits than the basic salary in order to keep their insurance contribution payments down. Therefore, research has shown that although the current contribution rate of 22%, excluding the unemployment insurance portion, appears high at first sight, it is, in reality, only around 7.5% of the total salary.

[57] Nguyen (2011)「Social Protection Reforms in Vietnam –Experiences and Challenges-」.

Some have also noted the issue of employers avoiding obligatory contribution payments by repeatedly entering into short-term employment contracts of less than 6 months. However, instead of concerning the social insurance system, these issues are general labor problems. For this reason, coordination within the departments of MOLISA is essential; however, some have noted that the departments have not necessarily coordinated sufficiently with each other in relation to these issues.

10.2.3. Sustainability of social insurance funds

Trial calculations have indicated that, in terms of sustainability, the social insurance fund will face a financial crisis around 2032 due to the aging of the population. Thus, the management and investing methods of the social insurance fund will require both legal and practical improvements. During 2012-2013, the social insurance laws are expected to be revised, and both evaluations and investigations of the system based on current results are being planned.

In fact, the yield on investments of the pension fund has been less than increase in the consumer price index.

Furthermore, the lack of pension specialists at MOLISA and VSS, which are the main ministries responsible for managing the social insurance funds, has also been noted. Moreover, the lack of specialists, particularly pension actuaries, has resulted in a situation where the organizations are incapable of making their own projections.

10.3. Issues for the future of elderly policy

Although the population will continue to age in Vietnam, there are currently very few elderly facilities. At present, elderly facilities have only been provided for elderly persons with no families or who are recognized as being poor.

A few private-sector elderly care facilities exist, but due to their exorbitant rents, they are accessible only to certain high-income earners. Consequently, as the population ages in the near future, the government will be forced to decide whether to require families to take care of the elderly as the number of elderly people requiring nursing care increases, or to train professional caregivers as has been done in industrialized nations. Currently, Vietnam strictly upholds the policy of having the family or community take care of the elderly[58].

In addition, when dealing with the elderly in the broad sense, i.e. including elderly persons in the community who are strong and well, the Vietnam Association of the Elderly (VAE), with its extremely wide membership, its own media outlets (newspapers and TV stations for the elderly) and strong sphere of influence, will become a crucial organization for considering future partnerships.

[58] Based on interviews with VAE.

11. Priorities to be addressed in Vietnam

Vietnam, which is expected to proceed fairly rapidly aging future, aging measures have become an urgent priority. Aging measures will require infrastructure development related to social security in general such as enhancement of medical facilities, shelter enhancement of the elderly, ensure financial assistance for elderly public funds and social insurance funds and social care insurance. In addition, they are going to need to be addressed in terms of system software such as caring for the elderly. Currently, the Vietnamese government is the policy of family and community support to care for the elderly. However, when aging progresses, it is expected that only family and community can not cope, so it becomes also requires training of professional caregivers. Vietnam must develop human resources who can respond to issues of aging in each ministry. At that time, anti-aging expert knowledge of Japanese is always helpful.

Also, medical fee payment system improvements in health care are a priority. Currently, led by the MOH, the conversion of payment method has been made to pay capitation from fee-for-service system. This measure is not based on estimates of future financial health, but it has been implemented in order to suppress the short-term medical expenses. This problem seems to have received support from the Thai government academic. It is necessary to develop a financial expert who can estimate future medical care in Vietnam and reform the financial system to health care drastically. Although it is considered that in the short term the need for direct technical cooperation of Japan is not high, in the medium to long term expert knowledge exchange of medical administration in Japan is useful.

Chapter VI Thailand

1. Social Security Overview

1.1. Social security in the constitution

The provisions of the 1997 Constitution of Thailand related to social security include Chapter III (Rights and Liberties of the Thai People), Sections 52 (Right to receive public health service), 54 (Income security for elderly) and 55 (Protection of PWDs), and Chapter V (Directive Principles of Fundamental State Policies), Section 86 (Social measures for employees).

Figures VI-1 Related provisions of the Constitution (Excerpt)

Section 52, Paragraph 1: A person shall enjoy an equal right to receive standard public health service, and the indigent shall have the right to receive free medical treatment from public health centres of the State, as provided by law.
Section 52, Paragraph 2: The public health service by the State shall be provided thoroughly and efficiently and, for this purpose, participation by local government organizations and the private sector shall also be promoted insofar as it is possible.
Section 53, Paragraph 1: Children, youth and family members shall have the right to be protected by the State against violence and unfair treatment.
Section 53, Paragraph 2: Children and youth with no guardian shall have the right to receive care and education from the State, as provided by law.
Section 54: A person who is over sixty years of age and has insufficient income shall have the right to receive aids from the State, as provided by law.
Section 55: The disabled or handicapped shall have the right to receive public conveniences and other aids from the State, as provided by law.
Section 86: The State shall promote people of working age to obtain employment, protect labour, especially child and woman labour, and provide for the system of labour relations, social security and fair wages.

Source: "Constitutions of Asia", 'Kingdom of Thailand' translated by Kiyoko Tojo; 2004; Akashi Shoten

1.2. Current state and basic direction of government policy for social security

1.2.1. Trends of the overall social security system

In the health security front, Thailand established the "30 Baht Health Scheme[1]" covering the entire nation including the informal sector[2] in 2002. Since then, the amount of

[1] 1THB=2.631JPN(as of May 2012 JICA internal rate)

[2] In Thailand, "informal sector" implies the working people with obvious contract such as self-employed, agricultural or fishery workers. However in the broad sense, it may include the people which are not covered by

government budget for the Scheme is increasing year by year. Even in the fiscal years of 2008 and 2009 affected by the Lehman Crisis where most sectors faced a budget cutback, the health-related budget still increased. The health security policy has been strongly supported by the nation and currently become the primary issue for the Thai government.

In terms of income security for workers, the Social Security Scheme (SSS) which started to be applied to the employees of the private sector in the 1990' has added the unemployment benefit and extended to the informal sector. While the contribution to the unemployment benefit started to be collected in 2004, the two methodologies for extending to the informal sector have currently been presented: Extension of the SSS to the informal sector, and establishment of the National Savings Fund (NSF) as an income security for retired, which should be further discussed from a perspective of sustainability and affinity to the informal sector.

1.2.2. National Economic and Social Development Plan

Since the "People-Centered Development" policy was advocated in the 8th National Economic and Social Development Plan (1997-2001), the Thai government has focused on not only infrastructure development but also improvement of the quality of people's lives. The 9th National Economic and Social Development Plan (2002-2006) prepared after the Asian currency crisis in 1997 centered the concept of "Sufficiency Economy Philosophy" and highlighted the resilience and sustainability of the society to improve the quality of people's lives.

Later, the 10th National Economic and Social Development Plan (2007-2011) has presented the strategic measures against preventable diseases, including improvement of access by the nation to the public health service. In this regard, the government organizations, mainly the Ministry of Public Health (MOPH) and the National Health Security Office (NHSO), have promoted health promotion and disease prevention at a community level since 2007.

These initiatives have been supported by increasing the public finance for the past decade including the period affected by the Lehman Crisis. However, the management and containment of cost has become more and more important year by year from the perspective of a sustainable system, and the capitation unit cost of the universal coverage (UC) scheme[3] is expected to level off. Furthermore, the public finance for income security including unemployment insurance is likely to be hiking.

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any existing schemes including students or housekeepers.

[3] For the outpatient treatment under the UC system, the amount to be calculated by multiplying the number of insured (who are registered in medical institutions in an area) by the capitation unit cost is allocated to each medical institution.

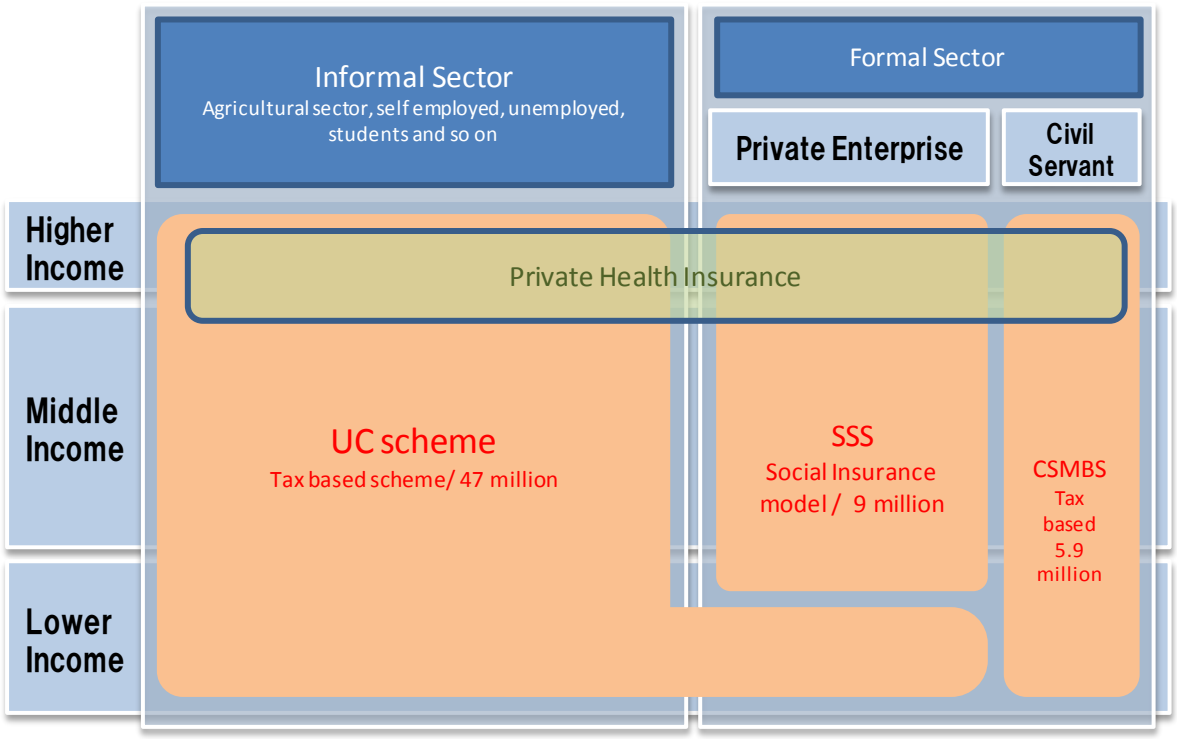
1.3. Outline of the social security system

1.3.1. Health security

Thailand has had a universal health security system with the following three schemes: Civil Servant Medical Benefit Scheme (CSMBS) mainly for government officers, Social Security Scheme (SSS) for the employees of the private sector, and UC scheme for other people than the above.

While the UC scheme covers any persons other than those who are entitled to enroll the other two schemes for the formal sector, few of the wealthy who do not fall in the formal sector (e.g. lawyer) generally utilize the UC scheme but buy a private health insurance instead. In addition, some employees of the private sector who are the insured of the SSS also enroll in a private health insurance, if they afford. While the Thai government is seeking to establish a national health security system managed by a single organization under the 2001 National Health Security Act, it has not yet have a clear idea on the integration of the current three scheme, which is an ultimate target in the Thailand's health security front. In 2012, the emergency medical service has been integrated (including private insurances), which is the first scheme operated under the uniform standards and rules. Similar developments are expected in other areas.

Figures VI-2 Health security overview



Source: Compiled by Mitsubishi UFJ Research and Consulting.

1.3.2. Income security

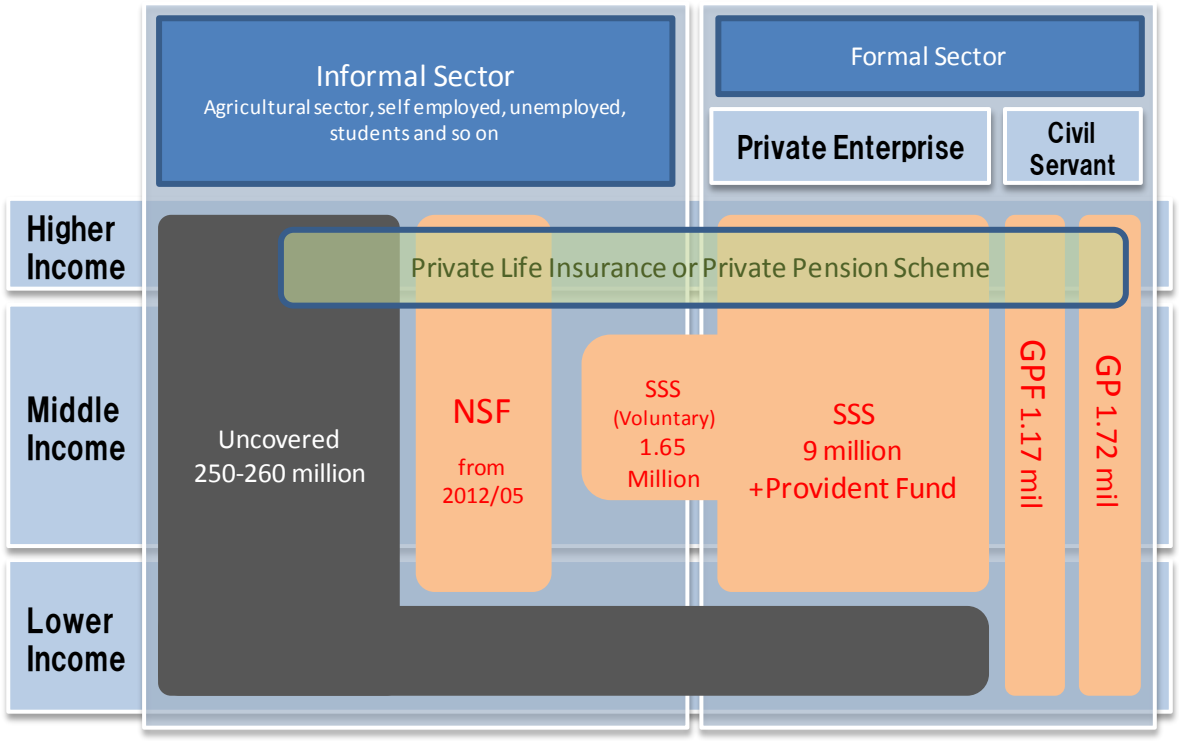
The income security system such as old-age and disability pensions mainly consist of the

Government Pension Fund (GPF) for government offices, the Social Security Scheme for the employees of the private sector and a retirement allowance fund called the Thailand Provident Fund (TPF). In addition to them, the National Savings Fund (NSF) mainly for the informal sector has been introduced since May 2012.

Despite the growing establishment of schemes, due to their incomplete coverage, there are still a number of employees with no insurance or security. Especially, extension of the coverage to the informal sector is delayed, as it is difficult to figure out their income and they may not afford continuous contribution.

The cash benefit as the social assistance is paid to all of the elderly people except the elderly retired from government officer.

Figures VI-3 Pension and other income security schemes overview



Source: Compiled by Mitsubishi UFJ Research and Consulting.

2. Organizations Involved in Social Security

2.1. Ministry of Public Health (MOPH)

The Ministry of Public Health (MOPH) is one of the central government organizations in charge of the public health/medical services and responsible for planning health care policies. The allocation of health budget for UC scheme which the MOPH used to be in charge is basically handled by the National Health Security Office (NHSO) since the introduction of the UC scheme in 2002. The Minister' Secretariat of the MOPH is still in charge of managing and operating public hospitals. In general, while the NHSO is seen as a "purchaser', the MOPH acts as a "provider".

The Provincial Health Office (PHO) and the District Health Office (DHO) as branch offices of MOPH are set up in each province and each district. Furthermore, district-level community hospitals under the control of the MOPH play a role of delivering health care services. While the Health Centers located in each tambon[4] is under the control of the Ministry of Interior (MOI), in practice, they support local health care services as a primary care unit (PCU) in collaboration with community hospitals.

2.2. Ministry of Social Development and Human Security (MSDHS)

The Ministry of Social Development and Human Security (MSDHS) is one of the central government organizations mainly in charge of social welfare-related policies. The MSDHS is expected to play a primary role in elderly administration and acts as the Office of the National Elderly Committee[5]. The MSDHS is also in charge of public assistance, and consists mainly of the Department of Social Development and Welfare, the Office of Women's Issues and Family System, the Office of Protection and Stable Support for Children, Youth, Social Vulnerable and Elderly, and the Office of the National PWD Welfare Improvement Committee.

The MSDHS has its offices in each province where social workers and other experts provide professional advices in the social welfare field to the local Tambon Administration Organization (TAO). Unlike the MOPH, no MSDHS's office is set up at an administrative unit below district.

2.3. Comptroller General's Department (CGD)

The Comptroller General's Department (CGD) under the control of the Ministry of Finance (MOF) is responsible for managing and supervising public expenditures. As for the health security function, the Civil Servant Medical Benefit Scheme Group within the CGD is

[4] Thai local administration bodies consists of 76 province, 795 districts, 7,255 tambon (sub-district), and 69,307 villages

[5] The cross ministerial organization setting the basic policy orientation, chaired by the Prime Minister.

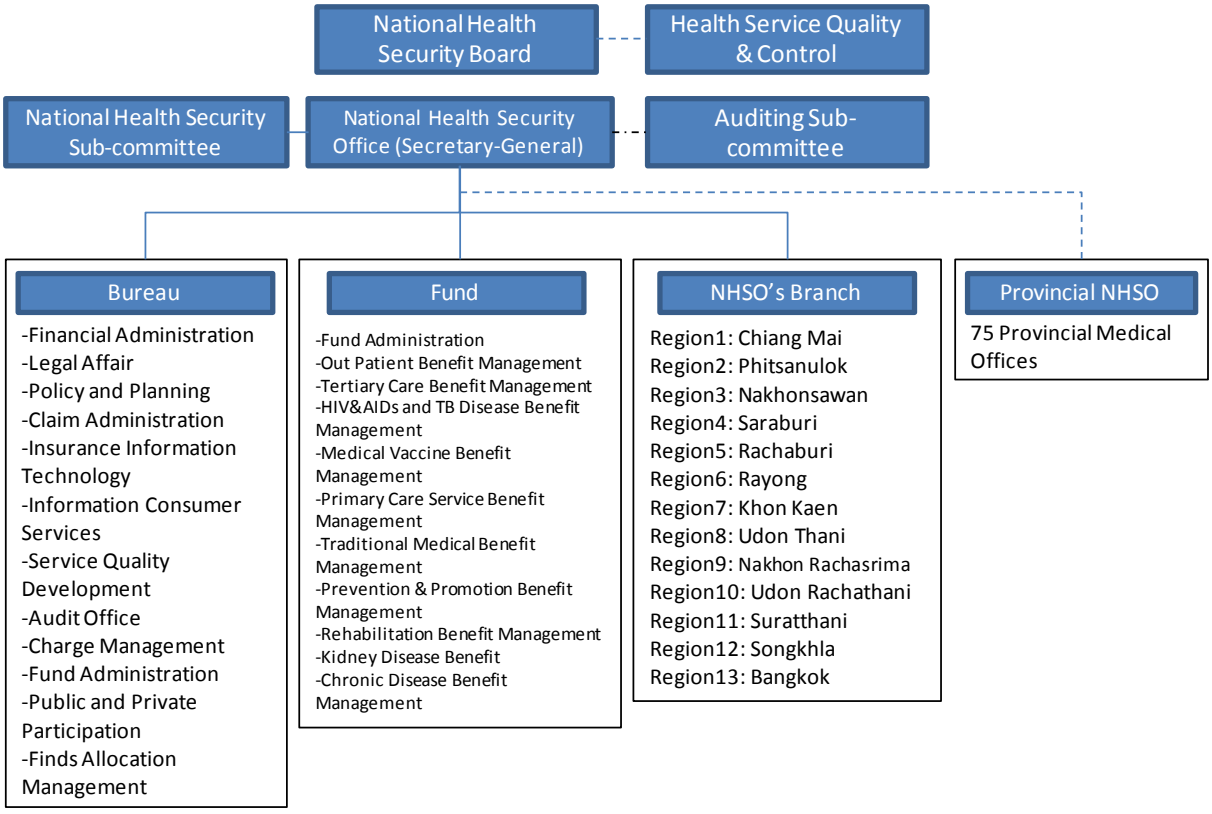
in charge of the CSMBS.

2.4. National Health Security Office (NHSO)

The National Health Security Office (NHSO) was organized under the National Health Security Act in 2002 where the "30 Baht Health Scheme", the predecessor of the UC scheme, was established. The NHSO is an independent organization from the MOPH and plays a role as a purchaser of medical services. Almost all authorities related to the operation of the UC scheme are conferred to the NHSO, including determination of insurance payment, standardization of medical services, and definition of the standards of fund management and certified medical institutions.

The NHSO currently has 13 offices across the country. The health budget is allocated from the NHSO's Head office to "contract unit for primary care" medical institutions through the local offices (medical services to be purchased from "contract unit for primary care" medical institutions).

FiguresVI-4 Organization Chart of the NHSO



Source: NHSO's website

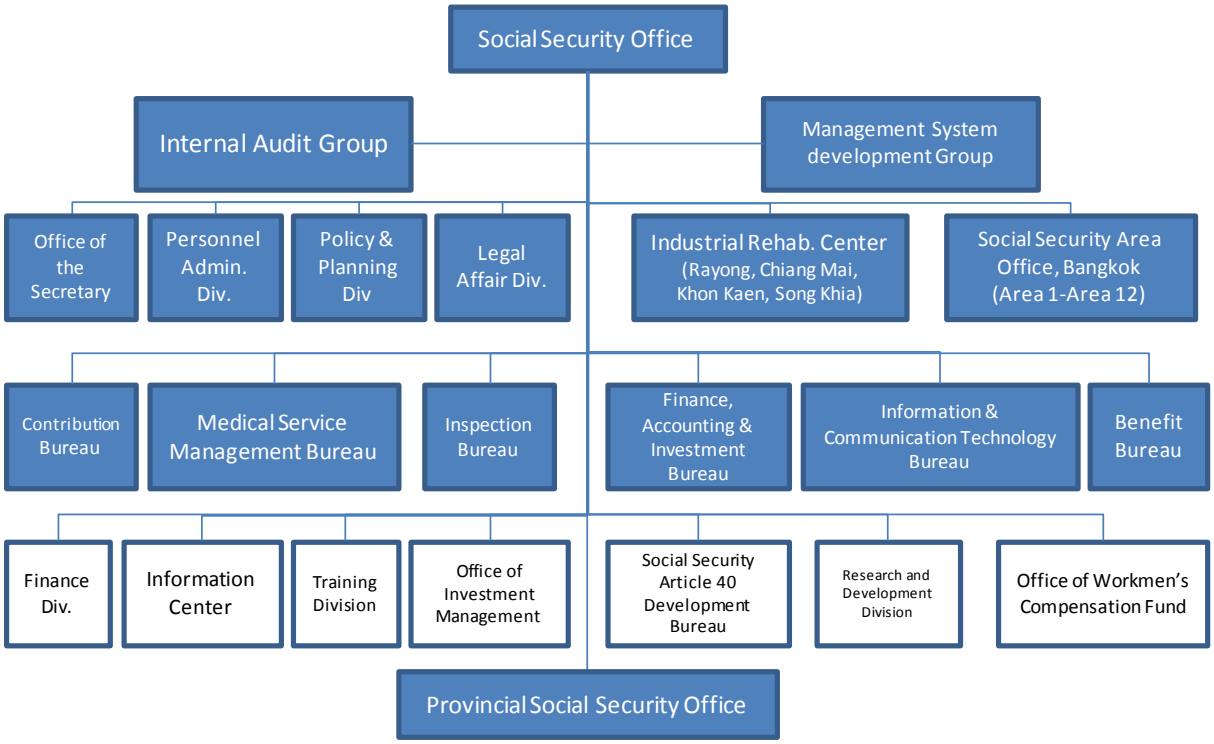
2.5. Social Security Office (SSO)

The Social Security Office (SSO) was organized on September 3, 1990 under the Social Security Act, as an organization under the MOI to take over the employee social security scheme from the Department of Public Welfare and the Workmen's Compensation Fund

(WCF) from the Ministry of Labour. The SSO was transferred to the Ministry of Labour and Social Welfare which was newly established in 1993. Later, since the reorganization of government ministries in 2002, the SSO has been transferred back to the Ministry of Labour.

The SSO is responsible for the administration of the SSS and the WCF, from the collection of contributions to the management of funds. The transfer of the medical benefit administration to the NHSO had been considered before[6], but was not supported by the SSS. This is because the transfer may require the integration of the benefit package of the funds and the SSS has a more favourable package.

FiguresVI-5 Organization chart of the SSO



*Those in white letters are ministerial regulations divisions, while those in black letters are internal divisions.
Source: SSO, Annual Report 2553 (2010)

2.6. International Health Policy Program (IHPP), Ministry of Public Health

International Healthy Policy Program (IHPP) is a research institution under the MOPH which is for capacity development of domestic and international health systems. The IHPP contributed to the establishment of the UC scheme by compiling and researching data related to medical economy. While the IHPP has recently promoted cooperation to China, Laos, Vietnam and the Philippines for formulating the UC based on its experience to establish the UC scheme in Thailand, its domestic initiatives include research on various issues such as tobacco and alcohol, and proposal of policies thereof.

[6] Based on the interview with the SSO.

2.7. Health System Research Institute (HSRI)

Health System Research Institute (HSRI) is a research institution under the MOPH. The HSRI also functions as a funding body to allocate research grant to universities and other research institutions, and is allocated a higher amount of budgets than the IHPP. In these years, the HSRI has also performed its own research programs based on which it has provided data and findings relating to the health policy. The HSRI's primary fields of research are health care providing structures and finance systems.

Research teams and organization are set up under the HSRI as provided by law or for the purpose of studying specific strategies, as shown in Figure 6.

FiguresVI-6 Research institutions under the HSRI

Abbr.	Official Name	Description
TCMC	Thai CaseMix Center	Thai CaseMix Centre (TCMC) functions as a central mechanism for maintaining and developing financial tools for health insurance system in Thailand. Health services data will be analyzed by these tools in order to develop a standard for compensation so that budget management in health insurance system for Thai people can be operated efficiently.
NHFDO	National Healthcare Financing Development Office	The NHFDO is working under the National Health Care Financing Development Committee which Chair by the Prime Minister
MADO	Medical Audit Development Office	Its mandates include developing an audit for health care reimbursement both inpatient and outpatient in public hospitals, as well as proposing guidelines for efficient care and reimbursement especially those high-cost diseases.
THI	The Institute of Thai Health	No detail information available.
CHI	Central Office for Healthcare Information	The Office aims to develop and standardize database of health service system. Also, CHI supports Ministry of finance and the National Health Security Office (NHSO) regarding data management for the reimbursement system of the Civil Servant Medical Benefit Scheme (CSMBS) and the Universal Coverage Scheme (UC)
IHRP	Institute for Development of Human Research Protection	IHRP aims to develop policies, legislations, regulations, and notifications, and build capacity of organizations and personnel.
HISRO	Health Insurance System Research Office	Its objectives include conducting research, monitoring & evaluation and surveillance, by means of participatory approaches, so as to support the development of health insurance systems of Thailand.
IHPPD	The Institute of Health Promotion for Persons with Disability	The institute aims to promote disability-related health promotion networking as well as social communication.

Source: Complied by Mitsubishi UFJ Research and Consulting based on various data.

2.8. Government Pension Fund (GPF)

The Government Pension Fund (GPF) controlled by the MOF is responsible for the administration of the GPF under the 1996 Government Pension Fund Act, which is based on decisions of the Board of Directors. The Board of Directors mainly consists of the government (employer), representative of government officers and retired officers, and is

authorized to determine the policies of fund administration and investments. The Permanent Secretary of the MOF shall preside at the Board of Directors of the GPF under law.

For fund investments, the Investment Committee led by the Director of Fiscal Policy Office of the MOF is responsible for establishing the standard of selection of external fund managers, monitoring the overall fund, reporting the outcome of investments and proposing investment policies to the Board of Directors. In addition, the GPF also has the Member Relations Committee for providing information to the insured.

2.9. Securities and Exchange Commission Thailand (SEC)

The Securities and Exchange Commission Thailand (SEC) was established in March 1992 as a regulatory body of stock exchange under the Securities and Exchange Act. Since 2003, the SEC has also regulated derivative transactions. In terms of its relationship with the social security system, the SEC is positioned as a regulatory body of the TPF and private insurance companies.

3. Social Security Budgets

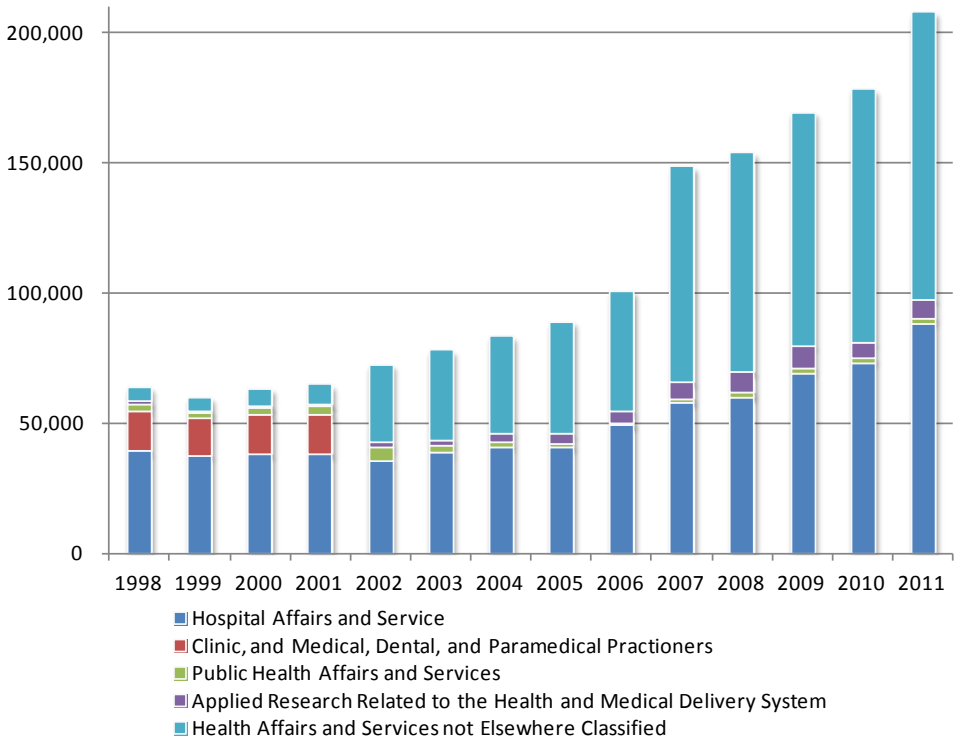
3.1. Health budget

In Thailand, the health budget is increasing year by year. Even in the fiscal year 2010 affected by the Lehman Crisis in 2009 where most sectors faced a budget cutback, the health-related budget still increased. The health-related budget in the fiscal year 2011 exceeds 200 billion Baht, which accounts for 10.1% of the total budget.

Following the introduction of the "30 Baht Health Scheme" in 2002, the structure of the health-related budget allocation has been changed. More specifically, the budget for "clinics, medical, dental and paramedical practitioners" which used to be allocated directly from the government has come to be allocated through the NHSO, and is currently categorized as "others"[7].

The reasons why the amount of "others (mainly consisting of the budget for the NHSO)" jumped in the fiscal year 2007 would be because the government had promoted shift the "30 Baht Health Scheme" to a free health security scheme and the budget for capitation had been increased.

FiguresVI-7 Health-related budget of the Thai government (Unit: 1 million Baht)



*The most updated data is used, if any discrepancies in data of different years.

[7] Although the budget provided as "hospital affairs and services" was also allocated through NHSO after 2002, it is not classified as "others" in the statistics. The background and reason for this are not known.

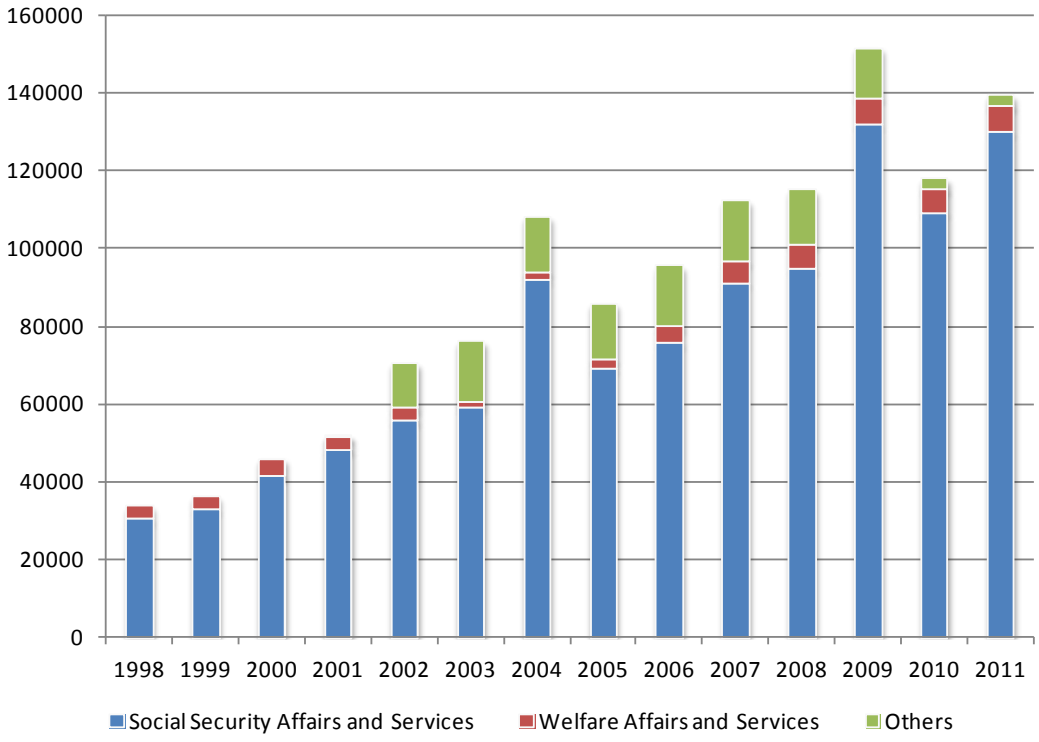
Source: Complied by Mitsubishi UFJ Research and Consulting based on the "Budget in Brief" of the MOF.

3.2. Social security-related and services / social welfare-related and services budget

"Social security-related and services / social welfare-related and services budget" in the fiscal year 2011 amounts to 139.4 billion Baht, which accounts for 6.7% of the total budget. The total amount of "Social security-related and services" budget is expected to be increasing in step with the aging of the population.

"Social security-related and services budget" which are mainly used for paying the old-age pension to government officers are of great size, which account for over 90% of the total "Social security-related and services / social welfare-related and services budget". Benefits for the poor and low-income populations are included in the "social welfare-related and services", which account only for less than 5% of the total "Social security-related and services / social welfare-related and services budget" or about 0.3% of the total government budget.

FiguresVI-8 Social security-related and services / social welfare-related and services budget (Unit: 1 million Baht)



*The most updated data is used, if any discrepancies in data of different years.
Source: Complied by Mitsubishi UFJ Research and Consulting based on the "Budget in Brief" of the MOF.

4. Health Security

4.1. National plans for the health security sector

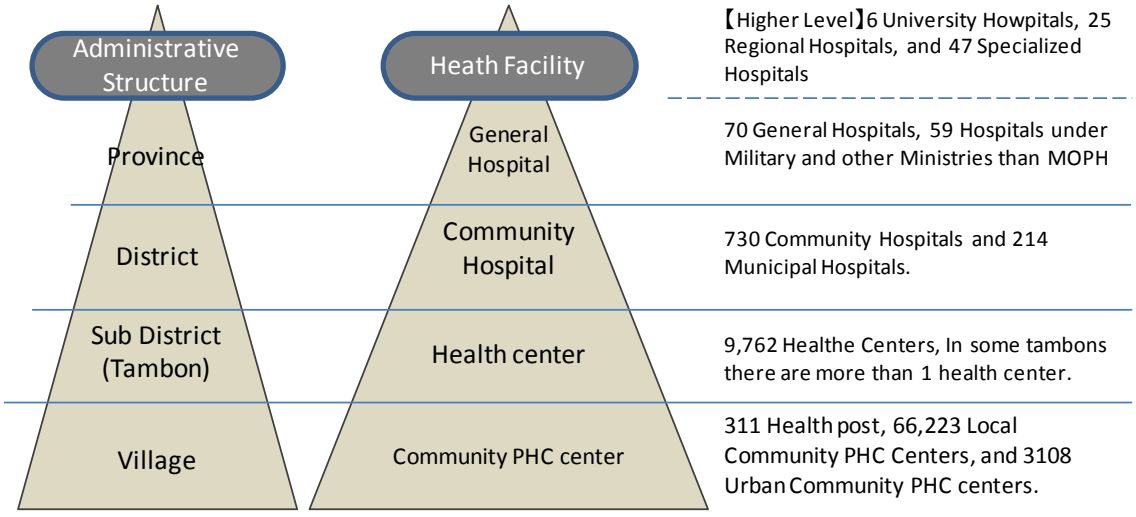
The national plans for the health security sector are generally designed in accordance with the National Economic and Social Development Plan. The current policies are prepared based on the 10th National Health Development Plan. The 10th plan succeeded 9th plan and advocated "sufficiency economy" and "people centered" approach. It should be noted that the necessity for the preparation for the aging society was mentioned in the plan. The 11th National Health Development Plan for the period from 2012 to 2017 is currently under review.

Apart from the National Health Development Plan, the Thailand Healthy Lifestyle Strategic Plan 2011-2020 is also designed. While the National Health Development Plan covers a wide range of issues, the Thailand Healthy Lifestyle Strategic Plan is prepared as a basic plan specifically for common health issues among middle income countries such as heart diseases, cancers and diabetes.

4.2. Salient features of health care delivery systems

The health care delivery systems are operated based on the referral system mainly by hospitals under the MOPH. While there are a number of public hospitals and clinics in urban areas, public medical institutions are still playing a primary role in the health care services. Local primary care is supported by health centers set up in each tambon (9,762 throughout the country) and community hospitals at a district level as a primary care unit (PCU).

FiguresVI-9 Basic structure of public medical institutions



In Bangkok metropolitan, there are 26 General Hospitals, 14 Specialized Hospitals and 68 Health Centers.

Source: Complied by Mitsubishi UFJ Research and Consulting based on the "Thailand Health Profile 2005-2007".

In terms of finance, community hospitals are positioned as a contractor unit for primary care (CUP: Contractor unit for primary care), and receive the budget based on capitation from NHSO. Several health centers (PCU: Primary Care Unit) at a tambon level under the CUP share fund resources allocated on a capitation basis with CUP.

In general, doctors are assigned to community hospitals and above, and health centers which are authorized to prescribe a drug only have nurses and/or technical nurses. Based on the MOPH's policy, the enhancement of functions of community hospital has been recently promoted, whereby the number of beds in community hospitals is increasing. The number of beds per community hospital is basically set to be 10 to 150. While the percentage of community hospitals with 10 beds to the total number of hospitals reduced to 4.7% in 2007 from 31.3% in 1997, that of hospitals with 30 beds and with 60 beds increased to 55.9% from 47.6% and to 25.5% from 14.6% respectively[8].

Private medical institutions are also play an important role in the Thailand's health security system[9]. Although private medical institutions have been set up not only in Bangkok but also in local cities, and .meet the demand of users of middle income class and uppers, the participation to the UC scheme of private sector is reluctant.

FiguresVI-10 Number of private medical institutions

Type of medical institution	
Hospital	344
Clinic	16,800
Modern pharmacies	8,801
Modern pharmacies selling only packaged drug	4,525
Traditional medical drugstore	2,096

Source: Thailand Health Profile 2005-2007

4.3. Basic structure of the health security system

The Thailand's health security system consists of three schemes which are for government officers, employees of the private sector and others respectively. Among them, the CSMBS was first established in 1963 and revised to the current scheme based on the Royal Decree published in 1980[10]. However, the number of users of the CSMBS had not been tested for a long time, as it has been by nature designed as part of the fringe benefits for government offices. Furthermore, some experts have pointed out that medical expenses under the CSMBS have not been managed effectively and efficiently, as the medical benefit is paid through

[8] Thailand Health Profile 2005-2007

[9] Private clinics cannot be compared with public health centers, as they have doctors and are authorized to perform medical treatment at a certain level. Easy comparison of the number between private hospitals and public medical institutions is also impossible. This is because their functions as a medical institution have not been identified.

[10] The old system had a different structure, e.g. no limitation of the number of dependent children (Benjaparn, M (2008), The possible cost driver of the expenses under the Civil Servant Medical Benefit Scheme in Thailand).

reimbursement by the MOF to government officers who used medical services.

FiguresVI-11 Health security system in Thailand

	CSMBS	SSS	UC
Year of establishment	1963(1980)	1990	2002
Related Act	Royal Decree	Social Security Act	National Helath Security Act
Administrative agency	MOF	MOL	MOPH
Implementing Agency	CGD	SSS	NHSO
Model	Non contributory	Contributory	Non contributory
Condition of membership	Fringe benefit	Compulsory	Based on registration
Target group	Civil Servants, Government Employees, and Retired	All entities employing more than 1 personnels and their employees	All people who are not covered by existing 2 schemes on the left
Number of Beneficiaries	[2008] 1,883,253[Member]3,985,045[Dependents] 5,868,298[total]	[2012] 8,994,501[Section 33] 891,961[Section 39] 757,421[Section 40] 10,643,883[Total]	Approx. 47-49 million [Changing]
Coverage to population	Approximately 9%	Approximately16%	Approximately 75%
Dependents	Members and Dependents (Up to 3 children under 20 years old)	Only for insured, Dependents may buy private insurance or UC sheme	Individual registration including dependents
After Retirement	Applied	Transferred to UC scheme or voluntary member of SSS	No condition on age
Payment System for OP	Fee for Service	Capitation	Capitation
Payment System for IP	DRG-RW	Capitation	DRG-RW
Main IP provider	Both Public and Private	Both Public and Private	Mainly Public
Referral	No	No	Yes
Copayment	None [Reimbursement applied but pre-registered patients]	No	No
Annual budget input from tax per capita (2008)	8,785THB+Administration cost	579THB +Administration cost	1,659THB +Administration cost
Annual health expenditure per capita(2008)	8,785	1,738	1,659
Health promotion and prevention	Only for Civil servant [dependents excluded]	Not included	Included

*The coverage is calculated based on the total population as of the end of 2010 (6.544 million).
Source: Complied by Mitsubishi UFJ Research and Consulting based on various data.

The first health security system to people other than government officers is the Social Security Scheme (SSS) under the 1990 Social Security Act, which an employer having 10 employees or more (currently, revised to an employer having 1 employee or more) is required to participate in. While all employees defined by the Labor Act are entitled to the SSS, in practice, the employees of individual business owners or the informal sector were

not covered. Furthermore, there was no health security system applicable to the poor, the agriculture sectors, students and dependents of the employees of the private sector.

Under these circumstances, the “30 Baht Health Scheme” was established in 2002, which covers those who are not entitled to the CSMBS and the SSS. This is understood universal coverage has been achieved. In 2006, 30 Baht of out-of-pocket medical cost was abolished and the current UC scheme has been completed.

4.4. Medical benefit system for government officers (Civil Servant Medical Benefit Scheme (CSMBS))

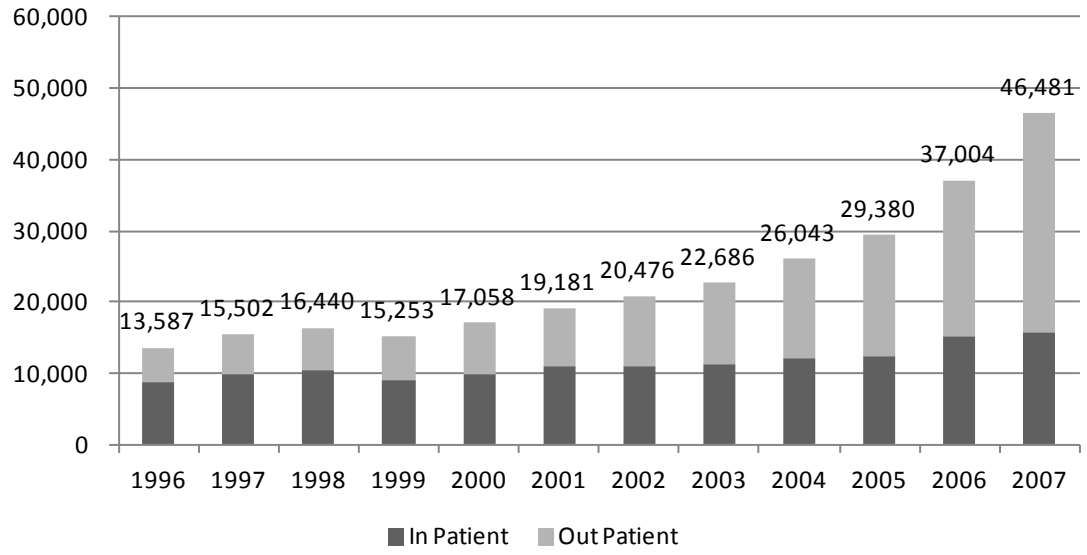
4.4.1. Basic structure of the medical benefit system

The Civil Servant Medical Benefit Scheme (CSMBS) is a medical benefit system for government officers (civil servant) and government employees (permanent employee) and their dependents, and retired government officers, which is controlled by the Comptroller General’s Department (CGD) of the MOF. The CSMBS is financed by tax revenues, as it is part of the fringe benefits for government officers.

4.4.2. Payment method and financial matters

A notable difference in the CSMBS from the other two schemes is the adoption of the fee for services system for outpatient treatment. It has been criticized that the amount of expenditures per patient under the CSMBS is higher than those of the other two schemes since the introduction of the UC scheme in 2002. A major reason why it is difficult to control expenses of the CSMBS is the adoption of the fee for services system where medical institutions (more specifically, doctors) are given considerable discretion in determining an inpatient period and prescribing a drug. This has been noticeable since 1980 where the current scheme was formulated.

FiguresVI-12 Expenditures for the CSMBS (Unit :Million Baht)



Source: The Comptroller General's Department

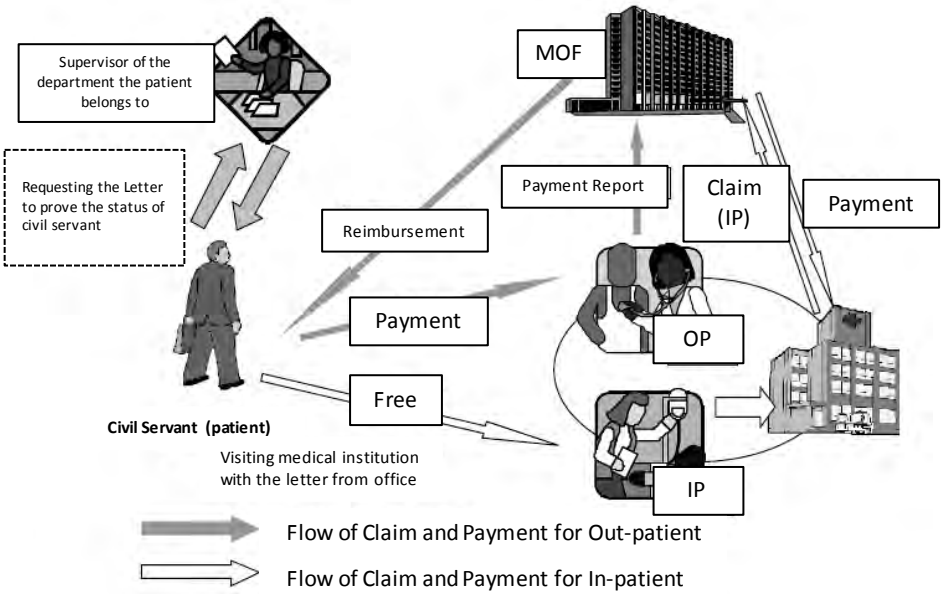
While DRG has been introduced to inpatient treatment since 2007, outpatient treatment is still applicable to free for services, which has caused cost control issues. In the middle of 2000', the outpatient fee exceeded the inpatient fee. This would be because imported originals are prescribed for the patients covered by the CSMBS, while generics are used in most UC schemes [11].

In the CSMBS, while a patient is not required to register designated medical institutions but allowed to use any public medical institutions, for medical fee, a patient is required to make advance payment for reimbursement by the CGD (outpatient only).

In recent years, a patient has been able to receive the medical benefit without paying medical fee, only when a medical institution has been registered in advance (cashless system). However, some experts view that this has given a negative impact on services of medical institutions due to the uncertainty of subsequent reimbursement (the risk of refund of fee has not been borne by a patient anymore), as a result of which a patient may be encouraged "hospital-hopping" [12].

[11] Based on the interview to the IHPP.
[12] Based on the interview to Dr. Chanvit of the MOPH.

FiguresVI-13 CSMBS structure and fee reimbursement



Source: Research report on the social security system in the Kingdom of Thailand; Japan Bank for International Cooperation (2002)

4.5. Social Security Scheme (SSS)

4.5.1. Medical benefit under the SSS

The Social Security Scheme (SSS) is a social security system for the employees of the private sector. The medical benefit is included in the comprehensive benefit under the SSS (sickness benefit, disability benefit, death benefit, maternal benefit, old-age benefit, child allowance and unemployment benefit). The medical benefit grouped into an in-kind benefit and a cash benefit: While the in-kind benefit which comprises the provision of medical services are available only for the insured (employee) at pre-registered medical institutions, the cash benefit which somewhat functions as compensation for salary during sick leave is paid regardless of expenses for medical treatment.

Since the benefits cover only the insured, their dependents are required to use the UC scheme or private health insurance.

In the section of health security, the SSS means the in-kind sickness benefit under the SSS. For the details of the overall employee social security system such as qualifications, refer to the “Pension and other income security scheme” section.

4.5.2 Benefit package

The benefit package covers both inpatient and outpatient treatment, excluding the following 15 cases:

- Psychosis except in case of acute psychosis which requires immediate treatment and for

a period of not more than 15 days.

- Disorders or injury due to the use of narcotic substance under the law government narcotic drugs.
- The same disease which requires hospitalization period of more than 180 days in one year.
- Hemodialysis except:
  - In the case of acute kidney failure which requires hospitalization period of not more than 60 days shall be entitled to medical service benefits.
  - In the case of chronic kidney failure of final stage for which medical service benefits shall be granted by means of hemodialysis with the use of dialyzer; by means of the Chronic Peritoneal Dialysis (CPD) and by kidney transplant according to the criteria, the terms and conditions and rates prescribed in the Notification of the Zone Office of Social Security.
- Any action taken for beautifying purpose with absence of medical indications.
- Treatment in the course of doing researches and experiments.
- Infertility.
- Examination of mucus membrane for organ transplant except bone stem cell transplant.
- Any examination that is exceeding the needs for curing such disease.
- Organ transplant operation except the bone stem cell transplant according to the established criteria.
- The sex change.
- Artificial insemination
- Service provided in the course of recuperation.
- Dental service except in the case of tooth extraction, filling and removal of dental plaque.
- Spectacles.

In the case where the insured needs to be transferred to another medical institution for advanced medical treatment, transportation cost not exceeding 500 Baht/day may be paid. For transfer to a medical institution in a different province, the insured may also be entitled to the additional benefit of 6 Baht/km.

4.5.3. Financing

The SSS has introduced the capitation system for both outpatient and inpatient treatment, which makes cost management relatively easy. The budget allocated to each medical institution is calculated by multiplying the number of the insured who has registered such a medical institution by a unit price.

For the finance system of the employee social security system which is the source of

payment, refer to the “Pension and other income security scheme” section.

4.5.4. Medical treatment structure and contracted medical institutions

The referral system is not mandatory to the SSS, and the insured thus may receive medical treatment at any hospital upon the first visit without an introduction letter from a clinic [13]. In the case where the insured requires advanced medical treatment or needs to be examined at other medical institutions than those which have been registered, they may visit any network medical institution of that private medical institution [14].

FiguresVI-14 Number of annual insurance payments per insured under the SSS (Unit : Time/person/year)

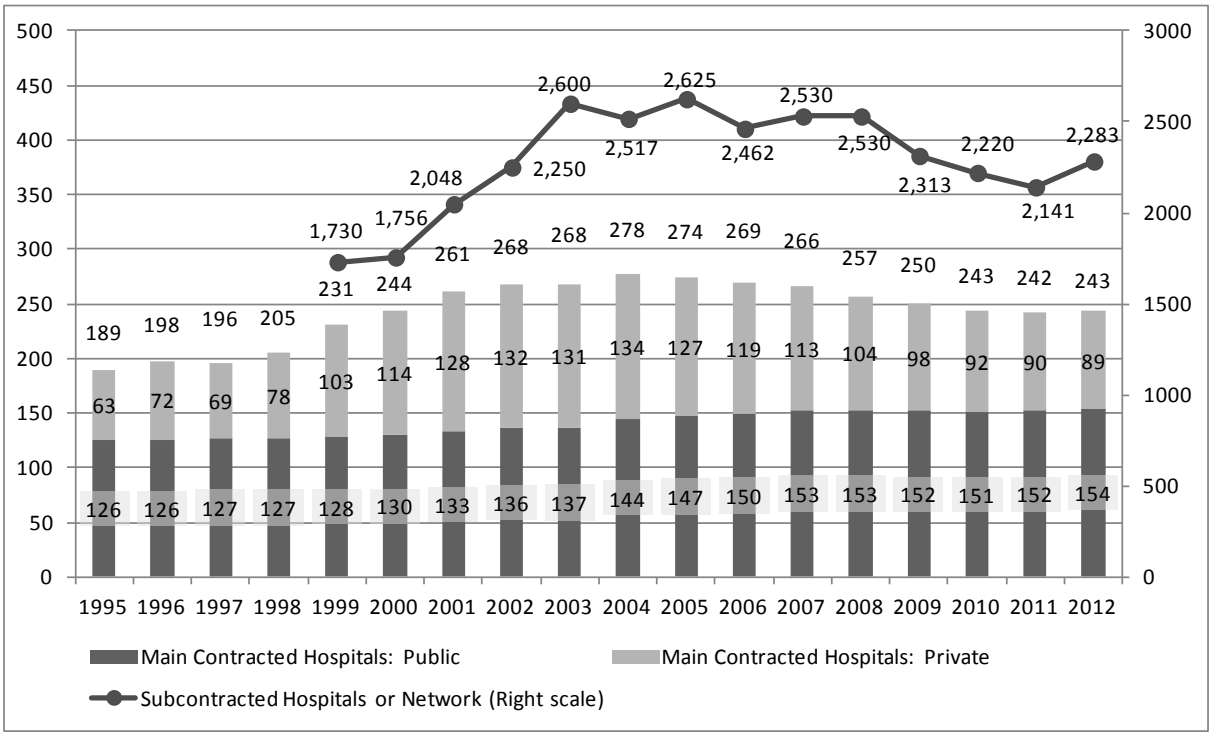
	2003	2004	2005	2006	2007	2008	2009	2010
Out Patient	2.54	2.58	2.37	2.51	2.59	2.61	2.68	2.7
Public Med. Inst.	2.41	2.5	2.17	2.38	2.48	2.54	2.59	2.62
Private Med. Inst.	2.63	2.63	2.51	2.61	2.67	2.67	2.75	2.77
In Patient	0.046	0.047	0.049	0.052	0.051	0.053	0.049	0.053
Public Med. Inst.	0.043	0.045	0.048	0.051	0.051	0.051	0.045	0.05
Private Med. Inst.	0.049	0.048	0.05	0.053	0.052	0.054	0.052	0.057

Source: SSS’s data

Most insured of the SSS reside in large cities such as Bangkok and prefer private medical institutions to public medical institutions. In fact, the ratio of the contracted hospitals between public and private used to reach nearly 1:1. The number of contacted medical institutions had being increased since the introduction of the UC scheme in 2002 but has currently been on the decline. The current ratio between public and private is 3:2.

[13] Patients generally have to queue up for receiving medical treatment at hospitals.
[14] In the SSS, a patient is referred within the network of a medical institution, unlike the referral system of public medical institutions, etc. This is because some literature cites that the SSS has no referral system.

FiguresVI-15 Changes in the number of contracted hospitals under the SSS



Source: Complied by Mitsubishi UFJ Research and Consulting based on the statistic data of the SSS.

4.6. UC scheme

The UC scheme is a tax-based system which has been evolved from the "30 Baht Health Scheme" established by the Taksin government in 2002. The outpatient treatment under the UC scheme is based on the capitation system where the budget of 1,202 Baht (as of 2002) per registered person (insured) is allocated to each CUP such as community hospitals which provide health/medical services in the community [15]. Since 2006, 30 Baht of out-of-pocket medical cost has been abolished, and medical services have been provided free of charge under the UC scheme [16].

Due to the lower level of its services compared to the other public health security schemes, the UC scheme is often deemed to be a "system for the poor". However, in about one-third of items the benefit package under the UC scheme is more advantageous than the SSS [17]. Furthermore, the UC scheme covers some health services not provided by the CSMBS and the SSS, such as vaccination and health check-up, whereby it is not necessarily an "inferior scheme". While the budget per capita for the UC scheme is lower than the other two schemes, over the past few years the government has enhanced financial supports to community hospitals which play a key role in providing services under the UC scheme, as a result of

[15] It is understood that expenses for public health such as local health, health promotion and disease prevention are included in the UC budget.
[16] The low-income group had been exempted the out-of-pocket medical cost before 2006. Since the change of government in 2006, the out-of-pocket medical cost has been fully abolished.
[17] Based on the interview to the NHSO.

which the gap between the UC scheme and the other two schemes has become closer. [18].

4.6.1 Insured

The insured of the UC scheme is any Thai nation not covered by the CSMBS and the SSS. This is why it is said that with the UC scheme universal coverage has been achieved in the Thailand's health security system. The number of insured is currently estimated to be about 47 million, which accounts for 75% of the total population of the country. The insured may apply to enrollment on an individual basis at any community hospital, NHSO's office, provincial health office, etc. in the location where they reside. The Gold Card which is an insured certificate is then issued for the insured to present at a medical institution to receive medical examination free of charge. For inpatient treatment, part of examination fee, inspection fee, treatment (operation) fee, room charge, meal expense and transportation cost is also exempted.

The insured is required to use the medical institutions (generally, health centers or district-level community hospitals) which they have registered in advance, except for an emergency. In the case where any secondary care or advance medical treatment is required, the insured will be introduced to any medical institution at a higher level (referral system).

4.6.2. Benefit package

1) Basic benefit package

The benefit package is comprehensive, which provides the in-kind benefit to all medical treatment actually performed. The package also include general inspection fee, medical fee, medical materials cost, drug cost and other expenses necessary for medical treatment. The maternal benefit is paid up to the second child. General patient's room charge and meal expense are also covered. In addition, the benefit package includes basic dental treatment and prescribed drugs listed in the list published by the government.

2) High-cost / emergency medical services

The UC scheme has covered emergency medical services since its establishment, whereby the insured may receive such services at any medical institution contracted under the UC scheme, regardless of whether it has been registered in advance. High-cost medical services such as artificial organs and prosthetic devices are also covered.

3) Prevention / Health promotion

Unlike the other two schemes, the UC scheme allocates a certain amount of the budget to health promotion and disease prevention, which include provision of an individual health check book, health check and before-childbirth care for women in pregnancy, annual heath

[18] Relative merits among the three schemes cannot be evaluated simply by comparing the budgets. This is because each scheme covers a different scope, and actual expenditures at each medical institution cannot be analyzed precisely due to lack of accounting records.

checkup, prescription of antiretroviral agent (ARV) for preventing HIV infection from mothers to infants, home visit, provision of health-related knowledge, counseling and prevention by oral care. These services are provided at a community level.

4.6.3. Finance method

The users of the UC scheme are required to register medical institutions which they are entitled to use, as it emplies capitation system and allocate budget to local medical insitituions based on the number of registered patients. The NHSO pays to a relevant CUP through the NHSO local branch the amount to be calculated by multiplying the number of registered users (who hold the Gold Card issued to certify the registration in the UC scheme) by the annual budget per person stipulated by the government. This is applied to outpatient. Medical institutions tend to repel high-cost patients, as they provide medical services within the pre-determined budget, which is the weak point of the UC scheme. On the other hand, medical fee control is relatively easier under the UC scheme. For inpatients, DRG-RW(DRG Relative Weight) with global budget system is applied.

Figures VI-16 Breakdown of budgets in the capitation system (Unit: Baht)

	2003	2004	2005	2006	2007	2008	2009	2010
Out patient	574.00	488.20	533.01	582.80	645.52	645.52	666.96	754.63
In Patient	303.00	418.30	435.01	460.35	513.96	845.08	837.11	894.28
For special area (on top)	—	—	—	—	—	—	72.25	72.25
Prevention and Promotion	175.00	206.00	210.00	224.89	248.04	253.01	262.06	271.79
Influenza vaccine							7.60	11.36
High cost care and Disease Management	57.00	86.00	124.21	244.38	260.58	145.26	179.47	186.00
Capital Replacement	83.40	85.00	76.80	129.25	142.55	147.73	148.69	148.69
Emergency Medical Service	10.00	6.00	6.00	6.00	10.00	12.00	—	—
Rehabilitation	-	4.00	4.00	4.00	4.00	4.00	5.00	8.08
No-fault liability(Section 41 of NHS Act)		5.00	0.20	0.53	0.53	—	1.00	
Rural Hospital		10.00	7.07	7.00	30.00	30.00	—	—
Compensation for health personnel work injury		—	—	—	0.40	0.40	0.85	0.78
Quality based pay	—	—	—	—	20.00	20.00	20.00	40.00
Compensation of abolishment of 30Bscheme		—	—	—	24.11	—	—	—
Thai Traditional Medicine		—	—	—	—	1.00	1.00	2.00
Promotion of primary care in rural area								10.63
Support special tertiary care								0.84
ARV drug					58.56	83.70	94.29	63.45
Renal replacement therapy								32.54
Total	1,202.40	1,308.50	1,396.30	1,659.20	1,958.25	2,183.70	2,296.29	2,497.32
Increase		8.8%	6.7%	18.8%	18.0%	11.5%	5.2%	8.8%

Source: NHSO's data

4.6.4. Coverage

1) Coverage of the number of insured

The introduction of the UC scheme in 2002 achieved universal coverage (UC) of health security in Thailand. Since the medical services provided under the SSS are available only to employees, their families (dependents) who are not entitled to the medical benefit under the

SSS are required to register to the UC scheme. Given that the UC scheme is a tax-based system and expected to face financial issues in the future, the inclusion of employees' dependents to the SSS should be considered. However, this requires the increase of the contribution rate, which would cause political arguments. Improvement of the UC scheme would not be easy.

On the other hand, a large amount of the insured of the SSS use private health insurance, due to shorter queuing time and no restriction in drugs to be used. As such, the current universal coverage has achieved health security as a right, but not in practice.

2) Coverage of the benefit package

It tends to be understood that free medical services available under the UC scheme are limited, but this is not correct. Such misunderstanding would be because the UC scheme is for the informal sector mainly in relatively poor rural areas. In reality, the UC scheme which covers health check and vaccination not provided by the SSS is never a "system for the poor". The benefit package of the UC scheme has become in no way inferior to the other schemes, which has covered prescription of ARV since 2007 and renal replacement therapy (RRT) since 2010. The entitlement of RRT is determined by the NHSO and the MOPH's research institutions with support from the ILO, including cost estimation.

3) Coverage of medical cost

The insured is hardly required to bear the out-of-pocket medical cost, as in the Thailand's health security system even the medical benefit under the UC scheme covers almost all general medical treatment. The ratio of out-of-pocket to the total medical cost is 13.9%[19], which is as low as developed countries. This means the coverage of medical cost is also high in Thailand[20].

4.7. Role of private health insurance systems and recent trends

Even in Thailand where the universal coverage health security system has been formulated upon the introduction of the UC, private health insurance systems remain popular and playing an important role, as some people are not satisfied with the benefit package and services under the public health security system. Most private health insurance is sold in addition to life insurance products.

While it is not easy to analyze the actual gap in the benefit package of different health insurance based on objective data, Thai people, especially the wealthy, tend to think that the benefit package of the UC scheme is inferior to that of the SSS or private health insurance is

[19] The ratio of out-of-pocket referred here does not imply co-payment at the window of the medical institution, but the ratio of out-of-pocket expenditure of entire patients against total health expenditure including medicine expenditure at the pharmacies, or expenditure for out of insurance benefit.

[20] Based on the "Health Nutrition and Population Statistics" by the World Bank. The ratio of out-of-pocket in Japan is 14.3%, not taking account of the level of medical services.

more satisfactory than the SSS, and prefer to buying private health insurance. The predominant gap between public health insurance and private health insurance is said to be queuing time and services at hospitals. Some people buy the full private health insurance package, despite the enrollment of the SSS.

The number of insured cannot be identified precisely, as one person may purchase more than one insurance products. According to private insurance companies which are the members of the Thai Life Assurance Association, the number of insured who has added the health insurance benefit package to their life insurance is 23,704,991 as of the end of 2010. For non-life insurance companies where most customers buy health insurance as additional security to other insurance products, the number of insured is 485,060. This means the total number of insured is 24,190,051. However, given that any insurance product is sold in conjunction with others (there is the insured who has purchased more than one products) and may also cover families of insured, the actual number of insured entitled to private health insurance is assumed to be much higher.

4.8. New movements toward harmonization and integration ~ Integration of emergency medical services

The Thai government has announced to standardize the definition, benefit package, procedures and payment method of emergency medical services among the three public health insurance systems and private health insurance systems in April 2012. While the emergency transportation service has been provided through the toll free "1669" since the establishment of the Emergency Medical Institute of Thailand (EMIT) in December 2008, different medical institutions and payment method have been used. The integration intends to eliminate these inconsistencies.

As the above policy has just been proposed in March 2012, it would not be achieved as scheduled due to time constraints. In any case, this is the first challenge including not only the three public insurance systems but also private health insurance where the health security system is managed under a uniform rule, and from a medium- and long-term perspective is expected to breakthrough the integration of public and private insurance in the future [21].

According to the Deputy Secretary General of the EMIT, as of April 2012, there has been no confusion as expected [22].

[21] Bangkok Post 14 March
[22] Based on the phone interview to Dr. Prachaksvich Lebnak.

5. Pension and other income security schemes

5.1. Basic structure of pension and other income security schemes

The current income security system for workers has been developed mainly for government officers and private sector's employees for the past two decades. The Government Pension Fund (GPF) was established in 1997, reforming the old tax-based government pension system to a social insurance system. For the employees of the private sector, the Thai Provident Fund (TPF) and the Retirement Mutual Fund (RMF) have been organized to compensate the SSS, as the amount of the old-age pension paid under the SSS since 1990 is not sufficient.

On the other hand, the informal sector has been left without insurance for a long time. The MOF plans to establish the National Savings Fund and implement it in May 2012 in order to form the old-age income security system mainly for the informal sector.

FiguresVI-17 Basic structure of pension and other income security scheme

	Target group	Outline	Administrative Agency
Government Pension [GP]	Civil Servants	The old pension scheme for thecivil servants. Non contributory and defined benefit scheme. When GPF was introduced, members chose to stay on GP or move to GPF.	MOF
Government Pension Fund [GPF]	Civil Servants [Compulsory]	Employee contributes 3% of salary. Same rate is also applied to the government. There is an additional contribution from the government as compensation of 2% as a transitional measure to the institutional reforms.	MOF
Government Permanent Employee Fund [GPEF]	Government Permanent Employees [Compulsory]	Provident fund for government permanent employees working in the government agency. 3% from employee and government respectively.	MOF
Social Security Shceme [SSS]	Private employees [Compulsory]	Old age pension will be paid after 55 years old with more than 180 month contribution. Tripartite contribution from employer, employee and government.	SSO
National Savings Fund [NSF]	All nations including informal sector [Voluntary]	Provident fund for informal sector. From May 2012. The government contributes according to the age of member.	MOF NSFO)
Thailand Provident Fund [TPF]	Private employees [Voluntary]	Provident fund operated by private financial institutions. Contributions from employer and employees based on agreement from 2 to 15% of salary.	SEC
Retirement Mutual Fund [RMF]	Private employees [Voluntary]	Provident fund operated by private financial institutions. Contributions from employer and employees based on agreement from 3 to 15% of salary.	SEC

Source: Complied by Mitsubishi UFJ Research and Consulting based on various data.

5.2. Government Pension Fund (GPF)

5.2.1. Outline of the scheme

The GPF is a pension scheme for government officers, which is based on a social insurance method where the government (employer) and government officers (employee) pay the contribution to the fund at the equal rate to be managed by a fund manager and withdrawn at the time of mandatory retirement[23]. Separately, the Government Permanent Employees Provident Fund (GPEF) is provided for government permanent employees who are not categorized as government officers. The employees of state enterprises shall be a member of GPF.

5.2.2. Background of scheme reform

In Thailand, government officers used to be entitled to the Government Pension (GP) as part of favourable fringe benefits for government officers. The GP is the oldest social security scheme, which was originated in the 1902 Pension Act.

The conventional pension insurance is non-contributing pension based on a defined benefit (DB) and pay-as-you-go system (PAYG), which is considerably beneficial to the insured but cause financial burdens on the government.

In step with the increasing number of retired government officers from 155,000 persons in 1990 to 217,000 persons in 1996, government spending relating to pension for government officers also rose from 6.6 billion Baht to 19.7 billion Baht. Under those circumstances, in 1997 the GPF was established as a social insurance scheme based on a defined contribution and funding system in order to reduce financial burdens on the government and make the scheme sustainable.

The GPF consists of several benefit packages but is basically designed to be a lump sum retirement allowance to be paid upon compulsory retirement in combination with various benefit programs.

5.2.3. Legal basis

The GPF is based on the 1996 Government Pension Fund Act. The GP was established under the 1951 Government Pension Act.

5.2.4. Benefit package

1) Old-age benefit

The insured is entitled to lump sum retirement payment at the time of compulsory retirement (age 60).

The current benefit package includes only lump sum payment upon retirement, and there is

[23] Similar schemes to the GPF are also provided local government officers, which is under the control of the MOI.

no life annuity scheme offering monthly installments. It is not allowed to port to other schemes.

Nevertheless, as a transitional measure, government officers who were employed in/before 1997 are entitled to a certain amount of pension paid by the old defined benefit-type scheme.

1) Additional programs

While the GPF is mainly for funding lump sum retirement payment, it also provides other benefits to the insured as additional services, including the Residential Financing Program providing a financing program for the insured to purchase a residence in collaboration with the Government Housing Bank (GHB), the Educational Financing Program providing jointly with Krung Thai Bank Plc a loan program for school expenses of the insured's family and a financing program for the insured to purchase a PC, and the Life Insurance Program selling private life insurance products (e.g. medical benefit, retirement savings) to the insured. The Insured is also entitled to discount at contracted commercial facilities by presenting the insured certificate of the GPF.

5.2.5. Eligibility of enrollment

The eligible persons to enroll the GPF are currently grouped into 12 categories. The number of the insured is approximately 1.17 million as of 2008.

FiguresVI-18 Categories of the insured of the GPF

1.Civil officials under the law on civil official rules
2.Judicial officials under the law on judicial official rules
3.Civil officials in a university under the law on civil official in the university rules
4.Public prosecutors under the law on public prosecutors rules
5.Teachers under the law on teacher rules
6.Ordinary parliamentary officials under the law on ordinary parliamentary official rules
7.Police officials under the law on police official rules
8.Military officials under the law on military official rules
9.Judicial officials under the law on Constitutional Court rules
10.Civil officials of the Office of the Administrative Court
11.Civil officials of the Office of the National Counter Corruption Commission
12.Civil officials of the Office of the Auditor General of Thailand

Upon the establishment of the GPF which has been shifted from the long-standing non-contributing GP, a transitional measure was taken, whereby while all government officers who had been employed on/after March 27, 1997 shall be treated as the "contributing insured" without any exception, those who had been employed before March 27, 1997 were allowed to select any of the old scheme, or the contributing insured or the non-contributing insured under the new scheme. About 70% of the insured amounting to 1.5 million persons selected to enrol the GPF.

5.2.6. Contribution rate

The GPF's accounts consist of the individual count and the government account.

1) Individual account

The contributing insured contributes 3% of their monthly remuneration. The government (employer) also reserves the amount equivalent to 3% of the insured's monthly remuneration to the individual account. Under the current scheme, it is not allowed to pay the contribution exceeding the statutory contribution rate of 3%. The contribution of the insured not exceeding 300,000 Baht is exemption from the personal income tax.

In order to minimize the impacts by the scheme reform, any government officers who selected to become the contributing insured are entitled to additional contribution of 2% by the government (tax revenue) according to the accumulated service months, as a post-reform compensation. Furthermore, the government pays to the individual account the additional contribution equivalent to the amount of the insured's contribution during such period.

Any government officers who selected non-contributing insured are not entitled to the contribution by the government (employer), but if the amount of an entitlement is reduced due to the scheme reform the government contributes 2% as a pre-reform compensation[24]. The contribution to the GPF is reserved in the individual account and managed through investments for future old-age benefit.

2) Government account

The government account is based on Section 72 of the Government Pension Fund Act, from which the amount not exceeding 20% of the annual contribution to the GPF may be allocated to the government reserve. If the amount reserved in the government account exceeds 300% of the annual pension budget, the surplus is required to be returned to the national treasury.

5.2.7. Funds and operational bodies

Fund management is subcontracted to Thai Administration Services Co., Ltd. In order to ensure the resource of pension to be paid to the insured, the GPF Act requires managing at least 60% of the GPF by sound investments.

5.3. 5.3. Social Security Scheme (SSS)

5.3.1. Legal basis

The SSS is based on the 1990 Social Security Act, as amended in 1994 and 1999.

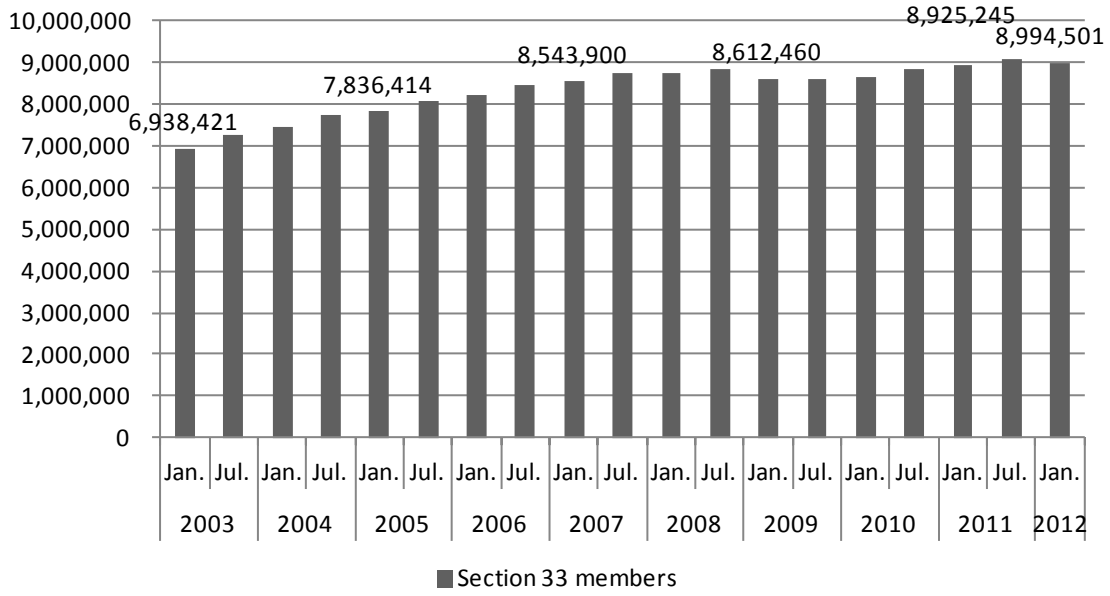
5.3.2. Eligibility of enrollment

While the employee social security system is a compulsory system for the employees of the formal sector defined as the insured in Section 33 of the Social Security Act (employees

[24] With the reform in 1996, the base to calculate pension under the old scheme (defined benefit) was changed from the salary at the time of retirement to the average salary for a certain period before retirement, as a result of which the amount of defined benefit was reduced. To relieve this, the government paid the additional contribution of 2% as a post-reform compensation.

of a business having one or more employee(s)), it also covers the voluntary insured, such as the insured defined in Section 33 who is retired or out of employment as provided in Section 39 and those who belong to the informal sector as provided in Section 40. The number of the insured defined in Section 33 is approximately 8.99 million as of January 2011 (the insured defined in Sections 39 and 40 will be discussed later).

FiguresVI-19 Number of the insured of the employee social security system defined in Section 33 (Compulsory insured)



Source: SSO's data

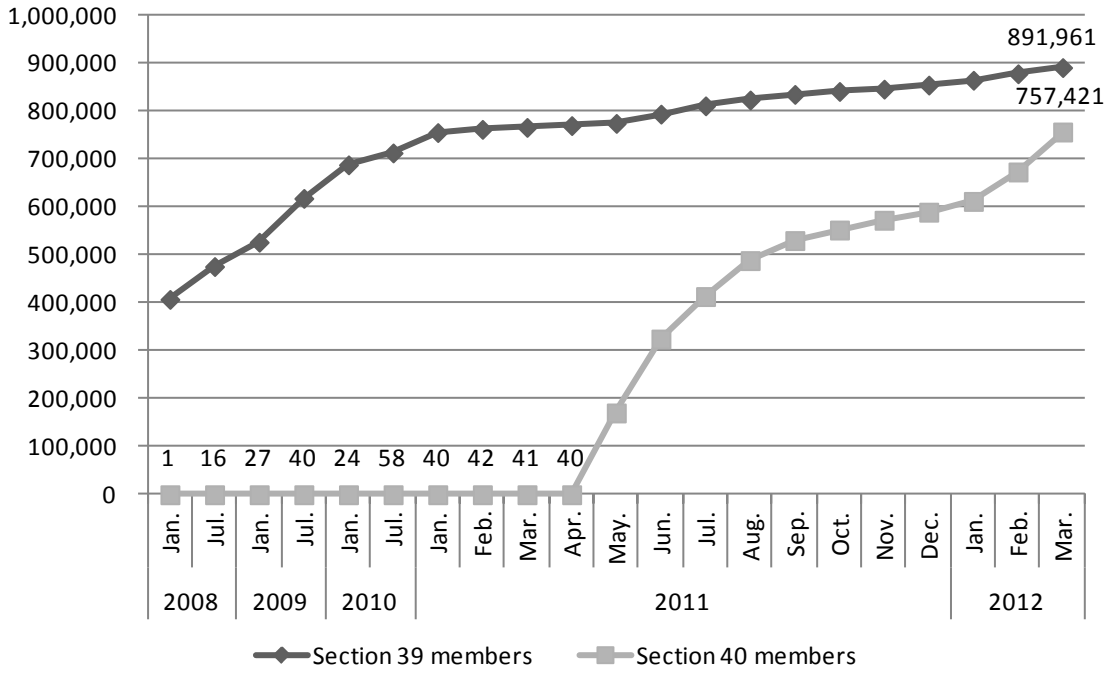
According to the National Statistical Office of Thailand (NSO), of the total working population in Thailand (37.8 million), the number of the informal sector workers, i.e. wokers who do not have a formal employment contract or an employer defined in the Labour Law is estimated to be 24.1 million (63.7% of the total working population). While Section 40 of the Social Security Act allows the informal sector workers to enrol in the SSS voluntarily, the number of the voluntary insured is limited, e.g. 40 persons in April 2011. The old voluntary scheme of SSS was designed as inferior to compulsory scheme, which did not contribute to the increase of insured persons.

Under these circumstances, the government implemented a nationwide campaign to extend the coverage to the informal sector as a part of "New Welfare Policy" of Prime Minister Abhisit, by sending travelling offices to each community and encouraging enrollment to the local network such as leaders of the TAOs and villages.

Prime Minister Abhisit expected that 2.4 million people in the informal sector would consider enrollment in the employee social security system, when the above initiative was announced in 2011. The actual number of the voluntary insured defined in Section 40 is 0.76 million in 2012, which is much lower than expected but significantly increased from 40 in

April 2011. This would indicate some positive results of the government's initiative [25].

FiguresVI-20 Changes in the number of the insured in Sections 39 and 40



Source: SSS's website.

5.3.3. Contribution rates and benefit package of the compulsory insured (Section 33)

The current benefit package includes seven benefits at the maximum: old-age benefit, unemployment benefit, child allowance, death benefit, sickness benefit, disability benefit and maternal benefit, which varies according to the type of the insured.

[Old-age benefit] Define benefit pension scheme. The insured that has paid the contribution for at least 180 months (which may not be consecutive) is entitled to the old-age benefit when they reach the age of 55 and end their status as the insured. The old-age benefit equivalent to 15% of standard remuneration for 60 months immediately before retirement is paid as the pension benefit. The insured that has paid the contribution for at least 180 months is entitled to additional 1% per year according to the number of years of contribution.

[Child allowance] The insured in Section 33 or 39 that has paid the contribution for at least 12 months in 36 months before they are qualified to receive the child allowance is entitled to the child allowance, the monthly amount of which is 350 Baht per child and paid. Payment is deposited into the bank account. The child allowance for legitimate child aged not more than 6 years old shall be limited to not more than 2 children for the entitlement

[Death benefit] When the insured dies, 30,000 Baht is paid as funeral assistance.

[Disability benefit] The insured that has paid the contribution for at least 3 months in 15 months before they are assessed as PWDs by the Medical Committee is entitled to the

[25] ASSA News, Vol.24

disability benefit. The disability benefit includes 50% of monthly remuneration and expenses for prosthetic devices.

[Maternal benefit] The insured that has paid the contribution for at least 7 months before childbirth is entitled to the maternal benefit. If the contribution period is less than 7 months, no maternal benefit is paid.

For the sickness benefit, refer to the section of health security. For the unemployment benefit, refer to Page VII-37.

FiguresVI-21 Changes in the number of beneficiaries

	Injury or sickness benefit	Invalidity benefit	Death benefit	Maternity benefit	Old age benefit	Child Allowance	Unemployment benefit
2001	16,067,396	435	13,637	184,281	16,963	663,621	Not cover
2002	18,247,247	614	15,209	194,641	22,063	688,466	Not cover
2003	21,331,082	504	18,362	226,841	41,662	812,924	Not cover
2004	22,793,859	708	17,433	254,848	46,782	692,109	15,722
2005	22,164,334	760	17,441	251,960	60,874	773,280	28,021
2006	23,694,845	706	17,662	102,792	65,696	1,095,707	39,902
2007	26,935,417	683	17,691	282,199	76,248	1,169,778	56,581
2008	28,467,919	828	18,567	295,455	89,519	1,212,359	71,951
2009	28,984,350	795	18,343	291,966	98,035	1,254,102	139,165
2010	29,802,623	917	19,357	282,277	114,268	1,255,645	89,965
2011	30,981,222	881	20,197	291,376	153,217	1,256,114	98,142

Source: SSS's website.

5.3.4. Contribution rates and benefit package of the voluntary insured

Any persons between the ages of 15 and 59 are eligible to enroll the SSS voluntarily. There are two types of the benefit package according to the contribution. Option 1 which of the monthly contribution is 100 Baht does not include the old-age benefit but limited to the sickness benefit, the disability benefit and the death benefit. The insured who has selected Option 2 may specify the amount of their own contribution up to 1,000 Baht.

During the campaign in 2011, 99.35% of the insured selected Option 2[26].

FiguresVI-22 Benefit package for the information sector

		Injury or Sickness Benefit	Invalidity Benefit	Death Benefit	Old age benefit
Option 1 100 Baht	Insured: 70 Baht Government: 30 Baht	○	○	○	×
Option 2 150 Baht	Insured: 100 Baht Government: 50 Baht	○	○	○	○

Source: SSS's data.

[Sickness benefit] The insured that has paid the contribution for at least 3 months in 4 months before sickness and needs to be hospitalized for over 2 days is entitled to the sickness benefit of 200 Baht/day for a period not exceeding 20 days. While the benefit

[26] ASSA News Vol.24

package for the voluntary insured under the SSS does not cover medical services at medical institutions (in-kind benefit) which shall be provided for the formal sector, the insured in the informal sector may use the UC scheme.

[Disability benefit] The insured that has paid the contribution for a certain period and become disabled is entitled to the disability benefit of 500 to 1,000 Baht per month according to the contribution period, for a period not exceeding 15 years.

[Death benefit] The insured that has paid the contribution for at least 6 months in 12 months before death is entitled to the death benefit of 20,000 Baht to cover funeral expenses.

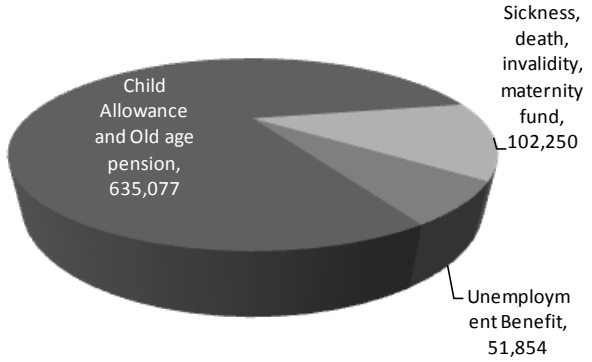
[Lump sum old-age benefit] The old-age benefit is paid at lump sum, not pension, when the insured reach the age of 60. The amount of the old-age benefit varies, as it applies the funding system.

5.3.5. Operation of the employee social security fund (Social Security Fund: SSF)

The SSS's fund is grouped into three types according to benefits. The largest fund is that for the old-age pension benefit and the child allowance, which amounts to 635.077 billion Baht, 79.39% of the total employee social security fund, followed by the fund for the sickness benefit, the death benefit, the disability benefit and the maternal benefit (102.250 billion Baht, 13.75%) and the fund for the unemployment benefit (51.854 billion Baht, 6.86%).

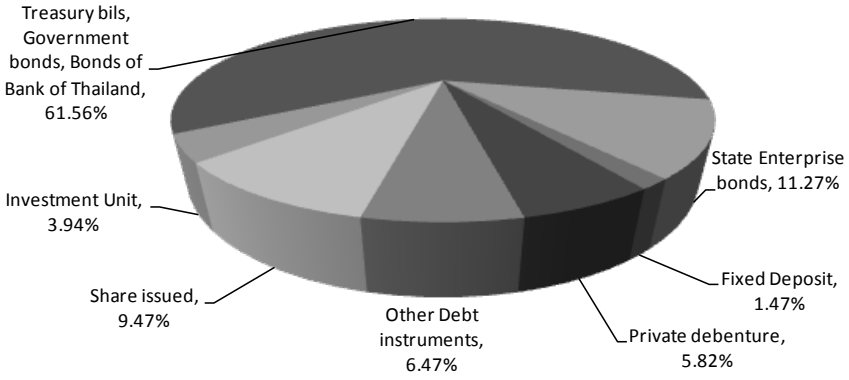
80% of these funds are managed by low-risk investments, and the remaining 20% are invested in high-risk products. Investments in government treasury bills, government bonds and Thai state bank bonds comprise approximately 60% of the total fund.

FiguresVI-23 Scale of the employee social security fund (2010)



Source: SSO Annual Report 2010

FiguresVI-24 Investment portfolio of the employee social security (2010)



Source: SSO Annual Report 2010

FiguresVI-25 Annual revenue and expenditure of the employee social security fund

(Unit: Baht)	2009	2010
Contribution	92,927,221,434.72	115,628,389,608.64
Fine for late contribution	272,712,241.88	328,740,386.58
Interest Revenue	23,692,892,455.75	25,743,465,232.30
Dividends	2,101,345,596.11	3,281,786,953.13
Gain (loss) on securities trading	868,652,095.36	4,746,334,284.23
Unrealized (loss) on investment	1,111,563,590.23	247,277,897.63
Other revenue	610,445,136.80	106,185,444.11
Total Revenue	121,584,832,550.85	150,082,179,806.62
Benefit expenses	43,901,677,787.26	43,546,297,754.14
Administrative expenses	3,058,782,702.00	3,720,024,256.00
Bad Debts	2,597,259.91	3,924,245.38
Doubtful Debts	1,358,357,544.60	54,055,352.20
Wage for Local Fund Manager	14,688,817.58	1,452,292.37
Unrealized (loss) on investment	0.00	
Other expenditure	14,089.22	69,352.75
Total Expense	48,336,118,200.63	47,325,823,252.84
Surplus before provision adjustment	73,248,714,350.22	102,756,356,553.78
Provision for old-age pension	60,645,764,377.70	77,884,998,677.96
Net Surplus	12,602,949,972.52	24,871,357,875.82

Source: Social Security Office Annual Report 2553 (2010)

5.4. National Savings Fund (NSF)

5.4.1. Legal basis

The National Savings Fund (NSF) is a saving system established based on the 2011 National Savings Fund Act. While the NSF was initially planned to be named the National Pension Fund, it is finally established for providing the basic level of old-age income security mainly for the informal sector which is not covered by any existing old-age income security system. Application to register in the NSF will start on May 8, 2012, under the law[27].

[27] The outline of schemes is based on information provided by the MOF as of March 2012 (before

5.4.2. Outline of schemes

At the initial stage, the NSF planned to be designed for approximately 13 million people in the informal sector not covered by any pension/old-age saving scheme with the social insurance method where the contribution is equally shared between an employer and an employee (3% of salary each). Based on experts' advices, it is finally formed as a saving method.

5.4.3. Estimation upon scheme design

At the stage of scheme design, the MOF has estimated the monthly pension amount would be 1,316 Baht for the insured that had paid the monthly contribution of 100 Baht between the ages of 15 and 60. Supposing 20% of the informal sector employees enroll in the scheme, the reserved amount is estimated to reach at least 14.911 billion Baht in the first year. The MOF expects that such a huge reserve will make the capital market stable.

5.4.4. Benefit package

The NSF is a defined contribution-type voluntary long-term saving pension system, assuming the insured as their own individual account. The insured may withdraw the sum of their own reserve in the individual account, reserve contributed by the government and an investment profit during contribution.

5.4.5. Eligibility of enrollment and contribution

Any persons between the ages of 15 and 59 who are not covered by any existing old-age pension program are eligible to enroll the NSF. The insured (member) may pay the contribution at least 50 Baht per deposit but not exceeding 13,200 Baht (1,100 Baht at monthly basis) at any time.

The government contributes the amount equivalent to a certain percentage of the insured's contribution according to the age: 50% of the insured's contribution but not exceeding 600 Baht per year for those between the ages of 15 and 29, 80% of the insured's contribution but not exceeding 960 Baht per year for those between the ages of 30 and 49, and 100% of the insured's contribution but not exceeding 1,000 Baht per year for those between the ages of 50 and 59.

5.4.5. Funds and operating bodies

While the National Savings Fund Office (NSFO) under the MOF has a primary responsibility to operate the NSF, the leading five banks in Thailand, the Government Saving Bank (GSB) and the Bank of Agriculture and Agricultural Cooperation (BBAC) are also involved in fund management. The minimum interest rate will be secured for a certain period.

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implementation).

5.5. Retirement allowance fund: Thai Provident Fund (TPF)

5.5.1. Outline of schemes

The TPF is a retirement allowance saving scheme for the employees of the private sector. The benefit will be paid upon not only compulsory retirement but also retirement for other reasons. The TPF thus does not intend solely to provide the old-age benefit, but would also compensate the unemployment benefit, as the insured may be entitled before a retirement age.

5.5.2. Legal basis

Provident Fund Act, 1987

5.5.3. Benefit package

Under the TPF, an employer defines the benefit package based on agreement with its employees and under the supervision of the SEC. The fund is managed by an external fund manager.

5.5.4. Eligibility of enrollment and contribution

The contribution varies from employer to employer. In general, an employee who wishes to enroll the TPF agrees with their employer on the contribution rates of an employee and an employer (2% to 15% of salary), criteria of disqualifications and other conditions, confirms the NAV (described below) and a benefit calculation formula, and submits an application.

5.5.5. Funds and operating bodies [28]

Despite of its public nature, the TPF is primarily operated by each employer which is supported by external management companies and custodians at their own capacities. In addition to an employer and the SEC, the following four bodies are involved in operating the TPF.

FiguresVI-26 Related bodies of the TPF

Agency	Role
Management Company	The management companies that can manage provident funds must hold the private fund management license. The management companies will also assist the funds in communication with the SEC. Currently 16 companies are registered
Custodian	A custodian is the company that is responsible for safekeeping of fund assets. The custodian will also follow up any benefits deriving from the investment of the fund, such as dividend and voting right receiving from investment. The Custodian must be approved by the SEC. Currently 13 custodian are registered.

[28] The number of bodies certified by the SEC is based on information available as of 2010.

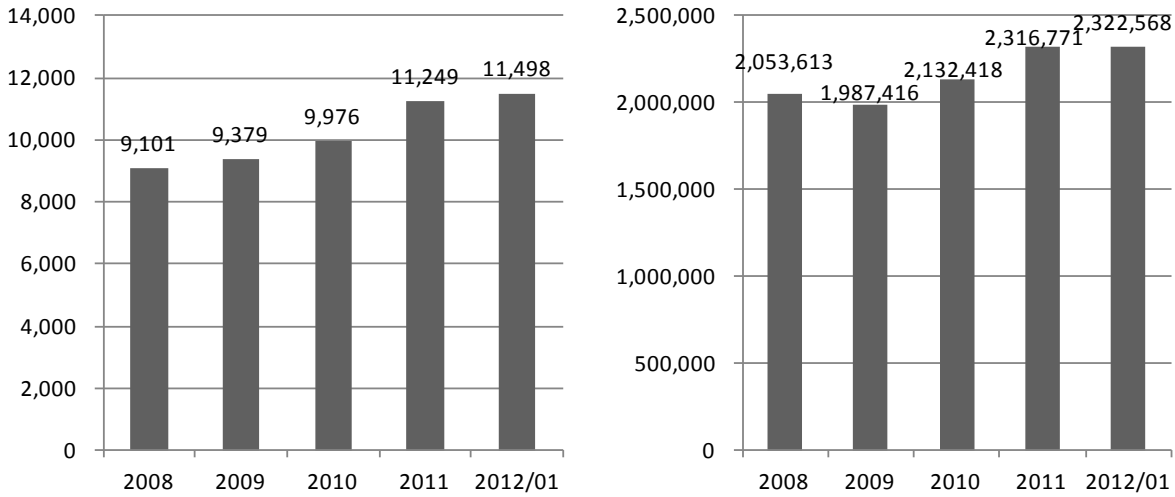
NAV Verifier	A NAV verifier is the company that is responsible for verification of net asset value calculated by management companies as to correctness and in compliance with the rule. Since NAV is crucial in calculating provident fund units for fund members. NAV Verifier must be approved by the SEC. Currently 13 NAV Verifiers are registered.
Auditor	An auditor is the person who is responsible for auditing financial statements of the funds. Provident funds of less than or equal to 100 members, or provident funds with asset value less than Baht 100 million are required a Certified Public Accountant (CPA) to audit its account. Other cases are required to have an auditor who got approval from the SEC. Currently 27 auditors are registered.

Source: TPF's website.

5.5.6. Enrollment figures

As of January 2012, the number of the insurers (employees) is 11,498, and the number of insured (employees) is 2,322,568.

FiguresVI-27 Numbers of insurers (employers) and insured (employees)



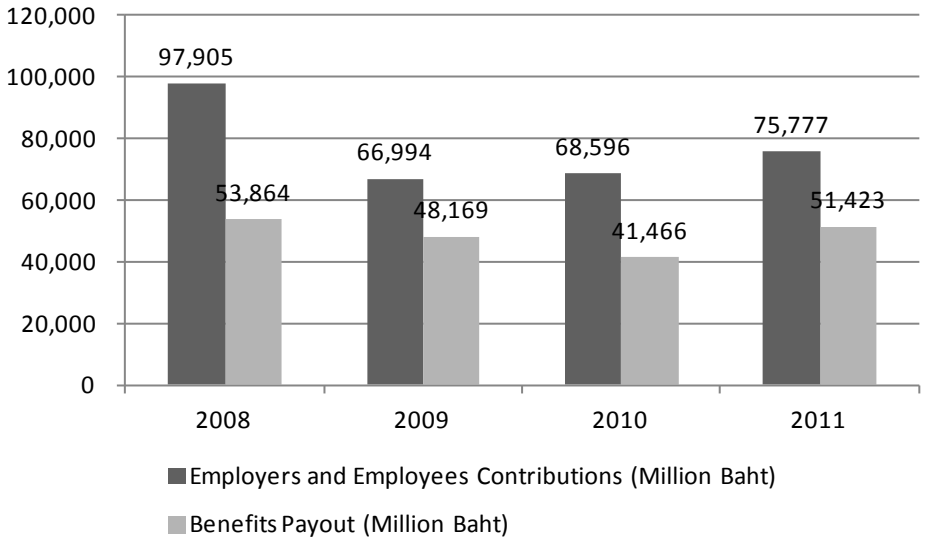
Source: TPF's website.

5.5.7. Contribution and actual benefit payments

As of 2011, the contribution amount by employers and employees is approximately 75.777 billion Baht, and the amount of actual benefits paid is 51.423 billion Baht. The total contribution amount was decreased in 2009 due to the Lehman Crisis, but is gradually increasing in step with the recovery of the salary level.

FiguresVI-28 Changes in the contribution amount and actual benefits paid of the TPF

(Unit: 100 million Baht)



Source: TPF's website.

5.6. Retirement Mutual Fund (RMF)

The RMF is generally positioned as the third level of pension insurance, which is enrolled by employees whose employers do not participate in other pension schemes such as the GPF and the TPF, or who have participated in any other pension scheme but intend to have more reserve upon retirement. The RMF is under the control of the SEC, same as the TPF.

The minimum reserve of the RMF is the smaller of 3% of annual income or 5,000 Baht. Contribution is basically made once a year, but one year of a grace period is allowed.

The benefit paid to the insured is tax exempted. The insured's contribution deducted from salary, including capital gain, is also not subject to the personal income tax, provided that the contribution is made for at least 5 years and the benefit is not paid until the age of 55. If the benefit is paid before the fifth year, any tax benefit is waived.

5.7. Unemployment insurance [29]

The employment benefit was included in the employee social security system as the seventh benefit, and the contribution thereto has been collected since January 2004. The compulsory insured (Section 33) of the employee social security system is automatically entitled to the unemployment benefit. The eligibility of enrollment is the same as that of the insured defined in Section 33 of the Social Security Act, as it is not allowed to individually enroll in the unemployment insurance.

[29] The unemployment insurance is included in the benefit program of the SSS.

5.7.1. Legal basis

The unemployment insurance is based on the 1999 Social Security Act (the unemployment benefit is part of the benefit package of the SSS).

5.7.2. Contribution rate

An employer and an employee contribute 0.5% of salary respectively, and the government makes an additional contribution of 0.25%.

5.7.3. Benefit payment conditions

The insured is required to pay the contribution for at least 6 months in 15 months before unemployment. Other conditions include termination of an employment relationship, unemployment not due to any event violating law, and no damage to an employer. An applicant for the unemployment benefit is also required to be capable of working and willing to work, and may not refuse to participate in job training course or skill development programs provided by the government.

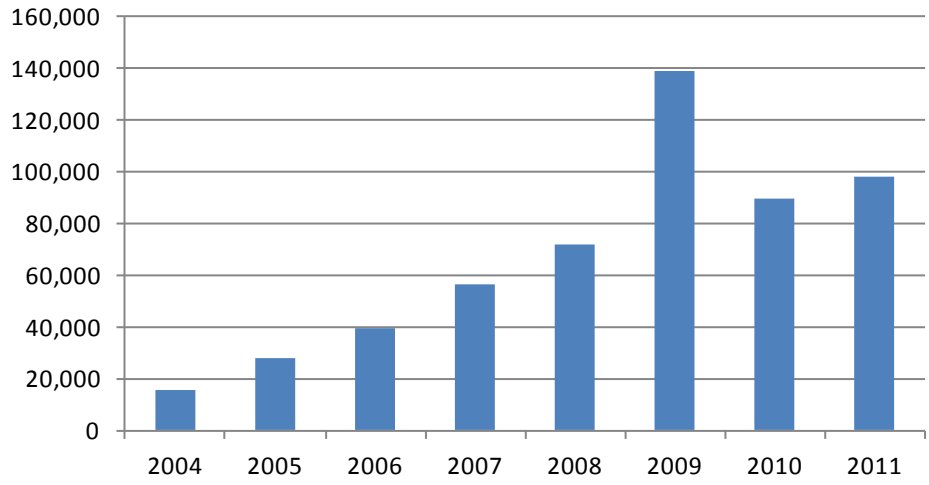
The unemployment benefit is 50% or in case of the retirement for employee's convenience 30% of the last income, which is paid for 180 days in a year at the maximum.

In 2009, the maximum period of benefit payment was temporarily extended from 180 days to 240 days due to the effects of the Lehman Crisis in 2008.

5.7.4. Enrollment figures

The beneficiaries of the unemployment insurance benefit are significantly affected by changes in the economic situation. Since the introduction of the unemployment benefit in 2004, the number of beneficiaries was steadily increasing and reached 140,000, almost double of 2008, in 2009 due to the economic crisis, supported by the government's emergency relief measures.

FiguresVI-29 Number of the beneficiaries of the unemployment insurance benefit



Source: SSS's website.

The number of unemployed people in Thailand largely varies between farming season and farming off-season. This is because in farming off-season people in rural areas move to urban areas to obtain a job in the service sector, while in farming season they go back to home. While the seasonal variations have recently become smaller in step with the increasing number of employees who regularly work in the service sector, Thailand has still shown a special state in terms of unemployment, which should be further discussed, including the definition of “unemployment”.

6. Social welfare System and Community-based Assistance Schemes

6.1. Development of databases to identify low-income populations

6.1.1. Outline of "Household Basic Minimum Needs (BMN)"

The Household Basic Minimum Needs (BMN) has been developed to identify low-income populations, the basic concept of which was presented in the 3rd National Economic and Social Development Plan (1972-1976) and which started to be implemented under the 4th National Economic and Social Development Plan (1977-1981), including the pilot projects. Data gathering is supported by local governments and people, under the supervision of the MOI.

The BMN compiles the results of research on community people's living conditions on a household basis according to the evaluation indicators in the following six areas: Medical (13 indicators), housing (8 indicators), basic education and literacy (7 indicators), finance (3 indicators), values (6 indicators), community participation (5 indicators) (42 indicators in total) (as of 2011).

The BMN is designed for community people to identify the current situation of their own community based on objective data and to confirm progress of development. It also intends to encourage community people to deepen their understandings on community issues and solve them in the course of data gathering. The data gathered in the BMN is expected to be used as a basic database for a project in each community.

6.1.2. Issues and challenges

The BMN does not work as a basic register for proving an individual with social welfare services and social assistance. This is because the BMN intends to evaluate the living standard of the overall community, rather than to identify income on a household basis precisely, as well as the data has not been updated periodically. Furthermore, given that the BMS is not linked with various benefits offered by the MSDHS, it has not functioned efficiently.

The government will be required to design more efficient and effective benefits in response to economic growth and expansion of the social security system. Government officials are fully aware of the necessity of databases to identify low-income populations precisely and to avoid overlapped benefit payments [30].

6.2. Social assistance systems

There are several types of public assistance to provide cash or in-kind benefits to households with income under a certain level, but public assistance by cash benefits covers

[30] Based on the hearing with the MSDHS.

only limited groups meeting specific requirements such as the elderly and PWDs. A general public assistance system to identify low-income populations through means test and compensate the minimum income is still in the process of study.

6.2.1. Target beneficiaries

The target beneficiaries include PWDs, HIV (500 Baht/month), elderly (60 to 69: 600 Baht/month, 70 to 79: 700 Baht/month, 80 to 89: 800 Baht/month, and 90 or more: 1,000 Baht). Other cash benefits are a one-off payment of 3,000 Baht per year to abused elderly, and housing renovation assistance of 2,000 Baht for PWDs and 10,000 Baht for elderly.

Retired government officers are not eligible for the above benefits. A social assistance for the elderly is not provided to low income elderly, but all elderly people regardless their income.

6.2.2. Consistency with the old-age pension scheme

There will be the first elderly group which has paid the contribution for a specified period under the SSS and become qualified to receive the old-age pension in a few years. They may select either of the following two payment method: Lump sum old-age benefit and the monthly social assistance benefit, or monthly old-age benefit and no monthly social assistance benefit.

This has been proposed by the SSO to the MSDHS for negotiation. Most beneficiaries are expected to select the lump sum payment. While the first option is beneficial to the SSO due to a fixed amount to be paid, it requires a large amount of money upon start of benefit payment. The second option which does not require paying the social assistance benefit has the disadvantage that the total amount of a pension benefit cannot be estimated.

6.2.3. Actual benefit payments

The eligible elderly population is expected to be 6.87 million, which accounts for 95% of the total elderly population. Among them, the number of elderly registered in the TAOs is 5.65 million, which accounts for 82.2% of the total eligible elderly population. The amount of benefit payment was approximately 33.9 billion Baht (actual in 2010), equivalent to 0.37& of GDP.

6.2.4. Implementing bodies, social workers

The MSDHS's office located in each province is responsible for managing the public assistance system. A few trained social workers have been assigned only to each province. There is no expert at a tambon level.

6.2.5. Issues and challenges

Thailand is becoming a middle income country and has sufficient financial resources to establish minimum income security schemes. However, these schemes are available only to

low-income needy dependents such as children/persons with disabilities and orphans, and a general public assistance system to identify low-income populations through means has not yet been established.

The current social assistance schemes involve noncompliance issues such as double and false entitlements, due to many overlapped schemes and lack of the government's preventive measures. Another issue is that any list or database to identify low-income populations has not yet been established.

7. Community-based Poverty Alleviation and Social Welfare Schemes

7.1. Small, Medium, and Large Community (SML) Project

The Small, Medium and Large Community (SML) Project has been initiated by the then-Prime Minister Taksin to achieve self-sustained poverty alleviation in the community by utilizing excess tax revenues supported by steady economic growth in the early of 2000'.

The SML Project is designed to encourage community people to discuss community issues, and consider and implement corrective measures themselves. The most notable point of the SML Project is that funds were directly sent to community people, not through the TAOs or other local public organizations, for their own decision.

The government funded each community according to their population (200,000 Baht for a village with the population of 100 to 150, 250,000 Baht for a village with the population of 500 to 1,000, 300,000 Baht for a larger community with the population of 1,000 to 1,500, and 350,000 Baht for an area with the population of 1,500 or more) to support them in solving issues. The total fund amount increased from 2 billion Baht in 2005 to 18 billion Baht in 2009. The SML Project had been extended to the end of October 2010, and later re-extended, which is still in operation. Any international institution had not involved in the SML Project.

7.2. Health promotion and disease prevention fund: Tambon Health Insurance Fund (THIF)

In 2001 immediately before the introduction of the "30 Baht Health Scheme", the Thai government established the Thai Health Promotion Fund (THPF) with the special purpose tax that is a 2% increase of the excise tax on tobacco and liquor. The social campaign for health promotion such as anti-smoking had also been developed, based on the concept that health promotion should reduce medical cost. These initiatives have been taken over by the NHSO, and the Tambon Health Insurance Fund (THIF) has been established to extend these initiatives to community people.

Based on the concept that the initiative for health insurance and disease prevention at a community level should eventually reduce medical cost, the THIF funds these initiatives by community people. While the NHSO provides the funds, it delegates the authority to determine how to use them to the local committees consisting of community people representatives, local health experts and local governments. When the NHSO provided the funds of 37.5 Baht per capita, the relevant TAO is required to the matching fund equivalent to 10%, 20% or 50% of the total budget according to its financial capacity.

The activity is designed by stakeholders in the community by employing the method of process management so-called "Strategic Route Map (SRM)". All community has to attach

this SRM to the application for THIF budget. The guidelines are prepared for drafting SRM in the community, including “dengue fever”, “environmental sustainability and restrictions of chemical use”, “strengthening good relationships in the family”, and “surveillance of H1N1 strain of influenza”

In Muang Mai community, such projects as “Rehabilitation for people with disability” or “Self checking for breast cancer” for the women at the age of 35 and over were implemented since 2008.

The number of TAOs establishing the THIF is increasing year by year: 869 in 2006, 2,677 in 2008, and 3,933 in 2009. The number of the TAOs having the THIF is currently 7,851 [31].

[31] WHO (2010)Funding health promotion and prevention –the Thai experience

8. Care and Welfare for the Elderly

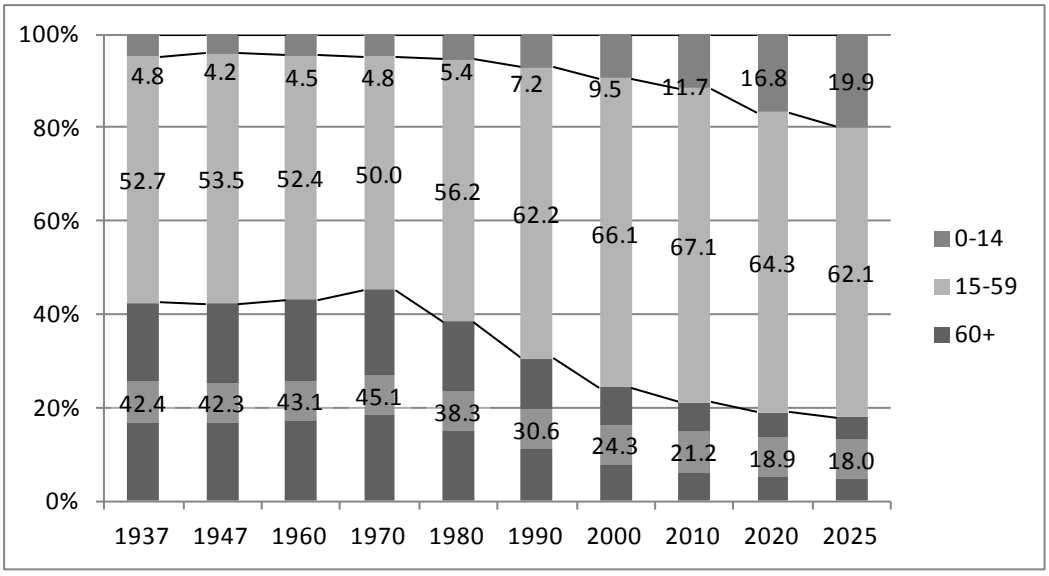
8.1. Policy initiatives and framework for the elderly

As regards the measures for the elderly, in 1982 the National Commission on the Elderly presided by the Prime Minister was established, the Office of which is currently located in the Bureau of Empowerment for Older Persons under the Office of Welfare Promotion, Protection and Empowerment of Vulnerable Groups (OPP).

The Thai government's measures for the elderly have been prepared based on the 2nd National Plan for Older Persons (2002-2012) prepared in 2002 following the 1st National Plan for Older Persons (1982-2001) and in response to the Madrid Declaration in 2002 which includes the following five strategies: (1) High-quality post-retirement life, (2) Health promotion, (3) Enhancement of the social security system, (4) Related schemes, human resource development, and (5) Verification and implementation of measures.

Each measure is implemented not by a single organization but jointly by more than one organizations. Many measures are overlapped due to their experimental nature. Experimental initiatives for development of facility infrastructure have been actively promoted in several departments within not only the MSDHS but also the MOPH.

FiguresVI-30 Aging population in Thailand



Source: Population and Housing Census, National Statistics Office (data up to 1999), and the estimate data by the NESDB in Population Projection Thailand 2000-2025 (data in/after 2000).

8.2. State of elderly facilities and services

We will find major two trends in elderly care facility according to their target beneficiaries: One is the public elderly care facility to protect the low-income elderly without family (nursing home in Japan), and the other is elderly housing services for the

wealthy mainly provided by private operators.

Due to the limited capacity of protective facility provided by public bodies, their users are generally selected by administrative organizations. However, the period of stay is often limited. Churches and temples are said to receive those who have to leave facility and have no family.

8.3. Income security for the elderly

In Thailand, several pension schemes are established for the income security for workers, GPF for civil servants, old age benefit of SSS or withdrawal from TPF for the employees in the private enterprises. For the further information, see the section "Pension and other income security scheme".

For the people who have already been at the age of retirement, the government provides monthly cash benefit of 600-1,000THB as a social assistance scheme. For more information, see the section "Social welfare System and Community-based Assistance Schemes".

8.4. Types of elderly facilities

Despite the growing development of elderly care facility, its capacity is limited. Especially for public facility, their functions are still experimental for the future aging society.

"Assisted living" that is a housing complex for the elderly is set up in six locations within the country. All of them are private facility and have full-time social workers. It is private facility for the elderly, the target of which is expected to be the wealthy.

All "Long-stay hospitals" are also private hospitals, except for one or two public facility, which are very expensive and mainly care chronic diseases based on the regulations of therapeutic facility for chronic diseases. While this type of facility provides a space and medical services, it is mainly for the wealthy due to a higher service fee of about 20,000 to 30,000 Baht.

"Nursing home" rather focuses on medical treatment, which may be located in a "Long-stay hospital" or provide terminal care for cancer patients. There are three public facility (Chang Mai, Chonburi and Samutprakarn (within Chulalongkorn University, semi-public), which offer a cheaper service fee. However, "Nursing Home" is out of the UC scheme, while medical treatment at public hospitals are provided free of charge. A patient who moves from a public hospital to a public Nursing home will have to fully bear the service fee [32].

Cancer facility in a temple in the Northeast region provides hospice care, which is for not only the elderly but also patient who need general terminal care.

[32] If a patient cannot afford the service fee, they will have to go back to home or move to any charity body.

8.5. Development of new facility forms

8.5.1. Unitary Care Home

In addition to the above elderly care facility, the Institute of Geriatric Medicine of the MOPH plans to develop the "Unitary Care Home" which provides both home care and care facility. The user of each function is expected to the elderly who is relatively independent for home care services and the elderly who is a dependent user with no relatives. To ensure that this unitary facility functions efficiently and effectively, further discussion will be required.

8.5.2. Elderly Health Promoting Center

The Elderly Health Group of the MOPH has a pilot project to establish the Elderly Health Promoting Center in Nakon Rachasima for the purposes of (1) Short-stay facility to improve the elderly lifestyle which may cause preventable disease, and (2) Train care workers. The capacity is expected to be 14 rooms with the area of 29.25m^2 (4.5m x 6.5m2) with 3 beds (42 bends in total), and the area per person will be 9.41m^2. Each room has a bathroom and a washroom [33].

The Elderly Health Promoting Centers plan to be built within tambon health promoting hospitals (means the CUPs such as community hospitals and health centers), and it is thus expected be funded by the capitation system budget allocated by the NHSO. The Elderly Health Promoting Center plans to be set up in the four regions, and will be increased in future.

From a long-term perspective, it is also expected that the Elderly Health Promoting Center will function as a technical training center for care workers from the ASEAN countries and promote fostering of care workers in collaboration with nursing collages within a province, which is still discussed within the MOPH. Future projects are planned in Nakhon Si Thammarat, Ayutthaya and Chaiyaphum upon approval of the budget.

Future developments are unknown at this moment due to success of the pilot project and political factors involved.

8.5.3. Tambon nursing program

In the tambon nursing program operated by MOPH, any tambon which meets the six requirements will be accredited to be an autonomous body promoting nursing care. The program has been currently promoted in two tambons per province, targeting to accredit all tambons.

The six requirements are 1) Well-managed elderly information, 2) Establishment of an elderly club, 3) Elderly volunteers in place, 4) Home health care programs in place, 5) Oral care programs in a health center, and 6) Rehabilitation practice in place.

[33] Since the budget approved (20 million Baht) is only half of that requested (40 million Baht), the building plan has been changed from three-story to two-story.

Any tambon which meet all these requirements will be issued a certificate and allocated the budget from the NHSO. The final target is that all tambons are accredited.

8.6. Fostering of care workers

At this moment, the Thai government has not yet presented clear strategies or guidelines relating to fostering of care workers. While there is no strategic fostering program due to lack of the system at the service provider side, including career management of trained care workers, the care worker fostering curriculums have been prepared by the MOPH, the MOL and the Ministry of Education (MOE). The MSDHS which is responsible for measures for the elderly intends to promote human resource fostering jointly with the MOPH, while it has not presented its plan[34]. In addition, the Ministry of Commerce (MOS) has promoted private-level human resource fostering programs in collaboration with Japanese companies, the Midwives' Association and the TICA.

Care workers who are trained are expected to be employed by private entities or medical institutions mainly providing services to affluent class, due to the limited number of public institutions. The MOPH is currently preparing the training materials based on the curriculums in cooperation with the Chulalongkorn University Hospital, the MOE, the MOL, and doctors and nurses, which are expected to be completed by May 2012 for trainers and by the end of 2012 for trainees.

In the facility in Nakon Ratchasima mentioned earlier, fostering programs plan to be provided based on these texts. However, how far tambons will implement these initiatives is still uncertain, which should be a long way[35].

8.7. State of international cooperation

The Japan International Cooperation Agency (JICA) had performed the Project on the Development of a Community Based Integrated Health Care and Social Welfare Services Model for Thai Older Persoons (CTOP) from 2007 to 2011.

The CTOP Project intends that relevant local organizations plan, implement, evaluate and improve a community-based elderly care system while encouraging voluntary commitment by community people. The CTOP Project had been performed in four model areas for 4 years in order to achieve integrated health care and social welfare services.

Korean NGO "Help Age" has been supporting Thailand through the project on human resource development of care workers. This project is implemented in all ASEAN countries. The detail of the activity is not known.

European Commission has deployed the consultant to the NHSO from the earlier 2000s, and provided information mainly on health financing as a technical cooperation, which has

[34] Based on the interview to the MSDHS.
[35] Based on the interview to the Elderly Health Group of the MOPH.

already terminated.[36]。

WHO has mainly been supporting health financing and universal coverage issue including the simulation on the health expenditure management or review on the UC scheme which has been 10 years since its establishment.

[36] Based on the interview to the NHSO.

9. Issues Facing Social Security in Thailand and Cooperation by Japan

9.1. Issues facing the health security system

9.1.1. "Harmonization" among the three health insurance schemes

Since the introduction of the UC scheme in 2002, the major challenge in the health security system has been the integration of the three health insurance schemes. While the 2002 National Health Security Act seeks to establish a single health security scheme, including finance resources, the initiatives for the past decade have rather focused on the integration of each function to make payment mechanism or administrative procedures consistent among the three schemes. In fact, these movements have been positioned as "harmonization", rather than "integration", the major outcome of which include the integration of payment mechanism for the inpatient sector between the CSMBS and the UC scheme, and the shift from the fee for services system to the DRG system in the inpatient sector of the CSMBS. The emergency medical service system has been integrated since April 2012.

9.1.2. Gap between the CSMBS and the UC scheme

It is said to be difficult to analyze efficiency and superiority among the three schemes, due to different financing systems and different age compositions of insured. The major concern is different payment methods in the outpatient sector: While the UC scheme has adopted the capitation system, i.e. global budget system, where it is easier to control a medical fee as the amount of expenditures is limited to the budget allocated earlier, the CSMBS has still applied the fee for services system, which allows considerable discretions to doctors and makes cost management difficult in terms of drug prescription. In fact, the ratio of generic drugs under the CSBMS is much lower than the UC scheme.

To reduce the above gap, the capitation unit cost under the UC scheme is increasing each year. It is notable that the budget for the UC scheme is still increasing in/after the fiscal year 2009 affected by the Lehman Crisis [37]. On the other hand, the budget for the CMBS under the fee for services system is also increasing, as a result of which the gap between the two schemes remains unchanged.

9.1.3. Gap between the SSS and the UC scheme

The SSS is more similar to the UC scheme in terms of cost management, as it has adopted the capitation system in the outpatient sector. Due to the increasing budget for the UC scheme for the past decade, the gap between the two schemes has been reduced. However, these movements have revealed the issue of different financial resources. The UC scheme

[37] For political reasons, experts hesitate to discuss reduction of medical spending due to the success of the UC scheme, as a result of which medical spending has kept increasing in the past decade.

which is a tax-based system does not cause direct burdens on the insured, and most of the insured of the UC scheme is the low-income group which is not subject to the personal income tax. On the other hand, the insured of the SSS which is a social insurance system is required to be deducted the contribution from salary, in addition to payment of the personal income tax. Such gap in financial burdens has been offset by the gap in benefits. Under the recent circumstances where the gap in benefits has been reduced, equal burdens should be ensured.

9.2. Issues facing the employee social security system

9.2.1. Lack of inter-ministerial coordination

For income security for workers after retirement, several schemes have been operated in parallel, which should be integrated, same as the three health insurance schemes. While the "Harmonization Committee" has been organized among the three health security schemes whereby joint research activities have been actively performed, in the old-age pension sector such inter-ministerial coordination is still very limited. This is because it is not easy to reform a scheme based on long-term contribution like the old-age pension scheme.

The NSF for the informal sector has been recently developed, and the number of the voluntary insured in the SSS is sharply increased for the past few years. It is expected that there will be many people who are entitled to more than one schemes. It will be required to discuss functional differences between these two schemes.

9.2.2. Financial needs and sustainability

Behind the recent growing number of schemes, the government's intention in terms of financing is coming to our view. Upon the establishment of the NSF, the MOF clearly commented that it expected the NSF would contribute to expansion of the financial asset market in Thailand. In other words, such financial assets have motivated the government to introduce a new scheme. On the other hand, in a medium- and long-term, the sustainability of pension financing and the replacement rate of pension benefit to maintain the living standard of post-retirement are concerned. As we have seen in many developed countries, allocation of tax revenues may be required in the future.

9.3. Issues facing the social welfare system

While Thailand has established various benefit schemes along with economic growth, the overall picture of social welfare benefits is not clear. There are a number of non-contributing schemes to provide low-income persons with cash benefits, including short-term and permanent programs, whereby we can find multiple benefit payments.

In Thailand, it is certain that more and more taxes will be injected in the social sector following the introduction of the UC scheme. Under these circumstances, it is crucial to

make benefit payments fair, and for this purpose to promote data management of low-income populations, and reorganization and integration of welfare benefits. This should be a big challenge for Thailand where the vertically-structured administrative system is deeply rooted.

Another issue is the consistency of old-age income security frameworks for the informal sector which are growing under the NSF and the SSS with public assistance schemes provided by the MSDHS and financed by tax revenues.

9.4. Issues facing elderly care

The issue of aging population is one of the primary issues in Thailand. The measures for the elderly have been presented in the 2nd National Plan for Older Persons (2002-2012), all of which are still experimental. The issue of aging populations by nature involves challenges across ministries, including income security for the elderly by the MSDHS, saving for post-retirement by the SSO of the MOL, nursing prevention and elderly health care by the MOPH, and life-long education by the MOL.

Despite the MSDHS's efforts on inter-ministerial coordination, practical measures still tend to be completed in a single ministry, and even within the MOPH initiative are not always consistent. Going forward, it is expected to build the best practice from these experimental initiatives and to clarify a specific direction.

For future elderly care, it would be shifted to community-based care systems not dependent on tax revenues while utilizing existing local resources. This has the same orientation as recent community-based comprehensive care in Japan.

As such, the future initiatives would be training for volunteers in elderly clubs or community bodies as well as to assign trained health staffs to the community.

To follow the initiatives provided since the middle of 2000' such as the SML program and the THIF by the NHSO, it would become more important for autonomous bodies to build a system promoting self-sustained elderly care based on their own decision by improving care-related techniques for this purpose.

9.5. Prioritized Issue for cooperation in Thailand

Thailand is one of the most advanced countries among ASEAN countries in the development of social security system. Thus, the basic design of the system has already been completed, improving the operation and expansion of coverage has become a central challenge. Because the basic structure of health security system is different from Japan, it is not appropriate to transfer the Japan's experience directly to Thailand. However, both countries have common issues such as health expenditure management, hospital management, fee schedule issue. Therefore it is prioritized issue to share the experience of both countries

on these issue through the periodical information exchange such as seminar or symposium.

Although the elderly care in Thailand is an important issue, the grand design for this field has not been set. With cultural affinity between Japan and Thailand, it is effective to transfer Japan's experience to Thailand from the viewpoint of comparative advantage to other developed countries.

From the mid and long term viewpoint, it is key to mobilize social resources in the community including family and volunteers, because of the financial restriction. It is prioritized issue to provide opportunities for training and specialized knowledge in order to upgrade the capacity and standard of activity and services provided by community members.

In addition, the field of anti-aging, for the Thai government, is a field, yet important issues, poor accumulation of experience, because it does not also decided grand design of concrete anti-aging, to communicate the experience of Japan There is also a cultural affinity, high field say it is also comparative advantage, may be useful. On the care of the elderly to transfer the experience of Japan, would be a powerful field. Anti-aging in Thailand, when viewed over the medium to long term, but in the environment from the constraints of financial, must take advantage of social resources of the community, including family, volunteer, in the field of nursing, social resources of the region to raise to a high level of services and activities provided by the provision of training opportunities for cooperation that is a problem or priority, provision of expertise for the purpose of improving technical.

Chapter VII Cambodia

1. Social Security Overview

1.1. Social security in the constitution

Upon the signature on the Paris Peace Agreement in 1999, Cambodia ended the long-lasting civil war since the 1970s. In September 1993, the Constitution of the Kingdom of Cambodia was promulgated under the interim administration by the UN Transitional Authority in Cambodia (UNTAC), whereby the Kingdom of Cambodia was born.

The constitution provides social security in Articles 36 and 46 of Chapter III (THE RIGHTS AND OBLIGATIONS OF KHMER CITIZENS) and Articles 72 to 75 of Chapter VI (EDUCATION, CULTURE, SOCIAL AFFAIRS) as follows[1].

Article 36: “Khmer citizens of either sex shall enjoy the right to choose any employment according their ability and to the needs of the society. Khmer citizens of either sex shall receive equal pay for equal work. The work by housewives in the home shall have the same value as what they can receive when working outside the home. Every Khmer citizen shall have the right to obtain social security and other social benefits as determined by law. Khmer citizens of either sex shall have the right to form and to be member of trade unions. The organization and conduct of trade unions shall be determined by law.”

Article 46: “The commerce of human beings, exploitation by prostitution and obscenity which affect the reputation of women shall be prohibited. A woman shall not lose her job because of pregnancy. Woman shall have the right to take maternity leave with full pay and with no loss of seniority or other social benefits. The state and society shall provide opportunities to women, especially to those living in rural areas without adequate social support, so they can get employment, medical care, and send their children to school, and to have decent living conditions.”

Article 72: “The health of the people shall be guaranteed. The State shall give full consideration to disease prevention and medical treatment. Poor citizens shall receive free medical consultation in public hospitals, infirmaries and maternities. The State shall establish infirmaries and maternities in rural areas.”

Article 73: “The State shall give full consideration to children and mothers. the State shall establish nurseries, and help support women and children who have inadequate support.”

Article 74: “The State shall assist the disabled and the families of combatants who sacrificed their lives for the nation.”

Article 75: “The State shall establish a social security system for workers and employees.”

[1] http://cambodia.ohchr.org/KLC_pages/klc_section01.htm

1.2. Current state and basic direction of government policy for social security

In Cambodia, the development of the social security system is delayed in comparison with neighbouring countries in Asia, due to the long-standing civil war and a number of intellectuals including medical professionals killed during the Pol Pot regime. The Cambodian government is addressing the development of the social security system, supported by various international organizations and NGOs.

The current social security schemes include the National Social Security Fund (NSSF) which was established in 2007 under the Social Security Law promulgated in 2002 and provides the employment injury insurance to the private formal sector[2], and the National Social Security Fund for Civil Servants (NSSF-C) implemented in 2008, and the National Fund for Veterans implemented in 2010. In addition, the government is working on developing a comprehensive scheme.

Three major plans involving various areas including social security are as follows:

1.2.1. Rectangular Strategy

The “Rectangular Strategy” is a national development strategy announced upon the inauguration of the 3rd government in 2004, which focuses (1) Reinforcement of the agriculture sector, (2) Restoration and development of infrastructure, (3) Development of the private sector and employment creation, and (4) Capacity building and human resource development. In September 2008, the subsequent “Rectangular Strategy - Phase II” was announced, which states priority challenges, including “Reinforcement of emergency assistance in natural disasters”, “Poverty reduction”, “Provision of health services to the poverty”, “Education”, “Employment improvement” and “Enhancement of welfare for the elderly, PWDs, children and women”. In terms of health services, the government has emphasized on infants and pregnant women especially in the poverty group, which has brought good results, including a significant decrease in the mortality rates of infants, children of the age less than 5 and parturient women. While the “Rectangular Strategy - Phase II” recognizes such initiative to be continued, it also focuses on prevention and treatment of infectious diseases through “Development of medical institutions”, “Fostering of health experts”, “Improvement of working conditions of medical professionals and midwives”, “Increased medical professionals and midwives in rural areas” and “Dissemination of information and provision of services through the health insurance scheme in rural areas”[3].

1.2.2. National Strategic Development Plan (NSDP) 2009-2013

The NSDP 2009-2013 is an update version of the NSDP 2006-2010 prepared following the

[2] The formal sector is "the employed in a private enterprise or the government and the family", the informal sector is "agricultural worker, self-employed, unemployed people and the family".
[3] RGC(2008),Rectangular Strategy Phase II

introduction of the Rectangular Strategy - Phase II and the global economic downturn, which is positioned as a roadmap to realize the Rectangular Strategy - Phase II. The most important target of the NSDP 2009-2013 is poverty reduction and economic development. The NSDP 2009-2013 specifies challenges and priority policies to put the Rectangular Strategy - Phase II into effect, responsible ministries and departments, and target figures by sector in 2013. The priority policies in the welfare sector include "Social welfare for the poverty", "Child welfare and juvenile rehabilitation", "PDW welfare", "Welfare and social security system for old-age civil servants and citizens", "Welfare and social security system for veterans", and "Capacity, cooperation and financing in organizations"[4].

1.2.3. National Social Protection Strategy (NSPS)

In Cambodia, development projects in the social protection area tend to be performed individually. The NSPS prepared in March 2011 is a comprehensive social protection strategy, one of the objectives of which is reinforcing collaboration between the nation and development partners, and improving effectiveness and efficiency of the projects.

The NSPS was initiated upon the agreement between the Cambodian government and aid organizations on the policy to "Develop a more integrated social safety net system" at the 2nd Cambodia Development Cooperation Forum in 2008, and designed on the initiative of the Council for Agricultural and Rural Development (CARD). The NSPS plans to be reviewed in 2013 and 2015[5].

While the NSPS includes individual projects to be implemented on a ministry basis, it is positioned as a higher plan across various areas related to the social protection policies in Cambodia.

1.3. Outline of the social security system

1.3.1. Health security system

There is no nationwide comprehensive health security system in Cambodia, but individual initiatives by the government and NGOs are taken for the poverty. The Health Equity Fund (HEF) is a health security service for the poverty which accounts for about one-third of the total population of the country. As of 2010, the number of the insured of the HEF is approximately 3.3 million, equivalent to 76.8% of the total poverty population (4.2 million). The Community Based Health Insurance (CBHI) is a social insurance scheme for the informal sector which is a little wealthier than the poverty (including part of the formal sector). While the number of the insured of CBHI was 270,000 in 2011, which accounts for only 3.9% of the total informal sector population excluding the poverty and the wealthy (7 million). But it means that it largely spreads that the number of the insured was 140,000 in

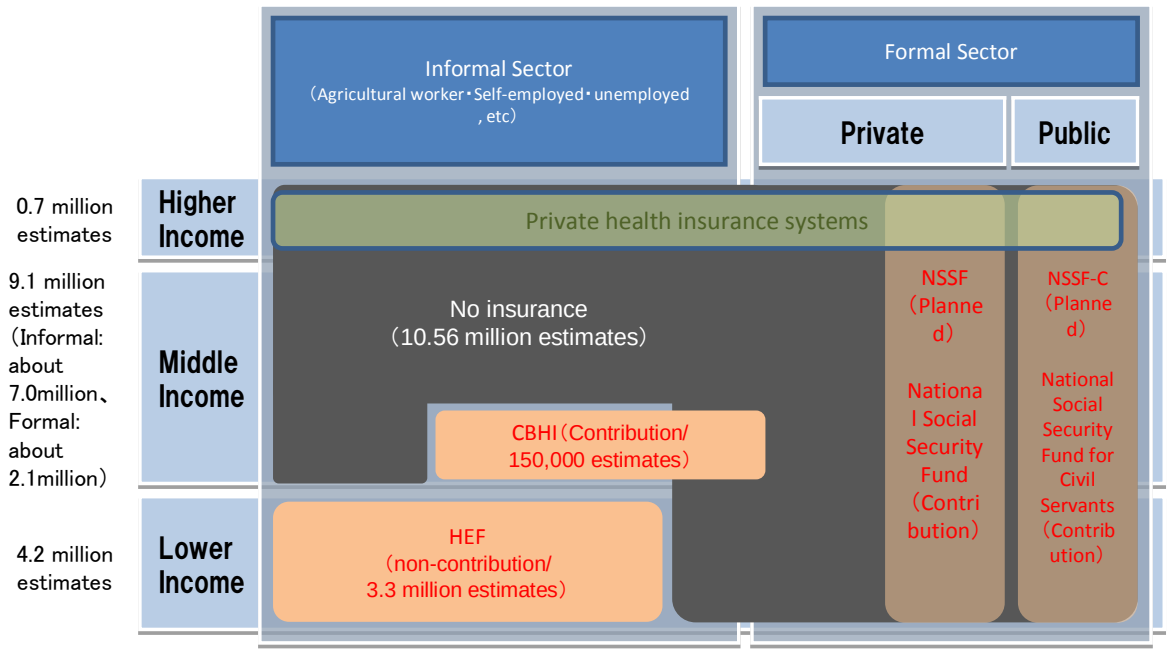
[4] RGC(2010),National Strategic Development Plan UPDATE 2009-2013
[5] RGC(2011) , National Social Protection Strategy for the Poor and Vulnerable

2010.

The health security system for the private formal sector and civil servants are in the process of design within the frameworks of the NSSF and the NSSF-C respectively. The NSSF plans to introduce the health insurance scheme in 2012.

Private health insurances are also available, but their customers are limited to foreigners and part of the wealthy due to a higher price.

Figures VII-1 Health security system in Cambodia (2010)

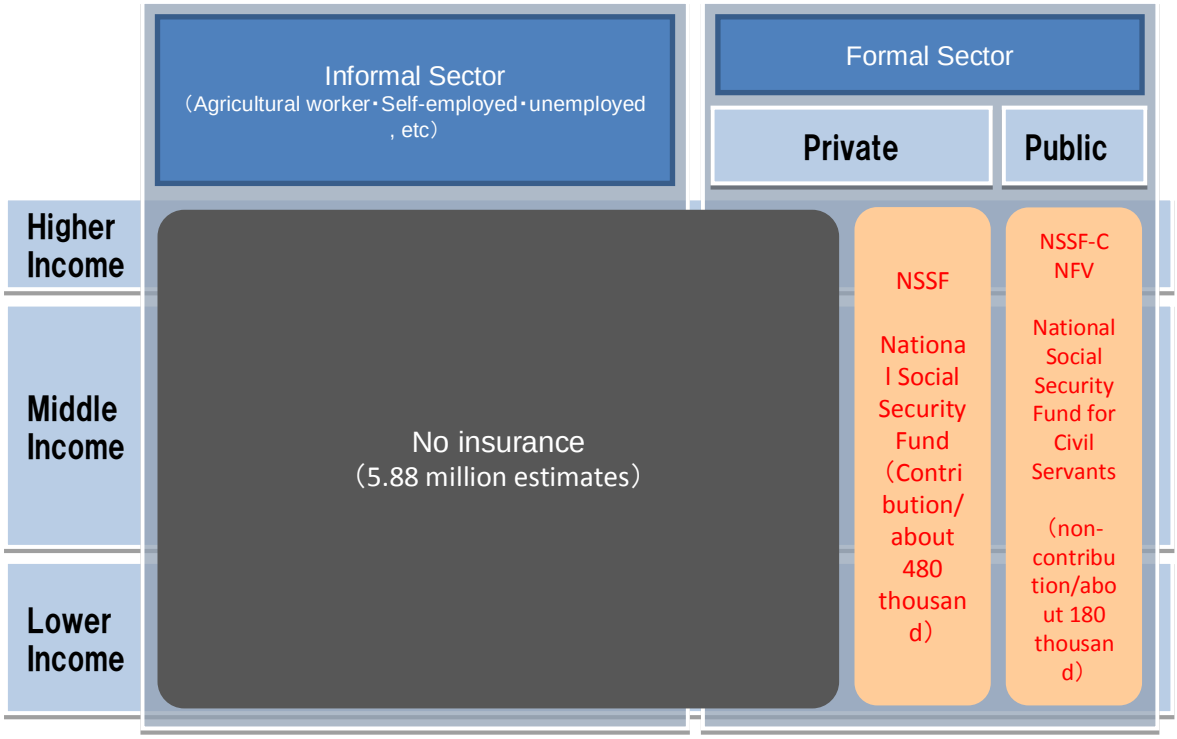


1.3.2. Pension and other income security schemes

As regards the income security system in Cambodia, while a comprehensive scheme is developing for the formal sector[6], there is no system for the informal sector. The income security system (e.g. pension, employment injury) for the private formal sector and civil servants is included in the NSSF and the NSSF-C respectively. The income security system for veterans, etc. is the NFV.

[6] In the income security system, the total of formal sector population and the informal sector population means total worker population (The family is not included).

Figures VII-2 Pension and other Income security in Cambodia (2010)



The NSSF is mandated all employers having at least eight employees, which has approximately 480,000 of the insured as of 2010. The NSSF-C covers all civil servants, estimated to be 180,000 (currently, on duty), equivalent to 10.1% of the total employees (6.5 million). The NSSF-C and the NFV are based on the non-contribution scheme but plan to transit to the contribution scheme.

2. Organizations Involved in Social Security

2.1. Ministry of Health (MOH)

The MOH is responsible for implementing and evaluating policies based on the national strategies so that all the people including the poverty should enjoy their fair and healthy lives. More specifically, the main roles of the MOF are provision of basic public health care, prevention of infectious and non-infectious diseases, and mother and child health programs for the poverty. The current plans of the MOF include the "Health Strategic Plan 2008-2015 (HSP2)" and the "Strategic Framework for Health Financing 2008-2015 (SFHF)".

2.2. Ministry of Labor and Vocational Training (MOLVT)

The MOLVT is in charge of educational training and resolution of labor disputes, more specifically, job training, child labor issues, labor protection, as well as the social security system such as pension and employment injury. The MOLTV controls the social security system for all employees covered by the Labor Law. The NSSF which is the social security fund for private formal sectors is technically under the MOLVT and financially under the MOEF.

2.3. Ministry of Social Affairs, Veterans and Youth Rehabilitation (MOSAVY)

The MOSAVY is in charge of social welfare, more specifically, relief of the socially vulnerable such as the elderly, PWDs and orphans, relief of the young involved in drugs, prostitution and theft, child protection, food aid for tubercular patients, and rehabilitation programs for the juvenile offenders.

The NSSF-C, the social security fund for civil servants, and the NFV, the social security fund for veterans are technically under the MOLVT and financially under the MOEF.

2.4. Ministry of Women's Affairs (MOWA)

The MOWA is in charge of protection of a damaged woman of the violence, sexual exploitation, human traffic, and promotion of the social advance of the woman.

The current plan of the MOWA includes the "Neary Rattanak Ⅲ 2009-2013 ".

2.5. Ministry of Planning (MOP)

The MOP is play a cross-ministry role in the social security system through development of social and economic development plans, and government statistics. The MOP is specifically in charge of the "Identification of Poor Households (ID-Poor)" which is a database to identify to the poverty that needs supports.

In the NSPS, the ID-Poor plans to be utilized as a targeting tool for all social protection policies, which is the important base of social protection policies in future. The current plan of the MOP includes the "Ministry of Planning Strategic Plan (MPSP) UPDATE 2009-2013."

3. Social Security Budgets[7]

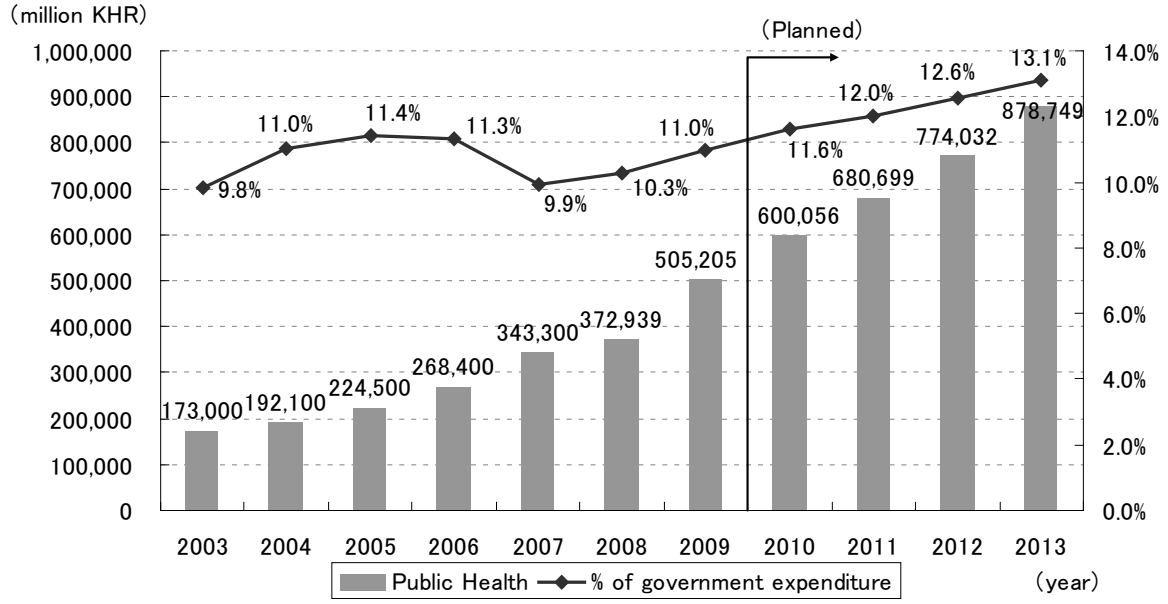
3.1. Budgets in the health sector

As shown in FigureⅧ-3, the budgets in the health sector are increasing year by year, whereby the total budget of 2009 amounted to approximately 270% of that of 2003. Given that the increase they are sharply increasing in/after 2008 covered by the HSP (2008-2015), the budgets are assumed to be allocated according to the plan. The budgets of 2009 (approximately 500 billion KHR[8]) mean USD9.28[9] per capita and account for 11.0% of the total government budget.

The budgets of 2013 are expected to reach nearly 170% of those of 2009, and the ratio of budget in health sector is expected to gradually increase.

As shown in FigureⅧ-4, about 40.8% of total social health expending is financed by donors. It decreases year by year, but is at a still high standard.

FiguresVII-3 Changes in the health budget



※1RIEL(KHR)=0.020JPY
Source: MOP, National Institute of Statistics, "Statistical Yearbook 2008", Table 19.8 (2003 to 2008), and RGC (2010), National Strategic Development Plan UPDATE 2009-2013 (2009 onward).

[7] This budget is the total of the central government and the province. This budget is the budget for whole Kingdom of Cambodia, because a province is a branch of the central government. The support by donors is not included

[8] 1RIEL(KHR)=0.020JPY(JICA monthly business rate (reference level), May, 2012)

[9] Converted based on 1USD=4,000KHR

FiguresVII-4 Total social health expenditure and revenue

(million US$)

	2007	2008	2009	2010
■EXPENDITURE				
①Government	63.5	80.7	99.9	138.2
②NSSF		0.5	0.7	1.2
③Donors	75.9	75.0	75.0	88.2
④HEFs	4.3	4.8	6.5	7.0
⑤CBHIs	0.2	0.5	0.6	0.7
⑥TOTAL EXPENDITURE	143.9	161.5	182.7	235.3
■REVENUE				
⑦Tax(Government)	63.5	80.7	99.9	138.2
⑧NSSF		2.5	4.2	4.8
⑨Subsidies(Donors)	75.9	75.0	75.0	88.2
⑩HEFs	4.3	4.8	6.5	7.0
⑪CBHIs	0.2	0.5	0.6	0.7
⑫TOTAL REVENUE	143.9	163.5	186.1	238.8
■Ratio of Donor Funds (③+④+⑤)÷⑥	55.9%	49.7%	44.9%	40.8%

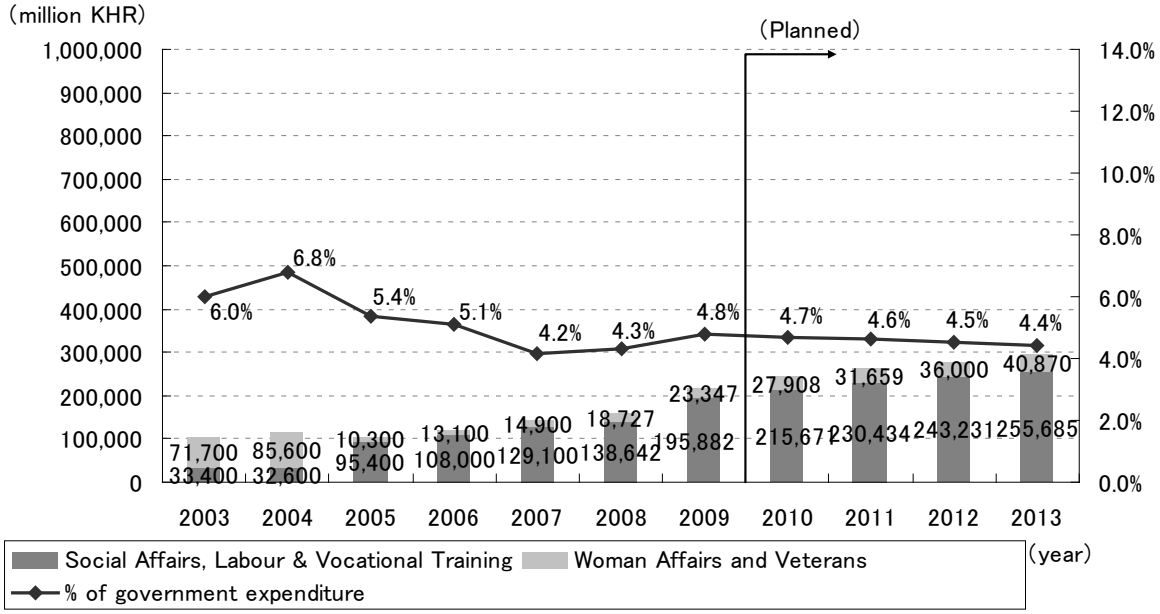
Source: Compiled by Mitsubishi UFJ Research and Consulting based on “Social Protection Expenditure and Performance Review (2011)”

3.2. Budgets in the social welfare sector

FigureⅦ-5 shows changes in the budgets for “Social affairs, labor and vocational training” and “Woman affairs, veterans”, which are part of the social welfare sector. Except for a sharp increase of the budgets for “Woman affairs, veterans” from 2003 to 2004, the budgets are gradually increasing, whereby the total social welfare budget of 2009 (approximately 220 billion KHR) amounted to approximately 210% of that of 2003, which accounts for 4.8% of the total government budget.

The budgets of 2013 for “Social affairs, labor and vocational training” and “Woman affairs, veterans” are expected to increase by 30% and 80% respectively from 2009. But the ratio of budget in social welfare sector is expected to slightly decrease.

FiguresVII-5 Changes in the social welfare budget[10]



※1RIEL(KHR)=0.020JPY
Source: MOP, National Institute of Statistics, "Statistical Yearbook 2008", Table 19.8 (2003 to 2008), and RGC (2010), National Strategic Development Plan UPDATE 2009-2013 (2009 onward).

[10] Sum of "Social affairs, labor and vocational training" and "Woman affairs and veteran".

4. Health Security

4.1. Health Strategic Plan 2008-2015 (HSP2)[11]

The current national plan in the health security sector is the HSP2 under the control of the MOH. The HSP2 is prepared based on the evaluation of the HSP1 (2003-2007) prepared in 2002. The framework of the HSP2 consists of the three major goals and the twelve objectives to achieve the targets (FigureⅦ-6).

FiguresVII-6 Structure of the Goals and objectives of the HSP2

Goals	objectives
Goal 1 Reduce maternal, new born and child morbidity and mortality with increase reproductive health	1 To improve the nutritional status of women and children 2 To improve access to quality reproductive health information and services 3 To improve access to essential maternal and newborn health services and better family care practices 4 To ensure universal access to essential child health services and better family care practices
Goal 2 Reduce morbidity and mortality of HIV/AIDS, Malaria, TB, and other communicable diseases	5 To reduce the HIV prevalence rate 6 To increase survival of People Living with HIV/AIDS 7 To achieve a high case detection rate and to maintain a high cure rate for pulmonary tuberculosis smear positive cases 8 To reduce malaria related mortality and morbidity rate among the general population 9 To reduce burden of other communicable diseases
Goal 3 Reduce the burden of non-communicable diseases and other health problems	10 To reduce risk behaviors leading to non-communicable diseases (KAP): diabetes, cardiovascular diseases, cancer, mental illness, substance abuse, accidents and injuries, eye care, oral health , etc 11 To improve access to treatment and rehabilitation for NCD: diabetes, cardiovascular diseases, cancer, mental illness, substance abuse, accidents and injuries, eye care, oral health, etc 12 To ensure Essential Public Health Functions: environmental health:, food safety, disaster management and preparedness

Source: MOH (2008), Health Strategic Plan 2008-2015.

The HSP2 is supported by the Health Sector Support Project 2008-2015 (HSSP2) which is the Sector Wide Management (SWiM) involving several aid organizations, and implemented jointly by the Comabodian government and these aid organizations. The organizations involved in the HSSP2 include the WB, the DfID, the UNFPA, the AusAID, the AFD, the UNICEF and Belgian Technical Corporation (BTC).

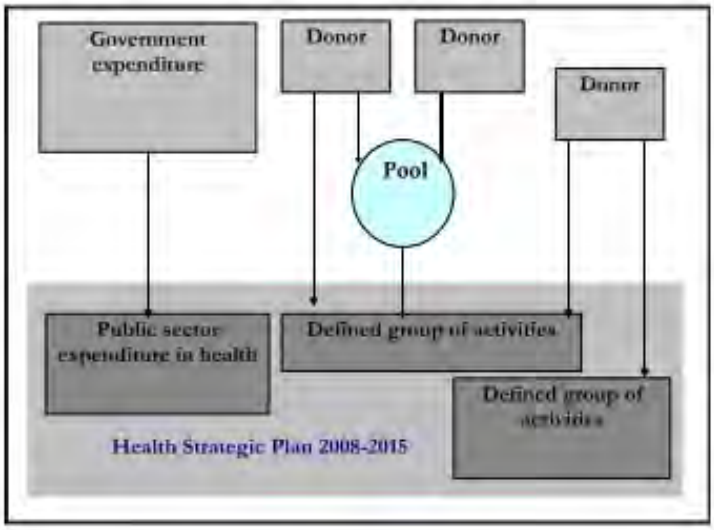
The Cambodian government and the aid organizations have executed the Joint Partnership Arrangement (JPA) to facilitate the implementation of the HSSP2, which specifies the roles

[11] MOH (2008) , Health Strategic Plan 2008-2015

of each organization, annual plans and contributions, and under which the JPA Development Partner Interface Group (JPAG) is organized as a coordinator among the organizations concerned.

The funds from the aid organizations consist of those contributed through a pool fund and those contributed by each organization directly, as shown in FigureⅧ-7. FigureⅧ-8 shows the financing plan of the HSSP2. According to the plan, the contribution amount of the Cambodian government is approximately USD11.4 million, which if equivalent to only 7.6% of the total contribution. This means that the funds are largely dependent on the aid organizations.

FiguresVII-7 Financing arrangements of the HSS2



Source: MOH (2008), OPERATIONAL MANUAL Second Health Sector Support Program.

FiguresVII-8 Financing plan of the HSSP2

Source	Note	Est. US$: Exchange Rate at the signing of agreement
AFD	2008-2013	10,000,000
AusAID	2009 to June 2011 (Future funding to be confirmed)	30,000,000
BTC	2009-2011	4,500,000
DFID	2009-2013	50,000,000
UNFPA	2009-2010 (Future funding to be confirmed)	8,867,000
UNICEF	2009-2010 (Future funding to be confirmed)	4,000,000
WB(IDA Caredit)	2009-2013	30,000,000
Royal Government of Cambodia	-	11,400,000
Grand Total		148,767,000
Source	Pooled Fund(US$)	
MDTF※ (may increase)	52,092,675	
IDA(5years)	30,000,000	
UNICEF(2009)	539,000	
UNFPA(2009)	500,000	

Total Pooled Fund	83,131,675	

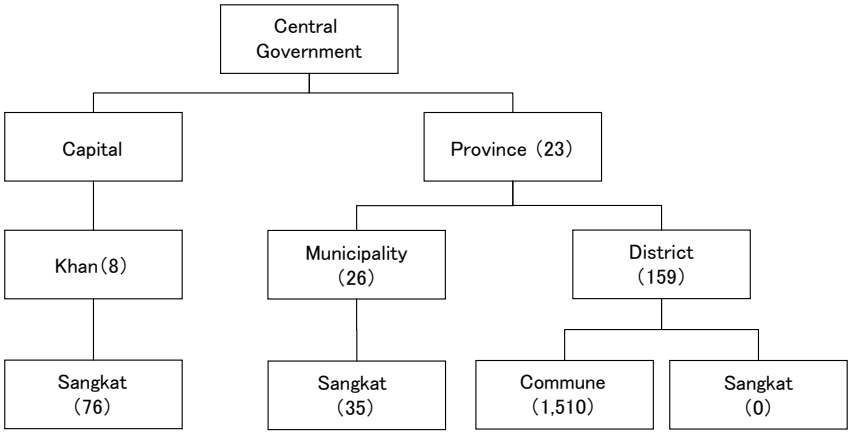
*Multi-donor trust fund by the DfID and the AusAID.
Source: MOH (2009), 2009 Annual Performance Monitoring Report.

4.2. Salient features of health care delivery systems

The Cambodia's administrative divisions consist of four levels, as shown in FigureⅧ-9. The capital (Phnom Penh) and "provinces" are organized under the central government. The capital has "khans" and "sangkats". Provinces are subdivided into "municipalities" and "districts". Municipalities and districts are further divided into sangkhats and communes, and then further divided into villages. Villages are not administrative bodies but a kind of neighbourhood associations[12]. Under the HSP2, it is planned to develop referral hospitals at a province/capital and district/municipality/district level, and health centers at a sangkat/commune level.

Apart from these administrative divisions, an Operational District (OD) is formed as a minimum unit of health care delivery systems, according to areas, populations, economic scales and public health care delivery. The HSP2 divides 24 municipalities/provinces[13] into 10 ODs as of 2007 and plans to form 90 ODs in total through 2015. The HSP2 expects 24 referral hospitals, 957 health centers and 95 health posts (HP) as of 2007, and 99 referral hospitals and 1,697 health centers as of 2015.

FiguresVII-9 Local administrative bodies in Cambodia[14]



*The figures in parentheses are based on those as of the local election in May 2009.
Source: Yutaka Oinuma, "New local administrative system of the Kingdom of Cambodia", State-owned enterprises (2009.11).

FigureⅧ-10 shows the facility standards of the Health Coverage Plan (HCP) which is prepared based on the population forecast (1998-2020) by the MOP in 2004. Based on this, it

[12] "Local authorities in Cambodia", Councils of Local Authorities for International Relations"
[13] Before the revision of the Constitution in 2008, it consisted of 20 provinces and 4 municipalities without a capital.
[14] Local administrative divisions under the Law on Administrative Management of the Capital, Provinces, Municipalities, Districts and Khans" promulgated in 2008. At the time of the local election in May 2009, there was not sangkat under a province.

is planned to be one referral hospital per 100,000 to 200,000 persons and one health center per 10,000 persons. The Complementary Package of Activities (CPA) and the Minimum Package of Activities (MPA) which are the standards of facilities have three levels respectively in descending order of functions (CPA1, CPA2 and CPA3 or MPA1, MPA2 and MPA3).

The standards of the CPAs and MPAs are still much lower, in comparison with the HCP [15].

FiguresVII-10 Facility standards under the HCP

Criteria	(1)Population	(2)Accessibility
Health Center (HC)MPA	Optimal：10,000 Vary：8,000-12,000	Radius：10 km or Max. 2 hrs walk
Referral Hospital (RH)CPA	Optimal：100,000-200,000 Vary：60,000-200,000	20-30 km between 2 RHs or Max. 3 hrs by car/boat

Source: MOH (2008), Health Strategic Plan 2008-2015.

4.3. Basic structure of the health security system

There is no nationwide comprehensive health security system in Cambodia, but individual initiatives by the government and NGOs are taken for the poverty. The HEF is a health security service for the poverty which accounts for about one-third of the total population of the country, by which any household which is certified as the poverty through the identification system may receive free health care services at designated medical institutions.

FiguresVII-11 Health security system in Cambodia

	CBHI	**HEF**
Started	Year 1998	Year 2000
Sub-Decree	Sub-decree on Micro Insurance Business	Sub-decree on subsidies for the poor (Prakas #809)
Competent authority	MOH(Operation) MOEF(Finance)	MOH(Operation) MOEF(Finance)
Administration organization	NGOs	Royal government of Cambodia ・NGOs
Model	Contribution scheme	Non-contribution scheme
Entry Obligations	Option	Option
Target group	(Mainly)The informal sector which is near to the poor	Poor Level 1、Poor Level 2
The number of the members	Approximately 140 thousand(Year 2010)	Approximately 3.3 million(Year 2010)
Reward system	Capitation(Fee for Service and case-base payment are possible, too)	Capitation(Fee for Service and case-base payment are possible, too)
Referral system	None	None
Out of pocket	None	None
Budget per capita(Case of Capitation)	Approximately 5.0 US＄(Year 2010)	Approximately 2.1 US＄(Year 2010)

[15] MOH (2008) , Health Strategic Plan 2008-2015

	CBHI	HEF
Health expenses expenditure(Annual)	Approximately 0.7 million US$ (Year2010)	Approximately 7.0 million US$ (Year2010)
Covered by warranty (Direct Benefit)	Transportation costs upon referral, Transportation cost from home to health centre・Funeral grant(conditional) .etc	Health services, transport costs, Extra food, grants
Covered by warranty (Indirect Benefit)	Strengthening the quality of health care provided, Health education, Administrative costs, Training costs, Reserve funds .etc	Pre-Identification, Pay for training the network of community volunteers, Management and improvement of schemes costs

The CBHI is a social insurance scheme for the informal sector which is a litter wealthier than the poverty. The CBHI is managed by NGOs and micro-finance institutions. The insured of the CBHI is required to pay the monthly contribution and in return may receive free health care services at designated medical institutions. The health insurance scheme for private sector employees and civil servant is now under consideration.

4.4. Health Equity Fund (HEF)

4.4.1. Outline of the HEF

The MOH started designing the HEF around 2002 and implemented it under the HSSP1 covering a period from 2004 to 2008. The HSSP1 was implemented by the SWiM, with collaboration of the ADB, the WB, the DFID and the UNFPA, same as the HSSP1. In the Health Sector Review (HSR) of 2007 which intended to evaluate the progress of the HSP1 (2003-2007) and the HSSP1 (2004-2008) and to determined the policies in the subsequent plans, i.e. the HSP2 (2008-2015) and the HSSP2 (2009-2013), the HEF was evaluated that it would contribute to more opportunities for the poverty to receive health care services and reduced poverty caused by health issues as well as it would be cost effective[16]. As of 2010, the coverage of the HEF is approximate 3.3 million persons[17] (equivalent to 24% of the total population) and 57 ODs (of 79 ODs)[18].

4.4.2. Four groups under the HEF

The HEF have been managed by the funds mainly from aid organizations. In 2008, the MOH and the MOEF issued the Parakas No. 809 to grant government subsidies to national hospitals and the Operational Districts Offices (ODOs). The current HEF is mainly grouped into four schemes according to the financial resources, as shown in FigureⅧ-12. Groups 1 and 2 are granted subsidies from the government. While Group 1 are national hospitals, Group 2 are those operated by ODOs. Groups 3 and 4 are the conventional types that are mainly financed by aid organizations. While Group 3 is required to obtain prior approval

[16] MLSP (2007), Health Sector Review(2003-2007)
[17] Dr.Sok Kanha , DPHI MOH(2010),Health System and Health Financing Development in Cambodia
[18] http://www.cbhi-cambodia.org/hef.php

from the MOH and receive funds through the MOH, Group 4 receives funds not through the MOH. However, even Group 4 is required to submit quarterly reports. This indicates the government's intention to centralize the HEF which has been individually operated.

The salient features of the groups which receive subsidies from the government are a limited scope of direct and indirect benefits, compared to the other two groups. While Groups 3 and 4 cover transportation and meal for patients, and other necessary goods and nursing care (direct benefits), and prior identification and administrative expenses for provision of public health care services to poor patients (indirect benefits), Groups 1 and 2 do not cover indirect benefits. Given that the HEF guideline prepared by the MOH defines that the HEF is applicable to indirect benefits, a limited scope of Groups 1 and 2 should be reviewed.

FiguresVII-12 Four groups under the HEF

	Group 1	Group 2	Group 3	Group 4
Scheme Type	SUBO	SUBO	HEFI※ or HEFO	HEFI or HEFO
Scheme's Responsible	National Hospital Director	Operational District Office Director	HEFI Manager Unless otherwise (see MOH contract)	The Manager of the agency;
3rd party player	no	no	yes	yes
Funding Source	National Budget (Prakas #809)	National Budget (Prakas #809)	Non-pooled funding from at least one donor via MOH	Funding not via MOH
Direct Benefit Package	As defined in Inter ministerial Decrees: delivery of public health service outputs to poor patients	As defined in Inter ministerial Decrees: delivery of public health service outputs to poor patients	1. Delivery of 2. 1. Health service to poor patients as defined in MPA, and CPA 2. Transport costs, Food and other items that directly benefit the poor patient, 3. Appropriate Tertiary care.	1. Delivery of 1. 1. Health service to poor patients as defined in MPA, and CPA 2. Transport costs, Food and other items that directly benefit the poor patient, 3. Appropriate Tertiary care.
Indirect Benefit Package	none	none	Pre-Identification and community representation in supervision of public health service delivery and to poor patients in particular	Pre-Identification and community representation in supervision of public health service delivery and to poor patients in particular
Post-Identification system	MOH model	MOH model	MOH model(unless otherwise stipulated in the contract)	MOH model(unless otherwise stipulated in the contract)
Pre-Identification system	MOP model	MOP model	MOP model	MOP model
Accountable for use of funds to:	MOH	MOH	MOH	Donor
Before the	MOH-DPHI	MOH-DPHI	MOH-DPHI	Quarterly reports

	Group 1	Group 2	Group 3	Group 4
Scheme starts, approval from:				to MoH DPHI: plans, starting dates and the progress through the standard Quarterly Reporting;

※HEFI : Health Equity Fund Implementer
Source:MOH(2008),Guideline for Implementation of Health Equity Funds and Government Subsidy Schemes

4.4.3. Identification system

The HEF requires procedures to identify the poverty, as it is health security for the poverty. For this purpose, the pre-identification system and the post-identification system are formed. The pre-identification system which is based on the poverty household identification program "ID-Poor" intends to identify the poverty before visits through questionnaires and discussion at a community level. On the other hand, in the post-identification system which intends to compensate the pre-identification system, the Health Equity Fund Operator (HEFO) or the Subsidy Operator (SUBO) will identify the poverty upon visits in a simplified manner. The information collected through the post-identification system will be forwarded by the HEFO and the SUBO to the Commune Council to improve the coverage of the pre-identification system.

4.5. Community Based Health Insurance (CBHI)

4.5.1. Eligibility of enrollment

In Cambodia, the CBHI has been operated as a community-based non-profit health insurance scheme mainly by NGOs since it introduction in 1998. The CBHI targets mainly the poor in the informal sector which is not covered by the HEF and can afford the contribution. The insured of the CBHI will pay the monthly contribution and in return may receive free health care services at designated medical institutions. The CBHI is a voluntary scheme. The target group is not limited to the informal sector, and employees of the formal sector may also enroll in the CBHI. The guideline states that the formal sector employer of an employee who enrolls in the CBHI should bear 50% of the contribution [19].

4.5.2. Financial resources

The main income sources of the CBHI are the contributions paid by the insured as well as funds from aid organizations, and donations by individuals and businesses. The CBHI is allowed to use these fund not only to provide health care services but also for transportation upon referral or from home, funeral (with conditions), improvement of health management quality, health education, administrative works, trainings and reserves. The CBHI is required to allocate medical fee paid at contracted medical institutions as follows: 39% to operating expenses, 60% to staff salaries and 1% to taxes. For the HEF, medical fee is required to be

[19] DPHI(2006), Guideline for the Implementation of Community Based Health Insurance, Department of Planning and Health Information

allocated 40% to operating expenses and 60% to staff salaries, and tax is exempted.

FiguresⅧ-13 and Ⅷ-14 show the monthly contribution rates of "SKY" which is a major CBHI project operated by a French NGO Groupe de Recherches et d'Echanges Technologiques (GRET). The average annual contribution is USD4 in rural areas and USD9 in urban areas. As of 2011, the total number of the insured of the CBHI is 270,000 (Figure Ⅷ-15), which accounts for 2% of the total population.

FiguresVII-13 Monthly contribution in rural areas (SKY) (Unit: KHR)

Family Size	Old Zone	New Zone
1 person	2,500	4,000
2-4 persons	5,500	7,500
5-7 persons	7,500	9,500
8＋ persons	9,000	11,000

※1RIEL(KHR)=0.020JPY
Source: ILO, SKY HEALTH INSURANCE SCHEME.

FiguresVII-14 Monthly contribution in urban areas (SKY) (Unit: KHR)

Family Size	Informal	Semi Formal	Formal
1 person	8,000	12,000	18,000
2-4 persons	12,000	16,000	24,000
5-7 persons	16,000	20,000	28,000
8＋ persons	20,000	22,000	32,000

※1RIEL(KHR)=0.020JPY
Source: ILO, SKY HEALTH INSURANCE SCHEME.

4.5.3. Operational bodies

Under the Sub-Decree on Micro Insurance Business issued by the MOEF and the MOH, an operational body of the CBHI is required to obtain a certificate from the MOH and submit a business plan to the MOEF for registration[20]. Like the HEF, this indicates the government's intention to the CBHI which has been individually operated.

[20] Government of Cambodia (2009), CBHI Section of 2008 National Health Financing Report for Cambodia

FiguresVII-15 List of projects under the CBHI (2011)

	Started	Province/Municipality	OD	Members	
GRET (SKY)	1998	Kandal	1 OD	961	
	2001	Takeo	5 ODs	38,178	
	2005	Phnom Penh	1 OD	10,661	
	2008	Kampot	1 OD	25,755	
CAAFW	2005	Banteay Meanchey	1 OD	44,264	
	2009	Odor Meanchey	1 OD	32,128	※1
BFH	2006	Takeo	1 OD	10,885	※2
AFH	2010	Kompong Thom	1 OD	10,774	※2
CHO	2009	Battambong	2 ODs	7,046	
CHSFA	2010	Pusat	2 ODs	3,566	
RACHA	2010	Prey Veng	1 OD	6,607	
CHC	2011	Siem Reap	1 OD	4,477	
STSA	2011	Siem Reap	1 OD	74,727	
Total	-	11/24(41.7%)	18/79(22.8%)	270,029	

※The number of the insured is as of April (※1), October (※2) or September (others).
Source: Compiled by Mitsubishi UFJ Research and Consulting based on http://www.cbhi-cambodia.org/ (Accessed in March 2012).

4.6. Coverage

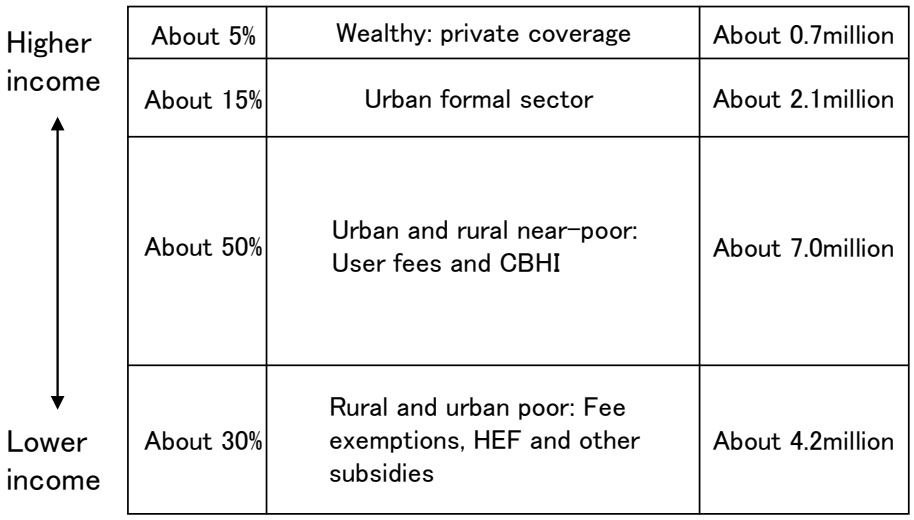
FigureⅧ-16 shows the population composition according to the income level as of 2012. The population under the poverty line is expected to amount to 4.2 million, which accounts for 30% of the total population of the country (14 million as of 2010). Other components include 50% (7.0 million) of the informal sector excluding the poverty, 15% (2.1 million) of the formal sector in urban areas and 5% (0.7 million) of the wealthy (all figures are estimate).

Supposing the target groups of the HEF and the CBHI are 30% of the poverty and 50% of the group new the poverty line, the coverage will be 78.6% for the HEF or 3.9% for the CBHI respective [21].

In Cambodia, those who become sick or get injured will not only lose their jobs but also sell their assets to pay medical fee, as a result of which they tend to drop from the "near-the-poverty-line" to the "poverty". Given that the CBHI intends to prevent such a situation, it is required to increase the coverage of not only the HEF but also the CBHI.

[21] On a population basis, the coverage is 3.3 million for the HEF (2010) and 0.27 million for the CBHI (2011).

FiguresVII-16 Population composition according to the income level (2010) [22]



4.7. Role of private health insurance systems and recent trends

In Cambodia, the Asia Insurance Group and other private insurance companies sell health insurance products as part of various non-life insurance products. However, their customers are limited to foreigners and part of the wealthy due to a higher price.

For example, the annual contribution amount of the "Fig Tree Blue" sold by FORTE Insurance having three offices in Phnom Penh, Siem Reap and Battambang is USD770 for the cheapest "Standard" plan and USD2,020 for the "Super plus Out-Patient" plan covering outpatient treatment (as of February 2011) [23]. Given the GNI per capita of Cambodia in 2010 is approximately USD750 [24], ordinary people should not afford.

[22] Complied by Mitsubishi UFJ Research and Consulting based on (1) Cambodia: Developing a Strategy for Social Health Protection, P.18 (2) Dr. Sok Kanha, DPHI, MOH (2010), Health System and Health Financing Development in Cambodia (3) Jean-Claude Hennicot, Social Protection Expenditure and Performance Review (SPER) & Social Budgeting in Cambodia.
[23] FIG TREE BLUE PREMIUM TABLE(Effective 1st February 2011)
[24] WB , World Development Indicators & Global Development Finance

5. Pension and other income security schemes

5.1. National Social Security Fund (NSSF)

The NSSF established in 2007 is a social security fund for the private sector employees. While NSSF plans to implement employment injury, health and pension insurances, it currently provides employment injury insurance (including disability and survivor pensions) only.

5.1.1. Legal basis

The relevant laws include the Labor Law promulgated in 1997 and the Law on Social Security Schemes for Persons Defined by the Provisions of the Labor Law (the "Social Security Law").

In March 2007, the Sub-Decree on the Creation of the National Social Security Fund was issued to establish the NSSF.

5.1.2. Benefit package [25]

Any accident which occurs during work or working hours is qualified as a work related accident, regardless of whether or not a salary is paid. Any accident during transportation from home to an office is also qualified. Work related accidents include not only injuries but also diseases related to work.

The benefit is 70% of the average wage for six months before an accident. In a severe case, 50% of care taker cost is also paid. The benefit period is 180 days at maximum. To be qualified as a work related accident, its effects must remain for at least five working days. Otherwise, a normal wage will be paid for a period of 4 days or less.

When the insured temporarily suffers any physical disability, a per diem will be paid. The per diem is paid until the relevant disability is cured or the insured dies due to the relevant sickness or injury. In the case where less than 20% of the physical capabilities is lost, the disability benefit will be paid. In the case where 20% or more of the physical capabilities is lost, the permanent physical disability pension will be paid. In the case where the insured fully loses capabilities of working and requires permanent nursing cares from others, 50% of pension will be paid.

In the case where the insured dies, the funeral cost (1,000,000 KHR) and the survivor pension will be paid. The parents of the dead insured are entitled to the survivor pension for life. The spouse of the dead insured is entitled to the survivor pension, for life, or until he/she gets remarried and his/her child reaches the age of 18 (if going to a university, the age of 21) or gets married.

[25] http://www.nssf.gov.kh/

5.1.3. Eligibility of enrollment and contribution rates

Under Article 4 of the Social Security Law, The NSSF covers "all workers defined by the provisions of the Labor Law", "state workers and any persons engaging in public works who are not governed by the Common Statue for Civil Servants or the Diplomat Statue", "any persons who are temporarily engaging in public services", "trainees who are attending in rehabilitation centers", "persons wok in self-employed profession", and "seasonal or occasional workers", regardless of nationality, race, gender, religion, political opinion, blood, social origin, membership of a trade union or act in a trade union.

The NSSF is currently applicable to an employer having at least eight employees. The contribution which is 0.8% of the average monthly salary (before tax) (not less than 1,600 KHR but not exceeding 8,000 KHR) is borne by an employer. The monthly salary include a salary, overtime pay, remuneration and gratuity.

Pursuant to the Prakas dated June 29, 2009[26], the contribution rate of the sewing and shoemaking businesses were temporarily reduced to 0.5% (0.3% borne by the government) due to the global economic downturn, which has been returned to 0.8% since January 2011[27].

5.1.4. Funds and operational bodies

The NSSF is a public organization under the control of the MOLVT for operations and the MOEF for finance. Its head office is located in Phnom Penh.

5.1.5. Enrollment figures

As of the end of 2010, the number of the employers registered in the NSSF is 1,910 and the number of the insured (membership) is 594,686[28] (however, the number of the insured that pays the contribution (active contributors) is estimated to be 480,446[29]). Approximately 90% of the insured is those who work in the sewing and shoemaking businesses[30], and the ratio of women amounts to 80% (Male: 386,678, Female: 93,768).

5.1.6. Actual benefit payments

In 2010, the total amount of the contributions of 14,366 million KHR, and the total amount of the benefit payments is 2,423 million KHR. These figures are equivalent to USD3.6 and USD0.6 respectively[31].

The total amount of operating cost of the NSSF for the same period is 1,930 million KHR, and the total amount of investment cost (including depreciation) is 727 million KHR[32].

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[26] Prakas #133 (MOLVT) on Payment of the Occupational Risk Contribution by the Garment and Shoe Enterprises and Establishments for the Year 2009-2010
[27] Notification #132 (MOLVC) on Employment Risk Contribution Payment of Garment and Footwear for 2011
[28] KINGDOM OF CAMBODIA,NSSF Organization Profile
[29] http://www.ilo.org/dyn/ilossi/ssimain.updSchemeAffiliation?p_lang=en&p_geoaid=116&p_scheme_id=2898&p_social_id=2330
[30] ILO(2010), Cambodia: Moving forward toward Better Social Security
[31] Converted based on USD1 = 4,000 KHR.
[32] http://www.ilo.org/dyn/ilossi/ssimain.updSchemeAffiliation?p_lang=en&p_geoaid=116&p_scheme_id=2898&p_social_id=2330

5.2. National Social Security Fund for Civil Servants (NSSF-C), National Fund for Veterans (NFV)

The NSSF-C is a social security fund for civil servants and their dependent families which was established in January 2008 under the Royal Decree and has been implemented since May 2009. While the NSSF-C intends to reform social security for government offices fully financed by tax revenues to the contribution scheme requiring the collection of the contribution, it is still operated based on the non-contribution scheme. The NSSF-C also covers pensions. A research to add the health insurance has been performed with support of the GTZ since 2010 [33].

The NFV is a national fund established under the Royal Decree promulgated in July 2010 which covers soldiers, state police officers under the Ministry of Interior (MOI) and veterans (including citizens who registered as solders during war). The benefit package of the NFV includes employment injury and pensions. The NFV plans to be shift to the social insurance system in future [34].

5.2.1. Legal basis

The relevant legislations of the NSSF-C include the Royal Decree on Social Security Scheme for Civil Servants issued in January 2008 and the Sub-Decree on the Establishment of National Social Security Fund for Civil Servants issued in February 2008.

The relevant legislations of the NFV include the Royal Decree on The Social Safety Net for Veteran issued in July 2010 and the Sub-Decree on Establishment of National Social Security Fund for Veterans.

5.2.2. Benefit package [35]

The NSSF-C covers employment injury and pensions. The employment injury scheme covers sickness and injuries related to work, under which medical services and cash benefits are provided until cure. Permanent disabilities are entitled to the disability pension, and temporary disabilities of working are compensated by full payment of a salary. In case of death, the survivor pension is paid. The amounts of the old-age pension and the disability pension are 63% and 57% of the average salary. According to the estimate of the ILO, the amount of the survivor pension is 2% of the average salary of dead civil servants.

The NFV also covers employment injury and pensions. Under the employment injury scheme, medical services and cash benefits are provided to temporary (or permanent) disabilities. The amount of the long-term disability pension is 50 to 60% of the last salary. In case of death of the insured, benefits (e.g. cash benefits, funeral benefit and survivor pension) are paid to surviving families. The monthly amount of the survivor pension which a

[33] NIOS, MOP (2010), Labour and Social Trends in Cambodia 2010
[34] Jean-Claude Hennicot, Social Protection Expenditure and Performance Review Findings
[35] http://www.ilo.org/dyn/ilossi/ssimain.viewScheme?p_lang=en&p_scheme_id=3193&p_geoaid=116

spouse and a child of the age not over 16 is 6,000 KHR and 5,000 KHR respectively. The retired insured of the age of 55 or more and the service years of at least 20 years is entitled to the old-age pension, which is 60 to 80% of the total of the last salary and allowances. The retirement allowance is separately paid.

5.2.3. Eligibility of enrollment

The NSSF-C covers civil servants and their dependent families. The NFV covers soldiers, state police officers and veterans (including citizens who registered as solders during war).

Social security for civil servants is mostly covered by the NSSF-C and the NFV.

5.2.4. Contribution rates

The contribution rate of the NSSF-C is 24% of a salary, consisting of 18% of tax and 6% of employee's (civil servants') contribution.

However, as of 2010, the contribution is fully borne by tax.

5.2.5. Funds and operating bodies

Both the NSSF-C and the NFV are under the control of the MOLVT for operations and the MOEF for finance. Due to a transition period, it is still organization within the MOSAVY in administration.

5.2.6. State of coverage

The NSSF-C covers approximately 180,000 civil servants (including their families, approximately 675,000)[36]. In 2009, approximately 67,500 persons received the pensions, and there were approximately 4,500 of cash benefit payments. The total amount paid was approximately USD2.3 million.

For the NFV, as of 2010, approximately 199,000 persons received the pensions, the total amount paid was USD1.9 million[37].

5.3. Savings schemes and other forms of social security (including those targeting the informal sector)

Cambodia has no other saving schemes at the moment.

5.4. Unemployment insurance

Cambodia has no unemployment insurance at the moment.

[36] Valerie Schmitt, ILO (2011), Cambodia's National Social Protection Strategy
[37] Jean-Claude Hennicot, Social Protection Expenditure and Performance Review Findings

6. Social Welfare System and Community-based Assistance schemes

6.1. Development of databases to identify local-income populations

6.1.1. Outline of databases

In Cambodia, the poverty household identification program "ID-Poor" is operated jointly by the MOP and the Department of Local Administration (DPLA) to identify the poverty households [38].

The program aims at establishing a standardized mechanism to identify the poverty households and disseminating it throughout the country. As mention earlier, in the NSPS, the "ID-Poor" plans to be utilized as a targeting tool for all social protection policies, which is the important base of social protection policies in future.

6.1.2. Targeting process

The key point related to the targeting process of the "ID-Poor" is the initiatives of representatives of communes and villages. This is for improving community capacity and sustainability. Village people are encouraged to participate in discussion in order to improve process transparency and targeting accuracy.

The targeting process consists of the following seven steps.

FiguresVII-17 Targeting process of the "ID-Poor"

	Process
Step1	・Establish and train the Planning and Budgeting Committee Representative Group (PBCRG) at the commune level.
Step2	・Establish and train Village Representative Group (VRG)
Step3	・VRG compiles List of Households in the Village , conducts household interviews , considers special circumstances of households. ・Commune Review Meeting , compiles and publicly displays the First Draft List of Poor Households in the village.
Step4	・VRG conducts Village Consultation Meeting on First Draft List of Poor Households, receives villager complaints, prepares and displays Final Draft List of Poor Households, and submits the List to the Commune Council.
Step5	・Commune Council reviews and approves Final List of Poor Households, sends data to Provincial Department of Planning
Step6	・Provincial Department of Planning enters all data into Provincial Database of Poor Households
Step7	・Photography of poor households ・Distributes Equity Cards to poor households

Source: Complied by Mitsubishi UFJ Research and Consulting based on MOP (2008), Implementation Manual on the Procedures for Identification of Poor Households.

The salient feature of the process in FigureⅦ-17 is its two-level structure of objective

[38] http://www.mop.gov.kh/Projects/IDPoor/tabid/154/Default.aspx

survey and community-level discussion. The interview at Step 3 is mainly in a form of questionnaire based on designated items with selective answers each of which is a score is specified for totalization. This enables to perform objective evaluation, as shown in FigureⅦ-18. The questionnaire also includes some questions without a score to identify specific situation of each household.

The process involves commune review meetings at Step 3 and discussion with village people at Step 4 to consider special situation of each household which cannot be evaluated only with the scores in FigureⅦ-18. This contributes to qualitative evaluation.

The questionnaire consists of fifteen questions, including eleven items with scores such as "asset status (e.g. own house or not, materials of roof and wall, and transportation means)", "income source (e.g. business, and livestock and fishing goods owned)", and "household composition (e.g. number of infants, elderly and income earners)," and four items without a score such as "any serious issue which has made lose income, lack of food, sale of assets, borrowing money in the past twelve months", "absence of children of the age between 6 to 11 from school for one month or more in the past twelve months", and "any assistance from relatives in the past twelve months".

FiguresVII-18 Evaluation based on the score

Poor Level 1	59-68 points
Poor Level 2	45-58 points
Other	0-44 points

Source: MOP (2008), Implementation Manual on the Procedures for Identification of Poor Households

Another feature is a series of evaluation process mainly at a community and village level. The Provincial Facilitation Team (PFT) and the District Facilitation Team (DFT) provide training to representatives but are not directly involved in evaluation. Interview, discussion and preparation of list are fully done at a commune and village level. This is based on the important perspective of the "ID-Poor" that is improvement of local capacity and system sustainability.

6.1.3. Data updates

According to the manual, the database is to be updated every two years, and the PFT and the DFT are to send trainers to give guidance to commune and village representatives before updating.

It is recommended to replace at least two-thirds of the VRG members each year so that accumulated know-how should be transferred smoothly. This is to ensure the accuracy of the database.

6.1.4. Range of database utilization

In 2011, the Sub-Decree on Identification of Poor Households plans to be promulgated to

form a legal basis to avoid overlapping with similar databases. The Sub-Decree is expected to appoint the MOP as the exclusive government agency which has the responsibilities and authorities of poverty household identification management, to specify the "ID-Poor" as the national standard system, and to mandate all service providers in any regions where the "IP-Poor" is available to use the "ID-Poor" as a targeting tool.

6.1.5. International cooperation

The "ID-Poor" is developed with technical assistance of the GIZ, and financial assistance of the German government, the EU, the AusAID, the UNICEF and the Cambodian government. In 2009, a trust fund to support the MPSP was established by the WB, the DFID and the MOP, which is used to disseminate the "ID-Poor". A cover rate of December, 2011 is overall approximately 25% including the urban area. [39]

6.2. Social assistance systems

In Cambodia, there is not permanent social assistance system.

However, there are some scholarship programs for children of the poverty, which are supported by international aid organizations.

The current programs include the Japan Fund for Poverty Reduction (JFPR) since 2002 and the Education Sector Support Project since 2005. These programs are a kind of conditional cash transfer (CCT), because regular school attendance (less than 10 days of absence in a year without "due reason") and maintaining a passing grade are conditions.

6.3. Community-based assistance schemes

No scheme or program is identified in this survey.

6.4. Other social welfare and community-based initiatives

6.4.1. Programs by the MOSAVY

The programs by the MOSVAY include support centers for food support to the poverty (e.g. natural disasters) and orphans, and circulating clinics for PWDs.

Under the orphan support center, over 150 offices are operated by the MOSAVT, and international and domestic NGOs which provide food support, formal or informal education and job trainings. The circulating clinics for PWDs provides services to PWDs in local areas who cannot go to rehabilitation centers or health centers, in collaboration with NGOs.

6.4.2. Rehabilitation programs for PWDs

The rehabilitation programs for PWDs include Physical Rehabilitation Centres (PRC) by the Handicap International - Belgium (HIB) and the Capacity Building of people with Disabilities in the Community (CABDIC), both of which provide rehabilitation services.

[39] From the interview the JICA Cambodia officer in charge of ID-Poor.

In Cambodia, the initiatives to protect the interests of PWDs is reinforcing, including the promulgation and enactment of the Law on the Protection and the Promotion of the Rights of Persons with Disabilities in 2009 [40].

[40] Kenji Yotsumoto, Asia Study World Trend No.181 (2010), The challenge is achieving effective right security ~ Cambodia

7. Care and Welfare for the Elderly

In Cambodia, the pension scheme for the poverty is not yet developed, and poor elderly who lives alone is one of the social issues. However, in fact, “It is common in Cambodia that the elderly without any family lives in temples located throughout the county.” The elderly issue obtains less attraction from international aid organizations, compared to orphans and UXO, no notable initiative is observed, except for minor ones by a domestic body in urban areas such as Phnom Penh [41].

The initiatives for elderly welfare are very limited, compared to other areas such as local development, health and education.

The pension scheme has NSSF-C for public employees and NFV for veterans. In NSSF for the private sector employees, the start of the pension scheme is planned from 2015.(Cf.Ⅷ-20 pages)

[41] Katsufumi Urushibara, Overseas social security study, Spring2009 No.166, New developments of PWD welfare in Cambodia

8. Issues Facing Social Security in Cambodia

8.1. Issues facing the health security system

8.1.1. Dissemination and extension of the health security system, improvement of the quality of medical services

Currently, the HEF and the CBHI are operated as the health social schemes mainly for the poverty, their coverage against the total population is not high (HEF: 78.6%, CBHI: 3.9%). The coverage of the CBHI is especially low due to the monthly contribution. Given that the CBHI contributes to prevention of drop from the "near-the-poverty-line" to the "poverty", its dissemination and extension would be the key challenge.

Another important challenge is improvement of the quality of medical services which is far away from the plan.

8.1.2. Equalization of health security schemes

The services under the HEF and the CBHI are not standardized due to different operating bodies.

Especially for the HEF, the scope of benefits of the schemes operated by the government is limited in comparison of those operated by NGOs, and the benefits vary according to regions or medical institutions. In addition, the pre-identification system and the post-identification are used in parallel to identify poverty households to be covered by HEF, which would cause inconsistencies of the standards of identification. In this regard, the coverage of pre-identification system is required to be improved.

8.1.3. Establishment of the health insurance system in the formal sector

Under the NSSF for private sector employees and the NSSF-C for civil servants, early maintenance of the health insurance is a preferential problem, because it is not yet maintained.

The NSSF is expected to introduce the health insurance scheme in 2012 (and the pension scheme in 2015) [42]. This new scheme will cover medical services (both inpatient and outpatient), and cash benefits for sickness and childbirth, but it is not uncertain to cover families too [43].

8.1.4. Breakaway from dependence on external funds

In Cambodia, various projects are currently developed under the HSP2. The Cambodian government contribution to the HSP2 is only USD11.4 million or 7.6% of the total budgets, and the projects are largely dependent on financial supports from aid organizations.

[42] Jean-Claude Hennicot, Cambodia, Social Protection Expenditure and Performance Review Findings
[43] http://www.ilo.org/dyn/ilossi/ssimain.updSchemeExpenditure?p_lang=en&p_geoaid=116&p_scheme_id=2898&p_social_id=2330

Breakaway on external funds is also one of the key challenges to establish the self-sustained health security system.

8.2. Issues facing the income security for workers

8.2.1. Extension of the coverage to employees of private enterprises

The NSSF is currently mandated only to an employer having at least eight employees, and in fact not all applicable employers join the system. While the NSSF plans to extend to health insurance and pensions, it currently covers employment injury only. The in-kind benefit package for employment injury is also insufficient, including limitation of medical institutions available.

As a small-size employer having less than eight employees is also governed by the Labor Law, it is required to prove employees with certain benefits such as wage during maternity leave, working hours and holidays. However, security under the Labor Law is not sufficient, as “the minimum wage is specified only for the sewing business” and “an employer is not obliged to pay wage to an employee during sick leave”.

While the NSSF forms a base to develop social security for private sector employees, the future challenge is to extend its coverage.

8.2.2. Extension of the coverage of social security for government employees and transition to the contribution scheme

The NSSF-C and the NFV plan to reform social security for government office financed by tax revenues to the contribution scheme, which is in a transition period. While these two systems cover employment injury and pensions, the inclusion of health insurance is still under consideration.

Unlike the NSSF for private sector employees, the NSSF-C and the NFV cover almost all civil servants, but their transition to the social insurance system is not in progress. The key challenges should be to shift the existing pension and employment injury schemes to the social insurance system as well as to extend the coverage to health insurance.

9. The priority issues that you should work on in Cambodia

In Cambodia, expansion of the coverage of each system is just going to be hurried in both sides of health security system and income security system. However, in particular about a health security system, its dependence to the external fund is as high as about 40% in the present condition, it has not become independent system of Kingdom of Cambodia itself. Moreover, it has the influence of the longstanding civil war and it is in the situation where the quality and quantity of the health service (e.g., the number of doctors or the equipment level of health facilities) are behind as compared with neighboring nations. It can be said that it is the greatest problem that the base for well-developed social security such as people, materials and money is vulnerable.

Therefore, in addition to aiming at expansion of the coverage of each system, it is quite important that the investment for enhancement of stocks, such as human resource development and facility improvement. It is expected that the social security system for the formal sector which is certain income level (NSSF and NSSF-C) shift to a contribution scheme in terms of financial independence. Furthermore, about the informal sector, improvement of ID-Poor could be mentioned as an important issue from a viewpoint of an effective and efficient investment. In the case of the development of the health security system of Cambodia, SWiM in which multiple donors participate is proceeding with HSSP2, and several donors including GIZ are supporting the maintenance of ID-Poor. It is thought that the necessity of support of JICA in the field of social security system in a present stage is not necessarily high.